

Exploring the Experiences of Neonatal Nurses in Providing End-of-Life Care to Newborns and their Families

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Abstract: **Background:** Caring for critically ill newborns at the end of life is among the most emotionally and ethically demanding roles in nursing. Neonatal intensive care unit (NICU) nurses must simultaneously manage the physical needs of fragile infants and the grief of families who are often wholly unprepared for what lies ahead. **Purpose:** This study set out to understand how neonatal nurses at Doctor Soliman Fakeeh Hospital in Jeddah, Saudi Arabia, experience end-of-life care in practice and what weighs on them emotionally, the moral conflicts they encounter, how Islamic and family-centered values shape their work, and what helps them carry on. **Method:** Ten neonatal nurses participated in semi-structured interviews employing a phenomenological approach. Reflexive thematic analysis identified patterns related to emotional strain, moral tensions, the influence of religious beliefs, and the sources of meaningful support for the nurses. **Results:** Four main themes emerged: First, nurses faced significant emotional burdens due to prolonged exposure to infant death, leading to grief or emotional numbness. Second, ethical issues created moral conflict, with some nurses feeling anguish over a baby's suffering while feeling compelled to act. Third, cultural and Islamic values, along with family expectations, influenced care delivery, with prayer and Quranic recitation providing comfort but sometimes conflicting with clinical decisions. Fourth, coping mechanisms and support systems were essential for nurses. **Conclusion:** Neonatal nurses in Saudi Arabia encounter considerable emotional, ethical, and cultural challenges. While personal resilience and support from colleagues help, a deficiency in structured training and institutional backing is notable. To enhance care for nurses and families, improvements in ethics education, support programs, and culturally appropriate communication tools are necessary.

Keywords: Experiences, Emotional challenge, Ethical issues, End-of-Life Care, Families, NICU, Newborn, Neonatal Nurses, Palliative care, Nursing.

1. Introduction

Neonatal end-of-life EoL care in NICU is undoubtedly sensitive and complex than other areas of palliative care approaches. This care is delivered by neonatal nurses who are at a great risk due to patient fragility and high family members' emotional dependence. Neonatal which means the first 28 days of life is a vulnerable stage of life when the child may be diagnosed severe life-threatening illness often require the

inevitable treatment decisions (Banazadeh & Rafii, 2020).

During this fragile period of time, the nurses besides delivering the best quality and standardized clinical care to the patient are also entrusted with the role of emotionally supporting grieving families who need to accept the fact of probable impending loss of their offspring (Cerratti et al., 2020).

The organization of EoL care in NICU is also an issue that raises ethical questions and moral stress. The nurses often face cases when they are in the middle of complicated decision making regarding the life-supporting care and treatment of newborns simultaneously taking into account their quality of life (Ferro et al., 2024). These professional experiences are in addition to cultural and religious beliefs that always dictate care decisions due to the need to acknowledge the wishes of families (Beltran & Hamel, 2021). These complex tasks put an emotional stress on nurses and thus can bring negative impacts on their health.

Despite these challenges, neonatal nurses continue to play a crucial role in providing compassionate care to mothers, infants, and their families. Understanding their experiences and the obstacles they face is essential for advancing palliative care and enhancing the support nurses offer to patients and families. This area of healthcare requires further research to identify the best approaches to addressing the emotional and ethical issues inherent in managing neonatal end-of-life care (Ramadan et al., 2025).

A. Background of the Study

Death and dying have become important topics of research and clinical focus in NICU. Neonatal nurses are involved in both physical and psychosocial caring in the EoL for infants with life-limiting illnesses (Banazadeh & Rafii, 2020). Neonatal nurses are usually provided with the greatest amount of interaction not only with the neonate and his/her family but also in terms of diagnostics and therapeutics (Ramadan et al., 2025). This is a very complex task they have to perform whereby on one hand; they have to give the family hope that their loved one will get better, on the other – prepare the family for the worst. These nurses must also assist in meeting other

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needs of the families since they may also need counseling, encouragement and directions during such time (Thornton et al., 2021).

The delivery of palliative care in the NICU is therefore complex and many of the difficulties are inherent in the work. These newborns are typically either very low birth weight or born with congenital diseases that will not allow them to survive even with the use of state-of-the-art technology. In such instances, the nurses are expected to offer comfort care, in that they need to control the baby's pain, update the family on the health status of the baby and support the family in case they have to make some tough decisions on whether or not to remove the life-sustaining treatments (Cerratti et al., 2020). It raises ethical dilemmas that may prove emotionally taxing to nurses; for instance, where one holds a different view with specific medical decisions or when they feel that nothing much can be done for the infant's suffering (Han et al., 2023).

Although neonatal nurses are central in these vulnerable patients' end of life, studies show that they do not feel adequately prepared for the emotional and ethical demands of this work. Researchers have noted that there is poor preparation and more significantly, poor structures in place to assist nurses to manage emotions in their work (Beltran & Hamel, 2021). The participants pointed out that nurses suffer from isolation, stress, and moral dilemmas that result in burnout, and compassion fatigue (Cerratti et al., 2020). These are additional pressures that further explain why EoL decisions are often made in the NICU within very short time frames, without much time for deliberation (Dombrecht et al., 2020).

Neonatal nurses working in Saudi Arabia more so in Jeddah; have not been the subject of many studies. Although prior worldwide research has given valuable indicators in comprehending the difficulties observed among NICU nurses, there is a need to carry out local research that considers issues of culture, religion, and institutions that may affect EoL care practices in the region. To address this need, this qualitative study is seeking to identify and describe the emotional, ethical and professional experiences of neonatal nurses in Saudi Arabia while delivering EoL care.

B. Statement of the Problem

EoL care in neonatal care, raises ethical issues and becomes emotionally challenging for the healthcare providers especially the nurses who are most times at the center of patient care. In many situations the neonatal nurses are challenged when they are left in the dilemma of continuing or withholding/withdrawing the life-supporting treatments for the neonates; often the ethical policies and protocols are not very clear and often they are in conflict (Kim et al., 2019). This in turn may lead to high levels of moral stress since trying to balance professionalism and emotional feelings plus values is quite challenging, (Siewert & Ayyala, 2025). Neonatal nurse is an essential profession in the delivery of EoL care and yet there is very little literature available regarding experiences of these professionals, especially in the Middle Eastern countries like Saudi Arabia where culture and religion may influence practice in special ways (Tong-Hui et al., 2023).

A recurring finding in nursing research is how underprepared nurses feel for end-of-life care with newborns. They often have no formal training in how to handle the emotional and ethical realities of this work (Kim et al., 2019). Without that preparation, moral distress sets in, alongside feelings of helplessness and, eventually, burnout. Care quality suffers too (Siewert & Ayyala, 2025). The situation is made worse by the absence of psychological support for nurses after difficult cases unprocessed grief and distress do not just disappear; they compound over time and can end careers (Dombrecht et al., 2020).

The cultural and religious environment adds another layer entirely. In Saudi Arabia, Islamic principles around the preservation of life mean that families and sometimes clinicians resist withdrawing treatment even when continued intervention serves no medical purpose (MANI, 2024). This creates friction between family expectations, religious belief, and clinical judgment, and nurses are often caught in the middle. When they believe the right thing to do medically contradicts what the family wants or what their culture demands, the moral weight is considerable (Han et al., 2023). This study uses the experiences of nurses at DSFH in Jeddah to examine these tensions closely.

By documenting the lived experiences of nurses in Saudi NICUs, this study aims to give policymakers, educators, and hospital administrators a clearer view of what actually happens in this work what nurses face emotionally, where the ethical pressure points are, and what sustains them. That understanding is necessary for designing training programs and support structures that are actually useful rather than generic (Cerratti et al., 2020). Improving conditions for nurses ultimately means better care for the infants and families they serve.

C. Significance of Study

There is a real shortage of research on neonatal end-of-life care in Saudi Arabia, and this study contributes directly to addressing that gap. Focusing on nurses at DSFH in Jeddah one of the region's leading centres for neonatal care the research provides ground-level insight into an area that the international literature has largely overlooked. One of the study's key contributions is its attention to how Islamic values and family dynamics specifically shape clinical practice and decision-making in this setting (Thornton et al., 2021).

What distinguishes this study is its focus on experience rather than attitudes or knowledge. Nurses' voices their accounts of grief, moral conflict, and the ways they find to keep going are what this research centres. That kind of evidence is not just academically useful. It has direct practical value for hospitals in Saudi Arabia and across the region that are trying to build better support systems for nursing staff.

The practical implications are clear: understanding what nurses need allows institutions to build programs that actually match those needs. When decision-makers have access to nurses' own accounts of their training gaps and support deficits, they are better placed to respond with targeted, relevant interventions ones that protect nurses' wellbeing and, in turn, raise the quality of care for dying neonates and their families

(Banazadeh & Rafii, 2020).

D. Aim of the Study

This study aimed to explore the lived experiences of neonatal nurses delivering EoL care at Doctor Soliman Fakeeh Hospital Jeddah, Saudi Arabia, with particular attention to emotional burden, ethical dilemmas, cultural and religious influences, and coping strategies.

Research Questions:

What are the emotional, ethical, and professional difficulties of neonatal nurses regarding the giving of end-of-life care to the newborns and their families in Doctor Soliman Fakeeh Hospital?

How do neonatal nurses manage the stress related to end of life care in neonatal settings in Saudi Arabia?

Definition of Terms:

Conceptual Definition of Terms:

- End-of-life care: Refers to medical treatment given to patients who are considered terminally ill and whose condition does not respond to the curative measures.
- Neonatal nurse: A trained individual professional nurse working in the Neonatal Intensive Care Unit to attend to newborns who are pre-term, sick or requiring close attention.

