ORIGINAL ARTICLE

Professionalism and Medical Ethics in End-of-Life Decision-Making: A Phenomenological Study of ICU Physicians at Public Teaching Hospital, Sahiwal, Pakistan

Muhammad Waseem[1], Muhammad Omer Ajmal[2], Waleed Ahmed Butt[3], Amaidah Mir[4*], Urfa Zaryab Mir[5], Aasma Qaiser[3]

ABSTRACT

Objective: The study aimed to explore the lived experiences of ICU physicians in Pakistan regarding professionalism and medical ethics in end-of-life decision-making, with particular focus on emotional burden, ethical dilemmas, religious and cultural influences, family involvement, and institutional challenges.

Study Design: A qualitative phenomenological study using a hermeneutic approach.

Place and Duration of Study: The study was conducted in the Medical Intensive Care Unit at Sahiwal Teaching Hospital, Sahiwal, Pakistan, from November 2024 to April 2025.

Methods: Semi-structured, in-depth interviews were conducted over a period of six months in the Medical Intensive Care Unit at Sahiwal Teaching Hospital with eight physicians and postgraduate trainees. They were selected using a purposive sampling technique, and were directly involved in decision-making regarding end-of-life care. Data was analyzed through thematic analysis. Credibility and dependability were ensured through participant validation and expert peer review.

Results: Six key themes emerged from the analysis using thematic analysis based on Braun and Clarke's framework and supported by NVivo 12 Pro software: Emotional burden of decision-making, Religious and cultural influences, Family-centered pressure and misunderstanding, Systemic and institutional gaps, Personal beliefs, professional ethics, and reflection, and External interference and hierarchical pressure. Physicians described moral distress, emotional exhaustion, and fear of legal repercussions in the absence of clear institutional protocols or legal protection. Family expectations and cultural norms frequently conflicted with medical judgment, intensifying ethical challenges.

Conclusion: End-of-life decision-making among Pakistani intensive care physicians is influenced by emotional, cultural, ethical, and institutional pressures. The findings suggest a need for improved institutional guidance, ethics training, and structured communication with families to support ethical practice, reduce physician distress, and promote more consistent end-of-life care.

Keywords: *End-of-Life Care, Ethics, Intensive Care Units, Medical Professionalism, Moral Distress.*

How to cite this: *Waseem M, Ajmal MO, Butt WA, Mir A, UZ Mir, Qaiser A. Professionalism and Medical Ethics in End-of-Life Decision-Making: A Phenomenological Study of ICU Physicians at Public Teaching Hospital, Sahiwal, Pakistan. Life and Science. 2026; 7(1): 17-24. doi: http://doi.org/10.37185/LnS.1.1.1042*

[1]*Department of Pulmonology/Anesthesia and ICU*[2]
Sahiwal Medical College, Sahiwal, Pakistan
[3]*Department of Medical Education/Anatomy*[4]*/Biochemistry*[5]
CMH Kharian Medical College, Kharian, Pakistan

Correspondence:
Dr. Amaidah Mir
Assistant Professor, Anatomy
CMH Kharian Medical College, Kharian, Pakistan
E-mail: amaidahmir@gmail.com

Received: Jun 13, 2025; 1st Revision Received: Aug 17, 2025
2nd Revision Received: Oct 30, 2025; Accepted: Nov 07, 2025

Introduction

Intensive Care Units (ICUs) are the places where the most critically ill patients are treated and physicians working there often face some of the toughest medical and ethical decisions.[1] Among them, end-of-life decision-making (EOLDM) is one of the most sensitive and morally challenging aspects of critical care.[2] ICU doctors often deal with complex scenarios. They are constantly balancing the goals of saving lives, maintaining the dignity of patients, and

