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Death in the Line of Duty: Lived Experiences of Lifesaving Professionals

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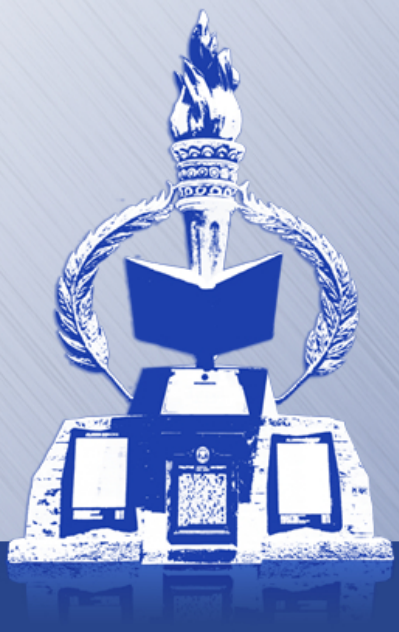

Death in the Line of Duty: Lived Experiences of Lifesaving Professionals

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CHAPTER I

The Problem and Literature Review

Background of the Study

Lifesaving are actions which within a short period of time, mitigate or avert direct loss of life, physical and psychological harm or threats to a population (Central Emergency Response Fund, 2010). Great honor and responsibility are placed on the shoulders of professionals who have pursued this career. Medical practitioners have been trained to recognize and respond to life-threatening emergencies and similar critical situations, a reason why this profession is considered a life-saving one. The appropriate medication and treatment interventions they provide to their patients are geared towards saving and lengthening the patients' lives. With this vital role in the society, becoming a medical practitioner is one of the most prestigious and reputable profession. In consideration of such prestige, medical practitioners are motivated to try their best in helping their patients' conditions, not just in alleviating pain and illness, but somehow postponing death.

In the Philippines, after basic and secondary education, it takes at least twelve (12) years for a student to become a doctor: four (4) years for pre-med bachelor's degree, five (5) years in medical school which consists of three years of academic instruction, one year of clinical clerkship and one year of post-graduate internship (CHED, 2016). Before entering the Doctor of Medicine program, they should have passed the National Medical Admission Test (NMAT), and in some colleges, additional requirement of passing an entrance exam and the interview is needed prior to acceptance in the program. A copy of their police clearance and a recommendation letter from a reputable source and from their previous college dean or any faculty of member of their previous school should have been submitted (CHED, 2016).

Additionally, for them to be a full-fledged medical practitioner, a graduate of the Medicine program ought to pass the Philippine Physician's Licensure Examination. The Board of Medicine (BOM) facilitates the exam under the supervision of the Professional Regulations Commission (PRC). The process would not end in passing the board. Board passers should be eligible to enter the Residency Training Program which would take three (3) to six (6) years depending on their field of specialization (CHED,2016). Residency is significant for much of their learning comes from their patients. It allows a resident to perform as a licensed practitioner. During this time a resident receives training that would provide growth both in their clinical knowledge and professional development (Association of American Medical Colleges, 2019). The years devoted to tedious study and test of limits prepare medical practitioners to be ready in the real field; where unforeseen circumstances or maybe unavoidable circumstances set in, like sudden death.

It has been revealed that most medical student trainees said that the effect of a patient's death on them is highly and emotionally impactful. While the finality of death and sudden death are the two items that evoke their strongest emotions. Moreover, the respondents disclosed that if a patient who has been taken care of by a team dies, colleagues would not have any discussion in the aftermath of the patient's death (Rhodes-Kropf, Carmody, Seltzer, Redinbaugh, Gadmer, Block, and Arnold 2005).

In addition, the medical trainees of North of Scotland Foundation physicians-in-practice confirmed that they have been frequently exposed to patients' death, and stated that their most memorable patient death has been emotionally distressing. They also had recent experience of significant personal bereavement (Linklater, 2010)

The lived experiences of physicians dealing with death by Paul Richard Whitehead (2012) supported other studies that said that doctors experience or think that death is just part of their

normal life but could still trigger strong emotions when it suddenly pops into their consciousness. The said study revealed five essential themes that provided concrete descriptions of the lived experience of patient death for these physicians. The themes proved that physicians or medical practitioners experience very strong and lasting emotional reactions to some patient deaths, and that patient death elicits intense experiences that relates to professional responsibility and competence. The key findings indicated that physicians should have balance between personal and professional reactions in the face of patient death. Difficulties in negotiating this balance may lead to unintended lapses in compassion and suboptimal outcomes in patient care.

Above studies stated that having experienced this phenomenon was really difficult for medical practitioners. Moreover, their reactions might not always be silent grief. For instance, a study by Granek, Tozer, Mazzotta, Ramjaun, and Krzyzanowska (2012) revealed that in the case of a Canadian oncologist, grief may occur even before they lose their patient. The fact that they hold the poor medical results or likely have knowledge already of the patients' approaching death before revealing it to the patients and/or to the families, oncologist would have been experiencing sadness, crying and loss of sleep for they have this sense of responsibility to their patients' life. Feelings of powerlessness, self-doubt, guilt, and failure are also included.

Furthermore, the pressure caused by the death of their patient tend to make them do "more" in their next patient, leading them to provide more aggressive chemotherapy, to put a patient in a clinical trial, or to recommend further surgery when palliative care might be a better option. They also tend to have a distanced or withdrawn relationship with their patient and to his/her family as the patient gets closer to dying, including fewer visits in the hospital, fewer bedside visits, and less overall energy expended toward the dying patient.

In relation to all stated studies above about medical practitioners, this study has been inspired by Granek, et. al's (2012) findings on how an Oncologist has been impacted by a patient's death. For medical practitioners who have been saving peoples' lives, what would happen to them when they experience their first patient death? Could their twelve to fifteen (12-15) years of study be sufficient enough in preparing them to face the inevitable death of their patient?

When applied to Philippine setting, this study aims to know how medical practitioners experience first patient's death. Second is to understand the resulting emotions they feel and their cognitive reactions in the aftermath of death experience. Lastly, to determine the factors that enable them to deal with it, specifically, the reason why they still continue to practice.

Answers to these questions may contribute to further understand that lifesaving professions is not a joke; someone has to have enough courage to deal with its unforeseen and inevitable outcomes. In a way, people could also be more considerate with the feelings of the medical practitioners, for like us, they are humans, too. As well as for the medical practitioners, to accept the fact that despite all their efforts to postpone the death of their patients but if it has happened, they do not have to blame themselves.

Furthermore, this study aimed to deepen understanding on how medical practitioners developed (if any) post-traumatic stress disorder or any anxieties, if it is from the sudden fear of not being able to save a life again or it is for the reason that they blame themselves when their patient died. If published and read by the medical institution heads, this evaluation might help in developing a more suitable training program for them. Additionally, this study might also have its contribution on bereavement psychology, for it tackles how medical practitioners respond to the death of their patients.

Complexity lies on where and how to gather data for this study; this study needs eight (8) medical practitioners who have experienced patient death. Another is how this study would be able to generate answers that would not trigger the participants to remember their first patient's death.

Literature Review

Life Saving and Life Saving Profession

Lifesaving is an act done to prevent someone from dying. Another definition is the actions that can save someone's life when he/ she has fallen into water. Data about life saving professional were mostly anchored to being a lifeguard, the one who saves people from drowning. Information with regards to the general meaning of life saving and life saving professionals was not established. However, Lifeguard Singapore (2018) stated that lifesaving is a skill that is used to save a life whether on land or in aquatic situation. Having life-saving skills such as basic survival skills, basic lifesaving ensuring your personal safety first, resuscitation – expired air resuscitation (EAR) and cardiopulmonary resuscitation (CPR), basic first aid knowledge and using the correct techniques to rescue during different situations would definitely save a life. Performing such skills in times of emergencies could bridge the gap between the incident being discovered and the arrival of emergency services. In effect, early intervention applied during a rescue can make a crucial difference between life and death. Taking it as a profession, needed extensive training, studies and skills in order to perform the act adequately.

Medical Practitioners

Medical practitioners are people who diagnose physical and mental illnesses, disorders and injuries, and prescribe medications and treatment to promote or restore good health. They are to examine the patient to determine the nature of the disorder or illness and record the patient's

medical information. Medical practitioners are also the ones who order, perform and analyze laboratory tests, X-rays and other diagnostic images and procedures. They provide overall care for patients, aid in the prevention of diseases and disorders by advising patients on diet, exercise, hygiene and general health and refer patients to other medical specialists and exchange relevant medical details (Gooduniversitiesguide.com, 2018).

In the same site, it also states that medical practitioners are also involved in wide range activities such as consultations, attending to emergencies, performing operations and arranging medical investigations. When attending to patients, medical practitioners work with other health professionals, research is also included in their field. Unpleasant conditions due to patient's illness or injury are also dealt by them. Work hours vary depending on the area of specialization, hours may be long, demanding and irregular. This may include working on weekends and at night or being on call 24 hours a day.

In the Philippines, according to the Code of Ethics of the Philippine Medical Association, Article II – Duties of Physicians to their Patients (2017), a physician should be dedicated to provide competent medical care with full professional skill in accordance with the current standards of care, compassion, independence and respect for human dignity. They should also be free to choose patients. In times of an emergency, provided there was no risk to his or her safety, a physician should administer at least first aid treatment and then refer the patient to the primary physician and/or to a more competent health provider and appropriate facility, if necessary. Furthermore, in serious/difficult cases, or when the circumstances of the patient or the family so demand or justify, the attending physician should seek the assistance of an appropriate specialist. They should also exercise good faith and honesty in expressing opinion/s as to the diagnosis, prognosis, and

treatment of a case under his/her care. A physician shall respect the right of the patient to refuse medical treatment. Timely notice of the worsening of the disease should be given to the patient and/or family. A physician shall not conceal nor exaggerate the patient's condition except when it is to the latter's best interest. A physician shall obtain from the patient a voluntary informed consent. In case of unconsciousness or in a state of mental deficiency the informed consent might be given by a spouse or immediate relatives and in the absence of both, by the party authorized by an advanced directive of the patient. Additionally, informed consent in the case of minor should be given by the parents or guardian, members of the immediate family that are of legal age. The physician should hold as sacred and highly confidential whatever might be discovered or learned pertinent to the patient even after death, except when required in the promotion of justice, safety and public health. Lastly, in terms of professional fees, it should be commensurate to the services rendered with due consideration to the patient's financial status, nature of the case, time consumed and the professional standing and skill of the physician in the community.

Death

The National Conference of Commissioners on Uniform State Laws in 1980 formulated the Uniform Determination of Death Act. It states that: "An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem is dead. A determination of death must be made in accordance with accepted medical standards." This definition was approved by the American Medical Association in 1980 and by the American Bar Association in 1981.

While in the Philippines, legal definition of death consisted of three (3) these were based on the medical community, here in the Philippines and other countries. They used several criteria

in determining whether a person is dead or alive. First is, the heart-lung death, it is the irreversible cessation of spontaneous respiration and circulation**.** Second, the irreversible cessation of all functions of the entire brain, including the brain stem, even if the heart and digestive systems are still functioning. Lastly, higher-brain death**,** the irreversible cessation of all cognitive functions such as personality, consciousness, uniqueness, memory, judgment, reason, enjoyment, worry, etc.

Furthermore, Republic Act 7170 or the "Organ Donation Act of 1991" in Section 2, paragraph (j), has defined death as the irreversible cessation of circulatory and respiratory functions or the irreversible cessation of all functions of the entire brain, including the brain stem. A person shall be medically and legally dead if; one in the opinion of the attending physician, based on the acceptable standards of medical practice, there is an absence of national respiratory and cardiac functions and, attempts at resuscitation would not be successful in restoring those functions. In this case, death shall be deemed to have occurred at the time those functions ceased. Two, in the opinion of the consulting physician, concurred in by the attending physician, that on the basis of acceptable standards of medical practice, there is an irreversible cessation of all brain functions, and considering the absence of such functions, further attempts at resuscitation or continued supportive maintenance would not be successful in restoring such natural functions. In this case, death shall be deemed to have occurred at the time when these conditions first appeared.

It was also emphasized that the death of the person shall be determined in accordance with the acceptable medical practice and shall be diagnosed separately by the attending physician and another consulting physician, both of whom must be appropriately qualified and suitably experienced in the care of such patients. The death shall be recorded in the patient's medical record (Galacio, 2007).

First Experience of Death – Medical Practitioners

Rhodes-Kropf et al. (2005) study revealed fifty-seven percent (57%) of the thirty-two (32) interviewed medical student trainees, said that the effect of patient death for them was highly and emotionally impactful. Leaving the finality of death and sudden death as the two items that triggered their strongest emotions. In relation to disclosure of the patient's death, sixty-three percent (63%) of the respondents revealed that if a patient that they have taken care of as a team died, colleagues would not have any discussion in the aftermath of the patient's death.

North of Scotland Foundation confirmed that seventy-nine out of one-hundred thirty-two (79/132) physicians-in-practice were frequently exposed to patient death. Moreover, sixty-one percent (61%) of them stated that their most memorable patient death was emotionally distressing. (Linklater, 2010)

Another study by Paul Richard Whitehead (2012), about physicians dealing with patient's death, held in Canada revealed five essential themes that prevailed during their study. The first theme, *memories beneath the surface* where the physicians were asked about death, they would say that it is part of their normal lives. However, those experiences of memorable death held strong emotions for them; they were still vivid in their mind and could suddenly spring to their consciousness and would trigger incredible flood of sadness, emotions, grief, or fear. Most memorable patient deaths occurred early in the physicians' careers, for instance one of the interviewed physicians experienced a patient who had been in a car accident. At first though, she could not remember any—and then *boom* she suddenly recalled the unbelievable image of a 21-year-old guy who'd been in a car accident. This happened 20 years ago, and it's still one of the most vivid experiences that stays with her. While daily experiences of patient death may have

become ‘normal’, these memories carry a clarity and intensity reminiscent of traumatic memories, vividly powerful, just below the surface.

