End-of-life care provision: experiences of intensive care nurses in Iraq
Forough Rafii, Alireza Nikbakht Nasrabadi and Muaf Abdulla Karim

ABSTRACT
Background: Nurses play a key role in providing care for the critically ill in the intensive care unit (ICU). The physical, psychological, emotional and spiritual intimate care given by Kurdish nurses allows them to develop a therapeutic relationship with terminally ill patients in the ICU.
Aims: This study sought to explore the meaning of caring for terminally ill patients from the perspective of Kurdish ICU nurses.
Design: Van Manen's (1990) hermeneutic phenomenological design was adopted.
Method: The data were collected through in-depth semi-structured interviews with a purposive sample of 10 nurses working in ICUs. Interviews were transcribed and finally analysed according to Van Manen's method.
Results: Four major themes including emotional labour, death as a positive dimension, optimistic rather than futile care and working within constraints emerged.
Conclusions: Kurdish nurses in their caring encounters with terminally ill patients experienced a range of feelings from emotional strain to being optimistic while working within limited resources in the ICU. Further research is needed to explore the experiences of nurses with other cultures of caring for terminally ill patients in ICUs.
Relevance to practice: End-of-life care in ICU is emotionally challenging, therefore, nurses in this setting require psychological and spiritual support to ensure optimal care provision.

INTRODUCTION
Death is an inevitable event (Haisfield-Wolfe, 1996); recent technological advances and the consequent extension of life expectancy have increased the complexity for end-of-life care (Beckstrand and Kirchhoff, 2005). Caring for critically ill patients happens in intensive care units (ICUs) where about 20% of patients have been known to die (Angus et al., 2004). The mortality rate in ICUs of USA, Canada and Sweden has been reported to range between 10% and 20% (Cook et al., 2004; Beckstrand et al., 2006). Because of the complex nature of patients admitted to the ICU, death, end-of-life care and challenging decision-making is common place at the ICU (Shorter and Stayt, 2010). Hansen et al. (2009), however, report that many ICU nurses may lack essential knowledge and skills required to provide effective care for terminally ill patients and to offer support for their families and carers. Although, there are no firm statistical data about the mortality rate in private and general hospitals of Kurdistan region/Iraq or mortality rate in the ICUs of this region specifically, the death rate appears to be significant; therefore, the critical care nurses require developing essential skills in order to provide better care for these patients.

BACKGROUND
Patients suffering from life-threatening diseases such as cancer, heart disease, stroke and chronic respiratory diseases are admitted to the ICU of hospitals (Payne...
et al., 2008). The challenge for intensive care nurses is to provide the best possible care to patients (Valiee et al., 2012). Advancement in medical technology has contributed a lot to increasing patient’s life span, improving the quality of the provided care (Beckstrand and Kirchhoff, 2005).

As a result, further to a good level of knowledge and skills required for nurses caring for terminally ill patients, they should also be able to give best possible emotional and psychological support (Liu et al., 2006). Moreover, as families are involved in end-of-life care, both patients and their families should be considered when end-of-life issues are implemented (Kemp, 2005). The relatives of a critically ill patient believe that all measures of care should be considered for the patient (Keegan et al., 2001); therefore, with respect to the patient’s dignity, emotional handling of the patients’ family is required (Wong and Chan, 2007) as they experience feelings of sadness, misery and weakness (Eriksson and Lauri, 2000).

The kind of end-of-life care provided by nurses is affected by their knowledge and skills (Angus et al., 2004). According to Salih et al. (2014), Kurdish nurses who were educated to deal with the terminally ill had more positive attitudes towards care for such patients than those who lacked relevant education. Some nurses believe that end-of-life care is ineffective (Beckstrand and Kirchhoff, 2005). Calvin believed that ICU nurses experience hopelessness and dissatisfaction (Calvin, 2007). However, end-of-life care is considered a powerful challenge to add a greater sense of hope to both nurses and the families (Cheraghi et al., 2005). While the Kurdish society expects nurses to arrange the best possible care for terminally ill patients (Salih et al., 2014), patient’s cultural backgrounds can also affect health care services and their response to illness. Therefore, it influences the nurses’ and patients’ perceptions of health conditions and treatment (Gysels et al., 2012).

As Pang (1998) stated, nurses should update their knowledge, to learn how to treat patients from different cultures and backgrounds and in order to treat patients equally but not similarly. In other words, skilled and knowledgeable nurses are able to react appropriately in different and difficult situations. In the absence of documented information about Kurdish intensive care nurses’ experiences of caring for the critically ill, gaining a deep understanding of such experiences would be necessary for successful planning of effective interventions to improve the quality of care for this group of patients in ICUs. This research hence sought to heighten the existing awareness and understanding of the experiences of Kurdish ICU nurses responsible for end-of-life care.

