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# Prevention and Resolution of Ethical Issues that Arise in End-of-Life Care in Low- and Middle-Income Countries (LMICs): A qualitative study in a University Teaching Hospital in Nigeria

**Nnenma Ndidiamaka Udeh**

nnenma.udeh@unn.edu.ng

University of Nigeria

**Onyinye Hope Chime**

Enugu State University of Science and Technology

**Afam Callistus Udeh**

Enugu State University of Science and Technology

**ChimaUche John Bona**

University of Nigeria

**Ngozi Idemili-Aronu**

University of Nigeria

**Onochie I Okoye**

University of Nigeria

**Emmanuel R Ezeome**

University of Nigeria

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## Abstract

# Background

End-of-life (EOL) care is a critical aspect of healthcare that raises ethical concerns for patients, providers, and families. Preventing and resolving these ethical issues is essential to ensure high-quality care. While Western contexts have established guidelines based on lived experiences in high-income countries, these are often applied in low- and middle-income countries (LMICs) such as Nigeria, since empirical data on lived experiences are almost nonexistent. However, cultural factors and available tools in LMICs strongly shape end-of-life (EOL) care practices. Understanding the local context is therefore essential for improving ethical decision-making. This study examines strategies used at one of Nigeria's most developed Oncology and palliative care units to prevent or resolve ethical issues in EOL care within a teaching hospital.

# Methods

This cross-sectional qualitative study was conducted over two months at the University of Nigeria Teaching Hospital (UNTH), Enugu, Nigeria. In-depth and key informant interviews using semi-structured guides were used to investigate how ethical challenges faced by dying patients, families, and healthcare personnel were prevented or resolved. Ethical approval was secured, and written informed consent was obtained from all participants. Descriptive statistics were used to analyze demographic data, while qualitative content analysis of the interview data was performed using NVivo 12 software.

# Results

The study found a complete absence of clinical ethics committees and the use of advance directives. Ethical issues were often resolved through collaborative discussions and actions with relevant stakeholders, as well as discussions between healthcare teams and families or patients, and by upholding patients' values, although some issues remained unresolved. Strategies to prevent ethical challenges included involving families in patient care, holding family meetings, and fostering strong patient-doctor relationships. However, some preventive measures previously reported in the literature were not used.

# Conclusion

Family involvement and meetings, empathetic doctor–patient relationships, collaboration, discussions, and respect for patient and family preferences were identified as key strategies for preventing and resolving ethical issues in EOL care. Strengthening these existing methods is vital, as they remain

reliable in the absence of other reported approaches. Exploring preventive pathways not yet implemented is also critical for comprehensive EOL care in Nigeria.

# INTRODUCTION

End-of-life (EOL) care sometimes raises ethical issues that should be avoided or resolved to provide the best possible care for the individual. This care aims to provide a dignified quality of life at EOL by alleviating suffering, providing comfort, and respecting autonomy.[1] Adherence to informed, voluntary, and reasoned first-person consent in EOL care is crucial to avoiding ethical issues.[2]

Advance directives in the form of a written will, specific treatment directives, or appointment of a proxy decision-maker are avenues to ensure that patients' rights and autonomy are protected.[3][4] Oral or verbal AD is recognized.[5] Reviews suggest that AD effectively safeguards the autonomy of patients receiving EOL care.[6][3] If an advance directive (AD) or proxy is unavailable, a surrogate decision-maker from the patient's family may be appointed to make healthcare decisions on their behalf. The healthcare team may step in if the family is unavailable or unable to do so. In complex cases, ethical guidance may be sought from a clinical ethics committee or the legal system.[7] In the United States of America, for example, these processes are well captured by the Uniform Health Care Decision Act (UHCDA).[8] These streamlined pathways to EOL care (Fig. 1) help prevent decision-making crises and ensure that any challenges are managed with minimal disruption.

The existence of these pathways that could prevent crises in EOL care presupposes that healthcare givers and significant others involved in care anticipate, prepare, and use these measures.[9] Even with streamlined decision-making pathways, EOL care ethical issues are complex and involve numerous stakeholders, making collaboration essential for problem resolution.[10]

A survey of secondary care nurses in the UK found that collaborative teams were useful in resolving ethical issues, which involve a complex relationship between cultural and competing professional drivers.[11] Good communication, which may include negotiation, explanation, and restraint, is another effective method,[3] as attentive listening and quality conversations can help resolve disagreements with family or their kin.[6] Team meetings involving healthcare workers and non-healthcare providers have also proven effective.[12] In the United States,[12] two-thirds of study participants employed various methods to resolve ethical issues, including ethics consultation, family meetings, support of patient autonomy, involvement of the palliative medicine team, clarification of care goals, involvement of the family, staff education on ethical principles, and honoring patient wishes. Some issues, however, remained unresolved until the patient's death. Research among ICU nurses suggests that ethics committees are unhelpful or even unsatisfactory in resolving ethical issues in EOL care, because their deliberative processes are slow and do not match the urgent nature of dilemmas encountered at the bedside.[10]