Operational Definition of Terms:

- End-of-life care in this study: Blessing for the neonates at the terminal stage of life, which includes the management of pain, comforting of the babies, and communication to the family.
- Neonatal nurse in this study: These nurses are working in the NICU at Doctor Soliman Fakeeh Hospital in Jeddah

2. Literature Review

A. Introduction

We know that neonatal end-of-life care matters, but we know surprisingly little about how nurses in Saudi Arabia actually navigate it. The research that exists sends mixed signals: some studies point to resilience and faith as powerful coping resources, while others document significant moral distress and systemic failure to support nurses (Bozdogan et al., 2025; Elsharkawy et al., 2025; Lee et al., 2024). A further complication is that Saudi NICUs are staffed by nurses from many different countries and cultural backgrounds, which creates its own challenges when care must align with the values of predominantly Muslim families (Al Mutair et al., 2019; Mani, 2024). These gaps are not abstract, they translate into nurses burning out, care quality varying unpredictably, and ethical conflicts going unresolved (Almalki et al., 2024; Wong et al., 2023).

To make sense of the literature, this review works within a framework that treats emotional processing, ethical decision-making, and cultural competence as three interconnected forces shaping nurses' experiences (Elsharkawy et al., 2025; Mani, 2024; Ng & Fung, 2023) Emotional processing includes grief and compassion fatigue. Ethical decision-making covers the

navigation of moral distress and dilemma. Cultural competence means engaging sensitively with Islamic values and the particular dynamics of family-centred care. Together, these constructs align with established stress-and-coping and ethical frameworks in nursing, providing a structured way to examine what nurses are actually up against (Elsharkawy et al., 2025; Lee et al., 2024).

This review draws together current evidence on the emotional, ethical, and cultural challenges nurses face in providing neonatal end-of-life care in Saudi Arabia (Elsharkawy et al., 2025; Mani, 2024). The goal is to identify what we know, clarify what we do not, and point toward 8th the kinds of support strategies, educational programs, and policies that could make a real difference ones that are grounded in the specific socio-religious context of Saudi healthcare rather than imported from elsewhere (Akram et al., 2025; Davies & Yarrow, 2025) The review draws on a search across multiple databases, including both qualitative and quantitative studies focused on neonatal nursing in Saudi Arabia and comparable cultural contexts.

Studies were selected based on their relevance to the emotional, ethical, and cultural dimensions of end-of-life care. Findings were analyzed thematically and organized around the framework described above, with attention to the connections between nurses' personal experiences and the broader institutional and social forces that shape them (Davies & Yarrow, 2025; Elsharkawy et al., 2025; Mani, 2024).

B. Methodology of Literature Selection

1) Transformation of Query

The original research question was broken down into multiple targeted search queries, each focused on a specific facet of neonatal nurses' experiences, emotional burden, ethical decisionmaking, cultural competence, coping strategies, and institutional support. This approach ensured that the search was both thorough and manageable, with each query returning literature closely aligned with a particular dimension of the overall question.

The search queries were designed to capture a wide range of relevant material: ethical decision-making in neonatal care, the influence of Islamic values on clinical practice, conscientious objection among nurses, policy frameworks for palliative care in the region, and the emotional and psychological experiences of NICU staff in Saudi Arabia and comparable settings.

C. Screening Papers

Running the search queries against inclusion and exclusion criteria produced 62 candidate papers from a very large database. The review then used citation chaining in both directions: backward chaining tracked foundational work through the reference lists of core papers, while forward chaining identified newer studies citing those same core papers. This produced 111 additional relevant papers, bringing the total pool to 173. After ranking for relevance, 42 papers were identified as highly relevant to the research questions and are discussed in Table 1.

Table 1
Thematic review of literature

Theme	Appears in	Theme Description
Emotional Impact and Coping Strategies	10/42 Papers	Neonatal nurses experience profound emotional distress due to frequent infant loss, which manifests as grief, moral distress, and compassion fatigue. Coping strategies are often faith-based, involve meaning-making, selective detachment, and support from family and colleagues, contributing to resilience development over time (Bozdag et al., 2025; Elsharkawy et al., 2025; Lee et al., 2024). Institutional support remains inconsistent, amplifying emotional burdens.
Cultural and Religious Influences on Care	10/42 Papers	Cultural and religious beliefs, particularly Islamic values, critically shape nurses' approaches to end-of-life care, including decision-making, family involvement, and rituals. Nurses navigate cultural sensitivities to provide care aligned with patients' faith and traditions, facing challenges such as respecting family dominance and integrating spiritual needs (Al Mutair et al., 2019; Al-Harrasi et al., 2025; Mani, 2024; Ng & Fung, 2023; Shoaib et al., 2023). Variations exist in cultural competence and awareness among internationally trained nurses.
Ethical Dilemmas and Decision-Making	10/42 Papers	Ethical challenges arise from balancing life-sustaining treatments, family expectations, and clinical judgments in the context of neonatal fragility and prognostic uncertainty. Nurses confront moral distress due to therapeutic futility, role conflicts, and unclear protocols. Shared decision-making with families is emphasized but complicated by sociocultural factors (Babgi, 2009; Pinto & Pereira, 2024; Lee et al., 2024; Oskouie et al., 2024; salmani et al., 2018). Training in ethics and structured guidelines are often lacking.
Organizational Support, Training, and Education	9/42 Papers	Deficits in formal education, institutional policies, and organizational support hinder effective end-of-life care. Nurses report insufficient training in palliative care, lack of standardized protocols, and inadequate staffing, which exacerbate stress and compromise care quality. Educational programs, clear guidelines, and supportive leadership positively influence nurses' attitudes and competencies (Chin et al., 2021; Davies & Yarrow, 2025; Khraisat et al., 2023; Sousa & Curado, 2023; Shahintab et al., 2022).
Moral Distress and Professional Growth	8/42 Papers	Moral distress is a pervasive outcome of end-of-life care challenges, influenced by intrapersonal, interpersonal, organizational, and structural factors. While distress can negatively affect nurses' well-being, some experience post-traumatic growth and enhanced professional identity through reflection and resilience-building (Bozdag et al., 2025; Elsharkawy et al., 2025; Lee et al., 2024). Organizational culture and peer support are critical mediators.
Family-Centered and Culturally Sensitive Care	7/42 Papers	Family involvement is central to neonatal end-of-life care, demanding culturally competent practices that honor family roles and religious customs. Nurses often focus on facilitating parent-infant bonding and supporting family rituals, though cultural care is sometimes misunderstood or limited to specific tasks rather than holistic embodiment (Mutair et al., 2019) (Carew et al., 2024) (Mani, 2024) (Mani, 2024). Leadership and targeted education are needed to enhance this care model.
Knowledge and Attitudes Toward Palliative Care	6/42 Papers	Nurses generally hold positive attitudes towards neonatal palliative care but frequently lack sufficient knowledge and experience, particularly in communication about transition to palliative care, spiritual support, and code status discussions. Educational interventions improve knowledge and attitudes but remain inadequately implemented in many settings (Khraisat et al., 2023) (Abuhammad et al., 2023) (Chin et al., 2021) (BOZDAĞ et al., 2024).
Communication Challenges in End-of-Life Care	10/42 Papers	Effective communication with parents and within healthcare teams is a significant barrier, complicated by language differences, cultural misunderstandings, and emotional distress. Poor communication hinders shared decision-making, exacerbates ethical dilemmas, and affects family satisfaction (Mutair et al., 2019) (Sousa & Curado, 2023) (Alfahmi, 2022) (Ng & Fung, 2023). Training in culturally sensitive communication is emphasized.
Emotional and Spiritual Support for Nurses	10/42 Papers	Nurses require emotional and spiritual support to manage the psychological toll of caring for dying neonates. Education on grief management, mentoring, and post-mortem support enhance nurses' capacity to cope with loss, reducing feelings of isolation and role conflict (El-Sharkawy et al., 2025) ("Supporting The Neonatal Nurse In The (Welborn, 2021))(BOZDAĞ et al., 2024)(AL-Qatameen et al., 2023). Supportive interventions are crucial for nurse retention and well-being.
Impact of Sociocultural and Legal Contexts	9/42 Papers	Broader societal, legal, and cultural frameworks influence neonatal end-of-life care, including family dominance in decision-making, stigma surrounding death, and the role of Islamic bioethics and fatwas. These contexts affect nurses' practices and highlight the need for policies that reconcile medical ethics with cultural norms (Akram et al., 2024)(Oskouie et al., 2024)(Babgi, 2009)(Alfahmi, 2022). Collaborative approaches involving multiple stakeholders are urged.
Barriers to Implementation of Palliative Care	9/42 Papers	Barriers include lack of training, inadequate policies, insufficient staffing, unsuitable physical environments, and the association of palliative care with death leading to moral distress. These obstacles cause inconsistent application of neonatal palliative care and contribute to nurses' emotional burden (Sousa & Curado, 2023)(Shahintab et al., 2024)(Salmani et al., 2018). Institutional commitment is needed to overcome these challenges.
Novice Nurses' Experience and Preparation	6/42 Papers	Novice nurses face heightened emotional turmoil and ethical paradoxes due to limited experience and inadequate preparation for end-of-life care. The absence of structured support and education leaves them vulnerable to distress and hinders professional development (Shahzeydi et al., 2025) (Camara et al., 2024). Early integration of practical end-of-life education is recommended.
Cultural Diversity among Nursing Workforce	6/42 Papers	The culturally diverse nursing workforce in Saudi Arabia encounters challenges in delivering culturally congruent care due to language barriers, differing cultural backgrounds, and varying religious beliefs. Openness to diversity and targeted cultural competence education facilitate overcoming these challenges (Mutair et al., 2019) (Mani, 2024) (Davies et al., 2025).
Creation of Memories and Family Support	5/42 Papers	Facilitating memory-making with terminally ill neonates supports family coping and affirms the infant's dignity. Multidisciplinary teams with specialized skills are essential to address emotional and ethical complexities during the grieving process (Christina et al., 2023) (Moraes et al., 2015).
Compassion Fatigue and Its Correlates	5/42 Papers	Compassion fatigue among neonatal nurses is linked to age, education, shift work, and certification status. It negatively impacts care quality and is correlated with organizational resources. Addressing compassion fatigue requires institutional awareness and culturally tailored support programs (BOZDAĞ et al., 2024) (Salmani et al., 2018).
Communication in Pediatric Palliative Care	4/42 Papers	Communication strategies in pediatric palliative care must be culturally humble and family-centered, especially for neurologically ill children. Misaligned messaging and institutional hesitancy can impair trust and timely referrals (Benedetti et al., 2025) (Ng & Fung, 2023).