relieving their suffering.[3] These decisions may involve starting, withholding, or withdrawing life-sustaining treatments such as mechanical ventilation, vasoactive drugs, or dialysis.[4] However, EOLDM is rarely straightforward. Each case is influenced by multiple factors, including cultural values, social expectations, religious beliefs, emotional pressures, and economic realities.[5] In such situations, the principles of the patient's choice and family wishes also play an important role. As the number of patients with chronic critical illnesses rises, the frequency and complexity of EOLDM are also increasing.[6] This requires that physicians be able to cope with the burden of treatment failure, which can become easier if they actively engage in open discussions with the patient's family members. For all that, the physician should have good communication and critical thinking skills along with emotional maturity.[7] International studies have shown that ICU physicians frequently experience moral distress, emotional exhaustion, and ethical uncertainty while making end-of-life decisions, particularly in cases involving withdrawal of life-sustaining treatment. Studies from Europe and North America report that conflicts with families, fear of litigation, and a lack of clear institutional policies are major challenges for physicians in this context.[8] Research from Asian and Middle Eastern countries indicates that religious beliefs and family-centered decision-making significantly shape physicians' experiences, often placing them in ethically difficult positions when professional judgment conflicts with family wishes.[9] As compared to well-developed countries, these issues are even more complex in countries like Pakistan, where cultural, religious, and socio-economic status, along with the absence of national laws or hospital-level policies regarding end-of-life care, are more relevant. Other issues are weak legal frameworks and a lack of structured ethics committees in our setups that further complicate end-of-life practices. National studies from Pakistan have reported that physicians often rely on personal experience and informal discussions rather than formal ethical policies, leading to stress, uncertainty, and fear of blame or legal consequences. ICU doctors often have to make these decisions without legal protection or ethical guidance, relying mainly on personal judgment and family consent. Because of these circumstances, emotional distress and moral disputes are developing among physicians, especially when medical reasoning conflicts with cultural or religious expectations.[9,10]

Despite the ethical significance of this topic, there is limited research exploring the lived experiences of ICU physicians who make end-of-life decisions in Pakistan. Most available studies are focusing on the perspective of patients and their family members, while the emotional, professional, and ethical struggles of physicians remain underexplored. Understanding these lived experiences is crucial to improve professional practice, ethical standards and physician well-being in critical care settings. This study aims to explore how ICU physicians in Pakistan experience and interpret professionalism and medical ethics in end-of-life decision-making. By knowing their reflections, emotions and coping mechanisms, this study seeks to provide insights that can inform institutional policies, training programs and family communication practices. Ultimately, the findings may help to guide the development of more compassionate, culturally appropriate, and ethically sound end-of-life care practices in Pakistan.

Methods

This was a qualitative phenomenological study using an interpretive (hermeneutic) approach that is particularly suitable for exploring how individuals perceive, interpret, and make meaning of complex lived experiences in real-life clinical contexts. It was conducted over a period of six months from November 2024 to April 2025 in the Medical Intensive Care Unit (MICU) at Sahiwal Teaching Hospital, a public-sector tertiary care institution in Sahiwal, Pakistan. MICU admits critically ill patients referred from multiple specialties, including internal medicine, pulmonology, nephrology, and infectious disease. On top of that, common ICU interventions including invasive mechanical ventilation, vasopressor administration, and renal replacement therapy are routinely provided. A total of eight participants were selected by using a purposive sampling technique. All participants were ICU consultants who had been working in the medical ICU for at least one year. The study was approved by the Institutional Review Board (IRB) of Sahiwal Medical College vide Reference No:

SMC/IRB/2025/042, dated 18th September 2024. All participants were informed of the study before providing their written consent. Participant anonymity was maintained by numbering transcripts (e.g., P1, P2…). It was explained to the participants that they could choose to discontinue the study at any time without repercussion. Inclusion criteria were: postgraduate residents and consultants directly involved in end-of-life care decision making, who demonstrated willingness to participate, participants needed to have enough exposure to ethical and professional dilemmas experienced within the ICU settings, provided informed consent, and were proficient in English and Urdu, as interviews were conducted in both languages. Exclusion criteria included administrative staff, nurses, or physicians not engaged in end-of-life decision making, as well as attendants of patients.

Data were collected through semi-structured, in-depth interviews conducted in a private office adjacent to the ICU to ensure privacy and minimize distractions. A flexible, open-ended interview guide was developed based on existing literature and refined with input from an expert in medical ethics and qualitative research. The following key domains were examined:

Physicians' experiences with end-of-life decision making; moral and ethical dilemmas and religious perspectives influencing those decisions; professional responsibilities and integrity in ethically challenging situations; family involvement and institutional support mechanisms; impact on personal beliefs, emotions, and mental well-being;

External influences, such as administrative or political interference in clinical decision-making

Interviews took almost 2 and a half hours. To avoid bias, interviews were conducted by a trained qualitative researcher who was not part of the ICU team, in both English and Urdu, according to the participants' ease. Throughout the interviews, notes were taken to capture participants' non-verbal behaviors, emotional responses, and personal reflections on the interaction. Data collection continued until thematic saturation was reached, "the point at which no new codes or themes were emerging in subsequent interviews". Saturation was achieved after the eighth interview.