Most reports on approaches to resolution of these EOL care ethical issues have come from Western settings,[13] indicating the need to evaluate this in an unexplored setting, most especially in LMIC settings where decision-making pathways in EOL care are not well streamlined. In healthcare, cultural background influences reported patterns of prevention and resolution of ethical issues,[14] and shapes acceptance and outcomes of EOL care interventions.[15][16] For instance, written advance directives are common in developed countries but are not widely accepted in African settings.[17] In Nigeria, verbal advance directives are more common due to communal values and traditional family-centered practices.[5] Social and religious factors also influence ethical issues and practices in EOL care.[18][19]

We have previously reported that ethical issues are common in EOL care in Enugu, Nigeria.[20] In this report, we describe the practices and procedures for preventing and resolving EOL care ethical issues in the oncology/intensive care unit of the University of Nigeria Teaching Hospital in Enugu, Nigeria, aiming to address the lack of information on these issues to improve and ensure the best possible EOL care.

# METHODS

This study, conducted from March to May 2022, used a cross-sectional, qualitative approach and key informant/in-depth interviews to investigate approaches to prevent and resolve ethical issues in EOL care in an LMIC setting. It was conducted at the Oncology Centre and Intensive Care Unit (ICU) of the University of Nigeria Teaching Hospital, Enugu (UNTH-E). UNTH-E is located in Ituku-Ozalla, Enugu State, South-East Nigeria. It is one of Nigeria's oldest tertiary hospitals, established in 1970, and a major referral centre for the five states of the Southeast geopolitical zone—Enugu, Anambra, Imo, Abia, and Ebonyi—with a combined population of 21.9 million people.[21] Its catchment population for oncology care and ICU is the whole south-eastern region and beyond. UNTH's Oncology Centre, over the years, evolved into a comprehensive cancer treatment facility, designated as a national oncology hub by the Federal Government of Nigeria since 2022. Within the Oncology Centre is the Pain and Palliative Care Unit, one of the most developed palliative care units in Nigeria, established in 2008, and it provides comprehensive inpatient and outpatient palliative care services. The unit is supported by a multidisciplinary team of physicians, nurses, and allied health professionals. It has a regional and international network that promotes palliative care, collaborating with the African Palliative Care Association and other international bodies.

The study included adult patients receiving EOL care, one family member for each patient, and healthcare providers (nurses and doctors) from the oncology wards and ICU of UNTH. Patients in pain, distress, too weak to participate, or in isolation; family members who had spent less than a week with the patient; and healthcare providers not directly involved in patient care were excluded. In total, ten patients, ten family members, ten nurses, and ten doctors were recruited, and information saturation was reached with this sample.

A purposive sampling method was used. Eligible participants were identified with support from the nurse in charge of the oncology ward or ICU, and their doctors confirmed that they were receiving EOL care.

After explaining the study, the selected participants were invited to consent (written informed consent obtained) and participate in the study.

The questionnaire/key informant guide and the in-depth interview guide were used for the data collection (supplementary file shows the details). These study instruments were developed based on current theoretical and empirical literature, pre-tested, and refined following a pilot testing study, which confirmed their ability to effectively prompt participants to provide detailed information relevant to the study objectives. A key informant interview (KII) guide was used to interview the nurses and doctors. The guide collected data on participants' socio-demographics, duration of service in the ICU or Oncology Centre, and post-qualification ethics training. It also guided discussions of the study objectives and included prompts to probe and elicit detailed responses. An in-depth interview (IDI) guide was used to interview the patients and their relatives. This guide collected information on socio-demographics and duration of stay in the ICU or oncology wards, and included prompts to aid probing during the interviews. An expert in qualitative research methodology and bioethics guided the development of all interview questions.

The credibility and dependability of the instrument were ensured through thematic saturation, an open–coding process, presenting interview summaries to participants to confirm the content, and verifying preliminary analysis with attached codes to selected participants to confirm the results.

Each recruited participant was scheduled for a face-to-face interview at a convenient time. The researcher used a survey questionnaire/key informant interview, or an in-depth interview guide as appropriate. The interviews were held in the health facility (wards and offices in the oncology unit and ICU of UNTH). All interviews were audiotaped and transcribed. Field notes were also taken.

