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Intensive Care Nurses' Constrained Agency in End-of-Life Care: A Qualitative Descriptive Study

Chia-Wei Weng
National Cheng Kung University Hospital, National Cheng Kung University
Yi-Tsen Chu
yitsen@mail.cjcu.edu.tw

Chang Jung Christian University
Chien-Mei Sung
National Defense Medical University
Yen-Chung Ho
National Defense Medical University
Shiu-Yu C. Katie Lee
School of Nursing, National Taipei University of Nursing and Health Sciences

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Abstract

Background

Intensive care unit (ICU) nurses remain continuously present with patients and families as care shifts from life-prolonging treatment to end-of-life (EOL) care, but their formal authority in goals-of-care decisions may be limited. We explored how ICU nurses at Chi Mei Hospital, Liouying, a regional teaching hospital in southern Taiwan, managed clinical, communicative, and relational responsibilities during this transition.

Methods

This qualitative descriptive study recruited 30 adult ICU nurses at Chi Mei Hospital, Liouying, a regional teaching hospital in southern Taiwan, through purposive sampling and voluntary self-enrolment. Three focus groups were held in March 2024. Two researchers used inductive qualitative content analysis to analyse the Chinese-language transcripts. Rigour was enhanced through reflexive notes, independent coding, team discussions, peer debriefing, consideration of divergent cases, participant review of transcripts, and member checking of preliminary theme summaries by three participants (one from each group).

Results

Five themes described how continuous bedside involvement coexisted with limited formal authority: communicating from the margins of decision-making; moving from rescue towards comfort; preserving comfort and dignity beyond the monitor; mediating family conflict while protecting farewells from interruption; and carrying grief without consistent organisational support. Nurses translated bedside observations into action mainly through indirect strategies whose feasibility depended on individual initiative, time, privacy, and staff support.

Conclusions

Although ICU nurses carried substantial clinical, communicative, and relational responsibilities during transitions towards EOL care, they had limited authority to determine or formally change goals of care. Embedding nursing input in goals-of-care review, documenting the purpose and review points of treatment continued for a defined period, protecting family time, strengthening preparation for EOL communication, and providing accessible post-death support may make formal processes more responsive to bedside knowledge.

Background

End-of-life (EOL) care in the intensive care unit (ICU) encompasses decisions about life-prolonging treatment, symptom relief, preservation of dignity, and support for families facing sudden deterioration and uncertainty. Current critical care guidance identifies family-centred communication, elicitation of patient values, structured decision-making, and integration of palliative care as core elements of ICU practice [1–4]. In Taiwan, these processes take place within a legal framework that affirms patient autonomy while families continue to have a prominent role in serious-illness decisions [5–7].

Continuous bedside contact enables ICU nurses to recognise worsening symptoms, limited treatment response, and changes in family readiness before goals of care are formally reconsidered. Nurses also clarify information, provide comfort care, and support families after brief discussions with physicians. International reviews and qualitative studies report wide variation in nurses' involvement in decisions about treatment withdrawal and EOL care, reflecting role ambiguity, physician-led accountability, local law, and professional hierarchy [8–12]. In a prospective analysis of 199 ICUs across 36 countries, reported nurse involvement in EOL decisions ranged from 3% to 44% by region [13]. When nurses judge a situation to be ethically troubling but feel unable to act according to their professional judgement, they may experience moral distress; this differs from broader grief, emotional labour, and burnout [14–16].

Taiwanese cross-sectional studies have identified gaps in critical care nurses' knowledge of EOL legislation and disagreement between nurses and physicians about who should initiate EOL discussions [17, 18]. Cross-sectional data, however, offer little explanation of how authority, family communication, treatment uncertainty, and bedside responsibilities interact as care changes in practice.

