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BENEFICENCE VS AUTONOMY: STORIES OF NURSES WHO FACED PATIENTS' REFUSAL OF TREATMENT

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Abstract

Patients' refusal of treatment places nurses between the ethical principles of beneficence and patient autonomy, often evoking emotional and professional strain. This study aimed to explore and understand the experiences of 14 nurses from a primary hospital in Tagum, Davao del Norte. Using Colaizzi's (1978), trustworthiness of the study was established through verification and validation. A purposive sample of 14 staff nurses was interviewed using a semi-structured interview. Methodological rigor was maintained using data triangulation and member checking to verify participant perspectives. This approach strengthened the internal validity of the study's conclusions. Results revealed that nurses navigating treatment refusal experienced profound emotional and ethical tension marked by frustration and autonomy conflicts, utilized support systems and cognitive reframing as coping mechanisms, and gained insights centered on professional growth and ethical resilience. Overall, the findings show that treatment refusal is both emotionally demanding and professionally transformative for nurses. It is recommended that the nurses may prioritize active listening and empathetic communication when encountering treatment refusals, deliberately reframing these situations as opportunities to honor patient autonomy rather than personal failures, and engage regularly in peer debriefing and reflective practice to process emotional responses and build resilience.

Keywords: *Patients' Refusal of Treatment, Descriptive-Phenomenology, Tagum City*

Introduction

Nurses worldwide face significant challenges when patients refuse treatment, creating ethical dilemmas that affect care quality and professional well-being. Treatment refusal often leads to moral distress, burnout, and compromised care, with 23–38% of nurses reporting severe distress in such situations (Khezerloo et al., 2022). Cultural factors further complicate these cases, as nurses must balance respect for cultural beliefs with evidence-based practice (Pinho-Reis et al., 2023).

In the United States, treatment refusal is frequently linked to religious beliefs, distrust in providers, and financial concerns. About 31% of nurses encounter refusal weekly, especially in emergency and oncology settings (Williams et al., 2021). These situations raise documentation and legal concerns, and increasing sociopolitical polarisation has made politically motivated refusals more common, heightening moral distress among nurses (Rodriguez & Thompson, 2023).

Financial limitations, traditional healing beliefs, and family decision-making strongly influence the refusal of treatments in the Philippines. Nearly 42% of refusals are

due to the inability to pay (Santos & Ramos, 2022), and nurses often struggle when family wishes conflict with patient autonomy (Cruz et al., 2021). Workforce shortages—sometimes reaching ratios of 1 nurse to 50 patients—further hinder effective communication and consent processes (Mendoza & Fernandez, 2023).

Within the Davao Region, indigenous practices, religious diversity, language barriers, and uneven healthcare access shape treatment refusal patterns. Rural facilities report refusal rates as high as 28%, particularly among indigenous groups (Bautista & Torres, 2022). Limited staffing, with ratios of up to 1:40, restricts nurses' ability to engage in therapeutic communication, contributing to moral distress (Olayta & Santiago, 2023).

While a substantial body of literature exists, critical gaps remain. Research examining evidence-based interventions and communication strategies for treatment refusal is limited, nursing-specific perspectives are insufficiently represented, and interdisciplinary collaborations with social workers, chaplains, and cultural mediators remain underexplored. Consequently, there is an urgent need for studies that provide practical, nursing-led solutions (Zhang & Watanabe, 2023).

Methods

The researcher utilized a descriptive-phenomenological approach. Qualitative research involves collecting and analyzing non-numerical data to understand concepts, opinions, or experiences. Meanwhile, phenomenology is the study of structures of consciousness as experienced from the first-person point of view. The study was conducted at a primary hospital in Tagum, Davao del Norte. The participants of the study were the 14 nurses working at the hospital's wards. The participants were selected through purposive sampling and were subjected to an in-depth interview and a focus group discussion and were chosen through purposive sampling technique. The researcher utilized a researcher-developed interview guide as the study's research instrument. The primary data were sourced through in-depth interviews among nurses. To enhance the study's methodological rigor, the researcher provided a detailed account of the trustworthiness strategies employed to ensure data integrity. This included the use of member checking to validate participant perspectives, an audit trail to document the research process, and peer debriefing to mitigate individual bias. Furthermore, achieving data saturation confirms the depth and completeness of the findings. Given the researcher's multifaceted role in data collection and analysis, a dedicated section on reflexivity is crucial to acknowledge how their background and positioning may have influenced the interpretative process, thereby strengthening the overall credibility of the research. As the primary research instrument, the researcher facilitated recruitment, conducted and transcribed interviews to elicit the participants' lived experiences, and performed the subsequent data analysis. Lastly, the data were analyzed using Colaizzi's seven steps. The transcripts of the interview were read and reread one by one to generate the emergent themes and their cluster themes.

Results and Discussion

Table 1 shows the profile of the participants. The study included 14 registered nurses from a primary hospital in Tagum, Davao del Norte, comprising seven participants in individual in-depth interviews (IDI) and seven participants in a focus group discussion (FGD). Most participants were females, aged 26 to 38, with 2 to 10 years of service.

