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"We Desperately Need More Training": A Qualitative Exploration of Emergency Department Nurses' Experiences with and Training Needs for End-Of-Life Communication

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Abstract

Background

Approximately 75% of decedents aged ≥ 65 years visited the emergency department in their last six months of life, underscoring the emergency department as a pivotal setting for end-of-life communication. Nurses play a significant role in palliative care, however, little research has been performed on their end-of-life communication experiences and training needs.

Methods

A qualitative descriptive study reported with reference to the COREQ checklist was conducted. A total of 12 ED nurses from a tertiary hospital in Shenzhen, Guangdong Province, China, were recruited through a purposive sampling method. Semi-structured interviews were conducted from April to June 2026, audio-recorded, and transcribed verbatim. Data were analysed using qualitative content analysis with an inductive coding approach.

Results

Four overarching themes were identified, including: (1) *Complex emotional experiences (Powerless and conflicted; Compassionate and sorrowful; Fear of communication missteps; Compassion fatigue; Sense of mission and achievement)*; (2) *Multidimensional barriers (Environment-related; Patient-related; Family-related; Nurse-related barrier)*; (3) *Core knowledge and skills needs (Disease-related knowledge; Psychology-related knowledge; Breaking-bad-news skill; Empathy and emotion regulation skill)*; and (4) *Expectations for future training (Specialized teaching content; Practical teaching method; Accessible teaching format)*.

Conclusions

Participants perceived a need for practical and ED-specific EOL communication training. Future programs should adopt blended, simulation-based, and context-specific pedagogical frameworks to address the identified gaps.

Background

As population age and medical advances enable people to live longer with serious chronic illness, the number of individuals with life-limiting conditions is rising, placing growing strain on healthcare systems worldwide [1]. For many such patients, further medical curative or life-prolonging interventions offer diminishing benefit and instead impose avoidable physical and psychological burden [2]. Because acute crises and untreated symptoms remain common even in advanced disease, the emergency department

(ED) — traditionally oriented toward reversible illness — is increasingly a first point of contact where these patients seek crisis care and symptom relief [3, 4]. One study found that 51% of decedents aged ≥ 65 visited an ED in the final month of life and 75% within the final six months, underscoring how often the palliative care trajectory originates in the ED [5].

Given how often palliative care needs first surface in the ED, timely initiation of palliative care in this setting is increasingly recognized as a priority. Early palliative care involvement has been associated with shorter hospital stays, fewer ED returns, and greater hospice care utilization [6]. There is substantial evidence that early end-of-life(EOL) communication about goals of care and planning benefits patients, helping to ensure they receive the care they want while alleviating anxiety and supporting families [7–9]. Yet such communication remains infrequent in ED practice, usually constrained by environmental, knowledge-related and psychological barriers, with adverse consequences for symptom control and patient trust [7, 10, 11].

Although the perspectives of physicians and patients on EOL conversations have been studied, ED nurses' communication knowledge, the barrier they encounter in practice, and their educational needs for ED-specific communication remain comparatively unexplored [11–13]. This qualitative study therefore explores these under-examined dimensions through ED nurses' experiences of EOL communication, with the aim of informing future ED-targeted communication training.

Methods

Study Design

This study adopted a qualitative descriptive design to obtain a practice-based account of ED nurses' experiences and perceived training needs [14]. Individual semi-structured interviews were used for data collection. The study was reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist [15]. The completed COREQ checklist is provided as Supplementary File 1.

Setting, participants and recruitment

This study was conducted in the ED of Shenzhen People's Hospital, a large tertiary hospital in Shenzhen, Guangdong Province, China. The ED is a high-volume setting that provides acute and emergency care to a large and heterogeneous population, including a considerable proportion of patients with life-limiting illnesses, and therefore offers an appropriate context in which to examine EOL communication between nurses and patients and their families.