The second theme that emerged from this study was *expectation and responsibility*. The experience of death of the patient is constantly linked with the physicians’ intense feeling of responsibility and their awareness of the expectations of their patients, families, the medical system and society. They described how responsibility over life and death is attached to their role earlier than they expected. The expectations of them being the *“heroes”* were ingrained by their families first, and then encountered in medical school and residency. Several physicians described the expectations and responsibilities as *brutal* and *inhuman* or *impossible to fulfil.* One physician summarized the expectations as they are supposed to know everything, and have the answer for everything, and, somehow, be larger than life. Many described how the sense of intense personal responsibility over the life or death of a patient is something they are forced to come to terms with during their careers. One physician described it as *‘getting away from the expert culture of medicine’*. Furthermore, it was also described as being seen as a *‘miracle worker’* by many patients and families that he had to limit this kind of adulation: by saying to them that “The miracle wasn't me…that obviously feels good, but … *nobody* lives up to that”. These dynamics suggest that throughout a physician's career it can be difficult to balance the expectations of ‘*medical responsibility’* with the uncertain and unpredictable nature of patient care (Whitehead, 2012).

In addition, the physician’s *competence* is also questioned whenever they experience patient’s death. A lot of memorable patient deaths caused the physicians to question whether they had done everything they could have, or should have, for the patient. In some cases, they questioned whether certain decisions or actions may have caused harm, or even led to the patient's

death. Mortality and morbidity rounds are intended to review difficult patient outcomes, learn from mistakes and avoid personal blame; however, they often magnify the question of their competence.

Several physicians in this study commented that in order to feel they had acted competently, they needed to feel 'clean' about the patient's death—that is, for the physician to be able to say, 'I know that I've done everything that could conceivably have been done'.

The fourth theme is *breakthrough experiences*, it often encompasses awareness of mortality or other unresolved emotional experience for the physician. This is the moment where the physician will be *hit home* and find the value of mortality. *Action vs. Presence* is the fifth theme. Action is when the physician is in the *protocol mode,* physicians shift into this action-oriented state of mind to help them focus and set aside any emotional reactions. Presence is *"simply be at present"* this happens when there is nothing, he/she can do about the patient and all he/she has to do is to be there with the patient or with their family.

Unexpected Patient's Death, Breaking the Bad News

Isaacs and Mash (2004) study revealed themes which are related to issues in the pre-resuscitation period, the resuscitation, breaking the bad news, after breaking the bad news and post-event sequelae. In the pre-resuscitation period, there are problems in admitting, identifying and responding to acutely ill patients. During the resuscitation, the families and staff disagree about witnessing the resuscitation. *Breaking the bad news* is often difficult for the doctors and hindered by the physical environment. Afterwards, there are mixed feelings about the quality of emotional support, the use of medication and bereavement counselling. All agree that viewing the body is helpful and funeral arrangements are not a problem. There was no effective follow-up of the families. The doctors also experienced increased stress following unsuccessful resuscitations.

Experience of Recent Death

In line with the experience of patient recent death, it was revealed that most United Kingdom doctors (139/188,74%) who have participated in this study reported satisfying experiences in caring for a dying patient. Doctors reported moderate levels of emotional impact (M = 4.7, SD = 2.4) from the death (Redinbaugh, Sullivan, Block, Gadmer, Lakoma, Mitchell, Seltzer, Wolford, & Arnold, 2003). However, women and those doctors who had cared for the patient for a longer time, experienced stronger emotional reactions. In addition, their level of training was not related to emotional reactions, but interns reported needing significantly more emotional support than the attending physicians. Although most junior doctors discussed the patient's death with an attending physician, less than a quarter of interns and residents found senior teaching staff (attending physicians) to be the most helpful source of support. In conclusion, doctors who spend a longer time caring for their patients get to know them better but this also makes them more vulnerable to feelings of loss when these patients die. Medical teams may benefit from debriefing within the department to give junior doctors an opportunity to share emotional responses and reflect on the patient's death (Redinbaugh, Sullivan, Block, Gadmer, Lakoma, Mitchell, Seltzer, Wolford, & Arnold, 2003)

Grief

Grief is the natural response of a person when they loss someone or something that is important to them. Since it is natural, a person might feel variety of emotions, like sadness or loneliness. A death of a loved one, a relationship ended, a lost job and life changes, like chronic illness or a move to a new home, can also lead to grief. (DerSarkissian, 2018).

Everyone grieves differently, in terms of grief in medical practitioners, reactions have not always been in silence. In the case of Canadian oncologists, they were already experiencing grief even before the patient dies. For these doctors, knowing their patient's medical results or likely the patients' death before revealing it to the patients and/or to the families, the situation was already difficult for them. They experienced sadness, crying and loss of sleep for they had this sense of responsibility to their patients' life. Feelings of powerlessness, self-doubt, guilt, and failure were also included. (Granek, Tozer, Mazzotta, Ramjaun, & Krzyzanowska, 2012)

In addition to grief, they were also experiencing pressure caused by the death of their patient. This pressure gave them the strong urge to do "more" in their next patient, which led them to giving a more aggressive chemotherapy, putting a patient in a clinical trial, or recommending further surgery even if it was unnecessary, or even when palliative care was a better option. They also tended to have a withdrawn relationship with their patients and to their families as the patient started counting his/her remaining days; this includes fewer visits in the hospital, fewer bedside visits, and less overall energy expended toward the dying patient.

Furthermore, it is also revealed in Granek et. al's study that grief in the medical context is considered shameful, weak, and unprofessional which why most of the Canadian oncologist hid their grief. While oncologists spoke about burnout, the single most consistent and recurrent finding in the interviews was the description of compartmentalization resulting from patient loss. Compartmentalization, involved the physician's ability to separate feelings of grief about patient loss from other aspects of their lives and practices which they used as their coping strategy.

Impact of unacknowledged grief

Canadian oncologist suffered the following outcomes due to their unacknowledged grief like inattentiveness, impatience, irritability, emotional exhaustion and burnout. Half reported that grief could affect their treatment decisions and motivation to recommend care: more aggressive chemotherapy, referral for a clinical trial, or recommending further surgery when palliative care might be better. Moreover, they have developed that *need* to normalize death and grief as a natural part of life. (Granek, Tozer, Mazzotta, Ramjaun, & Krzyzanowska, 2012)

Grief reactions prior to or after the death of a patient

Focus on the loss

Medical practitioners who focus on the loss have experienced a wide range of grief reactions that were similar to those experienced by bereaved people who grieve over the loss of a loved person. Health professionals reported sorrow, depression, and sometimes anger or guilt after the death of a patient. Some of them cried while most think intensively of the patient and his or her family members. They often experience a need to withdraw into themselves and tend to lose interest in daily activities—for short periods of time. Yet, withdrawal seems to alternate with an active search for support—usually among colleagues—in order to share feelings and experiences. Attending the funeral is occasionally experienced as a symbolic closure to their relationship with a particular patient and family. Quite often, grieving may also include a sense of relief over the patient's death and a sense of recognition and satisfaction over one's contribution to the care provided. (Papadatou, 2000)

Moving Away

Moving away from the loss may range from simply containing one's grief expressions to denying the loss. These reactions are normal if temporary, and aim to protect health professionals from being overwhelmed by loss and grief, and to meet the demands of their work. (Papadatou, 2000). It is also cited in the study of Papadatou (2000) that Raphael (1986) described emotional shutting-out of feelings or psychic numbing described as one of the most common avoidance reactions. Similar reactions are common in health professionals who repress painful feelings and conserve energy in order to meet the challenges of work. This adaptive strategy functions as a protective barrier in threatening situations, and may be expressed in various forms. Furthermore, another common reaction includes the avoidance of contact with the patient and/or family members, either by removing oneself physically from the scene, or by distorting one's perception of reality while being present.

Synthesis

Studies stated above gave a view on the experiences of medical practitioners as lifesaving professionals and based from the researches, it is never an easy profession. The study on the Canadian oncologists revealed the fact that they went on helpless prostrate stage too and they fear the death of their patients. Whitehead (2012) study also revealed that there are instances that feelings of sadness due to this experience emerge and could be triggered from time to time. In addition, their competence is also questioned when patient's death occurs and there are cases that they themselves question their capabilities as well. They are busy attending to the lives of others to the extent that they blame themselves when unpleasant things happen to them.

There researches captured the interest to have a better and deeper understanding on how these medical practitioners experience this matter but this time this study is based on Philippine

setting. Also, to know the resulting feelings they experience and their cognitive reactions during those times and how they deal with it leading to their continuance of the practice. Emotional feelings and cognitive responses might also vary in terms of gender which is why, this study utilizes (if possible) the two sexes.

Lifesaving professionals are very eager to help those people in need. In return, this paper seeks to help them and the future medical practitioners in understanding the phenomenon. This paper may help them in believing that there is a huge possibility that medical practitioners who have undergone this phase and will again undergo it and it is acceptable and understandable to seek for help, if possible, to seek psychological help.

Statement of the Purpose

Using the phenomenological inquiry, this study sought to know how medical practitioners experience their first patient's death and how they dealt with it. Based from the findings, the factors leading to the continuance of their practice, its implications and how these would help the future medical practitioners will be determined.

Specifically, the study aims to:

1. Determine the contributing factors that led the participant in choosing to be in a life-saving profession.
2. Discover the experiences they went through, their resulting feelings and cognitive reactions that helped them in dealing with the first experience of patient's death.
3. Determine the contributing factors that led the participant in continuing his/her profession.

Conceptual Framework

Each life of an individual is significant. Having a profession such as a medical practitioner, whose job is to save other people's lives or to save others from being harmed is a difficult task since individuals' lives are on their hands.

Previous researches presented above were done in other countries to study how the death of a person affects the medical practitioners. Due to lack of researches here in the country in relation to this study, this, as shown in Figure 1 below, will make use of medical practitioners. These lifesaving professionals shared their experiences about their feelings, what they felt when they experience the death of their patients, how they react emotionally and cognitively, have they questioned themselves, their competencies and abilities, have they had a thought of giving up their profession, and how they face the family members and how they dealt with these resulting emotions and cognitive reactions, their coping mechanisms and their significant reasons on continuance of practice.

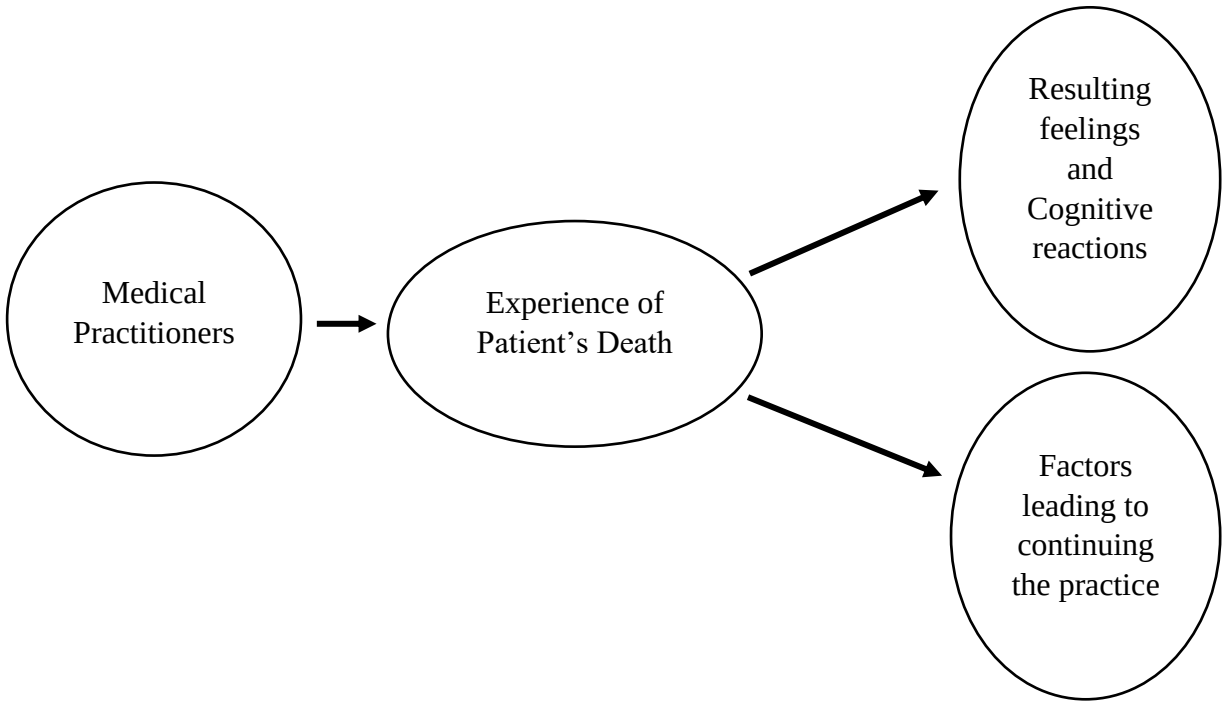

Figure 1. *Paradigm of the variables in the lived experiences of lifesaving professionals*

Definition of Terms

The following terms are defined to provide a clear and single understanding in relation to its use in the present paper.

Life-saving profession	a profession whose duty is to save lives of people from being harmed
Medical Practitioner	an individual whose job is to help people in identifying, preventing, or treating illness
Death	an event where all the vital functions of an individual has stopped.

