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Healthcare Professionals' Experiences in Providing Palliative Care in an Intensive Care Unit in Indonesia: A Phenomenological Study

Henny Suzana Mediani[1,*], Fidy Randy Sada[2,*], Aan Nuraeni[3,*], Muhammad Arsyad Subu[4,*]

[1]Department of Pediatric Nursing, Faculty of Nursing, Universitas Padjadjaran, Bandung, West Java, Indonesia; [2]Faculty of Nursing, Universitas Katolik De La Salle Manado, Manado, Indonesia; [3]Department of Critical Care of Nursing, Faculty of Nursing, Universitas Padjadjaran, Bandung, West Java, Indonesia; [4]Nursing Program, College of Health Sciences, University of Sharjah, Sharjah, United Arab Emirates

*These authors contributed equally to this work

Correspondence: Henny Suzana Mediani, Department of Pediatric Nursing, Faculty of Nursing, Universitas Padjadjaran, Bandung, West Java, 40132, Indonesia, Tel +62 822-1739-1965, Email henny.mediani@unpad.ac.id

Background: In the Intensive Care Unit (ICU), it is vital to meticulously monitor symptoms and thoroughly understand the treatment objectives for critically ill patients. This highlights the necessity of integrating palliative care in this environment. Despite the potential advantages, several barriers impede the effective integration of palliative care in the ICU. Notably, many healthcare professionals (HCPs) in Indonesian ICUs have not fully leveraged the incorporation of palliative care.

Purpose: This study aimed to investigate and clarify the experiences of healthcare providers (HCPs) involved in administering palliative care to ICU patients in Indonesia.

Methods: This research employed a qualitative descriptive phenomenological approach. Semi-structured, in-depth individual interviews were conducted with four nurses and three doctors working in an Indonesian hospital. Colaizzi's method was used for data analysis.

Results: The analysis identified six themes from the interviews, reflecting the experiences of healthcare professionals in delivering palliative care in the ICU. These themes are: 1) Provide Professional Caring, 2) Caring and curing collaboration, 3) Quality Intensive Communication, 4) End-of-Life Care, 5) Controlling Feelings, and 6) Provide Holistic Caring.

Conclusion: Providing care for ICU patients demands not only the expertise of HCPs but also compassion, communication skills, and a holistic approach to patient care. By offering comprehensive palliative care in the ICU, healthcare professionals can address the diverse needs of patients and their families, promoting comfort, respect, and an improved quality of life throughout the illness. This inclusive approach enhances the experience for both patients and their families while supporting healthcare providers in delivering empathetic and patient-centered care. It is recommended that hospitals develop policies to enhance palliative care services in Indonesia.

Keywords: ICU patient, healthcare professionals, palliative care

Introduction

Palliative care is a multidisciplinary approach aimed at optimizing the physical, psychosocial, and spiritual well-being of patients and their families who are affected by serious, life-limiting illnesses that impact their quality of life.[1] In the contemporary era, there has been a worldwide increase in the acknowledgment and need for palliative care services. This surge is primarily attributed to the rising population of individuals confronting severe and terminal illnesses. According to the World Health Organization (WHO) in 2021, annually, it is estimated that over 56.8 million people, including 25.7 million in their final year of life, require palliative care, with 78% of these individuals residing in low- and middle-income countries. However, it is believed that only around 12% of those in need of palliative care receive it.[2] The deficiency in access is notably prominent in low and middle-income nations, with Indonesia being a notable example.[3]

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Palliative care is not a new concept in Indonesia, having been developed since 1992. However, its progress has been slow and inconsistent throughout the country. At present, palliative care services are available mainly in a few major cities, where most cancer treatment facilities are situated. The development of these centers differs in terms of staff, facilities, and service delivery. While the basic concept of palliative care is widely recognized, the full understanding and implementation of it are still lacking among some healthcare practitioners.[3]

In the past two decades, palliative care has transformed into a crucial skill set for nurses employed in intensive care units (ICUs).[4] This transition signifies the growing acknowledgment of the significance of integrating palliative care principles into the delivery of comprehensive and patient-centered care, particularly for individuals grappling with serious illnesses in ICU environments.[4–8] With the escalating global demand for palliative care, healthcare systems and practitioners are placing greater emphasis on broadening the availability of these crucial services. The objective is to enhance the quality of life for patients contending with conditions that limit their life expectancy.[3,6,8,9]

Patients in critical condition within the Intensive Care Unit (ICU) necessitate meticulous symptom monitoring and a precise comprehension of treatment objectives, underscoring the imperative need for integrating palliative care in this context. Palliative care interventions can yield numerous advantageous results, such as diminishing the frequency of ICU admissions, abbreviating the duration of ICU stays, and optimizing the efficient utilization of existing resources.[4,5]

Despite the potential advantages, several factors impede the optimal integration of palliative care in the ICU. A prior study highlighted three primary barriers. Firstly, healthcare professionals, including ICU nurses and medical doctors, may believe they are already delivering high-quality end-of-life care, leading to reluctance in incorporating palliative care into their practice. Secondly, unrealistic expectations held by patients and their families regarding prognosis, or the effectiveness of ICU treatments can deter healthcare teams from seeking advice from palliative care specialists. Additionally, healthcare providers fear that adopting palliative care may be viewed as futile or could potentially harm the patient-physician relationship. Another notable challenge is the competency of healthcare professionals, especially nurses, in delivering palliative care within the ICU context. The lack of training and understanding of palliative care can hinder the provision of improved services to critically ill patients.[7–9]

The increasing number of critically and terminally ill patients in Indonesian ICUs underscores a growing demand for palliative care. Moreover, the elevated mortality rate among ICU patients underscores the essential role of palliative care, a responsibility that healthcare professionals, including nurses and doctors, should fulfill.[10–12] However, based on result of the study at General hospital in Indonesia, it was found that many nurses still equate palliative care with end-of-life care. This misconception leads them to believe that palliative care is only for patients who are terminally ill. This misunderstanding creates a dilemma among nurses regarding the appropriate care for patients.[13] Due to the dilemmas nurses face regarding palliative care, they tend to adhere strictly to medical treatments and provide only minimal care to patients until they pass away.[14] Palliative care not only aids patients in navigating the end of life with comfort and dignity but also provides crucial support to families facing challenging circumstances and the grieving process.