Theme	Appears in	Theme Description
Legal Perspectives on End-of-Life Care	3/42 Papers	Differences between Islamic and secular legal frameworks affect end-of-life care decisions and practices in Saudi Arabia versus other contexts like the United States, influencing nursing roles and ethical considerations (Babgi, 2009) (Akram et al., 2024).
Integration of Spiritual Care in Clinical Practice	3/42 Papers	Incorporating spiritual care into neonatal end-of-life practice addresses ethical tensions and supports patients' dignity. However, institutional frameworks for spiritual care are often lacking, necessitating development of culturally responsive protocols (Ali et al., 2025) (Ng & Fung, 2023).
Professional Identity and Meaningful Work	3/42 Papers	Nurses' sense of purpose and career motivation are influenced by cultural understanding, career growth opportunities, and societal perceptions of nursing in Saudi Arabia. Improving public image and addressing social determinants can enhance retention and job satisfaction (Davies et al., 2025).
Cross-Cultural Comparisons in End-of-Life Care	3/42 Papers	Comparative analyses reveal differing emphases on family-centric versus individualistic approaches to end-of-life decision-making between Arab Middle Eastern and Western contexts, impacting care delivery and ethics (McParland et al., 2025) (Kim et al., 2019).

Table 2
Summary of the studies

#	Study	Emotional Impact Assessment	Ethical Decision-Making Frameworks	Cultural and Religious Influence	Organizational Support and Education	Resilience and Professional Development
1	(Elsharkawy et al., 2025)	High emotional distress; faith-based coping and meaning-making.	Ethical dilemmas shaped by cultural-religious values; limited institutional guidance.	Strong influence of Islamic faith and family support on coping.	Limited organizational support; need for culturally sensitive interventions.	Resilience develops through career stages; professional identity integration.
2	(Al Mutair et al., 2019)	Emotional burden linked to communication challenges with Muslim families.	Ethical care framed by respect for cultural diversity and family needs.	Muslim cultural practices central to care; diversity among nursing staff.	Organizational challenges due to workforce diversity; emphasis on cultural competence training.	Coping strategies include self-care transcending cultural differences.
3	(Khraisat et al., 2023)	Moderate emotional impact; lack of training increases distress.	Ethical challenges in discussing DNR and transition to palliative care.	Cultural sensitivity needed in spiritual support discussions.	Deficiency in neonatal palliative care education and training programs.	Professional growth hindered by educational gaps.
4	(Pinto & Pereira, 2024)	Emotional challenges implicit in ethical dilemmas of neonatal palliative care.	Complex ethical dilemmas due to prematurity and long-term outcomes; shared decision-making emphasized.	Cultural and interprofessional collaboration challenges noted.	Need for integrated training and ethical decision frameworks.	Professional competence linked to education and interprofessional collaboration.
5	(Wong et al., 2023)	Distress from neonatal death; guilt and compassion fatigue prevalent.	Ethical discomfort with death; poor communication exacerbates dilemmas.	Cultural context influences family interactions and team dynamics.	Organizational support inconsistent; coping aided by team support and workflows.	Meaning-making and team cohesion foster resilience.
6	(Lee et al., 2024)	Moral distress prevalent; negative and positive impacts identified.	Moral distress analyzed via ecological and moral distress models.	Cultural factors influence moral distress experiences.	Organizational culture and policy support critical to managing distress.	Resilience linked to organizational support and training.
7	(Alshammari et al., 2023)	Emotional impact tied to beliefs about end-of-life care; feelings of hopelessness.	Ethical tensions in truth-telling and care approaches.	Cultural competence essential due to diverse beliefs among nurses.	Education and multidisciplinary collaboration improve care quality.	Professional development influenced by education and cultural competence.
8	(Sousa & Curado, 2023)	Emotional burden linked to lack of training and communication barriers.	Ethical dilemmas arise from conflicts between curative and palliative care.	Cultural and religious factors complicate communication and decision-making.	Organizational barriers include inadequate policies and environment.	Training and policy development needed for resilience and care consistency.
9	(Abuhammad et al., 2023)	Emotional impact related to inadequate knowledge and attitudes.	Ethical challenges stem from insufficient education and preparedness.	Cultural competence gaps affect care delivery.	Educational interventions improve knowledge and attitudes.	Professional growth dependent on targeted education.
10	(Chin et al., 2021)	Emotional distress mitigated by unit culture and education.	Ethical concerns about inappropriate care practices.	Cultural sensitivity enhanced by policy and education.	Presence of NPC policy and education correlates with positive attitudes.	Professional sustainability linked to supportive unit culture.
11	(Lindsay et al., 2012)	Emotional toll from proximity to suffering and death.	Ethical tensions in managing end-of-life care.	Cultural context shapes relational patterns with families.	Organizational support not explicitly detailed.	Professional identity shaped through narrative experiences.
12	(Welborn, 2021)	Emotional distress from role conflict as final comforter.	Ethical challenges in providing comfort without family presence.	Cultural expectations influence nurse roles.	Education, mentorship, and grief support critical.	Resilience fostered through education and peer support.
13	(Shahintab et al., 2022)	Emotional challenges due to poor adherence to care standards.	Ethical concerns from inadequate care provision.	Cultural factors implicit in care quality issues.	Lack of comprehensive guidelines and training.	Professional development hindered by systemic gaps.
14	(Brichard et al., 2025)	Emotional burden linked to moral and ethical challenges.	Ethical dilemmas prominent; need for earlier palliative integration.	Cultural context influences team cohesion and care quality.	Training and team strengthening recommended.	Resilience enhanced by education and team support.
15	(Bozdog et al., 2025)	Compassion fatigue and moral conflict prevalent.	Ethical conflicts related to palliative care provision.	Cultural attitudes affect moral/ethical conflicts.	Organizational resources and education impact compassion fatigue.	Resilience linked to organizational support and education.
16	(Redman et al., 2024)	Emotional impact underexplored; focus on cultural disparities.	Ethical considerations in culturally sensitive care.	Cultural diversity shapes neonatal palliative care needs.	Organizational gaps in addressing cultural disparities.	Professional development requires cultural competence training.
17	(Carew et al., 2024)	Emotional stress from balancing clinical priorities and family needs.	Ethical challenges in family-centered and cultural care.	Cultural needs often misunderstood or conflated with family care.	Organizational leadership and education needed for cultural competence.	Professional growth linked to leadership and education.
18	(Shoaib et al., 2023)	Emotional challenges in managing Islamic perspectives on care.	Ethical decision-making guided by Islamic law and fatwas.	Islamic beliefs central to care decisions and family interactions.	Organizational need for culturally informed protocols.	Professional competence linked to understanding Islamic bioethics.
19	(Montes Bueno et al., 2024)	Emotional burden from lack of training and protocols.	Ethical dilemmas due to absence of standardized EOL protocols.	Cultural factors influence care practices in Iberoamerica.	Organizational deficits in training and protocol availability.	Professional development limited by systemic shortcomings.

#	Study	Emotional Impact Assessment	Ethical Decision-Making Frameworks	Cultural and Religious Influence	Organizational Support and Education	Resilience and Professional Development
20	(Mani, 2024)	Emotional challenges in providing culturally sensitive care.	Ethical tensions in balancing cultural and medical practices.	Islamic beliefs and family central to care approach.	Organizational need for cultural communication training.	Resilience supported by education and holistic care focus.
21	(MANI, 2024)	Emotional burden from intercultural anxieties and family dynamics	Ethical dilemmas in honoring diverse spiritual needs.	Islamic faith and family involvement emphasized.	Organizational challenges in cultural sensitivity training.	Professional growth through cultural competence and advocacy.
22	(Akram et al., 2025)	Emotional impact from evolving EOL care landscape.	Ethical frameworks aligned with Islamic principles.	Cultural and religious values integrated into legal and care systems.	Organizational progress in legislation and infrastructure.	Professional development supported by national initiatives.
23	(Al-Harrasi et al., 2025)	Emotional burden from stigma and systemic challenges.	Ethical issues related to cultural acceptance of palliative care.	Islamic teachings and family traditions shape care.	Organizational barriers include limited training and access.	Resilience fostered through community engagement and education.
24	(Ali et al., 2025)	Emotional labor from managing spiritual fasting conflicts.	Ethical tensions between autonomy and care responsibility.	Islamic spiritual practices influence care decisions.	Organizational lack of support for spiritual care noted.	Professional resilience requires ethical and cultural training.
25	(Davies & Yarrow, 2025)	Emotional distress from poor working conditions and discrimination.	Ethical challenges linked to workforce inequities.	Cultural and social determinants affect nurse wellbeing.	Organizational deficits in support and education.	Resilience hindered by systemic inequities and lack of growth.
26	(Benedetti et al., 2025)	Emotional challenges in cross-cultural communication.	Ethical complexities in interdisciplinary PPC.	Cultural humility essential for family-centered care.	Organizational need for structured communication tools.	Professional development through cultural competence training.
27	(Alabdullah et al., 2022)	Emotional stress from workload and death exposure.	Ethical challenges implicit in workplace stress.	Cultural factors influence stress management.	Organizational support variable; stress management needed.	Resilience linked to individual and organizational strategies.
28	(Cuartero-Castañer et al., 2025a)	Emotional impact from cultural and spiritual care challenges.	Ethical tensions in integrating spiritual beliefs.	Cultural and spiritual diversity affects care approaches.	Organizational need for culturally competent training.	Resilience linked to cultural sensitivity and education.
29	(Oskouie et al., 2024)	Emotional burden from social and legal decision-making factors.	Ethical dilemmas influenced by societal and legal gaps.	Cultural and religious norms shape parental participation.	Organizational need for collaborative legal and ethical frameworks.	Resilience dependent on systemic support and education.
30	(Leguia & Arnedo, 2023)	Emotional challenges in bioethical decision-making.	Ethical emphasis on shared decision-making with families.	Cultural respect essential in ethical care.	Organizational need for multidisciplinary involvement.	Professional growth linked to ethical training.
31	(Kim et al., 2019)	Emotional distress from limited parental involvement.	Ethical challenges in decision-making trends.	Cultural and religious factors influence care practices.	Organizational variability in EOL care implementation.	Professional preparedness linked to cultural context.
32	(Shahintab et al., 2022)	Emotional burden from poor adherence to care standards.	Ethical concerns from inadequate EOL nursing care.	Cultural factors implicit in care quality.	Organizational lack of guidelines and training.	Professional development hindered by systemic gaps.
33	(Shahzeydi et al., 2025)	Emotional turmoil in novice nurses facing death.	Ethical paradoxes and systemic gaps identified.	Cultural-spiritual meaning-making critical.	Organizational lack of support for novice nurses.	Resilience fostered through education and support systems.
34	(Babgi, 2009)	Emotional impact from legal differences in EOL care.	Ethical frameworks differ between Saudi and US contexts.	Islamic law central to Saudi EOL legal issues.	Organizational legal frameworks influence care.	Professional competence linked to legal understanding.
35	(Almalki et al., 2024)	Emotional distress from ICU environment and cultural challenges.	Ethical dilemmas in ICU EOL care practices.	Cultural and spiritual practices affect care.	Organizational structure and communication impact care.	Resilience linked to organizational improvements.
36	(salmani et al., 2018)	Emotional burden from multiple barriers to palliative care.	Ethical distress from conflicting values and knowledge gaps.	Cultural and religious beliefs influence barriers.	Organizational deficits in policies and education.	Professional development requires systemic solutions.
37	(Alfahmi, 2022)	Emotional challenges in disclosure practices.	Ethical tensions between family authority and patient autonomy.	Cultural values influence disclosure norms.	Organizational need for ethical guidelines.	Professional growth linked to ethical education.
38	(AL-Qatameen et al., 2024)	Emotional stress in providing comfort care.	Ethical challenges in quality comfort care provision.	Cultural beliefs shape care experiences.	Organizational lack of policies and education.	Resilience supported by staffing and policy improvements.
39	(Ng & Fung, 2023)	Emotional impact from spiritual and cultural diversity.	Ethical complexities in individualized EOL decisions.	Cultural and spiritual diversity requires tailored care.	Organizational need for culturally sensitive counseling.	Professional development through cultural competence.
40	(McParland et al., 2025)	Emotional burden from differing cultural decision-making.	Ethical differences between Arab and UK contexts.	Cultural and spiritual factors shape EOL decisions.	Organizational implications for culturally coherent care.	Resilience linked to cultural understanding.
41	(Camara et al., 2024)	Emotional impact on nursing students in EOL care.	Ethical challenges in education and support.	Cultural competence needed in student training.	Organizational need for improved education and support.	Professional growth fostered by early education.
42	(Christina et al., 2023)	Emotional toll in creating memories with terminal neonates.	Ethical considerations in family support and dignity.	Cultural and spiritual practices central to memory-making.	Organizational role in multidisciplinary support.	Resilience fostered through team and national initiatives.

