



INTENSIVE CARE NURSES' EXPERIENCES REGARDING PATIENT DEATH; A QUALITATIVE STUDY

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Abstract

Objective: This study aimed to explore the experiences of intensive care nurses regarding patient death and the meanings they attribute to this process.

Methods: This qualitative study was conducted using a phenomenological design. Data were collected through in-depth interviews with 19 intensive care nurses using a semi-structured interview form. The data were analyzed using inductive thematic analysis.

Results: Three main themes and ten sub-themes were identified: reality of death, change and transformation, and need for support. The findings revealed that nurses experience death as a complex and multidimensional process involving emotional burden, personal and professional transformation, and various coping strategies.

Conclusion: The findings indicate that intensive care nurses' experiences of death constitute a dynamic process involving emotional burden, transformation, and meaning-making, shaped by both professional experience and institutional support. These results contribute to a better understanding of nurses' adaptation to death and emphasize the importance of structured interventions to support their psychological well-being.

Keywords: *Death, Experience, Intensive care, nurse, Qualitative research.*

Introduction

Intensive care nurses are frequently exposed to patient death and are often present at the final moments of life, a situation that requires not only clinical competence but also significant emotional and psychological engagement.¹ Providing care to dying patients, witnessing death, managing post-mortem processes, and coping with the lasting emotional impact of these experiences constitute a complex and demanding aspect of nursing practice.^{1,2} These experiences may influence not only nurses' emotional well-being but also the quality of care they provide, particularly in relation to end-of-life care, communication with patients' families, and the provision of spiritual support.

Previous studies have shown that nurses' attitudes toward death and their emotional responses can shape their caregiving practices. Difficulties in accepting death, fear of death, and avoidance behaviors have been associated with lower coping capacity and challenges in delivering holistic and compassionate care.^{3,4} In intensive care settings, where death is a frequent and often unpredictable event, nurses may struggle to provide adequate spiritual and emotional support, which are essential components of end-of-life care.¹ Therefore, understanding how nurses perceive and interpret death is critical for improving both their well-being and the quality of care they deliver.

Existing literature has explored various aspects of nurses' experiences with death, including perceptions of a "good death," emotional challenges, coping strategies, and the importance of supporting patients and their families.⁵⁻⁹ These studies indicate that nurses often view death as a natural part of life while simultaneously experiencing fear, anxiety, and emotional burden. However, much of the existing research tends to examine these aspects in isolation, focusing primarily on specific dimensions such as emotional responses or coping mechanisms.

Despite the growing body of research, there remains a lack of integrative qualitative studies that examine how intensive care nurses simultaneously experience, interpret, and make sense of patient death within the context of their everyday clinical practice. In particular, limited attention has been given to how these experiences are interconnected and how they evolve over time, shaping both professional identity and personal life. This gap impedes a comprehensive understanding of death as a multidimensional, meaning-oriented process in nursing practice. Understanding nurses' experiences with death is essential, as their perceptions and interpretations may directly influence end-of-life care practices, communication with patients' relatives, and their own psychological resilience. Moreover, understanding how nurses construct meaning around death and cope with its emotional impact can inform the development of targeted educational programs and institutional support systems to enhance nurses' well-being and professional effectiveness in intensive care settings.

Accordingly, the aim of this study is to explore intensive care nurses' experiences of patient death and to examine how they interpret and make sense of these experiences in their professional and personal lives.

The study was guided by the following research question: "What are the experiences of intensive care nurses regarding death and the dying process?"

Methods

Study Design

This qualitative study employed a phenomenological design to explore intensive care nurses' experiences of patient death. The study was reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ).¹⁰⁻¹³

Population and Sample of the Study

The population of the study consisted of nurses working in general and internal intensive care units. The intensive care units where the nurses worked had a minimum of 10 and a maximum of 18 beds. General and internal intensive care nurses were specifically selected because these units involve frequent exposure to patient death, prolonged end-of-life care, and continuous interaction with patients and their families. These characteristics provide a context in which nurses experience death-related processes more intensively and multidimensionally.

The study primarily employed homogeneous purposive sampling to select nurses with similar professional experiences related to patient death in intensive care settings. Although a relatively homogeneous group was targeted in terms of clinical context, participants had varying levels of professional experience, allowing exploration of differences in perceptions across experience levels.