Transcriptions from these recordings were analyzed via a process of transcription and thematization following Braun and Clarke's (2006) six steps; introduction to the data, developing initial codes

1. rooking for themes
2. recapitulating themes, developing and Naming Themes, drafting the report

Data were analyzed by using NVivo 12 Pro (QSR International), a qualitative data analysis software that helped to organize coding, group related ideas, and retrieve relevant participant quotes efficiently.[11] For the first round of coding, two independent coders analyzed the transcripts separately to reduce personal bias, and any differences were resolved through discussion. A codebook was developed and continuously refined as new points emerged during the analysis. The identified main themes and subthemes were then combined to create a thematic map, representing the core patterns related to professionalism and ethical decision-making in end-of-life care. To ensure the accuracy and trustworthiness of the findings, early interpretations were shared with three participants for member checking, and a peer reviewer with experience in qualitative research examined the coding and themes. Reflexivity was maintained through the primary researcher's reflective notes, an audit trail was maintained by documenting key analytical decisions, and thick description was ensured through rich participant quotations. Transferability was supported by providing detailed contextual information, and potential researcher bias was minimized through independent coding, external review, and the use of a non-ICU interviewer.

Results

The analysis of in-depth interviews with eight ICU physicians identified six major themes, each containing several subthemes. These themes highlight the professional, emotional, cultural, institutional, political, and ethical factors that shape end-of-life decision making (EOLDM) within Pakistani ICUs. (Figure 1).

Participant responses are contextualized and supplemented with coding quotes, many of which capture distinct sociocultural, professional, and hierarchical challenges faced across many parts of Pakistan.

Theme 1: Emotional Burden of Decision-Making

Moral Distress: Physicians (P) frequently described

Table 1: Major Themes and Sub-Themes Identified from ICU Physicians' Experiences in End-of-Life Decision-Making (EOLDM)

Themes	Sub-Themes
Emotional burden of decision-making	Moral distress Emotional exhaustion
Religious and cultural influences on EOLDM	Reliance on divine intervention Influence of religious leaders
Family-Centered Pressure and Misunderstanding	Demands for Maximal Intervention Mistrust and Accusations
Systemic and institutional gaps	Absence of protocols for end-of-life care fear of legal andadministrative consequences
Personal beliefs, professional ethics, and reflection	Ethical Challenges and Value Conflict Personal and professional Growth through experience
External interference and hierarchical pressure	Political and administrative influence on clinical decisions

Fig.1: End-of-life decision-making by ICU physicians

the internal conflict they experienced when required to continue treatment that they believed to be medically futile. This moral distress mainly arose from the tension between their professional judgment and the demands of patients' families.

"I feel helpless when I have to keep a patient on the ventilator just to satisfy the family." (P-2)

"I feel like I'm adding misery to someone every time I intubate a brain-dead person." (P-5)

"It's not fair, but we are compelled to bear the pain for the sake of our job." (P-7)

Emotional Exhaustion: All participants reported feelings of burnout and emotional fatigue due to repeated exposure to ethically distressing situations. Many described these experiences as emotionally draining and psychologically overwhelming.

"I take those decisions home with me. I feel that they hate me; I can't sleep at night." (P-1)

"I've started becoming desensitized to the pain of families. That scares me." (P-2)

"Sometimes I feel like I have nothing left to give, not to my patients and not even to my family." (P-8)

Theme 2: Religious and Cultural Influences on EOLDM

Reliance on Divine Intervention: Families often relied on their faith and belief in divine miracles, refusing to withdraw life-sustaining treatment even when physicians considered further care medically meaningless. However, in some cases, religious faith also helped families accept physicians' recommendations with peace.

"Even when the organs have failed, the families say, 'Allah will bring him back.'" (P-7)

"They tell us stopping the ventilator is against God's will." (P-6)

"One family even said, 'Doctor sahab, aap khuda nahin hain,' when I discussed the prognosis." (P-1)

Influence of Religious Leaders: Families frequently sought guidance from religious scholars, whose advice sometimes conflicted with medical recommendations, increasing the emotional and ethical strain on physicians.

