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Experiences of Intensive Care Unit Nurses with the Provision of End of Life Care at Kamuzu Central Hospital, Lilongwe, Malawi

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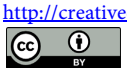

Abstract

Background: End-of-life care (EOLC) is increasingly recognized as an essential aspect of critical care, particularly in resource-limited settings where patients often present with complex needs and poor prognoses. In the ICU, some patients reach a terminal stage requiring a shift from life-sustaining treatment to EOLC. Nurses' roles in this process vary across cultural, religious, organizational and legal contexts. In Malawi, limited evidence exists on ICU nurses' experiences with EOLC. This study explored their emotional, ethical and professional perspectives. **Methodology**: A descriptive phenomenological design was used to explore ICU nurses' experiences with EOLC at Kamuzu Central Hospital's main ICU in Lilongwe. Purposive sampling recruited 12 ICU nurses. Data were collected through in-depth, audio-recorded interviews guided by the core question: "What are your experiences as an ICU nurse providing EOLC?". Interviews were transcribed verbatim and analysed thematically using Braun and Clarke's six-step approach, supported by NVivo for data organization. **Results**: Five themes with sixteen sub-themes emerged: 1) conceptualisation of EOLC, 2) holistic practice, 3) emotional distress, 4) institutional constraints, and 5) need for enhanced support. Nurses' understanding of EOLC was shaped by culture, beliefs and professional exposure. Holistic practice involved meeting physical, psychological and spiritual needs. However, limited training, resource shortages and lack of dedicated spaces heightened emotional strain. Participants emphasised the need for better training, resources and multidisciplinary collaboration. **Conclusion**: Nurses strive to provide dignified, holistic EOLC, but institutional barriers hinder practice. Strengthening training, improving resources, supporting palliative care structures and enhancing teamwork are essential to improving EOLC quality and consistency.

Keywords

Intensive Care Nurse, End-of-Life Care, Experience, Intensive Care Unit

1. Introduction

End-of-life care (EOLC) is a vital component of healthcare aimed at alleviating suffering and preserving dignity for individuals with life-limiting conditions [1]. In Malawi, the need for EOLC continues to rise due to the increasing burden of non-communicable diseases, cancer, HIV/AIDS, and an aging population. Intensive Care Units (ICUs) represent one of the most complex environments for EOLC delivery, as critically ill patients often deteriorate rapidly in highly technological settings characterised by uncertainty and emotional strain [2] [3]. ICU nurses frequently manage patients at the threshold of life and death, making rapid decisions while simultaneously supporting distressed families [4].

Despite global recognition of EOLC as a public health priority, many low- and middle-income countries face challenges such as limited resources, inadequate training, and a lack of structured guidelines, all of which significantly shape nurses' experiences [5] [6]. In Malawi, these challenges are particularly evident in tertiary hospitals like Kamuzu Central Hospital (KCH), where high mortality rates, constrained resources, and insufficient institutional support place substantial emotional, ethical, and professional demands on nurses involved in EOLC [7] [8]. Understanding their experiences is essential for identifying context-specific needs and strengthening the quality, consistency, and ethical delivery of care.

At KCH, the experiences of ICU nurses regarding EOLC have not been extensively explored. Exploring these experiences provides critical insights into local challenges and facilitators and allows comparison with global and regional trends. Such knowledge is crucial not only for improving patient and family experiences during dying but also for enhancing nurse well-being, reducing burnout, and strengthening retention.

Existing literature highlights that ICU nurses globally experience significant emotional and moral strain when providing EOLC. However, there is limited empirical evidence from Malawian ICUs, where unique contextual challenges further shape care delivery. Understanding nurses' experiences is essential to inform policy development, strengthen EOLC training, and enhance institutional support systems. This study explored the experiences of ICU nurses at KCH in providing EOLC, focusing on emotional, ethical, cultural and institutional factors that influence care in a resource-constrained environment.

2. Methodology

2.1. Study Design

A descriptive phenomenological design was employed to explore the lived expe-

riences of intensive care unit (ICU) nurses involved in the provision of end-of-life care (EOLC). This approach enabled an in-depth understanding of how nurses perceive, interpret and give meaning to their experiences.

2.2. Study Site

The study was conducted in the main ICU of Kamuzu Central Hospital (KCH) in Lilongwe, Malawi. As a tertiary referral and teaching hospital, KCH manages a large volume of critically ill patients requiring advanced care, including those at the end of life. The ICU functions with limited bed capacity and resources, characteristic of many resource-constrained healthcare environments.