A purposive sampling strategy was used to recruit ED nurses who could provide rich, practice-based accounts of EOL communication. Eligible participants were registered nurses currently working in the ED who had experience caring for patients at end of life and were willing to discuss their experiences. They were approached face-to-face by the first author (SW) during their regular shifts. Sampling continued until data saturation was achieved. Data saturation was assessed by monitoring the emergence of new

codes across consecutive interviews; when analysis of recent transcripts yielded no new codes or themes, two additional interviews were conducted to confirm saturation before data collection concluded [17]. The sample size was also informed by the principle of information power [16]. In total, 12 ED nurses participated in this study. As detailed in Table 2, participants varied in age (23–44 years), sex, professional title, marital status, years of ED experience (1–24 years), educational background, and work area—covering the emergency ward, emergency intensive care unit (EICU), rescue room, and observation room—thereby capturing diverse perspectives across ED sub-units.

Data collection

Interviews were conducted by the first author (SW), a male Master's student in Nursing with prior ED clinical experience at the same tertiary hospital, and a second researcher (JS), a female Master's student in Nursing as well, assisted as an observer and note-taker. Both researchers had received systematic training in qualitative research and interview skills. Neither interviewer held any clinical, educational, or supervisory role over the participants, and a brief rapport-building conversation preceded each formal interview to encourage open disclosure.

An interview guide (Table 1) was developed by the research team from a focused review of the literature on EOL communication in emergency and critical-care settings and was aligned with the study aims. Miller's Pyramid of Clinical Competence was used as a sensitizing framework to help ensure the interview guide covered the range of competency levels from what nurses "Know" and "Know How" to do, to what they "Show" in practice and actually "Do" in clinical settings [18-20]. The framework informed question development only; data analysis followed an inductive approach and was not constrained by the pyramid structure. The guide was refined through team discussion and two pilot interviews with eligible ED nurses; because the substantive questions remained unchanged after piloting, the two pilot participants were retained in the final sample (N = 12). Before each interview, the researcher explained the purpose and methods of the study, after which participants completed a short demographic questionnaire.

Interviews were carried out between April and June 2026 in a separate and undisturbed meeting room within the hospital. Each participant was interviewed once, and all interviews were audio-recorded with the participant's written consent. Interviews lasted about 40 minutes.

Given the sensitive nature of discussing care for dying patients, participants were informed before the interview that they could pause or withdraw at any time and were offered the opportunity to debrief with the interviewer or consult a hospital psychologist if they experienced distress. Immediately after each interview, the note-taker (JS) recorded field notes on non-verbal cues, the interview atmosphere, and contextual observations.

The research protocol was approved by the Clinical Research Ethics Committee of Shenzhen People's Hospital (Approval No. LL-KY-2026030-01).

Table 1 Interview guide

Questions	The corresponding level of Miller's Pyramid of Clinical Competence
1. How would you describe what "end-stage disease" means in your clinical experience? Can you share some examples?	Knows
2. How do you experience your communication with EOL patients? What difficulties do you encounter?	Does
3. What knowledge or skills do you find yourself needing when communicating with EOL patients? Please explain why.	Knows How
4. Have you attended any training on nurse-patient communication? How do you perceive these training programs? How do you evaluate these training programs? Is there anything you feel could be improved?	Shows How
5. What content do you expect to learn in EOL communication training? What teaching forms and formats do you prefer?	All levels
6. Do you have any other suggestions for our future communication training program?	/

Data analysis

All interviews were audio-recorded and transcribed verbatim within 24 hours. Each transcript was cross-checked against the original audio recording and the field notes to ensure accuracy and completeness, and was then imported into NVivo 15.0 to support data management and coding.

Data were analysed using qualitative content analysis with an inductive approach. SW and JS coded the transcripts independently; coding discrepancies were resolved through team discussion, with FC consulted as a third reviewer when consensus was not readily reached. Initial codes were developed directly from participants' accounts and were iteratively compared and contrasted across transcripts. Through team discussion, related codes were grouped into categories, which were subsequently synthesized into broader themes.

Because the interviews were conducted in Chinese, all quotations selected for presentation were translated into English. Semantic equivalence was ensured through back-translation by an independent bilingual researcher (SX), and any discrepancies were reviewed against the original Chinese transcripts and resolved by team consensus to preserve participants' intended meanings.

