Experiences and Emotions of Critical Care Nurses Toward Dealing with Patients and Their Families in Process of Withdrawal of Life-Sustaining Treatments

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ABSTRACT

Background: Withdrawal of life-sustaining measures involves a complex balance of legal and ethical considerations and few healthcare providers have been specifically trained to withdraw life-sustaining measures. **Aim of the study:** This study was conducted to explore critical care nurses' experiences and emotions toward dealing with patients and their families in the process of withdrawal of life-sustaining treatments. **Research design:** A Qualitative phenomenological design was used in this study. **Subjects:** A Purposive sample of 15 nurses of both sexes. The study has been conducted in seven critical care units at Ain Shams University Hospitals **Tools**: Open-ended semi-structured audio-recording interviews were utilized to collect data. Study results revealed that the sample age ranged from 24 to 38 years. Critical care nurses' experiences were reflected through 3 main themes and related subthemes. **Results:** The 3 main themes that shaped nurses' experiences were challenging emotions, nurses' role toward patients, and family support. **Conclusion:** Nurses had encountered several difficult feelings and experiences that shaped their experiences and emotions toward Withdrawal of Life-Sustaining Treatments. **Recommendations:** Further qualitative and quantitative studies are recommended. The study should be replicated on a large sample in different hospital settings to generalize the results.

Keywords: Withdrawal of life-sustaining measures, nurses, experiences, emotions, qualitative design, themes, subthemes.

Introduction

Withholding or withdrawing LST or support such as Mechanical Ventilation (MV), renal replacement therapy, vasopressors, tube feeding, and hydration is to reduce the suffering of patients and their families.

The aim is to avoid prolonging the dying process and allowing the patient a good death when it has become clear that he/she cannot benefit from or maintain a meaningful life through aggressive medical treatments ***(Chang et al., 2020).***

Withholding is defined as the decision not to start or increase a life-sustaining intervention. Withdrawal is the decision to actively stop a life-sustaining intervention being given. These decisions are being extensively applied in ICUs ***(El Jawiche et al., 2020).***

It is rare to raise debate recently about withholding and withdrawing LST as ethicists routinely point out that there is no ethical difference between the decision not to start and the decision not to continue a specific treatment, ***(Emmerich & Gordijn, 2019).***

It is important to determine when to withhold or withdraw LST in critically ill patients in the ICU, as some medical interventions in this setting may be futile or against the wishes of terminally ill patients. LST for terminally ill patients without expected recoveries also leads to considerable costs ***(Lee et al., 2020).***

Withdrawal from life-sustaining therapy is a complex phenomenon, and many nurses are uncomfortable participating in the process. Nurses have reported experiencing moral distress. Guidelines have been developed to help nurses, as they strive to provide quality end-of-life care to patients and their families ***(Wiegand et al., 2018).***

Promoting patient comfort is central to the nurse's role in the provision of end-of-life care and includes the management of pain, anxiety, dyspnea, restlessness, and psychological distress through both pharmacological and non-pharmacological strategies ***(Bloomer et al., 2021).***

The development of an empathic relationship between the nurse and the patient is a fundamental component of the nursing

practice, as it affects the patient's empowerment and impacts positively on the therapeutic process Empathy is also an important aspect of nursing care in Intensive Care Unit ***(Stavropoulou et al., 2020).***

To be a nurse it means spending more time with patients and families than any other health professional as they face serious illness. Expert nursing care reduces the distress and burdens of those facing death, and the ability to offer support for the unique physical, social, psychological, and spiritual needs of the patients and their families ***(Schroeder & Lorenz, 2017).***

Supporting patients and their families in discussions about resuscitation is one of the critical care nurses' responsibilities. They advocate for communication about code status preferences among all involved parties and anticipate patient's preferences, values, and goals of care ***(Michelson et al., 2018).***

Nurses should assess patients' and caregivers' requests for WLST by listening to their wishes and providing correct information in response to their requests, collaborate with the rest of the medical team to provide emotional support for the patients and caregivers, and help the bereaved families to move on with their lives ***(Coombs et al., 2016).***

Families rely on nurses for information about the patient's condition and response to therapy and for support when going through the decision-making process. A key role of nurses is to facilitate communication between the healthcare team and the family so that all participants in the process have as much information and support as possible ***(Ganz, 2019).***