Palliative care has become an integral element of ICU services for both patients and their families. However, it is noteworthy that many healthcare professionals (HCPs) in Indonesian ICUs have yet to fully optimize the integration of palliative care. Additionally, a lack of comprehensive studies and assessments specific to this context means that the obstacles, benefits, and challenges encountered by HCPs in delivering palliative care in ICUs remain unexplored. Hence, the principal aim of this study is to explore the firsthand experiences of nurses and doctors engaged in the execution of palliative care within the ICU setting. The key research question guiding this investigation is: What is the significance and fundamental essence of the experience of providing palliative care for nurses and doctors attending to critically ill patients in the ICU? This research endeavors to illuminate the distinctive viewpoints, obstacles, and insights of healthcare professionals involved in delivering palliative care in Indonesian ICUs. Ultimately, the study aspires to contribute valuable knowledge that can enhance palliative care practices in this crucial healthcare environment.

Methodology

Study Design

The choice of a qualitative study using a phenomenological approach as the study design stems from the research's core aim, which is to delve into the experiences of healthcare professionals (HCPs) in the delivery of palliative care within the

ICU setting.[15,16] Phenomenology, as a philosophical approach, is particularly well-suited to this research objective because its primary purpose is to uncover and gain deep insights into the firsthand experiences of individuals.[16] The adoption of a phenomenological research design is deemed appropriate and advantageous for this study. It will facilitate a comprehensive and profound understanding of the experiences encountered by HCPs who are actively involved in providing palliative care to patients in the Intensive Care Unit. Through this approach, the study seeks to capture the nuanced and subjective aspects of their experiences, shedding light on the complexities and challenges inherent in delivering palliative care in this critical healthcare context.

Participants and Setting

The study participants in this research were comprised of both nurses and doctors employed at the Intensive Care Unit (ICU) of a general teaching hospital located in Indonesia. It's important to note that, at the time of the study, the hospital did not have a dedicated palliative care room. However, palliative care services were provided within the ICU setting, highlighting the relevance and importance of exploring the experiences of healthcare professionals in delivering palliative care in such a context.

A purposive sampling approach was employed to select the participants, and specific inclusion criteria were applied. These criteria included the following: participants must have direct experience in providing care to patients in the ICU, possess a minimum of 2 years of work experience in the ICU, hold at least three nursing diplomas (excluding doctors), and willingly consent to take part in the study. Key participants suggested potential candidates for the study, after which the researchers initially reached out to the head nurse of the ICU to explain the study. Following this, we met with ICU nurses and medical doctors working in the ICU. The researchers then provided further explanations to the candidates. Once the candidates agreed to participate, we commenced data collection. The sample size was determined based on the concept of data saturation, which occurred when no new themes or insights emerged from the interviews with participants. This saturation point was reached with a sample size of seven participants. Additional details about the participants can be found in Table 1.

To protect the participants' privacy and encourage open and confident expression, their names and identities were kept confidential and replaced with pseudonyms, as explained to them before the interviews. Each participant was assigned a pseudonym, such as P1, P2, P3, and so on. Prior to data collection, participants were thoroughly briefed on the study's nature and informed of their right to withdraw from the study at any point without needing to provide any reason. The participants informed consent include publication of anonymized direct quotes.

Data Collections

Data was collected from August to October 2021, through semi-structured in-depth interviews.[17] Due to still in the Covid-19 pandemic situation, two participants were interviewed virtually using Zoom meetings, while the remaining five participants were interviewed face-to-face at the ICU ward. To ensure confidentiality, a unique code was randomly

Table 1 Characteristics Participants

Participant Code	Gender	Age (Year)	Education	Period Of Working In ICU
P1	Female	33	Nurse (Bachelor)	6 years
P2	Male	34	Nurse (Diploma)	4 years
P3	Female	41	Nurse (Bachelor)	5 years
P4	Male	34	Nurse (Bachelor)	5 years
P5	Female	32	Doctor (Bachelor)	6 years
P6	Female	31	Doctor (Bachelor)	4 years
P7	Male	27	Doctor (Bachelor)	2 years

assigned to every participant. Prior consent was obtained from each participant to activate the video camera and record the interview. The researcher (HSM) determined data saturation after the seventh interview conducted. The interviews commenced with an open-ended question that allowed participants to describe their experiences freely and spontaneously in providing palliative care to critically ill patients in the ICU. The researchers also used probing questions to further explore the participants' experiences, including any obstacles encountered when integrating palliative care in the ICU. Each interview with the participants was conducted once and recorded, either in audio or video format, and lasted approximately 45 to 60 minutes. Data collection and analysis were carried out simultaneously.

Data Analysis

The analysis of data utilized Colaizzi's approach comprised the subsequent seven stages: (1) thoroughly reading all transcripts three to five times to comprehend the conveyed meanings; (2) scrutinizing each description and isolating noteworthy statements; (3) devising interpretations for these noteworthy statements; (4) organizing the construed meanings into groups of themes; (5) amalgamating the discoveries into a comprehensive portrayal of the phenomenon; (6) presenting the exhaustive portrayal to participants for affirmation of sentiments; and (7) integrating any pertinent new information into the ultimate depiction of the essence of the phenomenon.[7] All researchers extracted significant and meaningful statements related to the phenomenon from the transcripts. Themes and sub-themes were subsequently established through collaborative discussions, considering similarities and differences. All emerging themes were defined within a comprehensive framework, with any discrepancies, overestimations, or misused themes and sub-themes resolved through consensus. The agreed-upon themes formed the final structure of the study. To validate the findings, member checking was performed, where descriptive findings were shared with the participants for verification. The researchers obtained feedback from all participants, confirming that the research findings accurately reflected their experiences. This validation process followed established guidelines.[18–20]

Throughout the entirety of the data analysis process, the researchers were dedicated to maintaining objectivity and distancing themselves from their own thoughts, emotions, and viewpoints regarding the phenomenon they were investigating, as well as the data they had collected. This approach was guided by the concept of "bracketing", as advocated by Husserl. Bracketing involves temporarily setting aside personal biases and preconceived notions to prevent them from influencing the analysis. By adopting this approach, the researchers aimed to reduce the potential for data distortion, oversimplification, or exaggeration that could result from their personal influence. Instead, their primary focus was on comprehending and confirming the perspectives, attitudes, and emotions expressed by the participants in their statements. This approach ensured a more precise and genuine representation of the participants' experiences, reinforcing the integrity of the research findings.