METHODS

Aim

The aim of this study is to explore the Kurdish nurses’ experiences of caring for terminally ill patients in ICUs.

Design

We used the hermeneutic phenomenological approach developed by Van Manen (1990) to focus on Kurdish ICU nurses’ lived experiences of providing effective end-of-life care. The approach connects human science, phenomenology and hermeneutics, allowing researchers to develop methods, techniques and procedures to build inductively theoretical answers to specific sensitive research questions. This was chosen because this topic has not been investigated in Kurdistan/Iraq; more specifically speaking, this study sought to explore the Kurdish nurses’ experiences of caring for terminally ill patients in ICU therefore providing a useful research framework for future similar studies.

Participants

The participants included 10 eligible ICU nurses who were recruited by the corresponding author with prior approval of the hospital manager. The inclusion criteria for participation in this study were as follows: (1) Kurdish registered nurses working in ICUs in Erbil city; (2) having cared for adult terminally ill patients and (3) cared for at least three terminally ill patients; (4) having at least 2 years of ICU experience and (5) willingness to participate in the study.

The age of participants ranged from 26 to 35 years, with a mean of 30 years. Participants included five men and five women and described themselves as Kurdish. Seven participants held a BSc in nursing and three had a diploma. Years of experience of working in ICU ranged from 4 to 12 years, with a mean of 6 years. During an initial phone call with potential participants, they were provided with a detailed description of the study and its risks and benefits, confidentiality of data and the informed consent procedures.

Data collection

The corresponding author conducted in-depth semi-structured interviews. All the interviews were conducted in Kurdish, in an ICU setting of one of the Erbil city hospitals. Data were collected until the research teams were satisfied that they had reached the point of saturation and no new concepts or ideas were being generated. In total, 10 nurses participated in the study.

Participants were asked about their experience of providing end-of-life care and subsequent questions were framed around their responses. Follow-up
Intensive care nurses’ experience of end-of-life care

questions were then posed to encourage the participants to further explain their perceptions. These questions included ‘Can you explain more?’, ‘Can you give me an example?’, ‘How did you feel/think about that?’, ‘What was it like?’ and ‘You mean …?’. For a better understanding, the researcher sometimes remained silent as a tactful way to prompt the participants to recall and describe their experiences. Each interview lasted between 33 and 70 min. All the interviews were digitally recorded, immediately transcribed and then analysed.

Ethical considerations
This research proposal was approved by the Ethics Committee of Tehran University of Medical Sciences. Prior to participation, all potential participants received some explanations about the research aim, the methods of data collection and were reassured about the issues of confidentiality and were informed about their right to withdraw from the study at any time and without giving any reasons. Informed consent was then obtained from all the participants. Anonymity and confidentiality were maintained by allocating a code to each participant and storing data files in a locked cupboard.

Data analysis
Van Manen’s six methodological activities were used to guide the researcher for data analysis (Van Manen, 1990). In order to analyse the data, the recorded interviews were listened to (for several times) and transcribed verbatim. The transcriptions were then compared with the recorded interviews to ensure their accuracy and were translated into English by a native bilingual translator familiar with medical texts and issues. Holistic, selective and detailed approaches were then adopted to extract a number of themes (units of meaning). In fact, the transcriptions were re-read many times until a thorough understanding of the participants’ experiences was achieved. In the next stage, the interviews were broken down to words, phrases and sentences and the major themes explaining the Kurdish nurses’ experiences of caring for terminally ill patients in ICUs were extracted.

Rigour
In qualitative research, rigour determines the trustworthiness of the conclusions drawn by the researcher (Holloway and Wheeler, 2010). In order to accomplish credibility, 10 nurses who were capable of describing their feelings of end-of-life care provision in the ICU were recruited by purposeful sampling. Peer checking, to enhance the accuracy and rigour of the findings, was accomplished by two professors (N. A. N. and F. R.) and were responsible for revising the transcripts and the extracted codes. The researchers independently analysed the data by identifying and categorizing codes from the subjects’ responses to each question. The rigour of this study was facilitated by close association between the participants and the researcher. After completely analysing, the data were discussed with the participants for getting their feedback (member checks). Meanwhile, two more professors’ expert in the field remained involved in every stage and their suggestions were taken into consideration. In an attempt to ensure prolonged engagement, data collection was done during a 9-month period. Moreover, the researcher who conducted the interviews was a PhD candidate of Nursing (A. M. K) and had worked in Kurdistan/Iraq with relevant experience in critical care nursing. So the researcher credibility was also achieved.