Critical care nurses might experience different emotions, feelings, and thoughts as they are faced with end-of-life issues in the intensive care unit. It is thus important to explore the experiences of critical care nurses to understand and support them when dealing with end-of-life issues ***(Jordan et al., 2017).***

Qualitative description has been identified as important and appropriate for research questions focused on discovering the (who, what, and where) of events or experiences and on gaining insights from informants regarding a poorly understood phenomenon ***(Kim et al., 2016).***

Significance of the study

Currently, withdrawal of life-sustaining treatment is a significant issue and a topic of debate in intensive care settings but understanding of nurses' experiences and emotions is lacking so exploring critical care nurses' experiences and emotions toward withdrawal life-sustaining treatments as a part of a multidisciplinary team could be a great support to minimize burnout syndrome, relive stress, stop mental exhaustion and emotional draining for nurses dealing with end-of-life issues.

Add to that improve the understanding of end-of-life issues and provide guidance to facilitate the process to decrease the sense of Inferiority as doctors make decisions but nurses live with it.

Aim Of The Study

This study aimed to explore critical care nurses' experiences and emotions toward dealing with patients and their families in the process of withdrawal of life-sustaining treatments.

Research question:

What are critical care nurses' experiences and emotions toward dealing with patients and their families in the process of withdrawal of life-sustaining treatments?

Subjects And Methods

Research Design:

A qualitative phenomenological study design was utilized to achieve the aim of the study. The qualitative approach is chosen to explore critical care nurses' experiences and emotions toward the withdrawal of life-sustaining treatments and enrich the interpretation of the phenomena of interest.

Research Setting:

The study was conducted in seven critical care units at Ain Shams University Hospitals: The participating ICUs were 7 different adult ICUs (Internal medicine ICU, Trauma ICU, Neurology ICU, Isolation ICU, CCU, GIT ICU, and Ahmed Shawky Geriatrics ICU).

Participants/informants

In phenomenological research, participants are interviewed by researchers to provide a considerable amount of data.

A purposive Sample of critical care nurses from different critical care units who

were accepted to participate in the study, who were working part-time or full-time in the ICU and had a minimum of six months experience in the ICU. The power of purposive sampling in qualitative research lies in selecting information from rich cases to study in-depth and from which the investigator can learn about the phenomena under study. In qualitative designs, the predetermination of the number of participants is almost impossible as the sample size is not determined by the number of participants but by achieving data saturation. A total of 15 ICU nurses agreed to participate in the study, 10 males and 5 females After 9 interviews, 80% of the information was gathered. Saturation of information was reached after 15 interviews.

Instrumentation:

Data collection was obtained by using the following tool:

Semi-structured interview: In this study, the researchers collected data through semi-structured interviews of the individuals included in the study: the tool developed by the researchers using mother language in conversation based on the review of relevant recent related literature in which the researchers simply guided the participant in an extended discussion.

The interview covered two parts as the following:

Part I: Demographic data: It is concerned with the critical care nurse's personal data such as gender, age, religion, educational level, place of work, and years of experience.

Part II: Open-ended semi-structured Interviews: include several audio-recorded online meetings organized by the researchers and participants due to the difficulty of conducting meetings during work time and precautions of the pandemic. Interviews were conducted by the researchers using an interview guide containing 27 open-ended questions. Interviews were recorded using a high-quality recording application to ensure the recording of comprehensive, accurate, and true reflective descriptions of critical care nurses' experiences and emotions toward the withdrawal of LSTs.

Pilot Study:

With the expert's approval the pilot interviews were conducted to achieve the following purposes: to test the feasibility, objectivity, and applicability of the study tools. From the data provided by the pilot interviews the final interview tool was modified.

Administrative design: An official permission was obtained from Ain Shams University Hospital in which the study was conducted.

Ethical Considerations:

The ethical considerations in the study include the following:

- The research approval was obtained from the ethical committee in the faculty of nursing before starting the study.
- Verbally recorded consents obtained from participants.
- The researcher clarified the aim of the study to participants included in the study.
- The researcher assured confidentiality, respect, and dignity of participants.

Procedure of data collection:

After receiving institutional and personnel approval, data were collected from February 2022 to July 2022.15 Nurses were recruited by the investigator, and contact was initiated, online meetings were organized by the researchers and participants due difficulty of conducting meetings during work time and precautions of pandemic, Interviews recorded using a high-quality recording application.