CHAPTER II

Procedures

This chapter deals with the method used in the study, the ethical standards, and the discussion about the research participants, setting, sample size and procedures. Furthermore, this portion also provides the analyzation techniques of the gathered data which created themes that are used in clearly understanding the data.

Qualitative Design and Methodology

Qualitative design was utilized in this study. It is a method used to understand human behaviors, themes or phenomena. It provides a depth of understanding about phenomena that cannot be achieved in other ways (Shuttleworth & Wilson, 2018). Specifically, phenomenological research design was used as the overall design. It is a holistic approach which considers the

contexts within which human experience occurred and is thus concerned with learning from particular instances or cases (Qdatraining.com, 2018). Through this, it aided in the exploration of the contributing factors that led the participants in choosing lifesaving as their profession and discovered the experiences they went through when they experienced their first patient's death.

Moreover, constant comparative method was also applied for the results were compared within themselves. This helped in accessing and analyzing the participants articulated perspectives that explained the phenomenon under this study.

The participants had the right to informed consent where the purpose and relevance of the study have been stated. The participants were given the choice whether or not to participate in this study. They also had the right to withdraw their participation. They were also informed about the benefits of their participation. It was also ensured that the selection of participants in this study was fair. The identity of the participants as well as the result of this study remained confidential. Lastly, the researcher ensured that the questions that was asked was validated by experts to guarantee that no question triggered emotions of the participants since experience of patient's death was talked about. No participant has experienced distress hence, none was referred to capable professionals for counseling.

Research Site

The participants of the study were medical practitioners from Metro Manila or officially known as National Capital Region. Metro Manila is the seat of government and the most populous region of the country which is composed of Manila, the capital city of the country, Quezon City, the country's most populous city, the Municipality of Pateros, and the cities of Caloocan, Las Piñas,

Makati, Malabon, Mandaluyong, Marikina, Muntinlupa, Navotas, Parañaque, Pasay, Pasig, San Juan, Taguig, and Valenzuela.

Metro Manila was chosen as the research site for this study for it is believed that many hospitals are found around the area for the fact that Metro Manila is designated as a global power city. NCR exerts a significant impact on commerce, finance, media, art, fashion, research, technology, education, and entertainment, both locally and internationally (Local Government Academy, 2018).

Selection Criteria and Participants

This study is delimited to medical practitioners who have been in service for at least 3 years. The number of participants is eight (8), residing in Metro Manila only. The researcher used purposive sampling to generate the number of participants needed.

Medical practitioners who have a license but not practicing in a hospital or clinic are excluded in the study. In addition, those medical practitioners who have been practicing below three (3) years are not permitted to participate in the study. Furthermore, those who are not residing within the Metro Manila area were also excluded.

Since, it is challenging to obtain participants, snowball sampling method was applied. The use of snowball sampling eased the data collection, for an individual who participated first in the study recommended potential participants. In order to ensure that the study is free from biases, it is assured that the participant is not related to the researcher.

Table 1. *Demographic profile of the participants*

Case ID	Age	Gender	Years in Service	Specialization
1. A	45	Male	12	Pediatrician
2. B	53	Female	20	Obstetrician-Gynecologist
3. C	38	Female	12	Obstetrician-Gynecologist
4. D	29	Female	3	General Physician
5. E	40	Male	9	General Physician
6. F	36	Male	36	Public Health/ International Health
7. G	58	Female	30	Family Physician
8. H	42	Male	15	General Physician

There were eight (8) medical practitioners who participated in this study, four (4) males and four (4) females. They are aged from 29 being the youngest and 58 being the oldest. In terms of specialization, three (3) of them is a general physician, two (2) Obstetrician-Gynecologist, 1 (one) Family physician, 1 (one) Pediatrician, and 1 (one) is in Public health or International health.

Gender Difference

On the factors that affected the participants in choosing their profession, most females decided to pursue this because of the decision of their family while the male participants leave their fate with the Divine Providence. In terms of how they react with the experience of first patient's death almost all of them said that they were somehow affected except for participant C who is a female obstetrician-gynecologist who is firm with her answer that she was not affected and was confident enough to say that she did her part. Furthermore, most of them also said that death is more painful to accept when it is a relative especially for participant G who experienced

the death of her grandmother right after she got her license however not in the case of participant H who has not experienced it with his immediate family, he also added that he might be affected by the death of a relative but it will not last for more than 24 hours. On the contrary, the connection of gender and coping mechanism is still in question and needs to be studied further.

Age Difference and Years in Service

In terms of age difference most of them though they differ in age have chosen the profession based on their family's decision, which implies that even if they lived in different generation particularly participant D who is 29 years old and participant G who is 58 years old it is still their family who has the final say in their profession. This also implies that Filipino traditional parenting is still evident. In years of service, the coping with the experience vary on their years of service, those who have been exposed to death of a patient for a longer period of time was saddened by the incident but could moved on within a day, however participant E stated that though he was already exposed to numerous death and was able to cope immediately, it is a different story when his father died, it took him years to move on.

Data Collection

The interview took place in a neutral setting the participants find comfortable and convenient. A letter of consent was given to each of the participants and that served as an agreement to participate in the study. In the consent, the benefits that the participants would receive as well as the purpose and nature of study are stated. All questions to each participant with regards to the study were answered. In case a participant does not want to participate in the study, he/she has the right to withdraw anytime from the study, at any time.

Upon the participant's approval to be involved in the research, a semi-structured interview was conducted to accomplish the aim of the study. Semi-structured interview or open-ended questioning allows the participant to articulate his/her perceptions and experiences freely and spontaneously. The estimated duration of the interview is about thirty to forty-five minutes (20-30) minutes only. The questions used in the interview were validated by experts who ensured that they covered all the research questions of this study. The participants were asked if the researcher could use a voice recorder in recording the interview. The interview was then recorded in a voice recorder. After the interview, it was ensured that the participant undergone debriefing. The questions related to the study was also be entertained again by the interviewer. It was also ensured that no deception is used in the study.

The gathered data are stored in a password protected computer and would be kept for five (5) years. The researcher made sure that only the researcher and her adviser have the access to the information. The specific, personal result of the study would be available upon the request of a respondent.

Data Analysis

The data collected were transcribed into text. Each of the participants had a case I.D. to maintain the confidentiality of their identity. Transcribed data underwent thematic analysis which gave categories that were coded to determine factors and themes. General themes emerged from the answers of the participants. Within case analysis was done, where themes generated from each case were compared among themselves. This study also considered sex differences of participants in the comparison, to determine whether answers vary between the two sexes. Additional notes

and observations in relation to the participant's responses were also included in analyzing data. The generated themes were used in answering the research questions.

Through the use of validated semi-structured interview, data were obtained. After the transcription, the responses of the eight (8) medical practitioners were analyzed through thematic analysis. The experiences and meaning of life experiences of the participants were comprehended and conveyed.

Role of the Researcher

The role of the researcher is as facilitator of the data collection. The researcher was the one who did the questioning and the observation in relation to the participant's responses during the interview. In addition, the researcher was also responsible in securing the confidentiality of the information that the participants disclosed. The researcher did the analysis of data herself and most importantly, the one who interpreted the data.

Methods of Validation

A semi-structured interview was used in collecting data for this study. The interview questions were reviewed and validated by at least three (3) experts in the field of Psychology and Counseling such as licensed guidance counselors, professors, and researchers. These experts reviewed the interview questions in terms of face and content validity. The comments and suggestions of the experts were considered in revising and improving the interview questions.

The emerged themes from the data analysis underwent expert verification from a professional deeply involved in qualitative research to ensure that the emerged themes were credible. This process was done to increase the trustworthiness of the results of this study. Expert verification is one of the strategies in qualitative research that addresses rigor, credibility and trustworthiness of a study, it is a process where an expert critiques all important aspects of the study that need to be reviewed especially in terms of how the emerged themes answer the research purposes (Simon, 2011)

Ethical Considerations

To avoid ethical issues in this study, ethical principles were considered for the welfare of the participants.

(a.) Respect - The participants' involvement in the study was voluntary. Informed consent form was given to each, for them to know the nature, purposes, and procedure of the study. In case the participant did not want to continue the procedure in the study, he/she has the right to withdraw from participation. Their identity was kept confidential, that instead of using their real names, code names were utilized. Their privacy was respected. Questions which might intrude into their personal life were not asked.

(b.) Beneficence - The participants were informed on the advantages or benefits they would acquire from the study. In addition to that, they have the right to know the results of the study. Furthermore, they were assured that conducting this study would have significant contribution to

the participants well-being and to the community. For instance, the results of the study would help the participants to be understood by the people who would happen to judge them instantly without knowing what they would be feeling. Especially, nowadays that medical practitioners or doctors shaming is prevalent in the country. In addition, a token of appreciation was given to each participant as a compensation for their time and participation in the study.

(c.) Justice - This study observed criteria for the selection, and these criteria were free from biases. It was ensured that the selection of participants in this study is fair.

(d.) Confidentiality – The identity of the participants as well as the name of the hospital they are affiliated with are kept confidential; case ids was given to each of them. All the information disclosed by the participant are secured. The data are stored in a password protected computer and would be kept for five (5) years. Information are protected from unauthorized access, modification or loss. This ensures the trust relationship between the research and the participant to maintain the integrity of the project as well.

(e.) Nonmaleficence – The researcher ensures that the questions that would be asked have been validated by experts to guarantee that no question will trigger the emotions on the participants since experience of patient's death would be talked about. However, if the interview would cause discomfort to the participant, he/she will be asked whether to continue with the interview or not, if not, then the interview would be immediately terminated. In case that the participant experience distress or be unstable, he/she would be referred to capable professionals for counseling.

CHAPTER III

FINDINGS AND DISCUSSION

This chapter presents the themes that have emerged from the data and the discussion of their interpretation vis-à-vis the research purpose of the study. This also shows how the findings may support or contradict some of the literatures about the topic.

Contributing factors that led the participant in choosing to be in a life-saving profession

British Medical Association (2018) found out that as students, many doctors choose to be in the medical field for its social value and opportunities to help other people. It was also revealed that earnings and status are not their major considerations early on and have a generally minor influence on subsequent career decisions. When applied to Philippine setting this study seeks to know the factors that led the participants decide to be in a life-saving profession. These factors might contribute on the eagerness of the participant to save the life of their patients especially if it was their own will to pursue the profession. Four themes emerged from the responses: *family-based decision, vocation to help, honor and benefits, and Divine Providence.*

Table 2. Factors that contributed in choosing life-saving profession.

Themes	Descriptions	Sample Responses
Family-based	Due to their family's expectations from them, the participants had to compromise for the satisfaction of other people's wants.	*"None. To be honest, I was only forced by parents."* *"It is because, it's my mom interest to have a doctor in our family."*
Vocation to help	The practitioners are willing to learn and enhance their skills in order to be suitable in serving the public.	*"Financial benefits only come second if you are a doctor, because wage is not definite. Being a doctor is more of a community service."*
Honour and Benefits	Physicians are highly respected and viewed as economically advanced people of the society.	*"I was inspired, to be honest, because of the opportunities that it will take me to abroad."* *"Well, it's one of the more noble professions that we have."*
Divine Providence	Faith and fate played a role in their decision.	*"Probably, I'm already in this course, might as well stand by. It has become a mission, and for God as well."* *"I was lucky enough to qualify under the Intramed Program in a certain university, so instead of taking up BS Economics, I shifted to medicine."*

Family-based decision

Forced

The physicians are aged from 29 to 58 years old, and live in a generation where the career they should pursue was decided on by their parents. As B said *"iyon ang uso noon eh"* (That was

the trend before). The career was chosen not because they want to, but because they had to. As they expressed:

> *B: Ah, ituloy ko na? Para lang ma-please ko yung mommy ko, yung parents ko actually kasi… Kung anong sabi ng magulang mo, ayun ang susundin mo. So ayun. (*I go on with it to please my mom, my parents actually. Whatever your parents decide you have to follow.)
>
> *E: Wala (laughs). Actually, napilitan lang din ako sa parents ko.* (None. To be honest, I was only forced by parents.)

They stated that they value their parents' decision that much that they had to sacrifice the career that they really wanted. "*Yung mom ko din yung naging reason but ang gusto ko talaga nursing."* (My mom was the reason but I really wanted to pursue nursing.)

This kind of culture is very evident in the Philippines, where Filipino children must obey their parents as Filipinos have strong family ties. Filipino children are likely expected to recognize their parents' authority and sacrifice personal interest to prioritize familial responsibilities (Medina, 2011 as cited in Alampay, L. P., & Jocson, R. M. 2011).

Such implied expectations are included in the value of the Filipinos' *utang na loob* ("debt of one's being") or the life-long "debt" owed to another person that exists not merely because of receipt of some favor, but because of deep respect and gratitude (Enriquez, 1994 as cited in Alampay, L. P., & Jocson, R. M. 2011). Children are supposed to have a sense of *utang na loob* towards their parents for having reared them, which in turn must be manifested in respectfulness and honoring of family obligations. Otherwise, the son or daughter will be known as without *hiya* or without *utang na loob*—no honor or gratitude—signifying that one is not a "good" child, much

less a decent person. It seems that most of the participants have traditional parents and still hold on to the values of Filipino families as proven by their answers above.

Motivated

These statements:

> *G: It is because, it's my mom uhm interest to have a doctor in our family.*
>
> *A: "The proud feeling that your parents had, that pride they have in you that you are able to finish this was a good enough, it is a reward for me, so that was my inspiration".*

prove that the decision was also based on their families however the difference is that they used it as their motivation in pursuing the profession. These participants claimed that despite having forced by their family, they have become more motivated to pursue the said profession. They said that it is empowering that their parents believed in their capabilities. From this, it can be inferred that as time passes, participants learned to be emerged with the profession, and see the profession from other perspectives such as a vocation, or as a social status.