Table 1. Participants' Profile

Code Name	Sex	Age in Years	Years of Service	Study Group
Participant 1	Female	30	7	IDI
Participant 2	Female	32	2	IDI
Participant 3	Male	27	4	IDI
Participant 4	Female	35	8	IDI
Participant 5	Female	29	5	IDI
Participant 6	Female	26	3	IDI
Participant 7	Female	30	6	IDI
Participant 8	Male	31	6	FGD
Participant 9	Female	33	9	FGD
Participant 10	Female	37	6	FGD
Participant 11	Female	36	10	FGD
Participant 12	Female	38	7	FGD
Participant 13	Male	37	8	FGD
Participant 14	Male	34	7	FGD

A total of 182 significant statements were derived from the 14 transcripts. Immediately after extracting significant statements from all participants' data sources, the researcher assigned meaning to participants' statements. Each formulated meaning was coded using the initials of potential cluster themes for its significant statement, yielding multiple formulated meanings. There were more formulated meanings than significant statements because some meanings fell into multiple thematic categories. Table 2 below illustrates examples of the development of formulated meanings from significant statements.

Emergent Theme 1: Encountering Emotional and Ethical Impact

This theme represents the complex internal responses nurses experience when patients decline recommended interventions. This theme also encompasses the range of feelings, from frustration and anxiety to empathy and helplessness, that arise when professional judgment conflicts with patient autonomy. Nurses described experiencing significant emotional turmoil, often questioning their effectiveness while simultaneously trying to understand patients' perspectives. These emotional responses reflect the deeply personal investment nurses have in patient outcomes and the psychological burden of witnessing potentially preventable deterioration in ealth status (Morrison & Sulmasy, 2021).

Cluster Theme 1.1: Feeling Frustrated and Worried

Initial emotional responses represent the immediate affective reactions nurses experience when first confronted with a patient's refusal of life-saving or health-promoting treatment. These reactions stem from the tension between professional knowledge of what could help the patient and the reality of being unable to implement that care. The participants said:

"I felt anxious and sad. I know he had chances of recovering only if he accepted the treatment." -- (T4, IDI-P4, L67-75)

"I felt pity and frustrated. I know it is just financial reason why the patient does not want to be treated." -- (T4, IDI-P7, L67-73)

"At first, I felt frustrated and worried. I thought, 'Why would he refuse something that could help him get better?' But at the same time, I tried to understand his point." -- (T4, IDI-P1, L112-125)

Nurses' initial frustration upon encountering treatment refusal is a natural response rooted in their professional identity and commitment to patient welfare. Research indicates that nurses experience significant