Rigor

To enhance trustworthiness, Lincoln and Guba's framework was adopted [21]. Credibility was established through member checking: transcripts were returned to all 12 participants to verify accuracy. Their feedback led to minor wording corrections, which were incorporated into the final records. Additionally, investigator triangulation was employed — two researchers (SW and JS) independently

coded the transcripts, with discrepancies resolved through discussion with a third researcher (FC). Dependability was enhanced through systematic documentation of all analytical decisions and regular team debriefings to ensure coding consistency. Confirmability was addressed via a reflexive journal kept by the first author (SW) throughout data collection and analysis, which served to document and encourage ongoing reflection on pre-existing assumptions and potential researcher bias. Transferability was addressed by providing thick description of the research context, participant characteristics, and interview settings.

Results

A total of 12 ED nurses participated in the study. Participants were distributed across different work areas in the ED, with clinical experience ranging from 1 to 24 years. Detailed demographic characteristics of the participants are presented in Table 2. Through qualitative content analysis, four overarching themes were identified using a theme-participant-quote matrix (Fig. 1): (1) *Complex emotional experiences*; (2) *Multidimensional barriers*; (3) *Core knowledge and skills needs*; (4) *Expectations for future training*.

Table 2 Demographic characteristics of the participants (N = 12)

No.	Age	Sex	Professional title	Marital status	Working years	Educational background	Work Area
1	23	Male	Registered nurse	Unmarried	1	Bachelor	Emergency ward
2	24	Female	Senior nurse	Unmarried	2	Bachelor	EICU
3	23	Female	Registered nurse	Unmarried	1	Bachelor	Rescue room
4	29	Male	Senior nurse	Unmarried	4	Master	Rescue room
5	30	Female	Charged nurse	Married	10	Bachelor	EICU
6	44	Female	Charged nurse	Married	24	Bachelor	EICU
7	31	Male	Registered nurse	Married	7	Bachelor	EICU
8	32	Female	Charged nurse	Married	9	Bachelor	Emergency ward
9	43	Female	Charged nurse	Married	20	Associate	Rescue room
10	37	Female	Charged nurse	Married	13	Bachelor	Observation room
11	28	Female	Senior nurse	Unmarried	5	Bachelor	Observation room
12	35	Female	Charged nurse	Married	16	Bachelor	Emergency ward

Theme 1: Complex emotional experiences

EOL communication elicited layered, at times contradictory, emotional response among the participating nurses. Instead of a uniform reaction, nurses described oscillating between feelings of powerlessness and inner conflict, compassion and sorrow for patients, fear of communication missteps, and progressive depletion of personal emotional reserves. Some nurses also reported deriving a sense of professional meaning from effective EOL communication.

Powerless and conflicted

Nurses frequently described being caught between clinical realities and family hopes, experiencing powerlessness and internal conflict, a tension that could not be resolved through medical interventions alone. This strain manifested in quiet feelings of helplessness, the careful guarding of their words, and the moral tension of families' hopes while recognizing that further treatment would not alter the clinical outcome.

“I just feel so sorry for them… I don't know how to make them feel even a little better. When facing them, I don't know what to say, words come out stiff and awkward. And sometimes I feel so powerless, because words alone can't ease the sufferings they carry.” — Nurse 2

“My heart is really torn. I totally understand the family unwilling to let the patient go. But when I look at the patient, tubes everywhere, struggling to breathe… (sighed) very agonizing. I know further interventions won't change anything, yet I can't get the family to accept this reality. I have to soothe the family's emotions while still telling them the truth, it's a real ordeal.” — Nurse 9

Compassionate and sorrowful

Nurses reported deep compassion for their patients, intertwined with sorrow for the losses they observed. Witnessing patients' suffering and the grief of families, nurses described an empathetic pain, alongside an urgent desire to comfort and stand with both patient and family.

“Because some of them are right in their prime, in their 30s or 40s. It just feels like—if they hadn't gotten sick, they could have had a much better life.” — Nurse 2

“I said, ‘Sir, you’re in the hospital now, we have you on oxygen, just breathe slowly.’ He didn’t speak, but his eyes stayed on me, there was fear in them, and a plea for help. Later, when he’d settled a little, he asked if he was dying soon… How miserable!” — Nurse 6

Fear of communication missteps

A distinct and frequently reported emotional concern, particularly among less-experienced nurses, was the fear of making missteps during EOL conversations. This apprehension constrained both the depth of their discussions and their willingness to take initiative in EOL communication.