In addition, snowball sampling was used as a participant recruitment strategy. Participants were reached through nurse communities and social media (Instagram), and the first participant guided the researchers in reaching other eligible participants. The sample consisted of 19 registered intensive care nurses.

Research Selection Criteria

Nurses who had worked in intensive care units for at least two years and agreed to participate in the study were included.

Data Collection Tools

Data were collected using a descriptive information form including socio-demographic information of the nurses and a semi-structured interview form.^{14,15}

Introductory Information Form: It consists of questions to determine the nurses' age, gender, working years, and recent bereavement.

Semi-structured Interview Form: The semi-structured interview form consisted of open-ended questions developed based on previous literature examining nurses' perceptions of death and their experiences of caring for patients during and after the dying process.

Semi-structured Interview Questions

1. As an intensive care nurse, what do you think death means?
2. What have you experienced about death in your working life or in the ward where you work?
3. How do your personal experiences of death and dying affect your life?
4. What do you think about the meaning of these experiences?
5. How do you evaluate your organization's approach/support in coping with death and dying?
6. What kind of support would you like to see in the approach to death and dying?

Data Collection Process

Data were collected between March and May 2023 by the first and second researchers using a personal information form and a semi-structured interview form. The interviews were conducted online via Zoom, audio-recorded with participants' permission, and lasted approximately 50 minutes on average. During the interviews, participants were

encouraged to share their experiences in depth, and additional probing questions were used when necessary to enrich the data.

All recordings were transcribed verbatim by the researchers and repeatedly reviewed during the analysis process. Data collection and analysis were conducted simultaneously, and interviews continued until data saturation was achieved, that is, when no new themes or categories emerged from the data. Appropriate environmental conditions were maintained throughout the interviews to ensure effective communication and interaction between the researchers and participants.

Data Analysis

The interview data were analyzed using an inductive thematic analysis approach based on Braun and Clarke's six-phase framework.^{16,17} This approach enabled themes to emerge directly from participants' narratives without relying on predetermined categories.

All interviews were transcribed verbatim and repeatedly reviewed to ensure familiarity with the data. Meaningful units were identified, and initial codes were generated inductively, remaining close to participants' expressions. Codes were then compared and grouped into broader categories based on conceptual similarities. These categories were iteratively reviewed and organized into themes and sub-themes, with continuous comparison between coded extracts and the overall dataset to ensure coherence and consistency.

Themes were subsequently refined, defined, and named through researcher discussions, and supported with representative participant quotations to preserve contextual depth. To enhance rigor, three researchers independently conducted coding and analysis, and discrepancies were resolved through consensus. Additionally, expert feedback from researchers experienced in qualitative methods and death-related studies was obtained to strengthen the credibility and trustworthiness of the findings^{16,17}.

During the coding process, the researchers systematically examined the interview transcripts to identify meaningful expressions and recurrent patterns related to nurses' experiences with patient death. Initial codes were generated inductively from the data while remaining closely grounded in participants' own narratives, consistent with Braun and Clarke's thematic analysis approach. Codes reflecting similar meanings and experiences were compared and grouped into broader conceptual categories. Subsequently, these categories were organized into sub-themes and overarching themes through an iterative and reflective analytical process. For example, codes such as "death is inevitable," "everything comes to an end," and "there is no return from death" were clustered under the sub-theme "The End" within the theme "Reality of Death." Similarly, codes related to emotional exhaustion, helplessness, and avoidance behaviors contributed to the development of the sub-theme "Emotional Burden." Throughout the analysis, themes and sub-themes were continuously reviewed, refined, and compared with the original data set to ensure internal coherence, conceptual consistency, and accurate representation of participants' experiences.

Credibility and Trustworthiness of Qualitative Data

To ensure credibility and trustworthiness, multiple strategies were employed throughout the study. Prior to data collection, preliminary interviews were conducted to establish rapport, provide information about the study, and ensure informed consent. Member checking was implemented by summarizing interview content during and after data collection, allowing participants to confirm accuracy and add

further insights. In addition, participants reviewed transcripts and findings to verify consistency.

An expert review was conducted during both the development of the interview guide and the analysis process to enhance credibility. Researcher triangulation was applied by involving multiple researchers in data collection and analysis, thereby reducing potential bias. All interviews were audio-recorded, transcribed verbatim, and supported by field notes, and direct quotations were included in the reporting to preserve authenticity. Furthermore, the research process and design were described in detail to ensure transparency and methodological consistency.

