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Original Article

Nurses' Experience Facing Terminally Ill Patients in Tunisian Intensive Care Units: A Qualitative Study

Hamdi Fatma[1]*, Hdhiri Achref[1], Mansouri Hakima[1,2,3]

[1]*Higher School of Health Sciences and Techniques of Sousse, University of Sousse, Sousse, Tunisia*
[2]*Faculty of Nursing Sciences, University of Laval, Québec, QC, Canada*
[3]*LR21ES03 Research Laboratory "Oncogenesis and Tumor Progression", Faculty of Medicine of Sousse, University of Sousse, Tunisia*

Abstract

Background: Palliative care is essential in Intensive Care Units (ICUs), where many patients face life-threatening conditions and may not survive. ICU nurses are at the frontline of End-Of-Life (EOL) care, requiring strong competencies in communication, empathy, and symptom management. They also face significant emotional and ethical burdens when caring for dying patients. A deeper understanding of their experiences is crucial to improving the quality and delivery of EOL care in critical care settings. This study aimed to explore the experiences of nurses caring for terminally ill patients in the Intensive Care Units (ICUs).

Methods: This qualitative descriptive study was conducted in the ICUs of Sahloul University Hospital in Sousse, Tunisia. Five experienced nurses from three different units were purposively selected. Data were collected through semi-structured interviews using a semi-structured interview guide, inspired by Jean Watson's philosophy, which comprises fourteen open-ended questions examining perceptions, emotions, support practices, and barriers. Data were analysed inductively using Paille's five-step model.

Results: The data analysis revealed five main themes: (1) The representation of the concept of "End-of-life" by healthcare staff, (2) The emotions experienced, (3) The specific support provided, (4) The barriers raised, and (5) The psychological support for the patient and family. These five themes covered fourteen sub-themes.

Conclusion: This Research emphasizes the need for strong interpersonal skills, patient-centred strategies, and effective communication with both family and patient, to improve care and support caregivers in their crucial roles to provide palliative care.

Keywords: End-of-life - Intensive care - Palliative care - Experience - Nurses – Caring

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1. Introduction

Intensive care is a specialized ward of healthcare for patients with life-threatening conditions, severe injuries, or organ failure. It is provided by a team of healthcare professionals in the Intensive Care Units (ICUs) and extends to emergency care, treatment of very ill patients, and follow-up care after treatment [1].

However, it is important to note that not all individuals receiving such care will recover [2]. Thus, the focus of care may shift from aggressive life-sustaining interventions to situations in which patients become dependent and require external support [3,4]. In these circumstances, the role of ICU nurses transitions from curative treatment to providing End-Of-Life (EOL) care [3]. In this context, EOL care represents a key aspect of the responsibilities of intensive care nurses, who are uniquely positioned to collaborate with families in delivering care to patients during their final stages of life [5]. Hence, the EOL situation calls for palliative care, which, according to the World Health Organization (WHO), is an approach designed to enhance the quality of life for patients and their families dealing with potentially life-threatening illnesses. It focuses on preventing and relieving suffering through early recognition, accurate assessment, and treatment of pain and other issues, whether physical, psychosocial, or spiritual [7].

Although the aims of palliative care and critical care may initially seem different, their values and goals are similar, as saving or prolonging life may conciliate with alleviating suffering and enhancing quality of life, and death [8]. Once limited to hospice support, palliative care is now recognized as an integral component of ICU practice, guided by core ethical principles such as autonomy, beneficence, nonmaleficence, justice, and fidelity [9]. Indeed, most patients in these units experience unrelieved and distressing symptoms [9].

Importantly, an estimated 14 to 20% of ICU patients meet the typical criteria for palliative care consultation [10]. Furthermore, the integration of palliative care into ICU settings has been associated with measurable clinical and economic benefits. A study conducted in Lebanon among 346 patients who received palliative care consultations demonstrated a 10% reduction in daily hospital costs, reinforcing the cost-effectiveness of such interventions even in resource-limited settings [11].