D. Results

1) Descriptive Summary of the Studies

The body of literature on this topic is methodologically varied — it includes phenomenological studies, cross-sectional surveys, systematic reviews, and narrative analyses — and covers NICUs primarily in Saudi Arabia and culturally similar settings. Across this range of studies, certain themes keep appearing: emotional distress, ethical conflict, the influence of

Islamic values, gaps in organizational support, and the slow, uneven development of nurse resilience. What this breadth of evidence makes clear is that neonatal nurses face challenges that cut across multiple domains simultaneously, and that gaps in education, policy, and support are felt throughout the Emotional Impact Assessment.

Across thirty studies, the finding was consistent: neonatal nurses carry significant emotional weight. Grief after infant

death, compassion fatigue from sustained exposure to family suffering, and moral distress from ethically ambiguous situations all feature prominently, and all tend to be worsened by poor training and inadequate organizational support (Bozdog et al., 2025; Elsharkawy et al., 2025; Wong et al., 2023).

How nurses cope emotionally is deeply shaped by their cultural and religious context. Prayer, faith-based acceptance, and finding personal meaning in difficult work are among the most commonly reported strategies alongside a more protective emotional distancing that helps nurses' function without being overwhelmed (Al Mutair et al., 2019; Ali et al., 2025; Elsharkawy et al., 2025).

Newer nurses are particularly at risk. Without the experience and professional identity that develops over years of practice, they face the same emotionally intense situations as their senior colleagues but with far fewer internal and external resources to draw on. The research is clear that structured mentorship and support matter most in those early career stages (Shahzeydi et al., 2025; Welborn, 2021).

2) *Ethical Decision-Making Frameworks*

Twenty-eight studies documented the ethical complexity nurses encounter in end-of-life care. Decisions about withdrawing life-sustaining treatment, how much truth to tell families and when, and how to navigate the shift from curative to comfort-focused care all generate genuine moral difficulty (Alfahmi, 2022; Fernandes Pinto & Pereira, 2024; Lee et al., 2024).

In the Saudi context, Islamic bioethics and family-centered cultural norms significantly shape how ethical decisions are made. The emphasis is on collective rather than individual decision-making, with family involvement often taking precedence over patient autonomy as understood in Western frameworks (Alfahmi, 2022; Babgi, 2009; Shoaib et al., 2023).

When institutional protocols are unclear, absent, or applied inconsistently, nurses are left to make difficult ethical judgments without adequate guidance. This institutional vacuum is a documented source of moral distress in its own right (Mani, 2024; salmani et al., 2018).

3) *Cultural and Religious Influence*

Thirty-five studies pointed to the same conclusion: Islamic beliefs, family-centred values, and broader cultural norms fundamentally shape how care is provided and how families engage with clinical staff in Saudi Arabia and similar settings (Al-Harrasi et al., 2025; Elsharkawy et al., 2025; Mani, 2024).

The nursing workforce in Saudi hospitals is highly multicultural, and this diversity introduces real communication challenges. Nurses from different countries and traditions may hold different assumptions about end-of-life care, and these can create friction in care delivery if not actively addressed through training (Al Mutair et al., 2019; Alshammari et al., 2023; Carew et al., 2024).

Cultural and spiritual sensitivity is not just a nice quality to have it is central to delivering care that genuinely respects the person dying and the family left behind. And this sensitivity needs to extend to diversity within religious communities, not just between them (Cuartero-Castañer et al., 2025; Ng & Fung, 2023).

4) *Organizational Support and Education*

Organizational failings are a recurring theme. Thirty-two studies found significant gaps in the formal support available to nurses: no education in palliative care, chronic understaffing, a lack of clear policies, and almost no psychological support when things go wrong (Davies & Yarrow, 2025; Khraisat et al., 2023; Sousa & Curado, 2023).

Where policies and education programs do exist, the difference is measurable. Nurses in settings with structured support show better attitudes toward palliative care and deliver more consistent, higher-quality care (Chin et al., 2021; Mani, 2024). The recommendations that emerge from this literature are consistent: communication training that is culturally grounded, genuine multidisciplinary collaboration, and regular structured debriefing after difficult cases. These are not radical innovations — they are practical measures that institutions have been slow to implement (Mani, 2024; MANI, 2024).

5) *Resilience and Professional Development*

Twenty-seven studies found that resilience in this work is not a fixed trait but something that builds over time through accumulated experience, a clearer sense of professional identity, and workplaces that actually support nurses rather than simply expecting them to manage (Brichard et al., 2025; Elsharkawy et al., 2025; Lee et al., 2024).

Professional development does not happen in a vacuum, and systemic barriers are real. Inadequate training, discriminatory workplace practices, and poor working conditions all impede growth and expatriate nurses, who make up a large share of the Saudi NICU workforce, are disproportionately affected (Davies & Yarrow, 2025; Shahzeydi et al., 2025).

What actually builds resilience, according to the evidence, is investment: in education, in mentorship relationships, and in support systems that genuinely reflect the cultural context nurses are working in. Without these, compassionate care becomes impossible to sustain over a career (Camara et al., 2024; Christina et al., 2023; Welborn, 2021).

6) *Thematic Review of Literature*

Reading across the literature, what stands out is how interconnected the challenges are. Emotional burden, ethical conflict, cultural expectation, and organizational failure do not operate independently they reinforce each other. A nurse struggling with grief from a recent death is also more vulnerable to moral distress, especially if the institution provides no debriefing and the family's religious expectations made the clinical decisions more fraught.

E. *Theoretical and Practical Implications*

1) *Theoretical Implications*

Taken together, the findings support and extend existing theoretical work on moral distress and nurse coping. What the Saudi context adds is a richer understanding of how faith and cultural identity mediate both the experience of stress and the choice of coping strategies. Islamic bioethics does not simply create ethical dilemmas, it is also a resource nurses draw on when they are struggling (Alfahmi, 2022; Elsharkawy et al., 2025; Lee et al., 2024).

The literature reviewed here also challenges the dominant

Western framing of end-of-life care, one built around individual patient autonomy. In Saudi Arabia and similar contexts, family involvement and collective decision-making are not peripheral but central to how care unfolds.

Theoretical frameworks that cannot accommodate this reality are of limited use in these settings, and there is a genuine need for models that reflect local sociocultural values rather than simply translating Western assumptions into a different language (MANI, 2024; Mani, 2024; McParland *et al.*, 2025).

The evidence also fits well with post-traumatic growth frameworks. Resilience among neonatal nurses is not something they either have or do not have, it is built through experience, through making meaning of difficult events, and through the particular cultural and religious lenses through which nurses interpret their work. This is a dynamic, ongoing process rather than a fixed outcome (Elsharkawy *et al.*, 2025; Shahzeydi *et al.*, 2025).

Multi-level models of moral distress are well supported by this literature. The ethical difficulties nurses face do not stem from personal weakness or individual failure — they are produced by a combination of factors operating at the level of the individual nurse, the team, the institution, and the broader cultural system (Alabdullah *et al.*, 2022; Lee *et al.*, 2024).

The literature also reveals gaps in the ethical frameworks available to practitioners. How to handle disclosure decisions when family authority is culturally dominant, how to balance Islamic imperatives with clinical judgment, these are questions that existing bioethical frameworks do not adequately address. There is a need for culturally grounded bioethics that takes these tensions seriously rather than resolving them by default toward a Western model of patient autonomy (Alfahmi, 2022; Babgi, 2009).