Existing Taiwanese and international evidence documents communication barriers, role ambiguity, resource constraints, and emotional strain, but less clearly describes how nurses manage these pressures when they converge in daily ICU practice. Their expression may also vary with local law, family-centred decision norms, and organisational arrangements [5–7]. In particular, little is known about how nurses convert bedside knowledge into action when formal decision-making authority rests elsewhere, or how that constraint affects communication, treatment transitions, family support, and emotional consequences. Close examination of one clinical context can distinguish mechanisms that may transfer across settings from those that require local interpretation.

The study aimed to explore how ICU nurses at Chi Mei Hospital, Liouying, a regional teaching hospital in southern Taiwan, negotiated clinical, communicative, and relational responsibilities during transitions from life-prolonging treatment to EOL care.

Methods

Study design and setting

A qualitative descriptive design was used to provide a clinically grounded account of participants' experiences. Focus groups enabled participants to compare routine practices, differences, and tacit professional norms across the participating units [19, 20]. The study took place in the adult medical-

surgical ICUs at Chi Mei Hospital, Liouying, a regional teaching hospital in southern Taiwan. The study protocol for this site was reviewed and approved by the Institutional Review Board of Chi Mei Medical Center. Physicians led formal prognostic and goals-of-care discussions; palliative care consultation was available; family access was generally time-limited, with flexible exceptions near death; and most bedside care occurred in shared clinical spaces. These contextual features informed participants' accounts of communication, privacy, and farewell.

Given the sensitivity of EOL experiences, several safeguards were used in the focus groups: sessions were held in a private clinical skills centre, the moderator invited disagreement and monitored dominant voices, and participants could decline any question. Individual interviews were available if a participant preferred to discuss a sensitive or emerging issue privately. None was conducted because no participant requested one, post-session debriefs identified no unresolved issue requiring follow-up, and the later groups repeated the main categories. Limitations of the group format are considered below.

Participants and recruitment

Purposive sampling was used. Eligible participants (1) held a registered nurse licence, (2) were employed in an adult ICU and had more than one year of ICU experience, and (3) had direct experience caring for patients receiving EOL care. This experience threshold was selected to ensure sufficient clinical exposure to describe EOL practice in context, although it may have excluded newly qualified ICU nurses whose perspectives could differ.

Recruitment occurred in March 2024 through posters and unit announcements. Interested ICU nurses used a QR code to contact the research team and completed a brief eligibility and demographic form. Eligibility was assessed from the self-reported form and confirmed during direct contact before consent. The sampling strategy sought variation in age, years of experience, and nursing career ladder level. All participants provided written informed consent. Because nurses enrolled themselves, the number who saw the recruitment materials but declined or did not participate could not be determined.

Research team and reflexivity

A nursing faculty member (PhD, RN) with experience in qualitative research and group moderation facilitated all focus groups. An ICU nurse researcher served as observer and co-moderator, recorded interactions and non-verbal behaviour, and asked clarifying questions when invited by the moderator. The ICU nurse researcher had worked in nursing since 2014, including more than seven years in cardiac, respiratory, and medical ICUs, and had completed palliative care training, a palliative ward placement, and graduate coursework in qualitative methods and research ethics. Before data collection, the research team and two qualitative experts reviewed the study questions, interview guide, and facilitation sequence. The two-person data-collection team comprised one male and one female researcher. Neither researcher had a prior relationship with the participants. Participants knew the researchers only as

members of the research team and received information about the study purpose during recruitment and consent.

The ICU nurse researcher's insider knowledge supported contextual understanding but could also influence questioning and interpretation. Reflexive journals and analytic memos were maintained from data collection through theme development. The moderator emphasised that there were no correct answers, invited differing experiences, and avoided evaluative responses. Seating was circular or oval; quieter participants were invited, but not pressured, to speak; and dominant contributions were summarised before discussion was reopened to others. Together with confidentiality agreements, these measures sought to minimise hierarchy and social desirability pressures.

