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Navigating Palliative Care in the ICU: A Phenomenological Study of Indonesian Healthcare Professionals' Experiences

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Abstract

Within intensive care units (ICUs), close attention to symptom management and clear awareness of therapeutic goals are fundamental when caring for patients with life-threatening conditions. These demands illustrate why embedding palliative care into ICU practice is increasingly important. Although it carries clear benefits, numerous obstacles still prevent the seamless incorporation of palliative care approaches in this setting. In particular, a substantial proportion of healthcare professionals (HCPs) practicing in Indonesian ICUs have yet to utilize palliative care strategies fully. The present study was designed to examine and elucidate the personal experiences of healthcare providers (HCPs) who deliver palliative care to patients admitted to ICUs in Indonesia. A qualitative descriptive-phenomenological design was used in this investigation. Data were gathered through semi-structured, in-depth individual interviews involving four nurses and three doctors employed at a hospital in Indonesia. Analysis of the transcribed interviews followed Colaizzi's procedural steps.

Six distinct themes emerged from the interview data, capturing the lived experiences of healthcare professionals providing palliative care in the ICU. These themes are: 1) provide professional caring, 2) caring and curing collaboration, 3) quality intensive communication, 4) end-of-life care, 5) controlling feelings, and 6) provide holistic caring. Delivering effective care to ICU patients requires more than clinical proficiency on the part of HCPs; it also demands genuine compassion, effective communication, and an all-encompassing perspective on patient needs. Implementing comprehensive palliative care in the ICU enables healthcare teams to meet the multifaceted needs of patients and their loved ones, fostering greater comfort, dignity, and a higher quality of life throughout the trajectory of serious illness. Such an integrated model improves outcomes and satisfaction for patients and families alike, while also empowering providers to offer more compassionate, individualized support. Hospitals in Indonesia are therefore encouraged to formulate specific policies to expand and strengthen palliative care delivery.

Keywords: ICU patient, Healthcare professionals, Palliative care, End-of-life care

Introduction

Palliative care is a collaborative, interdisciplinary approach focused on enhancing the physical, emotional, social, and spiritual dimensions of well-being for individuals and families confronting life-threatening illnesses that compromise daily functioning and overall quality of life [1]. Over the past few decades, awareness and demand for palliative care have expanded considerably worldwide. This trend stems largely from the steadily increasing population of people living with advanced and terminal conditions. Data from the World Health Organization (WHO) in 2021 indicate that more than 56.8 million individuals worldwide require palliative care annually, among whom 25.7 million are in their final year of life; notably, 78% of those in need reside in low- and middle-income countries. Despite this widespread requirement, only approximately 12% of affected people actually gain access

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to such services [2]. Shortfalls in availability are especially pronounced in resource-limited settings, and Indonesia exemplifies this broader pattern [3].

Although palliative care was first introduced in Indonesia in 1992, nationwide implementation has advanced slowly and unevenly. At present, dedicated services remain concentrated in several large urban centers—primarily those that host specialized cancer care facilities. These existing programs show considerable variation in personnel, infrastructure, and service-provision models. While the core ideas underlying palliative care are widely familiar, deeper comprehension and consistent application among healthcare workers remain incomplete in many areas [3].

Over the last 20 years, mastery of palliative care principles has become a vital competency for nurses practicing in intensive care units (ICUs) [4]. This development mirrors heightened appreciation for merging palliative care concepts with conventional critical care to achieve truly holistic, person-centered support for patients facing severe illness in high-acuity environments [4-8]. In response to rising global needs, health systems and frontline clinicians are directing greater attention to expanding access to these essential services, with the ultimate aim of safeguarding and improving the quality of life for those whose conditions carry a limited prognosis [3, 6, 8, 9].

Individuals admitted to the ICU with critical illness require vigilant symptom surveillance together with a thorough grasp of care objectives; these elements strongly support the integration of palliative care principles in such environments. When applied appropriately, palliative measures can yield multiple benefits, such as lowering ICU readmission rates, reducing overall length of stay, and promoting a more judicious allocation of limited healthcare resources [4, 5].

Even so, a range of obstacles continues to limit optimal uptake of palliative care in ICU settings. One earlier investigation pinpointed three central impediments. First, many ICU nurses and physicians assume they are already furnishing excellent end-of-life support and therefore see little reason to adopt additional palliative frameworks. Second, overly optimistic expectations expressed by patients or family members about recovery chances or treatment efficacy can discourage clinical teams from involving specialist palliative consultants. Third, providers sometimes worry that shifting toward palliative priorities might be misinterpreted as abandonment or could undermine trust in the therapeutic relationship. Beyond these attitudinal issues, gaps in professional preparation—particularly among nurses—pose another serious constraint. Inadequate education and limited familiarity with palliative care concepts frequently limit the ability to deliver high-quality support to patients with critical conditions [7-9].