Finally, the literature makes a strong case for extending our theoretical understanding of palliative care beyond the biomedical. Spiritual practices and cultural rituals are not supplementary to care — they are, for many families and nurses, its substance. Recognizing this is not just ethically important; it changes what good care looks like in practice (Castañer *et al.*, 2025b; Ng & Fung, 2023).

2) *Practical Implications*

Saudi healthcare institutions need to develop end-of-life care guidelines and training programs that are genuinely built around the local context not adapted from Western templates, but developed with Islamic ethical principles and family-centred care as their foundation. Nurses cannot be expected to navigate these situations without that backing (Mani, 2024; Mani, 2024; Akram *et al.*, 2024).

Policy changes are also necessary. Institutional barriers the absence of formal palliative care education, chronic understaffing, and negligible psychological support do not fix themselves. Without explicit policy commitment to addressing them, moral distress and compassion fatigue will persist, and so will high turnover among the nurses who do this work (Khraisat *et al.*, 2023; Sousa & Curado, 2023; BOZDAĞ *et al.*, 2024).

Mentorship deserves particular attention. Nurses who take on intimate roles sitting with a dying infant, supporting a family in the final hours need structured grief education and follow-up

support, not just informal peer conversations in a break room. These roles carry real emotional cost, and recognising that cost institutionally is a necessary first step (Elsharkawy *et al.*, 2025; Welborn, 2021).

Workforce equity is also a practical issue. Expatriate female nurses represent a large proportion of the neonatal care workforce in Saudi Arabia, yet often face worse pay, more limited career development, and higher rates of discrimination than their Saudi counterparts. Addressing this is not just fair it is essential for a stable, competent workforce (Davies *et al.*, 2025).

Communication training is one of the most actionable recommendations in the literature. Teaching nurses how to have culturally sensitive conversations about death and dying conversations that meet families where they are, within their religious and cultural framework can reduce misunderstanding, ease ethical tension, and support genuinely shared decision-making (Carew *et al.*, 2024; MANI, 2024; Mani, 2024).

Structurally, hospitals that establish dedicated neonatal palliative care units and invest in multidisciplinary teamwork create environments where nurses are not carrying the ethical and emotional burden alone. That matters for nurse wellbeing, for family experience, and for the quality of care neonates receive in their final hours (Alshammari *et al.*, 2023; Brichard *et al.*, 2025; salmani *et al.*, 2018).

F. *Limitations of the Literature*

A recurring limitation across the reviewed studies is geographic bias. Many investigations are confined to specific regions or countries, which restricts the external validity and generalizability of findings. This narrow focus risks overlooking cultural nuances and differences in healthcare systems that shape nurses' experiences in end-of-life care. For example, El-Sharkawy *et al.* (2025), Mutair *et al.* (2019), Bozdağ *et al.* (2024), Davies *et al.* (2025), and Salmani *et al.* (2018) all situate their research within localized contexts, thereby limiting the applicability of their conclusions to broader, multicultural settings.

Another methodological constraint is the reliance on small, purposive samples, particularly in qualitative studies. While such designs allow for in-depth exploration, they inherently limit statistical power and reduce representativeness. This affects the robustness and transferability of conclusions, making it difficult to generalize findings to larger nursing populations. Studies such as El-Sharkawy *et al.* (2025), Mutair *et al.* (2019), Carew *et al.* (2024), and Shahzeydi *et al.* (2025) exemplify this limitation, as their sample sizes restrict the breadth of perspectives captured.

The absence of longitudinal designs is a significant gap in the literature. Without tracking nurses' experiences over time, it is challenging to understand how coping mechanisms and resilience evolve in end-of-life care contexts. This limitation reduces insight into professional growth and the sustainability of support strategies. El-Sharkawy *et al.* (2025) and Shahzeydi *et al.* (2025) highlight this issue, as their cross-sectional approaches provide only a snapshot rather than a developmental trajectory. Most studies concentrate on experienced nurses,

leaving the unique challenges faced by novice practitioners underexplored. This imbalance affects the comprehensiveness of workforce analyses and obscures the specific support mechanisms needed for early-career nurses. Shahzeydi *et al.* (2025) illustrate this limitation by focusing primarily on seasoned professionals, thereby neglecting the perspectives of those newly entering end-of-life care roles.

Cultural diversity is another underrepresented dimension. Several studies focus predominantly on either local or expatriate nurses, without adequately capturing the interplay of multicultural workforce dynamics. This narrow lens limits understanding of cross-cultural challenges and the support needs of diverse teams. Mutair *et al.* (2019) and Mani (2024) exemplify this limitation, as their research does not fully address the complexities of multicultural nursing environments.

Heavy reliance on self-report methods, such as surveys and interviews, introduces potential biases including social desirability and recall bias. These methodological weaknesses compromise the accuracy and objectivity of reported experiences and attitudes. Bozdağ *et al.* (2024), Ali *et al.* (2025), and Al-Qatameen *et al.* (2023) all depend primarily on self-reported data, which may distort findings and reduce reliability. Limited Interprofessional Perspectives The exclusion or minimal inclusion of other healthcare professionals besides nurses restricts the holistic understanding of end-of-life care.

Without multidisciplinary perspectives, findings risk being overly narrow and less applicable to team-based clinical settings. Sousa and Curado (2023) and Al-Qatameen *et al.* (2023) illustrate this limitation, as their studies focus almost exclusively on nursing viewpoints.

Variability in measurement tools and the lack of validated, neonatal-specific instruments reduce comparability across studies. This inconsistency hinders cumulative knowledge building and makes it difficult to synthesize findings. Sousa and Curado (2023), Abuhhammad *et al.* (2023), and Chin *et al.* (2021) exemplify this issue, as their differing instruments limit cross-study integration.

Few studies deeply explore institutional policies, organizational culture, or systemic factors influencing nurses' experiences. This omission restricts understanding of structural barriers and facilitators in end-of-life care. El-Sharkawy *et al.* (2025), Lee *et al.* (2024), Mani (2024), and Davies *et al.* (2025) highlight this gap, as their analyses remain largely individual-focused rather than organizationally contextualized.

Finally, ethical dilemmas and legal frameworks specific to neonatal end-of-life care remain underexplored. This reduces the depth of insight into decision-making complexities and moral distress experienced by nurses, particularly in culturally sensitive contexts. Pinto and Pereira (2024), Babgi (2009), and Alfahmi (2022) illustrate this limitation, as their work touches only superficially on these critical dimensions.

G. Research Gap

Several high-priority gaps stand out from the literature. Training programs rarely integrate Saudi-specific cultural and religious values, meaning nurses are often sent into end-of-life

situations without the preparation they need to navigate them sensitively (Khraisat *et al.*, 2023; Sousa & Curado, 2023; Mani, 2024). The ethical frameworks that exist are largely theoretical, they have not been rigorously tested against the practical realities nurses face (Pinto & Pereira, 2024; Lee *et al.*, 2024; Alfahmi, 2022). New nurses, who are arguably most at risk, remain largely invisible in the research (Shahzeydi *et al.*, 2025; Welborn, 2021). The organizational gaps, no formal policies, no psychological support make moral distress worse rather than better (Sousa & Curado, 2023; Mani, 2024). Expatriate nurses face inequities that the literature acknowledges but does not adequately address (Davies *et al.*, 2025). Also the absence of standardized palliative care programs means that care quality depends too heavily on the particular hospital and particular nurse rather than on any systemic guarantee (Al-Alaiyan & Al-Hazzani, 2009; Shahintab *et al.*, 2022).

A second set of gaps, somewhat lower in urgency but still important, concerns workforce diversity, longitudinal resilience, family engagement, and spiritual care. Saudi NICUs employ nurses from many different countries and traditions, yet we know very little about how this multicultural composition affects team cohesion or care quality, and even less about what interventions might help (Mutair *et al.*, 2019; Mani, 2024). Almost all resilience research is cross-sectional, we have snapshots, not stories of development over time (Elsharkawy *et al.*, 2025; Lee *et al.*, 2024). Family participation in end-of-life decisions is shaped by communication barriers and cultural assumptions that current engagement models are not designed to address (Carew *et al.*, 2024; Oskouie *et al.*, 2024; Alfahmi, 2022). And spiritual care central to how Muslim families experience illness and death is barely present in NICU practice or nurse training, despite its documented significance (Shoib *et al.*, 2023; Ali *et al.*, 2025; Castañer *et al.*, 2025). Collectively, the research agenda in this field needs to take both sets of gaps seriously.

H. Conclusion

The literature paints a consistent picture: neonatal nurses in Saudi Arabia are doing profoundly difficult work with insufficient backup. The emotional toll grief, compassion fatigue, moral distress, guilt, is real and pervasive, and it is made worse by the fact that training and institutional support are often inadequate or entirely absent. Faith and cultural frameworks are genuine sources of strength for many nurses, and peer solidarity matters, but these informal resources cannot substitute for structured support. Beginner nurses are especially exposed, and the evidence suggests that without mentorship and grief education, the early career years are particularly damaging.

Ethically, nurses are navigating genuinely contested territory. The interplay between Islamic bioethics, family authority, and clinical judgment creates dilemmas that existing frameworks inconsistently applied as they are do not reliably resolve. When family expectations run up against medical evidence, nurses bear the weight of that conflict with little institutional guidance to help them. Clearer policies, developed collaboratively across disciplines and grounded in

Islamic ethical principles, would provide nurses with a firmer foundation.

Cultural and religious influences profoundly shape end-of-life care practices, with Islamic beliefs and family involvement forming the cornerstone of care approaches. The multicultural composition of the nursing workforce introduces additional challenges in communication and cultural competence, necessitating targeted education and culturally sensitive communication training to bridge gaps and enhance care quality. Despite recognition of the importance of cultural competence, standardized training programs and organizational strategies to support cultural diversity remain insufficiently developed and implemented.

The organizational picture is one of chronic underinvestment. Education, staffing, psychological support, clear protocols all of them in short supply. The contrast with settings where these things are in place is striking: nurses who are trained and supported consistently deliver better care and hold more positive attitudes toward palliative work. The evidence for investing in people is strong. What is missing is institutional will to act on it, particularly for expatriate nurses who face discrimination and limited career pathways on top of everything else.