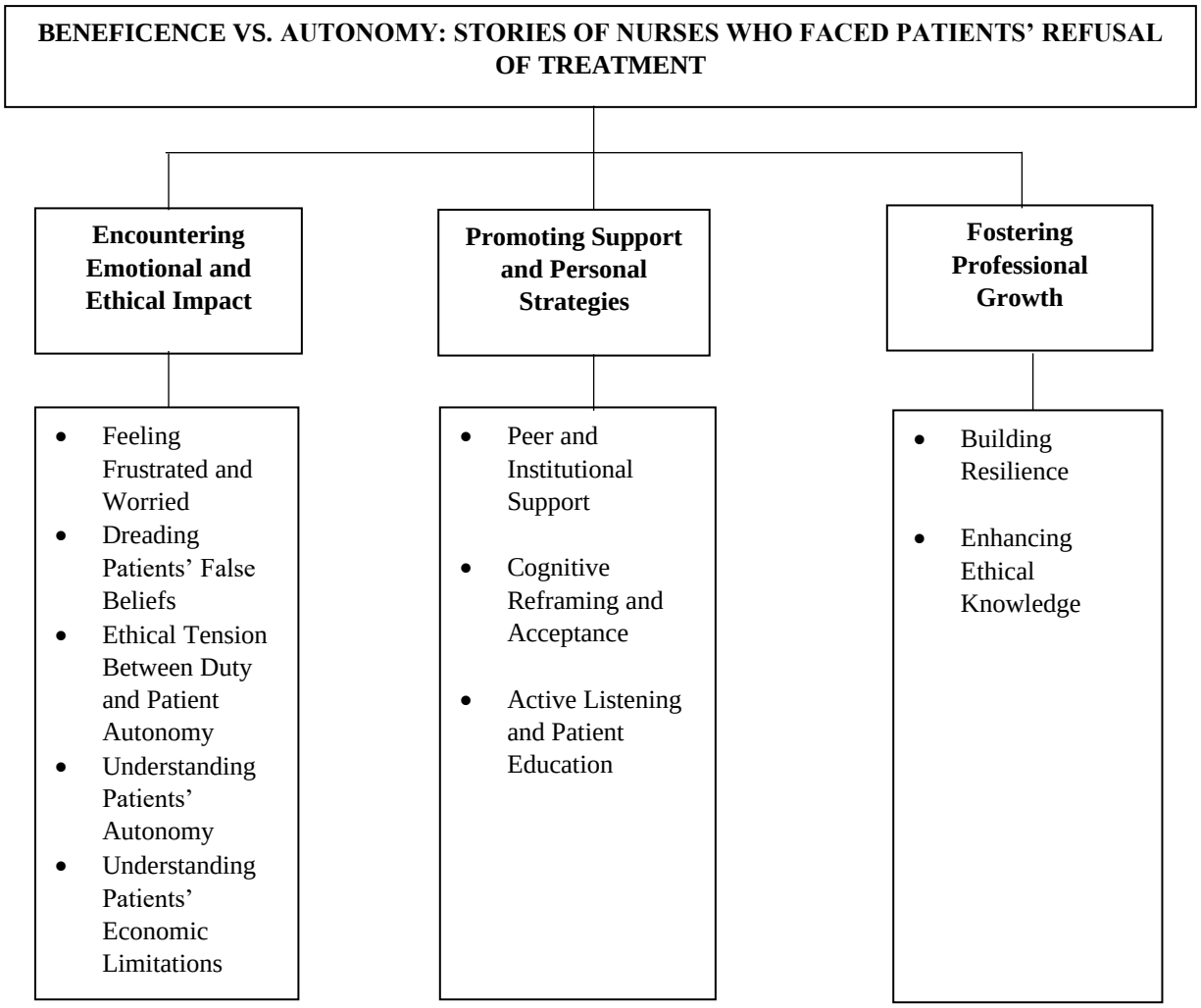

Figure 2. Thematic Map

moral distress when unable to provide care they believe is necessary, particularly in life-threatening situations (Jacobs et al., 2023). Feelings of professional inadequacy compound this emotional response, as nurses may internalize the refusal as a failure in their communication or rapport-building abilities (Morrison & Sulmasy, 2021). The immediate worry that accompanies frustration stems from nurses' anticipatory anxiety about potential adverse outcomes, including patient deterioration or death, which they feel professionally and morally obligated to prevent (Rushton et al., 2022).

The complexity of these initial emotional reactions reflects the multifaceted nature of nursing care, which extends beyond technical competence to encompass deep interpersonal connections with patients (Doherty & Thompson, 2024). Nurses often experience cognitive dissonance when their evidence-based recommendations are rejected, leading to feelings of helplessness and concern about their professional responsibility for patient outcomes (Austin et al., 2023). Understanding that patients' refusals may stem from fear, cultural beliefs, or personal values helps nurses reframe their initial frustration into more constructive emotional responses (Chen et al., 2021). This transition from frustration to understanding represents an important developmental milestone in nurses' professional maturity and emotional intelligence.

Cluster Theme 1.2: Dreading Patients' False Beliefs

This theme encompasses patient refusals motivated by anxiety about medical procedures, skepticism toward conventional medicine, or belief in the superiority of traditional or complementary healing modalities. Dreading patients' false beliefs made Nurses recognize fear as the underlying motivation, which can employ specific communication strategies, including gradual exposure, detailed procedural explanations, relaxation techniques, and exploration of less invasive alternatives, to help patients overcome anxiety while respecting their right to refuse if fear proves insurmountable. The participants said:

"That patient was about 60 years old. He was admitted for moderate pneumonia and had difficulty breathing. The doctor ordered IV antibiotics and oxygen support, but after a day, he kept saying he did not want to continue because he wanted to use herbal medicine instead." (T4, IDI-P1, L67-88)

"She said she didn't like needles and wanted to try guava leaves and ampalaya juice instead." (T4, IDI-P2, L67-72)

"I remembered a patient who was afraid to have surgery due to appendicitis. He was afraid he might not wake up after the operation. We tried to convince him, but he still refused treatment." (T5, FGD-P1, L1-8)

Preference for alternative or traditional medicine represents another complex dimension of treatment refusal that requires cultural sensitivity and openness to integrative approaches (Stub et al., 2022). Rather than dismissing these preferences, effective nurses explore opportunities for integrative care that combine evidence-based medicine with culturally meaningful practices when safe to do so (Chao et al., 2023). This approach acknowledges that healing encompasses physical, emotional, cultural, and spiritual dimensions, and that respecting patients' health beliefs—even when they differ from biomedical models—is fundamental to patient-centered care. When integration is not medically advisable, nurses can still validate the importance of patients' beliefs while clearly explaining why

certain alternatives may be insufficient for their specific conditions, maintaining respect and therapeutic alliance even when patients ultimately choose paths nurses cannot professionally endorse.

Cluster Theme 1.3: Ethical Tension Between Duty and Patient Autonomy

This theme describes the moral dilemma nurses face when their obligation to provide beneficial care appears incompatible with honoring patients' autonomous decisions to refuse recommended treatment. The participants said:

"Yes, I did. I felt conflicted because my duty is to save lives and promote recovery, but I also know that patients have the right to decide for themselves. It was a moral dilemma --- between doing what I think is best and respecting what the patient wants." -- (T4, IDI-P1, L163-182)

"My duty is to save life but there's a need to respect his autonomy. It's a fine line between caring and controlling." -- (T4, IDI-P2, L140-147)

"Yes, it conflicted with my moral duty. I wanted to help him but I cannot help him financially." -- (T4, IDI-P7, L90-97)

The tension between professional duty and patient rights creates significant moral distress for nurses, who are trained to prioritize patient welfare while simultaneously upholding the ethical principle of autonomy (Jameton, 2024). This conflict is particularly pronounced in nursing, where the professional identity is deeply rooted in caring, advocacy, and protecting patients from harm (Beauchamp & Childress, 2023). Nurses describe feeling torn between two equally important obligations: their fiduciary duty to act in patients' best interests and their ethical responsibility to respect patients as autonomous decision-makers (Epstein & Delgado, 2021). Research indicates that this ethical tension is among the most common sources of moral distress in nursing practice, often leading to emotional exhaustion and questioning of professional effectiveness when nurses must witness potentially preventable adverse outcomes.