Trustworthiness of the Study

Rigor and trustworthiness criteria, were employed in this study.[21] Credibility was established by maintaining transparency with the interviewees. This was achieved by recording the interviews and taking detailed field notes. Interview instructions were utilized to elicit comprehensive responses and expand upon the answers provided. To ensure confirmability, the audio-recorded interviews were transcribed by the first author, and the second author cross-checked the transcribed data against the audio recordings for accuracy. Transferability was upheld by the first author (HSM) to ensure that the data accurately represented the perspectives of the interviewees. Throughout the data analysis process, the authors documented memos detailing their assumptions. By implementing these measures, the researchers aimed to establish the trustworthiness of the study and maintain the neutrality and reliability of the findings.

Ethical Considerations

This study obtained ethical approval from the Research Ethics Committee of Universitas Padjadjaran (Ethics approval no. 366/UN6.KEP/EC/2021) and the Hospital Health Research Ethics Committee (number: 002/KEPK-SP/V/2021). Prior to data collection, participants were provided with comprehensive information about the study's purpose, the reporting of study results, and the recording of interviews. Written informed consent was obtained from all participants, indicating their voluntary participation in the study. It was explicitly communicated to the participants that they had the right to

withdraw from the study at any time without facing any negative consequences. These ethical measures were implemented to ensure that the study adhered to ethical considerations and respected the rights of the participants throughout the research process.

Results

Demography Data

The participants in this study consisted of 4 nurses and 3 medical doctors employed at the ICU of a general teaching hospital in Indonesia. More than a half participant in this sample were female (57%). The mean age of the participants is 23.2 years old. The mean length period of participants working experiences in ICU is 4.57 years. Table 1 shows in detail participant characteristics (Table 1).

Indeed, the characteristics of the participants, including their mean age, gender, and other relevant attributes, offer valuable context for comprehending the experiences and perspectives of nurses and doctors involved in delivering palliative care within the Intensive Care Unit (ICU). These demographic and professional factors can influence how healthcare professionals approach their roles, communicate with patients and families, and navigate the challenges of providing palliative care in the ICU setting. Understanding these characteristics helps researchers and readers interpret the findings and insights gleaned from the study in a more comprehensive and nuanced manner.

Study Outcomes

As a result of data analysis, the researchers identified six themes that emerged from the interviews. These themes described the experiences of healthcare professionals (HCPs) in providing palliative care in the ICU: 1) Provide Professional Caring, 2) Caring and curing collaboration, 3) Quality Intensive Communication, 4) End of Life Care, 5) Controlling Feelings, 6) Provide Holistic Caring. These themes collectively capture the core aspects and elements of the HCPs' experiences in providing palliative care in the ICU setting. For a visual representation of these themes, refer to Figure 1.

Provide Professional Caring

The theme of "Provide Professional Caring" encompasses the crucial aspect of the healthcare professionals' experiences in delivering palliative care in the ICU setting. It highlights the dedicated and compassionate approach taken by the HCPs in providing high-quality care to patients. This theme reflects the commitment and dedication of healthcare professionals in providing optimal care to ICU patients requiring palliative care.

The participants expressed that these tasks were carried out as part of their daily responsibilities and were essential for providing optimal care to palliative patients in the ICU. Here are some statements provided by a nurse participant:

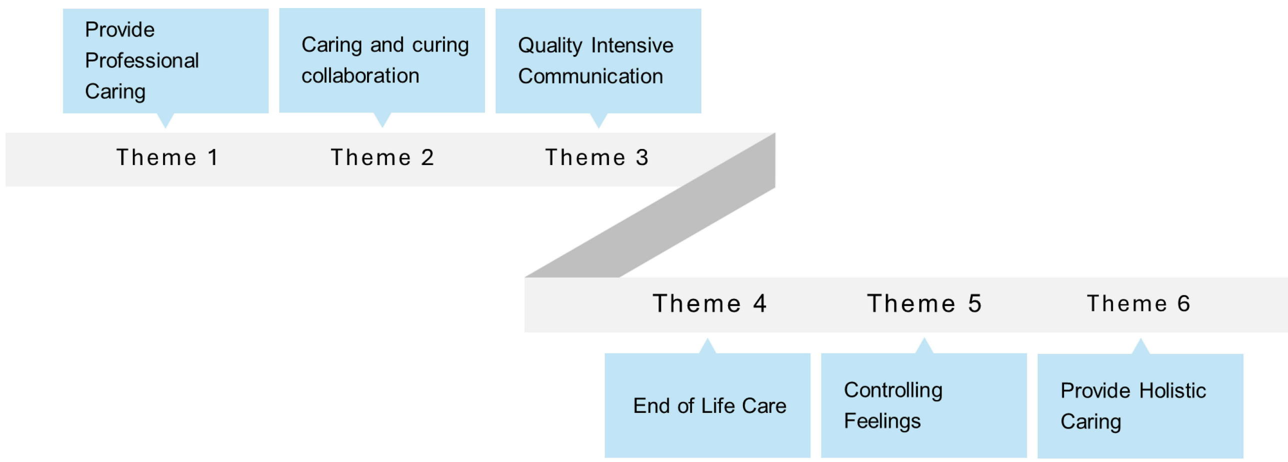

Figure 1 Six themes of the experiences of HCPs in providing palliative care in the ICU.