The conclusion is straightforward even if the path to it is complex: Saudi healthcare institutions need to take neonatal end-of-life care seriously as an organizational responsibility, not just an individual nursing challenge. That means building education programs that actually reflect the cultural and religious context, creating structured support systems for nurses, and developing the kind of multidisciplinary teamwork that distributes the moral weight more fairly. When that investment is made, both nurses and families benefit.

Conceptual and theoretical Framework: This study focuses on exploring the lived experiences of neonatal nurses in providing EoL care to newborns and their families within the NICU at DSFH, Jeddah. The problem is that neonatal nurses face profound emotional, ethical, and cultural challenges in EoL care without adequate institutional support. The purpose of the study is to understand these experiences in order to inform training, policy, and culturally sensitive practice. The population consists of neonatal nurses working in Saudi NICUs, and the context is the intersection of clinical decision-making, family support, and cultural expectations. Key concepts include emotional burden, ethical dilemmas, cultural and religious influences, coping strategies, and institutional support (Banazadeh & Rafii, 2020; Cerratti et al., 2020; Han et al., 2023; Khraisat et al., 2023).

Rather than testing a single theory, the study uses a conceptual framework that maps the relationships between several constructs simultaneously. This approach is better suited to qualitative research in this kind of setting, where nurses' experiences are shaped by clinical stress, cultural identity, religious belief, and institutional context all at once, and where separating these threads would distort what they are actually experiencing.

Lazarus and Folkman's (1984) transactional model of stress and coping provides a useful starting point. The model draws

attention to how individuals appraise stressors, whether a situation is experienced as threatening or manageable, and how that appraisal shapes the coping strategies they reach for, whether problem-focused or emotion-focused (Folkman et al., 1986). Among ICU nurses in Saudi Arabia, religious belief has been found to be the most frequently reported coping strategy, a finding that reflects how deeply faith is woven into everyday stress management in this context. The flip side is also documented: strategies like self-blame and behavioural disengagement tend to amplify perceived stress rather than reduce it (Alharbi & Alshehry, 2019).

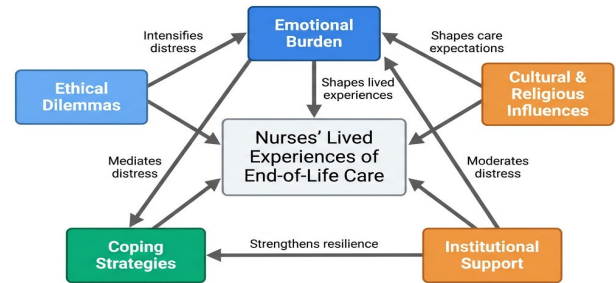


Fig. 1. Conceptual framework for neonatal nurses' experiences of End-of-life care in Saudi NICU

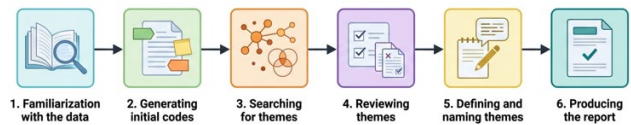


Fig. 2. Six-phases reflexive thematic analysis

Leininger's Cultural Care Theory (1991) adds the cultural dimension that stress-and-coping models on their own cannot fully capture. Her framework insists that how people understand illness, care, and dying is always shaped by cultural and religious values and that good care must be congruent with those values, not indifferent to them (Leininger, 1996). In the Saudi NICU context, this means taking Islamic beliefs, family involvement, and traditional practices seriously as clinical realities rather than peripheral concerns. Research with Saudi ICU nurses consistently shows that themes of faith, family presence, and collective moral responsibility are at the heart of how both nurses and patients experience care (Alanazi, 2024; Mani, 2024).

Used together, these two frameworks offer a more complete picture. When a nurse encounters a morally difficult situation, a DNR order that feels wrong, a family in crisis, an infant in pain, she brings both a cognitive appraisal process and a culturally and religiously shaped set of meanings to that encounter. Those meanings influence which coping strategies feel available and acceptable. Faith-based responses fit within Lazarus and Folkman's category of emotion-focused coping, but their specific form and texture are only intelligible through Leininger's cultural lens (Leininger, 1996).

The framework maps five interconnected constructs: the stressors nurses face (clinical, cultural, and organizational), the appraisal process through which they interpret those stressors, the coping strategies they draw on, the institutional support that

shapes what is available to them, and the outcomes, for the nurse and for the families they care for. Culture and religion are not confined to one stage of this process. They shape how stress is perceived and how it is managed, and they are present throughout.

Using this framework in a qualitative study means being able to follow the full shape of nurses' experiences, not just cataloguing stressors, but understanding how culture mediates everything from initial appraisal to the strategies nurses reach for when they are struggling. That kind of nuanced, contextual understanding is what is needed if the goal is to develop support interventions that will actually work in a Saudi NICU setting.

Bringing Lazarus and Folkman together with Leininger produces a theoretical foundation that is both rigorous and culturally grounded, precisely what is needed for a study asking how nurses experience end-of-life care in Saudi Arabia. It allows the research to be systematic without stripping out the cultural specificity that makes the Saudi context what it is (Alanazi, 2024; Alharbi & Alshehry, 2019; Mani, 2024).

The framework on key constructs in neonatal EoL care identifies five core variables affecting nurses' experiences. Emotional burden refers to the psychological strain felt by nurses caring for dying infants and families, manifested through grief and compassion fatigue. Ethical dilemmas involve moral distress from conflicting priorities between life preservation and directives like DNR orders. Cultural and religious influences emphasize the role of Islamic bioethics and family expectations in care practices, noted through rituals and decision-making conflicts. Coping strategies are adaptive methods such as peer support and emotional distancing that nurses employ to manage stress. Lastly, institutional support encompasses organizational resources that provide training and psychological assistance. The relationships between these constructs indicate that emotional burden is exacerbated by ethical dilemmas and cultural influences; while coping strategies mitigate distress and institutional support enhances resilience, ultimately influencing the quality of care provided. Each construct is operationalized through qualitative indicators, shaping the interview questions and thematic analysis for data collection (Braun & Clarke, 2022).

3. Methods

A. Study Design

The present work used a qualitative method to understand the circumstances surrounding the delivery of palliative care by neonatal nurses to newborns and their families in DSFH, Jeddah. This paper is best suited for qualitative research mainly because it focuses on the individual and emotional/ethical experiences of the targeted neonatal nurses in healthcare facilities.

Phenomenology was used to analyze the ways in which a number of nurses understood their tasks in the context of neonatal EoL care. This approach is appropriate because it involved embracing the global phenomena from the view point of individuals who have firsthand encounter of it (Banazadeh & Rafii, 2020).

The semi structured interview tool best fit the phenomenological paradigm because the research interviews are almost unstructured but are not completely so; the participants can state and display their emotions as well as their challenges in detail. This method will particularly suitable for generating large amount of qualitative data while at the same time having control on what is traditionally considered important areas of concern such as ethical issues, stress, and resilience (Cerratti *et al.*, 2020). Thus, by applying this design, the study obtained rich qualitative data regarding the ethical and emotional experience of neonatal nurses in Saudi Arabia and the ways to enhance it and, therefore, the quality of neonatal care.

B. Study Setting

The research was conducted in DSFH which is in Jeddah, KSA. This private hospital was among the best NICU provider; they have implemented the modern medical approach with 48 cultural considerations (Dombrecht *et al.*, 2020). The hospital is well suited for research due to its extensive NICU personnel population and because the NICU treats newborns who are critically ill from all the surrounding areas. The NICU of the center has modern facilities and was manned by qualified personnel, thus can serve as an appropriate setting to study various emotional and ethical issues that nurses encountered in the delivery of EoL care for neonates.

Since the hospital complies with IMSS and Saudi Arabian culture, the latter impacted EoL choices. The NICU of DSFH works in this culturally sensitive environment and posed certain challenges upon the nursing staff – to remain culturally sensitive while providing medical care that will not compromise religious expectations of the patient's families. The site chosen will enable an analysis of how the identified dynamics are managed by nurses, especially in cases where the use of Life-Sustaining Treatment is an issue.

C. Study Population

The target group was the neonatal nurses who are employed in NICU of Doctor Soliman Fakeeh Hospital in KSA-Jeddah. These nurses are chosen because they practice actual EoL care for ICNIC patients during which they develop strong emotional and ethical connections. For neonatal nurses working in this context, their understanding of experiences and child death involved managing physical, technological and emotional care as well as addressing; the organizational policy on supporting grieving families while balancing medical responsibilities.

Participants included both junior and senior nurses to ensure that a diverse selection of experiences and perspectives was attained. Such sampling variation enhanced the understanding of nurses' experiences as per their training level and interaction with end-of-life situations (Cerratti *et al.*, 2020). As Doctor Soliman Fakeeh Hospital had multicultural and multiregulated staff, the study benefited from multiple views in depth regarding emotions and ethics concerning newborn care.

D. Sampling and Sample Size

A purposive sampling method was used in this study with the aim of getting participants. The reason why purposive sampling

is suitable for qualitative study is because it involved the deliberate selection of participants who had some understanding of the study area of concern (Beltran & Hamel, 2021). Specifically, only neonatal nurses who had opportunities to practice giving end of life care to infants were recruited.

This study interviewed 10 neonatal nurses, thus was the point of data saturation, this point referred to the stage at which no further themes or information were obtained from the interviews. Concept saturation also helped to prevent the research from providing repetitive information.

Altogether, this was a reasonable sample size for qualitative research but at the same time diverse enough.

Inclusion Criteria: 1.2. Neonatal nurses with more than one year of working experience in the NICU at Doctor Soliman Fakeeh Hospital. This criterion was established to ensure that participants had reached a level of professional maturity and had sufficient time to encounter the complex dynamics of the NICU environment.

Nurses who had personally attended to infants at the end of their lives and their families. This was essential to ensure that the data collected were grounded in direct personal experience of the phenomenon under study. 503. Nurses who were open to discussing their emotional and ethical experiences. Qualitative research relies on the depth of participant disclosure, making willingness to share a critical requirement for data richness.