At the time of each participant's interview, the purpose, significance, and nature of the current study were explained before any data collection. All interviews were initiated using the mother tongue language (Arabic). The average time for each interview ranged between 20 minutes to 50 minutes until all guided questions were covered.

Critical care nurses were encouraged to express themselves freely in their own words using an interview guide, which consists of 27 open-ended questions that were designed by the investigator based on literature to allow a deeper exploration and lead to a rich description and understanding of their experience.

Data collection interviews were terminated when participants were exhausted by describing phenomena under study, no new codes, categories, and themes were emerging, and when there were repetitions of similar data among participants (data saturation).

Procedure of data analysis:

Data collection methods used in this type of research are unstructured and cannot provide numerical data that will be analyzed through statistical techniques. Interviews were audio recorded and transcribed verbatim by the researcher.

As it is a qualitative study; data analysis was started from the moment the researcher listened to the records and translated them into transcriptions then read the records transcripts to identify essential patterns in the data and to capture essential relationships among participant's narrative statements. Assigning codes to statements and clustering similar thematic data into categories to achieve final themes of data.

Trustworthiness of data:

Data integrity and trustworthiness were ensured by the interviewer by keeping an audit trail by providing a transparent description of the research steps taken from the start of the research to the development and reporting of findings, member checking, and reviewing transcribed data for accuracy. The trustworthiness of content analysis results depends on the availability of rich, appropriate, and well-saturated data. Improving the trustworthiness of content analysis begins with preparation before the study and requires advanced skills in data gathering, analysis, and result reporting.

Conformability, dependability, credibility, and transferability are four criteria to increase the rigor of the study. Conformability is guaranteed by preserving all evidence in all research steps.

Dependability refers to the stability of data over time and under different conditions. The researchers checked the dependability of the study through revision and member checks and, the use of fellow workers and methodological experts for guaranteeing dependability in qualitative research.

To ensure credibility participants in research were identified and described accurately and the researchers put a lot of thought into how to select the most suitable data for content analysis. The credibility of the data was ensured by including copies of the transcribed interviews in the research report.

Transferability was ensured by giving a dense description of the participants, the research methodology, data collection, and data analysis process. Furthermore, transcriptions of the one-on-one interview were provided to ensure findings could be generalized or transferred to other settings or groups.

Results

Participants of this study had shown different feelings and experiences regarding the withdrawal of life-sustaining measures. Three main themes and related subthemes were identified as

follows: challenging emotions, nurses' role toward patients, and family support.

Theme 1: Challenging emotions.

An example of a challenging emotions theme; conflicting emotions faced with withdrawal of LST subtheme; a 30-year-old female participant, reported that “My feelings towards this matter are that I should not withdraw treatment, but rather give the patient a chance to recover or receive treatment until their time comes…".

A 26-year-old male participant expressed that “…When one sees too much of these things, they may not be able to distinguish their feelings towards them…"

An example of Difficulty in performing withdrawal of life-support treatment subtheme; a 39-year-old female participant expressed "… It will be difficult for me, but I carry out the orders of doctors, and the doctor is responsible for his decision …".

A 24-year-old male participant had expressed "… Undoubtedly, there will be difficulty in carrying out the procedure. You are giving me a choice between two opposite emotions …"

An example of a psychological and emotional stress subtheme; is a 29-year-old female participant who expressed that “…these are the doctor's orders. Due to the high number of cases, one may become familiar with this situation. For example, in the isolation ward where I work, there are 13 beds, and sometimes I have to deal with six cases of death and then receive new patients. This can cause psychological distress …".

A 24-year-old male participant had expressed “…I try not to think deeply on the

matter because it can be exhausting and mentally draining. If I think about it in this way, every patient who dies will be my responsibility, but we have no control over the matter, and God is our witness…"

For the subtheme of burnout, a 25-year-old male participant reported "…To be honest, I am not struggling with this matter, and if I reach the peak of exhaustion, I can continue normally the next day…".

A 24-year-old male participant had expressed "…I am struggling with this matter, and it is the biggest challenge for me. There are two aspects to this matter: the first is related to patients in the intensive care unit, and the second is related to elderly patients who have stable conditions. Dealing with these patients can be extremely stressful…"

For the subtheme of coping, a 38-year-old female participant, reported "…. Honestly, I did not plan to continue, but I am still doing it because of the work distribution in our facility. At the same time, I can't say 'enough' and withdraw because this is not about one patient but rather a recurring situation …".