> "By consistently addressing the patients' needs, monitoring their vital signs, and ensuring their physical well-being, healthcare professionals strive to create a supportive environment that promotes comfort and stability. This focus on routine care aims to optimize the patients' overall experience and contribute to their improved quality of life during their time in the ICU." (P4)

These statements highlight the participant's perspective on the routine care provided to palliative patients in the ICU, emphasizing the importance of daily tasks to maintain stability and support the overall well-being of the patients.

All participants expressed their commitment to delivering care to all patients until the end, irrespective of their condition or prognosis. The healthcare professionals acknowledged that every patient deserves to receive appropriate medical treatment, regardless of whether they are in palliative care or not. As a medical doctor mentioned:

> I continue to administer medications and provide necessary interventions to patients until the end of their lives, without discriminating against those in palliative care. I understand the importance of ensuring comfort, managing symptoms, and maintaining the patients' well-being throughout their entire journey, regardless of the prognosis (P7)

Caring and Curing Collaboration

All the participants emphasized the significance of collaboration between caring and curing in the provision of healthcare. Nursing participants recognized that while curing focuses on the medical interventions and treatments aimed at curing diseases, caring is centered around providing compassionate support, comfort, and holistic care to patients. Here as a nurse stated:

> By fostering collaboration between nurses and medical doctors as healthcare professionals, we can work together to provide a balance between curative treatments and supportive care. Caring and curing are not mutually exclusive but rather interconnected elements that contribute to the overall well-being and quality of life of patients (P4)

Quality Intensive Communication

The theme of "Quality Intensive Communication" reflects the participants' recognition of the importance of effective and meaningful communication in the context of providing palliative care in the ICU. This theme highlights the significance of clear, open, and empathetic communication between healthcare professionals, patients, and their families.

The participants recognized the importance of giving education to families in the context of providing palliative care in the ICU. They emphasized the need to educate and empower families with the knowledge and skills necessary to actively participate in the care of their loved ones. As a medical doctor mentioned:

> It is important we provide patient care education to families to enable them to understand the patient's condition, prognosis, and the goals of palliative care. It involves providing information about symptom management, medication administration, wound care, and other aspects of daily care. By educating families, healthcare professionals aim to enhance their confidence and ability to provide optimal support and care to the patient (P7)

The participants' recognition of the importance of active and two-way communication in the context of providing palliative care in the ICU.

> We know that in the ICU we must conduct interactive communication involving actively listening to patients and their families, allowing them to express their concerns, fears, and preferences It underscores the importance of establishing trust and rapport with patients and families, promoting transparency, and ensuring that their voices are heard and valued throughout the palliative care journey in the ICU (P3)

End of Life Care

The theme of "End of Life Care" represents the participants' recognition of the unique and crucial aspects of providing care to patients nearing the end of life in the ICU. The participants in the study recognized the importance of providing compassionate and comprehensive care during this stage, focusing on meeting the unique needs and preferences of patients in their final moments.

> It is important to emphasize the significance of maintaining patient comfort and dignity. Patients really need to reduce their pain and symptoms effectively through providing medication administration, implementing comfort measures, and ensuring the patient's physical well-being. (P3)

Some participants believe that they have responsibility in delivering the best services and palliative care involves providing comprehensive and compassionate support to individuals who are facing serious illnesses or nearing the end of their lives. As one participant mentioned:

> as healthcare professionals we must continuously evaluate and improve the quality of services and care provided. This involves monitoring outcomes, soliciting feedback from individuals and families, and implementing changes to enhance the overall experience and effectiveness of care. By prioritizing these aspects, healthcare providers can deliver the best services and palliative care, promoting comfort, dignity, and support for individuals and their families during challenging times. (P3)

Controlling Feelings

The theme of controlling feelings represents importance when providing care in the ICU (Intensive Care Unit) during the end-of-life stage. It can be challenging to manage emotions in such emotionally charged situations.

> Offer emotional support to patients and their families, particularly during challenging times. Show empathy, provide comfort, and be attentive to their emotional needs. (P1)

The experience of participants showed that when providing palliative care in ICU should not be too carried away with the situation of grieving. Participants also revealed that they must be able to control their feelings to strengthen the family in dealing with the patient's situation and condition. This must be considered so that the services provided remain professional. Several statements from participants related to this experience are as follows.

> So, we really. that means we can empathize, share our condolences, but we also can't get carried away with that situation, because otherwise we will not rational. (P2)

The participant expressed feelings of heaviness and sadness when witnessing patients nearing death and empathizing with their families. They also mentioned the importance of imagining themselves in the family's position and recognizing the need to maintain professionalism while still experiencing their own emotions.

> It's quite overwhelming. (laughs). The heaviness refers to the fact that almost every day, we witnessed situations where we were on the brink of death or coming dangerously close to it. As a result, we began to envision ourselves as a family in such circumstances. Oh. (expresses sadness) it was like that. Particularly for those who had been undergoing treatment for an extended period. We would empathize with each other and shed tears when a patient passed away. (looks sad). It was truly challenging. So, if we were asked about our emotions, we would admit feeling sorrowful. However, considering our responsibility to-wards the family, we had to remain strong. After all, how would the family cope if we weren't? Hence, we continued to provide professional care. (P3)

Provide Holistic Caring

Participants revealed that when the patient was in a palliative condition, especially in ICU, both nurses and doctors provided more psychological and spiritual reinforcement to the patient and family. The reinforcement given was in the form of positive motivation that everything was in God's control. The statements expressed by participants regarding this experience are as follows.

> But if. there were also patients who were conscious condition. Yes. usually psycho-logical and spiritual gave to the patient. Also, to the family we help their psychologically needs. (P2)

Experience that expressed by participants in this theme, namely interventions related to holistic therapy directed at families and providing spiritual services to patients and families. Participants revealed that when palliative patients were

in a coma, they had more bio, psycho, social, and spiritual interventions to the family. The statements expressed by participants regarding this experience are as follows.

