Moral and Ethical Responsibilities Among Nurses in Geriatric Healthcare Decision-Making: A Phenomeonological Study

Paciencia H. Valle

University of Perpetual Help System DALTA – Las Piñas, Bacoor, Cavite, Philippines

DOI: https://doi.org/10.51244/IJRSI.2025.120800151

Received: 12 August 2025; Accepted: 21 August 2025; Published: 16 September 2025

ABSTRACT

This phenomenological study examined the moral and ethical responsibilities of nurses in geriatric healthcare decision-making in selected healthcare facilities in Davao, Philippines. Guided by Colaizzi's descriptive method, in-depth interviews were conducted with eleven staff nurses who had at least one year of experience in caring for older adults. The study aimed to uncover how nurses navigate ethical dilemmas, interpret their professional responsibilities, and reconcile institutional policies with personal values and cultural beliefs. Participants were predominantly female (64%) and aged 35–44 years (73%), with most having 5–10 years of clinical experience. Analysis of the qualitative data generated seven key themes: (1) Ethical Principles in Geriatric Healthcare, (2) Ethical Dilemmas in Geriatric Practice, (3) Moral Responsibility and Ethical Reasoning in Nursing, (4) Institutional Support and Ethics Education, (5) Moral Distress and Emotional Labor in Geriatric Care, (6) Cultural and Contextual Factors in Ethical Decision-Making, and (7) Balancing Patient Needs with Personal Beliefs. Findings revealed that while nurses consistently applied ethical principles such as autonomy, beneficence, and justice, they frequently experienced tension when institutional policies conflicted with patient needs or family expectations. Moral distress was common, especially in end-of-life care, with nurses highlighting the emotional burden of ethically complex decisions. Cultural norms, personal beliefs, and religious values strongly shaped ethical reasoning, underscoring the need for culturally sensitive ethics education. The study concludes that ethical decision-making in geriatric nursing is a dynamic, reflective, and deeply personal process requiring sustained institutional support, targeted ethics education, and emotional resilience. Recommendations include integrating case-based ethics training, fostering reflective practice, establishing mentorship programs, and developing emotional support systems to mitigate moral distress among geriatric nurses.

Keywords: geriatric nursing, ethical decision-making, moral responsibility, moral distress, nursing ethics, cultural competence, phenomenology

INTRODUCTION AND BACKGROUND OF THE STUDY

Moral and ethical responsibilities in geriatric healthcare decision-making are grounded in the principles of autonomy, beneficence, non-maleficence, and justice, which collectively safeguard the dignity, safety, and well-being of older adults (Beauchamp & Childress, 2019). These principles are particularly critical in geriatric care, where patients often face cognitive decline, chronic illnesses, and increased dependency on healthcare providers. In the Philippines, the complexity of ethical decision-making in such contexts is heightened by systemic constraints, resource limitations, and cultural dynamics that influence both professional practice and patient expectations (Corpuz, 2022). Nurses, as front-line caregivers, often navigate ethical dilemmas involving consent, end-of-life care, and conflicts between patient autonomy and family wishes, frequently making decisions under emotionally charged and time-sensitive conditions (World Health Organization, 2020). The ability to apply ethical principles consistently is influenced not only by individual competence but also by institutional support, policy clarity, and access to ethics education (Silva & Andrade, 2021).

The philosophical foundation of this study is rooted in moral philosophy, specifically Beauchamp and Childress's Four Principles of Biomedical Ethics—autonomy, beneficence, non-maleficence, and justice—and Andrew Jameton's Theory of Moral Distress. The former offers a universal framework for clinical ethical decision-making, while the latter emphasizes the psychological strain experienced by healthcare professionals

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XII Issue VIII August 2025

when systemic or institutional barriers prevent them from acting on what they believe is ethically right (Jameton, 1984; Epstein & Hamric, 2009). In the Philippine healthcare context, where disparities in resources and ethics infrastructure persist, these frameworks provide a dual lens for understanding how nurses interpret and enact their ethical obligations. This study is also anchored in phenomenology as articulated by Moustakas (1994), focusing on the lived experiences of nurses as they confront ethically challenging situations in geriatric care.