All data obtained were kept confidential with no identifiable name tags. Socio-demographic data were analyzed using descriptive statistics while qualitative data were analyzed through thematic content analysis. NVivo 12 software was used to code and manage the transcripts. A hybrid coding approach, combining inductive and deductive coding approaches, was used. Two researchers independently carried out the coding. The Health Research Ethics Committee of the University of Nigeria Teaching Hospital, Enugu State, Nigeria, granted ethical approval for the study. The Nigerian National Code of Health Research Ethics (NCHRE) and the tenets of the Declaration of Helsinki were adhered to in the study.

# RESULTS

In total, 40 interviews were conducted: 20 key informant interviews (KIIs) among 10 doctors and nurses each and 20 in-depth interviews (IDIs) of 10 patients receiving EOL care and 10 family caregivers of these patients. The doctors were from varying specialties (surgical oncology, radio-oncology, pain/palliative care, intensive care); while the nurses were from oncology care wards/centers, and pain /palliative care units.

# CHARACTERISTICS OF PARTICIPANTS

Participants' ages ranged from 23 to 66 years. Most KII participants have worked in the ICU or oncology unit for over 10 years. Twelve of the 20 KII participants had no formal ethics training post-qualification. Most of the IDI participants have been sick for over a year. Characteristics of the participants are summarized in Tables 1 and 2.

Table 1
Socio-Demographic and Professional Characteristics of Healthcare Providers (KII participants)

| Characteristic | Categories | Doctors (n = 10) n (%) | Nurses (n = 10) n (%) | Total (N = 20) n (%) |
|---|---|---|---|---|
| **Age (years)** | Mean ± SD | 48.2 ± 5.6 | 44.1 ± 8.7 | 46.2 ± 7.4 |
| | < 40 | 0 (0.0) | 2 (20.0) | 2 (10.0) |
| | 40–49 | 6 (60.0) | 6 (60.0) | 12 (60.0) |
| | ≥ 50 | 4 (40.0) | 2 (20.0) | 6 (30.0) |
| **Sex** | Male | 6 (60.0) | 1 (10.0) | 7 (35.0) |
| | Female | 4 (40.0) | 9 (90.0) | 13 (65.0) |
| **Education** | Postgraduate (PG) | 10 (100.0) | 10 (100.0) | 20 (100.0) |
| **Occupation** | Doctors | 10 (100.0) | – | 10 (50.0) |
| | Nurses | – | 10 (100.0) | 10 (50.0) |
| **Marital Status** | Married | 10 (100.0) | 8 (80.0) | 18 (90.0) |
| | Single | 0 (0.0) | 2 (20.0) | 2 (10.0) |
| **Years of Practice** | Mean ± SD | 12.5 ± 4.1 | 10.4 ± 6.7 | 11.5 ± 5.5 |
| | < 5 years | 0 (0.0) | 3 (30.0) | 3 (15.0) |
| | 5–10 years | 2 (20.0) | 1 (10.0) | 3 (15.0) |
| | > 10 years | 8 (80.0) | 6 (60.0) | 14 (70.0) |
| **Ethics Training** | Yes | 4 (40.0) | 4 (40.0) | 8 (40.0) |
| | No | 6 (60.0) | 6 (60.0) | 12 (60.0) |

Table 2
Socio-Demographic and Clinical Characteristics of Patients and Caregivers (IDI participants)

| Characteristic | Categories | Patients (n = 10) n (%) | Caregivers (n = 10) n (%) | Total (N = 20) N (%) |
|---|---|---|---|---|
| **Age (years)** | Mean ± SD | 47.5 ± 9.2 | 39.8 ± 11.4 | 43.7 ± 10.8 |
| | < 40 | 2 (20.0) | 2 (20.0) | 4 (20.0) |
| | 40–49 | 3 (30.0) | 3 (30.0) | 6 (30.0) |
| | 50–59 | 4 (40.0) | 4 (40.0) | 8 (40.0) |
| | ≥ 60 | 1 (10.0) | 1 (10.0) | 2 (10.0) |
| **Sex** | Male | 5 (50.0) | 3 (30.0) | 8 (40.0) |
| | Female | 5 (50.0) | 7 (70.0) | 12 (60.0) |
| **Education** | None | 0 (0.0) | 1 (10.0) | 1 (5.0) |
| | Primary | 3 (30.0) | 2 (20.0) | 5 (25.0) |
| | Secondary | 4 (40.0) | 5 (50.0) | 9 (45.0) |
| | Postgraduate (PG) | 3 (30.0) | 2 (20.0) | 5 (25.0) |
| **Participant status** | Patients | 10 (100.0) | – | 10 (50.0) |
| | Caregivers | – | 10 (100.0) | 10 (50.0) |
| **Marital Status** | Married | 7 (70.0) | 7 (70.0) | 14 (70.0) |
| | Single | 1 (10.0) | 3 (30.0) | 4 (20.0) |
| | Widowed | 2 (20.0) | 0 (0.0) | 2 (10.0) |
| **Stay / Care Duration** | ≤ 2 weeks | 3 (30.0) | 4 (40.0) | 7 (35.0) |
| | 1 month | 3 (30.0) | 4 (40.0) | 7 (35.0) |
| | 2–5 months | 4 (40.0) | 1 (10.0) | 5 (25.0) |
| | ≥ 1 year | 0 (0.0) | 1 (10.0) | 1 (5.0) |
| **Duration of Illness (patients only)** | 1–2 years | 7 (70.0) | – | 7 (70.0) |
| | 3–4 years | 3 (30.0) | – | 3 (30.0) |