*Corresponding Author: Fatma Hamdi, fatma.hamdi@esstsso.u-sousse.tn/ hamdifatma301@gmail.com

ICU nurses deliver continuous, compassionate care [17], yet this role is demanding [12]. Their constant presence at the bedside positions them as not only caregivers but also educators and coordinators, ensuring holistic support for patients and families [13]. In this context, healthcare professionals are exposed to a substantial emotional and moral burden resulting from sustained engagement with suffering, death, and complex clinical situations [14]. Moreover, The complexity of decision-making and care practices exposes them to ongoing ethical dilemmas that can affect their emotional stability [14]. To manage this burden, healthcare professionals adopt emotional strategies to cope with the stress and uncertainty associated with patient care [15]. Nevertheless, prolonged exposure to these conditions is associated with adverse psychological outcomes, including anxiety, depression, and complicated grief [16].

Yet, despite growing demand for high-quality EOL care, its delivery in ICUs remains limited and often below standards [3], hindered by barriers related to patients and families, healthcare providers, and institutions [3].

Thus, critical care nurses identified the most significant barriers to EOL care as a heavy workload, inadequate ICU design, and unrestricted visiting hours. Family-related challenges included a lack of understanding regarding life-sustaining interventions and frequent demands for updates. Additionally, nurses reported insufficient training in grief management and EOL care, as well as difficulties in understanding patients' preferences due to communication barriers. Institutional barriers included nurses being excluded from care planning and inconsistent physician opinions on treatment approaches [17]. Therefore, high-quality EOL care demands personal reflection on nurses' core values, the development of interpersonal skills, and the acquisition of theoretical knowledge from various disciplines in order to fully understand the complexity of human nature [18]. These considerations highlight the need for further research to identify the most effective strategies for delivering palliative care to ICU patients and their families [9].

To support and deepen this insight, particularly in the context of EOL care, this study draws upon Jean Watson's Theory of Human Caring (1979). Rooted in a humanistic perspective, the theory emphasizes compassion, empathy, and authentic presence, highlighting the significance of holistic care that addresses emotional, spiritual, and psychological dimensions. By promoting a person-centred approach, it reinforces the importance of establishing trusting relationships that support well-being, healing, and dignity at the EOL [19].

Despite extensive international research on ICU nurses' experiences of end-of-life care, evidence remains limited in Tunisia, where ICU practices, resources, and cultural norms differ. Therefore, exploring nurses' experiences in Tunisian ICUs is essential to address this research gap and to inform context-specific strategies for supporting healthcare professionals in emotionally demanding situations. In this regard, this study aimed to explore the experiences of nurses caring for terminally ill patients in ICUs.

2. Methods

Research design

This study adopted a qualitative descriptive design to explore the experiences of nurses caring for terminally ill patients in Tunisian ICUs, as this approach provides a clear and detailed understanding of the phenomenon while recognizing that reality is shaped by the meanings individuals assign to their experiences [20,21]. Thus it allows for an in-depth exploration of a phenomenon from the participants' perspective, offering insights into what is experienced and how it is lived [22],which directly supports the aim of this research.

Sampling and setting

The study was conducted in the ICUs of Sahloul University Hospital, located in Sousse, Tunisia. This hospital was selected due to its large capacity, the diversity of its ICU services, and its status as a regional reference center for care. The ICUs included the Surgical ICU, Medical ICU, and the Post-Operative Critical Care Unit (POCCU). These units are organized into multiple sections with single-patient rooms, and nurse-to-patient assignments typically range from two to three patients per nurse. Each unit is staffed by a multidisciplinary team, including specialized nurses. This organizational structure provides a representative context for exploring nurses' experiences in intensive care settings.

A purposive sampling strategy was employed to recruit nurses who had substantial experience with EOL care, were able to articulate their experiences clearly, and were willing to participate in in-depth interviews [20].

Inclusion criteria required participants to have at least one year of professional experience in their respective specialty areas (intensive care, surgical, medical, and post-operative critical care units), to ensure that participants possessed sufficient exposure to unit routines and the emotional and clinical demands of EOL care. Exclusion criteria encompassed interns, nurses with less than one year of experience, and individuals who declined participation. Eligible participants were approached directly within their units. Demographic and professional variables such as gender, years of experience, and prior training in palliative care, were collected to contextualize the sample and support a comprehensive interpretation of participants' perspectives. The final sample included five participants, offering diverse clinical contexts that enriched the perspectives on EOL care in the ICU.