The purpose of this research is to explore and describe the lived experiences of nurses in fulfilling their moral and ethical responsibilities in geriatric healthcare settings in Davao, Philippines. It seeks to uncover how nurses respond to ethical dilemmas, the personal and institutional factors influencing their decisions, and how they reconcile professional obligations with personal values and cultural norms. The scope of the study is limited to nurses with at least one year of direct experience in geriatric care, including intensive care, emergency, medical, and surgical settings. Eleven participants from selected healthcare facilities were engaged through in-depth interviews, ensuring that findings reflect diverse yet context-specific experiences. While the study is limited by its qualitative design and reliance on self-reported narratives, its phenomenological approach allows for a nuanced and in-depth understanding of ethical decision-making in geriatric nursing.

The significance of this study spans nursing service, education, and research. For nursing service, the findings can inform policy development, ethics guidelines, and institutional support systems aimed at reducing moral distress and improving quality of care for older adults. In nursing education, the study offers insights that can be integrated into curricula through case-based learning, reflective practice modules, and ethics simulations, thereby enhancing the ethical competence of future nurses. From a research perspective, the study enriches the body of qualitative nursing literature on ethics in geriatric care and lays the groundwork for developing culturally sensitive frameworks for ethical decision-making in resource-constrained healthcare environments. By amplifying the voices of nurses navigating these ethical landscapes, the study contributes to advancing patient-centered, culturally competent, and ethically grounded geriatric care in the Philippines.

METHODOLOGY

This study employed Colaizzi's descriptive phenomenological method to explore the lived experiences of nurses in fulfilling their moral and ethical responsibilities in geriatric care. The phenomenological approach was chosen to capture the essence of participants' experiences, free from researcher bias, through the process of bracketing as described by Husserl (as cited in Moustakas, 1994). Colaizzi's (1978) seven-step process was followed, beginning with reading all participants' descriptions to obtain an overall understanding, extracting significant statements, formulating meanings, clustering themes, developing an exhaustive description, identifying the fundamental structure, and returning the findings to participants for validation. This approach aligned with the Consolidated Criteria for Reporting Qualitative Research (COREQ) standards for qualitative rigor (Tong et al., 2007).

The study population consisted of registered nurses currently employed in healthcare facilities in Davao City who were actively engaged in geriatric care. Purposive sampling was applied to select participants with rich experiential knowledge relevant to the phenomenon under investigation (Creswell & Poth, 2018). Inclusion criteria required that participants (1) had at least three years of nursing experience, (2) were assigned in critical areas such as emergency or intensive care units for a minimum of three years, and (3) were willing to participate in the study. To capture a diverse range of perspectives, maximum variation sampling, a subtype of purposive sampling, was also employed (Patton, 2015). Eleven nurses were recruited through personal visits, phone calls, and online invitations. Both in-person and virtual interviews were conducted to accommodate participants' availability.

The study was conducted in selected public and private healthcare facilities in Davao City that provide geriatric services. Davao City, a major urban center in Mindanao, was considered an ideal setting because of its growing elderly population and its mix of cultural diversity and family-oriented values, which influence healthcare decision-making. The selected facilities included hospitals, specialized geriatric clinics, and long-term care institutions chosen for their direct involvement in geriatric healthcare and decision-making processes.

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XII Issue VIII August 2025

Data were collected using a researcher-developed semi-structured interview guide designed to elicit rich narratives about moral and ethical decision-making in geriatric nursing. The instrument was informed by relevant literature on nursing ethics and geriatric care and consisted of open-ended questions grouped into thematic areas such as moral and ethical decisions, ethical responsibilities, ethical challenges, influencing factors, and coping strategies. The interview guide began with demographic questions, followed by prompts to encourage participants to share specific experiences, reflections, and perceived consequences of their decisions.

In qualitative research, validity was addressed through credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). Credibility was enhanced through prolonged engagement, triangulation of data sources (face-to-face, online, and written interviews), and member checking, wherein transcripts were returned to participants for verification. The interview guide underwent expert review by two qualitative researchers and a healthcare ethics educator, and a pilot interview was conducted with one nurse not included in the main study. Transferability was supported by providing thick descriptions of the study setting, participant demographics, and procedures. Dependability was ensured through the maintenance of an audit trail documenting all methodological decisions. Confirmability was achieved by reflexive journaling and peer debriefing to minimize researcher bias.

Ethical approval was obtained from the Institutional Review Board of the University of Perpetual Help System Dalta before data collection commenced. All participants provided informed consent after receiving a detailed explanation of the study's purpose, procedures, potential risks, and benefits. Participation was voluntary, and participants could withdraw at any time without penalty. Confidentiality was safeguarded by removing identifying information from transcripts and storing all data on password-protected devices. Physical documents, such as signed consent forms, were kept in a locked cabinet accessible only to the researcher. Data will be retained for five years and then securely destroyed. The researcher declared no conflicts of interest.