Data collection

A semi-structured interview guide comprising eight open-ended questions was developed from the study aim and literature review and refined with two qualitative experts (Table 1). Questions progressed from broad descriptions of current practice to concrete experiences, emotional responses, barriers, expectations, and possible solutions. Probes included 'What happened at that time?', 'What were you thinking or feeling?', 'Can you tell us more?', and 'What effect did that experience have on you?'

Three focus groups were conducted in a quiet, private room in the hospital's clinical skills centre. Each session began with ground rules covering respectful listening, voluntary sharing, non-judgement, and confidentiality outside the group. Discussions were audio-recorded using a primary and a backup device. The observer documented turn-taking, pauses, tone, emotional expressions, and group dynamics. At the end of each session, the moderator summarised the discussion and invited corrections or additions. The moderator and observer then held an immediate debrief and recorded field notes and reflexive observations. Session composition and duration are reported with participant characteristics in the Results. Only participants, the moderator, and the observer were present.

Table 1
Semi-structured focus group guide

No.	Question
1	How is EOL care currently provided in your ICU?
2	How does care move from active treatment towards EOL care?
3	What experiences and feelings have you had while caring for patients at the end of life?
4	What concerns do you have when providing EOL care?
5	Based on your experience, what would you hope to provide for patients receiving EOL care?
6	What makes it difficult to introduce or provide EOL care in the ICU?
7	What possible solutions could address these difficulties?
8	Which EOL care practices could be incorporated into critical care?

Note. EOL = end-of-life; ICU = intensive care unit.

Data analysis

The recordings were transcribed verbatim in Chinese and de-identified. Inductive qualitative content analysis comprised familiarisation with transcripts and field notes; identification and condensation of meaning units; open coding; comparison and clustering of codes into categories; development of subthemes; and abstraction into themes, with repeated reference to the original data [21]. Coding was organised in Microsoft Excel. We chose an inductive approach to preserve participants' language and avoid imposing a framework on family, professional, and cultural dynamics. Concepts introduced in the Discussion, including epistemic hierarchy, were considered only after themes had been developed from the data. Before coding, de-identified transcripts were returned to three participants, one from each focus group, for review and correction.

The ICU nurse researcher and a second researcher with qualitative experience independently coded the first transcript and agreed on initial code definitions after comparison. After each focus group, the moderator and observer reviewed emerging issues. The two analysts then met as codes were developed into categories, subthemes, and themes. They resolved disagreements by returning to the transcripts and field notes and discussing interpretations until consensus was reached. A third team member with expertise in qualitative research and critical-care EOL practice peer-debriefed the category structure and theme labels. Later transcripts were compared with earlier categories, and divergent accounts were retained when they qualified a developing interpretation. Categories recurred across groups, and no substantively new theme emerged in the third group, supporting the decision to end data collection [22].

Analysis was conducted in Chinese. Quotations selected for the manuscript were translated into English and independently checked against the Chinese text by a bilingual scholar; discrepancies were resolved

through discussion. Quotations are attributed using the de-identified participant codes assigned in the original transcripts. Wording was edited only minimally for readability without changing meaning.

Rigour

Credibility was strengthened through in-session summaries, independent initial coding, peer debriefing, and attention to divergent cases. After preliminary analysis, the same three participants reviewed concise theme summaries and commented on whether they reflected their experiences; this was member checking, not an additional data-generating interview. Detailed reporting of the setting, sampling, participant variation, and contextualised quotations supports assessments of transferability. An audit trail containing transcripts, field notes, code definitions, category revisions, analytic memos, and rationales for theme changes supported dependability and confirmability. Reporting was checked against the Standards for Reporting Qualitative Research (SRQR) and the Consolidated Criteria for Reporting Qualitative Research (COREQ) [23, 24].

Use of generative AI-assisted technology

During the preparation of this work, the authors used ChatGPT to assist with English-language editing and refinement of manuscript organisation and presentation. The tool was not used for study design, data collection, primary qualitative coding, or generation of findings. No identifiable participant data or raw transcripts were entered. After using the tool, the authors reviewed and edited the content as needed and take full responsibility for the content of the published article.