Researcher Positionality and Reflexivity

The research team comprised academics specializing in mental health and psychiatric nursing, with prior clinical experience in intensive care, oncology, and psychiatry. This background facilitated contextual understanding and effective engagement with participants.

Recognizing the potential influence of prior experiences and assumptions on data interpretation, reflexivity was maintained throughout the research process. Regular discussions were conducted during coding and theme development to critically examine researchers' perspectives. In addition, independent coding by multiple researchers and resolution of discrepancies through consensus enhanced the reliability and rigor of the analysis.

Ethical Dimension of the Research

The study was conducted in accordance with the principles of the Declaration of Helsinki. Ethical approval was obtained from the Social and Human Sciences Scientific Research Publication Ethics Committee of Beykent University (E-45778635-050.99-91352 / 01.02.2023). All participants were informed about the purpose of the study and provided informed consent prior to participation. Confidentiality was ensured by anonymizing participant data, with identifiers such as participant codes and gender used instead of names. Interviews were conducted by trained researchers experienced in qualitative methods. During analysis, a coding framework was developed and diverse cases were considered to enhance depth and variation in the data.

Results

The mean age of 15 female and 4 male nurses who participated in the study was 30.84 ± 7.24 years, and the years of employment ranged between 2 and 27 years (Table 1).

Table 1. Participant characteristics

Participants	Age	Working Year
K1	24	2 years
K2	35	13 years
K3	26	4 years
K4	33	6 years
K5	23	2 years
K6	27	9 years
K7	30	9 years
K8	32	8 years
K9	32	10 years
K10	43	16 years
K11	33	11 years
K12	53	27 years
K13	29	6 years
K14	27	3 years
K15	23	2 years
K16	24	2 years
K17	30	5 years
K18	30	3 years
K19	32	10 years

As a result of the analysis of the qualitative data obtained in the study, three main themes and 10 sub-themes were obtained: the reality of death, change and transformation, the need for support (Table 2).

Table 2. Themes and subthemes emerging from the interviews

Themes	Subthemes
Reality of Death	• The End • The Changing Shape of the Unchanging Death • Trace of the Pandemic
Change and Transformation	• Emotional Burden • Occupational Deformation • Development Professional and Personal Growth • Reflections of Death on Personal Life
The Need for Support	• Coping Resources and Limitations • Preparation for Death • Institutional Support Needs

Theme 1. Reality of Death

This theme represents the starting point of nurses' experiences, forming the basis upon which emotional and professional transformations develop. The intensive care nurses who participated in the study mostly expressed the reality of death when talking about their experiences with the concept of death and stated that death is an unchangeable end. The theme of the reality of death was evaluated with the sub-themes of the end, the changing form of unchanging death and the trace of the pandemic.

The End: While expressing the reality of death, intensive care nurses expressed that it is the end, life comes to an end, everything is over and there is no going back. While emphasizing that death is an end, the nurses expressed saying goodbye to the patient, shrouding the patient, taking the patient to the morgue and sharing the emotional burden of this last journey with the families. They also stated that death is an end when evaluating the meaning of death.

"Interventions are made to the end, but there is a reality, the reality of death. You can only intervene to a certain extent. And this is an inevitable end. People question themselves. I mean, more things seem meaningless rather than inadequate." (K19-32 years old)

"Death is an end, we've gotten used to it already. Life is coming to an end, it's over, meaning life is over for that person." (K4-33 years old)

The Changing Shape of the Unchanging Death: While describing their experiences, the nurses stated that they witnessed death in many ways, that death is inevitable, a reality that everyone can experience, and that although death does not change, the reactions to the way death occurs are also effective. They emphasized the importance of a peaceful, painless and good death and emphasized the difficulty of accepting sudden deaths, maternal and child deaths as well as deaths at a young age.