RESULTS AND DISCUSSION

The analysis of in-depth interviews revealed interrelated themes that reflected the complex ethical landscape of geriatric nursing. Nurses described ethical dilemmas, moral responsibilities, systemic influences, and personal belief systems as key factors shaping their decision-making. To capture these dynamics holistically, the findings are represented through the metaphor of an Ethical Compass, which symbolizes how nurses orient themselves when navigating morally complex terrain. At its center lies the guiding principle of patient-centered care, representing the "true north" of their ethical practice. Each compass point reflects a dimension of their lived experiences, illustrating the directions nurses must turn to when making difficult ethical decisions.

One recurring challenge, positioned at the north point of the compass, involved ethical dilemmas in end-of-life care, particularly surrounding Do Not Resuscitate (DNR) orders. Nurses struggled with tensions between honoring patient autonomy and responding to family requests, echoing Van Bogaert et al.'s (2012) findings that aggressive, non-beneficial treatments contribute significantly to moral distress in geriatric settings. The south point of the compass reflects the emotional burden of these situations, aligning with Corley et al.'s (2001) definition of moral distress, where nurses experience psychological discomfort from being unable to act according to their ethical judgment. Feelings of guilt, anxiety, and helplessness were common, particularly among less experienced nurses, whose vulnerability to compassion fatigue has been well-documented (Beck et al., 2016; Hiroko & Elsom, 2020; Poulsen et al., 2022).

The east and west points of the compass symbolize balance through support systems and shared accountability. Participants emphasized the importance of collaborative team environments, noting that solidarity from colleagues alleviated emotional strain and promoted ethical clarity. As one nurse reflected, "It helps when the team backs your decision. You feel less alone in making ethical calls." This supports Rafferty et al. (2003) and Pawar et al. (2019), who identified positive ethical climates as protective against moral distress. In this way, the compass metaphor illustrates how nurses recalibrate their orientation when supported by ethical dialogue and team solidarity. Beyond these cardinal points, the compass is further informed by the principles that guide its direction—autonomy, beneficence, and justice—which participants described as the foundation of ethical responsibility. This is consistent with Lindahl (1998) and Caren-Gutiérrez and Rodríguez (2020), who emphasized moral courage and patient advocacy as essential to nursing ethics. Nurses also highlighted moral

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XII Issue VIII August 2025

sensitivity as their "decision-making compass," enabling them to recognize and respond to dilemmas (Kim et al., 2021). Yet, hierarchical constraints often pulled them off course, excluding them from key decisions and fostering feelings of moral exclusion (Pinto & O'Brien, 2019). Systemic factors also influenced the compass's direction. Resource shortages, policy conflicts, and institutional priorities sometimes forced nurses to act against their ethical instincts, reinforcing Nathaniel's (2006) theory of moral reckoning and the persistence of moral residue. While formal ethical policies provided a framework, their effectiveness depended on interpretive judgment and situational adaptability (Feinsod & Wagner, 2005). Nurses also drew upon deeply held personal and cultural values to steady their ethical compass. Many cited spirituality and Filipino traditions such as paggalang sa matatanda as moral anchors. While these values served as sources of strength, they sometimes conflicted with institutional directives, requiring negotiation and ethical mindfulness (Beagleh, 2024; Schlüter et al., 2008). The compass was further sharpened by ethics education and reflective practice, which participants described as essential in refining their moral reasoning. Simulation-based training and structured reflection provided tools to navigate dilemmas with confidence (Hickman & Wocial, 2013; Qu et al., 2024). Together, these strategies helped nurses recalibrate their orientation, ensuring their decisions aligned with both professional standards and patient-centered principles.

Overall, the findings indicate that ethical practice in geriatric nursing is shaped by a dynamic interplay between personal values, institutional structures, and patient-centered principles. The Ethical Compass metaphor underscores that nurses do not follow a linear path but instead continuously reorient themselves in response to moral challenges. Addressing moral distress requires not only robust policies and training but also a supportive ethical climate that empowers nurses' voices in decision-making.