Data collection tools

To gather qualitative data, a semi-structured interview guide was developed based on Jean Watson's Theory of Human Caring. The guide aimed to explore nurses' experiences and perceptions of EOL care within intensive care settings. Prior to the interviews, participants completed a brief sociodemographic questionnaire. The interview guide was reviewed and validated by two faculty members with expertise in qualitative research to ensure the clarity and relevance of the questions. Data collection took place between January and

February 2024 and was discontinued once data saturation was reached, meaning that no new information, insights or themes emerged from additional interviews[22]. Saturation is commonly observed in focused and homogeneous clinical contexts such as ICUs, where professional roles and care responsibilities are closely aligned.

The interview guide, inspired by Jean Watson's Theory of Human Caring, comprised fourteen open-ended questions organized into thematic areas. The questions explored participants' professional background, including education, specialization, and work experience. Questions 2 to 4 examined personal perceptions, emotional responses, and attitudes when confronted with EOL situations (e.g., "How do you perceive the end-of-life phase in patient care?"; "How do you feel when facing a patient's end-of-life situation? Could you describe this feeling in your own words?"), reflecting Watson's emphasis on the subjective, relational dimension of care. Questions 5 and 6 focused on the knowledge required and the care approaches used in these sensitive contexts (e.g., "Can you describe your approach to care in this type of support?"). Questions 7 to 10 addressed the challenges encountered by nurses, their strategies for creating a supportive environment, and their efforts to maintain patient dignity, comfort, and peace elements aligned with Watson's caring practices (e.g How do you ensure comfort, dignity, and peace for yourself, the patient, and sometimes the family, despite the obstacles encountered?). Question 11 explored the tools used to assess symptoms such as pain and anxiety, while Questions 12 and 13 examined psychological support for families and nurses' involvement in medical decision-making, particularly regarding treatment withdrawal (e.g How do you provide psychological support to the patient's family, and how do you involve them during this phase of life?). The final question (14) focused on interdisciplinary collaboration and coordination in delivering EOL care.

Overall, the guide allowed for rich, in-depth narratives while providing a structured framework grounded in Watson's Theory of Human Caring to ensure consistency across all interviews

Procedure

One to two interviews were conducted per day at the participants' workplace, according to their shift availability (morning, afternoon, or night shifts). Each 30-45 minute the interviews were conducted in a quiet, private rest room to promote comfort, openness, and in-depth discussion. Prior to the interview, participants were given a brief verbal reminder of their rights, followed by the signing of an informed consent form.

All interviews were conducted in French and audio-recorded using two smartphones to ensure recording quality. Recordings were transcribed verbatim, a process taking three to four hours per interview, and the anonymized transcripts were securely stored digitally. In accordance with ethical guidelines, audio recordings were deleted one year following the dissemination of study findings. No follow-up interviews were considered necessary.

Data analysis

Interview data were analysed using Paille's inductive model of qualitative data analysis, which comprises five interconnected steps: coding, categorization (thematization), establishing relationships, presenting results, and verifying the data [23]. This method provided a systematic yet flexible framework suitable for exploring nurses' experiences of end-of-life care in intensive care units, while capturing the depth and complexity of their perspectives. The analysis followed a sequential process. First, during the coding phase, verbatim transcripts were segmented into meaningful units known as codes, reflecting nurses' perceptions, emotions, care practices, and challenges related to EOL situations in the ICU. These codes captured key ideas, recurring expressions, and common patterns emerging from the participants' narratives [23].

In the categorization phase, related codes were grouped into broader categories or themes corresponding to the study objectives, including nurses' conceptualization of EOL care, experienced emotions, provided support, perceived barriers, and psychological support for patients and families.

During the linking phase, relationships between the emerging categories were analysed to develop a holistic understanding of how nurses experience and manage EOL care within the intensive care context. The results were then presented through narrative descriptions, supported by tables and visual representations [23],

Finally, during the verification phase, the consistency and credibility of the findings were carefully assessed to ensure that the results faithfully reflected both the verbatim interview data [23] and nurses' reported experiences of EOL care in ICUs. Furthermore, Discrepancies between coders were systematically examined and resolved through reflexive dialogue and iterative discussions between the researchers until consensus was reached. This collaborative process, supported by the stepwise structure of Paillé's inductive model, contributed to the validation of themes related to emotional experiences, care practices, and perceived barriers, while preserving the authenticity of participants' narratives and reinforcing the credibility and clarity of the findings.