Vocation to Help

Despite the fact that some participants decided to be a medical practitioner to obey their parents, they stated that when they entered the field, they find it in themselves to like the profession as well. One of the physicians stated that it become her vocation to help, because for her if she did not care for a person or a patient it would be very difficult to be in this field. Also, as A said the primary goal of being a medical practitioner is for the patients to get better in terms of their health

and not anything else. He also saw this as a privilege to serve his fellow brothers and sisters who are less fortunate.

As they expressed:

> *D: I think being in this field is a vocation as well, if you don't care for a person or for a patient, I think it is very difficult to be in this career. So that's it, helping people.*

> *A: The primary goal of course is to help patients get better in terms of their health. Growing up as a Catholic you know with my profession, I am privileged that I am also helping others, especially the less fortunate brothers and sisters that we have. We are able to help them through whatever means possible that could be for their upliftment.*

Physicians tend to see their work as a "profession" but does not set aside the thought that it is also a vocation. They enjoyed in serving others and found a sense of fulfillment in those acts. As they recognized, physicians never know their vocation with certainty until they have had the opportunity to experience it, within a lengthy period of time (Hey & Nowakowski, 2013). D said, it took her considerable time during internship before she realized that the profession is for her.

> *D: I tried this career and upon learning during college days, during my duty days on my internship and being immersed to the community I was able to cope and wanted the course as well.*

This is a profession that should always be for the community since it serves to save the lives of people.

> *E: To help, syempre to help people. Secondary na lang yung financial kasi if you are a doctor, di mo rin naman masasabi kung kikita ka kasi minsan community service yan, community service talaga ang pagiging doctor*. (To help people. Financial benefits only come second if you are a doctor, because wage is not definite. Being a doctor is more of a community service.)

Supported by participant E's statement, physicians should always think that being a doctor is more than just a job but a truly special vocation. Since the rendered service always entails meaning and purpose, and not a job to make money or achieve fame but a conviction to give life to all. In addition, when seen as a vocation, physicians would want to mentor and teach the next generation of doctors so as that correct values will be inculcated: compassion, honesty and integrity (Goh, 2013).

Honor and Benefits

Aside from the above factors, some of them also took the profession for the honor and benefits that it may give them. It is recognized that being a doctor is one of the noblest professions in the society. It is stated in *Seeing our Medical Profession as a Vocation, 2013* medical doctors are highly respected in the society for they contribute a very significant aspect of God's work, which is to give and sustain life. As what the participants stated:

> *C: Siyempre, for better, for better income din. Aside from saving life, for better financial, ano din, status din. (For better income. Aside from saving life, for better financial and status)*

In connection with this, it also ignites the thought of the different opportunities that medical profession entails, such as going abroad. Participant D expressed*: To be honest, because of the opportunities that it will take me to go abroad.* It is true that being a doctor would definitely take them to places as it was revealed that in the past, Filipino medical workers in the United States were doctors, not nurses or physical therapists. The past generation of Filipino doctors did extremely well in the United States. Even as they became US citizens, they bring honor to Filipinos

by being respected medical practitioners. Indeed, many of them have become wealthy and have become card-carrying members of the Republican Party (Overseas Filipino Doctors, 2018)

In the question of which of the two should be the driving force of a doctor, honor would always prevail. As doctors they should not use their profession to make money or to gain fame. Patients should not be seen as means to make money. This thinking might lead to over-charging and neglect of the poor. On the side of Christianity, being God's healing instruments, physicians are expected to care most for the poor and not only for those who can afford medical treatment. As all life is sacred, there can be no discrimination in care, with regards to social status, religion, nationality, race or politics (Goh, 2013).

Divine Providence

Traditional theism holds that God is the creator of heaven and earth, and that all that occur in the universe take place under Divine Providence — that is, under God's sovereign guidance and control (McCann & Johnson, 2001). Interestingly, three (3) of the physicians let Divine Providence decide for them in choosing this profession, fate and faith played a significant role in their decision making.

Fate

H stated that even if he really desired to be a doctor, if he did not pass the entrance exam then it is not for him, he has to go somewhere else. Same with the case of F, where he initially wanted to take a social science course and go into law school after, however, he was *lucky* enough to qualify under the Intramed Program of a certain university so instead of taking up BS Economics he shifted to medicine.

H: When I hurdled my entrance exam in my undergraduate and my actual medical college entrance exam then that was the deciding factor for me, if I'm gonna pursue or not. Because if I didn't pass that exams, that's gonna make the decision for me it means that I'm not into that... I need to go somewhere else.

*F: Providence; I initially intended to take up a social science course and go into law school after. However, I was lucky enough to qualify under the Intramed Program of the ** College of Medicine so instead of taking up BS Economics in **, I shifted to medicine in **.*

Being bound by the customs and culture that Filipinos grow in, it is not surprising that these physicians leave the decision to fate and faith. It is known that Filipinos has this concept of *"tadhana"* and *"balaha na" or collectively "bahala na ang tadhana"* which means "fate" in Western countries. Filipinos have this tendency to believe that everything in this world are already predetermined by the supernatural forces, which dictate the fate of the individuals. Furthermore, for it is predetermined by supernatural forces, the future cannot be changed, thus, Filipinos would just live with it and go with its flow (Asilum, 2016). F who happened to be a fatalist proved the above statement as he said that "*I am to some extent a fatalist on some matters and regard my qualifying for the program as some form of divine intervention."*

Faith

In the case of *E* who was forced by his parents to take this profession, he let faith instead of fate, took over and decided and believed that this is his calling and make it his mission to serve the people and the Lord. As he expressed:

E: What made the decision? Okay Probably I'm already in this course, might as well, panindigan na, misyon na, misyon na natin 'to. Para sa Diyos na ito. (Probably, I'm already in this course, might as well stand by it. It has become a mission, and for God as well.)

The Philippine population is composed of more than 86% of Roman Catholics (Miller, 2018) which is why religion is also one of the foundations of the country's morals and values and sometimes this fact greatly affects the Filipinos in their decision making (Hays, 2015). This means that faith could really have a great impact in the lives of the Filipinos and in the case of E, he used it as a driving force to pursue this profession. He proved that strong personal faith and serving God enables Filipinos to face great difficulties and unpredictable risks in the belief that "God will take care of things."

The four themes emerged from the different factors that made the participants decide to be in a lifesaving profession. Foremost of them was to please their parents or to fulfill the dream of their parents to have a doctor in the family but eventually come to like the profession. Some of them think of it as their vocation, their calling, while there are also participants who think of the honor and benefits that the profession will give to them. However, three of them shared the same thought of leaving the decision with the Divine Providence. Factors such as vocation to help and benefits paralleled the study of British Medical Association (2018) where it revealed that students chose to be a doctor because of its social value and opportunity to help other people. However, this study contradicted their findings that earnings and status are not part of the major consideration. In addition, the factors that led them to this profession yield the same eagerness

from them to save lives whether it is their parent's decision, or the Divine Providence, the will to save a life is still the same.

Experiences the participants went through after their first patient's death.

As a medical practitioner whose major responsibility is to save life of people, of their patients, it is quite intriguing to know what they went through after experiencing first patient's death. The participants were asked to narrate the experiences they had to go through. From their answers, five essential themes emerged in which four of these themes are the parallel with the themes that emerged from Whitehead's (2014) study. The themes are; credibility, recollections, impact, response, and kinship.

Table 3. *Five essentials themes in experience of lifesaving professions on first death of Patient*

Themes	Descriptions	Sample Responses
Recollections	The physicians vividly remember what happened to their patients.	*"It was 2004, the patient, a 51 year old female, was diagnosed with Diabetes Mellitus Type 2 and have been complaining of chest pains. She was admitted at the Philippine General Hospital Medicine Ward for management of an Acute Coronary Event. Patient succumbed to heart attack within 6 hours from admission.*
Credibility	The physicians question their credibility as doctors and reflect on what they could have done.	*"I thought I was a big, big failure and I even thought I wasn't going to finish my residency program in pediatrics so, but then you know, there are more things in life than just one bad experience."*

Impact	Being witnesses of the patient's journey hit them in a personal depth, and put themselves into the position of those whom they left.	*"I felt deeply for the family and caregivers and had a sense of loss… It was as if I myself had a relative or close friend dying."*
Response	Given the nature of their work, the practitioners are often confused on how to respond to the death.	*"I gave the best IV fluids, the best antipyretics but despite that I wasn't able to help my patient and my patient still died. So that was an unforgettable experience for me in life not everything is by the book."*
Kinship	The death of a loved one is different from the death of a non-related patient.	*"Actually, it was expected due to the old age of my grandmother."* *"We become aggressive when it comes to our relatives because of the eagerness to cure them immediately."*

Recollections

Initially, when asked about the patient's death, the physicians would normally claim that it is part of their normal life. However, the physicians vividly remember the experience and display emotions as they reminisce the moment. Two out of the eight physicians displayed this when asked about their reaction on their patients' death. These statements from the participants:

> *C: Ah ano yun hmm, 49 years old na hmm. Actually nung, na-admit siya, profuse vaginal bleeding na siya. Tapos, dahil doon, mayroon siyang malaking bukol sa matres. Nag-ano rin siya, nag-arrest. Na-cardiac. Mayroon din siyang sakit sa puso. So, concomitantly lang.* (It was a 49 years old patient. When she was admitted, she had profuse vaginal bleeding. Because of that, she also had cyst in her uterus. She had cardiac arrest and heart complications as well. So, it was a matter of combined complications.)

> *F: "It was 2004, the patient, a 51-year-old female, was diagnosed with Diabetes Mellitus Type 2 and have been complaining of chest pains. She was admitted at the Philippine General Hospital Medicine Ward for management of an Acute Coronary Event. Patient succumbed to heart attack within 6 hours from admission. Even though I was not the attending physician that time and only served as the alternate clinical clerk, I was emotionally affected as it was the first death I handled."*

show how detailed the participants have remembered their lived experience although it took place years ago. Both participants C and F clearly remembers the age of their patients and complications. Participant C remembers all the complications her patient had, while participant F even remembers the year and the place where the death took place. Parallel to Whitehead (2014), physicians may not regularly display strong emotions at work, however some of their experiences trigger memories and bring them back to the moment when it happened. According to Zambrano & Barton (2011), the reactions of the physicians are embedded from the treatment phase until the death of the patient. From this, it can be inferred that there is a connection formed between the physician and the patient, which create attachment and relationship. Remembering the death of their patients may not only retrieve the day of their death itself, but also the memories they have created within their given time together. Moreover, some physicians keep in touch with the patients even if they are not the attending physician (Zambrano & Barton, 2011). The concern initiated by participant B is the reason why participant B felt sad even though he was not the attending physician of the patient who passed away.

Credibility

Physicians often feel powerless on situations they cannot control or think they could have done something to change it (Masia, Basson, & Ogunbanjo, 2010). Most of them suffer from culpability and insufficiency, and question their abilities as medical doctors. Three out of eight physicians have questioned their competence upon their patients' death:

> *B: "Yung parang feeling mo nagawa mo na lahat, pero namatay yung pasyente. So, at the back of your mind, meron ba kong kulang na ginawa? Parang ganun."* (It's that feeling where you did your best, but still the patient died. At the back of your mind, you ask yourself if you fail to do something. It's like that.)

> *A: "I thought I was a big, big failure and I even thought I wasn't going to finish my residency program in pediatrics so, but then you know, there are more things in life than just one bad experience."*

> *E: "I was an intern then. Naluha ako, syempre parang ganito ba talaga? Kailangang ganito, ganyan - mamatayan ng patient."* (I was an intern then. I shed tears and questioned if it was really necessary for a patient to die.)

From the response of participant B, it was clearly stated that he had questioned himself if he has done enough for the patient, even though he felt that he did. As supported by Whitehead (2014), some physicians have questioned whether they have caused harm that have led to the patient's death. Humans tend to question themselves whenever they fail to do something, especially if they feel like they were responsible for it. However, medical doctors need to understand that they are mere instruments to treat people. They need to understand that there are things humans are not in control of. Moreover, participant A looked at himself as a big failure. Although, he later on realized that one experience does not define everything in his life. Most of the doctors blame

themselves for not successfully saving the lives of their patients (Masia, 2010). Participant E asked if it was really necessary for a patient to die. Given the fact that he is an intern at that time, the feeling of lacking knowledge and insufficient experience might be another factor why he felt that way, because he is still in the process of learning. One of the participants in Masia (2010), stated that they would often feel incompetent, inadequate and ashamed. Moreover, he had wondered what if a more experienced doctor has handled the case.

Impact

Breakthrough experiences often involve a sense of identification or relationship with the patients which results in a personal awareness of mortality (Whitehead, 2014). It is described by the physicians as a *memorable patient death* since it includes unexpected details that jolt the physician out of his/her normal awareness. Some physicians related the death of their patients with their personal experiences, remembering their loved ones who have left them as well (Batley N.J, Bakhti R., Chami A., Jabbour E., Bachir R., El Khuri C., & Mufarrij A.J. (2017).). It could also be that the stories shared by the relatives about the patient who died would have given more impact to the emotion of the physician, it is when they got "hit home", they got hit in a personal way. This is parallel with what D said that when she experienced patient's death it leaves an impact on how short and important life is. In terms of her loved ones, she realized that while they are still there, she should let them know and show them how much she loves them and how much she values the time she spent with them instead of regretting it in the end.

> *D: Bale these experiences I went through nag-impact sa akin, uhm mahalaga at maikli ang buhay. And then syempre habang nandyan pa yung mga mahal mo sa buhay pakita mo na, na mahal mo sila at pinahahalagahan mo yung bawat minuto at oras na nandyan sila kaysa*

naman sa wala na sila. (These experiences I went through leave an impact to me that life is indeed short and important and because of this, we should show our loved ones how we love them and value the time we spent with them before it is too late.)