A 29-year-old female participant had expressed that"….I do not have coping mechanisms, and I am forced to live day

by day to work. If I were to be in their position one day, I would hope someone would take care of me. There were times when I felt terrible, but I never thought about leaving the nursing profession. However, this matter has become less of a priority for me now…"

Theme 2: Nurses' role toward patients.

An example of nurses' role toward patients' theme; involvement in the multidisciplinary team's subtheme; a 25-year-old male participant, reported that "…If the topic has become legal and the laws have been naturally amended, then it is possible to participate in it normally, if cases have been studied, and the topic has been well researched. In this case, we can't refuse to participate …".

A 30-year-old female participant reported, "…I do not actively participate in the topic…".

For the subtheme of Serving as the patients' advocate; a 32-year-old male participant, reported that "… Despite any personal discomfort, I must attempt to restore the patient's rights. If any member of the staff becomes upset, I will remind them that this is a patient and there should be no shame or embarrassment in accommodating their needs. Ultimately, our priority is to provide proper care and support to the patient …" A 25-year-old male participant had expressed "… Unfortunately, we have tried multiple times, and it has been futile. We are met with defense that is of no value and we are unable to assert our rights to uphold the rights of the patient …"

For the subtheme of promoting patient comfort, A 29-year-old female participant, reported "… Of course, there are patients who complain about the sound of the monitor, but unfortunately, in my case, I have a 13-bed isolation ward with artificial ventilation devices, and the resources to address the issue are not available …".

A 24-year-old female participant reported that "… Mostly, we prioritize the comfort of the patient, as we have a service of elderly care that is not a nursing assistant, but rather a male or female companion, whose role is to ensure that the patient eats regularly and is repositioned every two hours to prevent bedsores. This service is completely separate from medical treatments and has been implemented for approximately a year now …"

For the subtheme of empathic relationship, a 38-year-old female participant reported that yes, there is a great empathetic relationship; patients may be the father or brother…"

A 32-year-old male participant reported that"… Due to workload and shortage of nursing staff, nurses may not have enough time to express empathy and provide emotional support. This can lead to incomplete delivery of nursing services and may have a negative impact on patient outcomes. Therefore, it is essential to address the issue of nursing shortages and work towards providing adequate staffing for healthcare facilities to ensure nursing care is delivered comprehensively…"

An example of Ensuring Good Death; a 30-year-old female participant reported that "…The concept of ensuring a good death is applied based on available resources. Family members may be allowed to visit the patient, and if necessary, the doctor may be asked to administer pain relief medication to the patient …".

A 24-year-old male participant reported "… We make every effort to honor the patient during his/her final hours and avoid any procedures that may not be necessary, even in cases where cardiopulmonary resuscitation is required. We try to minimize discomfort to the patient and to avoid any unnecessary harm, such as rib fractures or other complications that may arise from resuscitation efforts, add to that providing all needed care …"

Theme 3: family support.

An example of family support, a supportive relationship with a family member's subtheme; a 38-year-old female participant reported that "… Providing emotional support to the patient's family is necessary as they often require someone to listen to their concerns and provide comfort during a difficult time. It is important to be honest and transparent about the patient's condition, but also to be empathetic and understanding of the family's emotional needs…".

A 26-year-old male participant reported "…We reassure and comfort the patient's family, letting them know that we appreciate their efforts and that we understand the fatigue and emotional distress they may be experiencing. We also encourage them to continue praying for the patient and offer any necessary support to help them cope during this difficult time…"

For the subtheme of family involvement decision-making, a 29-year-old female participant reported that "… There are some people who understand the medical field and give authority to the doctor in dealing with the patient, while others may blame the medical staff for the patient's condition and become violent towards them. However, no matter how strong the relationship is between me and the patient's family, I cannot guarantee that I will not encounter a situation where the patient or their family member becomes violent towards me, or any member of the medical staff and I witnessed situation like that with one of my colleagues…".

A 24-year-old male participant reported "…I believe that to ensure this, it is important to assess the level of the patient's family's cultural, educational, and social background, as well as their level of concern for the patient's well-being because this decision concerns the patient's life. However, I have not yet initiated any discussions of this nature with the patient's family …"

For the subtheme of Caring for the dying patient and their family wishes; a 26-year-old male participant, reported that "…Feeling helpless can be distressing, as we may feel powerless to improve the patient's condition beyond providing medical care. Patient's families often wish for their loved ones to pass away peacefully, and it is our duty as healthcare providers to respect their wishes while also providing the best possible care …".