This study concluded that ethical decision-making in geriatric nursing is a multidimensional process influenced by clinical guidelines, personal beliefs, cultural values, and the ethical climate of healthcare institutions. While nurses demonstrated strong moral responsibility and advocacy for patient dignity, their capacity to act ethically was sometimes constrained by hierarchical decision-making, systemic limitations, and conflicting stakeholder interests. Supportive team relationships, ethics education, and reflective practice emerged as critical in enabling ethical resilience.

The findings of this study point to the need for a multi-pronged approach to strengthen ethical decision-making in geriatric nursing. First, integrating scenario-based ethics simulations into continuing professional education would allow nurses to practice responding to complex dilemmas, particularly in end-of-life care and consent-related situations, thereby enhancing their moral reasoning and confidence in real-world settings. Equally important is the implementation of structured ethics reflection programs, such as regular debriefing sessions or guided journaling, which can help nurses process emotionally taxing experiences, reduce moral distress, and foster a culture of openness. Institutions should also ensure that clear, accessible, and context-specific ethical guidelines are in place, supported by functional ethics committees or designated ethics consultants to provide timely advice when dilemmas arise. Given the influence of cultural and religious values on decision-making, it is essential to embed cultural sensitivity into ethics training and policy formulation so that these beliefs can be respected while still aligning with professional standards. Moreover, providing mental health support and peer counseling can help mitigate the risk of compassion fatigue, which was identified as a recurring challenge. Establishing mentorship programs that pair novice nurses with experienced practitioners can further enhance ethical competence by facilitating the transfer of practical wisdom and critical thinking skills. Finally, integrating ethics-related performance indicators into institutional quality assurance systems would ensure that ethical practice is monitored, reinforced, and valued as a key component of geriatric care quality. Together, these recommendations aim to create an ethically supportive environment that empowers nurses to deliver dignified, patient-centered care while maintaining their own professional integrity.

This study was limited to a purposive sample of eleven nurses from selected healthcare facilities in Davao City, which may restrict the transferability of findings to other contexts. The qualitative design, while offering rich insights, does not permit statistical generalization. Additionally, participants' responses may have been influenced by recall bias or reluctance to discuss sensitive ethical conflicts openly. Future studies could expand to multiple regions, include a larger sample, and employ mixed-method approaches to deepen and validate findings.

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XII Issue VIII August 2025

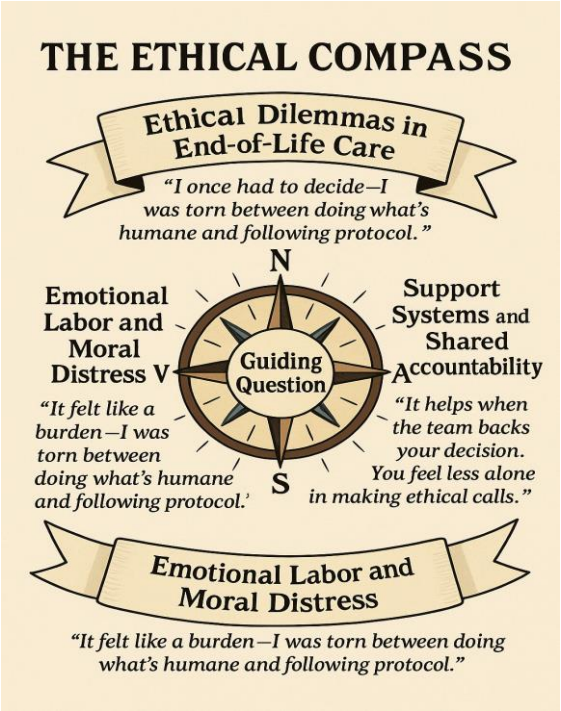

Figure 1: The Ethical Compass Metaphor for Ethical Decision-Making in Geriatric Nursing

This figure illustrates the Ethical Compass metaphor, representing how healthcare professionals navigate moral and ethical decision-making in geriatric care. At the center of the compass lies the guiding principle of patient-centered care, symbolizing the "true north" of ethical nursing practice. The north point represents ethical dilemmas in end-of-life care, highlighting conflicts between respecting patient autonomy and responding to family demands. The south point depicts emotional labor and moral distress, emphasizing the psychological burden of ethical decisions. The east and west points signify support systems and shared accountability, underscoring the role of teamwork, dialogue, and peer solidarity in buffering moral strain. Together, the compass symbolizes the dynamic process by which nurses continuously reorient themselves amidst personal values, institutional constraints, and cultural influences to deliver ethically sound and compassionate care.

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