Participant F also expressed the same feeling where he stated that even though he was not the attending physician, he felt deeply for the family and caregivers, and had a sense of loss. It was as if he himself has a relative or a close friend dying. This kind of breakthrough experiences indicated how these physicians were deeply moved by the *"human part of the tragedy"* (Whitehead, 2014).

F: Even though I was not the attending physician that time and only serve as the alternate clinical clerk, I was emotionally affected as it was the first death I handled. I felt deeply for the family and caregivers and had a sense of loss. The patient was jolly and cheerful just hours before, smiling and conversing with me with no premonition of what will transpire. It was all over in just a matter of hours. And just like that, a husband has become a widower and another family has become motherless. It was as if I myself had a relative or close friend dying.

Response

Action mode is best exemplified when the physician focuses on the application of the protocol in order to treat the critical condition of his/her patient, as if he/she entered a "*mode"* of intense focused attention in the action he/she must perform (Whitehead, 2014). This also means setting aside emotional reactions towards the patient. This happened to participant A when he had his first death as a pediatrician of a kid who was suffering from pneumonia. He reasoned out that since he was a fresh graduate way back then, he responded by the book. He treated the patient as a *"de-kahon kaso".* Also, he told himself that he gave the best antibiotic, the best IV fluids, the

best antipyretics but despite that he wasn't able to help the patient and the patient still died. Because of this situation, he realized that in life, not everything is by the book. Every patient is not a *de-kahon-kaso.* Each and every patient is a unique case, thus each and every patient should have a unique treatment and diagnosis. This could also imply that sometimes being in action mode could be very risky which is why physicians should be very careful and try to look at other angles before they fully enter the "action" mode.

Presence is when the physician does everything for the patient but it is already too late. The physician tries to treat the patient but there are just certain cases that cannot be treated, all he/she has to do is to be there for the patient and to the relatives (Whitehead, 2014). This is applicable in the case of participant G, where she wanted to respond, treat and extend help to her friend who was also in the save field as a nurse. However, she could no longer help her since her friend was diagnosed with acute myelocytic leukemia. As a doctor and a friend, she had this eagerness to help, but given the situation, she felt restless. Instead, she just stood by her friend till her last breath.

> *A: I remember my first death as a pediatrician, it was a kid suffering from pneumonia but when you're a fresh graduate, you follow the book. You're always doing it by the book and I said to myself 'Oh I gave the best antibiotic, I gave the best IV fluids, the best antipyretics but despite that I wasn't able to help my patient and my patient still died. So that was unforgettable experience for me that in life not everything is by the book. Every patient is not a 'de-kahon-kaso', each and every patient is a unique case so each and every patient should have a unique treatment and diagnosis.*

> *G: Kasi nung time na nasa hospital siya nandun kaming lahat ng friends niya. My friend is a nurse ah, nurse siya, nung time na yun talaga, maggive-up na siya. Yun yung time na may gusto kong gawin, hindi ko magawa. Tapos ayun nga alam ko namang mawawala siya kasi ang case niya ay AML, acute myelocytic leukemia.* (That time when she was

hospitalized, we are all there, her friends. She was a nurse by the way but that time she already wanted to give up. As her friend and a doctor, I really wanted to do something for her but I could not do anything about it. I know for a fact that she will eventually die because her case was acute myelocytic leukemia.)

Kinship

The fifth theme, kinship, supports the claims of the participants that acceptance of the death of a loved one is different from that of the non-relative patient. As participant G expressed that it would take years to forget if the patient who died is a relative. It was also supported by participant E when he narrated that he is saddened by the loss of his first patient but as he experienced it over and over and somehow "get used to it" eventually he already felt nothing. However, when it was his father who died, it pained him more than the first time he experienced patient's death and even took him 2 to 3 years before he finally moved on. It is also stated by G that if the patient is a family member, she tends to be more aggressive with the treatment for she has that strong desire and eagerness to treat him/her immediately. This type of aggressive management was also evident in the study conducted by Granek, et. al (2012) where the oncologists tend to do "more" and be more aggressive when it comes to their patient's chemotherapy because of the pressure caused by the death of a previous patient. Their statements:

E: Actually, pauli-ulit, paulit-ulit na nakakakita ako ng ganoong kaso dumarating din pala sa punto na nagiging manhid ka din no, mamamanhid ka din pero mas masakit kapag nangyare yun mismo sa sarili mo. I mean namatayan ka mismo ng kamag-anak compared sa hindi mo kakilala kasi yung daddy ko, nangyari na rin sa kanya so mas masakit pala kapag ganun. (Actually, I have seen a lot of (patient's death) over and over again then there will come a time that you will get numb but when it happened to you. I mean when you experience a death of a relative, it is more painful to handle than your non-related patients. Like when my father died, I realized that it is really throbbing.)

G: Kasi nagiging ano din eh, nagiging violent din ang management namin pagdating sa family, kasi mas gusto mong maging aggressive eh, gusto mo kasi gumaling kaagad. Yun ang ano dun eh. (We tend to get violent and aggressive when it comes to treating our relatives because we wanted to treat them immediately.)

The central themes were similar on Whitehead's (2014) study. Among the five essential themes, none of the participants fits the second category, expectation and responsibility; which is described as, *"due to the sense of responsibility over life and death, it is expected of them to do well."* From here, it can be inferred that the physicians, prior to the first death of their patients are not pressured by the expectations of the patient's family and other people related to the patient. This may suggest that physicians are confident in doing their job and are not affected by external factors that may hinder them from performing. Their respective field and specialization may also be one of the factors why none of the physicians felt that they were responsible for their patients' death. Medical doctors in the emergency department do not accede to the idea of having direct responsibility over the patient's life, hence there is less emotional reaction when patient dies (Batley et. al 2017).

In other cases, some first experiences of death are more emotionally moving and impactful compared to the preceding deaths (Batley et. al 2017), just like what happened to the case of participants A and F.

The resulting feelings and cognitive reactions that helped them cope with the experience

The coping mechanisms of the oncologists in Canada (Granek, 2017) revealed six central themes that have dominated: (1) social support, (2) professional support, (3) activities, (4) faith, (5) vacations and (6) distractions. In this study, social support and professional support are not prevalent, but it is counted as one. Vacations and distractions are considered as activities. Overall, the physicians use nature of work, faith, professional and social support, and activities as their coping strategies to be able to get through with the experience of first patient's death.

Table 4. *Four essentials themes in coping with first death of patient.*

Themes	Descriptions	Sample Responses
Nature of work	Death is inevitable and it is part of their work.	*"Death should be viewed in a professional manner. As a medical practitioner, there should be as minimal emotion as possible. However, this does not preclude having empathy towards patients and caregivers as well as other colleagues who are undergoing suffering too."*
Faith	Faith served as their "go to" when they had to unload the burden of what happened.	*"Being a Catholic, when we go to mass every week, we pray for the souls of the patient we encountered… for those who died we pray for the repose of their souls. It's a great burden unloading when we go to mass."*

Professional & Social Support	The Professional and Social support of the people around them has a significant contribution on their coping.	*"I have with me my co-residents, my co-doctors. My seniors have taught me that these are life experience that I will definitely go through."* *"I was going to quit but what helped me coped was my family. They were my inspiration first and foremost."*
Activities	Activities were used to clear their mind from what happened	*"I go out to forget."*

Nature of Work

Death is seen as part of their job as a physician, this very thought has helped them in coping with the experience. Physicians have stated that in the long run, they have learned to accept that it is the nature of their work even though it is saddening. The physicians must admit to themselves, as stated by participant H that they are not God, they are just humans and this gives emphasis on *physicians can cure but only God can truly heal.* In addition, physicians have stated that even though death is a negative thing, it is necessary to be experienced in order to become better and to be improved healthcare professionals in the future. In addition, participants A, F and E also reasoned that:

> *A: Napakaplastic naman kung doctor ka tapos wala ka ni isang death na naexperience. And I think, you really need that kasi that impact, although all be it negative, that impact will help you become better in the future.* (I think it is quite unbelievable if a doctor never, even just once has experienced patients' death. I think, you really need that for that impact, although all be it negative, that impact will help you become better in the future.)

> *F: Death should be viewed in a professional manner. As a medical practitioner, there should be as minimal emotion as possible.*

E: Siguro talagang ganun ang life most probably kailangan mo ring tanggapin na there will come a time… certain point of time, bata ka man o matanda lahat tayo may pupuntahan tayong ganun no. (Probably that's how life is, you need to accept that there is a certain point of time where all of us, the young and old, will definitely go *there.*)

Furthermore, the workload has helped them to move on as it diverted their attention to other patients in need than delivering to grieve for the loss of one. Due to the daily demands in the medical field, the physicians have intentionally pushed away their emotional attachment to their deceased patients. Additionally, there are other patients who are in need of their help and they need to focus on the current situation. To further emphasize, the health of other patients must not be compensated by the death of one.

H: Well as what I mentioned before because of probably the heaviness of the load of the patient that our day to day jobs helped us in coping with the death because it somehow pushes away our emotional attachment from the grief and we think that life must go on and the person has already died. Then, there is this another patient who is in need of our help so we focus on that, so in essence we focus on the current situation.

For the physicians to deal with the patient's death effectively, they tend to put distance between themselves and their patients to avoid distressing feelings that might occur after the death. Many physicians who are in the denial stage of grieving try to avoid the pain by detaching their emotions (Masia, Basson, & Ogunbanjo, 2010). This coping strategy is what the participants are also doing, where they put aside their emotions and continue working with their same routine; *C: Diretso lang. Same routine lang din. Trabaho pa din.* (Just continue with the same work routine). Separating work from emotions allows the physicians to deal with the inevitable side of medical

field. Devoiding emotions distances the physician from the pain experienced by the patients as well as their families (Zambrano & Barton, 2014)

Faith

The strong faith and prayer of the participants also served as their driving force to cope with the experience. They said that after experiencing patient's death they find time for themselves to ask for the forgiveness of the Lord. They also said that it is a great burden unloading when they go to church and hear mass every Sunday.

These statements:

> *H: Spiritual wise, of course being a Catholic when we go to mass every week we pray for the souls of the patients that we encountered and for those who are still alive to help them to- help them get better we ask the Almighty Father to help us in being instruments in helping-out the patients and then for those who have died we pray for the repose of their souls- okay it's a great unloading- burden unloading help when we go to mass every Sunday and then uhm when we also, well for those we are personally connected, we try to go to the wake and talk to the relatives when we see the relatives at peace and accepted the fate of their loved ones it's also helping us uhm cope and move on. Acceptance, the right word probably is acceptance*

prove that doctors also have this external care for their patients for they pray for the repose of the souls of the patients who already died and also for those who still alive for them to get better. They seek for the Almighty Father's guidance for they believe that as His instruments, He is the only one who can help them. Faith was also used by the doctors in the study of Masia, Basson, and Ogunbanjo (2010) where they seek comfort from the belief that even though what happened was too painful to bear, mortal life is only accessible through faith and within that larger existence,

what had occurred could make sense. Moreover, Canadian oncologists also turned to their faith as their coping strategies for their grief when a patient die, especially if the death of the patient was too difficult for them to handle (Granek, Barbera†, Nakash‡, Cohen ‡ and Krzyzanowska, 2017)

Professional Support, Social support and Activities

Support is always needed in times of grief and it also aids the participants not to give up as a doctor. Participant A stated that the thought of quitting came into his mind when he experienced patient's death but what helped him cope is his family for, they are his inspiration since the beginning of his profession. He expressed:

> *A: I was going to quit na nga pero what helped me cope up was my family you know. They were my inspiration first and foremost kasi.* (I thought of quitting but my family helped me coped, well they were really my inspiration ever since.)

In addition, he also shared that he has his friends with him, his co-residents, co-doctors and they taught him, especially his seniors that what he experienced are life experiences that he will definitely go through. (*A: Then of course I have my friends with me, my co-residents, my co-doctors and they taught me, especially my seniors that you know these these are life experiences that you will definitely go through.)*

Support is most effective if it is provided in the workplace (Bruce, Conaglen H., Conaglen J., 2005). The support should entail an ear that is willing to listen accompanied by simple support and words of encouragement. The role of the senior or "respected veteran" is very important in facilitating and giving credibility to the process just like what A's seniors did to him as it would somehow give more impact for, they have already been through a lot of experiences like this. Talking to a trusted colleague through a difficult situation can allow physicians to confront their

own emotions. This process can reduce isolation and help build the network of support that is necessary for complex and demanding clinical work (Meier, Back, & Morrison, 2001).

Canadian oncologists also sought professional support as their coping strategy 75% of them talked with a primary nurse or a nursing colleague, 15% with a social worker on health care, 6% with a spiritual worker on the team, 61% with other oncologists with whom they work, 22% with whom they don't work, and only 2% of them talked with a psychologist or other mental health professional about the patient death. It is quite saddening that only 2% of the Canadian oncologists sought psychological help. What is worse is that in the case of these Filipino participants, none of them sought psychological help for the grief they experienced.

In terms of activities, participant G said that she goes out, go to the mall to somehow forget the experience. She uses this time to clear her mind so that she can be ready and be equipped to face another patient again. In the study of Redinbaugh et. al 68.36% of the doctors used different activities to take their mind off the experience.