A 25-year-old male participant reported "… There was a case named Wafaa, who was 22 years old and married with two children. Suddenly, her condition deteriorated and we like our little sister. We even allowed her children to visit her, even though it was not allowed, to fulfill her wish. If the patient is young, the family usually holds onto hope until the very end. Sometimes, we are subjected to violence from the patient's family due to their inability to accept the situation. However, they usually apologize to us once they calm down …"

Discussion

This study was conducted to fulfill one major aim, which is to explore critical care nurses' experiences and emotions toward dealing with patients and their families in the process of withdrawal of life-sustaining treatments. Achieving the aim was completed through an organized discussion displayed in sociodemographic characteristics of participants and a discussion of study themes and related subthemes.

The data was collected from the study participants through extensive interviews to describe emotions, feelings, thoughts, and hopes that came out of the experiences they encountered while caring for end-of-life patients.

Related to the theme of conflicting emotions faced with withdrawal of LST participants explained various feelings most of them reported an internal conflict during the implementation of this procedure, being annoyed, psychologically tired, and helpless, but they had to implement Physician orders, and the sense of mercy to relieve the patient from pain and suffering, while some of them saw that is the best for those patients.

These findings are consistent with **Lee, Y. E., Jung, Y. J., Jang, Y. N., & Jeong, H. E. (2020)** who conducted a study about the effects of nurses' knowledge of withdrawal of Life-Sustaining Treatment and they reported that nurses have been found to suffer from negative emotions such as ethical conflicts, guilt, and depression while processing and implementing WLST.

From the researcher's point of view policies and guidelines will minimize conflicting emotions and guide nurses to the best decisions.

Concerning the theme of difficulty in performing withdrawal of life-support treatment most of the participants illustrate the difficulty of this procedure and they are involved in it obligatory, but they try to justify this situation by doing their best for their patients and their families by relieving their pain and allowing them to die peacefully.

These findings come in harmony with **Karlsson, M., Kasén, A., & Wärnå-Furu, C. (2016)** who revealed that nurses in end-of-life care are deeply involved with dying patients. They worry about causing unnecessary suffering and about violating their human dignity.

Regarding the theme of psychological and emotional stress Participant in the study revealed their feelings, some of them became used to these situations as they had witnessed it many times, others couldn't cope with this stress, and sometimes they cried especially for young patients with poor prognosis, and they are powerless, and their efforts have no results.

These findings agree with **Fossum, H., Alfhild Dihle, Hofsø, K., & Simen Alexander Steindal, (2020)** who showed that WLST processes are experienced as particularly emotional when the participants have established a particular connection with the patient or family. Emotional reactions can be related to the ICU nurse's perceptions of the quality of life of the patient, to feeling a sense of connection with the patient and relatives.

From the researcher's point of view emotional stress should be monitored to enhance nurses' ability to perform their duties effectively.

Concerning to theme of burnout some nurses reported that they became used to dealing with these situations while most of them explored their feelings with lack of interest in work in intensive care units, especially with elderly patients and end-stage patients, they live with frustrated emotions while dealing with patient with poor prognosis although with providing optimal care.

These findings are in harmony with **Sivakumar, M., Hisham, M., & Saravanabavan, L. (2019)** who conducted a study about Stress and Burnout among Intensive Care Unit Healthcare Professionals in an Indian Tertiary Care Hospital. They revealed that Working in an intensive care unit environment is known to be stressful. For all ICU healthcare workers more than the physical work, it is the psychological factor of dealing with seriously ill patients which leads to huge mental stress. This stress, when persisting for quite some time, can lead to burnout, which in turn can cause decreased personal well-being, increased absenteeism, more mistakes, and ultimately compromised patient care.

From the researcher's point of view, urgent programs should be developed to decrease burnout as it was noticed recently that large numbers of nurses started to travel to other countries that have better lifestyles and focus on quality of life.

Regarding the theme of coping participants showed a lot of mechanisms to deal with this stressful environment, some of them tried to change careers or at least find chances outside of intensive care units, while some of them tried to focus on developing themselves through on-the-job education and continuous education. Others try to cope with stressors by vacations and acquiring positive energy and many of them find as one of the best and merciful professions that exist in the world.

