

Moral Courage and Compassion Fatigue in Palliative Care Nurses: A Thematic Analysis

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Research Article

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Abstract

Background: Palliative care nursing involves complex clinical, emotional, ethical, and relational demands. Continuous exposure to patient suffering and family grief significantly impacts nurses' psychological well-being and professional sustainability.

Methods: A qualitative study design was utilized. Interview transcripts from 13 registered palliative care nurses were analyzed using MAXQDA software to conduct code frequency, matrix, density, and cross-tabulation analyses.

Results: Thematic analysis revealed four primary themes (totaling 208 codes). First, *Emotional Experiences and Psychological Burden* constituted the highest code density (34.62%, n=72), with "emotional impact" reported by 92.31%(n=12) of participants. Less experienced nurses exhibited higher distress code frequencies, whereas seasoned nurses demonstrated codes related to desensitization and acceptance. Second, *Professional Identity and Sources of Motivation* (30.77%, n=64) highlighted that intrinsic motivators specifically empathy (n=20) and spiritual/religious values (n=14) served as key protective coping mechanisms. Third, *Ethical Dilemmas and Decision-Making Dynamics* (28.37%, n=59) reflected moral distress regarding futile invasive procedures, where nurses exercised moral courage by honoring family requests to withhold aggressive interventions. Fourth, *Relationships with Patients' Relatives and Communication Processes* (6.25%, n=13) demonstrated that administrative and post-discharge coordination extended workload beyond bedside care, contributing to relational fatigue.

Conclusion: Palliative nursing requires substantial psychological resilience, moral courage, and communication management alongside clinical skills. To mitigate compassion fatigue and sustain ethical care quality, healthcare systems must integrate structured psychological support, ethics consultation resources, and interdisciplinary peer-support mechanisms into palliative care units.

BACKGROUND

Palliative care provides holistic support to manage the physical, psychosocial, and spiritual needs of patients with progressive, life-threatening illnesses and their families [1]. As primary care providers, nurses play a critical role in relieving suffering and supporting dignity during the end-of-life period [2]. However, prolonged exposure to the complex pain of terminally ill patients exposes nurses to substantial psychological and professional strain [3]. This emotional and ethical burden is further intensified in cultural environments like Turkey, where strong family structures often lead relatives to actively participate in care delivery and clinical decision-making [4].

Constantly managing patients' pain with high empathy while meeting heavy clinical demands can lead to severe emotional exhaustion, often termed "compassion fatigue" [5]. This vulnerability is closely tied to the stressful, unpredictable environment of palliative care units, where patient deaths are frequent [6]. As nurses face irreversible patient declines and repeated losses despite their best efforts, their emotional reserves diminish, leading to reduced empathy and job satisfaction [7]. Ultimately, this strain jeopardizes

nurses' personal well-being and professional retention while lowering the overall quality and safety of patient care [8].

Palliative care practice frequently presents complex clinical and ethical challenges. Decisions surrounding futile medical treatments, cardiopulmonary resuscitation, or truth-telling regarding terminal prognoses often cause significant moral distress among nurses [9]. In response, nurses must exercise "moral courage" to uphold professional ethical standards, protect patient rights, and serve as effective patient advocates [10]. Moral courage involves taking action aligned with ethical principles despite organizational pressure, fear of isolation, or potential professional risks [11].

Within palliative care, situations requiring moral courage usually involve interpersonal conflicts among the healthcare team and patients' families. While attempting to prioritize patient autonomy and comfort, nurses often experience tension with physicians, peers, or family members who struggle to accept a terminal prognosis [12]. Managing these disagreements alongside family expectations places additional emotional burden on nurses, triggering compassion fatigue while demanding consistent moral courage [13].

While international literature frequently examines compassion fatigue and moral courage as separate constructs through quantitative methods [14], qualitative evidence remains sparse. In Turkey, few studies have investigated how palliative care nurses personally experience the intersection of these two concepts during interpersonal conflicts with families and colleagues [15]. To address this gap, this qualitative study explores the lived experiences of moral courage and compassion fatigue among palliative care nurses in Turkey, focusing on how these two dynamics influence each other in clinical practice.