Overall, most of the participants use nature of work as their coping strategy for it is true that death is somehow expected in their field. With this awareness, some of them learned to detached their emotions from their work even before they entered the field. In addition, being in a catholic or a Christian country, most of the participants also turned into their faith and prayed for the soul of their lost patients. Support system is also evident in the coping strategy where participants also seek courage from their family and colleagues after the incident. One of the participants resorts to going out to somehow clear her mind. Although these coping strategies have been significantly helpful to the participants, Meier, Black, & Morrison (2001) warned that the use of unhelpful coping strategies may lead to mental health problems such as depression, substance abuse and "burn out" to the physicians.

Death Awareness

Death is perceived by the participants as something negative however they have been fully aware that it is inevitable. With the question of which is harder to accept when it comes to patient's death; unexpected or expected. Seven (7) answered unexpected death and only one (1) of them said that it was the expected death.

Unexpected Death

For those who answered unexpected death their reason is that when it comes to expected death somehow, they were briefed that eventually the patient would die and they have their time to prepare themselves to let go of the attachments they had with the patient. Unlike with the unexpected death where they said the patient goes to the hospital, tells his/her complaints to them then suddenly dies. They questioned themselves why it is so sudden because, of course, they hoped for the best for that patient; they hoped that it would not lead to death. These were supported by the following statements:

> *B: Mas mahirap yung unexpected syempre kasi kapag expected, na-anticipate mo na, ah itong patient na ito, mukhang very little chance na mababuhay yung ganun. Pero yung unexpected, kasi na buhay sayo dumating tapos biglang anong nangyari? Parang ganun, bakit ganun? Parang feeling mo, may kulang ba kong ginawa? So ganun.* (Unexpected death is more difficult because if it is expected somehow you would already anticipate what will happen to the patient, more likely there is a very little chance of him/her being alive. But when it comes to unexpected, that patient came to you alive then you will start to question yourself if there is something lacking on the procedure you did.)

> *F: When it comes to anticipated, there's that sense of release for burdened family*

members and caregivers. Also, family members have been primed to accept the worst-case scenario, especially in conditions marked by long suffering and heavy burden (financially, physically and emotionally). To some, death has even become an act of compassion, a form of release.

In addition, it is also stated that it is harder to accept when the patient who died is a child, for they believe that a child has a whole life ahead of him/her then all of a sudden, is cut. There is this feeling of regret because they know that the child has great potential to life but is not given a chance.

A: Yung unexpected, definitely for me ah, ang pinakamahirap kasi syempre you would always hope for the best eh. At least yung anticipated siguro may konting acceptance na yan eh. May konting reconciliation with your emotions and with your psyche na 'Ah sige we have to let go'. So medyo pag nawala na yung pasyente medyo easier ang letting go process pero kapag hindi siya anticipated, yung unexpected mahirap talaga especially when you're dealing with kids. Kasi bata pa sila eh, they have their whole life ahead of them tapos bigla na lang maka-cut. Yung potential nila sa buhay napakalaki tapos di mo malalaman kung ano yung magiging buhay niya sana, yung magiging relasyon niya sana. Mas mahirap ang unexpected death sa bata for me. (Unexpected, definitely for me is more difficult to accept, of course you would always hope for the best. At least when it comes to anticipated somehow you already accept it. There is a little reconciliation with your emotions

And your psyche that you really have to let go. So, when the patient dies, it is easier to let go. Yet when it comes to unexpected it is really difficult especially when you are dealing with kids. You see, they are still young, they have their whole life ahead of them, then suddenly it will be cut. Their potential in life is so great, their supposed to be relationship yet it never happened that is why unexpected death of a child is more difficult for me.)

In the death of a child/infant, as what participant A experienced, grief may overwhelm not only the parents but the doctor who cared for the child, as well (Mandell, McClain, & Reece, 1987 as cited in Masia, Basson, & Ogunbanjo 2010). It reported about losses of pediatric patients that a child's death is more tragic and unnatural than any other death. Unpreparedness for these intense experiences may negatively affect the attending doctor and the quality of care provided to survivors (Masia, Basson, & Ogunbanjo, 2010)

Expected Death

In terms of expected death, it was narrated that the physician had seen the patient from walking to deteriorating which is why she answered expected death is harder to accept. The thought of talking, attending and conversing with the patient while knowing that this patient will eventually die is very painful for her. Unlike with the unexpected deaths like heart attack where she did not have any chance to establish connection with the patient, she attended the patient as work, revived the patient but he/she died, no attachment built at the end. However, she repeats, that once it is a case of anticipated death of a patient, he/she had been part of her daily routine and she had a chance to mingle with that patient, it is harder for her to accept.

> *D: Masakit, para sa aming mga professional ah? Yung alam mo ah, if it is right, yung anticipated. Kasi, anticipated mo na magde-deteriorate yung tao pero nakakahalubilo mo siya. So yung rapport mo, yung daily routines mo na nakikita mo siya. Yun ang mahirap eh, yun yung attachment eh. Pag kasi namatay "lang" yan inatake, you don't have anything to talk with o ano ba, pinuntahan mo siya as a work, ni-revive mo siya, ni-resuscitate mo siya and then nagdeteriorate, tapos. But once yung anticipated mo, alam mo eh na mamatay siya pero nakakahalubilo mo pa siya ngayon so ayun yung mas mahirap para sa akin.* (Painful for us professional? If it is right, the anticipated (expected) death. Because you already know that the patient will eventually deteriorate but you are still mingling with

him/her and he/she is still part of your daily routines, there is an attachment. However, when the patient "just" died, for example heart attack. You attended the patient as work, you revived him but he eventually died, end of work. You do not have the chance to talk to him. But once it is anticipated, you know the fact that he/she will die but you are conversing with him/her, that is very difficult for me.)

These kinds of emotions are supported by the study of Redinbaugh et. al (2003) where it revealed that the amount of time a doctor spends taking care of a dying patient seems to be both a source of satisfaction and a source of distress. Longer duration of care was associated with a more satisfying experience and greater feelings of closeness to the patient. However, it was also associated with the finding that the death is more disturbing and emotionally powerful as well, as more reported symptoms of grief and trauma. These findings are also similar to Field (1998) where doctors described satisfaction in providing good end of life care while simultaneously expressing a sense of loss after a patient they knew well, died.

In contrast, Zambrano and Barton (2014) stated that expected death of a patient is somehow easier to accept for, the awareness and anticipation of death allows the general practitioners to prepare themselves, so that by the time the patient dies, their emotional reaction is more balanced.

Non-relative Vs. Relative Patient

This paper also reveals that in coping and moving on, it is easier for the participants to move-on if the patient is a non-relative compared to a relative. Moreover, it is also a different story if the patient who died is from their immediate family. As stated by G: *Kapag kamag-anak. Matagal. Years yan. Matagal talaga. kapag pasyente, sandali lang. Sandali lang pag patient, hindi ganoon katagal.* (When it comes to relatives, it would take years to move on but if it is "just" a patient, it would just take a little while). They also stated that there were instances that they were

able to move-on within the day, they do not want to appear insensitive but this is the truth for them. They inferred that this is because of the nature of their job itself; their job does not allow them to have the time to grieve for they have to attend to the next patient immediately, eventually they forget about what happened to their patient. However, there were also instances, when they first experienced patient's death, they were of course saddened but a member of their immediate family died, they realized how painful it was and start to relate and understand the loss of the relatives of their patients.

> *H: Probably I am a very insensitive person when I answer that question but usually just within the day I- so far, I have never encountered a patient that has died connected or not connected with me, that has bothered me for more than 24 hours. I'm just a type of person who can move on very fast, I am not really sure yet. Probably because the burden of our work immediately the next day we are seeing another patient. So probably the busyness of our career somehow covers up the grief or it facilitates our moving on.*
>
> *E: Actually, noong hindi pa ako namamatayan ng kamag-anak, syempre parang wala lang eh kasi part talaga siya ng trabaho mo. Pero noong nangyari na sa akin, doon ko naintindihan kung gaano ka-painful so from then on, yung mga sumunod na ah, di lang ako naging emphatic at the same time yung sympathy in regards to other relatives ng pasyenteng namatay.* (Actually, when I have not yet experienced a death of a relative, I felt nothing and think of it as part of my job but when it happened to me, that is the time that I understand how painful it is. From then on, whenever I experience death of a patient, I become more expressive of my sympathies to the relatives of the patient who died.)

Note: There were no studies found regarding the coping of physicians when it comes to the death of a relative. The researcher presumed that this was the case for they are refrained from handling patients that are related to them.

Contributing factors that made the participant continue their profession.

Continuing to be a medical practitioner (whose primary goal is to save life), after experiencing patient's death is quite difficult. From this study, these 4 (four) essential themes were used by the participants to help themselves in continuing to be in the profession despite the experience.

Table 5. *Four essentials themes in continuing profession despite experiencing death of first patient*

Themes	Descriptions	Sample Responses
Self-development	Participants seek self-development after experiencing the death of first patient.	*"There are two lessons for me. First is, greater sensitivity to the needs of the patients. Second, great loss leads to greater resiliency."*
Nature of profession	Experiencing death of a patient is a nature of their profession, it is part of their job.	*"Death will not hinder you from working. As I have said, the blame is not on you. So, it shouldn't be the factor to affect your daily living. They would say that you won't be able to work or move on because of death. Of course not, because all doctors experience death."*
Recognition	When the patients or the relative of the patients remembered them for their service, it a driving force to continue.	*"When the patients give you somethings, it's an implication that they remember you. Sometimes if you pass by, or you walk by the corridors, they would greet and thank you, although you don't remember them. It's a drive for me to continue working."* *"Our director came and congratulated me."*

Nature of Profession

In terms of continuing the profession, they see the experience as nature of work where it is understandable to experience patient's death as what participant A said: *Napakaplastic naman kung doctor ka tapos wala ka ni isang death na naexperience.* (I think it is unbelievable if a doctor has not experienced, even one patient's death.) Participant C was also firm when she expressed that:

> *C: Because death itself will not hinder you from working. Kasi tulad ng sinabi ko, hindi naman kasi siya, kumbaga wala namang blame sa'yo e. So, it shouldn't be a factor to affect your daily living. Kasi parang ano, sasabihin na, hindi na magta-trabaho or parang hindi ka na makaka-move on because of the death experience. Of course not. Kasi lahat naman ng doctor nakaka-experience ng death.* (Because death itself will not hinder you from working, Like, what I said not everything will be blamed on you. So, it shouldn't be a factor to affect your daily living. Like, they will say that you should quit or you will not able to move on because of what happened? Of course not, because all doctors have already experienced patient death.)

As supported by above literatures, death is seen to be part of their job. According to Franco (2017) death is very real and a natural part of the medical profession that physicians would not only face but must also learn how to handle. By being aware of the possibility of death one should be able to cope effectively and continue with the profession. However, she also stated that there are few physicians who look at death as defeat and cope by emotionally running away from dying patients. It is good to see death as part of the profession and to have set boundaries between work and emotions; however, physicians should also be cautious in using this thought as the patient or the relative of the patient might feel abandoned.

Self-development

Aside from thinking it as a nature of their work, they also use it as their way to develop themselves. They said that it helps them to reflect on what they did, to the diagnosis and treatment done; if ever there was something lacking in the procedure they did. It also helps them to be sensitive to the way they speak with the patients, to be careful in choosing their words for some patients may be hurt so easily; patience is really needed in handling patients. It also paves the way to make themselves updated with new medicines and treatment that they need to know to be able to treat other patients.

> *D: Naging mas careful and sensitive ako sa mga bibitawan kong salita during that time kasi di mo alam kung ... napakasensitive nang mga may sakit. Sabi nga ng aming head dati, professor (name of the professor). Ang sabi niya sa amin, try to understand your patients because the people went here in the hospital have something na nararamdaman hindi sila nasa normal state nila. Kung ikaw ngang iretableng tao, naiinis ka dba? Normal to wala kang nagagawa, wala kang ano, wala kang lagnat, what more yung may sakit? So doblehin yung pasensya, wag lang laging magagalit agad.* (I become more careful and sensitive in choosing my words when I am talking to a patient. Before, I did not know how sensitive a patient could be. Like what our head said, we should try to understand our patients because the people who went here have feeling something and they are not in their normal state. For example, you are well, you do not have fever or anything but you still feel irritable what more with those sick patients. So, we need to double our patience and we should not get mad so easily.)

In addition, the experience also taught them to look at each patient as a unique case and not a *"de-kahon kaso"*. Every patient is a unique case so each should have a unique treatment and diagnosis. The experience also led them to greater resiliency as participant F expounded:

F: Great loss leads to greater resiliency. Everything, no matter how painful, will pass. One has to have the proper perspective to know that everything is transient and one has the duty to separate the wheat from the chaff.

In regards to self-development as a doctor, it is proposed by other studies that part of medical training should be about grieving and accepting patient's death. It is revealed that doctors do not receive the proper training necessary in handling loss of a patient and coping with their families. Many studies have confirmed the inadequacy of training in this area which is really needed (Masia, Basson, & Ogunbanjo, 2010). For instance, the participants in this study felt that they are incompetent and questioned their purpose as a doctor, if they have done something wrong when they experienced patient's death. In fact, one of the participants also thought of quitting his profession. These resulting feelings of these doctors should be seriously taken into consideration and enhance their training in order for them to cope better and trust themselves again.

Recognition

One of the highlights and the most significant intrinsic motivation of the participants to go on is the recognition they receive though it is prohibited for them to accept anything from their patients, their simple *"thank you"* and their greetings are enough for them to continue. Participant F said that he had this sense of fulfillment when his hospital director congratulated him for being able to accept and treat a patient who has been denied by other hospitals. He narrates:

A: Ako lang yung doctor sa ER na tumanggap sa kanya, tapos dumating sa director naming tapos bumaba yung director namin tapos kinongratulate pa ako. So, these are things na nahahappy naman ako na parang I did something right din naman and these are experiences that really helped me through the bad times. (I am the only doctor who accepted the patient. Then the director of the hospital heard the news and congratulated

me. So, these are things that makes me happy, this make me believed that I did something right and these are experiences that really helped me through the bad times.)