Indonesia's ICUs are witnessing a steady rise in admissions involving patients with advanced or terminal illnesses, which intensifies the need for timely palliative involvement. High mortality figures among ICU populations further highlight the central contribution that palliative care should make, a duty shared by nurses, doctors, and the wider multidisciplinary team [10-12]. Nevertheless, research conducted within an Indonesian general hospital revealed that numerous nurses continue to view palliative care as synonymous with terminal care only. This narrow perspective leads them to reserve such approaches solely for patients perceived as actively dying, thereby generating uncertainty about how best to support other seriously ill individuals [13]. Faced with this confusion, nurses frequently default to aggressive curative interventions and restrict additional supportive measures until death is imminent [14]. In contrast, genuine palliative care assists patients in facing the final phase of life with dignity and minimal distress while simultaneously equipping families with the emotional resources needed to navigate loss and bereavement.

Palliative care now constitutes a core aspect of comprehensive ICU support for both patients and relatives. Yet many healthcare professionals (HCPs) working in Indonesian intensive care settings have still not fully realized its potential through systematic integration. Moreover, the relative scarcity of detailed, context-specific research means that the practical difficulties, advantages, and day-to-day realities encountered by HCPs when delivering palliative care in ICUs remain insufficiently documented. Consequently, the primary objective of the current study is to investigate the direct lived experiences of nurses and physicians actively engaged in palliative care in Indonesian ICUs. The guiding research question is: What is the deeper meaning and essential character of the experience of delivering palliative care for nurses and doctors responsible for critically ill ICU patients? Through this inquiry, the study seeks to uncover distinctive viewpoints, recurring challenges, and practical insights held by these professionals. In doing so, it aims to generate actionable knowledge that informs and elevates palliative care standards within this demanding clinical domain.

Materials and Methods

Study design

The central purpose of this investigation drove the selection of a qualitative phenomenological design: to explore the lived experiences of healthcare professionals (HCPs) when delivering palliative care in the ICU [15, 16]. As a philosophical tradition, phenomenology is especially well matched to this aim because it focuses on revealing and deeply understanding the personal, subjective realities of individuals [16]. Choosing a phenomenological approach proved suitable and beneficial for the present study. It enabled a rich, detailed examination of the encounters HCPs routinely have with patients in the Intensive Care Unit. By employing this method, the research aimed to illuminate the subtle, personal dimensions of these experiences and to clarify the intricate challenges and demands involved in providing palliative care in this high-stakes clinical setting.

Participants and setting

Study participants consisted of nurses and doctors working in the Intensive Care Unit (ICU) of a general teaching hospital in Indonesia. At the time of the research, the hospital lacked a specialized palliative care unit. Instead, palliative care was delivered directly within the ICU, which made it particularly relevant to examine how healthcare professionals navigate this role in such an environment.

A purposive sampling strategy was used to recruit participants, guided by clearly defined inclusion criteria. These criteria required that individuals must have firsthand experience caring for ICU patients, possess at least 2 years of clinical experience in the ICU, hold a minimum of three years of nursing education (this criterion applied only to nurses), and be willing to participate voluntarily. Key informants helped identify suitable candidates. The research team first contacted the ICU head nurse to introduce the study. Subsequently, meetings were arranged with ICU nurses and physicians. Detailed explanations were provided to potential participants, and once they agreed to join, data collection began. The final sample size was guided by data saturation, meaning recruitment continued until no additional themes or new information emerged from further interviews. Saturation was achieved with 7 participants. Further participant characteristics are presented in **Table 1**.

Table 1. Characteristics participants.

Participant code	Gender	Age (Year)	Education	Period of working in ICU
P1	Female	33	Nurse (Bachelor)	6 years
P2	Male	34	Nurse (Diploma)	4 years
P3	Female	41	Nurse (Bachelor)	5 years
P4	Male	34	Nurse (Bachelor)	5 years
P5	Female	32	Doctor (Bachelor)	6 years
P6	Female	31	Doctor (Bachelor)	4 years
P7	Male	27	Doctor (Bachelor)	2 years

To safeguard privacy and promote candid sharing during interviews, all names and identifying details were kept strictly confidential and replaced with pseudonyms. Each participant was assigned a code, such as P1, P2, P3, and so forth. Before any data collection, participants received comprehensive information about the study and were clearly informed of their right to withdraw at any time without explanation. Informed consent also explicitly covered the use of anonymized direct quotations in any publications.