Aim and Research Questions

This study aimed to examine the professional experiences, emotional burdens, coping mechanisms, ethical challenges, and family communication processes of nurses working in palliative care units. To achieve this aim, the study sought to answer the following research questions:

1. What are the emotional experiences and psychological burdens experienced by nurses working in palliative care units?
2. What are the primary sources of motivation, professional identity perceptions, and coping mechanisms used by palliative care nurses against burnout?
3. What ethical dilemmas do palliative care nurses encounter in clinical decision-making processes, and how do they demonstrate moral courage?
4. How do relationships and communication processes with patients' families shape the daily workload and relational experiences of palliative care nurses?

METHODS

1. Study Design

This study utilized a descriptive phenomenological design to explore how palliative care nurses experience and perceive moral courage and compassion fatigue [16]. Phenomenology allows researchers to capture the common features of individuals' lived experiences regarding a specific phenomenon [17]. To ensure transparency and methodological rigor, the study was reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines [18].

2. Participants and Sampling

The study included 13 registered nurses working in a palliative care unit at a hospital in Turkey. Participants were selected via purposive sampling to recruit individuals with direct, relevant experience regarding the research phenomenon [19]. To be eligible, nurses needed at least six months of continuous clinical experience in palliative care and a willingness to participate voluntarily. The six-month criterion ensured that participants had sufficient exposure to end-of-life care, complex clinical situations, and interactions with families and colleagues [20].

3. Data Collection

Data were collected through face-to-face, semi-structured interviews conducted by the researcher in a private room at the hospital, minimizing disruptions and ensuring confidentiality [21]. The semi-structured interview guide was developed specifically for the present study and has not been previously published elsewhere. The questions were developed by the researchers in accordance with the aim of the study and based on a review of the relevant literature on moral courage, compassion fatigue, and palliative care. The draft interview guide was evaluated by five experts, including two experts in psychiatric nursing, two experts in palliative care nursing, and one expert in public health nursing, to assess the clarity, relevance, and comprehensiveness of the questions. The interview guide was revised based on their feedback. The final interview guide consisted of open-ended questions designed to explore participants' experiences of compassion fatigue and situations requiring moral courage. The English version of the semi-structured interview guide is provided in Additional File 1.

With explicit permission from each participant, all sessions were audio-recorded and lasted between 30 and 40 minutes. Data collection was concluded when no new concepts or patterns emerged, indicating data saturation [22].

4. Data Analysis

Audio recordings were transcribed verbatim by the researcher. The data were analyzed using Braun and Clarke's six-phase thematic analysis approach [23]. This process involved reading transcripts repeatedly to ensure data familiarity, generating initial codes, organizing codes into candidate themes, reviewing and refining themes, defining final thematic labels, and drafting the final report [24]. To enhance data trustworthiness and analytical rigor, two researchers coded the transcripts independently. Any discrepancies in code or theme assignment were discussed until full consensus was achieved [25].

RESULTS

Demographic Characteristics

The sample consisted of 13 registered palliative care nurses (coded as N1 to N13) with a mean age of 37.62 years (range: 28–51). Participants had an average of 15.00 years of general nursing experience (range: 5–31) and a mean of 2.93 years of palliative care experience (range: 0.25–6). This sample reflected a broad spectrum of professional backgrounds, encompassing both long-serving nurses and those who had more recently transitioned into palliative care (Table 1).