# RESOLVING ETHICAL ISSUES EXPERIENCED IN EOL CARE

RESOLVING ETHICAL ISSUES EXPERIENCED IN EOL CARE

The KII and IDI participants described some practices, procedures, or measures they use to resolve ethical issues in EOL care. Most reports were from KIIs. The notable themes that emerged from their responses were collaboration, discussions/meetings, and upholding ideas. Some of the cases, however, remained unresolved.

## Collaborations

Collaboration among several people (the palliative care unit, social worker, in some instances, pastors and priests of the patient's religion, and other hospital staff) who contribute individually toward a goal with no immediate connection was useful in resolving some EOL care ethical issues.

Some participants also reported that collaboration with the palliative team helped resolve issues of truthful disclosure. A doctor commented, *"that the palliative care team or unit takes time beforehand to counsel the family — sometimes even visiting them — so that, even before they begin to feel overwhelmed, they have already received some ongoing counseling and truthful communication"* (KII: Doctor) Collaboration with others, like the spiritual leaders – pastors and priests of the patient's religion was said to be useful for patients who believe in spiritual healing. A radio-oncologist said, *"If the patient believes in the spiritual way of healing, pastors can be invited to help them through the moment by encouraging them. Inviting whosoever they feel can help to come around them at that moment is helpful."* (KII: Doctor) This collaboration has also been used in the resolution of issues with truthful disclosure. A nurse said that *"sometimes we may inform the priests and, in turn, they will inform the patients and help them. So, the solution is to involve people who could inform and help them."* (KII: Nurse)

## Discussions and meetings

The participants indicated that discussions/meetings, including goal-setting meetings, family meetings, and one-on-one discussions, have been used to resolve ethical issues in EOL care.

**Goal-setting meetings** are held by all the doctors (often from multiple specialties) involved in a patient's care to critically review the patient's status and develop the best care plan or resolve any conflicts in management. Only doctors who have used it reported that it helped solve some ethical issues. Although such goal-setting meetings mostly addressed issues of inter-professional conflicts, they helped update some doctors' knowledge and resolved some miscommunications. One doctor commented as follows: *"Team meetings and discussions with people updating themselves on current treatment protocols resolved the conflict of different doctors giving different management plans for patients."* (KII: Doctor) These meetings and discussions may occur during ward rounds, as a doctor commented: *"Of course, team ward rounds help make decisions to be done collectively*." (KII: Doctor) which resolves issues of conflicting instructions in the care of EOL patients. Also, another doctor said that: *"the multi-disciplinary*

*team meetings are done for all cases of breast cancer, where every discipline involved in the care makes an input […] it has been helpful."* (KII: Doctor)

**Family meetings** refer to a meeting between the patient's close family and the health-care team (doctors, nurses, and others) to discuss the patient's case and care. This has been used to manage the most common forms of ethical dilemmas. A participant commented that: *"[…] discuss with their family. I think it is the family discussions that have yielded a better result."* (KII: Doctor) Another participant reported: *"I use family meetings more than one-on-one discussions because it is easier talking to their relatives [...] they will not be so traumatized by the news and hopefully it will be transmitted to the patient."* (KII: Doctor).

Family meetings were used to resolve issues of treatment withdrawal or limiting treatment. A doctor commented that *"usually it is not easy, but they have to come to terms with the situation. A discussion with them (the family) that giving treatment will cause more harm than benefit has often been used."* (KII: Doctor) One nurse commented that in her experience the family meeting was used for: "*Explaining, discussing and correcting their relative's misconceptions, which have been of help in some cases."* (KII: Nurse)

In situations of withdrawal of family support or poor family support and stigmatization, a nurse explained that: *"talking to their husbands did not solve the problem, but it reduced it. The way they (husbands) care for their wives may improve, but it did not solve it entirely."* (KII: Nurse) Family meetings have also been helpful in situations where the family does not want competent patients to know their diagnosis. One of the nurses commented that: *"Discussion with their family has solved some but in some other cases, their family may insist on not telling the patient."* (KII: Nurse) Sometimes, the managing team will combine family discussions and goal-setting meetings. One participant said: "*I have used family/health team meetings"* (KII: Doctor) while another similarly said: *"I have mostly used family/health team meetings."* (KII: Doctor)