“Back then, I was afraid I would say something inappropriate… The toughest thing was I ought to be honest, but I also worry the bad news may upset him.” — Nurse 5

“The most prominent feeling… I think it’s fear. Not fear of the patients themselves, but fear that I might say something wrong. Every time I talk with families, there is a constant tension in my mind. I keep thinking, ‘Will saying this get me into trouble?’… Perhaps because I am young, with only five years of working experience.” — Nurse 11

Compassion fatigue

Close contact with dying patients took a cumulative emotional toll. Nurses described actively suppressing their own feelings to maintain a professional front, even as their mental and physical health suffered.

“The longer you care for them, the easier it is to become attached. Then the patient’s condition deteriorates, I witness them go from speaking freely to losing their strength to talk entirely. Every time that happens, I feel

sad." — Nurse 12

"But if I let myself get upset every time I care for a patient like this, I would not be able to keep my work going. I feel worn-out inside, yet I cannot show it outwardly; I just act as if I am fine. And that…(sighed) really wears me down." — Nurse 11

Sense of mission and achievement

Not all emotional experiences were negative. When ED nurses succeeded in supporting end-stage patients and families to reach decisions that alleviated suffering, they reported perceptions of professional value and meaning. These emotional rewards reaffirmed their sense of purpose in delivering EOL care.

"Sometimes during communication with this kind of patients, I brought warmth to them through my words… Then, even the patient eventually passed away, families grabbed my hand appreciatively and said, 'Thank you.' In those moments, I felt what I've done was completely worthwhile (laughed)." — Nurse 4

"Through my effort, I helped family members better cope with the pain of losing their loved one. When they took my hand to express their gratitude, I was aware of how demanding nursing work can be, yet these moments brought me a profound sense of professional reward." — Nurse 7

Theme 2: Multidimensional barriers

Nurses reported that barriers to EOL communication in the ED were multidimensional and mutually reinforcing, rather than resulting from any single determinant. These obstacles encompassed structural limitations of the emergency setting, patient-level clinical conditions, family-related issues including cultural beliefs around filial piety, and gaps associated with nurses' competence and interdisciplinary information sharing.

Environment-related barrier

Nurses mentioned that the chaotic emergency department environment, characterized by rapid workflow pace, persistent noise, and insufficient private consultation space, serves as a major physical barrier that hinders the delivery of focused and meaningful EOL communication.

"The ED is too noisy for an in-depth communication; monitors are beeping, phones are ringing, and staff are calling out. I want to have a good chat with the patient or their family, yet there is nothing but overwhelming noise all around us. It is hard to focus on end-of-life conversations in such conditions." — Nurse 1

"First, I think the environment is not good for communication. It is crowded, noisy, and the working pace is fast. A lot of the time, we're trying to talk to the family while rescuing the patient. There's no quiet or private space. And the family is so anxious, it's really hard for them to calm down and listen to what we're saying." — Nurse 4

Patient-related barrier

Patient-related barriers to EOL communication stemmed from a combination of physical limitations and psychological resistance. Physically, patients' impaired consciousness and endotracheal intubation rendered verbal interaction impossible. Psychologically, many patients refused to acknowledge their critical condition, adopting an illness denial mindset that actively blocked effective EOL communication.

"A lot of end-stage patients stay unconscious, and they rarely come around. Patients on endotracheal intubation have no way to communicate either. How can we have a talk with them?" — Nurse 3

"Most of these patients simply don't want to talk. Some refuse to accept their illness and remain in denial the entire time, shutting down all communication with us… They're afraid deep down." — Nurse 8

Family-related barrier

Nurses described family obstacles to EOL communication mainly manifested in three aspects: denial of grim prognoses, persistent demands for aggressive treatment driven by filial piety norms, and internal disagreements that prevented family members from reaching a unified medical decision.