2.3. Study Population and Eligibility Criteria

The study population consisted of registered nurses working in the ICU who had direct clinical involvement in EOLC. Nurses were eligible to participate if they had: at least six months of continuous ICU experience and provided hands-on care for at least one patient at the end of life. Nurses who were on leave, assigned to non-clinical administrative duties, or concurrently participating in similar studies were excluded.

2.4. Sampling Technique and Sample Size

The study used purposive sampling was used to deliberately select ICU nurses who possessed the knowledge and experience relevant to the study phenomenon. This method was appropriate because participants had previously provided EOLC as ICU nurses, resulting in shared commonalities of experience that supported in-depth exploration and the collection of rich, detailed data. Twelve (12) nurses met the eligibility criteria at the time of data collection and all the eligible nurses participated. Data was collected until saturation was achieved, giving rise to no new insights. Data saturation was achieved at interview number twelve.

2.5. Data Collection

Data were collected through face-to-face, in-depth interviews using a single guiding question: "What are your experiences with the provision of end-of-life care?" Follow-up prompts were used flexibly to encourage elaboration. Interviews were conducted in private rooms within the hospital, lasted 45 - 60 minutes, and were audio-recorded with participant consent. Field notes documenting observations and contextual details complemented the recordings. English language was used to conduct all the interviews as it is the officially used language in the training of nurses and practice settings in Malawi. None of the interviews required translation, therefore, all transcripts were analysed in their original language, preventing the risk of meaning being altered through translation.

2.6. Data Management

Audio files were transferred immediately to a password-protected computer and

stored in encrypted folders. Interviews were transcribed verbatim, anonymized and cross-checked for accuracy. Field notes and hard-copy materials were stored in locked cabinets accessible only to the research team.

2.7. Data Analysis

Thematic analysis guided by Braun and Clarke's six-step framework was used. The process included familiarisation with data, initial coding, generation of themes, review of themes, definition and naming of themes, and production of the final narrative. Coding and theme development were supported by NVivo software.

Even if this study was descriptive phenomenology exploring the lived experiences of ICU nurses, Braun and Clark's thematic analysis was selected as an approach for analysis because it provided a systematic and flexible method for identifying patterns of meaning across participants' account. The analysis consistently focused on the phenomenological aim and remained rich in the description of participant's experiences as well as minimizing researcher assumptions through reflexive engagement with the data. This approach enabled the identification of themes that captured the essence of ICU nurses' experiences of providing end-of-life care within the study context.

2.8. Ensuring Trustworthiness

In ensuring trustworthiness, rigor was established using Lincoln and Guba's criteria. Prolonged engagement, peer debriefing and limited member checking were done to enhance credibility. Preliminary interpretations of the findings were shared with a subset of participants to verify that the emerging themes reflected their experiences and intended meanings. Feedback received confirmed the credibility of the interpretations, and minor clarifications were incorporated where appropriate. Audit trial was maintained to strengthen dependability. Reflexive journaling and bracketing were done to support confirmability, while transferability was enhanced by providing thick descriptions of the study setting, participants, and context.

2.9. Reflexivity

Interviews were conducted by the first author, a registered nurse and postgraduate nursing student with an interest in critical care. Although familiar with the ICU setting, the researcher was not part of the ICU staff and had no supervisory relationship with participants. To minimise bias, the researcher used open-ended questions, reflected on personal assumptions through reflexive journaling and bracketing, and discussed coding and emerging themes with the research supervisors to ensure the findings accurately reflected participants' experiences.

2.10. Ethical Considerations

Ethical approval was obtained from relevant ethics committees in Malawi (National Health Sciences Research Committee, reference number 4596) and Zambia

(University of Zambia Biomedical Research Ethics Committee, reference number 6019-2024). Permission to conduct the study was granted by KCH management. Written informed consent was obtained from all participants. Confidentiality was maintained through pseudonyms, and participants were informed of their right to withdraw at any point without penalty.

3. Results

The study included a total of 12 ICU nurses who met the inclusion criteria. Table 1 shows that eight (66.7%) participants were female, and four (33.3%) were male. In terms of professional qualifications, eight (66.7%) participants held a diploma in nursing, three (25%) a bachelor's degree, and one had a master's degree, suggesting a gradual academic progression within the profession. Participants' ICU experience ranged from 1 to 17 years, with five having between 1 - 5 years, three (25%) having 6 - 10 years and four (33.3%) having 11 - 20 years of practice (Table 1).