The fine line between caring and controlling represents a critical boundary that nurses must navigate to maintain therapeutic relationships while respecting patient autonomy (McCarthy & Gastmans, 2022). Nurses who overstep this boundary by being overly persuasive or coercive risk damaging trust and violating ethical principles, while those who remain too passive may fail to fulfill their advocacy role (Turner et al., 2023). Professional guidelines emphasize that respect for autonomy does not negate the duty to educate and advocate, but instead requires nurses to ensure patients make informed decisions while ultimately accepting those decisions even when they disagree (Bandini et al., 2021). Successfully balancing these competing obligations requires emotional intelligence, ethical reasoning, and organizational support to help nurses process the moral complexity of treatment-refusal situations.

Cluster Theme 1.4: Understanding Patients' Autonomy

This theme describes the moral dilemma nurses face when their obligation to provide beneficial care appears incompatible with honoring patients' autonomous decisions to refuse recommended treatment. The participants said:

"Yes, I did. I felt conflicted because my duty is to save lives and promote recovery, but I also know that patients have the right to

decide for themselves. It was a moral dilemma --- between doing what I think is best and respecting what the patient wants." -- (T4, IDI-P1, L163-182)

"My duty is to save lives but I have to respect his autonomy. It's a fine line between caring and controlling." -- (T4, IDI-P2, L140-147)

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Cluster Theme 1.5: Understanding Patients' Economic Limitations

Patients refuse recommended treatments not because of a lack of desire for care but because of an inability to afford medical expenses, representing a unique ethical challenge in which structural inequities constrain autonomy. The participants said:

Yes, it conflicted with my moral duty. I want to help, but there is nothing I can do financially for him." -- (T3, IDI-P7, L69-74)

"I felt pity and frustration. Because I know it is just financial reasons, not a lack of willingness to seek treatment. " -- (T3, IDI-P7, L44-49)

"Support Nurses by providing financial assistance and listening to nurses' concerns." -- (T4, FGD-P7, L294-295)

Financial barriers to healthcare represent a distinct category of treatment refusal that raises questions about the authenticity of autonomous choice when constrained by poverty (Marmot & Allen, 2023). Unlike refusals based on values or preferences, financially motivated refusals reflect systemic healthcare inequities rather than genuine patient choice, creating moral

distress for nurses who recognize that patients would accept treatment if they could afford it (Ndumele et al., 2022). These situations highlight the social determinants of health and the ways structural factors beyond individual control shape healthcare access and outcomes (Braveman & Gottlieb, 2021). Nurses caring for patients who refuse treatment due to cost often experience frustration directed not at patients but at healthcare systems that create impossible choices between financial survival and health.

The unique character of poverty-driven refusals requires different nursing responses than those for other types of refusals, emphasizing social work referrals, exploring financial assistance programs, and advocating for policy changes (Rhoads & Murphy, 2023). Research demonstrates that nurses who understand social determinants of health are better equipped to address the root causes of health inequities rather than focusing solely on individual patient decisions (Thornton & Persaud, 2024). These situations also underscore the importance of healthcare institutions developing robust financial counseling services, charity care programs, and partnerships with community organizations to reduce economic barriers to essential care (Mitchell & Burnes, 2022). When nurses encounter financially motivated refusals, documenting these systemic barriers and advocating for institutional and policy-level interventions becomes as important as providing direct patient care, reflecting nursing's broader commitment to social justice and health equity.

Emergent Theme 2: Promoting Support and Personal Strategies

This theme represents the interpersonal networks and collegial relationships that nurses use to process, manage, and recover from the emotional and ethical challenges posed by treatment refusal situations. This theme encompasses the formal and informal support structures within healthcare settings, including debriefing with colleagues, guidance from senior nurses and supervisors, team-based decision-making, and institutional support mechanisms. Nurses consistently identified their healthcare teams as essential resources for validating their experiences, sharing the burden of difficult decisions, and receiving emotional comfort during morally distressing situations. The reliance on social support reflects nursing's collaborative nature and the recognition that ethical dilemmas are best navigated collectively rather than in isolation. These support systems serve both practical functions—guiding protocols and procedures—and emotional functions—offering empathy, reassurance, and normalization of complicated feelings associated with respecting patient autonomy in challenging circumstances.

According to Kanamori et al. (2020), mentorship relationships help novice and mid-career nurses interpret ethical dilemmas, understand institutional policies, and navigate issues related to patient autonomy. These supportive dynamics foster confidence, reduce emotional burden, and help ensure consistent adherence to professional standards. A study by De Almeida et al. (2021) underscores that effective team communication and shared decision-making strengthen a sense of collective responsibility, improving both emotional well-being and the quality of patient care. When nurses feel supported by their team, they are better equipped to handle the stress associated with patient refusal, uncertainty, or conflict.