Table 1
Sociodemographic Characteristics of the Participants

ID	Age	Education	Marital Status	Child	Professional Experience (year)	Experience in Palliative Care (year)
K1	51	University	Married	2	31	0,83
K2	29	Bachelor	Single	1	5	1
K3	30	University	Single	0	6	6
K4	39	Bachelor	Married	3	15	2
K5	34	Bachelor	Undisclosed	1	7	0,25
K6	45	Bachelor	Married	0	22	3
K7	28	Bachelor	Married	0	10	3
K8	46	Bachelor	Married	3	27	5
K9	33	Bachelor	Married	2	11	4
K10	41	Bachelor	Married	2	18	6
K11	37	Bachelor	Married	1	14	2
K12	32	Bachelor	Single	0	9	1
K13	44	Bachelor	Married	2	20	4

Thematic Analysis Results

Thematic analysis of the interview transcripts using MAXQDA software generated 208 initial codes. These codes were categorized into four main themes representing the ethical, relational, professional, and psychological aspects of palliative nursing (Table 2). The highest code distribution was observed in the theme "Emotional Experiences and Psychological Burden of Healthcare Professionals" (34.62%, n = 72), followed by "Professional Identity, Sources of Motivation, and Perception of Care" (30.77%, n = 64)

and "Ethical Dilemmas and Decision-Making Dynamics" (28.37%, n = 59). The theme "Relationships and Communication Processes with Patients' Families" had the lowest code density (6.25%, n = 13).

Table 2
Thematic Framework and Code Distribution Matrix (Total Codes = 208)

Main Theme	Frequency	Percentage
Emotional Experiences and Psychological Burden of Healthcare Professionals	72	34.62%
Professional Identity, Sources of Motivation, and Perceptions of Care	64	30.77%
Ethical Dilemmas and Decision-Making Dynamics	59	28.37%
Relationships with Patients' Relatives and Communication Processes	13	6.25%
TOTAL	208	100.00%

Main Themes and Related Sub-Codes

Based on the research findings, the four main themes and the codes associated with each theme are presented in (Table 2.1).

Theme 1. Ethical Dilemmas and Decision-Making Dynamics

This theme comprises a total of 59 codes, accounting for 28.37% of all codes. The codes under this theme include “consultation with family,” “I have not experienced a situation requiring moral courage,” “unethical,” “doctor’s decision,” “ethics,” “I would caution,” “I did not feel the need,” and “moral codes.” This finding indicates that decision-making behaviors in the palliative care process are shaped not only by individual assessment but also within the framework of family, physician decisions, ethical principles, and moral responsibilities.

Theme 2. Relationships with Patients’ Families and Communication Processes

This theme comprises a total of 13 codes, accounting for 6.25% of all codes. The codes under this theme include conversation, strong bonds with patients and their families, indifference on the part of family members, and burdens placed on family members. This result indicates that, in some participants’ narratives, the relationship with family members is viewed as a supportive space for communication, while in others, it is discussed alongside challenging elements such as additional workload and indifference.

Theme 3. Professional Identity, Sources of Motivation, and Perception of Care

This theme comprises a total of 64 codes, accounting for 30.77% of all codes. Codes under this theme include “religious,” “empathy,” “compassionate,” “it’s my job,” “appreciation,” “attentive,” and “various methods.” This structure indicates that participants associate palliative care services not merely with a technical care practice, but also with empathy, compassion, spiritual values, attentive care, and a sense of professional responsibility.

Theme 4. Healthcare Professionals’ Emotional Experiences and Psychological Burden

With a total of 72 codes, this theme accounted for 34.62% of all codes, making it the main theme with the highest percentage. Codes under this theme include “being affected,” “getting used to it,” “sadness,” “exhausting,” “burnout,” “weariness,” “there’s nothing left to do,” “not exhausting,” and “peace of mind.” This finding indicates that the palliative care process has a significant emotional and psychological impact on healthcare professionals. However, the themes of “adjustment,” “peace,” and “resilience” suggest that some participants were able to manage this process through professional experience and inner acceptance.