Ethical considerations

The study was conducted in the adult medical-surgical ICUs at Chi Mei Hospital, Liouying, a regional teaching hospital in southern Taiwan. The study protocol for this site was approved by the Institutional Review Board of Chi Mei Medical Center (approval no. 11211-L03). All procedures involving human participants were performed in accordance with the Declaration of Helsinki and relevant institutional guidelines and regulations. All participants provided written informed consent. Participants could decline questions or withdraw without consequences for their employment. Because confidentiality cannot be fully guaranteed in a group, this limitation and the expectation that participants would not disclose others' statements were explained before every session. Identifying details were removed from transcripts, and study data were stored securely with access limited to the research team.

Results

Participants and data set

Thirty ICU nurses participated in three focus groups of 9–11 participants; no participant attended more than one group. Sessions lasted 76–81 minutes (Table 2). Participants varied in age, years of ICU

experience, nursing career ladder level, and recent EOL education. Seventeen participants (56.7%) had received no EOL education in the preceding three years, and 10 (33.3%) had not cared for a patient formally identified as receiving EOL care in the preceding year, although all reported prior EOL care experience during eligibility screening.

Table 2
Participant and focus group characteristics (N = 30)

Characteristic	Category	Information
Data-collection period	Month and year	March 2024
Number of focus groups	—	3
Group size	Range	9–11 participants
Session duration	Range	76–81 min
Age (years)	20–29	12 (40.0)
	30–39	7 (23.3)
	40–49	11 (36.7)
Sex	Female	26 (86.7)
	Male	4 (13.3)
Education	Bachelor's degree	27 (90.0)
	Master's degree or higher	3 (10.0)
ICU experience (years)	1–10	17 (56.7)
	11–20	12 (40.0)
	21–30	1 (3.3)
Nursing career ladder	N0	1 (3.3)
	N1	5 (16.7)
	N2	10 (33.3)
	N3	6 (20.0)
	N4	8 (26.7)
EOL education in preceding 3 years	Yes	13 (43.3)
	No	17 (56.7)
Cared for a patient formally identified as receiving EOL care in the preceding year	Yes	20 (66.7)
	No	10 (33.3)

Note. EOL = end-of-life; ICU = intensive care unit; N = total sample; n = number of participants; N0-N4 = nursing career ladder levels.

Across the groups, nurses described continuous involvement with deteriorating patients and distressed families but limited authority over the timing or direction of formal EOL decisions. Five themes and 11 subthemes showed how they worked within this disparity, using indirect strategies to convert bedside observations into communication, treatment planning, comfort care, family support, and emotional management (Table 3).

Table 3
Themes and subthemes

Theme	Subthemes
1. Communicating from the margins of decision-making	Training gaps and a constrained communication role; power asymmetry and borrowed authority; time compression
2. Moving from rescue towards comfort	An unclear trigger for EOL care; gradual acceptance through trial-like practices
3. Preserving comfort and dignity beyond the monitor	Uncertainty when interpreting physiological indicators; varied comfort practices without a consistent process
4. Mediating family conflict while protecting farewells from interruption	Emotional work amid family disagreement; interrupted farewells and limited space for privacy and ritual
5. Carrying grief without consistent organisational support	Limited formal support; individualised and divergent coping strategies

Note. EOL = end-of-life.