"They brought a Mufti to the ICU, and he said stopping treatment is haram." (P-1)

"I've been forced to argue with clerics at the bedside of dying patients." (P-3)

"Even educated families seem to depend more on fatwas than on medical information." (P-8)

Theme 3: Family-Centered Pressure and Misunderstanding

Demands for Maximal Intervention: For many families, aggressive treatment symbolized hope and faith in recovery. Despite clear communication about the prognosis, physicians often faced relentless

demands to “do everything.”
“They want us to bring them back to life even when the patient is cold.” (P-8)
“One family member slapped a junior doctor for stopping CPR after 30 minutes.” (P-2)
“They believe more machines mean better care, it's terrible.” (P-6)
Mistrust and Accusations: A deep mistrust toward the healthcare system frequently resulted in confrontations and public accusations against physicians, particularly in public sector hospitals.
“They think we are abandoning the poor patient.” (P-7)
“'If it was your own father, you'd have done more!' shouted one man.” (P-6)
“The mistrust is glaring; people believe doctors work only for money.” (P-4)
Theme 4: Systemic and Institutional Gaps
Absence of Protocols for End-of-Life Care: Almost all participants expressed concern that the absence of institutional policies or standardized guidelines made end-of-life decision-making inconsistent and risky.
“DNR (Do Not Resuscitate) is not practiced in our hospital. Every doctor has their own way of deciding what's right.” (P-1)
“We need something written to keep us legally and ethically safe.” (P-3)
“In private hospitals, things are clearer, but in public hospitals, it's chaos.” (P-6)
Fear of Legal and Administrative Consequences: Physicians described living under constant fear of being legally or professionally penalized for clinically sound decisions.
“Even if the family agrees, there's no legal protection if they change their mind later.” (P-8)
“I've seen colleagues dragged into court just for withdrawing ventilation from a terminal case.” (P-5)
“The media can twist the story anytime, 'Doctors killed our loved one' makes a good headline.” (P-3)
Theme 5: Personal Beliefs, Professional Ethics, and Reflection
Ethical Challenges and Value Conflict: Physicians often faced a clash between their personal morals, professional ethics, and institutional expectations. They knew when care was futile but were still expected to continue treatment, leading to deep moral distress.
“I'm a Muslim; I value life, but I also believe in not inflicting pain.” (P-1)
“I wouldn't want this for my own parents, yet I did it for a patient.” (P-2)
“Sometimes I feel like I'm betraying both my ethics and my faith.” (P-7)
Personal and Professional Growth through Reflection: Despite the distress, repeated exposure to end-of-life cases encouraged self-reflection and professional maturity. Many physicians reported developing stronger empathy, resilience, and ethical awareness.
“These situations changed how I view my duty as a doctor.” (P-8)
“I've learned that professionalism also means knowing when to let go.” (P-4)
Several physicians reported that repeated exposure to end-of-life situations led to increased empathy, humility, and personal growth, viewing ethical discomfort as a catalyst for moral and spiritual development. (P-2, P-6)
Theme 6: External Interference and Hierarchical Pressure
Political and Administrative Influence: A challenge that is unique in the Pakistani healthcare setting was the interference of politicians, bureaucrats, and law enforcement officials in clinical decisions, especially in government hospitals.
“An MPA called the Medical Superintendent and strictly ordered that the patient must remain on the ventilator.” (P-3)
“CPR had to be continued for another 15 minutes, even though there was no pulse, because the patient was a senior bureaucrat's cousin.” (P-7)
“Sometimes it's not about the family; it's about who they know. That's how decisions are made here.” (P-4)
This creates so much stress for doctors and healthcare workers in the working environment. This then not only produces difficulty in ethical care but sometimes leaves ICU doctors to take some legal actions due to frustration.

Discussion

In Pakistani ICUs, end-of-life decision-making (EOLDM) represents a complex and ethically challenging process. Physicians often find themselves stuck between professional judgments, institutional limitations, and strong sociocultural and

religious expectations from patients' families.[12] The findings of the present study showed the emotional, cultural, and institutional factors that deeply impact the ethical reasoning and professional conduct of ICU physicians during EOLDM. (Table 1). These findings are in accordance with the broader South Asian literature that emphasizes moral distress and emotional exhaustion as defining features of critical care practice and ethical decision-making.