Ethical Considerations

This study adhered strictly to ethical and deontological guidelines throughout the research process. Administrative authorization for data collection was obtained from the relevant department heads. Informed and voluntary consent was secured from all participants using standardized consent forms, which included comprehensive information about the study's objectives, procedures, and participants' rights. The principles of anonymity and confidentiality were rigorously maintained: all recordings and transcripts were stored on password-protected computers and smartphones, accessible only to the research team, to ensure secure handling of all data.

3. Results

This section presents the results derived from semi-structured interviews (n = 5) conducted with ICU nurses at Sahloul University Hospital, aiming to explore their experiences in caring for terminally ill patients.

Participant Characteristics

Table 1 summarizes the sociodemographic and professional characteristics of the participants. The median age of participants was 38 years [30-50], and the median duration of professional experience in intensive care was 13.5 years [3-27]. The sample included three female and two male nurses, all residing in urban areas. Regarding their workplace, two nurses were employed in the surgical ICU, two in the POCCU, and one in the medical ICU. This diversity of clinical backgrounds provided a multifaceted view of EOL care practices in critical care settings. To ensure confidentiality, closed coding was applied, and each participant was assigned a code ranging from V1 to V5 (Table 1).

Key themes identified

The analysis revealed five main themes: (1) Nurses' conceptualization of the "EOL", (2) Emotions experienced, (3) Specific care and support provided, (4) Perceived barriers, and (5) Psychological support for patients and their families.

To support in-depth analysis, each primary theme was further broken down into sub-themes (Table 2).

Theme 1: Nurses' conceptualization of the "End-of-life"

According to participants, the concept of "end-of-life" is complex and multidimensional. Thus, their interpretations highlighted how professional experience and personal beliefs shape their understanding of the term.

Subtheme 1a: Palliative care

The participants commonly associated EOL with the initiation of palliative care measures, emphasizing the importance of relieving suffering and ensuring patient comfort. Accordingly, pain management and proper sedation are prioritized to maintain patient comfort at the EOL.

"When I think of a patient at the EOL, I think of palliative care, where the aim is to ensure that they feel no pain, by being in a state of sedation. That is all that comes to mind in these situations." (V2)

Subtheme 1b: Disconnection from the outside world

In the context of EOL care in the ICU, several participants noted a sense of disconnection from the outside world. While they acknowledged the difficulty of accepting inevitable death, they recognized it as an inherent and routine aspect of nursing practice. Nonetheless, participants expressed heightened emotional sensitivity when the dying patient was young, reflecting deeper empathy and a particular distress associated with premature or tragic cases.

"… it is a disconnect from the outside world, and although it is hard to admit, it is a common reality. However, I am particularly affected when it comes to a young patient." (V3)

Subtheme 1c: Death

One participant conveyed a particularly minimalist and emotionally detached view of the end of life, stating: "I don't have much to add, but to me, an EOL patient is simply a person who is destined to die, nothing more." (V4)

This statement reflects a reductionist and limited perspective, characterized by the absence of emotional, spiritual, or existential dimensions. The participant appears to conceptualize the EOL as a natural and inevitable biological event, adopting a primarily objective position.

Theme 2: Emotions experienced

Interviews revealed a spectrum of complex emotional responses to end-of-life experiences, including suffering, resilience, and, in some cases, avoidance of contact.

Subtheme 2a: Suffering

Several emotional challenges encountered by nurses during EOL care were identified. Notably, they expressed distress when their hopes for patient recovery remained unfulfilled. Thus, the confrontation with the limitations of medicine and the inevitability of death often contributed to feelings of demoralization. However, over time, many professionals appeared to develop strategies to cope with the challenges of EOL care.

"There are pain and disappointment at times, as we sometimes hope for the patient's recovery, but when we know the fatal outcome, it demoralizes us. Over time… however, these feelings can fade, as they are an inherent part of our work." (V3)

Subtheme 2b: Resilience

Resilience can be defined as a positive mechanism for change that occurs over time and serves as a protective factor against psychological distress [24]. In this regard, cultivating resilience allows healthcare professionals to better sustain composure, preserve inner peace and emotional stability, and effectively navigate the demands of EOL care. This perspective aligns with the experiences shared by participants.