Table 2.1
Main Themes and Related Sub-Codes

Primary Themes	n	%	Associated Sub-Codes (MAXQDA Nodes)
1. Ethical Dilemmas & Decision-Making Dynamics	59	28.37%	Consultation with family, instances of moral courage, unethical practices, physician-led decisions, ethical principles, intervening/warning, ethical consciousness
2. Family Relationships & Communication	13	6.25%	Casual conversations, strong therapeutic bonds, family indifference, caregiver burdens/drudgery
3. Professional Identity & Care Perception	64	30.77%	Religious/Spiritual values, empathy, compassion, vocational duty ("my job"), feeling appreciated, meticulous care, coping methods
4.Emotional Experiences & Psychological Burden	72	34.62%	Emotional impact, desensitization/getting used to, profound grief, exhaustion, burnout, apathy/weariness, futility ("nothing left to do"), internal acceptance, professional serenity

Code Frequencies and Conceptual Density

Analysis of code frequencies across participant transcripts highlights the primary challenges nurses face in palliative care settings. The most common code was "emotional impact," present in 92.31% (n = 12) of the interviews. This high occurrence indicates that exposure to chronic suffering and end-of-life care imposes a substantial emotional strain on nurses. "Consultation with family" also showed high

conceptual density, emphasizing the importance of family input in clinical decision-making. In addition, internal motivators were supported by codes including "religious/spiritual values," "empathy," and "compassionate." Notably, several participants reported "no perceived instances of moral courage," which may reflect institutional routine or limited professional autonomy.

Word Cloud and Linguistic Patterns

Lexical analysis of the raw transcripts using a word cloud revealed frequent occurrences of emotionally relevant terms such as "compassion," "courage," "affects," "distress," and "intensive." Key actors and relational domains were also prominent, marked by terms like "family," "physician," "patients," and personal pronouns ("I/you"). These linguistic patterns suggest that moral courage and compassion fatigue are not isolated psychological experiences; instead, they emerge through interactions involving the physician-nurse-family triad, heavy workloads, and professional duties.