"They simply failed to come to a consensus. The patient's wife wanted to try every option — every beneficial drug and every advanced medical device. In contrast, other family members believed ongoing resuscitation was futile, and would only prolong unnecessary suffering." — Nurse 7

"Traditional values also play a big role. In China, most people regard foregoing treatment as an act of unfilial conduct, seen as failing to fulfill their duties as a good child. Caught between concerns over social face and heavy emotional strain, families are reluctant to consent to the withdrawal of life-sustaining treatment." — Nurse 9

Nurse-related barrier

Nurses perceived themselves ill-equipped to conduct EOL communication, attributable to insufficient expertise, unclear professional role boundaries, and delayed information exchange with physicians. These drawbacks rendered nurses hesitant to initiate such discussions.

"I'm really not ready to handle these tough conversations. I only started working in the emergency department last year, so I don't have much hands-on experience yet. On top of that, I've never taken any training courses about end-of-life communication at all." — Nurse 3

"I think it really comes down to not having proper training… I often feel like I don't know enough, and I'm always unsure about what I'm supposed to say as a nurse versus what the doctor should be the one to say — I just don't know where my role ends and theirs begins." — Nurse 6

"We often don't get timely updates on finalized medical decisions from physicians, even though we care for patients around the clock right by their bedsides. When families come to consult us with questions, we

seldom have clear information ready, leaving us at a loss." — Nurse 12

Theme 3: Core knowledge and skills needs

Disease-related knowledge

A strong command of disease-related knowledge is a prerequisite for effective EOL communication. Without adequate knowledge of disease trajectories, treatment effects, and prognoses, nurses lack the confidence to answer questions from patients, leading to hesitation and avoidance of communication.

"I'd say nurses absolutely need to have a solid grasp of the disease fundamentals. If you don't understand the condition yourself—its causes, symptoms, and treatment logic—how can you possibly explain it clearly to a patient with confidence? Without that foundation, you're just guessing." — Nurse 10

"In my view, if you don't understand the disease you're dealing with, meaningful communication just can't happen. You need to know how the illness typically progresses, what changes to expect, and what matters at each stage. Only with that knowledge can you effectively communicate with patients and their families." — Nurse 1

Psychology-related knowledge

Multiple nurses pointed out that adequate psychology-related knowledge is crucial for conducting meaningful EOL communication. Mastering terminally ill patients' emotional fluctuations and coping mechanisms over the course of illness enables nurses to respond with empathy.

"Let me think... the 'five psychological stages for dying patients'?… I think it's quite important. If we can understand these psychological changes, we can provide better care for them." — Nurse 2

"We need to understand the psychological changes experienced by terminally ill patients and their families, particularly the emotional trajectory families undergo when confronted with a loved one's impending death." — Nurse 4

Breaking-bad-news skill

Nurses viewed the skill of breaking bad news as a pressing requirement for effective EOL communication. The task calls for balancing honest medical information with thoughtful consideration of patients' and families' emotional needs.

"I think breaking bad news is an important skill. We're expected to handle those difficult conversations. A structured approach would help us how to carry out a good communication. Without that training, I often find myself saying too much or too little, it's hard to find a balance." — Nurse 5

Empathy and emotion regulation skill

Nurses described empathy as the foundation on which trust and honest communication with patients and families are built. At the same time, many stressed the need for structured emotion-regulation training skills they saw as essential to protecting their own well-being and guarding against the compassion fatigue that palliative work so often brings.

"Nurses have to learn how to regulate their own emotions. Sometimes we see patients suffering from their illness, and we may feel terrible too… Some patients are really young. Because of the disease, they just… ah (shook head)… lose everything. " — Nurse 8

"Empathy is not the same as pity. It's standing in the patient's shoes, feeling their suffering and fear, their anxiety and grief. Only when you truly understand them can you build rapport, earn their trust, and get them to communicate proactively." — Nurse 7

Theme 4: Expectations for future training

Nurses described their expectations for future EOL communication training in the ED as comprehensive and concrete. They called for context-specific content tailored to the unique demands of emergency end-of-life care, practical teaching methods grounded in real ED cases, and flexible delivery modes that could accommodate demanding shift schedules and family responsibilities. Simulation-based learning and authentic case discussions were particularly emphasized as essential components of effective training.