> It was. same as what I said earlier. like a patient who has been in a comma. so it was related to the bio, psycho, social and spiritual aspects of the family. (P3 Q7 S1)

All participants describe that they need to improve the patient's quality of life, making the patient comfortable and painless, and making the patient's treatment as comfortable as possible. The statements expressed by participants related to this experience are as follows.

> Sometimes we made it more comfortable for patients, which was comfortable and painless. That's the principle of painless and comfortable I hope the QOL of the patients will become much better…I think so. (P4)

Discussion

Provide Professional Caring

The delivery of palliative care in the intensive care unit, as perceived by participants, was characterized as a professionally administered form of caregiving. The study's findings revealed that healthcare professionals demonstrated professionalism in their actions when delivering palliative care in the ICU. This included adhering to established standards for routine care, offering services without discrimination, showcasing the competence of healthcare professionals, and fostering collaboration between caring and curing. The National Coalition for Hospice and Palliative Care (NCHPC) emphasized the importance of professional management in palliative care, a perspective that was aligned with the notion of healthcare professionals engaging in professional acts while providing palliative care in the ICU,[22] as highlighted in the study.

At the research site, a standardized operating procedure (SOP) dictates that, before a palliative patient is admitted to the intensive care unit (ICU), a doctor assesses the patient to determine their priority level. As part of this assessment, the doctor conducts a screening process aligned with the palliative care module, and using a screening score for palliative care patients.[23] Participants shared their experiences, indicating that palliative patients entering the ICU typically fell into the third priority category. This observation aligns with the guidelines outlined in the Minister of Health Decree of the Republic of Indonesia No. 812/MENKES/SK/VII/2007, which specifies that palliative patients in the ICU may be considered for admission as third-priority cases.

The provision of professional palliative services by healthcare professionals in the ICU necessitates a foundation of robust competence. Participants identified key competencies essential for healthcare professionals, encompassing teamwork, knowledge, skills, experience, and the capacity to establish meaningful connections with patients and their families. According to participants, teamwork emerged as a crucial element supporting the implementation of palliative care in the ICU. This perspective is reinforced by Black and Hawks, the National Coalition for Hospice and Palliative Care (NCHPC), and earlier research by Penrod et al, all emphasizing the significance of interdisciplinary teamwork in ensuring the continuity of palliative care.[22,24]

Further substantiating these findings, additional research underscores the importance of healthcare professionals enhancing their knowledge and skills for self-development in the context of palliative care in the ICU.[6,24–26] Beyond expertise, participants highlighted the need for healthcare professionals to possess the ability to establish meaningful relationships with patients and their families. This aligns with other studies which identified conflict mediation and empathetic communication as crucial competencies for healthcare professionals engaged in palliative care in the ICU.[27]

Caring and Curing Collaboration

Within the realm of teamwork, the collaboration between caring and cure played a pivotal role in supporting the effectiveness of professional actions in palliative care within the ICU. Numerous research findings have underscored the necessity of collaborative efforts between nurses and doctors in the context of palliative care within the ICU, acknowledging that nurses and doctors serve as the primary service providers (first line) in the ICU.[28] Participants in the

study disclosed that collaborative practices were integral to nearly all palliative care interventions in the ICU, particularly in the administration of medications. This collaborative spirit extended to discussions between nurses and doctors concerning the patient's evolving condition. Regular communication involved sharing updates on patient progress and seeking the latest literature related to patient management whenever challenges arose in the delivery of palliative services in the ICU.

Quality Intensive Communication

Effective communication among healthcare professionals was identified as not only essential but insufficient in the successful implementation of palliative care in the ICU. Research findings highlighted the importance of high-quality, intensive communication in various contexts, including when healthcare professionals educate families on patient care, convey distressing news, or provide information about the deterioration of the patient's condition. Additionally, interactive communication was deemed crucial, involving not only patients' families but also multidisciplinary teams beyond nurses and doctors in the ICU. The significance of communication in palliative care was underscored by prior research, emphasizing that an effective communication strategy is a vital element in palliative care. This strategy serves to clarify the goals of care and contributes to an overall comprehensive approach to palliative care.[29]

Education for patients and their families was found to be a flexible and ongoing process, available at any time based on the patient's condition. The research indicated that healthcare professionals, including both doctors and nurses, had the opportunity to provide education whenever it was needed, with some participants noting daily educational sessions for families. Participants described a division of roles, where doctors typically conveyed information about the disease, while nurses focused on educating families about care services such as attending to basic human needs. Moreover, the education provided by healthcare professionals encompassed information about interventions or therapies, detailing the associated risks and benefits. This collaborative approach allowed for a comprehensive and well-rounded education for patients and their families, ensuring they were well-informed about the patient's condition and the care services provided.

Consistent with the principles outlined by two prominent palliative care organizations, the National Coalition for Hospice and Palliative Care (NCHPC) and the Worldwide Hospice Palliative Care Alliance/WHPCA, palliative care in the ICU was characterized as a team-based approach centered around patients and their families (patient-family-centered care).[3,22] Participants in the study echoed this theme, emphasizing that palliative care in the ICU involved extensive interaction with both families and patients. This interactive and intensive communication was a key aspect of the palliative care services provided by nurses and doctors. It highlighted a concerted effort to make patients and their families the focal point of communication, ensuring that information and education were effectively conveyed and understood in the context of palliative care in Indonesia.

The study underscored the importance of communication not only with patients and their families but also within a multidisciplinary team. Findings aligned with previous studies indicating that communication among healthcare professionals played a crucial role in decision-making and establishing treatment goals.[27,30] Additionally, other studies emphasized that discussions involving multidisciplinary teams and specialists involved in patient care were pivotal for supporting palliative care in the ICU.[24] Further emphasized in their research that healthcare professionals must possess the ability to engage in interprofessional communication, particularly when dealing with patients in critical condition.[25] This underscores the collaborative nature of palliative care, requiring effective communication among healthcare professionals from various disciplines to ensure comprehensive and well-coordinated patient care.