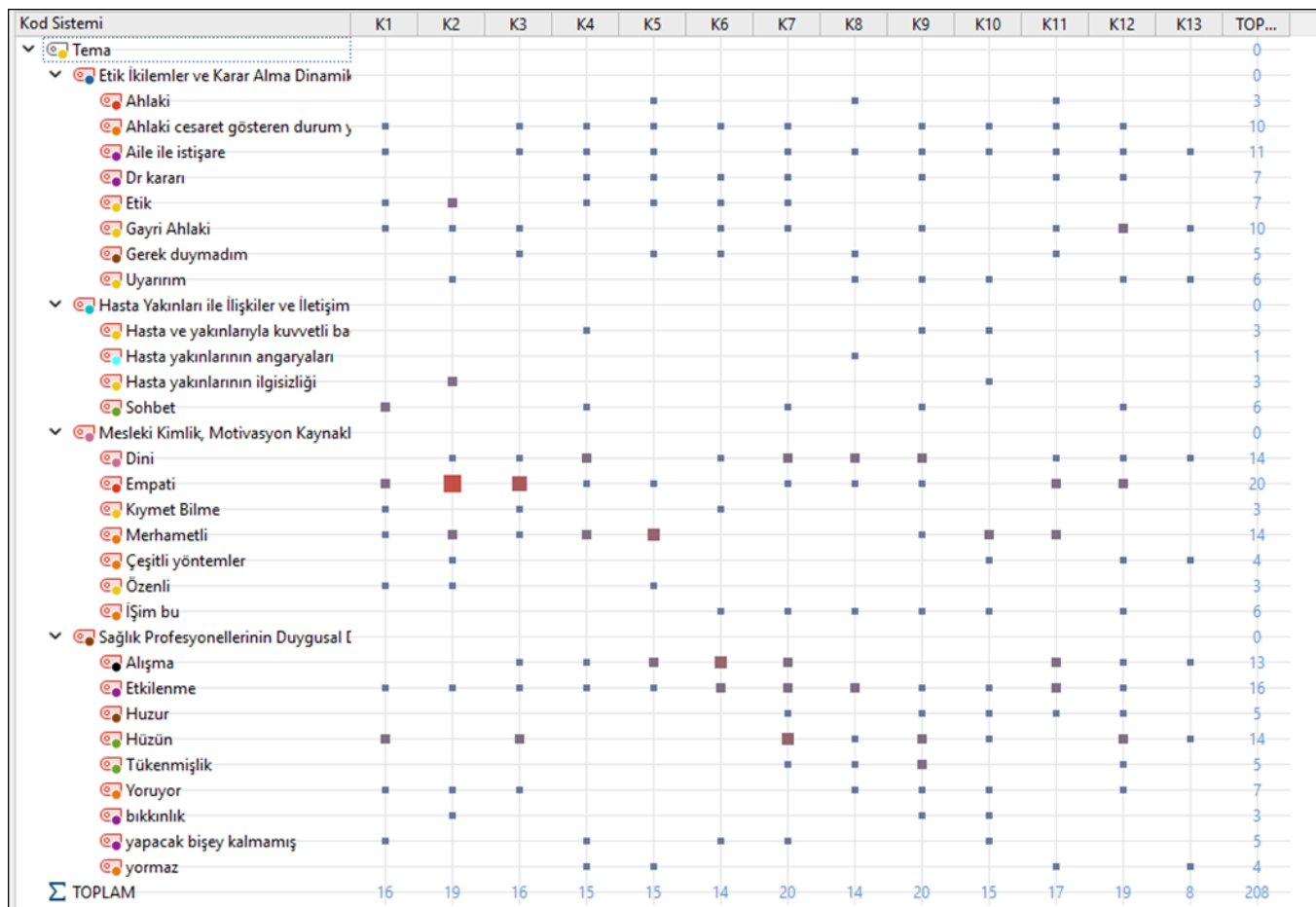
Document Map and Narrative Clustering

The Document Map analysis, based on coding similarities across participants, revealed both shared patterns and individual variations in nurses' experiences. Spatial proximity on the matrix showed that participants N4, N6, and N11 clustered closely together, indicating similar narratives regarding palliative care burdens and moral responses. In contrast, participants N2, N5, N7, N9, N10, and N12 were positioned more distantly from one another on the map. This variance suggests that individual factors—such as clinical tenure, personal coping strategies, or internal acceptance influenced how nurses experienced and managed moral courage and compassion fatigue.

Code Matrix Analysis and Density of Participant Experiences

The Code Matrix Browser analysis illustrated both common and individual patterns in participants' responses. Intrinsic motivators—such as "empathy," "religious/spiritual values," and "compassionate" alongside distress indicators like "emotional impact," "grief," and "exhausting," were consistently present across most interviews. However, code density varied according to professional experience. Less experienced palliative nurses showed higher code frequency for "emotional impact" and "exhausting," while more experienced colleagues exhibited higher representation of codes like "desensitization" and "internal acceptance/serenity." This difference illustrates how coping mechanisms and adaptation to compassion fatigue vary across clinical tenures.

Table 3: Cross-Tabulation Matrix of Code Densities and Cross-Participant Distribution (N=13)



Note: Visual densities from the MAXQDA Code Matrix Browser have been mathematically standardized. Three dots represent maximum conceptual cluster size; two dots represent enhanced focal coding; a single dot indicates baseline presence; empty cells indicate code absence for that participant.

Theme 1: Verbatim Narratives and Qualitative Quotes

Participants noted that performing repeated invasive procedures such as frequent blood draws and difficult peripheral line placements on terminally ill patients often felt unnecessary and distressing. As a result, nurses reported agreeing with families who requested a reduction in aggressive interventions. This shared experience highlights the ongoing conflict nurses face between institutional care protocols and ethical standards:

"You feel deeply, truly saddened because you realize how worn out they are. We draw blood too frequently here. The patients are literally riddled with puncture holes... We can no longer find a vein, we cannot draw blood. This was exhausting us. The patient's family eventually refused blood pressure monitoring, medication, blood draws everything. Inevitably, we also thought, 'It's a pity, this is truly an ordeal for them.'" **(Participant 7)**