From the researcher's point of view, nurses can face these difficult situations by asking for help and support from family members, colleagues, and close friends. Vacations and taking days off could help. Religious practice may help and changing lifestyle.

These findings agree with **Sapeta, P., Centeno, C., Alazne Belar, & María Arantzamendi. (2022**) who recommended four main strategies: Involving activities to achieve self-confidence and control situations and emotions, self-protection, self-awareness activities, with behavioral disconnection, self-

transformation coping, involving activities to accept limits and encountering deep professional meaning is a coping mechanism based on meaning, frequently considering the deepest meaning of work.

Related to the theme of involvement in multidisciplinary teams responsible for the withdrawal of life sustaining treatments some of the participants that they didn't involve in these teams before as it of physician authorities but they may participate if it is legalized and have rules and guidelines and receive proper knowledge and education about it while others reported that doctors are cooperative and consult them in these decisions as they are the first line in dealing with patients and know too much about their condition.

These findings agree with **Siri Hammersland Heradstveit, Marie Hamilton Larsen, Marianne Trygg Solberg, & Simen Alexander Steindal. (2023)** who conducted a study about critical care nurses' role in the decision-making process of withdrawal of life-sustaining treatment, mentioned in conclusion that The role of the critical care nurses in the decision-making process in withdrawal of life-sustaining treatment requires experience and the development of the clinical perspective of critical care nurses as they have great performing ethical decision-making to safeguard patients' concerns, guide the family's decision-making process and take on the role of the middleman.

From the researcher's point of view, hospital settings must consider investing in educational programs that enhance nurses' ability to be a part of multidisciplinary teams which has the authority to make these decisions.

Most of the participants confirmed that Serving as the patient's advocate in all situations where patients need them in it that depends on personality and experience while a few numbers of nurses felt that they have no authority to advocate for patients or at least advocate for themselves.

These findings disagree with **Nasim Hatefimoadab, Mohammad Ali Cheraghi, Benton, D., & Shahzad Pashaeypoor, (2022)** who conducted a study about Ethical advocacy in the end-of-life nursing care and reviewed that nurses can be with patients from birth to death and they help patients to recover from the most difficult conditions. In the absence of family, they even sit beside dying patients and comfort them in the last moments of their lives. Within these contexts, nurses frequently must advocate for patients' rights.

Concerning to theme of promoting patient comfort participants confirmed that they tried to apply it as much as possible, and we try to teach new staff this concept but they mentioned many reasons that reduce patients' comfort like monitor sound, lack of privacy related to the infrastructure of intensive care units, the difficulty of sleeping due doctors round especially in educational hospitals and lack of spaces between intensive care beds which may lead patient to ICU psychosis. All these problems didn't exist in the private sector.

These findings are similar to **Sepideh Olausson, Fridh, I., Lindahl, B., & Anne Britt Torkildsby, (2019)** who conducted a study about The Meaning of Comfort in the Intensive Care Unit and found that sound levels were too high and differed too little between day and night and recommended that ICU settings are important to actively reduce of disturbing sounds and lighting and the importance to give patients comfort, sustainable materials in textiles and furniture, and a view to outside greenery.

Regarding the theme of the empathic relationship between nurses and patients most of the participants showed that there is a great empathetic relationship between them, and their patients and they consider them as one of their families especially if they're conscious or young patients with poor prognosis while some of them linked that by the load of work and they couldn't provide more than nursing care.

These findings agree with **Foà C, Cavalli L, Maltoni A, Tosello N, Sangilles C, Maron I, Borghini M & Artioli, G. (2016)** who conducted a study about Communications and relationships between patients and nurses in an Intensive Care Unit, reported that analysis of the recent international literature proved that the communicative aspect of the care with patients hospitalized in ICU is slightly neglected by the nurses working in these contexts. That is because they pay more attention to the technical aspect of care, and they mainly communicate with responsive patients while they have more limited communication with unconscious patients.

From the researcher's point of view, nurses should promote their communication skills and try to have the ability to deal with these critical situations.

Related to the theme of ensuring good death participants showed that they try to apply this concept as much they can, they explained that may give patients more time with their families even if not in visiting time, ensure quality of life and hygiene, consider religious aspects, and ensure dying with dignity.

These findings are in harmony with **Ganz, F.D. (2019)** who conducted a study about improving family intensive care unit experiences at the end of life and showed that good death should ensure death with dignity, ensuring that the patient does not die alone, an appropriate environment, symptom management, following patient wishes regarding end-of-life care, acceptance of the impending death by the patient and the family, respect for individual differences, and good timely communication.