**One-on-one discussion**: Some participants used this with the patients to resolve ethical issues in EOL care. It was commented that for refusal of treatment issues, *"one-on-one discussions were often used."* (KII: Doctor) Another doctor said: *"By talking to them, some may change their minds."* (KII: Doctor) A nurse said she has observed that: *"The relatives with them often plead with them; they convince them that it is their life we are trying to save, that we are not here to kill but save life. So, the solution is dialoguing with them."* (KII: Nurse) A doctor recounted an experience of resolving a family member's request that a competent patient not be informed of her condition, using a one-on-one discussion with the patient. He narrated: *"I sat the woman down and had a frank discussion with her. The irony is her question: Doctor, what is the solution? I told her […] I turned to the daughters and said, you are the ones building the mountains."* (KII: Doctor)

One-on-one discussions had resolved issues of a patient requesting discharge against medical advice; one nurse said: *"But from my experience, all things being equal, talking to a patient works better because if you have convinced the patient, or won the patient over to do the right thing, it is surely a win-win all through."* (KII: Nurse) while another nurse commented that: *"If the family has financial challenges, you talk*

*to the patient that even if they are not on admission that they can try their best to receive what they can afford from their home.*" (KII: Nurse)

On issues of patients requesting medication they don't need, it was reported to have been resolved by *"one-on-one discussion with them and counseling;"* (KII: Nurse) and also by *"explaining to the patient. Once they are aware why we are doing this, why this has not been done, etc., the patient will be okay with it."* (KII: Nurse) It was also used to resolve the conflicts between patients and families concerning choices in their care. One participant said: *"We kept talking/convincing him until he agreed."* (IDI: Patient's family caregiver) While another participant said: "*He (the patient) feels, after all, that he is going to die. Why waste so much money? But please, it is not a waste if it is still affordable. He then accepted and received the care. (IDI: Patient's family caregiver).*

# Upholding ideas

In some instances, the ethical issue was resolved by affirmation of the patient's own ideas by honouring their wishes or upholding the family's ideas concerning the patient's care.

**Upholding the family's ideas/requests**: Only the doctors have used this approach. It was said that most patients do not have much liberty in making self-decisions due to their cultural background. Caregivers who respected the family's request and ideas resolved almost all known issues. One doctor said, *"It is most important to be on the same page with not just the patient but their relatives*." (KII: Doctor) Another doctor commented in the extracts below that:

The family has influence, except if the relatives are not the ones that can influence the patient enough; […] or if the patient is domineering and won't want you to discuss with the relatives. Our culture is predominantly family-centered; rarely does one individual make a decision (KII: Doctor)

**Upholding the patient's autonomy**: In certain situations, caregivers affirming patients' autonomy to make decisions for themselves is a way to make progress. This approach is particularly valuable in cases of confidentiality, beliefs, and conflicts between patients and their families. One doctor said: *"Some patients are concerned about sharing information with family at the end of life. Yes, some don't want anybody to know. The simple solution is, I will respect the patient's request*." (KII: Doctor) Another doctor commented that this is particularly important in resolving issues if the patient is from a polygamous background, as he said:

Sharing of medical information is often an issue in polygamous settings, where divulging some sensitive information may cause more harm to patients. [...], like they may start quarreling about properties instead of caring for the dying patient or may wish the patient should die off faster so that they may inherit properties. The solution lies in observing the patient's wishes. (KII: Doctor)

Commenting on the issue of beliefs, a nurse said: *"You can only try; just keep dialoguing and convince them but if they refuse, we leave them with their beliefs*." (KII: Nurse) and another said: "*We try to manage*

*them along with what the patient accepts*." (KII: Doctor)

For issues of conflicts between the patients and their families, a nurse said: *"Sometimes when we concur with the patient and tell them (their family), see what the patient said, he is not going home, he wants to and will stay in the hospital for care, they may yield."* (KII: Nurse)

## Unresolvable Ethical issues

This implies that the case could not be resolved. One doctor concerning issues of medical futility said: *"If they request it, we refuse, […]. We counsel them, those that don't agree, sign the DAMA and go."* (KII: Doctor) A nurse commenting on issues of treatment refusal narrated: *"One particular case I had, despite all the discussions and attempts to persuade him to take his medications, he refused and insisted he wanted to go home. He left and died that particular night."* (KII: Nurse) Some doctors reported that if the issue is associated with financing care, allowing the patient to be DAMA when requested was the only option to resolve dilemmas. One doctor commented that:

In a few cases, since there is nothing to cure the patient at EOL, they will say, let us reserve the money for burial. The family and the patient sign the discharge against medical advice and take the patient home. […] I inform or advise them that within the hospital, the healthcare team will be caring for the patient. Some will however, prefer otherwise. (KII: Doctor)

## PREVENTING THE OCCURRENCE OF ETHICAL ISSUES IN EOL CARE

Thematic analysis of responses on measures to prevent ethical issues in EOL care identified two themes: family involvement in patient care/meetings and establishing good patient-doctor relationships.