3.1. Demographic Data

Table 1. Demographic characteristics of the ICU nurses who participated in the study.

Characteristic	Group	Frequency
Gender	Female	8
	Male	4
Age	20 - 29 years	3
	30 - 39 years	6
	40 - 50 years	3
Education	Diploma	8
	Bachelors's degree	3
	Master's degree	1
ICU Experience	1 - 5 years	5
	6 - 10 years	3
	11 - 20 years	4

3.2. Themes

3.2.1. Conceptualisation of End-of-Life Care

Participants described end-of-life care (EOLC) as care focused on ensuring comfort, dignity, and a peaceful transition for patients nearing death. They emphasised that the goal is not to prolong life but to relieve suffering and support both patients and families. One participant explained: "*A patient should die a pain-free death… if there is pain, then you ease it.*" (P001) Others defined EOLC in clinical terms, recognising when further treatment becomes futile: As one nurse stated: "*The parameters show the patient will not survive.*" (P002)

Despite shared perspectives, some expressed uncertainty, highlighting the need

for clearer institutional guidance.

Cultural and religious beliefs strongly shaped how nurses delivered EOLC. Participants frequently navigated spiritual expectations, ritual practices, and refusals of treatment. For example, caring for Jehovah's Witness patients who decline blood transfusions was described as challenging yet respected: "*We honour their choices even when we know the patient could have benefited*." (P001)

Families also introduced herbs, blessed water, or anointing oils, which nurses managed with caution: "*We just receive the herbs but do not give them*." (P006) While some practices provided comfort, they also created moral dilemmas. As one participant remarked: "*It becomes emotionally draining*." (P012) These experiences underscored the need for culturally sensitive communication and supportive policies.

Participants also reflected on their multifaceted roles in EOLC, which included clinical care, emotional support, communication, and spiritual facilitation. Nurses described responsibilities such as monitoring, drug administration, and maintaining comfort. One participant described routine nursing responsibilities as: "*Giving total nursing care such as bed baths and feeding*." (P003) Another participant highlighted the importance of preparing families: "*The most important thing is explaining the procedure to the guardian*." (P011) Some viewed spiritual support as integral to care, while others felt administrative duties limited their bedside presence. Uncertainty about role boundaries was common due to the absence of clear EOLC guidelines. Overall, nurses saw themselves as central to holistic EOLC, though competing demands and ambiguity sometimes hindered consistent care.

3.2.2. Holistic Practice in Delivering End-of-Life Care

Holistic practice was central to how nurses implemented EOLC, integrating physical care, communication, teamwork, and ethical decision-making within the demands of the ICU. Participants emphasised that dying patients continued to require attentive, personalized care, rejecting the notion that EOLC involves reduced involvement. One participant explained: "*We do not abandon the patients… they go clean, not smelling, even when they die*." (P009) Bedside allocation ensured sustained support, although pain management varied due to workload and assumptions about patient responsiveness. One participant admitted: "*I feel like we neglect pain management sometimes*." (P004)

Communication with families was described as a core component of holistic care. Nurses provided continuous updates, counselling, and emotional preparation from admission onward. One participant stated: "*Right from admission, we move together daily so they understand the condition*." (P008) Sensitive disclosure of bad news and private discussions helped families cope, although the absence of clear communication guidelines and language barriers especially with refugee families posed challenges. One participant admitted: "*We all do what we feel is best, but I have never seen any guidelines*." (P012) Participants also highlighted multidisciplinary collaboration as essential to safe and ethical EOLC. Nurses

worked with doctors and anaesthetists to adjust interventions and discuss prognosis. One participant explained: "*We work as a team… we follow all the end-of-life care together*." (P002) However, they noted that some decisions particularly around treatment withdrawal were made unilaterally, limiting shared responsibility. De-escalation of non-beneficial interventions was described as a compassionate and necessary process, although constrained by national policies that prohibit withdrawal of life-sustaining treatment. One participant observed: "*You cannot take them off the machine… you continue because we cannot end it*." (P002) Despite legal, ethical, and cultural complexities, nurses framed de-escalation as an act of dignity and comfort grounded in professional standards.

