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Critical Care Nurses' Experiences Regarding Palliative Care: Phenomenological Qualitative Study

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Abstract
Background: *Palliative care is specialized healthcare that aims to relieve pain, stress, and other distressing symptoms among patients with serious illnesses in order to improve the quality of life of patients and their families. Critical care nurses play a vital role in providing palliative care within intensive care units (ICUs).*
Aim of this study: *to explore in depth the lived experiences of critical care nurses regarding palliative care.*
Design: *A qualitative phenomenological approach was utilized.*
Setting*: The study was conducted in medical ICUs at Badr Hospital in Badr City, Egypt.*
Subjects*: A purposive sample of 20 critical care nurses participated in the study.*
Tools: *Three tools were used; Demographic characteristics of the studied nurse, Semi-structure, face to faces open ended questions, and Audio tape recording.*
Results: *The current study findings revealed nine major themes describing nurses' experiences with palliative care in ICUs. Nurses reported conceptual misunderstanding and Conceptual confusion regarding palliative care. Their experiences were emotionally demanding, characterized by emotional burden, empathic involvement, and compassion fatigue. Multiple professional, organizational, communicative, and ethical challenges were identified, including inadequate training, lack of institutional support, time constraints, communication difficulties, and moral distress. Nurses also emphasized coping strategies, emotional resilience, and the importance of interprofessional collaboration and system improvement in enhancing palliative care delivery.*
Conclusion: *The current study concluded that critical care nurses experience significant emotional, professional, organizational, communicative, and ethical challenges while providing palliative care in ICUs. Conceptual confusion, emotional burden, and compassion fatigue were commonly reported. Strengthening education, organizational support, interprofessional collaboration, and emotional resilience is essential to improve palliative care practice in critical care settings.*
Recommendations: *Strengthening organizational support through structured educational programs, continuous professional training, clear institutional policies, and interdisciplinary collaboration is recommended to improve palliative care practice in intensive care units.*
Keywords: *Critical care nursing, Intensive care units, Nurses' experiences, Palliative care, Phenomenology.*
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I. Introduction

Intensive care units (ICUs) settings are recognized for their focus on delivering intensive, technology driven interventions to critically ill patients. However, for patients with poor prognoses particularly those whose likelihood of discharge with an acceptable quality of life is low due to disease severity, multiple comorbidities, or functional impairment an exclusive emphasis on life-saving treatment may lead to prolonged suffering, increased caregiving burden, and severe psychological stress for families. In such circumstances, integrating palliative care principles into ICU management can facilitate more informed decision-making, optimize symptom control, and improve the experience of both patients and their families. In this context, that the primary responsibility of ICU healthcare staff is to alleviate patients' pain and suffering rather than to cure them, as suffering and pain can, for humanity, be worse than death itself **(Castro, et al., 2023).**

Palliative care is an all-encompassing, multi-faceted strategy in medical practice, primarily intended to enhance the quality of life of individuals facing serious illnesses and to assist their families through the reduction of physical, emotional, social, and spiritual distress. Although this type of care has traditionally been associated with patients with cancer or terminal chronic illnesses, in recent years, its importance and necessity in intensive care unit (ICU) settings have received increasing attention **(Mehta, etal., 2023 & Downar, etal., 2023)**

The implementation of palliative care in the ICU is associated with multiple positive outcomes, including a reduction in unnecessary length of stay, improved family satisfaction, decreased use of non-beneficial end-of-life interventions, and optimization of healthcare resource utilization. Palliative care interventions in ICU patients, demonstrated that both integrative and consultative models of palliative care in the ICU can yield positive outcomes, particularly in reducing length of stay and increasing decisions related to treatment limitation. Nevertheless, considerable barriers such as insufficient specialized training of ICU staff in palliative care principles, ethical concerns related to treatment limitation, cultural differences in attitudes toward death, and the lack of supportive organizational structures have hindered the full integration of this approach in many countries, including middle income nations. Despite these challenges, familiarity with palliative care can be highly beneficial for nurses **(Wiencek, 2024 & Salins, et al., 2024).**

Critical care nurses play a pivotal role in the delivery of palliative care within intensive care settings because of their continuous presence with critically ill patients and their families. Nurses are responsible not only for physical care, but also for providing emotional support, communication, advocacy, and assistance in end-of-life decision-making processes. However, nurses frequently encounter emotional burden, compassion fatigue, moral distress, communication difficulties, and organizational barriers while providing palliative care. Inadequate training, shortage of staff, lack of institutional support, and unclear professional roles have been identified as major barriers affecting palliative care practice among critical care nurses **(Rubbai, et al., 2024).**

Therefore, the aim of this study is to explore critical care nurses' lived experiences regarding palliative care in intensive care units using a phenomenological qualitative approach. Understanding these experiences is essential for improving clinical practice, enhancing interprofessional collaboration, and guiding the development of educational and institutional strategies that support the integration of palliative care into critical care settings.