# Family involvement in patient care and meetings

Doctors reported that involving families in end-of-life care decisions helps prevent ethical issues in patient management. A doctor stated that: *"The major prevention of these ethical issues is by family meetings where the patient is a major contributor*." (KII: Doctor) Although family meetings are a common preventive process, they may not always prevent ethical issues. A nurse said; "*Prevention is talking to family members/relatives of these patients, but it is not often prevented.* (KII: Nurse). Another participant reported that the involvement of family in patient management to prevent ethical issues is more effective if there is: *"progressive discussion based on each patient's reactions."* (KII: Doctor)

# Establishing a good patient-doctor relationship

Establishing a good doctor-patient relationship full of empathy is commonly used to prevent ethical issues in EOL care. A doctor commented: *"The prevention lies in the patient-doctor/ nurse relationship*." (KII: Doctor). Another doctor explained that:

I explain the nature of the pathology and how we can help them. Offer them any care that can be given, even a spiritual healer, depending on their belief. I have an experience that after telling a terminal case all these, […] the son of that patient wrote me that they are happy I carried them along. (KII: Doctor)

Similarly, a few of the patients' relatives commented that the caregiver paying attention to the emotional needs of their sick relatives assures them that the best is being given to them and can prevent ethical and other issues. One family caregiver said: *"Doctors should pay attention to their patients' emotions and see that all is done to prevent problems and ill feelings."* (IDI: Patient's family caregiver)

Some key informants highlighted that breaking bad news effectively is a means of preventing ethical issues. It was said that this could be prevented *"By the health care givers […] especially the doctors going to seminars and learning how to break bad news."* (KII: Nurse)

## DISCUSSION

Our study provides one of the first empirical descriptions of the strategies used to prevent and resolve ethical issues in EOL care from the perspectives of healthcare professionals, patients, and family caregivers in Nigeria. These findings contribute to the limited empirical evidence from Nigeria and sub-Saharan Africa by demonstrating how ethical issues are prevented and resolved in a resource-limited setting where formal ethical support structures are largely unavailable. Preventive strategies were centered on family involvement, regular family meetings, and empathetic doctor–patient relationships. Strategies for resolution were primarily through multidisciplinary collaboration, discussions and meetings, and respect for patients' and families' preferences. Despite these approaches, some ethical dilemmas remained unresolved.

# Resolving ethical issues in EOL care

Collaboration, discussions, meetings, and upholding ideas were commonly used to resolve ethical issues in our study. A study conducted in the USA,[12] had a similar finding. However, their use of ethics committees and consultation services contrasts with our context. However, their report on utilizing ethics committees and consultation services contrasts with the findings of our study. Clinical ethics committees are absent in our hospital and, indeed, in most institutions across Nigeria. The development of such committees remains at a nascent stage in the country. Their demonstrated usefulness elsewhere underscores the need for sustained efforts to establish and strengthen these structures, including the training of bioethicists in clinical ethics within Nigeria.

Doctors and nurses reported using collaboration to resolve ethical issues in our research. A study among Portuguese nurses reported collaboration as the most effective method for resolving ethical issues.[10] Similarly, a study in England,[11] found that nurses could resolve ethical dilemmas by maintaining effective relationships with other professionals. Reports among oncology nurses similarly found that good collaboration between physician-nurse teams helps manage prognostic conversations.[14] These

similarities may likely stem from an interdisciplinary, collaborative approach that leverages the strengths of different parties to address the varied nature of ethical issues. Our findings emphasize the necessity of sustained collaboration with stakeholders when resolving ethical problems arising from end-of-life care.