Theme 1: Communicating from the margins of decision-making

ICU nurses' communication work was extensive, but families often treated it as provisional until a physician provided the same information. Nurses repeatedly explained deterioration, checked understanding, and remained with families after physicians had left. A participant described this difference in perceived credibility:

"We have explained it many times during routine care, but families usually do not really take it in until the physician has said it." (X)

"When the physician says the patient will die, the family accepts it more readily than when we say it." (Y)

This difference in perceived authority affected when nurses felt able to initiate EOL discussions. Although they could raise concerns within the team, many waited for a physician to establish the direction of care before discussing do-not-resuscitate orders or treatment limitations explicitly with families:

"If the medical side has not started the process, nursing does not know which direction to take. It is hard for us to bring up DNR when the physician feels, 'I have not even said we should stop yet.'" (A)

To work within this hierarchy, nurses anchored their explanations in previous medical statements before adding bedside observations and clarification. Families were more likely to accept the message, but the approach also left nursing knowledge dependent on physician endorsement. Limited education further reduced confidence when families were overwhelmed or raised practical and spiritual concerns. A less experienced participant explained:

“When a family is extremely distressed, I do not always know how to stay with them or what to say. I ask the team leader, a senior nurse, or the palliative care nurse to help.” (L)

Communication remained difficult even for trained nurses when time and staffing were limited. One participant described caring for two or three patients at night while also receiving emergency admissions; another noted that training could not compensate for the absence of protected time. Nurses' silence could consequently reflect uncertain role boundaries, limited preparation, or competing tasks rather than indifference.

Theme 2: Moving from rescue towards comfort

Nurses rarely experienced the transition from life-prolonging treatment to EOL care as a discrete event. They often recognised irreversible decline before the formal care plan changed, yet physician practices varied and no consistent clinical trigger prompted EOL review. A senior participant explained that nurses could assess the situation and suggest a review while the physician retained responsibility for the formal determination:

“The attending physicians in our units are different, so the approach also differs. We make our own assessment. Less experienced staff may find that difficult, but most ICU nurses can suggest to the physician that the patient may already meet EOL criteria.” (N)

During this period of uncertainty, participants described informal or variably structured practices that resembled time-limited trials. Because the study hospital had no formal programme, we refer to them as trial-like practices. Physicians proposed, or the team discussed, these plans; nurses monitored the patient's response, reiterated explanations, and helped families understand what would happen next. For some families, this interval created time to prepare for a transition that otherwise felt abrupt:

“The team may say, 'We will try for a few more days and see how the treatment works.' I think the preparation starts then. When the trial ends, some physicians explain clearly that we have tried and there is no sign of recovery.” (E)

When life-sustaining treatment was reduced, participants described analgesia or sedation as part of the shared care plan to relieve distress:

“Sometimes the family asks whether we can keep the patient comfortable and gradually reduce the vasopressors rather than prolong treatment. The team discusses the shared care plan, and symptom-directed analgesia or sedation is provided so that the patient does not suffer.” (J)

A gradual approach could also prolong ambiguity. When the purpose, timeframe, and stopping criteria were not explained consistently, relatives could interpret continued treatment as evidence of possible recovery. Nurses then implemented interventions they believed offered little benefit while responding to families' repeated questions. Participants considered trial-like practices useful only when goals, review points, and the interprofessional message were explicit and consistent.

Theme 3: Preserving comfort and dignity beyond the monitor

For patients who could not communicate, comfort was assessed through breathing patterns, facial expressions, movement, and physiological indicators. Analgesic or sedative infusions were common, but participants remained uncertain whether observable signs captured subjective suffering:

"If the patient is at the end of life and cannot express anything, we mostly look at the monitor. If the vital signs are fairly stable and there is no obvious struggling, we think the patient is probably more comfortable." (K)

"We may not know how to assess pain when the patient cannot communicate. We can only respond to the vital signs we can see, but the patient may be in pain that we cannot feel, or the pain may not be what we imagine." (Y)

Alongside symptom management, nurses used relational, spiritual, and symbolic practices. They asked about religious preferences, arranged visits from clergy, enabled family presence, groomed patients, created pastel artwork with relatives, and preserved keepsakes. One participant described a unit-based activity:

"Our unit has a pastel drawing activity. Whether the patient is awake or less conscious, we help the patient and family complete something together. The family can take it away, and it can bring comfort afterward." (Q)

"If I can give the patient the care they need at the end, provide basic comfort, preserve some dignity, and allow family companionship, I feel that matters and that the person can leave with fewer regrets." (H)

These practices varied across units and often depended on whether an individual nurse recognised the opportunity and had time to act. In participants' accounts, dignity was integral to comfort: it extended care beyond measurable symptoms to appearance, spiritual meaning, family connection, and the manner of farewell.