Data collections

Data collection took place between August and October 2021 through semi-structured, in-depth interviews [17]. Because the study took place during the ongoing COVID-19 pandemic, two participants were interviewed remotely through Zoom, while the other five were interviewed in person within the ICU ward. To maintain confidentiality, each participant was assigned a unique identification code. Prior approval was obtained from every individual to allow video recording during the sessions. The lead researcher (HSM) determined that data saturation was reached after the seventh interview. Each interview began with a broad, open-ended question that invited participants to describe their experiences in their own words when providing palliative care to critically ill patients in the ICU. Additional probing questions were used to delve deeper into specific aspects, including difficulties encountered when integrating palliative care practices in the ICU environment. Interviews were conducted once per participant and recorded in either audio or video format, with each session lasting roughly 45 to 60 minutes. Data collection and preliminary analysis proceeded concurrently.

Data analysis

Data analysis followed Colaizzi's seven-step method, which included the following procedures: (1) reading all transcripts repeatedly (three to five times) to develop a thorough grasp of the overall meanings; (2) carefully examining each account and extracting significant statements; (3) formulating meanings from those significant statements; (4) clustering the formulated meanings into thematic groups; (5) synthesizing the findings into an exhaustive description of the phenomenon; (6) returning the comprehensive description to participants for validation of their expressed feelings; and (7) incorporating any relevant new insights into the final description of the phenomenon's essential structure.7 All members of the research team independently identified meaningful statements from the transcripts that related to the studied phenomenon. Themes and sub-themes were then developed collectively through team discussions that considered both common patterns and variations. Every emerging theme was situated within a broader descriptive framework, and any inconsistencies, overinterpretations, or inappropriate categorizations were resolved through group consensus. The finalized themes provided the structural foundation for the study results. To strengthen trustworthiness, member checking was conducted by sharing the descriptive findings with participants for confirmation. Feedback was received from all participants, who verified that the presented findings accurately captured their personal experiences. This validation step adhered to recommended methodological standards [18-20].

Throughout the entire analytical process, the researchers maintained a deliberate commitment to objectivity by consciously setting aside their own preconceptions, emotions, and prior assumptions about the topic and the collected data. This practice was informed by Husserl's concept of "bracketing," which entails temporarily suspending personal biases and expectations to avoid contaminating the interpretation. By applying bracketing, the team sought to minimize risks of distortion, oversimplification, or overemphasis arising from their own perspectives. The primary emphasis remained on accurately understanding and reflecting participants' viewpoints, attitudes, and feelings. This disciplined approach helped ensure a more accurate and authentic portrayal of the participants' lived experiences, thereby enhancing the credibility of the research outcomes.

Trustworthiness of the study

This investigation applied recognized standards to ensure rigor and trustworthiness [21]. Credibility was strengthened by fostering openness during interactions with participants. All sessions were audio-recorded and supported by thorough field notes, while carefully designed interview prompts encouraged participants to provide rich, detailed accounts. Confirmability was addressed by having the first author transcribe the recordings, followed by an independent review by the second author, who compared the written transcripts with the original audio files to ensure precision. The first author (HSM) took responsibility for transferability by confirming that the data genuinely reflected the participants' own perspectives. The research team maintained reflective memos throughout the analytic process to document any personal assumptions. These steps collectively helped ensure the study's trustworthiness and upheld the objectivity and reliability of the conclusions.

Ethical considerations

Ethical approval was secured from the Research Ethics Committee of Universitas Padjadjaran (Ethics approval no. 366/UN6.KEP/EC/2021) and the Hospital Health Research Ethics Committee (number: 002/KEPK-SP/V/2021). Before commencing data collection, every participant received complete information regarding the study aims, how findings would be shared, and the use of interview recordings. Written informed consent was collected from all individuals, confirming their voluntary involvement. Participants were clearly informed that they could leave the study at any time without penalty or disadvantage. These procedures were followed to maintain the highest ethical standards and to protect the rights and dignity of everyone involved in the research.

Results and Discussion

Demography data

The study included 4 nurses and 3 medical doctors working in the ICU of a general teaching hospital in Indonesia. Slightly more than half of the sample were women (57%). Participants had an average age of 23.2 years, and their mean duration of experience in ICU settings was 4.57 years. A full breakdown of participant characteristics appears in **Table 1**.