3.2.3. Emotional Burden Associated with End-of-Life Care

Providing EOLC placed a significant emotional burden on ICU nurses, who frequently managed dying patients within resource-limited and ethically complex environments. Participants described emotional exhaustion and moral distress arising from repeated exposure to death and the cumulative weight of caring for patients whose outcomes were often predetermined. Many expressed deep attachments to patients, which intensified their grief. One participant reported. Another participant observed; "*It is very painful to know that even if I am caring for this patient, the result is that the patient is dying*." (P001) Long stays strengthened emotional bonds, leaving nurses drained and fatigued. One participant observed; "*You are losing energy without any outcome*." (P008) Burnout manifested as physical and mental fatigue, reduced alertness, and forgetfulness.

A major contributor to emotional strain was the absence of formal psychosocial support. Participants described working through distress without structured assistance. One participant commented: "*When we face difficult cases, we are left to deal with them on our own*." (P001) Informal support from colleagues and family offered some relief, but most felt unsupported institutionally. Ethical dilemmas further intensified emotional distress. Nurses were often required to continue life-sustaining interventions despite poor prognosis because withdrawal of treatment is not permitted. As one participant stated: "*Families ask us to remove machines, but we cannot do it*." (P001) Scarce resources added moral tension, particularly when beds or ventilators were occupied by patients unlikely to recover. Conflicts between religious beliefs and medical judgement created additional dilemmas, especially when families refused indicated treatments such as blood transfusion.

Participants also faced emotional strain from conflicts with families, particularly when guardians rejected clinical findings, introduced traditional remedies, or delayed decisions due to cultural hierarchies. Communication breakdowns within the healthcare system added further stress, as nurses were often tasked with explaining complex information without adequate support. One participant remarked: "*Doctors expect us to tell them what happened as if we were present*." (P008) Overall, the emotionally charged environment, coupled with limited guidance and support, contributed to profound and persistent emotional burden among ICU nurses.

3.2.4. Institutional Constraints

Institutional constraints significantly shaped how nurses delivered EOLC, with limited training, resource shortages, inadequate staffing, and lack of structured support undermining their ability to provide consistent holistic care. Participants described feeling underprepared for the emotional and ethical demands of EOLC due to the absence of formal training or written guidelines.

Many relied on personal judgment and observation, which created uncertainty. One participant said; "*At school we did it as a topic, but being trained here, no… I often feel anxious because I am not confident.*" (P008) Another participant described learning through observation rather than formal preparation: "*There is no formal training… we do the same things we saw somebody doing.*" (P003) Nurses stressed the need for CPDs, refresher courses, and educational materials for both staff and families to improve confidence and standardize practice. Lack of institutional support further demoralized staff, as the burden of preparedness fell entirely on individuals. One participant commented; "*Management does nothing for us; we only help ourselves.*" (P004) Although informal support from colleagues and family offered some relief, participants viewed structured training and organizational commitment as essential.

Staff shortages further limited the ability to provide individualized care. One participant explained: "*Maybe we are just two of us against six patients, it becomes overwhelming.*" (P006) Resource shortages also affected patient care. One participant stated: "*Sometimes the FIO2 is finished, we were wasting it on a patient who was not benefiting.*" (P004)

Participants further described communication challenges resulting from limited institutional resources. One participant reported; "*We use personal phones; it drains your energy with no support.*" (P003)

These systemic limitations affected not only technical care but also emotional and spiritual support at the end of life.

3.2.5. Need for Enhanced Support

Participants expressed a strong need for improved support systems to strengthen EOLC delivery. Although committed to providing dignified care, nurses described gaps in training, communication structures, institutional policy, and emotional support that limited their ability to offer consistent, compassionate care. Their reflections highlighted the importance of structured education, better communication systems, legal clarity, psychological support, and culturally responsive frameworks.

A major concern was the lack of formal EOLC training, leaving nurses reliant on guesswork and observation. One participant explained: "*We need to know what it means when we say end-of-life care… now we just do things ignorantly.*" (P007). Another participant added: "*Sometimes we are uncertain about the best course of action, with more training, we would feel more confident.*" (P002) Participants also valued the limited workshops they had attended and emphasized the need for training focused on communication and counselling. One participant re-

marked; "*If we were trained in communication skills, that would be important.*" (P012)

Communication was described as essential yet hindered by logistical and institutional barriers. One participant stated: "*Sometimes we ask colleagues for airtime… we wait until they come during visiting hours.*" (P007) Participants also highlighted legal challenges surrounding withdrawal of treatment: "*Because of the policy, you cannot end it, unlike other countries.*" (P002) Nurses advocated for clearer national guidelines that protect dignity while aligning with ethical practice.