End of Life Care

The critical condition of palliative patients receiving treatment in the ICU posed a significant challenge for healthcare professionals in delivering their services. The research findings indicated that addressing the needs of patients in critical conditions involved caring for those nearing the end of life, actively engaging with their families, and striving to provide the highest quality of care. Previous research had already established that palliative care was an integral and comprehensive component of ICU care, specifically tailored for all critically ill patients with poor prognoses.[31] Consequently, the assumption was made by the researcher that palliative care was a requisite for all critically ill patients in the ICU. This notion found support in earlier research highlighting the ICU as a setting where palliative care should be integrated,

essential for all critically ill patients, and a responsibility shared by all healthcare professionals involved in patient care.[9,24,30]

Caring for critically ill patients approaching the end of life emerged as the primary manifestation of palliative care. As indicated by other research, it was emphasized that both primary palliative care and end-of-life care should be administered with love and skillfulness.[31,32] The study's participants further disclosed that all palliative patients treated in the ICU exhibited poor prognoses and were in the terminal stages of life. These patients experienced challenging conditions such as decreased consciousness, a deteriorating general health status, reliance on assisted breathing through a ventilator, and the presence of multiple irreversible comorbid diseases. Interventions were tailored to the specific needs of each patient, such as managing pain until the patient achieved comfort and administering resuscitation when deemed necessary based on the patient's condition and family preferences, particularly when a Do Not Resuscitate (DNR) decision had not been made.

According to the National Coalition for Hospice and Palliative Care (NCHPC), encouraging family involvement in discussions about a patient's development aims to foster understanding among families and prevent conflicts between families and the care team.[22] Participants in the study also emphasized that healthcare professionals should consider the family accompanying the patient to be one that can comprehend the information being delivered. Additionally, healthcare professionals were noted for providing optimal care even for palliative patients in critical conditions. Despite the designation of palliative care, professionals approached their responsibilities with the utmost diligence, treating patients as if they were their own family. This commitment is in line with previous research emphasizing that healthcare professionals dealing with critically ill patients should possess the willingness and ability to deliver the best possible interventions during ICU treatment.[32] These principles align with the elements of palliative care outlined in the other previous studies, which highlights the importance of healthcare professionals fully supporting patients possible, even until the patient's passing, through effective communication strategies that help clarify the goals of care.[9] It is important to note that providing effective communication in inpatient situations and conditions nearing the end of life, as revealed in prior research, may lead healthcare professionals to experience emotional changes such as sadness, grief, and other distressing feelings.[6] In caring for patients with critical conditions or end life of care can offer insights that help nurses develop greater empathy and provide meaningful moral support to both the patients and their families.[31]

Controlling Feelings

Healthcare professionals in the ICU develop a sense of professionalism while delivering palliative care. According to research findings, managing emotions is crucial in this context, emphasizing the importance of respecting the patient and adapting to the grieving atmosphere. Moreover, healthcare providers are required to exhibit emotional control, especially in challenging and sorrowful situations. Underscores the necessity for palliative care practitioners to enhance psycho-social skills, enabling them to maintain professionalism under diverse circumstances. Consequently, it is posited that maintaining emotional composure is strongly advised for healthcare professionals involved in offering palliative care in the ICU to uphold a professional demeanor.[33]

When a palliative patient's condition becomes critical, healthcare professionals undergo emotional changes, experiencing concern for both the patient and their family. Participants noted that such situations prompted them to focus more intently on the needs of patients and their families. The researcher posits that these circumstances foster a respectful attitude toward patients among healthcare professionals delivering palliative care in the ICU. According to research findings, this respect is manifested through considerations such as acknowledging the patient from birth to death, giving special attention to patients and families, and considering the patient's beliefs when providing services. This viewpoint finds support in the National Consensus Project for Quality Palliative Care, as well as previous studies,[22,29,34] which advocate for the provision of palliative care that respects the values and beliefs of the patient and their family.[22,29,30]

Healthcare professionals shared another aspect of their experience related to managing emotions, specifically in adapting to the grieving atmosphere. Participants disclosed that they frequently grappled with feelings of sorrow, given the regularity of dealing with deceased patients. Despite expressing familiarity with such situations, they emphasized that it did not diminish their capacity for empathy. Participants acknowledged that exposure to these grieving circumstances had, in fact, accustomed them to regulate their emotions effectively, preventing them from succumbing to the pervasive

atmosphere of grief. The ability to control emotions emerged as a key competency for healthcare professionals engaged in palliative care in the ICU. This aligns with previous research highlighting the necessity of coping skills in palliative care, enabling healthcare professionals to navigate their emotions and redirect them towards positive aspects.[32]

Despite the imperative for healthcare professionals to control their emotions, participants acknowledged experiencing profound and sorrowful feelings when confronted with the critical condition of palliative patients. Earlier studies have indicated that physicians are susceptible to emotional and psychological stress when providing palliative care in the ICU.[30] Similarly, other studies have shown that nurses undergo significant emotional fluctuations during palliative care, including feelings of sadness, heaviness, and sympathy for the patients and their families.[35,36] However, another study emphasizes the necessity for healthcare professionals to cultivate psychosocial skills to effectively navigate these emotional changes and continue delivering palliative care with a high level of professionalism.[33]

Provide Holistic Caring

According to participants' experiences, a key intervention in providing palliative care in the ICU involves offering holistic services to patients and their families. The holistic services mentioned in this context encompass a psychological and spiritual approach aimed at providing compassionate care and ensuring the well-being of both patients and their families. This aligns with previous research emphasizing that palliative care should be comprehensive, of high quality, and consistently delivered in critical care settings.[29,34] As a result, researchers posit that healthcare professionals ought to provide or facilitate holistic care for palliative patients in the ICU.