Participant B also stated that the recognition she received from the patients who were able to deliver alive, still is enough for her to continue, for that experience of patient's death is just one setback for her and she felt that she could do more with the other patients that she has to attend.

B: That's just one patient. Out of the many patients na na-attendan ko, na nabuhay naman plus the baby so that's just one setback so kailangan go on pa rin parang feeling ko I can still do more with other patients. (That is just one patient out of the many patients that I have attended that is alive, both the mother ang the baby. That is just one setback, that is why I need to go on because I felt that I can still do more with other patients.)

In addition to the emerged coping themes and reasons of continuing the profession, a proposed model on how health practitioners should deal with grief was devised by Papadatou (2000), displaying the two routes for physicians who suffer from grief can take: (1) leaning towards the loss of experience and (2) away from the experience to engage more with life. This suggests that in order to cope with the experience one has to confront the experience and try to resolve it, and the other way is to take a break and engage for with personal life. In this study, none of the interviewed physicians decided to stop their practice.

Implications to Counseling

This study could contribute on the field of bereavement psychology, on how medical practitioners grieve, for people have different ways on how they will grieve depending on the circumstances of death (Psychology Today, 2019). This may provide future researchers the interest to study the grief process of medical practitioners here in the Philippines since related literature

where based on western countries. Furthermore, to explore on what type of grief these medical practitioners are under and what possible healing process could be provided for them.

With that, the Department of Health could provide more suitable training for them, collaboration with the Psychological Association of the Philippines and Philippine Guidance and Counseling Association could be a great help in planning for this. Furthermore, a comprehensive counseling process for medical practitioners could also be provided, this could help them unload the burden and if they have developed any psychological disorder (e.g. post-traumatic stress disorder), a proper psychotherapy will be provided for them.

It is suggested that the counselor might consider using individual counseling and use therapies such as Gestalt and Existential therapy. As per Gestalt therapy, it is suitable for physicians like participant G who might have this "unfinished business" with the death of her grandmother. Based from her statements she still has this feeling of guilt and grief towards the death even it happened years ago.

Physicians like her might have to undergo phenomenological inquiry that involves paying attention to what is happening now and not in the past. Confrontation can also be done for the physician to recognize what blocking his/her way out. Moreover, empty chair technique could also be considered in dealing with unresolved feelings. For instance, participant G could introject her "younger self" where her grandmother died and try to get in touch with the feeling or to the side of herself that she might be denying. This way, she could realize that it is part of her and this kind of intervention might discourage her from disassociating these feelings.

Group counseling might also be helpful for the participants to see that they are not the only ones who have experienced the death of a patient. Existential group counseling could enable the participants to be honest with themselves, to widen their perspective and on clarifying their present

and what they want in the future. This could help medical practitioners to be self-aware and be able to reflect and to decide. Just like what happened to Participant A who felt that he wanted to quit the profession after losing his patient, but after hearing his colleagues like in a group counseling and focusing his mind to his goals, being self-aware, he continued to be a pediatrician.

Different counseling actions might be given to the participants depending on their needs, and they are encouraged to seek help. As this paper also aims to destigmatize the belief that seeking professional help for themselves will put them into shame.

CHAPTER IV

Summary, Conclusions and Recommendations

This chapter presents the summary of the study, its findings, limitations and the conclusion and recommendation for future researches.

Summary of the Study

This study aimed to explore on the lived death experiences of the medical practitioners in line of their duty. The researcher chose this since the primary goal of their job is to save life. This captured the interest of the researcher to explore and understand the resulting feelings the practitioners have felt and their cognitive reactions in the aftermath of the death experience. Also,

a lot of studies regarding this matter were conducted abroad but not in the Philippines. This paper also seeks to help the medical practitioners to be understood by the people and somehow lessen doctor shaming which is very prevalent these days. In addition, for the medical practitioners to understand that experiencing this is "okay", and understandable, but then they are highly encouraged to seek psychological help if they have to.

The experiences of the medical practitioners were analyzed through qualitative research, specifically phenomenological research design. Five areas were explored in order to fully understand their lived experiences; 1) factors that contributed in choosing a life-saving profession 2) the experience of first patient's death 3) resulting feeling and cognitive reactions and 4) coping strategies 5) reasons to continue. In this study, eight (8) medical practitioners, four (4) males and four (4) females with varied specialization participated and shared their lived experiences. The needed data were collected through the use of interviews. The interviews were transcribed and results were produced through thematic analysis. Medical practitioners who were part of this study came from various ages with 29 being the youngest and 58 years old as the oldest. Each of them must be licensed, practicing in a clinic or in a hospital, and have experienced patient's death. These medical practitioners vary in their field of specialization. All of the participants have been practicing for at least 3 years.

Summary of the Findings

The findings of the study revealed four (4) themes that served as the factors that led the participants chose a life-saving profession. Namely; 1) family-based decision, 2) vocation to help, 3) honor and benefits, and 4) Divine Providence. In which most of the participants chose this

profession for it was their family's decision for them and interestingly, some of them just let Divine Providence chose it for them.

There are five central themes for the physician's reaction with patients' death, namely (1) recollections, where the participants have vividly remember the death of their patient (2) credibility, the participants have questioned their capability as a doctor and what possible treatment they could have done, (3) impact, the experience made them realize the importance of life, (4) response, the participants were usually confused on how they would respond to their patient and (5) kinship, where the grief for a death of a loved one is different from the death of a non-relative patient. Furthermore, in the study conducted, none of the participants fell into category of expectation and responsibility, it can be inferred that they are not pressured by the expectations of the patient's family and other people related to the patient**.** Moreover, study reveals that kinship is a critical factor in the reaction and coping mechanisms of the physicians.

The participants used these themes as their coping mechanisms: (1) nature of work, (2) faith, (3) professional and social support, and (3) activities. Social support and professional support are considered as one since it was displayed only once by the same participant. Most of the participants coped with their first experience of patient's death mainly because they have learned to understand the nature of their profession.

Despite their first patient's death experience, the participants continued in pursuing their job due to these reasons: (1) self-development, where participants seek self-development after the experience (2) nature of profession, the think of death as a nature of their profession and (3) recognition, set recognition as their driving force to continue.

Limitations of the Study

This study is delimited to medical practitioners who have been in service for at least three (3) years. The participants will be composed of eight (8) medical practitioners, residing in Metro Manila only. The participants' confidence in delivering their responses might have compromised their willingness to join. Not all answers may have been true since the information asked are confidential, and it also depends on the memory of the participants as they recalled the given situations. In addition, some questions might be skipped by the interviewer due to the *in the moment ambiance* in the duration of the interview. The comparison of the central themes is mostly based on western countries. The eastern countries are viewed as having more sense of attachment; hence, more emotions are displayed compared to western countries. There might be some differences on the central themes that have prevailed since the study was conducted in the Philippines due to cultural and religious variations. Furthermore, the study only covers the lifesaving professionals in the medical field.

Conclusions

1. The lifesaving professionals cater to the needs of the people. Nonetheless, the people must keep in mind that these professionals are in no exception as they, too, rely on the decision of their parents and Divine Providence in choosing this profession. Furthermore, despite the different reason on why they ended up in this profession, the eagerness and the will to treat patients are the same.

2. Medical practitioners as lifesaving professionals went through different challenges after experiencing patient's death. Some of them would vividly remember the exact scenario on that day even if it happened years ago and some may question their credibility as a medical

profession. This implied that experiences they went through could be very hard for them and must be take into consideration by their institution or the government.

3. Death is something they have to deal with and experience every day. Contrary to the popular belief, medical doctors have grieved for their patients' death in their own ways. In the duration of their service, they have learned how to cope up with every death encountered. The most alarming coping mechanism is the avoidance strategy wherein physicians detached themselves from emotions and feelings which may result into long-term chronic effects on personality and performance, since the suppression of expression could have impact at this extent. There is no constant mechanism one must employ, rather a mix of various strategies is used in order to cope with death in day to day basis.

4. Despite their experiences they looked into the more positive side of their profession and take it as a way for them to seek self-development. Recognition is also helpful for them to bring back their self-confidence.

Recommendations

1. The institutions must consider the mental health of these the lifesaving professionals who based on the findings of the study have devoided their emotions and set aside their grieving in order to serve the public. This study firmly suggests the implementation of seminars, and monthly performance and health evaluation of people in the healthcare field for further progress of the healthcare industry. The lives of the lifesaving professionals are ironically at risk as they are exposed to various illness every day. The society may aid in lessening the toxicity of death experiences of these professionals by understanding their deepest thoughts and intentions

of their hearts. While these professionals build bridges to life, death may come easily and destroy every brick used.

2. The Department of Health (DOH) should initiate the possibility of having counseling sessions for physicians who have experienced patient's death and grief management program that would explore strategies in dealing different kinds of death whether expected or unexpected. It is also recommended for the DOH to have its collaboration with the Psychological Association of the Philippines and Philippine Guidance and Counseling Association to aid them in constructing a more comprehensive counseling program. Furthermore, DOH must also consider monitoring the mental heath of both urban and rural doctors most importantly, those medical practitioners who works on public hospitals.

3. Different coping mechanisms should also be provided by the participant's institutions as well as the Department of Health (DOH) depending on the situation experienced by the medical practitioners. Also, their colleagues and even their seniors should be more open on the fact that this is the nature of their work and give them advises on how to deal with it. Most importantly to tell them that it is understandable to feel sad and unload the burden instead of avoiding the feeling.

4. To date, there has been no research regarding the coping mechanisms of Filipino lifesaving professionals in the field of teaching and counseling here in Philippine Normal University. The mere fact that this is the first study conducted concerning the aforementioned topic strongly emphasizes the need for further research. Deeper study on the grieving process of lifesaving professionals should be considered, number of participants as well as their location could also be a factor, participants from rural area must be included. Also, this study only caters

the lifesaving professionals in the medical field, others such as the firefighters or those who's on Red Cross and the first aiders could also have different experience that needs to be studied. Furthermore, effective counseling strategy that would help the mental health of the lifesaving professionals should also be provided.

Thesis Epilogue

I have been very intrigued on how medical practitioners deal with their patient's death which is why I read literatures about them and started to have an interest in conducting this study. My sole purpose is just to know if they felt like quitting or questioning themselves, because based from the movies I have watched, they have these thoughts, they have their own emotional breakdowns and having a first hand interview with the said professionals, I get the chance to know their feelings and coping mechanisms. And it is true, doubting themselves and thoughts like quitting have already crossed their minds but eventually they learned to accept that it is the nature of their work.

All of the thesis process was going smoothly for me and I was happy since all of the medical practitioners generously give me their time despite of their busy schedule. Until my father was diagnosed with cancer, I am so dumbfounded and I feel like I do not want to continue my study anymore. Since it was stage 4 cancer, I was torn between going to school or staying by my father's side, I choose the latter. I am still fortunate since I have already finished my grand demo and all was left was this thesis so I can do it at the hospital. However, what struck me the most is the mistreatment of one of my father's doctor. I can really say that my father was fighting for his life because he really wanted to be there on my graduation but he started to act otherwise and just sleep

on his bed when he heard the doctor said in an impolite manner, “bakit niyo pa iba-biopsy ‘yan, eh wala na namang pag-asa ‘yan”. After that, as I said, he just sleeps for the whole Friday, sleep and did not drink his medicines on Saturday and died on Sunday, 1am. Imagine how fast it took my father to give up his life just because of that rude doctor.

Since this happened, I don’t want to pursue my study anymore because one my purpose is to lessen doctor shaming which is very prevalent in our country. With this study I want the community to understand the experiences they went through; I want the people to understand that they are humans too. However, how can I do that if my father was mistreated by a doctor which is why finishing this thesis was both a pleasure and pain for me. Pleasure for it is the key for me to graduate and pain because of what me and my father have experienced.

Completing this thesis made me realized that there are different kinds of doctors or medical practitioners, the one that I encountered during my interviews and the one who mistreated my father. I have always dreamed of becoming part of the lifesaving professionals and if ever I will become one, I will always choose to become the former.

I really want to congratulate myself for getting this far despite all the struggles I went through. It is truly a job well done.

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Appendix A

Time Table

Activity	*Aug.*	*Sept.*	*Oct.*	*Nov.*	*Dec.*	*Jan.*	*Feb.*	*Mar.*
Title Defense	✓							
Colloquium			✓					
Data Gathering				✓				
Data Analysis				✓	✓			
Results and Discussion						✓	✓	
Final Defense								✓

Appendix B

Letter of Permission to Conduct Research

Date

Dr. (Name):

Dear Dr. (Name):

Greetings of peace!

I am Patricia Anne F. Dayrit, currently enrolled at the Philippine Normal University and finishing my Bachelor of Science-Master of Arts degree in Psychology and Counseling. I am currently working on my thesis on ***Death in the Line of Duty: Lived Experiences of Lifesaving Professionals***. This phenomenological study seeks to determine how medical practitioners responded to the death of their patients and how they coped with it, leading to their continuance of practice. The participants of the study will include medical practitioners (physicians) that have been practicing in a hospital within three to ten years and have experience patient's death.

In line with this, I would like to request the participation of your employees in this study. I would like to ask permission to conduct my study on your practitioners who met the selection criteria.

Herewith is the copy of the interview guide questions that will be use for the said study.

I am hoping for your favorable response.

Thank you!

Sincerely yours,

Patricia Anne F. Dayrit
09064159083
dayrit.paf@pnu.edu.ph

NOTED BY:

Prof. Vanessa Laura S. Arcilla, RPm, RGC
Thesis Adviser

Appendix C

Letter to the Participant

Date

Dr. (Name):

Dear Dr. (Name):

Greeting of peace!