"Some families do not want their patients transferred to the ICU; it is already the terminal phase, the end of life. They do not want further interventions. They say, 'Let them pass away peacefully in their bed. Let us stay in the hospital, but just in this bed.' We respect that." **(Participant 10)**

Theme 2: Emotional Experiences of Healthcare Professionals and Compassion Fatigue

Participants reported that frequent exposure to patient deaths and family grief caused gradual emotional exhaustion, regardless of their clinical background. Notably, nurses often shifted their empathetic focus from the deceased patient whom they viewed as no longer suffering toward the emotional distress experienced by surviving family members:

"When people think of palliative care, only sadness comes to mind. Seeing the suffering of the patients, and then seeing their relatives... you look past the patient and feel even more devastated for the family. In the end, the patient passes away and is liberated from that agony, but it becomes much more dramatic for their loved ones..." **(Participant 3)**

"The palliative unit is a completely different domain; it is a difficult place. It heavily impacts human psychology on an emotional level because deaths happen constantly, and relatives are crying, screaming... No matter how much a person claims to be unbothered, standing by that patient as they draw their final breaths profoundly affects you." **(Participant 6)**

Theme 3: Professional Identity, Sources of Motivation, and Perceptions of Care

Participants reported that their motivation to work in palliative care was primarily driven by high levels of empathy, professional commitment, and personal meaning rather than financial rewards. Furthermore, working in end-of-life care influenced nurses' broader life perspectives and professional ethics:

"I go to work with genuine affection. I have never thought, 'Well, I receive a salary here, I earn money, so I am forced to do this.' Money has never been my primary focus. No, I love what I do... And that empathy is vital, both in how you treat the relatives and how you approach the patients. Because they are in a desperate situation; the families' psychologies are already completely shattered." **(Participant 11)**

"Ever since I started working in this department, my perspective on life has profoundly changed. There are far more valuable things in life. No one should hurt or break one another over trivial matters. Life is so short, so beautiful, so precious... What people need most here involves the elderly... Most importantly, if you have raised a good child, they look after you; otherwise, nothing else avails." **(Participant 1)**

When describing how nurses maintain motivation during severe compassion fatigue and burnout, participants emphasized that personal faith and spiritual accountability (fear of God) served as a key coping mechanism, often proving more influential than organizational or financial incentives:

"Not because it is just my profession... I don't think, 'You are forced to do this.' These are elderly people. It's like this: perhaps my spiritual side carries more weight. In fact, in a way, I am glad to be working in

such a unit; I have witnessed so many things... [My religious side] motivates me. The fear of God. It does. It absolutely does." (Participant 4)

Theme 4: Relationships with Patients' Relatives and Communication Processes

The findings suggest that nurses view interactions with patients' families as more than brief clinical encounters. Instead, they handle continuous administrative duties, care coordination, and communication that often continue after discharge. Furthermore, by observing family visitation patterns and caregiving involvement, nurses form observations about family structures and support systems:

"It is never a case of 'the patient is discharged from here, and the story ends.' Formula feeds, medical supply approvals, diaper reports... You are in a state of continuous, uninterrupted communication with the family and the relatives." (Participant 10)

"The approach of the family members is critical. It mirrors their underlying family dynamics. In fact, by observing their attentiveness, how they come to care for them and look after them, we get to learn the true nature of the family relationships of all these patients here. We witness it firsthand." (Participant 1)

DISCUSSION

Emotional Burden and Compassion Fatigue in Palliative Settings

The findings demonstrate a substantial emotional burden associated with palliative care nursing, as 92.31% (n = 12) of participants described experiencing an "emotional impact." Correspondingly, the highest code density occurred in the theme addressing clinicians' psychological burden (n = 72, 34.62%). The experience of witnessing patient deaths and witnessing family grief as reported by N3 and N6 aligns with Galiana et al. [3], who documented similar emotional strain among end-of-life care teams.