Participants highlighted that when a patient reached a critical condition, especially with a decreased level of consciousness, healthcare professionals shifted their focus towards a holistic approach for the patient's family. This observation aligns with the perspective of the National Consensus Project for Quality Palliative Care (NCHPC), which emphasizes that palliative care is a form of interdisciplinary care designed to address the holistic needs of both patients and their families.[22] The study's findings indicate that, in this scenario, participants directed holistic therapy interventions toward the patient's family. Holistic therapy, predominantly involving spiritual aspects, was frequently provided by healthcare professionals. This often took the form of facilitating prayer or offering motivational words to help families cope with the critical situations of their loved ones.

Participants frequently expressed the provision of psychological and spiritual care as integral components of the holistic services in palliative care. Psychological care involved offering positive advice and guidance to the family, while spiritual care encompassed recommending the involvement of religious leaders to assist patients in adhering to their beliefs. Healthcare professionals encouraged patients and their families to draw closer to their faith, surrendering everything to a higher power and maintaining belief in the possibility of miracles. In critical situations, healthcare professionals consistently motivate patients and their families, fostering resilience and a positive outlook. This approach aligns with prior research emphasizing that the implementation of palliative care in the ICU should address the psychological and spiritual needs, alleviating burdens for both patients and their families.[29,35,36]

This research findings indicated that holistic services were furthered by providing comfort and painless care, with a focus on enhancing the patient's quality of life, alleviating pain, and ensuring maximum comfort. This approach aligns with the definition of palliative care by the World Health Organization (WHO) as emphasized by the Worldwide Hospice Palliative Care Alliance (WHPCA).[3] Palliative care is a holistic approach intended for patients and families facing life-threatening diseases, aiming to improve the quality of life and provide comfort rather than focusing on curative measures.[20,37,38] It is therefore, holistic care is crucial for nurses, particularly when caring for patients with terminal conditions, as it plays a key role in enhancing the patient's quality of life.[6,28,31,36,38] Participants took concrete actions in line with these principles, addressing patient complaints, particularly pain, by implementing optimal interventions to minimize or eliminate pain, ensuring that patients experience comfort even in their final moments.

Conclusion

Our study examining the experiences of nurses caring for critically ill patients in the ICU reveals that this role is both delicate and demanding, requiring a comprehensive approach to palliative care. By integrating holistic palliative care into ICU services, healthcare providers can effectively address the complex needs of patients and their families, ensuring

comfort, dignity, and a better quality of life throughout the illness. This approach not only enhances the experience for patients and families but also empowers healthcare providers to deliver compassionate, patient-centered care. It is essential for ICU healthcare providers to be well-versed in these issues, and ICU nurses should receive specialized training in palliative care principles. Moreover, the hospital is responsible for ensuring that HCPs are well-trained in holistic care principles. This includes training on effective communication, cultural sensitivity, and the integration of physical, emotional, and spiritual care in their practice. Continuous education and training programs help healthcare providers stay updated on best practices in holistic care. Improving professional education and training in palliative care is crucial to ensuring that all critically ill patients and their families receive the high-quality palliative care they need to meet their specific needs effectively.

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References

1. Ito K, George N, Wilson J, Bowman J, Aaronson E, Ouchi K. Primary palliative care recommendations for critical care clinicians. *J Intensive Care*. 2022;10(1):1–8. doi:10.1186/s40560-022-00612-9
2. WHO's Newsletter. Implementing World Health Assembly Resolution on Palliative Care. World Health Organization. Available from: https://www.who.int/news/item/12-10-2021-implementing-world-health-assembly-resolution-on-palliative-care. Accessed August 22, 2024.
3. Connor S, Morris C, Jaramillo E, et al. *Global Atlas of Palliative Care*. 2nd, ed. Eorldwode Hospice Palliative Care Alliance; 2020.
4. Ma J, Chi S, Buettner B, et al. Early palliative care consultation in the medical ICU: A cluster randomized crossover trial. *Crit Care Med*. 2019;47(12):1707–1715. doi:10.1097/CCM.0000000000004016
5. Romano AM, Gade KE, Nielsen G, et al. Early palliative care reduces end-of-life intensive care unit (ICU) use but not ICU course in patients with advanced cancer. *Oncologist*. 2017;22:1–6. doi:10.1634/theoncologist.2016-0227
6. Coelho CBT, Yankaskas JR. New concepts in palliative care in the intensive care unit. *Rev Bras Ter Intensiva*. 2017;29(2):222–230. doi:10.5935/0103-507X.20170031
7. Kyeremanteng K, Gagnon LP, Thavorn K, Heyland D, D'Egidio G. The impact of palliative care consultation in the ICU on length of stay: A systematic review and cost evaluation. *J Int Care Med*. 2016;33(6):1–8. doi:10.1177/0885066616664329
8. Aslakson RA, Randall Curtis J, Nelson JE. The changing role of palliative care in the ICU. *Concise Defin Rev*. 2014;42(11):2418–2428. doi:10.1097/CCM.0000000000000573
9. Radbruch L, De LL, Knaul F, et al. Redefining palliative care d a new consensus-based definition. *J Pain Symptom Manage*. 2020;60(4):754–764. doi:10.1016/j.jpainsymman.2020.04.027
10. Alshehri HH, Wolf A, Öhlén J, Olausson S. Healthcare professionals' perspective on palliative care in intensive care settings: An interpretive descriptive study. *Glob Qual Nurs Res*. 2022;9. doi:10.1177/23333936221138077
11. Pan H, Shi W, Zhou Q, Chen G, Pan P. Palliative care in the intensive care unit: Not just end-of-life care. *Intensive Care Res*. 2022;3(1):77–82. doi:10.1007/s44231-022-00009-0
12. Nelson JE, Cortez TB, Curtis JR, et al. Integrating palliative care in the ICU: The nurse in a leading role. *J Hosp Palliat Nurs*. 2011;13(2):89–94. doi:10.1097/NJH.0b013e318203d9ff
13. Astuti NP, Sriyono S, Yunitasari E, Kurniawati ND, Baidhowy AS. Dilemma of identification patients palliative care needs in critical care unit. *Indones J Glob Heal Res*. 2024;6(1):223–230. doi:10.37287/ijghr.v6i1.2664
14. Sugiarto Hadiyanto AV, Miranti IP, Prajoko YW, Istiadi H. Histological and clinical stage profiles of young-aged breast carcinoma. *Diponegoro Int Med J*. 2022;3(1):1–6. doi:10.14710/dimj.v3i1.13944
15. Afiyanti R. *Metodologi Penelitian Kualitatif Dalam Riset Keperawatan*. PT Rajagrafindo Persada; 2014.
16. Creswell JW. *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*. Sage; 2009.
17. Galletta A. *Mastering the Semi-Structured Interview and Beyond*. New York University; 2013.
18. Abalos E, Rivera R, Locsin R, Schoenhofer S. Husserlian phenomenology and colaizzi's method of data analysis: Exemplar in qualitative nursing inquiry using nursing as caring theory. *Int J Hum Caring*. 2016;20:19–23. doi:10.20467/1091-5710-20.1.19
19. Morrow R, Rodriguez A, King N. Colaizzi's descriptive phenomenological methodology. *Psychologist*. 2015;28(8):643–644.
20. Wirihana L, Welch A, Williamson M, Christensen M, Bakon S, Craft J. Using Colaizzi's method of data analysis to explore the experiences of nurse academics teaching on satellite campuses. *Nurse Res*. 2018;25(4):30–34. doi:10.7748/nr.2018.e1516
21. Guba EG, Lincoln YS. *Effective Evaluation: Improving the Usefulness of Evaluation Results Through Responsive and Naturalistic Approaches*. Jossey-Bass; 1981.
22. NCHPC. *Clinical Practice Guidelines for Quality Palliative Care by National Consensus Project for Quality Palliative Care*. 4th ed. National Coalition for Hospice and Palliative Care; 2018.
23. Putranto R. *Modul Paliatif RSCM*. Rumah Sakit Dr. Cipto Mangunkusumo; 2015.