The demographic and professional profile of the participants—such as their average age, gender balance, and related attributes—supplies valuable background for interpreting the lived experiences and viewpoints of nurses and doctors engaged in palliative care within the Intensive Care Unit (ICU). These individual and occupational factors can shape the ways healthcare professionals fulfill their duties, interact with patients and families, and manage the demands of palliative support in a critical care environment. Recognizing these details allows readers and researchers to understand the study insights with greater context and sensitivity.

Study outcomes

Data analysis revealed six central themes that described the experiences of healthcare professionals (HCPs) when delivering palliative care in the ICU: 1) provide professional caring, 2) caring and curing collaboration, 3) quality intensive communication, 4) end of life care, 5) controlling feelings, and 6) provide holistic caring. These themes together represent the key dimensions of HCPs' encounters with palliative care provision in the intensive care setting. A graphical overview of the themes is provided in **Figure 1**.

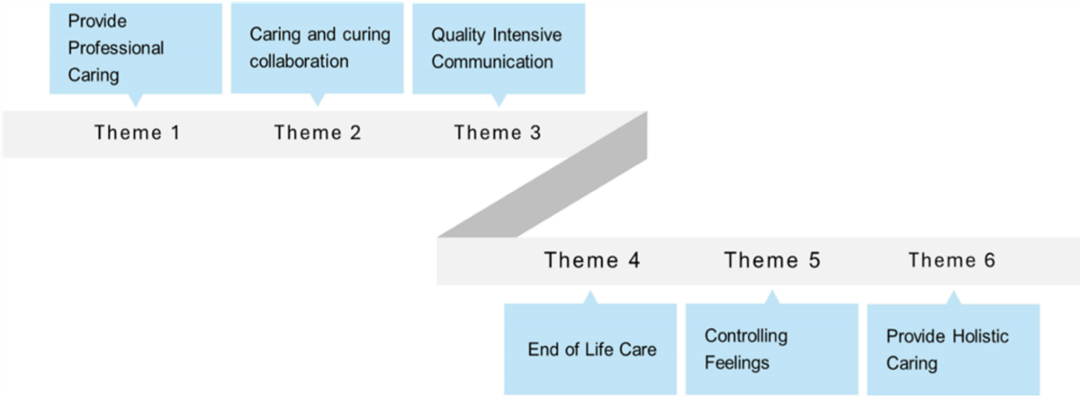

Figure 1. Six themes of the experiences of HCPs in providing palliative care in the ICU.

Provide professional caring

The theme "Provide Professional Caring" addresses a core element of how healthcare professionals experience palliative care delivery in the ICU. It emphasizes the committed and empathetic manner in which HCPs delivered excellent support to patients. This theme illustrates the strong dedication of healthcare teams to meeting the needs of ICU patients who require palliative interventions.

Participants indicated that these activities formed a regular part of their workday and were indispensable for delivering appropriate care to patients receiving palliative support in the ICU. One nurse described this aspect as follows:

"Through regular attention to patients' requirements, close observation of vital signs, and efforts to safeguard their physical condition, healthcare staff work to build an environment that encourages comfort and steadiness. Concentrating on these everyday responsibilities helps enhance patients' overall stay and supports a better quality of life while they remain in the ICU" (P4).

Such comments underscore participants' belief that consistent daily tasks play a vital role in maintaining stability and promoting the well-being of palliative patients in the intensive care setting.

Every participant expressed a clear resolve to continue caring for all patients through to the final stages, regardless of their medical status or outlook. The healthcare professionals stressed that each person deserves appropriate medical attention, regardless of whether they are receiving palliative care. One medical doctor expressed this position in the following way:

"I keep providing medications and carrying out essential procedures for patients right up to the end of life, treating those receiving palliative care no differently from others. I recognize how important it is to relieve discomfort, control symptoms, and sustain patients' well-being across their full care journey, irrespective of the expected outcome" (P7).

Caring and curing collaboration

All participants stressed the critical role of integrating caring and curing when delivering healthcare services. Nurses in particular acknowledged that curing centers on medical procedures and treatments intended to address the underlying disease, whereas caring emphasizes compassionate assistance, comfort, and holistic attention to the patient's overall needs. One nurse explained this balance as follows:

"Through close teamwork between nurses and doctors, we can combine curative interventions with supportive measures. Caring and curing are not opposing forces but rather complementary aspects that together enhance patients' well-being and overall quality of life" (P4).

Quality intensive communication

The theme "quality intensive communication" captures participants' strong awareness of the vital role that clear, meaningful dialogue plays in palliative care in the ICU. This theme underscores the value of transparent, open, and compassionate exchanges among healthcare professionals, patients, and family members.