Cluster Theme 2.1: Peer and Institutional Support

The practice of processing complex patient care experiences through conversations with fellow nurses who share similar professional contexts, challenges, and values provides mutual understanding and emotional validation. The participants said:

"Yes, definitely. My team and our head nurse were very supportive. We discussed the situation together and followed the proper process. It really helped knowing that we were all on the same page." -- (T4, IDI-P1, L278-293)

"Yes, ma'am. My head nurse always supports us. We talk as a team before acting." -- (T4, IDI-P2, L261-266)

"Yes, I feel supported by my healthcare team during the situation. The patient did not refuse the treatment, and my son did not give up emotionally." -- (T5, FGD-P7, L226-234)

Peer debriefing serves as a critical emotional outlet, allowing nurses to express feelings of frustration, guilt, and helplessness in a psychologically safe environment where colleagues offer empathy and validation (Havaei et al., 2021). Research demonstrates that structured debriefing sessions following ethically challenging cases significantly reduce moral distress and enhance nurses' sense of professional efficacy (Kinman & Leggetter, 2022). The shared professional context enables colleagues to understand the nuances of treatment-refusal situations in ways non-healthcare workers cannot, facilitating more meaningful emotional processing (Sheppard et al., 2023). Informal conversations during shift changes, lunch breaks, or after challenging encounters create opportunities for spontaneous emotional release and perspective-sharing that complement formal debriefing structures. These collegial interactions reinforce professional norms of respecting patient autonomy while simultaneously acknowledging the emotional toll of witnessing patients' decline and the potential benefits of care.

The normalization function of peer support is particularly valuable, as it helps nurses recognize that their emotional reactions to treatment refusals are everyday professional experiences rather than personal failures (Rushton et al., 2021). When colleagues share similar stories and validate one another's feelings, individual nurses develop greater emotional resilience and reduced isolation (Wei et al., 2020). The reciprocal nature of peer support—where nurses both give and receive emotional assistance—strengthens team cohesion and creates a culture of mutual care that extends beyond patient interactions (Moloney et al., 2024). Organizations that intentionally create time and space for peer debriefing demonstrate a commitment to nurse well-being and recognize that collectively processing ethical challenges enhances both individual coping and overall care quality. The therapeutic benefit of feeling understood by those who share similar professional demands cannot be overstated in sustaining nurses through emotionally demanding aspects of their work.

Cluster Theme 2.2: Cognitive Reframing and Acceptance

This theme involves deliberately changing one's interpretation of treatment-refusal situations from viewing them as personal failure or professional inadequacy to recognizing patient autonomy as a fundamental ethical principle, thereby reducing emotional distress through altered thinking patterns. The participants said:

"I also remind myself that I cannot control everything --- my role is to educate and

support, but the final decision is still with the patient." -- (T4, IDI-P1, L190-200)

"I think I also fulfill my duty as a nurse. I think the art of listening and respecting other's beliefs is effective." -- (T4, IDI-P3, L138-150)

"Through time, I learned to detach emotionally while still being caring." -- (T5, FGD-P1, L138-141)

Cognitive reframing allows nurses to transform potentially demoralizing experiences into affirmations of ethical practice by consciously shifting the focus from desired clinical outcomes to the successful fulfillment of professional duties, including education, advocacy, and respect for autonomy (Folkman & Greer, 2020). This mental strategy involves recognizing that patient refusals do not represent nursing failures but rather appropriate exercises of self-determination, thereby protecting nurses' professional self-esteem and sense of efficacy (Carver & Scheier, 2023).

Moreover, research indicates that healthcare professionals who successfully reframe ethical dilemmas as opportunities to uphold principles rather than obstacles to overcome experience significantly less moral distress and greater job satisfaction (Hoff et al., 2021). The deliberate cultivation of calm responses through cognitive strategies—such as internal self-talk and reminding oneself that education, rather than persuasion, is the goal—helps nurses maintain emotional equilibrium during challenging interactions. By reframing their role from controller of patient decisions to facilitator of informed choice, nurses can find professional meaning even when patients choose paths they personally disagree with.

The maturation of reframing skills over time reflects the growth of professional wisdom and emotional intelligence gained through repeated exposure to treatment refusals (Lazarus & Folkman, 2024). Experienced nurses report that they have learned to automatically engage cognitive strategies that novice nurses must consciously practice, suggesting that reframing becomes more efficient and effective with experience (Troy & Mauss, 2022). Accepting that documenting refusals and providing complete information constitute successful nursing care—regardless of the patient's ultimate decision—represents a sophisticated understanding of professional boundaries and responsibilities. Organizations can facilitate the development of these cognitive skills by providing training in stress management techniques, cognitive-behavioral approaches, and mindfulness practices that help nurses observe their thoughts and emotions without being overwhelmed by them (Webb et al., 2021). The protective effect of successful cognitive reframing extends beyond individual encounters, shaping nurses' overall resilience and capacity to sustain long careers in emotionally demanding healthcare environments.