"We are more upset about sudden deaths. Like a heart attack, for example. It is more upsetting, frightening, astonishing, frightening when it happens suddenly. On the other hand, those who go through that process and are hospitalized seem to accept death more easily." (K18-30 years old)

"I think that even if a cancer patient whose organs have all failed and whose cancer has metastasized were brought back to life, the pain and suffering would continue. Instead, there should be a way of dying that is painless, or what we call a good death..." (K3-26 years old)

Trace of the Pandemic: Intensive care nurses frequently mentioned the difficulties they experienced during the

pandemic. They talked about the difficulties in the process, the frequent encounters with death, the distress of the patients, especially the high number of young deaths and the sad processes experienced by the relatives of the patients. Moreover, the sudden deaths of patients due to COVID-19, their suffering from respiratory distress, their deaths without being able to say goodbye to their relatives, and the fact that their relatives could not see the patients in any way caused nurses to have difficulties during this period.

"... your mother, your father, you cannot see them, you cannot even see the dead being buried because there is a pandemic. We are the only ones with the patients, we are their daughters, granddaughters, hands, feet, arms. We break the bad news about them and this affected me a lot, their deaths felt heavy..." (K2-35 years old)

"The consecutive deaths during the COVID period shattered my mental state, and it took me a very long time to recover. I will never forget those screams; the relatives of the patients affected me deeply..." (K14-27 years old)

Themes 2. Change and Transformation

According to the experiences of the intensive care nurses who participated in the study about the deaths they encountered in the unit, it was revealed that death caused change in them. The theme of change was addressed with the sub-themes of emotional burden, occupational deformation and professional and personal growth and reflections of death on personal life.

Emotional Burden: Several participants described that working with deceased patients created stress and emotional burdens on them. They stated that they felt sorry for deceased patients and their relatives, that they felt helpless because the patient did not come back to life despite the interventions, and that the emotional burden they experienced affected their daily lives. Emotional burden brings their losses to light. The fact that they equated past losses, future losses, and deceased patients with the reality of death in their own lives caused an emotional burden to form in nurses after a while. They emphasized that they exhibited avoidance behavior to eliminate the weight of the emotional burden.

"I can't get used to death, let me tell you that. I get asked this question a lot, how many years you've been a nurse, do you get used to death, you shouldn't have a feeling in you, you see tens of hundreds of dead people? There is no such thing. You don't get used to death. You don't just say he's dead and forget about him. Even if it is my birthday, that day is very bad." (K2-35 years old)

"We are affected, and inevitably, we reflect this in our lives. The stress of this job is already very tiring. I notice that I'm more tense on busy days. No matter who I talk to, I might sometimes offend those around me. Because the stress, the intensity, and what we see at work affect us." (K5-23 years old)

Occupational Deformation: Some experienced nurses described that being in a profession where death is very common causes burnout, fear and desensitization, and that knowing and witnessing the treatment and care process during and after death causes fear and anxiety about the death of themselves and their relatives.

"We stand in the same space with a dead person for maybe an hour, maybe an hour and a half, but we are not affected in any way. We pass by because it is no longer at a level that will affect us, or at least not at a level that will affect me. Because we are so used to it. It's a shameful thing. I mean, I don't want to think about what one of my family members went through when they are in bed one day, I would be very tired." (K6-27 years old)

"I'm very afraid of one of my loved ones passing away, everyone is afraid, of course... What will I do afterwards? I mean, everyone is probably afraid, but... We know how those interventions are done, and so on. Like how CPR is done..." (K8-32 years old)

Professional and Personal Growth: Nurses reported that caring for dying patients contributed to both professional and personal growth by enhancing their awareness of life's value and fostering a present-focused perspective. Repeated exposure to death was interpreted as a transformative process, promoting acceptance, resilience, and psychological maturity. In this context, encounters with death functioned not only as a source of emotional burden but also as a catalyst for self-reflection and personal development.

"The things that used to upset me before are not really important anymore. What matters is now. The things we are experiencing are valuable. I used to be more argumentative, but now I am calmer and more positive. I don't make a big deal out of things anymore... because there is death at the end." (K1-24 years old)

"It taught me to adapt to differences. I was normally a person who couldn't adapt to anything very well. My acceptance process towards life used to take a very long time, but now I can accept whatever happens to me very easily and I've moved on to the acceptance phase." (K13-29 years old)

Reflections of Death on Personal Life: Intensive care nurses reported that repeated exposure to death had significant effects on their personal lives, extending beyond the clinical setting to influence their emotional experiences, relationships, and overall life perspectives. These experiences were described as both enhancing empathy, emotional awareness, and personal growth and contributing to compassion fatigue, emotional exhaustion, and burnout. Overall, exposure to death emerged as a complex and multidimensional process that simultaneously fosters sensitivity and emotional strain, shaping nurses' personal lives and prompting reflection on their own relationships and life priorities.