A key finding of this study is that nurses often direct their emotional distress away from the patient who is perceived as no longer in pain—and toward the surviving family members. This observation aligns with the relational nature of compassion fatigue. As outlined in Cocker's [5] model, continuous exposure to patient suffering frequently results in secondary traumatic stress. Although the matrix analysis (Table 3) showed that more experienced nurses developed "desensitization" and "internal acceptance" supporting Li et al.'s [6–8] finding that professional tenure can serve as a protective factor longer clinical experience does not completely eliminate emotional vulnerability.

Medical Futility and the Execution of Moral Courage

The theme "Ethical Dilemmas and Decision-Making Dynamics" (n = 59, 28.37%) reflects the moral distress nurses experience when balancing institutional protocols and physician directives with their professional ethics. Participant 7 described the distress caused by repeated, non-beneficial invasive procedures on elderly patients, illustrating the practical impact of medical futility. This finding aligns with

Morley et al. [9], who observed that nurses experience significant ethical conflict when required to participate in aggressive interventions that offer no clinical benefit to the patient.

Participants' decisions to honor family requests to withhold further non-beneficial interventions (N10) reflect the concept of moral courage in daily nursing practice described by Gallagher [10] and Numminen et al. [11]. However, exercising moral autonomy often leads to conflict with medical hierarchies and attending physicians, which can increase nurses' short-term ethical distress [12, 13]. As emphasized by Goethals et al. [14] and Kahriman et al. [15], integrating nurses into end-of-life decision-making and providing institutional support for ethical concerns are essential for maintaining ethical standards in palliative care.

Spirituality and Relational Empathy as Protective Shields

The cross-tabulation matrix (Table 3) indicates that intrinsic motivators, specifically "Empathy" (n = 20) and "Spiritual/Religious Values" (n = 14), represent key recurring themes across the interviews. Participant 11 prioritized professional affection over financial incentives, while Participant 4 identified "fear of God" as a core coping mechanism against burnout. These findings illustrate the protective role of spiritual beliefs in this group of nurses. This observation supports Uzun's [4] finding that local cultural and spiritual values function as primary coping mechanisms for nursing staff in the Turkish healthcare context.

As noted by Galiana et al. [3] and Puchalski [26], spiritual beliefs can help clinicians cope with exposure to end-of-life care, offering protection against compassion fatigue. At the same time, operational demands such as managing post-discharge supply and formula approvals (N10) and evaluating family dynamics (N1) demonstrate that palliative care extends into domestic networks. These responsibilities require nurses to manage administrative tasks and family coordination alongside direct patient care, adding to their overall workload and contributing to relational fatigue [21].

CONCLUSION AND IMPLICATIONS

The qualitative findings derived from MAXQDA analysis demonstrate that healthcare professionals' experiences in palliative care center on three main themes. The first involves psychological burden, marked by emotional impact, grief, exhaustion, and burnout. The second encompasses professional motivation, sustained by clinical empathy, compassion, spiritual/religious values, and a sense of professional duty. The third reflects the complexities of clinical decision-making, shaped by family communications, physician directives, and ethical accountability.

Ultimately, this study demonstrates that palliative nursing requires significant emotional resilience, moral courage, and psychological coping strategies alongside standard clinical skills. To reduce compassion fatigue and maintain quality in end-of-life care, healthcare systems should implement structured psychological support, ethics consultation resources, and interdisciplinary peer-support mechanisms for nursing staff.

Abbreviations

HP

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Declarations

Ethics approval and consent to participate

The study was approved by the Firat University Ethics Committee, Türkiye (Approval No. 2025/18). Written and verbal informed consent was obtained from all participants before the interviews. The study was conducted in accordance with the ethical principles of the Declaration of Helsinki.

Consent for publication

Not applicable.

Availability of data and materials

The datasets generated and/or analyzed during the current study are not publicly available due to the confidentiality and privacy of the participants but are available from the corresponding author on reasonable request.

Competing Interests

The author declares that there are no competing interests.

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Authors' contributions

HP: Conceptualization, study design, data collection, data analysis and interpretation, literature review, and writing of the manuscript. The author read and approved the final manuscript.

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