RESULTS
Four main themes emerged from the data including emotional labour, death as a positive dimension, optimistic rather than futile care and working within constraints (Table 1).

Emotional labour
Based on this theme, the studied Kurdish nurses usually focused on emotional labour during their care tasks in the ICU. This theme had two subthemes including caring for young/hopeless patients and family’s reactions.

Caring for young/hopeless patients
The participating Kurdish nurses believed that caring for young patients was more difficult and painful than caring for old patients. ‘Caring for dying patients differs from one type of patient to another. For instance, if

<table>
<thead>
<tr>
<th>Themes</th>
<th>Subthemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional labour</td>
<td>Caring for young/hopeless patients</td>
</tr>
<tr>
<td>Death as a positive dimension</td>
<td>Getting used to the job</td>
</tr>
<tr>
<td>Optimistic rather than futile care</td>
<td>Being under religious influences</td>
</tr>
<tr>
<td>Working within constraints</td>
<td>Insufficient resources</td>
</tr>
<tr>
<td></td>
<td>Poor coordination among health professionals</td>
</tr>
</tbody>
</table>
an old person is admitted, my caring is somehow normal, but if our patient is young it will make a great pain,’ participant 5 stated.

The Kurdish nurses analogized caring for brain dead patients in the ICU to a chess game. They regarded the brain as the ‘king’ of the body and reported that the body will not be able to function well if the brain dies. ‘Caring for dying patients in the ICU is like a chess game! When a patient’s brain is dead, all other parts of his body are healthy except the dead brain! In chess, if the king dies, the game will end even if other pieces like pawns, bishops, and knights are safe,’ participant 10 said.

**Family reactions**

Removing the ventilator, even following the request of patient families, was described as upsetting by the nurses as it would finally lead to death. ‘The decision about the patient is in the family’s hand. For example, the father of a patient came to us and said he wanted to take his patient home. The patient was on a ventilator. We removed the ventilator slowly within a few minutes and the patient died. It was so sad for us because we knew if we removed the ventilator, the patient would surely die,’ recalled participant 3.

**Death as a positive dimension**

Care for terminally ill patients in the ICU has positive impact on Kurdish nurses in terms of improving their clinical skills and confidence. This was as a result of ICU nurses spending more time with critically ill patients compared with ward nurses. This theme comprised of two sub-themes including getting used to the job and growth and development.

**Getting used to the job**

Kurdish nurses believed that with time, they gained more experience in ICU to make better plans to properly care for patients and it made life easier for nurses in this respect. ‘The experience of death is more difficult at the beginning. Then, continuous contact with dying patients in the ICU makes a nurse get used to everything’ reported participant 10.

ICU nurses played a vital role in providing care and were responsible for excellent care even with reduced staffing levels and a lack of equipment. ‘The nursing staffs always play a vital role in the ICU environment. They are responsible for providing the best and continue to care for patients despite limited staff and equipments,’ believed participant 9.

Based on the following quotation, gaining a reward following patient’s full or partial recovery and sometimes the appreciation and support they received from the patient’s family, triggers better work and commitment in the nurses. ‘From time to time, my family tells me that you live with dead persons. But this is my job and I love it. The reason which makes me comfortable with this job is that sometimes the critical and unstable patients recover which is an unbelievable experience for me,’ participant 1 reported. ‘Family members believe the life of the dying patient is in the hand of nurses. That’s why nurses make every effort to save patients’ life,’ stated participant 8.

**Growth and development**

Particular physical problems that occasionally occur at the time of caring for terminally ill patients provided the nurses with greater assurance and strength for future challenges. ‘When my patients die, my whole body is covered by sweat and I get paled. I console myself that I have done my best to save his life and that I’ve put all my efforts. This gives me more strength for future challenges,’ indicated participant 2.

**Optimistic rather than futile care**

The participating Kurdish nurses reported that they have provided confident and optimistic services from the first to the last stage of care because of their cultural background and their religious and ethical beliefs. They believed that they must care for the patients, regardless of their illness or religion. This theme comprised of two subthemes, i.e. being under religious influences and being compassionate.

**Being under religious influences**

Most of the participants believed that Islam recommends nurses to take care of the patients. This encouraged the nurses to continue their caring activities even if there was a poor chance of survival. For examples: ‘Most of the critical patients who were admitted to the ICU have feeble chance to survive. So, I usually get upset with this situation. However, Islam recommends us to care for patients even at the end of life and this encourages us to work in the ICU,’ clarified participant 5. And participant 4 confirmed that: ‘Working in the ICU involves a great level of hopelessness. However, our religion helps us, as nurses, to be hopeful under any circumstances. Therefore, we never truly feel hopeless.’