Cluster Theme 2.3: Active Listening and Patient Education

This theme involves intentionally focusing on understanding patients' perspectives, concerns, fears, and values through attentive presence, validation of feelings, and non-judgmental responses that create psychological safety for authentic dialogue about treatment decisions. The participants said:

"Active listening and empathy. I let the patient talk first about their fears and beliefs, then I respond in a way that acknowledges their feelings." -- (T4, IDI-P1, L219-228)

"I use layman's terms, avoid medical jargon." -- (T4, IDI-P3, L235-242)

"I think every time the patient refuses the treatment. My colleagues decide to undergo the treatment. When I show to my colleagues that because of my listening to the patient's concerns, their decision making has changed, I think I can contribute how other nurses can be more resilient, how they can be more supportive, not only to their patients, but also to the patients themselves." -- (T5, FGD-P3, L197-218)

Active listening serves as both a communication technique and a coping strategy by shifting nurses' focus from persuasion to understanding, thereby reducing their sense of failure when patients continue to refuse after being heard (Kourkouta & Papathanasiou, 2024). This approach involves setting aside one's own agenda to genuinely attend to patients' expressed and unexpressed concerns, creating space for patients to articulate fears, values, and reasoning that inform their decisions (Arnold & Boggs, 2023). Research demonstrates that healthcare providers who practice active listening experience less moral distress because they feel confident, they have fulfilled their ethical obligation to ensure informed decision-making, even when disagreeing with the ultimate choice (Back et al., 2021). The temporal investment in listening—truly giving time rather than rushing to document refusal—communicates respect that often transforms adversarial dynamics into collaborative relationships. Empathetic responses that validate feelings (e.g., "I understand this is frightening," or "I hear that this conflicts with your beliefs") help patients feel seen and valued as individuals rather than simply cases to be managed, potentially increasing their receptivity to medical guidance while respecting their autonomy.

The transformation many nurses described—from immediately presenting waiver forms to investing time in listening—represents significant professional growth and recognition that communication quality affects both patient outcomes and nursing satisfaction (Bramhall, 2021). Cultural sensitivity as a component of active listening requires attentiveness to diverse ways of understanding health, illness, and healing that may differ from biomedical frameworks, enabling nurses to identify culturally acceptable alternatives or adaptations when possible (Kaihlanen et al., 2023). The practice of listening before responding allows nurses to identify the actual barriers to treatment acceptance—whether fear, misunderstanding, financial constraints, or values conflicts—and tailor their educational approach accordingly (Street et al., 2024).

Emergent Theme 3: Fostering Professional Growth

This theme reflects the transformation of personal experiences into transferable professional insights that can benefit the broader nursing community. Participants articulated clear recommendations emphasizing the importance of maintaining composure, prioritizing listening over persuasion, demonstrating empathy and respect, avoiding personalizing patient decisions, and focusing on patient education rather than coercion.

Moreover, these insights represent distilled wisdom from frontline practice, offering pragmatic strategies that balance ethical principles with emotional sustainability. The consistency of recommendations across participants—regardless of their specific patient populations or clinical contexts—suggests these represent core competencies for ethical nursing practice in situations involving treatment refusals. This collective wisdom

serves as an informal curriculum that complements formal education, providing realistic guidance grounded in lived experience rather than idealized scenarios.

A 2024 qualitative study on ethical challenges in nursing found that nurses rely heavily on experientially acquired wisdom, developed through exposure to repeated moral dilemmas and difficult patient decisions (Martinsen & Glasdam, 2024). This wisdom includes knowing when to step back, engaging compassionately, and balancing advocacy with respect for autonomy.

Benner's Novice-to-Expert theory continues to be supported by recent research. A 2023 systematic review (Sastre-Fullana et al., 2023) found that clinical wisdom deepens over time and enables nurses to act with intuition, ethical clarity, and improved judgment in complex situations—including situations involving refusal of care.

Cluster Theme 3.1: Building Resilience

This theme involves nurses developing a sense of acceptance and understanding, and setting emotional boundaries, when supported by reflection and mentorship, progressively enhancing their capacity to manage emotional challenges, tolerate ethical ambiguity, and sustain compassionate practice despite repeated challenging encounters. The participants said:

"Before, I cry after duty but now, I learned to accept them. It is always patients' rights that have to be followed." -- (T4, IDI-P2, L235-241)

"Over time my coping mechanisms have matured as I gain more experience and emotional strength." -- (T5, FGD-P3, L167-172)

"Over the years, I've learned to handle refusals with more grace and less frustration." -- (T4, IDI-P4, L235-242)

The concept of team resilience emphasizes that collective processing of difficult experiences strengthens entire healthcare units rather than only benefiting individuals who share their stories (West et al., 2020). When nurses openly discuss feelings of conflict, frustration, and uncertainty regarding treatment refusals, they create psychologically safe environments where others feel permission to acknowledge similar struggles without shame or fear of appearing incompetent (Edmondson & Lei, 2024). Research on healthcare teams demonstrates that psychological safety—the shared belief that team members can express concerns and admit mistakes without punishment—significantly predicts team performance, innovation, and member well-being (O'Donovan & McAuliffe, 2020). The transformation from being controlled by fear to managing it through communication and reassurance represents crucial emotional regulation development that protects both nurses and patients from the negative consequences of anxiety-driven interactions. Experienced nurses who model this growth provide living evidence that challenging experiences need not lead to burnout but can instead strengthen professional capacity.