Emotional trauma associated with end-of-life decision-making is one of the most commonly observed challenges faced by ICU physicians. (Table 1). Participants in this study reported intense moral distress when their professional roles involved them in ethically conflicting situations where boundaries of right and wrong were blurred. The concept of moral distress was first introduced by Andrew Jameton in 1984 and refers to situations in which clinicians recognize the ethically appropriate course of action but are constrained by institutional or systemic factors from acting accordingly, often resulting in the provision of care they perceive as non-beneficial to patients. Consistent with local findings on ICU mental health, this persistent ethical and emotional burden contributes significantly to burnout among ICU staff.[13]

Consistent with local findings on ICU mental health, this continuous emotional toll contributes significantly to the high incidence of burnout among ICU staff.

Families often do not follow medical advice because religious and cultural beliefs frequently supersede the recommendations of medical professionals.[14] In Pakistan and other Islamic societies, there is strong faith in divine healing even when medical treatment is deemed futile.[15] As noted by physicians in this study, families often involve religious reasoning to postpone or delay making end-of-life decisions, particularly regarding withdrawal of life support (Table 1). This observation aligns with previous research done by Muishout G et al. showing that, in many Islamic contexts, discontinuing life-sustaining treatment is perceived as “giving up” and interfering with God's will.[16] Family pressure, along with cultural and personal expectations, further increases the challenges of end-of-life decision-making. Plus, physicians in this study reported that they were being pressured by family to continue aggressive treatment even if it was no longer beneficial. Similar findings have been reported in the study of Khan M et al. in a tertiary care hospital of Peshawar, Pakistan, where ICU interventions are often related to hope, and families have to struggle hard to accept a poor prognosis.[17] This clash between cultural expectations and clinical realities creates tension, emotional distress, and dissatisfaction for both families and healthcare providers.[17] Institutional shortcomings also played a significant role in shaping EOLDM. Most participants expressed concern about the absence of formal guidelines, ethical committees, and training from hospitals that are related to EOLDM. Fear of legal consequences is also there. (Table 1). All of them left the physicians to rely on their own choices and often followed no clear pattern of what to do.[18] This lack of structured support remains evident in many Pakistani hospitals, where doctors frequently make end-of-life decisions alone. The threat of legal liability further creates obstacles in ethical decision-making, particularly in a context where terminations from jobs and harassment of doctors are very common. Without national legislation or clear hospital protocols regarding Do Not Resuscitate (DNR) orders or withdrawal of life-sustaining treatment, physicians fear that such actions could be taken as 'murder'.[12] According to the study of Baker M et al., doctors in countries with existing laws and guidelines for palliative care frameworks also report limited institutional protection.[19] Our results are consistent with the study by Jafarey AM et al., who also emphasized that Pakistani physicians often practice in settings where formal legal backing and enforceable ethical guidelines are weak, and clinical decisions — including consent processes — tend to rely heavily on physician judgment and surrogate (family) involvement.[20] The absence of robust enforceable policies and ethics oversight in Pakistan's healthcare system has been highlighted in the literature, noting limited implementation of ethical codes and challenges in patient decision-making processes, which may compel doctors to continue treatments perceived as futile to avoid legal or social repercussions.

Among several participants, there were conflicts between personal values and professional duties. (Table 1). Some admitted that they would not choose similar aggressive interventions for their own family

members that highlighted the inner ethical struggle faced by many physicians. Such ethical challenges are not unique to Pakistan but are seen globally. However, in settings with limited financial, cultural and institutional support, their impact on physicians' mental health can be even more profound. This defines the need for institutional structures that enable moral reflection, such as discussing difficult cases with one's peers.[21,22]

A more reassuring finding of this study was that some physicians reported personal growth as a result of repeated exposure to end-of-life situations (table 1). Many described that with the passage of time and experience, they are becoming more empathetic, humble, and reflective, suggesting that ethical discomfort is a source of moral and spiritual development. These findings are in line with other qualitative studies done by Diego R et al. and McDarby M et al., showing that experienced clinicians often develop personal and spiritual growth by dealing with ethically complex cases. Structured debriefing sessions and regular discussions on ethics can help to produce a more supportive environment.[23,24] There are several ways to solve this problem. As mentioned in the study by Hales and Hawryluck, this might include implementing end-of-life communication education at the post-graduate level, establishing contextually relevant Center policies, or promoting cross-design family meetings.[25] Moreover, establishing functional ethics committees within all tertiary care hospitals is essential to guide complex decision-making. National regulatory bodies and bioethics organizations should also work to develop standardized protocols for Do Not Resuscitate (DNR) orders and end-of-life care nationwide.