Theme 4: Mediating family conflict while protecting farewells from interruption

After physicians provided prognostic information, ICU nurses often remained with families to clarify its meaning and respond to the immediate emotional impact. They asked what relatives had understood,

explained likely next steps, and helped family members articulate different concerns:

“Sometimes the physician explains the situation briefly and leaves. We then step in and ask, 'After hearing that, what are you thinking?'” (E)

“When the physician has said the condition is unlikely to improve and the family is still undecided, we become a bridge. We help them understand what may happen next and what choices they have about the direction of treatment.” (B)

Disagreement within families arose from differing interpretations, strained relationships, or financial dependence on the patient. Nurses generally did not try to resolve it in a single conversation. They spoke with relatives separately and gradually brought their concerns into a shared discussion:

“When family members disagree, we talk with them one by one, find out what each person is worried about, and slowly see whether they can reach some common ground.” (N)

Participants distinguished continuity of communication and family support from continuity of nursing assignment. Their concern was to preserve sufficient, uninterrupted time for understanding and farewell. Routine ICU work repeatedly curtailed this time: suctioning, turning, bathing, paperwork, visiting restrictions, and pressure to prepare a bed for the next admission fragmented families' time together:

“The family is already crying, but my next question has to be, 'Have you called the ambulance? Have you prepared the clothes?' The team leader is also telling me that another patient will need the bed.” (AB)

“Even with flexible visiting, there are time limits. The ICU is not private. With unfamiliar people nearby, patients and families may find it difficult to say what they want to say.” (L)

Moving a grieving family to administrative tasks before relatives had completed their farewell caused nurses discomfort. Alongside clarifying information, they tried to preserve time and space against institutional interruption.

Theme 5: Carrying grief without consistent organisational support

Formal support after a patient's death was inconsistent. Palliative care staff were not always available, particularly on holidays, and the bed sometimes had to be cleaned immediately for another admission. One participant described the speed of this transition:

“After they leave, we have to ask staff to clean quickly because emergency patients are waiting, especially on holidays. Your own feelings have not settled and the bed is not even cold, but you have to receive the next patient.” (AA)

Some participants described physical manifestations of grief, such as dizziness, nausea, or vomiting. Others cried privately or sought support from a trusted colleague. One participant recalled an unmet

request that remained emotionally vivid:

“I kept thinking, why did I not meet that need at the time? I did not know when the patient would deteriorate, and now there was no other chance. After the patient died, I went into the bathroom and cried. Even now, talking about it makes me want to cry.” (D)

Coping was not uniform. Some ICU nurses reframed an expected death as relief from suffering; others deliberately separated work from personal emotion. A divergent account emphasised emotional distancing:

“I came to treat it as work. I do what I should do, and when I leave that environment I move on because there are other tasks. I do not keep that emotion inside.” (S)

Participants' responses reflected varied forms of emotional distress and grief. Across groups, emotional processing remained largely individual and usually occurred in private or after working hours. They requested practical education, access to experienced palliative care colleagues, and recognised time for reflection after difficult deaths.

Discussion

Interpretation of findings

Nurses' continuous bedside involvement did not translate into equivalent authority over goals-of-care decisions. They observed deterioration, clarified information, managed symptoms, and supported families, while formal changes in care remained physician-led. This accords with reviews and qualitative studies that attribute variable nursing participation to role ambiguity, professional hierarchy, and local team practices [9–12, 25], as well as multicountry evidence of substantial regional variation [13]. In the present study, nurses responded through indirect strategies: anchoring explanations in physician statements, assessing family readiness over repeated encounters, implementing trial-like plans, and escalating concerns. These practices constituted constrained agency because nurses could influence care, but largely through channels defined by an unequal decision-making structure.