The empowerment dimension of reflection extends its benefits beyond the individual to the collective nursing profession, creating ripple effects as resilient nurses support colleagues facing similar challenges (Labrague et al., 2022). This mentorship function—whether formal or informal—ensures that experiential wisdom is transferred across generations of nurses rather than being repeatedly discovered through individual trial and error (Jakubik et al., 2021). The balance between firmness and kindness that experienced nurses describe

reflects sophisticated emotional intelligence, maintaining professional boundaries and ethical principles while remaining compassionate and approachable (Codier & Codier, 2020). Organizations that recognize reflection and experience-sharing as professional development activities—allocating time, creating structures, and rewarding participation—leverage the growth potential inherent in challenging clinical situations. The insight that personal reflection serves collective empowerment reframes what might be perceived as navel-gazing or self-indulgence into essential professional practice that strengthens healthcare teams' capacity to provide excellent care in the face of ethical complexity and emotional demands.

Cluster Theme 3.2: Enhancing Ethical Knowledge

The nurses recommend that healthcare institutions and educational programs provide more comprehensive, ongoing training in ethical decision-making, cultural competence, and communication skills, alongside accessible support resources such as ethics committees, counseling services, and structured debriefing opportunities. The participants said:

"Maybe more regular ethics training or case discussions. It would also help to have a counsellor or ethics committee available when situations like this arise." -- (T4, IDI-P1, L340-351)

"I think nursing schools should include more real-life ethical scenarios in their training. In hospitals, there should be clear policies and guidance for handling treatment refusals --- so nurses know what to do without feeling uncertain or guilty." -- (T4, IDI-P1, L352-370)

"I think once every six months, the hospital should conduct a seminar to remind nurses to be kind, to remind nursing responsibilities, and if there are situations like this, they should be reminded what to do." -- (T5, FGD-P3, L224-235)

Regular ethics training recognizes that ethical reasoning is not static but requires continuous development and refreshment, particularly as healthcare contexts evolve and new ethical challenges emerge (Monteverde, 2023). The recommendation for accessible ethics committees or consultation services reflects nurses' need for real-time guidance when facing complex cases rather than only retrospective analysis after decisions have been made (Fox et al., 2021). Research demonstrates that institutions with robust ethics consultation services report lower levels of moral distress among staff and better resolution of ethical conflicts (Tapper et al., 2020). The inclusion of counseling services acknowledges that ethical dilemmas can take an emotional toll, requiring professional support beyond what colleagues can provide, particularly when nurses repeatedly experience morally challenging situations. Biannual seminars serve as structured opportunities to revisit core ethical principles during the press of clinical work, where fatigue and time pressures can erode commitment to thoughtful ethical deliberation.

The emphasis on real-life scenarios in both hospital training and nursing education addresses the limitation of abstract ethical principles that students and practitioners struggle to apply in concrete clinical situations (Numminen et al., 2021). Case-based learning using actual treatment refusal scenarios enables nurses to practice ethical reasoning, communication strategies, and emotional regulation in low-stakes environments before encountering similar situations with real patients (Jeffries et al.,

2023). The recognition that fatigue affects ethical decision-making highlights the intersection of working conditions and care quality, suggesting that ethical support must address both educational needs and workplace factors that impair judgment (Scott et al., 2024). Organizations that invest in comprehensive ethics infrastructure—including education, consultation services, and wellness resources—communicate that ethical practice is a priority worthy of dedicated resources rather than expecting nurses to navigate complex situations with minimal guidance. The integration of ethics education throughout nursing careers, rather than concentrating it in initial preparation, recognizes that professional development is ongoing and that experiential learning prepares novices for more sophisticated ethical concepts than they can fully appreciate.

Implication to Practice

Based on the findings, the lived experiences revealed a complex interplay of emotional and ethical impacts that profoundly impact nursing practice. Nurses felt frustrated and worried. Also, nurses experienced dreading patients' false beliefs. There was ethical tension between duty and patient autonomy. Additionally, the struggles of patients who refused treatment are due to their economic limitations.

The findings also revealed that the coping mechanisms employed by nurses facing treatment refusals included promoting support and applying personal strategies. Nurses rely heavily on peer and institutional support as well as cognitive reframing and acceptance. Also, the nurses actively listen to one another to improve patient education.

The findings also revealed that the insights shared by nurses reflected accumulated professional wisdom that emphasized fostering professional growth. The nurses believed that building resilience and enhancing their ethical knowledge can improve their experiences.

For nursing practice, the findings emphasize the need for nurses to develop sophisticated communication skills, emotional regulation strategies, and ethical reasoning that balances beneficence with patient autonomy. At the same time, institutions must establish robust support systems, including peer debriefing, ethics consultation services, and clear policies to guide nurses through morally distressing situations.

In nursing education, nurse educators may help prepare their students to manage. Nursing curricula should incorporate real-life case scenarios, simulation-based learning, enhanced therapeutic communication training, and instruction on managing tensions between professional duty and patient autonomy through reflective practice.

For nursing research, this phenomenological study opens avenues for investigating evidence-based interventions to reduce moral distress, longitudinal studies examining how ethical reasoning evolves across career stages, research on the influence of institutional policies on nurse resilience, and cross-cultural studies exploring how nurses navigate treatment refusals in diverse healthcare contexts. These implications demonstrate that supporting nurses in the face of treatment refusals requires comprehensive approaches that span individual skill development, organizational infrastructure, educational reform, and ongoing research to inform best practices for patient-centered care.