Despite the important insights this study provides, several limitations must be acknowledged. The findings are based on a small sample of physicians from selected tertiary care hospitals, which may limit the transferability of the results to other healthcare settings or regions in Pakistan. As this was a qualitative phenomenological study, the data relied on participants' self-reported experiences, which may be influenced by recall bias or social desirability. Moreover, the absence of perspectives from patients, family members, and other healthcare professionals restricts a more holistic understanding of end-of-life decision-making in the ICU. Future research should therefore include the views of patients and families to help develop culturally sensitive and ethically appropriate end-of-life care policies. In addition, comparative studies involving junior and senior physicians are recommended to explore differences in ethical reasoning, professional maturity, and emotional coping, which may further inform targeted training and institutional support mechanisms.

Conclusion

This study highlights the significant emotional and ethical challenges ICU physicians in Pakistan face in end-of-life decision-making. Physicians struggle to balance clinical judgment with family expectations, religious beliefs, and institutional limitations, leading to moral distress and emotional exhaustion. In the absence of clear hospital protocols and legal frameworks, they rely largely on personal ethics and experience to guide their decisions. The findings emphasize the need for structured institutional support and ethical guidelines to promote consistent and compassionate end-of-life care while safeguarding physicians' professional integrity and well-being.

Acknowledgement: None

Conflict of Interest: The authors declare no conflict of interest

Grant Support and Financial Disclosure: None

REFERENCES

1. Christensen M, Liang M. Critical care: A concept analysis. International journal of nursing sciences. 2023; 10: 403-13. doi: 10.1016/j.ijnss.2023.06.020
2. Mobarki K, Guo P, Mobarki MI, Efstathiou N. End-of-Life Care Experiences, Attitudes and Perceptions of Intensive Care Clinicians in Middle Eastern Countries: A Systematic Integrative Review. Nursing in critical care. 2025; 30: e70201. doi: 10.1111/nicc.70201
3. Latour JM, Kentish-Barnes N, Jacques T, Wysocki M, Azoulay E, Metaxa V. Improving the intensive care experience from the perspectives of different stakeholders. Critical Care. 2022; 26: 218. doi: 10.1186/s13054-022-04094-x
4. Lee SI, Hong KS, Park J, Lee YJ. Decision-making regarding withdrawal of life-sustaining treatment and the role of intensivists in the intensive care unit: a single-center study. Acute and Critical Care. 2020; 35: 179-88. doi: 10.4266/ACC.2020.00136
5. Veena H, Palnati SR, Saajan B. Understanding the influence of culture on end-of-life, palliative, and hospice care: a narrative review. Cureus. 2025; 17: e87960. doi: 10.7759/cureus.87960