Participants also noted a significant lack of emotional support. One participant remarked; "*We give emotional support… but we do not receive emotional support; we need therapy sessions.*" (P012) Informal coping strategies such as humour, journaling, or family support were helpful but inadequate. Nurses called for formal counselling, debriefing, and routine mental health support. Finally, participants emphasised the importance of cultural and spiritual support: "*We should make sure guardians are present at the bedside to offer spiritual support.*" (P001)

Overall, participants described enhanced support as critical to improving EOLC quality, consistency, and dignity.

4. Discussion

This study aimed to explore ICU nurses' experiences in providing end-of-life care (EOLC) at Kamuzu Central Hospital, and the findings show that nurses encounter multiple emotional, ethical, cultural, and institutional challenges while striving to provide dignified and compassionate care. This is consistent with existing literature, EOLC in the ICU was experienced as complex and demanding, particularly in resource-limited settings [3] [9]-[11]. Nurses in this study articulated that although they prioritised patient comfort, dignity, and support for families, they often felt underprepared and constrained by limited resources, inadequate guidance and emotionally charged situations. This aligns with previous studies reporting that ICU nurses frequently face barriers at the institutional, family, and personnel levels that complicate the delivery of EOLC [12].

The most important finding of this study was the centrality of communication with families. Nurses described difficulties when communicating bad news, preparing families for terminal prognoses, or supporting those who remained in denial. These challenges are similar to those documented in prior studies, which show that communication at the end of life is influenced by nurses' communication skills, time constraints, the family's emotional state, cultural beliefs, and ability to understand clinical information [3] [13]. Simillary, denial among family members was common, especially when the patient appeared physically stable or death occurred unexpectedly [14]-[16]. In such circumstances, nurses in this study emphasised the importance of compassion, patience, and empathy approaches advocated in literature as essential for engaging with families experiencing shock or disbelief [17] [18]. As in previous studies, nurses recognised that their role as the most

present healthcare providers positioned them to offer emotional support and build trust, yet many felt inadequately prepared for these challenging conversations [18]-[20].

Participants also described the holistic practices they used to ensure comfort during the dying process. Spiritual care through prayer, pastoral visits, and allowing family rituals was widely emphasised and is consistent with findings that spirituality is central to end-of-life experiences in many African settings [4]. Spiritual care plays a vital role in supporting acceptance and providing comfort to both patients and families [8] [21] [22]. However, as reported elsewhere, its implementation remained inconsistent due to lack of training and institutional support [8]. Basic nursing care, such as hygiene, positioning and pain management, was maintained even after curative treatments were withdrawn. This reflects the fundamental commitment of ICU nurses to preserve dignity and ensure comfort, similar to findings in other contexts where hands-on care forms the core of EOLC [12] [23].

Decision-making at end-of-life was another important aspect of the nurses' experience. Consistent with the literature, the role of nurses in EOLC decision-making was limited, with physicians leading most decisions despite nurses' close proximity to the patient [11] [18] [21]. Participants often described feeling insufficiently involved or lacking the confidence to contribute meaningfully, echoing findings that nurses who are inexperienced or under trained may hesitate or withdraw from the decision-making process [8] [21]. Although family involvement in decision-making is culturally important in Malawi, it also presented challenges when relatives had conflicting expectations, unrealistic hopes or culturally rooted beliefs about death. This reflects broader findings that cultural norms and family hierarchies heavily influence EOLC decisions in African and Asian contexts [18] [24].

Emotional burden emerged as a major theme. Participants described psychological distress, sadness, and moral conflict when caring for dying patients, consistent with studies showing that exposure to repeated deaths can lead to fear, compassion fatigue, and burnout among ICU nurses [18] [25]-[27]. In line with studies indicating that senior nurses have more positive attitudes toward death because of their experience [15] [17] [28], older nurses in this study expressed greater comfort with EOLC, while younger nurses reported uncertainty and emotional strain. Empathy was central to the nurses' experiences, with participants describing efforts to emotionally connect with families and understand their situation. However, as in prior research, nurses in this study lacked access to structured debriefing or psychological support, leaving them to rely on informal coping strategies [3] [18] [29].

Institutional and resource constraints substantially shaped nurses' experiences. Shortages of staff, essential supplies, analgesics, and communication tools hindered the delivery of consistent and comprehensive EOLC, echoing widespread findings from low-resource ICU settings [15] [26] [30]. Legal restrictions prohibiting withdrawal of ventilatory support further intensified ethical dilemmas, par-

ticularly when caring for brain-dead patients who required life-sustaining interventions that provided no benefit. Similar constraints are reported in sub-Saharan Africa, where legal and policy gaps limit decisions around withdrawal of care and contribute to prolonged suffering and moral distress among healthcare workers [10] [24] [27]. Participants in this study echoed calls for clearer legal and institutional guidance to support ethically consistent EOLC practices.