"I try to do everything I can for him, keeping in constant contact and staying calm so I can respond effectively. Otherwise, the situation is likely to get worse." (V3)

"I stayed calm and read him the Koran and the Shahada, … and that is all I could do… Even if he is dying, I treat him like any other bedridden patient in the intensive care unit in terms of hygiene and daily care, …." (V4)

Subtheme 2c: Avoidance of contact

The participants demonstrated awareness of the negative impact of certain patients' relatives. In such cases, they limited interactions with individuals perceived as emotionally harmful or distressing to protect their own emotional well-being and maintain focus on the patient. This was particularly noted by participant V2.

"I prefer to avoid communicating with the family, as my words are sometimes misinterpreted, which can lead to aggression on their part. My priority is to feel comfortable in the situation." (V2)

Theme 3: Specific support provided

According to the participants, specific support during the EOL phase results from a harmonious combination of knowledge, communication, empathy, and a balanced approach to both humanistic and technical aspects of care.

Subtheme 3a: Knowledge

Nurses stressed the necessity of knowledge, particularly concerning psychological aspects. They further highlighted the need for a holistic approach that encompasses physical, emotional, and cultural dimensions to ensure the delivery of optimal care.

"…knowledge is constantly evolving, and each patient requires a unique approach with no fixed standards. The most important knowledge we need to acquire is psychological, so that we can respond to each patient in the best possible way." (V3)
"…the psychological aspect is of paramount importance in the treatment process. These approaches are all linked by the training and practical and theoretical knowledge of health professionals, recognizing that patient comfort does not depend solely on medical treatment." (V5)

Subtheme 3b: Experience and Communication Skills

The value of experience and communication skills was emphasized, particularly in the care of critically ill patients. Additionally, participants emphasized the differing approaches required for unconscious versus conscious patients, reinforcing the crucial role of empathy and communication when interacting with conscious individuals.

"Solid experience in this field is essential. When I take charge of an unconscious, intubated and ventilated patient, I limit myself to performing the necessary gestures. However, if he is conscious, it is crucial to know how to communicate with him, and to adopt an emotional and psychological approach, as he is particularly vulnerable at this stage. It is important to try and find out what he likes, so that he does not feel treated like a mere object." (V1)

Subtheme 3c: Human-centred and technical care approaches

According to the participants, human-centred care refers to the relational and emotional aspects of caregiving, such as active listening, emotional support, empathetic communication, and respect for dignity, comfort, and peace.

"Sometimes, I recommend reading the Quran to find inner peace." (V3).

In contrast, technical care refers to the clinical skills and medical interventions necessary for patient management. These include pain assessment (e.g., Visual Analog Scale, Numeric Rating Scale, physiological monitoring), anxiety evaluation (e.g. Generalized Anxiety Disorder scale), and assessment of consciousness (e.g., Glasgow Outcome Scale) along with medication administration and monitoring of vital signs. Both dimensions contribute to establishing a supportive and comprehensive care environment.

"We use a synchronized scale called GAD (General Anxiety Disorder) to assess both anxiety and depression because anxiety can lead to depression and vice versa. To assess pain, we use a simple self-report scale like a VAS (Visual Analog Scale) when I am the one doing the assessment. If I want to involve the patient in the assessment, we could use a numerical scale, for example." (V5).

Theme 4: Perceived barriers

In the sensitive context of EOL care, it is essential to identify both the emotional and practical barriers faced by nurses, as well as the strategies they employ to maintain a supportive environment for patients and their families.

Subtheme 4a: Identification of barriers

According to participants, heavy workloads and intense routines can compromise care quality and increase the risk of staff demotivation. Additionally, aggressive behaviour from patients' relatives can create a tense and stressful work environment that further undermines nurses' emotional well-being. The lack or failure of treatment often leads to frustration, as healthcare professionals feel powerless in the face of the patient's deteriorating condition. Moreover, limited direct contact with the patient, often due to physical limitations or specific care protocols, can make it difficult to establish empathetic connections.

"For intensive care unit staff, when we are overloaded with an intense routine and know that a patient is terminally ill, it can have a demoralizing impact on us. The quality-of-care declines unconsciously, influenced by human nature and the circumstances around us. Sometimes, families can be aggressive towards us, blaming us for the patient's condition compared to what it was before. This happens especially when we announce that the patient is going to die, this aggressiveness often being due to a lack of knowledge on their part about the disease. Other obstacles may also be present, such as the lack of analgesic treatment, although these may seem negligible." (V1)

Subtheme 4b: Management of the stressful environment

Despite the challenges encountered, participants described several coping strategies, including limiting interactions with family members, maintaining vigilance, and adhering to safety measures.