Concerning to theme of Supportive relationships with family members, most participants showed that they support patients' families, especially in psychological aspects, patience in dealing with them, trying to assure them but at the same time not by false assurance, appreciating their suffering and pain and they put that in consideration and thank us for that and sometimes they remember this favor after patient discharge or death.

These findings are in harmony with **Schroeder, K., & Lorenz, K. (2017)** who focused on the role of expert nursing care to reduce the distress and burdens of those facing death, and the ability to offer support for unique physical, social, psychological, and spiritual needs of the patients and their families. Some participants reported that they have no authority to deal with patient families as it's the physician's responsibility regarding hospital policy.

Related to the theme of family involvement in decision-making related to the end stage of life participants explained that doctors allow patient families to participate in these decisions based on their level of knowledge, report any updates on their patient's condition and they have the right to refuse medical intervention.

These findings agree with the findings of **Trees, A. R., Ohs, J. E., & Murray, M. (2017)** who conducted a study on family communication about end-of-life decisions and the enactment of the decision-maker role. They demonstrated that there can be important variations like family interaction about the decision-making role. In some families, the collective input was a key component of the decision-making, and in other family contexts, collective conversations were an opportunity for the decision-maker to help other family members understand what decision should be made.

From researcher point of view nurse must have training to have ability to be a member of a team who can disclose patient's prognosis to his family and help them to make right decisions.

Against that, some participants reported that in governmental hospitals the level of patient families' education and their level of awareness doesn't qualify them to make these decisions, so doctors notify them, but it remains a medical decision.

Concerning the theme of family preparation for end-of-life decisions most of the participants explained that the issue is based on the level of awareness and cultural background of family members, some families accept these conversations and others refuse but they didn't start this type of conversation with family members before.

These findings are not like **Ganz, F.D. (2019)** who conducted a study about improving family intensive care unit experiences at the end of life and confirmed on importance of critical care nurses' role in helping family members of dying patients through this difficult time and how best to accomplish this to meet family members' needs.

Regarding the theme of caring for dying patients and their family wishes, participants told many situations this point about the difficulty of feelings to lose patients, especially conscious patients, and their attempts to dignify their deaths. They make exceptions for their families to spend more time with them, they also allow and respect religious practices for Muslims or Christians.

These findings are in harmony with **Akdeniz, M., Yardımcı, B., & Kavukcu, E., (2021)** who mentioned that the families of dying

patients experience a period of high stress that can be manifested by anger, depression, interpersonal conflict, and psychosomatic problems. Family members are also primary caregivers for the dying patient. They may feel hopelessness, anger, guilt, and powerlessness when they cannot relieve the suffering of their terminally ill family member.

From the researcher's point of view helping patients and their families in these critical times and trying to satisfy their needs and wishes is a part of our humanistic mission.

Limitations Of The Study

Many obstacles faced the researchers including difficulty conducting face-to-face meetings during work time and precautions of the pandemic. Some nurses refused to participate in the study based on their beliefs, and religious reasons. Despite the limitations, the results obtained from the study can be generalized to nurses of Ain Shams University Hospital in Cairo, Egypt. Also, larger samples may be used in future studies.

Conclusions

Based on the findings of the current study, it can be concluded that: Critical care nurses who were participants of the current study had shown several feelings, life experiences, and emotions toward withdrawal of life-sustaining treatments which were reflected through 3 themes and related subthemes that include: challenging emotions, nurses' role toward patients, and family support.

Recommendations

Online consulting services for nurses caring for end-of-life patients are recommended to provide necessary information for ethical and legal dilemmas. Establish in-service training programs to continuously update nurses' knowledge of end-of-life challenges. Implementation of an educational program for nurses on ethical and legal issues in critical care units and end-of-life care issues.

Acknowledgment

The author is grateful to all nurses who participated in the study.

Conflict of interest

The authors declare no conflict of interest.

Ethical approval

The ethics committee of the Faculty of Nursing at Ain Shams University approved this study.

Consent of Participation

All participants gave verbal consent including in audio-recorded interviews as it was difficult to conduct face-to-face meetings during the precautions of the pandemic.

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Author's contribution

All authors (IAA, SYM, DAA) contributed to the study conception, design, data analysis, preparation, and revision of the manuscript.

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