Specialized teaching content

The majority of current communication training for nurses addresses general interpersonal skills rather than the specific demands of end-of-life communication in the emergency department. Nurses hope future training can be based on real EOL communication cases from the ED, with concrete guidance on what to say to patients and families. That way, the learning content would be more practically useful and directly applicable to their work.

"Yeah, I've attended some communication training but they're kind of general — not specifically designed for our ED setting. It could apply to any other department. So, I hope we can learn something more specific to our own department. That would be great." — Nurse 11

"Mostly it's just general stuff, like how to talk to patients, how to handle disputes... But there's almost nothing specifically about end-of-life patient… We've barely had any training on that." — Nurse 9

"It would be great if there were real cases that clearly show me what to say, what not to say, and when to say. In that way, I'd actually know how to talk to patients. Adding some communication examples to the course would make me feel more confident." — Nurse 6

Practical teaching method

Existing communication training programs are largely theoretical, with few practical components like scenario simulations or role-play. As a result, learning outcome does not transfer effectively to clinical

practice.

“The problem is, there's very little practical training component on how to talk to terminally-ill patients. It's mostly just theory— not much role-play or scenario practice. So we just sit through the courses. Never get a chance to try it out.” — Nurse 5

“The knowledge gained in the lecture is difficult to apply directly when faced with families experiencing an emotional breakdown or patients who are deeply troubled… Learning more practical skills will also help me cope with these situations better.” — Nurse 8

“But I'd also like some group discussions or role-play sessions as part of offline sessions. That would be better for me.” — Nurse 10

Accessible teaching format

Due to demanding shift schedules, heavy workloads, and family care responsibilities, compounded by limited access to training information, multiple barriers prevent ED nurses from participating in training. Accordingly, the nurses interviewed expressed a need for a blended learning model that integrates both online and offline components.

“Honestly, I have no idea where I can sign up for training like this… No one has ever informed us about relevant courses, and I don’t even know who I could turn to for advice. Our daily clinical workload is extremely heavy, and I also have household responsibilities to manage. All these things combined make it really tough to spare time for further learning.” — Nurse 6

“I prefer learning little by little in my fragmented spare time. That’s why online training would suit me best; I can log on and study whenever I get a moment free. I’m not keen on lengthy offline courses that require fixed hours after work, since overtime and household chores already fill most of my spare time. Flexible online learning fits the busy schedule of emergency nurses far better.” — Nurse 10

Discussion

This study explored ED nurses’ experiences and training needs in EOL communication and identified four interrelated themes: complex emotional experiences, multidimensional communication barriers, core communication knowledge and skills, and training expectations.

Central to participants’ accounts were the complex emotional experiences ED nurses undergo during EOL communication. Nurses’ affective responses encompassed not only negative feelings—powerlessness, sorrow and compassion fatigue—but also positive perceptions of professional mission and accomplishment. International research consistently links ED working conditions to frustration, anxiety and distress among emergency nurses [22–24], while this study further highlights that positive affective experiences may buffer this burden. Novice nurses are particularly vulnerable to communication-related psychological strain, whereas positive feedback from patients and their relatives

can foster a strong sense of professional accomplishment and reinforce nurses' commitment to the profession.

Nurses also described a constellation of multidimensional barriers that constrain their engagement in EOL communication. These barriers are not discrete from the emotional demands described above; the communication anxiety they engender compounds nurses' affective burden and further inhibits their initiative. Insufficient clinical experience and ambiguous role boundaries heighten nurses' anxiety about making communication missteps, and this apprehension in turn suppresses their willingness to initiate or deepen EOL discussions. Consistent with Al-Kalaldeh, these barriers can be categorised into environmental, knowledge-related and psychological dimensions [10]. Environmental constraints, such as the absence of enclosed private rooms and the use of curtain-partitioned bays, directly impede confidential EOL communication. Inadequate pre-service training, limited skill rehearsal and knowledge gaps further hinder clinical application. Beyond the universal barriers reported in Western studies, including uncertain prognoses and family distress, this study identified culture-specific obstacles within the Chinese healthcare context: guided by filial piety, many families may persistently request aggressive life-sustaining therapies, consistent with broader research on filial attitudes in the Chinese cultural context [25]. Participants also highlighted interprofessional information asymmetry between nurses and physicians. Collectively, these layered barriers indicate that future training must simultaneously address skill deficits, communication anxiety, cultural sensitivity and interprofessional collaboration.