"First of all, I take care to maintain safety measures, both for myself and for the patient. I also make sure the patient's hygiene is good. For the family, I try to maintain trust by calming them down and limiting my words, as it is the doctors' responsibility to explain the situation." (V3)

Nevertheless, perceptions of the work environment varied: while some participants considered their wards to be supportive, others did not. The latter emphasized the need to adapt communication protocols, implement psychological support measures, ensure adequate staffing, improve working conditions, guarantee access to essential equipment, and guarantee patient safety.

"I find our environment very conducive. Each patient has his or her own isolated room, which does not bother us at all. We take care of each patient individually, according to their specific condition. I just concentrate on my patient as a whole. » (V1)

"I see the need for sufficient staff, adequate working conditions, and access to equipment on the ward. Since palliative care is not my first intention, I fear that the quality of care will decrease." (V2)

Subtheme 4c: Nursing interventions during the treatment withdrawal decision

Participants unanimously agreed that the decision to initiate therapeutic withdrawal falls exclusively within the medical domain. However, some also noted that healthcare professionals still play a crucial role in ensuring patient comfort during this phase, for example, through pain management with analgesics. At this stage, care extends beyond pain relief to include aspects such as maintaining body hydration and creating a supportive, family-like atmosphere.

"Withdrawal of therapy is an exclusively medical decision. Paramedical intervention is limited to ensuring the patient's comfort, for example, by administering pain medication." (V1)

"When we reach the withdrawal stage, … At this stage, we do not just focus on comfort and pain relief, but also on humidifying the organic body and creating a supportive home-like environment." (V5)

Theme 5: Psychological support for patients and their families

Subtheme 5a: Medical treatment

Participants highlighted the role of medication in alleviating patients' anxiety and distress, specifically mentioning the use of tranquilizers and muscle relaxants.

"…. we can use to reduce patients' fear and anxiety, such as tranquilizing and relaxing treatments." (V1)

Subtheme 5b: Patient and family support

Participants emphasized that reassuring EOL patients relies on an empathetic and comforting presence, with a focus on psychological support. they noted that patients, particularly those aware of their condition, primarily need someone who can offer calm and emotional reassurance. In addition, participants agreed on the importance of supporting the patient's family, including allowing them to visit and communicate with the patient, even when sedated. They also highlighted the value of engaging with family members in a calm, non-confrontational manner to foster open and compassionate communication.

"For me, the most important aspect of care is psychological. At this stage, what the patient really needs is someone to calm him down and provide psychological support, especially if he is aware of his situation." (V3)

"Psychological support for the family must be provided from the outset before the patient's condition worsens. It is essential to maintain open communication with the family to facilitate the care of their loved one. It is also important to explain the situation to the family to help them understand and cope better." (V5)

4. Discussion

The objective of this study was to explore the experiences of nurses in providing care to EOL patients in ICUs. A qualitative analysis of verbatim data led to the identification of five major themes: (1) Nurses' conceptualization of the "End-Of-Life", (2) Emotions experienced, (3) Specific care and support provided, (4) Perceived barriers, and (5) Psychological support for patients and their families.

Interviews revealed that participants had diverse perceptions about the "EOL" concept in the ICU. Indeed, nurses described EOL situations as a profound disconnection from the external environment. As a research revealed, this disconnection was largely attributed to the patient's dependence on advanced medical technologies, which were perceived as a barrier to natural human interaction [25].

In addition, some nurses adopted a detached, minimalistic view of EOL, perceiving it as a natural and inevitable process, where the patient was seen primarily as a person destined to die and devoid of spiritual significance. Studies show that despite technological advances that support the fundamental and primary goals of intensive care [26], death remains common in this environment [27] because recovery is not guaranteed for all admitted patients [2].

Consequently, participants highlighted the importance of integrating palliative care in this context, emphasizing the need to prevent patient suffering, ensure adequate sedation, and provide effective pain management and comfort. These findings align with the broader aims of palliative care, which the literature consistently describes as the prevention and management of severe physical, psychological, spiritual, and social symptoms to optimize quality of life during this phase [25].