In this study, discussions and meetings with the health team, family, or one-on-one with the patient clarified care goals and helped resolve ethical issues in EOL care. Health team meetings and discussions were particularly useful in addressing inter-professional conflicts. A study in the USA,[12] similarly reported that nurses used team meetings to resolve ethical dilemmas. Family meetings were utilized by doctors and nurses in this study to resolve most ethical issues, especially those related to withdrawal or limitation of treatment, withdrawal of family support and stigmatization, and situations where families insisted that competent patients should not be informed about their conditions. Upholding family ideas was also used to resolve nearly all identified issues. An American study,[12] likewise reported using family meetings and providing support to the family in resolving ethical issues. The finding that family meetings or upholding family values resolved almost all ethical issues in this study may be attributed to the family-centered culture of the study area. Therefore, promptly involving the patient's family, when indicated, is essential for resolving ethical issues. However, efforts should also be made to obtain the patient's consent before convening family meetings. One-on-one discussions identified in our study to resolve ethical issues were not reported in the literature reviewed, possibly because this is often regarded as part of routine daily care. A study among nurses reported that upholding patient autonomy could resolve certain ethical dilemmas.[12] This finding is consistent with our study, where upholding patient autonomy was also observed to address some ethical issues.

Some unresolved issues in this study included withdrawal or limiting/withholding treatments, medical futility, treatment refusal, and issues associated with financing the patients' health care. This is consistent with the findings of Cheon et al.,[12] who reported unresolved ethical dilemmas in end-of-life (EOL) care among hospice and palliative care nurses in the U.S. healthcare system. In their report, most unresolved cases were associated with the family's insistence on continuing non-beneficial interventions, financial constraints, involvement of children, and family avoidance of meetings or other forms of communication, among others.[12]

Despite these findings, other studies reviewed provided scant reports on resolving ethical issues, as greater attention focused on their prevention. These findings suggest that, although the identified methods are effective for resolving ethical dilemmas in this setting, there remains a need to adopt additional preventive protocols.

# Preventing ethical issues in EOL care

Our study identified family involvement in patient care, regular family meetings, and empathetic doctor–patient relationships as key strategies for preventing ethical issues in end-of-life care. The doctors reported that involving the patient's family in their care was an important strategy for fostering shared

understanding and minimizing the potential for ethical conflict. However, participants acknowledged that it did not prevent all ethical dilemmas. Patients' relatives also emphasized that empathetic communication and trusting doctor–patient relationships helped prevent ethical issues. This finding is consistent with previous research among nurses, which identified strong professional relationships as central to preventing and resolving ethical issues,[11] and with a Tanzanian study.[22] These findings suggest that relationship-centered care, characterized by meaningful family engagement and empathetic care, is fundamental to preventing ethical issues in end-of-life care within the study setting.

An important finding of our study was the non-utilization or absence of reported formal ethical support mechanisms to prevent EOL care issues, including advance directives, clinical ethics committees, and legal decision-making processes, which are commonly used in many developed countries to support ethical decision-making in end-of-life care. This finding contrasts with reports in the literature, where advance directives,[6][23] ethics committees,[12][10] formally appointed surrogate decision-makers, and legal mechanisms such as court intervention,[7] have been identified as important measures for preventing and managing ethical dilemmas in EOL care. Another notable finding was that participants did not report using formally appointed surrogate decision-makers, such as durable powers of attorney for healthcare; instead, EOL care and decision-making relied largely on informal family-centered shared decision-making. These findings in our setting likely reflect differences in healthcare systems, legal frameworks, institutional capacity, and sociocultural approaches to EOL decision-making. The finding may also be explained by the lack of a comprehensive statutory framework for adult surrogate decision-making or formal recognition of advance directives. Although Nigerian law affirms the right of competent adults to refuse medical treatment, as established in *Medical and Dental Practitioners Disciplinary Tribunal v. Okonkwo*,[24] this right has not been clearly extended to formally appointed proxies. In practice, healthcare professionals may rely on the Code of Medical Ethics by engaging the 'Next of Kin', although this approach is primarily intended to support life-preserving decisions.[25] Consequently, healthcare professionals rely heavily on family engagement and professional ethical guidance when navigating EOL decisions. These findings underscore the need to develop ethical and legal support mechanisms that complement family-centered practices while aligning with the sociocultural realities of EOL care in Nigeria.

In our study, clinical ethics committees (CECs) were not reported as a preventive measure, likely because such a committee does not exist in the healthcare facility (UNTH). Currently in Nigeria, ethics committees exist primarily as research oversight bodies, with CECs remaining rare and currently being advocated for.[17][20] While formal CECs are scarce across much of Africa,[26] initiatives in countries such as Kenya and Tanzania have introduced CECs to support ethical decision-making.[27] This highlights the need to explore establishing clinical ethics in UNTH, Nigeria. Ethics consultation has been shown to improve clinical management in selected cases and reduce moral distress among healthcare team.[28] Nevertheless, the presence of a CEC alone may not ensure its effective use. For example, Portuguese nurses reported limited reliance on ethics committees in clinical decision-making.[10] Also, a 10-year evaluation of a Hospital Ethics Committee in a non-Western setting found that its effectiveness

depended on institutional support, ethics training, and integration into routine clinical practice.[29] These findings suggest that successfully implementing Clinical Ethics Committees (CECs) in Nigeria will require more than simply establishing them. They should be supported by adequate institutional capacity and integrated into the family-centered, collaborative approaches to ethical decision-making identified in our study. There is a need to research and explore the possibility of using CECs to prevent ethical issues in the study area.