6. Pun J, Chow JCH, Fok L, Cheung KM. Role of family members in end-of-life communication. BMJ Open. 2023; 13: e067304. doi: 10.1136/bmjopen-2022-067304
7. Anderson RJ, Bloch S, Armstrong M, Stone PC, Low JT. Communication between healthcare professionals and relatives of patients approaching the end-of-life: a systematic review of qualitative evidence. Palliative medicine. 2019; 33: 926-41. doi: 10.1177/02692163 19852007
8. Roggero P, Grima AM, Crespo-Escobar P, Tapsas D, Yahav J. Conflict between parents, physicians, and healthcare professionals in medical decision-making: How to address it—A systematic review from the ESPGHAN Ethics Committee. Journal of Pediatric Gastroenterology and Nutrition. 2024; 79: 1071-80. doi: 10.1002/jpn3.12365
9. Bowers SP, Chin M, O'Riordan M, Carduff E. The end of life experiences of people living with socio-economic deprivation in the developed world: an integrative review. BMC Palliative Care. 2022; 21: 193. doi: 10.1186/s12904-022-01080-6
10. Ahmed SK, Mohammed RA, Nashwan AJ, Ibrahim RH, Abdalla AQ, Ameen BM, et al. Using thematic analysis in qualitative research. Journal of Medicine, Surgery, and Public Health. 2025; 6: 100198. doi: 10.1016/j.glmedi. 2025.100198
11. AlYahmady HH, Al Abri SS. Using NVivo for qualitative data analysis. International Interdisciplinary Journal of Education. 2013; 2: 181–6. doi: 10.12816/0002914
12. Khan RI. Ethical Issues in Anesthesia and Surgery Practice in Pakistan. Journal of Surgery Pakistan. 2009; 14: 101-2.
13. Bennett M. Moral distress, disempowerment, and responsibility. Philosophy of Medicine. 2025; 6: e210. doi: 10.5195/pom.2025.210
14. Swihart DL, Yarrarapu SNS, Martin RL. Cultural and religious competence in clinical practice. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025. Available at: https://www.ncbi.nlm.nih.gov/books/NBK493216/
15. Memon J, Abro AA, Soofi S, Hussain I, Sadruddin F. People attitudes toward shrine-based faith healing in Sindh, Pakistan. BMC Public Health. 2025; 25: 2931. doi: 10.1186/s12889-025-23428-2
16. Muishout G, Topcu N, de la Croix A, Wiegers G, van Laarhoven HW. Turkish imams and their role in decision-making in palliative care: A Directed Content and Narrative analysis. Palliative medicine. 2022; 36: 1006-17. doi: 10.1177/02692163221095200
17. Khan M, Ahmad IW, Ullah Z, Rehman S, Jaffar S, Nasar S. Family needs of patients admitted in critical care units of tertiary care hospitals, Peshawar. Review Journal of Neurological & Medical Sciences Review. 2025; 3: 87-93. doi: 10.5281/zenodo.15852508
18. Raoofi S, Arefi S, Zarnaq RK, Nayebi BA, Mousavi MS. Challenges of hospital ethics committees: a phenomenological study. Journal of Medical Ethics and History of Medicine. 2021; 14: 26. doi: 10.18502/jmehm. v14i26.8282
19. Baker M, Luce J, Bosslet GT. Integration of palliative care services in the intensive care unit: a roadmap for overcoming barriers. Clinics in chest medicine. 2015; 36: 441-8. doi: 10.1016/j.ccm.2015.05.010
20. Jafarey AM, Farooqui A. Informed consent in the Pakistani milieu: the physician's perspective. Journal of medical ethics. 2005; 31: 93-6. doi: 10.1136/jme.2002.002220
21. Quek CW, Ong RR, Wong RS, Chan SW, Chok AK, Shen GS, et al. Systematic scoping review on moral distress among physicians. BMJ open. 2022; 12: e064029. doi: 10.1136/bmjopen-2022-064029
22. Wocial LD, Slaven JE, Montz K, Monahan PO, Hickman SE, Callahan CM, et al. Factors associated with physician moral distress caring for hospitalized elderly patients needing a surrogate decision-maker: a prospective study. Journal of General Internal Medicine. 2020; 35: 1405-12. doi: 10.1007/s11606-020-05652-1
23. De Diego-Cordero R, López-Tarrida ÁC, Linero-Narváez C, Galán González-Serna JM. More spiritual health professionals provide different care": a qualitative study in the field of mental health. Healthcare. 2023; 11:303. doi: 10.3390/healthcare11030303
24. McDarby M, Miller M, Rosa WE, Buller H, Ferrell BR. Multidisciplinary oncology clinicians' experiences delivering spiritual care to patients with cancer and their care partners. Supportive Care in Cancer. 2024; 32: 586. doi: 10.1007/s00520-024-08773-z
25. Hales BM, Hawryluck L. An interactive educational workshop to improve end of life communication skills. Journal of Continuing Education in the Health Professions. 2008; 28: 241-55. doi: 10.1002/chp.191

Author Contributions

MW: Conception and design of the work
MOA: Writing the original draft, proofreading, and approval for final submission
WAB: Data acquisition, curation, and statistical analysis
AM: Manuscript writing for methodology design and investigation
UZM: Revising, editing, and supervising for intellectual content
AQ: Validation of data, interpretation, and write-up of results