Significance of the study:

Palliative care is required by approximately 40 million people each year, with 78% of them residing in low- and middle-income countries. Worldwide, only about 14% of people who need palliative care currently receive it. In addition, unnecessarily restrictive regulations on morphine and other essential controlled palliative medicines limit access to adequate palliative care services. Therefore, adequate national policies, programs, resources, and training in palliative care among healthcare professionals are urgently needed to improve access **(Osman, et al., 2022 & Gautam & Adhikari, 2021).**

In Egypt, palliative care and cancer pain management are still in the early stages of development. Few services are available, and significant barriers exist, such as limited access to opioids for medical use. With 78% of adults in need of hospice and palliative care residing in low- and middle income countries, there is a clear and urgent need for expanded palliative care services in Egypt **(Ibrahim, et al., 2024).**

Globally, over 29 million people die from conditions that require palliative care, with an estimated 20.4 million individuals needing palliative care at the end of life. Of those in needs, 94% are adults, with 69% being over 60 years old and 25% aged between 15 and 59 years. A significant portion, 78%, of those requiring palliative care reside in low- and middle-income countries. Palliative care is necessary for 40- 60% of all deaths worldwide. The majority of adults requiring palliative care suffer from chronic conditions, such as cardiovascular diseases, cancer, chronic respiratory diseases, AIDS, and diabetes mellitus. The global increase in chronic, severe illnesses has resulted in a decline in patients' quality of life, difficulties with medication adherence, inability to work, higher out-of-pocket costs, and a heavy burden on caregivers. These factors have significantly amplified the worldwide demand for palliative care services **(Murota, et al., 2024 & Fahim, et al., 2023**).

Therefore, the aim of this study lies in exploring the lived experiences of critical care nurses regarding palliative care in ICUs, identifying gaps in knowledge, emotional burden, and organizational barriers. The findings are expected to support improvements in nursing education, clinical practice, and healthcare policy, ultimately enhancing the integration of palliative care within intensive care settings.

Aim of the Study

This study aimed to explore in depth the lived experiences of critical care nurses regarding palliative care.

Research questions

What are the lived experiences of critical care nurses regarding palliative care?

Subject and Method:

Research design

A qualitative phenomenological approach was utilized in this study. Phenomenology is a qualitative research approach that aims to explore, describe, and interpret individuals' lived experiences of a particular phenomenon and the meanings they attribute to those experiences. It focuses on understanding participants' perceptions, feelings, and perspectives in order to gain a deeper insight into the essence of the phenomenon under investigation (Creswell & Poth, 2024).

Setting

This study was conducted in the Medical ICU at Badr Hospital in Badr City, Egypt, which is affiliated to capital university hospital. The Intensive Care Unit consists of two wards, each with five beds for critically ill patients, in addition to one isolation room.

Subjects

A purposive sample of 20 critical care nurses was utilized in this study. Sample size was determined based on data saturation, where data collection continued until no new themes emerged.

Inclusion criteria

The study included purposively selected nurses working in intensive care units and providing direct care to critically ill patients requiring palliative care, with at least one year of clinical experience in ICU settings, and who were willing to participate in the study.

Tools of data collection:

The researcher was used three tools to collect the data during the study:-

Tool I: Demographic characteristics of the studied nurse: This tool was developed by the researcher, based on the recent literature **(Zhou,et al., 2022 & Sarıkahya, et al., 2023).**Which included 6 items (age, gender, education level, years of experiences, Type of work, and attending any courses regarding palliative care)

Tool II: Semi-structure, face to faces open ended questions: it was adapted from **(Uzelli Yilmaz, et al., 2023)** to explore the lived Nurses, Experiences Regarding Palliative Care. It included several open-ended questions to help participants deeply express their feelings, beliefs, attitudes, and unique experiences regarding palliative care such as (What does palliative care mean to you, and how do you differentiate it from end-of-life care?, Can you describe a particularly emotional or impactful experience you had while providing palliative care in the ICU?, What are the main professional challenges you face when providing palliative care in the ICU?,..etc)

Tool III: Audio tape recording: was used as an instrument to record participants' own words. It plays an important role in ensuring the accuracy of interview details.

Administrative design:

An official permission was obtained from Dean Faculty of nursing Capital University to the director of Badr University Hospital and Head of medical ICU at Badr Hospital in which the study was conducted.

Operational design:

There were three distinct phases to the study that needed to be finished: planning, pilot study, and procedure.

Preparatory phase:

It includes reviewing related literature, and theoretical knowledge of various aspects of the study using books, articles, internet, periodicals and magazines to develop tools for data collection.

Pilot study:

A pilot study was conducted on 10% of the total study sample (2 nurses) to test the applicability, clarity, and effectiveness of the data collection tools. The pilot study also aimed to ensure the simplicity, relevance, and feasibility of the tools, as well as to estimate the time required for each interview and identify any potential obstacles. Based on the pilot study findings, minor modifications were made to improve the interview questions. Participants included in the pilot study were excluded from the main study sample and replaced by other.

Study Trustworthiness

Trustworthiness was ensured in the current qualitative phenomenological study through the criteria of credibility, dependability, confirmability, and transferability as proposed by Lincoln and Guba, (1985) and further discussed by Creswell and Poth, (2024).

Credibility

Credibility refers to the confidence that can be placed in the truth and accuracy of the findings and the extent to which they accurately represent participants' experiences and perspectives. Credibility was ensured through conducting in-depth individual interviews with critical care nurses, allowing for a rich and detailed exploration of their experiences regarding palliative care. All interviews were audio-recorded and transcribed verbatim to ensure accuracy and completeness of the data. Data collection continued until data saturation was

reached, with no new themes emerging from the final interviews. Member checking was also conducted by contacting selected participants to verify that the findings accurately reflected their experiences. In addition, a clear and detailed description of the study setting and participants was provided to enhance understanding of the context in which the data were collected.