Underpinning effective communication was a core set of knowledge and skills, comprising theoretical foundations and procedural competencies. Disease-related and psychological knowledge form the theoretical basis, whereas breaking bad news, empathy and emotion regulation constitute the core practical competencies. Mastery of disease mechanism and progression is widely recognized as a prerequisite for delivering consistent, accurate information to patients and their families [26]. Participants also emphasized the importance of understanding the psychological trajectories of dying patients, exemplified by Kübler-Ross's five stages of grief, which reflects the core tenets of palliative communication education [27]. Standardized communication frameworks such as SPIKES and NURSE provide structured guidance for breaking bad news, a competency consistently prioritized by interviewees [28, 29]. Empathy and emotion regulation function as complementary competencies: empathy builds authentic therapeutic relationships with patients, whereas emotion regulation enables nurses to sustain compassionate EOL care over time. This aligns with Bullington, who argued that communication training should extend beyond standardized skills to foster a capacity for genuinely listening to and understanding patients' experiences [30]. Psycho-social and spiritual support has also been recommended in the literature as an additional component of the EOL communication competency framework [31].

These accounts culminated in specific critiques of current training deficits and concrete recommendations for future education. Participants consistently reported that existing communication training is overly general, lacking dedicated modules tailored to EOL scenarios in the ED, which accords with the rationale for the EM Talk programme developed specifically for emergency clinicians [8]. Our

participants further emphasized that current training relies heavily on didactic lectures, with limited practical components. They expressed a strong preference for scenario simulation, role-play and case-based learning grounded in actual ED cases, to translate theoretical knowledge into clinical skill before encountering real EOL situations. Constrained by irregular shift patterns and heavy workloads, interviewees also called for flexible blended learning models with accessible online components. Taken together, these expectations indicate that future EOL communication training for ED nurses should adopt a context-specific pedagogical framework integrating blended learning and simulation-based practice.

Limitations

This study has several limitations. First, as a single-center study, the findings may limit transferability to other ED settings. Second, given the heavy workload of ED nurses, the relatively short interview duration may have constrained the depth of exploration. Third, participants were recruited through direct invitation, which may introduce self-selection bias. Finally, the reliance on self-reported data without observational corroboration calls for objective validation in future studies.

Conclusions

In conclusion, ED nurses face considerable emotional and structural barriers to EOL communication, yet current training does not meet their needs. We therefore recommend that EOL communication training shift from generic lectures toward simulation- and case-based, blended learning tailored to the emergency context. Furthermore, such training should build cultural sensitivity and address nurse–physician collaboration, given the context-specific challenges identified in this study. Finally, nurse managers and hospital leaders should work to identify and reduce the barriers that hinder nurses from engaging in EOL communication.

Abbreviations

ED Emergency Department

EOL End-Of-Life

COREQ Consolidated Criteria for Reporting Qualitative Research

EICU Emergency Intensive Care Unit

Declarations

Acknowledgement

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Authors' contributions

Sizhe Wang: Conceptualization, Methodology, Investigation, Formal analysis, Data curation, Writing - Original Draft. Jiani Shen: Investigation, Formal analysis, Data curation. Fengling Cai: Formal analysis, Validation. Shihai Xu: Supervision, Writing - Review & Editing.

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Data Availability

The datasets generated and/or analysed during the current study are not publicly available to protect participant confidentiality but are available from the corresponding author on reasonable request.