Beyond the implementation of palliative care, participants faced significant emotional and physical challenges, as verbatim revealed a range of complex reactions to EOL situation. According to a systematic review, the intensity of caregiving responsibilities posed substantial risks to nurses, resulting in heightened psychological stress and diminished professional effectiveness [28].

At the same time, our analysis indicated that participants managed stress and threatening situations by employing active coping strategies and by focusing on the positive aspects of caregiving, reflecting a process of resilience. As such, a study demonstrates that this adaptive capacity serves

as a psychological mechanism that mitigates the adverse effects of traumatic experiences and promotes effective adjustment to the challenges of illness and caregiving [29].

This adaptive process is consistent with Watson's perspective, which emphasizes meaning-making, hope, and reflective practice as essential mechanisms through which nurses transcend suffering, preserve human dignity, and maintain psychological harmony in the face of emotionally demanding caregiving situations [30].

Furthermore, strengthening personal resilience and enhancing emotional communication within families are critical strategies for coping with adversity and reducing the psychological impact of stressful situations [31]. Hence, participants emphasized the importance of protecting their emotional well-being by minimizing exposure to negative influences and aggressive behaviours, while fostering a positive and supportive work environment. Numerous studies have underscored the necessity of developing effective strategies to manage aggression, which encompass the use of appropriate communication skills and de-escalation techniques to enhance interactions between nurses and patients' families [32,33].

Therefore, according to the participants, optimal EOL support depended on a combination of knowledge, communication skills, and an integration of human-centered and technical care. This perspective is in accordance with the holistic principles of palliative care, which emphasize not only the management of physical symptoms but also the psychological, social, and spiritual well-being of patients [34].

Additionally, our findings demonstrated that effective and empathetic communication is fundamental to fostering a strong therapeutic relationship with patients and accurately identifying their needs. This is consistent with previous literature, which asserts the importance of attention, active listening, and empathetic communication in developing deeper, more meaningful nurse-patient connections in EOL contexts [35]. In concordance with Watson's theory, authentic communication, attentive listening, and relational presence are viewed as essential caring processes that enable nurses to truly understand the person beyond clinical indicators and to establish a meaningful transpersonal nurse-patient relationship [36].

Moreover, the interviews revealed that palliative care seeks to integrate humanistic care, centred on emotional and relational dimensions, with technical care, involving the clinical competencies and medical interventions required to manage physical symptoms. In this context, a study proposed framing the nurse's role in palliative care around two essential dimensions. The instrumental dimension focuses on clinical expertise and technical interventions, while the relational dimension highlights the importance of empathetic communication and emotional support within the nurse-patient relationship [37]. This integrative vision resonates with Watson's conception of caring as a balance between scientific knowledge, technical competence, and humanistic values [30].

Nonetheless, several barriers to the provision of EOL care in ICUs were identified in our study, with heavy workload emerging as a major challenge. As highlighted in an integrative review, the nurse's capacity for attentive presence may decline under the pressure of an increasingly demanding and complex workload, which could compromise the quality of care delivered [38]. From Watson's perspective, excessive workload can affect the nurse's ability to engage in authentic presence and caring consciousness, thereby limiting the expression of humanistic practices [30].

Furthermore, our research revealed that family aggression constitutes a significant barrier. In this regard, a recent systematic review and meta-analysis found that workplace violence against ICU nurses in Saudi Arabia, remains highly prevalent, with patient relatives often being the perpetrators [39]. This supports the idea that these professionals, frequently exposed to emotionally intense encounters, are particularly vulnerable to violence, which can lead to reactions such as anger or avoidance [39]. Within the Human Caring framework, emotionally charged situations challenge nurses to maintain caring relationships and stay emotionally present in hostile or threatening context [36].

According to participants' testimonies, another barrier to EOL care is the frequent use of sedatives, which often limits the possibility of meaningful communication with patients. Nonetheless, the literature emphasizes that communication extends beyond verbal expression to encompass a range of non-verbal signals, such as tone of voice, touch, smell, body language, and silence, which help maintain interaction when speech becomes restricted [40]. In Consistence with Watson's theory, communication may include non-verbal presence, and intentional being-with the patient [30].