**Being compassionate**

The participants believed that the most important thing is having a good relationship with patients and their families and giving them hope. ‘Usually the family members are worried about the health of their patient.
Our physicians and I are continuously urging them to be optimistic and to trust in God for the outcomes of treatment. Although saying such type of words to the patients is deceptive, it is the duty of health care personnel to address the psychological aspects of the disease, too' believed participant 2.

Participant number 6 said: 'I am sympathetic to the patients and regard them as my own family. I cannot neglect them because my conscience does not allow me to. We take care of them very carefully and eagerly. I have even laughed and cried with them because they are human, too'.

Working within constraints
This theme described how Kurdish nurses were performing difficult tasks while caring for terminally ill patients. It consisted of two sub-themes including insufficient resources and poor coordination among health care professionals.

Insufficient resources
The participants frequently mentioned limited resources as a crucial factor and they believed in spite of causing extra burden on the nurses, it also reduces the extent of provided care to the patients. According to the following quotations, the shortage of nursing staff in the ICU prevented the existing nurses from providing acceptable care for end-stage patients. 'Due to the lack of sufficient nursing staff, it is difficult to perform all the duties in the ICU and compensate for the shortage of personnel,' indicated participant 7. 'Patients in the ICU need special care because most of them are approaching death. But sometimes, two or three patients are about to die and one nurse cannot handle them perfectly,' affirmed participant 8.

According to the participants, they sometimes failed to provide appropriate care because of the lack of equipment and medicines. 'Sometimes, while doing difficult tasks in the ICU, patients needed endotracheal tubes, but it was not available there. Sometimes, atropine was needed for those who have heart block, but there was no atropine,' stated participant 6.

Poor coordination among health professionals
Some of the participants regarded the poor relationship between physicians and nurses as one of the greatest obstacles to provide quality care to terminally ill patients. 'The bad relationship between nurses and doctors affects patient treatment because doctors always regard themselves superior to nurses. This will create a gap between them and the nurses. The gap will then grow and the patients will be deprived of good care,' believed participant 1.

DISCUSSION
In this study, nurses with experience in end-of-life care emphasized the emotional nature of their duties. This is consistent with previous studies that have highlighted the high levels of emotional labour among nurses caring for terminal patients in ICUs (Meltzer and Huckabay, 2004; Stayt, 2007). This has been shown to be particularly difficult for ICU nurses providing care to younger, terminally ill patients, where nurses always try performing their duties to the best of their ability and with respect. Naidoo and Sibiya (2014) suggested that caring for young patients is more difficult in the ICU because it tends to make the whole situation highly emotional. Nouroozi-Kushali et al. (2013) found that nurses working in ICU are more depressed compared with general ward nurses. Another study in Iran confirmed that the mean score of general health in psychiatric nurses was lower than that of critical care nurses (Yavari et al., 2014). In this study, family members insisting on the discontinuation of medical care, caused embarrassment for Kurdish ICU nurses, which was a source of emotional burden. According to McMillen (2008), the decision of allowing a peaceful death by withdrawing care/treatment in the ICU has remained another factor influencing health care staff, especially nurses.

Furthermore, our participants believed that because of working in the ICU, they had learned to fully devote themselves to their responsibilities. In fact, they performed their duties independently of physicians by providing care for end-stage patients due to the high self-confidence they acquired from their experience. They provided excellent treatment modalities and constantly cared for the ICU patients. Some researchers believe that professional and skillful nurses can improve their abilities by developing enthusiasm in their work (Messmer et al., 2004). The staff was also respected by patient families who believed that their patients were looked after by skillful ICU nurses. This positive attitude towards ICU nurses was also caused by their longer presence in the ICU compared with other hospital staff. Experience and theoretical knowledge were shown to affect nurses’ understanding of illness and the quality of care they provide (Hebert et al., 2011). Expert nurses then become skilled at evaluating clinical situations, making timely and accurate diagnoses and prioritizing problems (Karen et al., 2005). In our study, most participants reported that spending more time in the ICU increased their experience and improved their ability to plan and implement end-of-life care. A study that was conducted with the aim of describing the relationships between the quality of patient care and the education and experience of the nurses providing that care showed that
controlling for patient acuity, hours of nursing care and staff mix, units with more experienced nurses had lower medication errors and lower patient fall rates than units with more baccalaureate-prepared nurses (Blegen et al., 2001).