One explanation for this disparity is an epistemic hierarchy in which the weight given to clinical knowledge depends partly on who presents it [26, 27]. The data do not indicate complete exclusion: nurses could suggest reviews, document concerns, and support family understanding and deliberation. Their agency was indirect and limited rather than absent. Moral distress was evident only in accounts that combined an ethically troubling situation with a perceived inability to act [14, 15, 28]. Reports of grief, sadness, nausea, and emotional labour were interpreted as emotional distress when participants did not also identify a specific ethical concern and constraint. Qualitative evidence similarly shows substantial emotional labour among nurses across ethically uncertain EOL practices [29].

Participants experienced trial-like practices ambivalently. Explicit purposes, timeframes, and stopping criteria allowed families time to understand the prognosis without framing withdrawal as abrupt abandonment; unclear arrangements prolonged uncertainty and left nurses implementing care they considered non-beneficial. A structured time-limited trial programme has been associated with more family meetings and lower treatment intensity without worse hospital mortality or family satisfaction [30], and qualitative work indicates that time can help teams manage prognostic uncertainty [31]. The American Thoracic Society defines a time-limited trial as a collaborative plan to use life-sustaining treatment for a defined period and then use the patient's response to decide whether to continue recovery-focused care, shift to comfort-focused care, or extend the trial; it also cautions that poor implementation may perpetuate harm [32]. This literature is principally interprofessional or physician-led. Our data instead delineate a nursing role in implementing and explaining trial-like practices and escalating bedside concerns, without implying unilateral nursing authority to design or terminate them. Shared explanations, predefined review criteria, and a formal route for nursing observations to inform team decisions are therefore important to their ethical use [4, 32].

Participants understood comfort as more than pain control. They combined physiological observation with grooming, spiritual support, keepsakes, and family presence, thereby preserving aspects of personhood that technology-centred workflows could obscure. Shared spaces, visiting restrictions, routine procedures, and bed turnover nevertheless fragmented families' opportunities to understand the situation and say goodbye. Current guidance, an umbrella review, and qualitative studies support structured communication, symptom management, family support, and integration of palliative care [1–4, 33–35]. A cluster-randomised trial also found that a physician-driven, nurse-aided, three-step support strategy reduced prolonged grief symptoms six months after an ICU death [36]. The present accounts indicate that protected time, privacy, continuity, and explicit responsibility for family communication are practical conditions for delivering such care.

Staff distress was tied to work organisation as well as individual coping. Responses ranged from private crying and peer conversation to reframing and emotional distancing, cautioning against assumptions that all nurses need or prefer the same form of support. Reviews identify limited support for critical care nurses after patient death [37] and wide variation in bereavement programmes for families [38, 39]. Units could offer, rather than require, debriefing and address the workload and workflow conditions surrounding difficult deaths; without these changes, support itself may become an additional demand.

Focus groups allowed participants to compare practices across units, challenge assumptions, and articulate otherwise tacit role boundaries. The sample varied in age, ICU experience, and nursing career ladder level, and the analysis retained divergent accounts of coping. Reporting of the research team, interview guide, group composition, analytic responsibilities, and quality procedures provides a transparent account of how the findings were produced.