Overall, this study reinforces findings from multiple settings that EOLC requires a combination of clinical knowledge, emotional competence, clear communication skills, and institutional support. Nurses in this study expressed strong commitment to patient dignity and compassionate care but emphasised the urgent need for structured training, supportive policies, and psychological support systems. Strengthening EOLC will require integrated interventions that address communication challenges, ethical uncertainties, workforce training, and institutional resource gaps. Such measures are essential to enhance nurses' confidence, reduce emotional strain, and ensure that patients approaching the end of life receive dignified, culturally sensitive, and compassionate care.

The findings highlight the need for improved ICU policies at Kamuzu Central Hospital to strengthen end-of-life care. Key priorities include staff training, structured communication with families, and multidisciplinary collaboration to improve care quality and reduce nurses' emotional burden. Integrating palliative care services, psychosocial support, and staff debriefing is also essential to enhance patient comfort, support families, and promote healthcare worker well-being.

5. Conclusion

This study revealed five interconnected themes demonstrating the complexity of providing end-of-life care (EOLC) in a resource-constrained ICU setting. Nurses experienced significant challenges related to communication with families, emotional and ethical dilemmas, institutional constraints, and limited formal preparation for EOLC. Although they showed strong commitment to preserving patient dignity, supporting families, and maintaining holistic bedside care, their efforts were often hindered by inadequate training, insufficient resources, unclear legal frameworks, and limited psychosocial support. The findings highlight the need for structured EOLC training, improved communication systems, culturally responsive policies, and institutional mechanisms that support ethical decision-making and staff well-being. Strengthening these components would enhance the quality, consistency, and compassion of EOLC. Further research is recommended to explore communication processes, ethical decision-making structures, and culturally grounded approaches to EOLC in similar low-resource contexts.

Limitations

The single-site sampling limits transferability, however, purposive inclusion of intensive care unit nurses with varied experience enhanced depth. Interview interruptions in the busy unit risked incomplete narratives, hence a private room was

used whenever available. Although member checking was undertaken, it was not completed with all participants because some were unavailable during the validation phase due to work schedules and shift commitments. Consequently, not all participants had the opportunity to review the preliminary interpretations. However, credibility was strengthened through peer debriefing, reflexive journaling, and the use of verbatim quotations to support the findings. Researcher interpretive influence was possible, thus bracketing, reflexive journaling, peer discussions, and an audit trail strengthened credibility.

What Is Known about the Topic?

1) ICU nurses play a central role in end-of-life care and often face complex emotional, ethical, and communication challenges while supporting dying patients and their families.

2) Resource limitations, inadequate training, and the absence of clear guidelines are well-documented barriers that affect the quality and consistency of end-of-life care in many low- and middle-income countries.

3) Nurses frequently report psychological distress, moral conflict, and feelings of unpreparedness when delivering end-of-life care, especially in high-acuity and resource-strained ICU environments.

What the Study Adds on?

1) The study provides context-specific insights into how ICU nurses in a Malawian tertiary hospital navigate emotional, ethical, and cultural challenges when providing end-of-life care.

2) It highlights critical gaps in institutional support, including limited resources, inadequate guidance, and the absence of structured psychological and communication support systems for nurses.

3) The findings underscore the need for context-appropriate training, clearer policies, and strengthened interdisciplinary collaboration to enhance compassionate, dignified, and culturally responsive end-of-life care in resource-limited ICU settings.

AI Tool Disclosure

ChartGPT-free online was used in language polishing and grammar correction for the manuscript.

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Author Contributions

Memory Msowoya (MM) conceptualised and designed the study, developed the proposal, conducted data collection, analysed and interpreted the data, drafted the manuscript, and undertook all revisions leading to the final version. Chileshe Mwaba (CM) provided methodological guidance, contributed to refining the study design, offered critical review of the manuscript, supported data interpretation, and approved the final version. Dr. Ruth Wahila (RW) provided overall supervision throughout the research process, offered expert input to ensure methodological and scholarly rigour, critically reviewed the manuscript for important intellectual content, and approved the final manuscript for submission. All authors read and approved the final manuscript.

Conflicts of Interest

The authors declare no conflict of interest regarding the publication of this article.