Exclusion Criteria: Neonatal nurses with less than one year of working experience in the NICU at Doctor Soliman Fakeeh Medical Center. This criterion was established to ensure that participants had reached a level of professional maturity and had sufficient time to encounter the complex dynamics of the NICU environment.

Nurses who hadn't personally attended to newborn at the end of their lives and their families. This was essential to ensure that the data collected were grounded in direct personal experience of the phenomenon under study. Nurses who weren't open to discussing their emotional and ethical experiences. Qualitative research relies on the depth of participant disclosure, making willingness to share a critical requirement for data richness.

This sampling technique ensured that the participants are qualified in neonatal EoL care and therefore provided adequate information to influence the analysis.

E. Data Collection Instruments

The data collection followed a structured and reflexive process. Each interview began with an explanation of the study's purpose and the securing of informed consent. I conducted semistructured, one-on-one interviews in a private room to ensure confidentiality and comfort. A brief introductory session was held to build rapport, followed by the core interview questions. In some 51 cases, follow-up interviews were conducted to clarify specific responses or to delve deeper into emerging themes, ensuring a "brief story" of the nursing experience was fully captured. This iterative process allowed for a richer narrative and ensured that the findings were grounded in the participants' authentic voices. Qualitative research was the most suitable for this study, since

the participant were encouraged to give opinions and feelings without much restriction, while some issues of discussion were predetermined (Beltran & Hamel, 2021). The interview contained general questions (Appendix I) including issues on emotions and ethics of nurses when attending to patients at their demise, their relationship with the families and methods they use to cope with stress.

Due to the structure, the interviewer was free to follow up on details provided by participants whenever necessary to further understand their experiences (Banazadeh & Rafii, 2020). Each interview lasted roughly between 45 minutes and an hour so that participants had ample opportunity to express what was on their mind. Face-to-face interviews were conducted in patient rooms, and some parts of the interviews were held in a private cabin in the hospital to maintain anonymity and help participants feel relaxed. Audio recording, with permission from participants, enhanced the validity of the data collected.

F. Data Collection Procedure

Before actual data collection, permission was sought from the Institution Review Board IRB at Doctor Soliman Fakeeh Hospital. After approval subjects were identified through direct contact with NICU managers and participation was based on consent. Eligible nurses were given an information sheet outlining the study purpose, their role, anonymity, and data security (Cerratti *et al.*, 2020).

The interviews were conducted in a separate room of the hospital to protect privacy and create an atmosphere of comfort. Once participants agreed to participate, they signed an informed consent form before interviews commenced. Interviews were voice-recorded when permitted to avoid distractions during note-taking. At the end of each interview, participants were offered the option to review transcripts and correct any inaccuracies. Participants were also debriefed to check their emotional state after the interview. This debriefing session was conducted informally to ensure participants did not experience any immediate psychological distress and to offer information about available institutional counseling services if needed. after the interview.

This process ensured that all data were collected while participants' rights and well-being were protected (Abdel Razeq & Al-Gamal, 2021).

G. Data Organization, Storage and Analysis

All data, audio recordings, notes, and transcripts were stored in a password-protected digital folder accessible only to the researcher. Participants were identified by code numbers in all documents, and any identifying information was removed from transcripts before analysis began (Piette *et al.*, 2022).

Transcripts were read multiple times to check accuracy before analysis began. Reflexive thematic analysis following Braun & Clarke, (2006) was used an approach suited to this kind of interpretive, exploratory research. The process moved through familiarisation, initial coding, candidate theme development, and theme review. NVivo 14 was used to manage the data and support systematic coding across all ten transcripts (Cerratti *et al.*, 2020).

H. Ethical and Administrative Considerations

Ethical and administrative issues were critical in this research since neonatal end of life care is highly sensitive and are most often sensitive. Ethical clearance was obtained from Doctor Soliman Fakeeh Hospital IRB in conformity with national and international ethical rules. Informed consent ensured participants' full understanding of study objectives, processes, and their right to withdraw at any time without explanation (Banazadeh & Rafii, 2020).

Participants' emotional states were debriefed after interviews, and those requiring support were directed to professional help. Data analysis was conducted without revealing participants' identities or the organization. Consent from the hospital was sought to conduct interviews with NICU clients, and all data collected complied with national data protection acts.

Raw data were accessed only by the researcher and supervisors. Further measures were taken to avoid interfering with hospital functioning or placing undue pressure on nurses' participants. Interviews were rescheduled at convenient times so as not to compromise work schedules.

4. Results

A. Qualitative Data Analysis

The study took an interpretivist stance a deliberate choice given the subject matter. Neonatal end-of-life care is not something that can be reduced to objective events or measurable outcomes. It is lived experience, shaped by professional context, personal history, and the particular dynamics of each family encountered. An interpretivist approach allows the research to sit with that complexity rather than flattening it. Qualitative data were analyzed using reflexive thematic analysis, following the six-phase approach described by Braun and Clarke (Braun & Clarke, 2006; Konstantinos, 2024), (1) Familiarization with the data, (2) Generating initial codes, (3) Searching for themes, (4) Reviewing themes, (5) Defining and naming themes, (6) Producing the report. This method was selected to support an in-depth, systematic, and interpretive examination of neonatal nurses' experiences of providing EoL care to infants and their families, while offering the necessary flexibility for analyzing a small dataset derived from semi-structured interviews (Braun & Clarke, 2006; Green & Thorogood, 2018). All interviews were audio-recorded, transcribed verbatim, and anonymized prior to analysis. NVivo 14 software was used to support systematic data management, iterative coding, reflexive memo-writing, and maintenance of a transparent audit trail (Nowell *et al.*, 2017).

Analysis began with reading and rereading the transcripts until the material felt genuinely familiar. Codes were generated inductively, starting from what nurses actually said rather than from predetermined categories (Braun & Clarke, 2006; Konstantinos, 2024). As coding progressed, codes were revised, merged, or expanded in response to new readings of the data. Candidate themes were developed by looking for patterns of meaning across the dataset, then tested through constant comparison within and between interviews to check that each

theme was coherent and distinct (Braun & Clarke, 2006; Green & Thorogood, 2018).

Reflexive memos were kept throughout to record interpretive decisions and track how the analysis developed. Theme development was discussed with the research team, not as a form of inter-rater reliability checking, which is inconsistent with reflexive thematic analysis, but as a way of stress-testing interpretations against alternative readings. Rigour here comes from transparency, reflexivity, and detailed description, not from pseudo-objectivist metrics (Braun & Clarke, 2022; Green & Thorogood, 2018; Konstantinos, 2024).

Data saturation was assessed as the interviews progressed, once no new meaningful patterns were emerging from additional interviews; saturation was considered reached. Reporting 56 followed the COREQ checklist and other established standards for qualitative research transparency and rigour.

B. Reflexivity Statement

The research was conducted reflexively throughout. As a health professional with a background in neonatal nursing and qualitative methods, I brought both sensitivity and potential bias to the interviews and analysis. My own experience in this clinical environment helped me understand what nurses were describing, but it also risked shaping what I noticed and what I did not. To manage this, I kept reflexive memos documenting analytical decisions and emerging interpretations as the study progressed. Regular team discussions were used to challenge my readings and check whether themes were genuinely grounded in what nurses said, rather than in what I expected to find. This process is not a guarantee of objectivity, reflexive thematic analysis makes no such claim, but it does produce a more honest and transparent account of how the analysis was conducted.

C. Results Overview

What emerged from the ten interviews was a picture that was both recognisable from the literature and specific to the Saudi context. Nurses described emotional, ethical, and cultural pressures that echoed findings from comparable studies internationally (Banazadeh & Rafii, 2020; Cerratti *et al.*, 2020; Han *et al.*, 2023). Faith, peer solidarity, and empathy were the main things keeping them going, but institutional training and structured support were, for most, conspicuously absent (Beltran & Hamel, 2021; Dombrecht *et al.*, 2020). Four major themes emerged from the analysis.

Theme 1: Emotional Burden of End-of-Life Care.

Subtheme 1.1: Nurses experience the grief of families as one of the most difficult aspects of end-of-life care.

Nurse 1 explained: 'The biggest challenge is facing parents in grief. I often don't know how to show empathy or console them.' This kind of uncertainty, not about clinical skill, but about how to be present with a family in the worst moment of their lives, is documented consistently in the literature on NICU nursing (Cerratti *et al.*, 2020; Thornton *et al.*, 2021). Parental grief in neonatal settings is intense and often acute; when nurses lack training in bereavement communication, they are left to

improvise, which increases both their own distress and the risk of unintentionally failing the family (Banazadeh & Rafii, 2020; Beltran & Hamel, 2021).

Nurse 7 added: 'The hardest part is seeing a patient die and knowing you cannot do anything. You can only provide end-of-life care and help them pass peacefully.'

Subtheme 1.2: Nurses are personally emotionally impacted by the death of infants.

(Nurse 3) shared: 'Sometimes I cry. I once lost my own baby, so I understand the reality of grief.'

(Nurse 5) reflected: 'The hardest part is knowing I may be the last person to touch the baby.'

I often cry, even after five years of experience.' (Nurse 9) described emotional desensitization: 'I even wished for the baby's death so that he could rest from his suffering.'

Subtheme 1.3: Nurses struggle with empathy challenges when supporting grieving families.

(Nurse 10) explained: 'We cannot cry with them, but we can use supportive and encouraging words. We remind them that acceptance is important from the beginning.' 2)

Theme 2: Ethical Dilemmas in Neonatal Palliative Care

Subtheme 2.1: Nurses face conflicts with DNR orders and their instinct to preserve life.

(Nurse 1) admitted: 'When babies are placed under DNR, sometimes we still feel the urge to resuscitate... it happens automatically, even if the doctor's order is different.'

(Nurse 7) shared: 'I faced an ethical dilemma with a DNR patient... Because of the DNR order, we could not add more interventions. It was very hard to watch the patient struggle'

Subtheme 2.2: Nurses feel morally conflicted when interventions prolong suffering.

(Nurse 9) explained: 'Continuing resuscitation seemed to prolong the baby's suffering, and I wished for the baby's death to bring peace.'

(Nurse 8) added: 'Sometimes, due to cultural and religious values, we continue interventions that do not benefit the patient... From a medical perspective, these measures only prolong suffering.'