Dependability

Dependability refers to the consistency and stability of the research process over time. Dependability was maintained through following a systematic and well-documented research process. This included clear procedures for participant recruitment, data collection through individual interviews, audio recording, transcription, and thematic analysis. Regular discussions with the research supervisor were conducted regarding the study findings and emerging themes to enhance the rigor of data interpretation. An audit trail was maintained through preserving interview recordings, transcripts, and analysis records throughout the research process.

Confirmability

Confirmability refers to the degree to which the findings are shaped by the participants rather than researcher bias, motivation, or interest. Confirmability was ensured by grounding the study findings in participants' own narratives as captured through audio recordings and verbatim transcripts. The researcher minimized personal bias by relying on the collected data during analysis and interpretation. The findings were supported by direct quotations from participants to demonstrate that the themes emerged from the data rather than the researcher's assumptions. In addition, all study documents, including audio recordings, transcripts, and analysis records, were maintained to ensure transparency.

Transferability

Transferability refers to the extent to which the findings can be applied or transferred to other settings or contexts with similar characteristics. Transferability was enhanced through providing a detailed description of the study setting, including the intensive care units, as well as participants' characteristics, time, the process of data collection and full description of data analysis process, and the research context. This rich contextual description enables readers to assess the applicability of the findings to similar clinical environments.

Procedure

The current study was conducted in two phases: the preparatory phase and the implementation phase. The preparatory phase focused on the development and preparation of the data collection tools, which included a demographic data sheet, semi-structured, face-to-face open-ended interview questions, and Audio tape recording. In addition, the necessary managerial approvals to conduct the study were obtained. The researcher submitted formal requests to the Hospital Director and the Director of the medical ICU. These requests were reviewed through the relevant departmental committee to obtain official approval for data collection.

Furthermore, this phase involved assessment of the study setting, included the physical layout of the medical ICU, the availability of nursing staff, and their willingness to participate and communicate. In addition, the researcher met with medical and nursing personnel to obtain clear information related to the unit workflow and staffing patterns. Permission was also obtained to be present in the unit during routine working shifts.

The implementation phase involved the actual data collection process. Data were collected through individual, face-to-face, semi-structured interviews with critical care nurses. The interviews were conducted in a private area within the medical ICU to maintain confidentiality and minimize interruptions. Each interview lasted approximately 30–45 minutes and was audio-recorded with the participants' permission to ensure accurate data capture. Prior to the interviews, the researcher explained the purpose of the study to the participants. Participants were informed that participation was voluntary, and they had the right to withdraw from the study at any time without any consequences. Data collection continued until data saturation was reached, when no new themes or information emerged from additional interviews.

Data were collected over a three-month period, starting at the beginning of July **(**2025**)** and completed by the end of September **(**2025**)**. After obtaining the necessary preliminary approvals, the researcher met with the director of nursing, the director of critical care, and the hospital manager to explain the aim of the study and submit an official letter from the Faculty of Nursing to obtain approval for data collection.

The researcher presented 2 days/week to collect data. Data was collected in the morning and afternoon. After participants agreed to participate, semi-structured, individual face-to-face interviews were conducted using a pre-prepared interview guide, which included open-ended questions designed to elicit the unique experiences, and perception of critical care nurses. Audio recording began once participants confirmed their willingness to be recorded. The interviews were conducted in Arabic, the language most comfortable for the participants.

Participants were encouraged to speak freely and describe their experiences in their own words. The researcher employed effective communication skills, including active listening and appropriate eye contact, to elicit detailed information. During the interviews, the researcher helped participants provide more in-depth explanations by asking clarifying questions such as, "What do you mean?" or "Please explain more about this." Interviews were conducted in the medical ICU**.**

To ensure participants' comfort, privacy, and convenience, interviews were conducted at suitable times within the ICU, taking into consideration the workflow and patient care demands. After all questions in the interview guide had been addressed, the researcher asked participants if there was any additional information they wished to share regarding their experiences and practices in critical care nursing. If participants continued to provide information, the researcher listened attentively. In cases where participants indicated that no further information was available or that they had nothing more to add, the researcher concluded the interview and thanked them for their participation.

At the end of each interview, the researcher informed the participants about the possibility of a second contact, either via telephone or, if feasible, during their work shifts in the medical ICU, to discuss the study findings and ensure that the results accurately reflected their experiences. Contact information for all participants was obtained. The second interviews were conducted through both telephone and in-person interviews within the unit. These follow-up interviews focused on checking and verifying the emerged themes to ensure the credibility of the data.

Ethical consideration:

Approval was obtained from the Scientific Research Ethics Committee of Faculty of Nursing at Capital University. The study facilitation letter to conduct the study was received from the department of postgraduate studies at Faculty of Nursing at Capital University and was sent to the nursing director of Bader Hospital. The researcher met with the head nurse and the medical intensive care unit manager to explain the purpose and procedures of the study. The meeting aimed to clarify the research objectives, discuss the unit workflow, and ensure that the study would not interfere with patient care or routine clinical responsibilities. Then, official permission for data collection was obtained. Formal consent was obtained from the nurses after informing them the purpose and nature of the study. Participation in the study was voluntarily and based on the nurses agreement to give informed oral consent. The researcher assured for maintaining anonymity and confidentiality of all nurses' data. Confidentiality was maintained on data collection forms by using codes to identify participants instead of names or any other personal identifiers. A master list of participant was kept separated from the data collection forms. All data collection forms were kept in a locked file in separate from the master list.