# CONCLUSION

In the study area, stakeholders' collaborations, discussions, meetings, and upholding ideas were essential for resolving ethical issues in EOL care when they occurred. Nevertheless, some issues remained unresolved. Preventing these issues involved some measures that differed from previously reported preventive measures. Exploring previously reported measures supported by strong research evidence could avert these issues in the study area. It is important to make resources for prevention and resolution available. EOL care should go beyond individual cases to policy and guideline formulation in response to new technology and knowledge.

# Abbreviations

**AD**
Advance directives
**DAMA**
Discharge against medical advice
**EOL**
End-of-life
**IDI**
In-depth interview(s)
**ICU**
Intensive care unit
**KII**
Key informant interview(s)
**UK**
United Kingdom
**UNTH**
University of Nigeria Teaching Hospital
**USA**
United States of America

# Declarations

**Ethics approval and consent to participate:** Before the study commenced, ethical approval was obtained from the Health Research Ethics Committee of the University of Nigeria Teaching Hospital, Enugu State, Nigeria (NHREC/05/01/2008B-FWA0000245 8-1RB00042323). The tenets of the Declaration of Helsinki and the Nigerian National Code of Health Research involving the use of human subjects were adhered to. Written informed consent was obtained from all participants.

**Consent for publication:** not applicable

**Availability of data and materials:** The datasets used and/or analyzed during the current study are available from the corresponding author upon reasonable request.

**Competing interests:** The authors declare that they have no competing interests

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# Figures

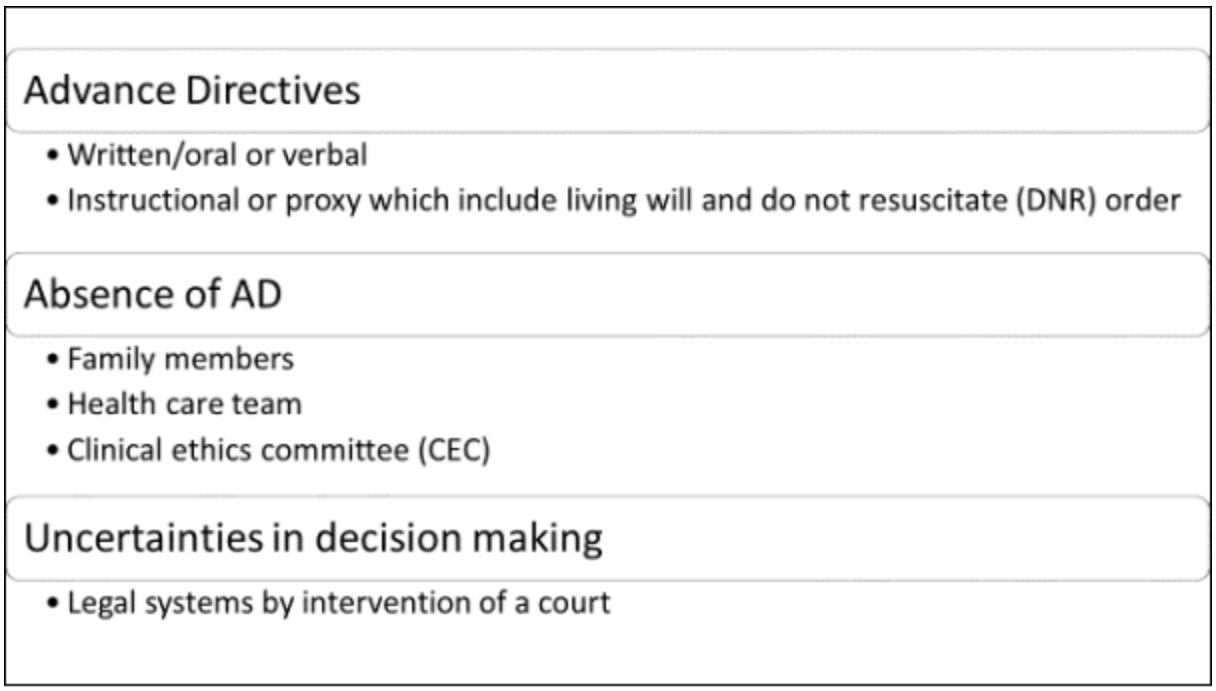



**Figure 1**

**Reported pathways that could prevent ethical issues in EOL care**

## Supplementary Files

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