Participants highlighted the importance of educating families as part of palliative care delivery in the ICU. They stressed the need to equip families with sufficient knowledge and practical skills so they could take an active role in supporting their loved ones. A medical doctor described this process in the following way:

"Educating families about patient care is essential so they can better understand the patient's condition, expected course, and the objectives of palliative care. This includes guidance on symptom control, medication use, wound management, and other daily care tasks. Equipping families in this manner boosts their confidence and enables them to offer more effective support to the patient" (P7).

Participants also recognized the value of active, reciprocal communication when providing palliative care in the ICU:

"In the ICU setting, we engage in ongoing interactive dialogue that involves truly listening to patients and their families, giving them space to voice their worries, anxieties, and wishes. This approach helps build trust and connection, encourages openness, and ensures that patients and families feel their perspectives are respected and taken seriously throughout the palliative care process" (P3).

End of life care

The theme "End of Life Care" reflects participants' awareness of the distinct and essential elements involved in supporting patients who are approaching the final stage of life in the ICU. Study participants emphasized the need for kind and thorough care during this period, with special attention to each patient's individual needs and wishes. Maintaining patient comfort and dignity was viewed as especially important. Effective pain and symptom relief was achieved through appropriate medication, comfort measures, and careful attention to the patient's physical condition (P3).

Some participants felt a strong professional duty to deliver the highest standard of service, noting that palliative care entails providing complete and compassionate assistance to those facing advanced illness or nearing death. One participant expressed this responsibility as follows:

"As healthcare professionals, we must regularly assess and refine the quality of care we deliver. This includes tracking results, gathering input from patients and families, and making adjustments to improve the overall experience and impact of our support. By focusing on these elements, we can offer the best possible palliative care, which promotes comfort, preserves dignity, and provides meaningful assistance to patients and their families during difficult periods" (P3).

Controlling feelings

The theme of controlling feelings highlights its importance when delivering care in the Intensive Care Unit (ICU), especially during the end-of-life phase. Managing personal emotions can be particularly demanding in such intense and emotionally charged circumstances.

Participants described the value of offering emotional support to patients and families in difficult moments by demonstrating empathy, providing reassurance, and remaining attentive to their emotional needs (P1).

The experiences shared by participants revealed that when delivering palliative care in the ICU, it is essential not to become overly absorbed in the family's grief. They noted that healthcare professionals must regulate their own emotions to remain steady and better support families facing the patient's condition. Maintaining this balance was considered necessary to ensure that care stays professional. Several participant statements illustrated this point:

"We can certainly empathize and express our sympathy, but we must avoid becoming overwhelmed by the situation, because losing our composure would prevent us from thinking clearly and acting rationally" (P2).

Participants described feeling a heavy sense of sadness when observing patients nearing death and sharing in the family's distress. They spoke of mentally placing themselves in the family's position while recognizing the simultaneous need to uphold professionalism despite their own emotional responses:

"It can feel quite overwhelming at times. Almost every day, we encounter situations where death is imminent or very near. This leads us to imagine ourselves in the family's place. It becomes especially difficult when the patient has been under our care for a long time. We often share the sorrow and sometimes shed tears when a patient passes away. When asked how we feel, we admit to feeling deep sadness. Yet, because of our responsibility toward the family, we have to stay strong. After all, if we break it down, how can the family find the support they need? So we continue to deliver care professionally" (P3).

Provide holistic caring

Participants explained that when patients entered a palliative phase, particularly in the ICU, both nurses and doctors offered increased psychological and spiritual support to patients and their families. This support often took the form of gentle encouragement and reassurance that events remained under God's guidance. The following statements illustrate this aspect of their experience:

"Even when patients remained conscious, we usually addressed their psychological and spiritual needs. We also provided psychological assistance to the family members" (P2).

Experiences shared under this theme included holistic interventions focused on families as well as spiritual services offered to both patients and relatives. Participants noted that when palliative patients were unconscious or in a coma, they paid more attention to the family's biological, psychological, social, and spiritual needs. One participant described this as follows:

"It was similar to what I mentioned before. For a patient who has fallen into a coma, we focus on the bio-psycho-social and spiritual dimensions concerning the family" (P3 Q7 S1).

All participants emphasized the importance of enhancing the patient's quality of life by ensuring comfort, minimizing pain, and making the overall treatment experience as pleasant as possible. Comments related to this experience included the following:

"We sometimes adjusted care to make the patient more comfortable and free from pain. The guiding principle is to keep things painless and comfortable. I believe this approach helps improve the patient's quality of life considerably" (P4).