Data analysis:

The collected data were analyzed using Colaizzi's phenomenological method. Interviews were transcribed verbatim and read several times to obtain a general sense of the content. Significant statements were identified, and meaningful units were extracted and coded. These were then organized into themes and subthemes that reflected critical care nurses' experiences regarding barriers and facilitators of palliative care in intensive care units.

The main findings of this study were summarized as follows:

Table 1: age ranged from 24 to 32 years, with clinical experience ranging from 4 to 10 years. Equal gender distribution was observed among the studied nurses, with females and males each representing 50% of the sample. Regarding educational qualifications, the majority of nurses 65% graduated from Technical Nursing Institutes, whereas 25% held a Bachelor's degree and 10% held a Master's degree. In relation to employment status, most participants 95% were employed on a full-time basis. Furthermore, the vast majority of the studied nurses 90% had not attended any training courses related to palliative care.

Table 2: major themes and related subthemes

Show that presents the thematic analysis of critical care nurses' experiences regarding barriers and facilitators of palliative care in intensive care units. The analysis identified nine major themes and related subthemes reflecting the multidimensional nature of palliative care practice. These themes encompassed nurses' perceptions of palliative care as a concept, emotional experiences, professional and organizational challenges, communication with patients' families, ethical and moral dimensions, coping strategies, suggestions for improvement, the impact on professional identity, and interprofessional collaboration. Each theme was further divided into specific subthemes that provided a deeper understanding of nurses' lived experiences in ICU settings.

1.Perceptions of Palliative Care as a Concept: The baseline understanding of critical care nurses regarding their role was considered a foundational element that in turn led to varied clinical applications and conceptual variations. This theme includes two sub-themes: misunderstanding of palliative care and conceptual confusion.

Misunderstanding of Palliative Care: associating it with pain relief, comfort measures, and end-of-life support. The concept was frequently described in relation to managing symptoms when curative treatment is no longer possible, rather than as a holistic and early-integrated approach to serious illness care. Overall, participants tended to emphasize physical comfort and relief of suffering, with less recognition of the broader psychological, social, and comprehensive nature of palliative care. One of the participants reflected that: "Palliative care means maintaining the patient comfort and reducing their pain even if there is no definitive cure" (Participant: 1)

Conceptual Confusion: Getting a clear distinction between care models was not established among all involved participants. Approximately, more than two-fifths perceived palliative care as a concept identical to end-of-life care. Participants believed that both terms are applied only when the patient's condition is hopeless or during the end stage of a disease. One of the participants reflected that: "I don't think there's any difference between them; they're the same thing, just with different names, we apply both when the patient's condition is hopeless" (Participant: 4).

2. **Emotional Experiences of Palliative Care:** Despite providing a profound humanitarian role for many of the participants, delivering palliative care within critical care environments created intense psychological demands. This theme covers three sub-themes: experiencing emotional burden; empathic involvement; and compassion fatigue.

Emotional Burden: In the current study, the majority of studied nurses described their constant interaction with life-threatening conditions as an event which is emotionally heavy, leaving a profound psychological impact due to repeated exposure to situations of loss and death. Participants used terms such as carrying the burden, difficulty to disconnect, and feeling like losing a family member to describe the high intensity of distress. e.g., ''I go home worried about the cases; unfortunately, I don't know how to disconnect. These moments are very difficult for us'' (Participant: 14).

Empathic Involvement: Maintaining human empathy was a vital element for involved participants. All Participants indicated that empathic involvement is a core component of their experiences during providing care. Participants reflected an ongoing dedication to stand by their patients during the most difficult moments of life, stating: ''I sat with her and encouraged her to talk and express her feelings, reassuring her that her presence mattered. This experience made me realize that kind words and emotional support are essential parts of care'' (Participant: 2).

Compassion Fatigue: Ongoing exposure to critical conditions created severe emotional exhaustion. The majority of studied nurses reported compassion fatigue which made them more inclined to professional burnout or emotional withdrawal as a self-protection mechanism. For example, a participant stated: ''Dealing with a patient in need of palliative care is psychologically draining; I feel like I'm still carrying the burden of the patient even after I finish my shift'' (Participant: 7).

3. Professional and Organizational Challenges: Frontline nursing staff encountered significant institutional barriers that severely hindered the quality and safety of palliative care delivery. This theme covers three sub-themes: lack of support and inadequate training; imposed time constraints; and unclear roles.

Lack of Support and Inadequate Training: Getting professional organizational back-up was a critical failure reported by involved participants. All Participants were aware that they lacked standardized protocols, staff allocation, and professional training opportunities. This caused feelings of working under extreme pressure with reliance on trial and error. One of the participants reflected that: "we don't have clear protocols for palliative care in the ICU, and everything is done by trial and error. we are not trained in palliative care'' (Participant: 2).

Imposed Time Constraints: Imposed operational limitations emerged among approximately more than three-quarters of participants who perceived that large work pressure and high patient-nurse ratios limit their clinical functioning. Therefore, they put limitations on the time dedicated to psychosocial support, stating: "The workload is heavy, and there isn't enough time to sit with the patient or explain things in detail to their family'' (Participant: 4).

Unclear Roles: Many participants experienced significant confusion regarding their professional boundaries because of interdisciplinary conflicts. Approximately, more than half of the participants indicated that they faced role ambiguity especially regarding clinical decision-making and communication with families, reflecting that: "A major obstacle is that each specialty tries to prove that the case 'isn't their responsibility.' Instead of integration, some specialties simply aim to say, 'This isn't my responsibility,' and finish quickly'' (Participant: 48).