In this context, our study revealed that the absence of adequate resources or skills to manage challenging situations can contribute to psychological tension among ICU nurses. This finding is supported by research from Saudi Arabia highlighting the importance of accessible support mechanisms in facilitating ICU nurses' coping strategies, which help them manage professional grief, emotional burden, and prevent psychological distress when they care for dying patients in critical care [41]. Furthermore, Watson's theory acknowledges that caring for others requires attention to the caregiver's own well-being, emphasizing the need for supportive environments that sustain nurses' emotional balance and caring capacity [18].

To address this issue, the interviewed nurses employed an empathetic and comforting presence, along with open dialogue and active listening, to understand the needs, concerns, and wishes of both patients and their families. This approach is consistent with a South African study demonstrating that through careful observation, meaningful dialogue, and attentive listening, nurses can identify potential discomfort and deliver care that respects patient autonomy [42]. This practice directly reflects Watson's caring processes, particularly the development of trusting, helping relationships grounded in empathy and respect for individuality [30].

According to our findings, participants emphasized the crucial role of the family's presence at the patient's bedside during EOL care. This aligns with previous research showing that allowing families to be present during the final moments offers them the opportunity to honour the patient's wishes and religious or cultural practices [43].In accordance with Watson's view, it is regarded as an essential component of caring to acknowledge and respect familial, cultural, and spiritual dimensions in order to preserve human dignity at the EOL[44].

Strengths of the study

This study is one of the few qualitative investigations conducted in Tunisian ICUs to examine nurses' lived experiences in caring for terminally ill patients. To the best of our knowledge, it is the first study in Tunisia to explore this phenomenon specifically within critical care settings using a theory-informed qualitative descriptive approach. The use of a semi-structured interview guide grounded in Watson's theoretical principles strengthened both the coherence and the interpretive depth of the data collection process. The purposive selection of experienced ICU nurses from three distinct units provided diverse perspectives that enriched the depth and relevance of the narratives. Furthermore, the rigorous application of Paillé's five-step inductive analysis model ensured methodological transparency and reinforced the credibility and confirmability of the findings.

Limitations of the study

While this study provides valuable insights, some limitations warrant acknowledgment. The research was conducted in a single hospital, which may restrict the transferability of findings to other ICUs with different organizational structures, resources, or cultural contexts. The small sample of five nurses, although sufficient for in-depth qualitative exploration, may not capture the full range of experiences across all critical care settings. Additionally, despite systematic transcription and analysis, qualitative data interpretation inherently involves subjectivity, and the researcher's perspectives may have influenced coding and theme development. Also, Participants' responses during interviews may be influenced by social desirability or contextual factors.

Recommendations

Enhancing EOL care in ICUs requires coordinated action at the personal, research, training, institutional, and policy levels. At the personal level, nurses should be more formally integrated into EOL decision-making, as their continuous presence at the bedside provides essential insight for patient-centered care.

Access to structured psychological support, such as counselling, peer-support groups, and regular debriefing, is crucial for managing emotional strain and preventing burnout. Additionally, reinforcing communication competencies and promoting holistic, interdisciplinary approaches remain central to improving the quality of EOL care. At the research and training level, further studies are required to examine the effects of holistic palliative care and to better understand resilience mechanisms among ICU nurses. Continuous professional development should incorporate specialized training in communication, symptom management, and emotional support to ensure that nurses are adequately prepared to meet the complex needs of terminally ill patients.

At the institutional and policy level, stronger organizational commitment is essential to enhance palliative care delivery. This includes allocating adequate resources, improving the physical environment to ensure comfort and dignity, and promoting a culture that values compassionate and patient-centered EOL care. Policymakers should also prioritize initiatives that strengthen training, research, and infrastructure.

Conclusion

EOL care in ICUs presents both emotional and clinical complexities. Nurses perceive this phase as multidimensional, shaped by personal and professional factors, with themes such as palliative care, disconnection, and the inevitability of death. Despite challenges like workload and family-related stress, they adopt coping mechanisms to support patients and families while preserving their own well-being. While EOL care is recognized as a core component of ICU practice, it remains underdeveloped in the Tunisian context, underscoring the need for further research tailored to local cultural, institutional, and human realities.

Declaration of Competing of Interest:

The authors declare that they have no conflicts of interest.

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