24. Penrod JD, Pronovost PJ, Livote EE, et al. Meeting standards of high-quality intensive care unit palliative care: Clinical performance and predictors. *Crit Care Med*. 2012;40(4):1105–1112. doi:10.1097/CCM.0b013e3182374a50
25. Cha E, Lee S, Lee J, Lee I. Health personnel's knowledge, attitudes, and self-efficacy related to providing palliative care in persons with chronic diseases. *Korean J Hosp Palliat Care*. 2020;23(4):198–211. doi:10.14475/kjhpc.2020.23.4.198
26. Altaker KW, Howie-Esquivel J, Cataldo JK. Relationships among palliative care, ethical climate, empowerment, and moral distress in intensive care unit nurses. *Am J Crit Care*. 2018;27(4):295–302. doi:10.4037/ajcc2018252
27. Holms N, Milligan S, Kydd A. A study of the lived experiences of registered nurses who have provided end-of-life care within an intensive care unit. *Int J Palliat Nurs*. 2014;20(11):549–556. doi:10.12968/ijpn.2014.20.11.549
28. Noome M, Genaamd Kolmer DM B, Van leeuwen E, Dijkstra BM, Vloet LCM. The role of ICU nurses in the spiritual aspects of end-of-life care in the ICU: An explorative study. *Scand J Caring Sci*. 2017;31:1–10. doi:10.1111/scs.12371
29. Schram AW, Hougham GW, Meltzer DO, Ruhnke GW. Palliative care in critical care settings: A systematic review of communication-based competencies essential for patient and family satisfaction. *Am J Hosp Palliat Med*. 2017;34:1–9. doi:10.1177/1049909116667071
30. Ke YX, Sophia HHU, Takemura N, Lin CC. Perceived quality of palliative care in intensive care units among doctors and nurses in Taiwan. *Int J Qual Heal Care*. 2019;31(10):1–7. doi:10.1093/intqhc/mzz003
31. Pratama AA, Wardaningsih S. Nurses' experiences in caring for dying patients: A literature review. *J Kedokt Dan Kesehat Indones*. 2020;11 (3):284–289. doi:10.20885/jkki.vol11.iss3.art10
32. Tse JWK, Hung MSY, Pang SMC. Emergency nurses' perceptions of providing end-of-life care in a hong kong emergency department: A qualitative study. *J Emerg Nurs*. 2016;42(3):224–232. doi:10.1016/j.jen.2015.10.025
33. Efstathiou N, Walker W. Intensive care nurses' experiences of providing end-of-life care after treatment withdrawal: A qualitative study. *J Clin Nurs*. 2014;23:3188–3196. doi:10.1111/jocn.12565
34. Mercadante S, Gregoretti C, Cortegiani A. Palliative care in intensive care units: Why, where, what, who, when, how. *BMC Anesthesiol*. 2018;18 (106):1–6. doi:10.1186/s12871-018-0574-9
35. Tripathy S, Routray P, Mishra J. Intensive care nurses' attitude on palliative and end of life care. *Indian J Crit Care Med*. 2017;21(10):655–659. doi:10.4103/ijccm.IJCCM_240_16
36. Jang SK, Park WH, Kim HI, Chang SO. Exploring nurses' end-of-life care for dying patients in the ICU using focus group interviews. *Int Crit Care Nurs*. 2019;52:1–6. doi:10.1016/j.iccn.2018.09.007
37. Mulyana AM, Rakhmawati W, Wartakusumah R, Fitri SYR, Juniarti N. The efficacy of internet-based interventions in family-centered empowerment among children with chronic diseases: A mixed-methods systematic review. *J Multidiscip Healthc*. 2023;16:3415–3433. doi:10.2147/JMDH.S440082
38. Mulyana AM, Rakhmawati W, Adistie F, Maulana S. Recent evidence regarding family-centred empowerment in improving quality of life and treatment outcomes among asian and African children with chronic diseases: A scoping review. *J Heal Transl Med*. 2024;27(1):7–20. doi:10.22452/jummec.vol27no1.2

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