Provide professional caring

According to the participants, palliative care delivered in the intensive care unit was viewed as a form of professional caregiving. The study found that healthcare professionals demonstrated professionalism in their conduct when providing palliative care in the ICU. This involved following established protocols for routine care, delivering services equally to all patients, demonstrating clinical competence, and promoting integration between caring and curing approaches. The National Coalition for Hospice and Palliative Care (NCHPC) has highlighted the value of professional oversight in palliative care, which corresponds with the professional behaviors observed among healthcare professionals in this study when supporting palliative patients in the ICU [22].

At the study location, a standardized operating procedure (SOP) requires that, before admitting a palliative patient to the intensive care unit (ICU), a physician evaluate the patient to establish priority level. This evaluation includes screening based on the palliative care module and applying a specific palliative care screening score [23]. Participants reported that palliative patients admitted to the ICU generally fell into the third-priority category. This practice is consistent with the Minister of Health Decree of the Republic of Indonesia No. 812/MENKES/SK/VII/2007, which identifies palliative patients in the ICU as eligible for third-priority admission.

Delivering professional palliative services in the ICU requires healthcare professionals to possess strong competencies. Participants identified several essential competencies, including the ability to work in teams, adequate knowledge, practical skills, relevant experience, and the capacity to build meaningful connections with patients and families. Among these, teamwork was repeatedly described as a vital factor in successfully implementing palliative care in the ICU. This view is supported by the National Coalition for Hospice and Palliative Care (NCHPC) [22] and by previous work by Penrod *et al.* [24], both of which stress the importance of interdisciplinary collaboration for maintaining continuity in palliative care.

Additional studies reinforce the need for healthcare professionals to develop their knowledge and skills in ICU-based palliative care continuously [6, 24-26]. Beyond technical expertise, participants also emphasized the importance of building strong interpersonal relationships with patients and their families. This finding echoes other research identifying conflict resolution and empathetic communication as key competencies for professionals involved in palliative care in intensive care settings [27].

Caring and curing collaboration

Within the broader context of teamwork, integrating caring and curing proved essential to the success of professional palliative care efforts in the ICU. Multiple studies have confirmed the need for close collaboration between nurses and doctors when providing palliative care in intensive care environments, recognizing that these two groups form the primary frontline providers in the ICU [28]. Study participants indicated that collaborative practices were central to almost every aspect of palliative interventions in the ICU, especially in medication management. This spirit of cooperation also appeared in regular discussions between nurses and doctors about changes in the patient's condition. Such communication routinely included exchanging updates on the patient's progress and consulting the most recent literature whenever difficulties emerged in delivering palliative services.

Quality intensive communication

High-quality communication among healthcare professionals emerged as a necessary but insufficient factor for effectively integrating palliative care within the ICU. The study results demonstrated that intensive and thoughtful dialogue played a vital role in several key situations, including teaching families how to participate in patient care, breaking difficult news, and updating relatives about a patient's declining health. Beyond this, truly interactive exchanges were considered essential, extending not only to families but also to multidisciplinary teams that included members outside the core group of nurses and doctors. Earlier investigations have consistently shown that strong communication forms a cornerstone of palliative care, helping to define care objectives and supporting a more rounded, patient-focused approach [29].

Teaching patients and their families proved to be an adaptable, ongoing activity that could occur whenever the patient's clinical situation permitted. Both doctors and nurses had regular opportunities to share knowledge as needs arose, and several participants reported conducting daily educational discussions with families. Responsibilities were often shared: doctors mainly explained the medical aspects of the disease, while nurses focused on practical caregiving, such as helping families meet the patient's basic daily needs. Education also covered specific treatments or procedures, including their potential advantages and drawbacks. This coordinated effort resulted in more complete and balanced information sharing, enabling families to gain a clearer understanding of the patient's situation and the care being delivered.

Aligning with recommendations from two major international palliative care bodies—the National Coalition for Hospice and Palliative Care (NCHPC) and the Worldwide Hospice Palliative Care Alliance (WHPCA)—palliative services in the ICU were described as a collaborative, team-driven process that placed the patient and family at the center of all activities [3, 22]. Participants reinforced this perspective, noting that effective palliative care in the ICU required ongoing, in-depth engagement with both patients and their relatives. This intensive style of interaction formed a central feature of the support provided by nurses and doctors, reflecting a deliberate focus on making patients and families the main recipients of clear, understandable information and education in the Indonesian ICU environment.