References

[1] Huffman, J.L. and Harmer, B. (2023) End-of-Life Care. StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK544276/

[2] Nacak, U.A. and Erden, Y. (2022) End-of-Life Care and Nurse's Roles. *The Eurasian Journal of Medicine*, **54**, S141-S144. https://doi.org/10.5152/eurasianjmed.2022.22324

[3] Alanazi, N.H. (2024) Intensive Care Unit Nurses' Experiences in Caring for End-of-Life Patients in Saudi Arabia: A Qualitative Study. *International Journal of Environmental Research and Public Health*, **21**, Article 931. https://doi.org/10.3390/ijerph21070931

[4] Dartey, A.F., Johnson, B.B., Klutsey, E.E., Zigah, J., Okai, B., Ahorli, R., *et al.* (2025) Experiences of Intensive Care Unit Nurses in End-of-Life Care at Ho Teaching Hospital, Ghana: A Qualitative Study. *BMC Nursing*, **24**, Article No. 699. https://doi.org/10.1186/s12912-025-03226-2

[5] Lastname, A.A. and Lastname, B.B. (2023) Nursing Care in the ICU. https://mdpi-res.com/bookfiles/book/10471/Nursing_Care_in_the_ICU.pdf?v=1780621839

[6] Utami, R.S., Pujianto, A., Setyawan, D., Naviati, E. and Rochana, N. (2021) Critical Care Nurses' Experiences of End-of-Life Care: A Qualitative Study. *Nurse Media Journal of Nursing*, **10**, 260-274. https://doi.org/10.14710/nmjn.v10i3.31302

[7] Kesecioglu, J., Rusinova, K., Alampi, D., Arabi, Y.M., Benbenishty, J., Benoit, D., *et al.* (2024) European Society of Intensive Care Medicine Guidelines on End of Life and Palliative Care in the Intensive Care Unit. *Intensive Care Medicine*, **50**, 1740-1766. https://doi.org/10.1007/s00134-024-07579-1

[8] Ratnasaria, F.R., Mariab, J.C. and Sitanggang, F.Y. (2025) Nurses' Experiences of End-of-Life Care in ICU. *NERS Jurnal Keperawatan*, **21**, 125-131. https://doi.org/10.25077/njk.v21i1.244

[9] Dibaji, S., Dibaji, N., Atti, L., Moqri, F., Makin, B., Shutayfi, O., *et al.* (2026) Effects of Critical Care Nurses' Emotional Intelligence on Patient Safety at King Fahad Hospital in Jazan Province. *Sage Open Medicine*, **14**, 1-12.

[10] Xu, D., Li, J., Ding, X., Ma, J., Hou, R., Chen, N., *et al.* (2025) Experiences of Providing End-of-Life Care in Adult Intensive Care Units: A Qualitative Study. *BMC Nursing*, **24**, Article No. 768. https://doi.org/10.1186/s12912-025-03340-1

[11] Albaqawi, H.M., Butcon, V.R. and Molina, R.R. (2017) Awareness of Holistic Care Practices by Intensive Care Nurses in North-Western Saudi Arabia. *Saudi Medical Journal*, **38**, 826-831. https://doi.org/10.15537/smj.2017.8.20056

[12] Setyawan, Y.D., Susanti, I.A., Kosasih, C.E. and Haroen, H. (2026) Nurses' Experience in Providing End-of-Life Care in Intensive Care Unit: A Scoping Review. *Healthcare*, **14**, Article 417. https://doi.org/10.3390/healthcare14030417

[13] Kisorio, L.C. and Langley, G.C. (2016) End-of-Life Care in Intensive Care Unit: Family Experiences. *Intensive and Critical Care Nursing*, **35**, 57-65. https://doi.org/10.1016/j.iccn.2016.03.003

[14] Ozga, D., Woźniak, K. and Gurowiec, P.J. (2022) Difficulties Perceived by ICU Nurses Providing End-of-Life Care: A Qualitative Study. *Global Advances in Health and Medicine*, **9**, 1-8.