Adding on, hospitals may invest in accessible ethics consultation services, regular training and debriefing sessions with patients and nurses, financial assistance programs for patients affiliated with the government, clear refusal policies, counseling services for moral distress,

adequate staffing for meaningful patient communication, and psychologically safe environments where nurses can discuss ethical challenges openly—recognizing that supporting nurses' ethical practice and emotional well-being is essential to delivering high-quality, patient-centered care that honors both clinical excellence and human dignity.

This study also provides insight into the need for additional research to evaluate strategies to curb treatment refusal. Specifically, patients should be more aware of the effects of refusing treatment. Furthermore, strategies to improve the community health providers' action plan may also be implemented.

This study aims to develop understanding by learning from the experiences of nurses who faced treatment refusal, thereby contributing to the body of knowledge in nursing practice, education, and research. This study provides an opportunity to hear the voices of nurses as they share their sentiments, experiences, coping mechanisms, insights, and how they overcame them, and their experiences as healthcare providers.

Recommendations for Future Research

The research findings from this study, with a qualitative, phenomenological focus, are rarely applicable to other contexts. It argues that the goal of phenomenology is to provide a comprehensive explanation of the phenomenon, thereby comprehending the fundamental structure of lived experience. Additionally, only eight participants were included in this study, seven of whom were female and one male. Therefore, if possible, future studies should include participants from diverse backgrounds.

The nurses may prioritize active listening and empathetic communication when encountering treatment refusals, deliberately reframing these situations as opportunities to honor patient autonomy rather than personal failures, and engage regularly in peer debriefing and reflective practice to process emotional responses and build resilience. They may also invest in continuous development of cultural competence and therapeutic communication skills, using plain language and patient-centered education to ensure genuinely informed decision-making while maintaining professional boundaries that separate caring from controlling.

The patients may openly communicate their values, beliefs, fears, and concerns regarding treatment options with their healthcare providers, recognizing that nurses are committed to understanding their perspective and supporting informed decisions that align with their personal circumstances. Also, the patients may exercise their right to refuse treatment after ensuring they fully understand the risks, benefits, and potential consequences, while remaining open to exploring alternative approaches that may honor both their values and health needs.

The hospital administrators may establish comprehensive support systems, including accessible ethics consultation services, regular ethics training programs, structured debriefing sessions, and professional counseling services to help nurses navigate the moral distress associated with treatment refusals. They should also develop and implement clear policies for documenting treatment refusals, enhance financial assistance programs to address socioeconomic barriers to care, and ensure adequate nurse staffing levels that allow sufficient time for meaningful patient communication and relationship-building.

The Department of Health may mandate regular ethics education and cultural

competence training as requirements for nursing licensure renewal, ensuring that all healthcare professionals maintain current knowledge of ethical principles and communication strategies that respect patient autonomy. They may also develop national guidelines and policy frameworks that address treatment refusals across diverse contexts, including standards for financial assistance programs, ethics consultation availability, and nurse well-being support systems that reduce moral distress and burnout.

Future researchers performing a similar phenomenological study on the lived experiences of nurses facing treatment refusal may diversify their sample pool to include nurses from various specialties (e.g., palliative care, emergency, critical care) and different healthcare settings (rural vs. urban, public vs. private) to capture a broader spectrum of experiences and ethical challenges. It is also recommended to consider a longitudinal component or follow-up interviews to explore the lasting emotional and professional impact of these refusal events on the nurses over time, adding depth to the understanding of their coping mechanisms and changes in practice. Furthermore, the study design should explicitly incorporate an opportunity for participants to suggest institutional or policy changes they believe could better support nurses in these difficult situations, thereby providing more direct, actionable recommendations for practice improvement.

Limitations

This study is subject to several limitations that should be considered when interpreting its findings. First, the study was conducted in a single primary (Level 1) hospital in Tagum City, Davao del Norte, which may limit the transferability of the results to other healthcare settings, such as tertiary hospitals or institutions with different organizational structures and patient populations. The context-specific nature of the setting may influence the experiences reported by participants.

Second, the study involved a relatively small sample of fourteen (14) nurses, which is appropriate for a phenomenological design but inherently limits the breadth of perspectives captured. Although qualitative research prioritizes depth over generalizability, the limited sample size may not fully represent the diversity of experiences among nurses in similar contexts.

Third, the study relied exclusively on self-reported data obtained through in-depth interviews and focus group discussions. As such, the findings may be influenced by participants' recall bias, social desirability bias, or subjective interpretations of their experiences. Additionally, the absence of other data sources (e.g., observations or document analysis) restricts the potential for methodological triangulation.

Finally, the cross-sectional nature of data collection, conducted within a specific timeframe in 2025, captures experiences at a single point in time and does not account for potential changes in perceptions or practices over time. Consequently, the findings should be interpreted within the temporal and contextual boundaries of the study. Despite these limitations, the study provides valuable insights into the lived experiences of nurses managing patients who refuse treatment, offering a foundation for future research and practice improvements in similar healthcare settings.

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