The findings also highlighted the importance of communication within the broader multidisciplinary team, not just with patients and families. These observations aligned with previous studies that identified interprofessional dialogue as a key driver of sound clinical decisions and the setting of realistic treatment goals [27, 30]. Other research has similarly highlighted that regular discussions involving various specialists and team members are crucial for strengthening palliative care efforts in intensive care settings [24]. Additional work has highlighted that professionals must develop strong cross-disciplinary communication skills, particularly when caring for patients with unstable or life-threatening conditions [25]. Collectively, these elements underscore the fundamentally collaborative nature of palliative care, which relies on clear, effective exchanges across healthcare disciplines to deliver well-organized, thorough patient support.

End of life care

The severe clinical status of palliative patients in the ICU created notable difficulties for healthcare professionals tasked with providing appropriate services. Study results showed that meeting the needs of these critically ill individuals required focused attention on those approaching death, active involvement of their families, and a sustained commitment to delivering excellent care. Earlier studies had already confirmed that palliative care constitutes a core and wide-ranging element of intensive care, specifically designed for critically ill patients who face limited recovery prospects [31]. Based on this, the researcher concluded that palliative care should be considered essential for every critically ill patient admitted to the ICU. This position is supported by previous literature that portrays the ICU as an environment where palliative principles must be embedded, where such care is necessary for all patients with poor prognoses, and where responsibility rests with the entire healthcare team [9, 24, 30].

Support for patients nearing the end of life represented the most prominent expression of palliative care in practice. As noted elsewhere, both general palliative care and terminal care should be delivered with genuine compassion and clinical expertise [31, 32]. Participants reported that every palliative patient in the ICU had a limited prognosis and was in the final phase of illness. These individuals typically faced complex challenges, including reduced levels of consciousness, progressive decline in overall health, dependence on mechanical ventilation, and multiple untreatable co-existing conditions. Care interventions were individualized—for instance, focusing on pain relief until the patient was comfortable, or providing resuscitation when indicated by the patient's status and family wishes, especially if no Do Not Resuscitate (DNR) order had been established.

The National Coalition for Hospice and Palliative Care (NCHPC) recommends involving families in conversations about the patient's progress to promote better understanding and minimize tension between relatives and the care team [22]. Study participants similarly stressed the need for healthcare professionals to ensure that family members present with the patient can comprehend the information shared. Professionals were also observed to deliver the highest standard of care even to patients classified as palliative. Despite the palliative label, they approached their work with full dedication, often treating patients with the same concern they would show family members. This attitude corresponds with earlier findings that professionals caring for critically ill patients must demonstrate both the willingness and capability to provide optimal support throughout the ICU stay [32]. These principles resonate with elements of palliative care described in other research, which emphasize that healthcare teams should provide comprehensive support to patients—even until death—through clear communication that helps establish realistic care goals [9]. It is worth noting that delivering effective communication during serious inpatient situations and at the end of life, as shown in prior studies, can trigger emotional responses in professionals such as sadness, grief, or other forms of distress [6]. Caring for patients in critical or terminal stages can also deepen nurses' empathy and enable them to provide more meaningful emotional and moral support to both the patient and their loved ones [31].

Controlling feelings

ICU healthcare professionals cultivate a professional mindset when offering palliative care. The study results show that regulating emotions is essential in this environment, particularly the ability to honor the patient while adjusting to a grief-filled atmosphere. Providers must demonstrate strong emotional self-regulation, especially when facing painful and distressing scenarios. This points to the need for palliative care practitioners to strengthen their psychosocial abilities so they can uphold professional standards in varied and difficult situations. Therefore, it is strongly recommended that healthcare professionals delivering palliative care in the ICU actively work to maintain emotional stability to sustain a professional attitude [33].

As a palliative patient's condition worsens and reaches a critical stage, healthcare professionals often experience internal emotional shifts, including increased worry for both the patient and the family. Participants reported that these moments prompted them to pay closer attention to the requirements of patients and their relatives. The researcher suggests that such conditions help nurture a deeper sense of respect toward patients among those providing palliative care in the ICU. Study findings indicate that this respect appears through actions such as recognizing the patient's complete life span from beginning to end, offering heightened attention to both patients and families, and respecting the patient's personal beliefs during care. This perspective is supported by the National Consensus Project for Quality Palliative Care and earlier investigations that emphasize the delivery of palliative services that fully honor the values and beliefs of the patient and family [22, 29, 30, 34].

Participants described another aspect of their emotional management experience: how they adapted to the surrounding grief. They shared that feelings of sadness arose regularly because patient deaths were a frequent occurrence in their work. Although they had become familiar with these events, participants clarified that this familiarity did not diminish their ability to empathize. On the contrary, repeated exposure to grief had helped them develop effective ways to manage their emotions, allowing them to avoid being swept up in the heavy atmosphere of loss. The skill of emotional regulation thus stood out as a vital competency for healthcare professionals working in ICU palliative care. This aligns with earlier research highlighting the value of coping strategies in palliative settings, which help professionals manage their feelings constructively and focus on positive contributions [32].