4. Communication with Patients' Families: Establishing effective contact with families was a highly sensitive and challenging task for involved participants. This theme covers three sub-themes: communication dilemmas; cultural sensitivity; and emotional negotiation.

Communication Dilemmas: In the current study, the majority of studied nurses described family interactions as a significant source of clinical friction. Participants faced persistent dilemmas balancing clinical honesty with preserving family hope, intensified by strict legal limitations on their medical authority. e.g., "Sometimes the patient's family wants hope, and we don't know how to balance honesty with their feelings. Sometimes we receive questions from the patient's family that we, as nurses, are not even allowed to answer'' (Participant: 4).

Cultural Sensitivity: Managing diverse background demands emerged as a critical element among all participants who perceived that cultural and religious beliefs significantly dictated how families responded to illness. Therefore, they adapted their speech and respected bedside religious practices, stating: "Sometimes we encounter situations related to culture and religion as leave holy books or religious symbols near the patient…I must respect the culture and religion of the patient and their family" (Participant: 45).

Emotional Negotiation: Ongoing contact required significant psychological adjustment from critical care staff. The majority of studied nurses reported emotional negotiation as a core element, describing an ongoing, exhausting effort to suppress their personal emotions while managing familial distress. For example, a participant stated: "It's natural for our feelings to be affected, but we always try to control our feelings when we talk to them" (Participant: 9).

5. Ethical and Moral Dimensions: Providing care to terminal cases within intensive settings introduced severe internal conflict regarding clinical duties. This theme covers two sub-themes: ethical dilemma and moral distress; and decision-making conflict.

Ethical Dilemma and Moral Distress: Facing moral conflicts regarding treatment futility was common among involved participants. More than half of the nurses described severe moral distress when forced to hide clinical truths at the family's request, or when continuing procedures that would not change the clinical outcome, reflecting that: "Sometimes the patient's family would ask me not to tell him the truth. while I believed that the patient had the right to know. The situation becomes difficult, and we continue with treatment procedures that we know will not change the outcome" (Participant: 1).

Decision-Making Conflict: Getting a shared collaborative decision-making framework was a major obstacle for involved participants. Several participants highlighted structural conflicts regarding patient autonomy, noting that legal structures like living wills or DNR orders are entirely unapplied in their setting, leaving them helpless against family obstruction. One of the participants reflected that: "Unfortunately, the concept of patient participation in treatment decisions, like what exists in other countries, such as writing a will not to perform CPR, is not implemented here" (Participant: 3).

6. Coping Strategies and Personal Support: staff deployed diverse adaptive frameworks to balance the intense emotional burdens associated with critical care demands. This theme covers three sub-themes: peer support; coping mechanisms; and emotional resilience.

Peer Support: Relying on clinical colleagues was a vital survival mechanism for involved participants. More than half of the participants designated peer support as an essential relief tool, emphasizing the unique value of disclosing shared professional distress to those on the same shift, stating: "Just having a colleague listen to me without commenting relieves me a lot. When a colleague shares the same experience, I feel like I'm not alone, and that relieves a lot of my stress'' (Participant: 7).

Coping Mechanisms: Controlling emotional distress required active personal engagement from critical care staff. All Participants reported utilizing diverse adaptive practices, including spiritual activities, post-shift

exercise, and reflective journals to release negative energy. For example, participants stated: "I pray and ask God to calm down. Exercise, especially walking after my shift, helps me get rid of negative energy" (Participant: 5).

Emotional Resilience: Navigating continuous exposure to terminal illness gradually built a dynamic, protective psychological capacity. All Participants clearly verbalized that continuous field exposure shifted their professional identity from emotional volatility to an adaptive state of endurance, reflecting that: "From the sheer number of cases, I've learned to deal with things calmly rather than emotionally. While working with these cases made me more resilient, at the same time I became stronger'' (Participant: 7).

7. Suggestions for Improvement: front-line professionals formulated clear organizational recommendations to optimize clinical delivery and safeguard practice. This theme covers three sub-themes: system improvement; policy recommendations; and team empowerment.

System Improvement: Demanding concrete structural adjustments was a unified response among involved participants. All Participants stressed the urgent need for optimizing nurse-to-patient staffing ratios, establishing dedicated units, and adding staff psychologists. e.g., "I suggest having a psychologist on the team to help the patient and their family. There needs to be a dedicated palliative care department, and we need people who are specialized in it" (Participant: 2).

Policy Recommendations: Getting standardized institutional protection was a critical requirement for involved participants. All Participants reported the absolute need for official procedure manuals to reduce professional confusion and prevent legal issues, stating: "We must have policies in place that we can implement and that protect us legally. Providing an official procedures manual will make it easier for us to deal with cases" (Participant: 15).

Team Empowerment: Building frontline capacity was highlighted by more than two-fifths of the studied nurses. Participants emphasized that institutional empowerment must include comprehensive specialized training and structured staff psychological support to counter high field burnout, reflecting that: "In my opinion, there needs to be psychological support and ongoing training for nursing staff working in palliative care. Because this field is extremely energy-intensive'' (Participant: 17).

8. Impact of Palliative Care on Professional Identity: Despite facing continuous clinical adversity, providing terminal care heavily transformed how participants viewed their long-term clinical role. This theme covers three sub-themes: growth; deeper empathy; and holistic perspective.

Growth: Contributing to palliative care directly enhanced the professional development of involved participants. All Participants confirmed that managing these complex clinical cases boosted their self-esteem, critical judgment, and clinical skills, elevating their view of nursing to an explicit mission. One of the participants reflected that: "I still feel that nursing is a mission, not just a job… it reinforces the value of humanity, compassion, and communication as an essential part of nursing" (Participant: 1).