[15] Lartey, J.K.S., Osafo, J., Andoh-Arthur, J. and Asante, K.O. (2020) Emotional Experiences and Coping Strategies of Nursing and Midwifery Practitioners in Ghana: A Qualitative Study. *BMC Nursing*, **19**, Article No. 92. https://doi.org/10.1186/s12912-020-00484-0

[16] Sheta, S.S., Elwan, A. and Nermeen, A.N. (2016) Risk Assessment of Intensive Care Stressors and Coping with It among Critical Care Nurses at Internal Medicine Department Zagazig University Egypt (An Intervention Study). *Current Science International*, **5**, 1-7. https://www.curresweb.com/csi/csi/2016/1-7.pdf

[17] Naidoo, V. and Sibiya, M.N. (2019) Critical Care Nurses' Experiences with Death and Dying: A South African Perspective. *Global Journal of Health Science*, **11**, Article 69. https://doi.org/10.5539/gjhs.v11n9p69

[18] Palmryd, L., Rejnö, Å., Alvariza, A. and Godskesen, T. (2024) Critical Care Nurses' Experiences of Ethical Challenges in End-of-Life Care. *Nursing Ethics*, **32**, 424-436. https://doi.org/10.1177/09697330241252975

[19] Paterson, L.A. and Maritz, J.E. (2024) Nurses' Experiences of the Family's Role in End-of-Life Care. *Health SA Gesondheid*, **29**, Article No. 2565. https://doi.org/10.4102/hsag.v29i0.2565

[20] Aschale, A., Gishu, T., Mengist, S. and Tsehay, M. (2025) Experiences of Intensive Care Unit Nurses in Providing End-of-Life Care in Public Hospitals: A Phenomenological Study. *BMC Nursing*, **24**, Article No. 1185. https://doi.org/10.1186/s12912-025-03849-5

[21] Curtis, J.R. and Levy, M.M. (2022) Providing Compassionate Care in the ICU. *American Journal of Respiratory and Critical Care Medicine*, **205**, 990-991. https://doi.org/10.1164/rccm.202112-2787ed

[22] Bilal, M., Mukhtar, F., Kousar, S., Ghani, M. and Khan, M.H. (2022) Nurses' Experiences in End-of-Life Care in an Intensive Care Unit at Tertiary Healthcare Setting, Lahore. *Pakistan Journal of Medical and Health Sciences*, **16**, 249-253. https://doi.org/10.53350/pjmhs22168249

[23] Carlet, J., Thijs, L.G., Antonelli, M., Cassell, J., Cox, P., Hill, N., *et al.* (2023) Challenges in End-of-Life Care in the ICU. *Intensive Care Medicine*, **30**, 770-784. https://doi.org/10.1007/s00134-004-2241-5

[24] Griffiths, I. (2019) What Are the Challenges for Nurses When Providing End-of-Life Care in Intensive Care Units? *British Journal of Nursing*, **28**, 1047-1052. https://www.britishjournalofnursing.com/content/focus/what-are-the-challenges-for-nurses-when-providing-end-of-life-care-in-intensive-care-units

[25] Selvam, S.D. and Sharmila, J. (2021) Roles and Responsibilities of Nurses in End-of-Life Care Patients and Delivering Palliative Care. *Journal of Nursing Practices and Research*, **1**, 1-4. https://doi.org/10.36647/jnpr/01.01.a001

[26] Orgambídez, A., Borrego, Y., Alcalde, F.J. and Durán, A. (2025) Moral Distress and Emotional Exhaustion in Healthcare Professionals: A Systematic Review and Meta-Analysis. *Healthcare*, **13**, Article 393. https://doi.org/10.3390/healthcare13040393

[27] Rong, J. (2022) The Lived Experience of Intensive Care Unit Nurses during the COVID-19 Pandemic. Graduate Student Research Symposium. https://dsc.duq.edu/gsrs/2022/proceedings/6

[28] Zhang, M., Zeng, D., Zeng, T., *et al.* (2026) Analysis of the Impact of Psychological Nursing Intervention on Psychological Status and All-Cause Mortality in ICU Patients with High Nutritional Risk. Alternative Therapies in Health and Medicine. https://www.researchgate.net/publication/401589907

[29] Bloomer, M.J., Brooks, L.A., Coventry, A., Ranse, K., Rowe, J. and Thomas, S. (2025) "You Need to Be Supported": An Integrative Review of Nurses' Experiences after Death in Neonatal and Paediatric Intensive Care. *Australian Critical Care*, **38**, Article 101149. https://doi.org/10.1016/j.aucc.2024.101149

[30] Uzelli Yilmaz, D., Yilmaz, D., Duzgun, G. and Akin, E. (2021) A Phenomenological Analysis of Experiences and Practices of Nurses Providing Palliative and End of Life Care. *OMEGA*: *Journal of Death and Dying*, **87**, 999-1016. https://doi.org/10.1177/00302228211037506