I'm Patricia Anne F. Dayrit, I'm currently working on my master's thesis entitled Death in the Line of Duty: Lived Experiences of Lifesaving Professionals. This study seeks to determine how medical practitioners responded to the death of their patients and how they coped with it, leading to their continuance of practice.

In line with this, I would like to request for your participation. Your participation is voluntary and you will not be penalized if you wish to withdraw your participation.

Attached is the Informed Consent Form, demographic profile sheet and a copy of interview guide questions that will be use for the said study

I am hoping for your favorable response.

Thank you!

Sincerely yours,

Patricia Anne F. Dayrit
09064159083
dayrit.paf@pnu.edu.ph

NOTED BY:

Prof. Vanessa Laura S. Arcilla, RPm, RGC
Thesis Adviser

Appendix D

Informed Consent Form

Researcher: Dayrit, Patricia Anne F.

Adviser: Prof. Vanessa Laura S. Arcilla, RPm, RGC

This study is entitled "Death in the Line of Duty: Lived Experiences of Lifesaving Professionals". The researcher aims to determine the contributing factors that lead the participant in choosing to be in a life-saving profession and to discover the experiences they went through when they experienced their first patient's death. The study aims to provide the participants a deeper understanding on the patient's death that they have experience. Also, for them to realized that they were not only the person that have experienced this and it is acceptable (if necessary) to seek psychological or professional help.

Procedures:

The medical practitioners that have been practicing in a hospital within three to ten (3-10) years and have experienced patient's death is invited to participate in this study. The procedure and purpose of the study will be discussed by the researcher. Informed consent forms will be given to the respondents and will be asked to sign on it to confirm that they agreed to participate. Once it has been signed, the participant will now be interviewed by the respondents. The estimated duration of the interview will be thirty to forty-five minutes (30-45) minutes only. A recorder will be used to ensure that the statements which will be used in this study is purely from the participant. If the participant chose not to participate or to withdraw from the study at any time, there will be no penalty.

Risks and Benefits:

There will be no risks associated with the participation in the study since the interview questions have been validated by the experts and it is rest assured that it will not trigger any strong emotions. However, if there is any question/s that may let the respondent feel uncomfortable of answering, the respondent can call the attention and have the right to withdraw the procedure. Furthermore, if after the termination of the interview and the participant is still uncomfortable, he/she will be immediately referred to a professional for counseling.

This study may help the participants to gain knowledge about patient death experiences. This will also let the participants to somehow be at ease for the fact that people in the same field experience this phenomenon too and if necessary, it is acceptable to seek for psychological help. Furthermore, it will be ensured that conducting this study will have an important contribution to the participants and to the community. For instance, the results of the study might help the participants to be understood by the people who happens to judge them instantly without knowing what they feel. Specially, nowadays that medical practitioners or doctors shaming is prevalent in the country. In addition, a token of appreciation will be given to the participants as a compensation for their time and participation in the study.

Confidentiality:

Anonymity of the participants as well as the name of the hospital they are affiliated to will be ensured in any possible condition so as their identity will not be revealed. Instead of using their real names in interpreting the data, code names or case ids will be utilized. The data obtained from this study will also kept private. All the information that will be gathered from each participant will be treated with utmost confidentiality. The data will be stored in a password protected computer and will be kept for five (5) years. The researcher will make sure that only the researcher and her adviser will have access to the information. The specific, personal result of the study will be available upon the request of the respondent.

For more questions regarding the study, you may contact the person below:

Patricia Anne F. Dayrit
dayrit.paf@pnu.edu.ph
09970684563

Reply Slip

I, Stuart G. Santos, MD being over the age of 18 years old (legally independent) hereby consent to participate in this study titled: **Death in the Line of Duty: Lived Experiences of Lifesaving Professionals.**

Participant's signature: _____ _____
Date

I certify that I have explained the purpose of research to the participant and consider that she/he understands what is involved and liberally consents to participate.

Patricia Anne F. Dayrit
Researcher
(Signature over printed name)

_____
Date

Reply Slip

I, Stuart G. Santos, MD being over the age of 18 years old (legally independent) hereby consent to participate in this study titled: **Death in the Line of Duty: Lived Experiences of Lifesaving Professionals.**

Participant's signature: _____ _____
Date

I certify that I have explained the purpose of research to the participant and consider that she/he understands what is involved and liberally consents to participate.

Patricia Anne F. Dayrit
Researcher
(Signature over printed name)

_____
Date

Appendix E

Demographic Profile Sheet

Demographic Profile Sheet	
Name	**Age**
Gender	**Civil Status**
Email address	**Contact no.**
Specialization:	
Hospital Affiliated to:	
Years of service:	

Appendix F

Letter for Expert Validation

Date

_____
_____
_____

Dear (Name):

Greetings of peace!

I am Patricia Anne F. Dayrit, currently enrolled at the Philippine Normal University and finishing my Bachelor of Science-Master of Arts degree in Psychology and Counseling. I am currently working on my thesis on ***Death in the Line of Duty: Lived Experiences of Lifesaving Professionals***. This phenomenological study seeks to determine how medical practitioners responded to the death of their patients and how they coped with it, leading to their continuance of practice. The participants of the study will include medical practitioners (physicians) that have been practicing in a hospital for at least three years and have experience patient's death.

With your expertise, I am humbly asking for your assistance through the validation of the research instrument I will utilize for the data gathering procedure of my study. Attached with this letter are the interview questions that I have constructed for this study. Comments and suggestions are welcome for the improvement of the questions.

Thank you!

Sincerely yours,

Patricia Anne F. Dayrit
09064159083
dayrit.paf@pnu.edu.ph

NOTED BY:

Prof. Vanessa Laura S. Arcilla, RPm, RGC
Thesis Adviser

Appendix G

Interview Question Validation Guide

This will serve as a guide for the validation of the interview questions. Please evaluate the following questions for the study **Death in the Line of Duty: Lived Experiences of Lifesaving Professionals.** Please check the appropriate column (Suitable, Not Suitable, Needs Revision)

corresponding to your evaluation per item. For items that need revision, kindly indicate on the last column your comment & suggestions for revision**.**

The following are the aims of the study that are to be considered in validating the interview questions:

1. Determine the contributing factors that lead the participant in choosing to be in a lifesaving profession.

2. Discover the experiences they went through when they experienced their first patient's death.
    a. Discover their resulting feelings and cognitive reactions that helped them in dealing with the first experience of patient's death.

3. Determine the contributing factors that lead the participant in continuing his/her profession.

Questions	Suitable	Not Suitable	Needs Revision	Comments/Suggestions
General Question **1. What inspired you in choosing this career?**				
General Question **2. What made you decide choosing your profession?**				

General Question	
3. In your years of service, what unforgettable experiences do you have in relation with your work?	
Probing question 1. Was there any unexpected experience, like a death of a patient?	
General Question	
4. How does these experiences impacted your life?	
Probing question 1. Your work?	
General Question	
5. How did you cope with the incident?	
General Question	
6. What helped you in continuing the profession, in dealing with it?	

Appendix H

Sample of Interview Guide Questions

Preliminary Questions

1. Could you tell me information about yourself Sir, like your name and the hospital you are affiliated to?

2. You've been in the profession for how many years?

3. Before you enter in this field Sir, what is your general view about being a doctor?

Questions

1. What inspired you to choose this career?

2. You have been inspired by (depends on the answer on number 1), but what made you decide to choose your profession?

3. You said earlier that you've been in service for (depends on the answer). In your years of service, what unforgettable experiences and/or challenges do you have in relation to your work?

4. How did these experiences and challenges have impacted your life?

5. How did you cope with the experience?

6. After the challenges you went through, what helped you in continuing your profession as a doctor, how did you deal with these challenges?

Appendix I

Sample Coding

Statement of the Purpose #1: Determine the contributing factors that lead the participant in choosing to be in a life-saving profession.

What inspired you to choose this career?

Participant	Response	Main Theme	Code	Description
B	Actually, hindi ako ang may gusto. Mommy ko ang may gusto nito pero okay naman din.	the career was chosen by her mother	1-A	The career was first chosen by her mother but decided that it is still "okay"
G	It is because, it's my mom uhm interest to have a doctor in our family.	The career was chosen by her mother because she wants to have a doctor in their family	1-A	the career was based on her mother's decision because she wanted to have a doctor in their family
D	I was inspired, first to be honest, because of the opportunities that it will take me to abroad. So that's the first point and then the second point is uhm during my duty days on my internship in a hospital I think being in this field is was also a vocation as well, if you don't care to a person or to a patient, I think it is very difficult to be in this career. So that's it, helping people	opportunities abroad, during intership she saw this career as a vocation to help people	2 & 3	Chosen career was based on the possible opportunities abroad, and was inspired during internship that it is really a vocation to help
C	Same din, ganun din. (to save life)	to save life	2	Was inspired in saving people's lives

A	Ahhhhh. Well it's one of the more noble professions that we have so its .. well growing up catholic you know with our profession I am it's uhhh a privilege that I am also helping others. Especially the less fortunate uuhh brothers and sisters that we have. We are able to help them through whatever means possible that could be for their upliftment	noble profession; to help the less fortunate brothers and sisters in whatever means possible that could be for their upliftment	2	Was inspired because it is a noble profession and a privilege to help others in whatever means possible that couldbe for their upliftment
E	Wala, (laughs) Actually, napilitan lang din ako, sa parents ko, pero nasabi ko rin sa sarili ko na nandito na tayo eh, siguro ito talaga ang misyon ko	none, was forced by parents	1-A	Chosen career because of parents, but told to himself that he was already there so might as well continue and he also think that it is really his mission
H	The inspiration behind pursuing a medical career is very complex for me, when I was in high school uhm the love for sciences has help me in pursuing a career in medicine ahh my parents are not doctors but some of my uncles and aunties are in the medical field as well- medical technology, pharmacy and have an uncle doctor who was a big contributor in my decision to be a medical doctor.	inspired because of his love for sciences, relatives who are in medical field	1-B	career was chosen because of his love for sciences and he has relatives that are in the medical field
F	Providence; I initially intended to take up a social science course and go into law	Providence, was lucky enough to	4	Chose career because of the "providence" he

	school after. However, I was lucky enough to qualify under the Intarmed Program of the UP College of Medicine so instead of taking up BS Economics in Diliman, I shifted to medicine in UP Manila.	qualify in College Medicine Program	received, he was lucky enough to qualify in a College of Medicine Program

Legend:

1. Family-based decision
    a. Forced
    b. Motivated
2. Vocation to help
3. Honor and Benefits
4. Divine Providence
    a. Fate
    b. Faith

You have been inspired by (depends on the answer on number 1), but what made you decide to choose your profession?

Participant	Response	Main Theme	Code	Description
B	Ah, ituloy ko na? Para lang ma-maplease ko yung mommy ko, yung parents ko actually kasi… kung anong sabi ng magulang mo, ayun ang susundin mo. So ayun.	to please her parents	1-A	Decide to choose the career because of the want to please her parents, and it is also a rule in their family that they should always obey their parents
G	Yung mom ko din yung naging reason but ang gusto ko talaga nursing. Med related din naman	have come to decide because of her mom	1-A	Choose to be a doctor because of her mom but initially wanted to be a nurse

D	Maybe because of my uhm my principle in life that if you're that situation there is no point of turning back, no turning back. Since I loved it also, with my principles and values that hold me to this profession.	Principles and values, she holds that if you're that situation there is no point of turning back, no turning back.	2 & 3	Decided to become a doctor because of the principles and values she holds that if you're in that situation there is no point of turning back, no turning back.
C	Siyempre for better, for better income din. Aside from saving life, for better financial, ano din, status din.	aside from saving life, better financial status	3	Decide to become a doctor to have a better income aside from saving lives
A	Ahh okay *laughs* Actually, honestly uhhh cause there's no doctor in our family eh and then my parents wanted me to become a doctor so well it's cool that I kinda perfomed kinda very well in school so they thought 'Oh maybe he can do medicine' so I took up medicine. So it may not have been my primary choice pero that that proud feeling that your parents had, that pride they have in you that you are able to finish this was a good enough uuhh reward for me so that was my inspiration.	There's no doctor in the family and good in school	2	Decided to become a doctor because of his family and of his being good in school
E	What made the decision? Okay Probably I'm already in this course, might as well, panindigan na, misyon na, misyon na natin 'to. Para sa Diyos na ito.	Mission for the Lord	4-B	It became his mission for the Lord since he was already in the course might as well continue

H	Hmm okay the, the ultimate decision was made when I hurdled college entrance exam it was my uhm go forth or go back decision issue, if I hurdled my entrance exam to my undergraduate and to my actual medical ahh college entrance exam then that with be *both laughs* the one deciding for me, if I'm gonna pursue or not. Because if I don't pass that exam, that's gonna make the decision for me it means that im not into that... I need to go somewhere else	Back and Forth decision issue	4-A	He let the result of the entrance exam decide for him
F	I am to some extent a fatalist on some matters and regard my qualifying for the program as some form of divine intervention. I was vacillating between pursuing economics and medicine but was persuaded by my parents and an aunt who told me that they will be very supportive of all my needs during medical school.	Parents and aunt supported him; fate	1-B; 4-B	He decided to be a doctor because it is really in his career choices and his familly is willing to support him and because he is a fatalist, it's truly a divine intervention

Legend:

1. Family-based decision
    a. Forced
    b. Motivated
2. Vocation to help
3. Honor and Benefits
4. Divine Providence
    a. Fate
    b. Faith

Appendix J

Invitation Flyer for Participants