Even though emotional control is necessary, participants admitted they still felt intense sadness and emotional burden when dealing with the serious decline of palliative patients. Previous studies have shown that doctors can face notable emotional and psychological strain while providing palliative care in intensive care units [30]. Similarly, other research has found that nurses frequently experience strong emotional fluctuations during palliative care, including sadness, emotional burden, and deep compassion for patients and their families [35, 36]. Nevertheless, further studies underscore the importance of healthcare professionals developing robust psychosocial skills to manage these emotional responses while continuing to deliver palliative care with a high degree of professionalism [33].

Provide holistic caring

Based on participants' accounts, a central element of palliative care in the ICU centers on delivering comprehensive, whole-person support to patients and their families. The holistic services described here include psychological and spiritual dimensions intended to provide compassionate support and promote well-being for both the patient and the patient's relatives. This observation is consistent with earlier research that calls for palliative care in critical care environments to be thorough, of a high standard, and reliably provided [29, 34]. As a result, the researchers conclude that healthcare professionals should actively deliver or enable holistic care for palliative patients in the ICU.

When a patient's condition became severe, especially with lowered consciousness, healthcare professionals redirected much of their attention to a holistic approach directed at the patient's family. This practice aligns with the National Consensus Project for Quality Palliative Care (NCP), which views palliative care as an interdisciplinary effort focused on meeting the full spectrum of needs of patients and families [22]. The study results showed that, in these situations, participants primarily applied holistic interventions to the family. These interventions, which often emphasized spiritual elements, were regularly carried out by healthcare professionals through actions such as arranging prayer opportunities or sharing encouraging messages to help families cope with their loved one's critical condition.

Participants repeatedly identified psychological and spiritual support as fundamental parts of holistic palliative services. Psychological assistance involved offering constructive advice and guidance to family members, while spiritual care often included suggesting the involvement of religious figures to help patients remain connected to their faith traditions. Healthcare professionals encouraged both patients and families to strengthen their connection to their beliefs, to entrust difficult outcomes to a higher power, and to keep hope alive for unexpected positive developments. Even during the most serious moments, professionals continued to inspire patients and relatives, helping them develop inner strength and a hopeful perspective. This practice aligns with previous studies that emphasize the importance of addressing psychological and spiritual needs in ICU palliative care to reduce the burden on patients and families [29, 35, 36].

The study results also revealed that holistic services were enhanced by emphasizing comfort and pain relief, with the clear aim of improving the patient's quality of life, reducing suffering, and achieving the greatest possible ease. This direction aligns with the World Health Organization (WHO) definition of palliative care, as advanced by the Worldwide Hospice Palliative Care Alliance (WHPCA) [3]. Palliative care provides a comprehensive framework for patients and families facing life-threatening illnesses, focusing on improving quality of life and delivering comfort rather than pursuing curative interventions [20, 37, 38]. For this reason, holistic care holds special significance for nurses caring for patients in terminal stages, as it plays a major role in improving the patient's overall quality of life [6, 28, 31, 36, 38]. Participants put these ideas into practice by responding directly to patient concerns—especially pain—through the most suitable interventions aimed at reducing or removing discomfort, thereby helping patients remain as comfortable as possible even in their final moments.

Conclusion

This investigation into the lived experiences of nurses caring for critically ill patients in the intensive care unit demonstrates that the role is both sensitive and highly challenging, requiring a thorough, multifaceted application of palliative care. Incorporating comprehensive, holistic palliative care into ICU services enables healthcare teams to respond effectively to the complex needs of patients and their families, thereby promoting comfort, preserving dignity, and enhancing quality of life throughout the course of serious illness. Such an approach not only improves the overall experience for patients and their loved ones but also equips healthcare providers to offer empathetic, individualized support. It is therefore vital that ICU healthcare teams develop strong familiarity with these matters, and that ICU nurses undergo targeted education in core palliative care concepts. In addition, hospitals are responsible for equipping healthcare professionals (HCPs) with a solid foundation in holistic care principles. This preparation should cover skills in clear communication, respect for cultural differences, and the seamless blending of physical, psychological, and spiritual dimensions into daily practice. Ongoing educational initiatives and training opportunities help healthcare providers stay current with evolving best practices in holistic care delivery. Strengthening professional development and training programs in palliative care remains essential to ensure that every critically ill patient and their family receive appropriate, high-quality palliative support tailored to their unique circumstances.

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