Limitations

Several limitations affect interpretation. The study drew on one hospital in Taiwan. Although role ambiguity, unequal decision-making authority, family uncertainty, and emotional burden have also been reported internationally, their expression is likely to vary with legal requirements, family decision norms, staffing, palliative care availability, visiting rules, and the use of shared clinical spaces. Transferability to other countries, hospitals, and ICU types should be judged cautiously. Voluntary self-enrolment may have attracted nurses with greater interest in or experience of EOL care. Focus groups may favour socially acceptable accounts, suppress sensitive disagreement, and reproduce seniority hierarchies; groups of 9–11 participants may also have limited individual speaking time despite active moderation. Private sessions, balanced facilitation, and confidentiality ground rules reduced but could not remove these risks. Individual interviews or ethnographic observation may elicit experiences not voiced in a group. Prior EOL experience was self-reported rather than verified against clinical records, and one third of participants had not cared for a patient formally identified as receiving EOL care in the preceding year. Recall and variation in how EOL care was labelled may have influenced their accounts. The analysis represents nurses' perspectives only; patient, family, physician, and palliative care perspectives are needed to examine how authority and communication are negotiated across the team. Translation may also have reduced cultural nuance despite bilingual checking.

Implications for nursing practice and research

Four practice implications follow. ICUs could (1) define nursing triggers for interprofessional goals-of-care review, such as persistent symptom burden, repeated family misunderstanding, or a marked discrepancy between treatment and the patient's expressed values; (2) include a brief nursing contribution in family meetings and rounds that addresses symptom burden, family understanding, and unresolved concerns; (3) document the purpose, duration, clinical review criteria, and communication plan when treatment is continued for a defined period; and (4) protect privacy and uninterrupted family time during active dying while providing education in EOL communication, access to palliative care consultation, and optional post-death debriefing. Nursing triggers would prompt interprofessional review, not transfer decision-making authority to one profession. These recommendations are consistent with guidance that embeds palliative and family-centred care in ICU systems [2–4, 32, 33, 36, 40, 41] and with a recent meta-synthesis linking nurses' moral dilemmas to non-beneficial treatment, limited nursing voice, insufficient family involvement, and inadequate organisational support [42].

Conclusions

In this single-hospital study, ICU nurses had limited formal authority despite their continuous involvement in EOL care. They clarified information, supported gradual changes from rescue-oriented to comfort-focused care, attended to dignity beyond physiological measures, mediated family disagreement, and tried to preserve time for farewell. Their ability to act depended heavily on individual initiative and was restricted by role boundaries, time, privacy, and inconsistent staff support. Institutional mechanisms that incorporate nursing observations into goals-of-care review, specify the purpose and

review points of treatment continued for a defined period, protect family time, prepare staff for EOL communication, and offer post-death support may better support these responsibilities.

Abbreviations

COREQ
Consolidated Criteria for Reporting Qualitative Research
DNR
do-not-resuscitate
EOL
end-of-life
ICU
intensive care unit
SRQR
Standards for Reporting Qualitative Research.

Declarations

Ethics approval and consent to participate

The study was conducted in the adult medical-surgical ICUs at Chi Mei Hospital, Liouying, a regional teaching hospital in southern Taiwan. The study protocol for this site was approved by the Institutional Review Board of Chi Mei Medical Center (approval no. 11211-L03). All procedures involving human participants were performed in accordance with the Declaration of Helsinki and relevant institutional guidelines and regulations. All participants provided written informed consent before participation.

Consent for publication

Not applicable. No identifiable individual data are presented.

Competing interests

The authors declare that they have no competing interests.

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Author Contribution

C.-W.W. and Y.-T.C. contributed to conceptualization, methodology, validation, formal analysis, investigation, and writing of the original draft. Y.-T.C. also contributed to writing – review & editing, supervision, and project administration. C.-M.S. and Y.-C.H. contributed to validation, formal analysis, writing – review & editing, and supervision. S.-Y.C.K.L. contributed to validation, writing – review & editing, and supervision. All authors have read and agreed to the published version of the manuscript.

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Data Availability

An earlier version of this manuscript has been posted as a preprint on SSRN (https://doi.org/10.2139/ssrn.6844788). The preprint has not undergone peer review. The current manuscript has been substantially revised in its analytic framing, reporting, and interpretation.

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