Ethics approval and consent to participate

Ethical approval was obtained from the Clinical Research Ethics Committee of Shenzhen People's Hospital (Approval No. LL-KY-2026030-01). Our research adhered strictly to the ethical principles outlined in the Declaration of Helsinki, ensuring compliance with all pertinent guidelines and regulations. Written informed consent was obtained from all participants.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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Figures

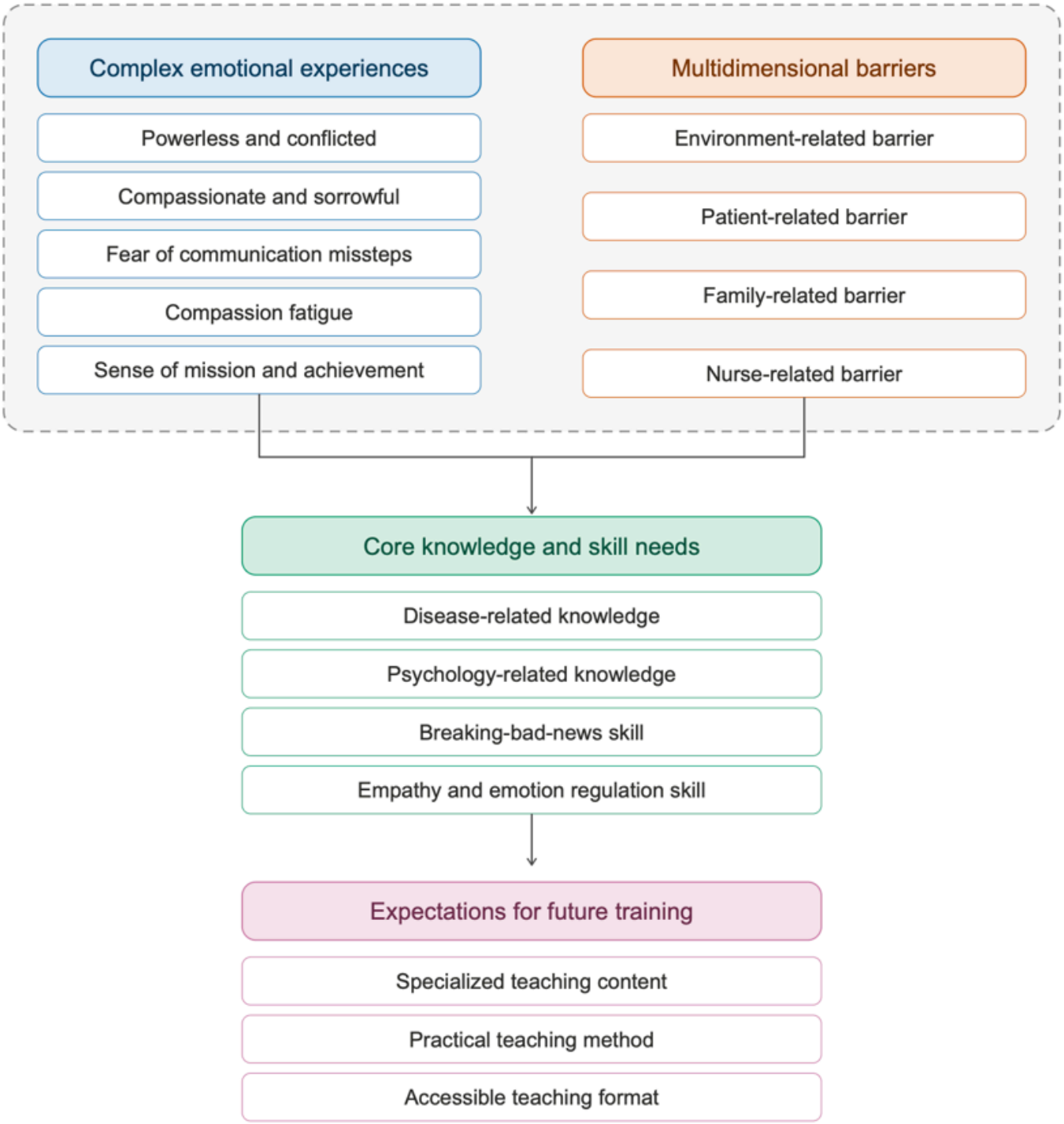


Figure 1

Themes and sub-themes of end-of-life communication among emergency nurses

Supplementary Files

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- COREQchecklist.docx