Deeper Empathy: Prolonged clinical exposure significantly expanded the emotional capacity of involved participants. The majority of studied nurses reported a distinct redefinition of professional mercy, shifting their vision to prioritize humane care over clinical machinery. For example, a participant stated: "I became more patient and empathetic; I was able to see the patient as a human being before seeing them as a case or a file" (Participant: 2).

Holistic Perspective: Developing a comprehensive care paradigm was a prominent outcome for involved participants. The majority of studied nurses transitioned from a rigid biomedical focus to a broad model incorporating psychological and spiritual dignity, stating: "Palliative care made me see that nursing is not just physical therapy, but also psychological and spiritual support… our role is not only to prolong the patient's life, but also to make them feel comfortable during the time they have left" (Participant: 14).

9. Interprofessional Collaboration in Palliative Care: The final theme details the interdisciplinary climate surrounding terminal care delivery within tight ICU structures. This theme covers two sub-themes: team dynamics; and marginalization.

Team Dynamics: In the current study, the majority of studied nurses reported that interdisciplinary coordination heavily dictated overall clinical quality. While proper teamwork facilitated better family contact, participants noted a prominent operational gap where physicians focused strictly on medical tasks, leaving the psychological burden entirely to nursing staff. e.g., "Nurses handle most of the communication and emotional support, and doctors sometimes focus solely on medical treatment. I wish there was more balance" (Participant: 4).

Marginalization: Experiencing systematic professional exclusion was a major challenge for involved participants. All Participants reported experiencing poor clinical autonomy and complete exclusion from critical decision-making regarding terminal pathways. One of the participants reflected that: "The nursing perspective on patient care is not always considered. Although we have more contact and are closer to the patient, we are not always part of the final decision" (Participant: 3).

Table (1): Frequency and percentage distribution of the studied nurses according to their demographic characteristics (n=20).

Demographic Characteristics	Frequency (n)	Percentage (%)
Age		
• 24 - 25 years	6	30.0%
• 26 - 27 years	6	30.0%
• 28 - 29 years	4	20.0%
• 30 - 32 years	4	20.0%
Gender		
• Male	10	50.0%
• Female	10	50.0%
Educational Level		
• Technical Nursing Institute	13	65.0%
• Bachelor's Degree	5	25.0%
• Master's Degree	2	10.0%
Experience in Nursing (years)		
• 4 - 5 years	10	50.0%
• 6 - 7 years	6	30.0%
• 8 - 10 years	4	20.0%
Work Status		
• Full-time	19	95.0%
• Part-time	1	5.0%
Attending Palliative Care Courses		
Yes	2	10.0%
• No	18	90.0%

Table (2): major themes and related subthemes

Themes	Subthemes
Theme 1: Perceptions of Palliative Care as a Concept	• Misunderstanding of palliative care • Conceptual confusion
Theme 2: Emotional Experiences of palliative care	• Emotional burden • Empathic involvement • Compassion fatigue
Theme3: Professional and Organizational Challenges	• Lack of support • Inadequate training • Time constraints • Unclear roles
Theme 4: Communication with Patients' Families	• Communication dilemmas • Cultural sensitivity • Emotional negotiation
Theme 5: Ethical and Moral Dimensions	• Ethical dilemma and moral distress • Decision-making conflict
Theme 6: Coping Strategies and Personal Support	• Peer support • Coping mechanisms • Emotional resilience
Theme 7: Suggestions for Improvement	• System improvement • Policy recommendations • Team empowerment
Theme 8: Impact of Palliative Care on Professional Identity	• Growth • Deeper empathy • Holistic perspective
Theme 9: Interprofessional Collaboration in Palliative Care	• Team dynamics • Marginalization

II. Discussion

The present study revealed that most participants had between four and seven years of nursing experience, while a smaller proportion had between eight and ten years of experience. This diversity in clinical experience enriched the understanding of critical care nurses' lived experiences regarding palliative care. Nurses with greater clinical exposure appeared to develop a deeper understanding of patients' palliative care needs and the complexities associated with end-of-life care. This finding is consistent with **Wells and Bressler, (2023),** who reported that repeated exposure to critically ill and dying patients contributed significantly to shaping nurses' perceptions, emotional responses, and professional approaches toward palliative and end-of-life care. Experienced nurses demonstrated greater awareness of the challenges associated with symptom management, communication with families, and ethical decision-making in critical care settings. Similarly, **Schallenburger, et al. (2024)** emphasized that nurses' clinical experience plays a crucial role in recognizing palliative care needs among critically ill patients and in facilitating timely integration of palliative care principles within intensive care settings.

Regarding educational preparation, the majority of participants were graduates of Technical Nursing Institutes, whereas fewer participants held bachelor's or master's degrees. Educational background may influence nurses' understanding of palliative care concepts and their readiness to address the multidimensional needs of patients receiving palliative care. This finding is supported by **Almahrizi, et al. (2025),** who found that critical care nurses frequently demonstrated deficiencies in palliative care knowledge, particularly in symptom management, communication, and psychosocial aspects of care. The authors emphasized that higher educational preparation was associated with better understanding of palliative care principles and increased readiness to provide comprehensive patient-centered care.