Subtheme 2.3: Nurses encounter communication barriers that complicate family understanding of end-of-life care.

(Nurse 10) highlighted: 'Sometimes we cannot explain the situation clearly because families may not understand English... This makes communication difficult and can hinder parents' understanding.' 3)

Theme 3: Cultural and Religious Influences 63

Subtheme 3.1: Nurses provide equal care across cultural and religious backgrounds.

(Nurse 1) emphasized: 'For us, life is the same regardless of religion or culture. We provide care equally to all babies.'

Subtheme 3.2: Nurses respect religious rituals and practices during end-of-life care.

(Nurse 2) explained: 'Sometimes parents want to perform prayers during the baby's final moments... we support this because it brings peace to the baby and comfort to the family.'

(Nurse 5) added: 'We recite Quran, make dua, and remind families that the baby will be in heaven, Insha'Allah.'

Subtheme 3.3: Nurses experience internal conflict when

cultural or religious expectations contradict medical practice.

(Nurse 7) noted: 'In our religion, some families do not understand the concept of DNR. They see it as killing or neglecting the patient.'

(Nurse 8) explained: 'Even when a DNR is signed, sometimes CPR is still performed because of cultural and religious pressures.'

(Nurse 10) contrasted contexts: 'In the Philippines, mercy killing is sometimes accepted culturally and medically, but here in Saudi Arabia it is not allowed because it is against Islamic beliefs.' 4)

Theme 4: Coping Strategies and Support Systems

Subtheme 4.1: Nurses rely on peer support and teamwork to cope with emotional challenges.

(Nurse 6) emphasized: 'In the NICU, we work as a team. Colleagues always support each other emotionally.'

(Nurse 7) added: 'My colleagues are very supportive... they reminded me that I did my best and that the outcome was not my fault.'

Subtheme 4.2: Nurses depend on institutional support, though availability is inconsistent.

(Nurse 5) explained: 'We are allowed two free visits per year to the psychiatric clinic.'

(Nurse 8) stated: 'Honestly, there is no support available for us.'

(Nurse 10) described: 'We have a support team that includes nurses, doctors, and counselors... Families should be involved from the very beginning.'

Subtheme 4.3: Nurses identify a lack of structured training in end-of-life care.

(Nurse 1) shared: 'Most of my training came from observing senior nurses... formal training was limited.'

(Nurse 10) added: 'I did not receive any formal training in end-of-life care. Everything I know, I learned gradually through years of experience.' 5) Nurses suggest improvements to support systems and training.

(Nurse 2) recommended: 'Rotating patients would help nurses stay emotionally balanced.'

(Nurse 4) suggested: 'Structured emotional support would help us cope better.'

(Nurse 10) emphasized: 'Hospitals should provide a hotline for families to contact after discharge, so they feel supported even after leaving.'

D. Results Summary

The findings confirm what the literature suggests but add important local texture. Every nurse in this study carried emotional weight from caring for dying infants. How they managed that weight varied, some developed genuine resilience over time, others described a protective numbness. DNR orders were a site of moral conflict for nearly everyone, especially when religious or family expectations pushed against clinical judgment. Faith and colleagues were the primary coping resources; the institution rarely was. The need for structured training and meaningful organisational support came through clearly in the data

E. Reflexivity

As researcher, I was simultaneously an insider and an observer. My clinical background in neonatal nursing meant I understood the environment nurses were describing in visceral terms I knew what it looks, sounds, and feels like. My Saudi cultural background attuned me to the religious and family dynamics that shaped their accounts. Both of these were assets. Both also carried risks: the risk of over-identifying with participants' distress, or of assuming shared meaning when it was not actually shared. Maintaining reflexivity throughout in the memos, in team discussions, in how I read and reread the data, was how I worked to keep the analysis grounded in participants' words rather than my projections

5. Discussion

This study set out to understand what neonatal nurses at DSFH actually experience when they provide end-of-life care. Nurses occupy a genuinely unique position in this work, they are present at the intersection of clinical decision-making, family grief, and cultural expectation in a way that no other member of the healthcare team is (Banazadeh & Rafii, 2020; Cerratti *et al.*, 2020; Ramadan *et al.*, 2025). In the Saudi context, where Islamic values and family-centred care fundamentally shape end-of-life practice, that position is especially complex (Beltran & Hamel, 2021; Tong-Hui *et al.*, 2023). The findings showed that nurses navigate profound emotional, ethical, and cultural challenges, and that they do so largely on their own, drawing on faith, peer solidarity, and personal resilience because the institution rarely provides what is needed.

The emotional weight nurses described was one of the study's most striking findings, not because it was unexpected, but because of how clearly the participants articulated it. Grief, sadness, the discomfort of not knowing how to help a mother who has just lost her baby, these were described with a kind of exhausted familiarity (Banazadeh & Rafii, 2020; Cerratti *et al.*, 2020).

Nurses who had experienced personal loss spoke with particular intensity; their professional experience of infant death was inseparable from their personal history. What Elsharkawy *et al.*, (2025), call 'disenfranchised professional grief', the grief that is not formally acknowledged because it belongs to a professional rather than a parent was clearly present in these accounts.

Resilience, where it existed, had been built over time and through relationships, not issued at orientation. . 67Ethical conflict centred most sharply on DNR orders an institutional directive that collided with the instinct to act, with Islamic expectations of life preservation, and sometimes with nurses' own clinical judgment about what was causing suffering (Han *et al.*, 2023; Piette *et al.*, 2022). Several nurses described the specific distress of watching an infant struggle while feeling unable to intervene. Language added another layer of difficulty: when families could not fully understand what was being explained to them, or when nurses could not communicate sensitively in Arabic, shared decision-making broke down (Green & Thorogood, 2018). Ethics training and clearer

institutional guidelines are badly needed.

The religious and cultural context shaped the texture of care in ways that were sometimes enriching and sometimes deeply difficult. Quran recitation, prayer, and the language of divine will gave families and some nurses, a framework for accepting death that had real comfort in it. But when those same frameworks led families to refuse DNR orders or demand interventions that nurses knew were extending suffering, the position nurses found themselves in was an unenviable one (Dombrecht *et al.*, 2020). They are not just caregivers in these moments, they become mediators between clinical reality and religious conviction, a role for which almost none had been prepared.

When it came to coping, nurses pointed again and again to colleagues and to faith. Talking to a peer who had been through the same thing, praying together, making sense of a baby's death through the lens of divine will, these were the strategies that worked (Shatnawi *et al.*, 2022).

Informal debriefing, in the break room or over the phone, filled the gap left by the absence of formal support (Wang *et al.*, 2025). The institutional picture was inconsistent at best. Some nurses had access to psychiatric services; others described a complete absence of any formal support 68whatsoever. Training was another gap — almost universally, nurses described learning to manage end-of-life situations by watching senior colleagues, not through any kind of structured preparation (Beltran & Hamel, 2021; Han *et al.*, 2023; Khraisat *et al.*, 2023). The suggestions nurses offered patient rotation, emotional support programs, family hotlines, were practical and specific. They are the kinds of interventions that are within institutional reach This study's reflexive approach acknowledges that the researcher's background in neonatal nursing and Saudi culture shaped sensitivity to participants' accounts. While this enhanced contextual understanding, it also necessitated vigilance against bias. Reflexive memo-writing and team discussions helped ensure that findings remained grounded in participants' voices rather than researcher expectations, consistent with Braun & Clarke, (2022) guidance on reflexive thematic analysis.

The study's reflexive design means this is an honest account of what nurses said, not what they were expected to say. My closeness to the context was useful, it helped me hear what nurses were describing and ask the right follow-up questions, but it also required ongoing self-scrutiny. The memos and team discussions served that purpose.

The implications are straightforward, even if acting on them requires real institutional commitment. Hospitals need structured support systems for nurses debriefing, counselling access, grief education, not as an optional extra but as standard practice. Ethics training is needed specifically around neonatal end-of-life care, and it needs to be grounded in Islamic bioethics rather than adapted from Western frameworks. Communication protocols, available in Arabic and designed for the cultural realities of Saudi families, would reduce misunderstanding and ethical 69friction. And nursing curricula need to take palliative care seriously as a clinical domain requiring specific preparation, not something nurses pick up informally over years

of exposure.

6. Conclusion and Recommendations

A. Conclusion

Neonatal end-of-life care in Saudi Arabia places enormous demands on the nurses who provide it. The emotional, ethical, and cultural pressures documented in this study do not operate in isolation, they compound each other, often without adequate institutional support to help nurses carry the weight. Getting this right is not just about nurse wellbeing, though that matters greatly. It is about ensuring that dying infants and their families receive care that is genuinely compassionate, culturally grounded, and ethically sound. That requires healthcare institutions to take their responsibility to nursing staff seriously, through investment in training, support, and the policies that make sustainable, humane care possible.

B. Recommendations

Drawing on both the study findings and the broader literature, the following recommendations are offered for hospitals, educators, and policymakers in Saudi Arabia. Hospitals should establish structured emotional support programs, including mandatory debriefing sessions after infant deaths, access to specialized psychological counseling, and "grief management" workshops. As suggested by El-Sharkawy et al. (2025), recognizing professional grief is essential for long-term resilience.

There is an urgent need to integrate neonatal palliative care modules into both undergraduate and postgraduate nursing education. Training should focus on emotional resilience, communication skills for breaking bad news, and the management of physical and psychological symptoms in neonates.

Hospitals should provide access to ethical consultation teams or ethics mentors (Al-Yateem et al., 2024). This would help nurses navigate the complex dilemmas associated with DNR orders and medical futility, reducing moral distress. Developing standardized, culturally sensitive communication tools available in multiple languages is vital for bridging the gap between medical teams and diverse families (Mani, 2024). This includes involving religious leaders or cultural liaisons in the decision-making process.

Practical measures such as rotating nurses away from high-stress EoL cases and providing dedicated "quiet rooms" for reflection can help mitigate compassion fatigue. Future studies should adopt multi-center designs to compare experiences across different regions of Saudi Arabia and incorporate the perspectives of physicians and grieving families to provide a 360-degree view of neonatal end-of-life care.

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