Kurdish ICU nurses believed that their religion, morality and independent work increased their pride and ability to remain optimistic. Notably, nurses with strong religious beliefs were more compassionate towards patients, promoting satisfaction among patients (and their family) who believed that Islam instructed the nurses to act accordingly. Kurdish culture also necessitates polite behaviour and requires propriety. Thus, their cultural, religious and ethical beliefs meant that nurses cared for patients, regardless of their illness or religion. This is consistent with the report by Valiee et al. (2012) who reported that most Iranian health care providers were Muslims who believed in life after death, and that social, cultural and religious backgrounds significantly affected their attitude towards end-of-life care. Most of our participants were pleased to care for any patient admitted to the hospital and used their skills to give the patients another chance to return to their daily activities and to live a normal life. Although they tried hard to care for patients for whom there was no hope of survival, the nurses agreed that such care was useless (similar to Sütçü et al. 2012). According to Espinosa et al. (2010), nurses frequently described futile and unnecessary care as one of the most difficult aspects of ICU care. Saving a human life is one of the most appreciated good deeds in Islam. However, an unavoidable aspect of ICU practice in relation to promoting positive death experiences includes withdrawal of futile life-sustaining treatment (McMillen, 2008).

Optimal care requires one nurse per patient, particularly for end-of-life ICU care (Beckstrønd et al., 2006). Care deficiencies were therefore seen in our study, particularly at night when there was a shortage of not only staff (i.e. two nurses for six patients) but also equipment and drugs. Other studies have also underscored these deficiencies in ICU staffing (Tiedje, 2000), showing that it leads to lower quality of care and heavier workloads. Another challenge to Kurdish ICU nurses was the poor relationship among health care professionals. This is consistent with previous reports where nurses cited disagreement about prognosis among physicians (Nelson et al., 2006) and poor relations or dissimilar opinions between nurses and physicians (Beckstrønd and Kirchhoff, 2005; Torjuul and Sorlie, 2006) to be major barriers to providing high-quality end-of-life care. Promoting communication among ICU professionals should therefore be integrated in all quality improvement programs, particularly because the quality of those relationships can determine patient outcomes (Miller, 2001).

LIMITATIONS
The findings of this study were derived from the experiences of ICU nurses working in two public hospitals. It is hence crucial to collect similar information from private hospitals of the same region. Moreover, as we merely recruited a purposive sample of 10 ICU nurses, the transferability of the findings will be limited to comparable settings. In order to facilitate judgments about transferability, Polit and Beck (2012) recommended researchers to provide accurate descriptions of their study procedures. We hence tried to describe the research setting as closely as possible without threatening the confidentiality of the critical care nurses who participated. Nevertheless, dialectic feelings of Kurdish nurses in the ICUs need further examination.

IMPLICATIONS
The themes that emerged in this study could be used by managers to understand nurses’ feelings and strains when caring for terminally ill patients in the ICUs with the same environmental conditions and problems. Also, nurses working in ICUs and patient families would be able to perceive the extent of nurses’ emotional exhaustion and their endeavour to save the patients’ lives.

CONCLUSION
Kurdish nurses in their caring encounters with terminally ill patients in the ICU experienced so much emotional labour. At the same time, they considered their caring as having positive dimensions and while they thought that caring for terminally ill patients is futile, they were optimistic at the same time because of their religious beliefs and tried their best to work hard against all the constraints and limitations within the ICU setting. Further research is needed to explore the experiences of nurses in other cultures of caring for terminally ill patients in ICUs.

ACKNOWLEDGEMENTS
The authors are grateful to Tehran University of Medical Sciences, International Campus (TUMS-IC) for their support. They also wish to thank the Director of Health in Erbil and the management and nursing staff of the corresponding hospitals. They truly appreciate all participants who made this study possible by willingly sharing their knowledge and experience.
WHAT IS KNOWN ABOUT THIS TOPIC

- Nurses have an essential role in the provision of end-of-life care for critical patients.
- Kurdish staff nurses face many obstacles in the ICU.
- There is very limited data about ICU nurses’ experiences of end-of-life care and this study is relatively novel regarding Kurdistan region/Iraq.

WHAT THIS PAPER ADDS

- Managers must provide nurses with the required psychological and emotional support.
- Suitable programs have to be designed to include nurses in the process of decision-making for providing end-of-life care.
- Religion can improve nurses’ ability to provide high-quality care in ICUs.
- Provision of special care equipments in ICUs would increase the likelihood of providing a more complete and ethical care for end-of-life patients by nurses.
- Increased cooperation between nurses and physicians in the ICU should be integrated in all quality improvement programs.

REFERENCES