Likewise, **Hävölä, et al. (2024)** reported that healthcare professionals identified educational preparation and continuing professional development as essential requirements for achieving competence in palliative care practice. The study highlighted that insufficient educational preparation may hinder healthcare providers' confidence and effectiveness when caring for patients with palliative care needs.

The present study revealed that only a small proportion of participants had attended palliative care training courses, whereas the vast majority had received no formal education or training in palliative care. This finding may explain many of the challenges, uncertainties, and educational needs expressed by participants throughout the study. This finding is congruent with **Wells and Bressler, (2023),** whose qualitative study identified that many critical care nurses felt "unaware and unprepared" when providing end-of-life care because of inadequate education and limited formal preparation in palliative care. Participants emphasized the need for specialized training programs to improve their competence and confidence in managing palliative care situations.

Similarly, **Gill, et al. (2024)** demonstrated that participation in palliative care training significantly enhanced healthcare professionals' confidence, professional fulfillment, communication abilities, and overall preparedness for providing palliative care. The study concluded that structured palliative care education is essential for improving the quality of care delivered to patients with life-limiting illnesses. Furthermore, recent evidence highlighted by Almahrizi et al. (2025) indicated that critical care nurses continue to experience important knowledge gaps in palliative care, reinforcing the need for ongoing education and specialized training programs to strengthen nurses' competencies and support effective palliative care integration within critical care settings.

The findings of the current study revealed that critical care nurses demonstrated varied and sometimes unclear perceptions of palliative care, with some associating it primarily with end-of-life care while others viewed it as a broader approach focused on comfort and quality of life. This variation may reflect differences in educational preparation as well as the dominant curative focus within ICU settings. These findings are supported by a qualitative study by **Omidi, et al., (2025),** titled "ICU nurses' perceptions of palliative care", which reported similar issues in nurses' Misunderstanding of palliative care. This suggests that nurses' conceptualization of palliative care is influenced not only by knowledge gaps but also by the prevailing clinical culture in critical care settings, highlighting the need for structured education and integration of palliative care principles into practice.

The findings of the current study revealed that critical care nurses experience significant emotional challenges while providing palliative care, particularly when caring for dying patients and supporting their families. These emotional experiences may be associated with continuous exposure to death, emotional attachment to patients, and the complexity of end-of-life care situations. This is consistent with a recent qualitative study by **Espejo-Fernández and Martínez-Angulo, (2025),** titled "Psychosocial and emotional management of work experience in palliative care nurses: A qualitative exploration", which highlighted that nurses frequently experience psychological distress, emotional burden, and the need for ongoing emotional regulation in palliative care settings. The study emphasized that managing these emotional demands is an integral part of nursing practice and requires effective coping strategies.

The findings of the current study indicate that critical care nurses encounter significant professional and organizational challenges that affect the delivery of palliative care in intensive care settings. These challenges are reflected in heavy workload, time constraints, and lack of specialized training, and insufficient institutional support, all of which may hinder the provision of holistic and patient-centered care. This is supported by da **Cunha, et al.,**

(2026), in the study titled "Palliative Care in Intensive Care Units: Nurses' Perspectives on Challenges and Strategies", which identified multiple barriers related to organizational constraints, insufficient training, and lack of clear protocols, in addition to challenges associated with communication and interdisciplinary collaboration. The study further highlighted that institutional limitations and resource constraints significantly impact nurses' ability to deliver comprehensive palliative care.

The findings from the present study reveal that communication with patients' families is a critical and challenging aspect of palliative care in intensive care settings. Participants described difficulties related to discussing poor prognosis, treatment limitations, and end-of-life issues with families who often experience fear, anxiety, denial, and emotional distress. Nurses reported the challenge of balancing honesty and transparency with the need to preserve hope and minimize psychological harm. They also emphasized the importance of providing emotional support, listening to family concerns, and communicating information in a clear and culturally sensitive manner. These findings suggest that effective communication in palliative care extends beyond the provision of information to encompass emotional, psychological, and supportive dimensions throughout the care process. These findings are supported by **Schwalbach, et al., (2025),** in the study titled "Family Bereavement Support Interventions in Specialist Adult Palliative Care: A Rapid Mixed-Methods Systematic Review," which found that structured communication and family support interventions before and after loss can reduce anxiety, grief, and psychological distress when care is individualized and accessible. The study further highlighted the importance of continuous communication and emotional support for families throughout the palliative care journey.

The findings from the present study further indicate that nurses frequently encounter emotional and ethical challenges during communication and decision-making processes in palliative care. Participants described difficulties in balancing truthful communication with sensitivity to the emotional state of patients and their families, particularly when discussing serious illness, treatment limitations, or end-of-life issues. Nurses also reported challenges when family expectations or preferences differed from what they perceived to be in the patient's best interest, creating emotional tension and uncertainty during care discussions. Furthermore, participants emphasized the need to carefully manage their own emotions while supporting patients and families through highly stressful situations. These findings are supported by **Kennedy, et al., (2025),** in the study titled "Relational Nature of Decision-Making Between Patients with Advanced Illness and Their Caregivers in Palliative Care: A Systematic Review and Narrative Synthesis," which highlighted that decision-making in palliative care is strongly influenced by communication patterns, emotional dynamics, family involvement, and the relationships between patients and caregivers. The study demonstrated that these factors can significantly affect the quality and timing of decisions and may contribute to emotional and ethical challenges for healthcare professionals.

The findings from the present study indicate that palliative care nurses utilize both interpersonal and individual coping strategies to manage emotional and occupational stress. Participants highlighted that peer support from colleagues represents a primary coping mechanism, where sharing experiences with coworkers who understand the clinical context helps in relieving emotional burden. Being listened to without judgment and discussing difficult cases with colleagues were reported as important sources of emotional relief. In addition, working within the same shift with peers who share similar experiences contributed to a sense of solidarity and reduced feelings of isolation. Participants also reported the use of individual coping strategies such as prayer, physical activity, and expressive writing. These strategies were described as helpful in regulating emotions, reducing psychological tension, and facilitating mental detachment from work before returning home. Some nurses also adopted cognitive coping approaches, such as accepting the limits of their role and recognizing that clinical outcomes are beyond their control. These findings are supported by **Bovero, et al., (2025)** , in the study titled "Self-Care in Palliative Healthcare Professionals: A Qualitative Study", which emphasized that palliative care professionals rely on a combination of emotional coping strategies, peer support, and lifestyle-based self-care practices to manage work-related stress. The study further highlighted the importance of collegial interaction and reflective practices in enhancing emotional well-being and team cohesion.

The findings of the present study highlight the need for comprehensive improvements in palliative care systems to enhance both patient care and healthcare professionals' wellbeing. Participants emphasized the importance of strengthening workplace support, increasing staffing levels, providing continuous training, and establishing clear policies and structured palliative care services. They also stressed the need for dedicated psychological support services and the formal integration of palliative care within healthcare systems to reduce workload pressure and improve the quality of care delivery. These findings are supported by **Patynowska, et al., (2026),** in the study titled "Workplace support, wellbeing and intention to leave among lone working healthcare assistants providing palliative and end-of-life care in the community: A mixed methods study", which demonstrated that targeted workplace support strategies are essential for improving wellbeing and reducing intention to leave among palliative care staff. The study further highlighted that adequate staffing, structured supervision, and accessible support systems significantly contribute to workforce sustainability and service quality.

The findings of the present study demonstrate that exposure to palliative care has a profound impact on nurses' professional identity, leading to a shift from a task-oriented perception of nursing to a more meaningful,

human-centered, and value-driven practice. Participants reported that working in palliative care strengthened their sense of purpose, enhanced their emotional engagement with patients, and reinforced the importance of compassion, presence, and ethical responsibility in nursing practice. This transformation reflects a deeper appreciation of the relational and moral dimensions of care. These findings are supported by **Létourneau, et al., (2025),** in the study titled "Professional identity and moral agency in palliative care: A review", who highlight that professional identity in palliative care is shaped by meaningful relationships with patients, advocacy for patient preferences, and recognition of the nurse's role in providing holistic care. The study further emphasizes that restrictive organizational cultures, workload pressures, and biomedical dominance may undermine professional identity and contribute to moral distress among nurses.

The findings of the present study highlight that interprofessional collaboration is a key component of effective palliative care delivery, where coordination between healthcare professionals directly influences the quality and continuity of care. Participants reported that nurses often play a central role in patient communication and emotional support, while physicians tend to focus more on medical management. This sometimes creates an imbalance in responsibilities and highlights the need for more integrated teamwork and shared understanding among disciplines. Participants also expressed concerns regarding limited involvement of nurses in final clinical decision-making, despite their close and continuous interaction with patients. This perceived marginalization may reduce professional satisfaction and affect collaborative efficiency. However, when effective communication and mutual respect exist within the team, care becomes more coordinated and patient outcomes improve significantly. These findings are supported by **Chin, et al., (2026),** in the study titled "Deprescribing for patients nearing end of life: views, barriers and facilitators of palliative care patients, carers and nurses", who emphasize that optimal palliative care requires strong interprofessional collaboration among nurses, physicians, patients, carers, and pharmacists. The study highlights that organisational support, clear communication, and shared decision-making facilitate effective deprescribing and enhance the quality of end-of-life care.

III. Conclusions

In conclusion, the present phenomenological study provided a comprehensive understanding of critical care nurses' lived experiences regarding palliative care within intensive care units. The findings revealed that nurses' perceptions of palliative care were influenced by conceptual ambiguity and limited understanding of its scope in critical care practice. Their experiences were characterized by significant emotional involvement, including emotional burden, empathic engagement, and compassion fatigue, in addition to multiple professional, organizational, communicative, and ethical challenges such as inadequate training, lack of institutional support, time constraints, moral distress, and difficulties in communication and end-of-life decision-making with patients' families. Despite these challenges, nurses demonstrated resilience through various coping strategies and relied on both personal and professional support systems to manage the emotional demands of care. Overall, the study highlighted that engagement in palliative care contributes to shaping nurses' professional identity by fostering personal growth, enhanced empathy, and a more holistic approach to patient care, while emphasizing the need for improved education, organizational support, and interdisciplinary collaboration to strengthen the integration and quality of palliative care in intensive care settings.

IV. Recommendations

Based on these findings of the present study the researcher recommended.

- Implement structured educational and training programs to improve critical care nurses' understanding of palliative care and reduce conceptual confusion regarding its scope and practice.
- Provide continuous professional development and ICU-based workshops to enhance nurses' competence and confidence in delivering palliative care.
- Establish psychological support systems for critical care nurses to address emotional burden, compassion fatigue, and empathic stress, including counseling services and structured debriefing sessions.
- Further qualitative and quantitative studies are recommended to explore the effectiveness of structured palliative care training programs in improving ICU nurses' competencies and patient outcomes.
- Future research should also investigate family perspectives regarding palliative care communication in intensive care units to develop more comprehensive care models.

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