"At first I was more sensitive, but now I am a bit used to it, because otherwise it is much more devastating. I used to feel very sad after each death because I empathized deeply with the patients." (K14-27 years old)

"...It really takes very strong emotions and being a very strong person for these things. The near-death experience again... This strength is reflected in our lives, I am affected by it" (K15-23 years old)

Themes 3. Need for Support

The intensive care nurses who participated in the study emphasized the need for support while expressing their experiences related to the concept of death and stated that health professionals and patient relatives should be supported more and their support needs should be recognized both in the pre-death period and in the post-death period. The theme of need for support was evaluated with the themes of coping resources and limitations, preparation for death, institutional support needs.

Coping Resources and Limitations: Nurses described a range of coping strategies in response to patient death, reflecting both available resources and existing limitations. While some relied on adaptive, meaning-oriented approaches such as spirituality and acceptance, others reported difficulties marked by emotional exhaustion, helplessness, and maladaptive behaviors, including avoidance and substance use. These findings indicate that coping with death is a dynamic and context-dependent process shaped by individual and socio-cultural factors. The coexistence of

adaptive and maladaptive strategies underscores the need for structured support systems to strengthen nurses' coping capacities.

"It is actually a religious acceptance. According to the religion I believe in, it is obvious that every human being will die. I see it as a natural process, so it is not difficult for me to accept death." (K17-30 years old)

"I'm doing so well that I got my Family Counseling certificate. I read personal development books, I mean, I actually learned those coping methods myself. When I'm really stressed out, I just escape somewhere for a few days." (K6-27 years old)

Preparation for Death: Another issue that came to the fore when nurses working in intensive care unit described their experiences related to death was the process of preparation for death. Nurses stated that they had difficulties especially when they had just started working and faced death for the first time. At the same time, they stated that the patients and their relatives in intensive care should be prepared for the death process spiritually (developing death rituals, praying, etc.).

"...We have colleagues who are just starting out. They ask, 'My patient died, what are we going to do?' They get upset. I tell them, 'Don't be upset, stay calm. This is our profession.' Sometimes, when people encounter death for the first time, they react like that. It happened to us just the other day." (K2-35 years old)

"...I mean, for example, I think especially new people should be given a lot. Because they encounter these jobs for the first time. They see death for the first time, they see terminal period for the first time." (K15-23 years old)

Institutional Support Needs: Nurses emphasized the lack of adequate institutional support in coping with patient death, despite frequent exposure to emotionally demanding situations. Participants highlighted the need for structured and accessible support systems, including psychological counseling, peer support, and regular monitoring of emotional well-being. The absence of such support was associated with increased emotional burden, burnout, and feelings of being undervalued. These findings underscore that coping with death extends beyond individual responsibility and requires organizational commitment to fostering a supportive work environment.

"...Our job is difficult. We are here day and night, we get tired, the fatigue becomes chronic and our emotions become dulled! In this respect, I would like there to be professional support. We would like to be understood, to understand our feelings, and to be helped." (K10-43 years old) *"Psychological support is very important. No matter how strong a person is, there are things they cannot see or handle on their own. People need to share their feelings. Maybe psychological support should even be mandatory, because sometimes people hide or suppress their emotions." (K16-24 years old)*

Less experienced nurses (2–5 years) primarily emphasized emotional burden, uncertainty, and difficulties in coping with death, whereas more experienced nurses (≥ 10 years) highlighted acceptance, professional development, and meaning-making. This suggests that professional experience facilitates a shift from initial emotional distress toward more adaptive and reflective coping processes over time.

Overall, the findings indicate that nurses' experiences of patient death represent a dynamic and interconnected process rather than isolated events. While the reality of death initiates emotional and cognitive responses, repeated exposure leads to transformation in professional identity and personal

perspectives. The extent to which this process becomes adaptive, however, is closely linked to the availability of coping resources and institutional support, underscoring their critical role in shaping nurses' meaning-making and adjustment.

Discussion

This study provides an integrative understanding of how intensive care nurses experience and interpret patient death as a dynamic, meaning-oriented process shaped by emotional, professional, and contextual factors. Consistent with previous research, nurses perceive death as an inevitable aspect of intensive care practice^{8,9}; however, the findings demonstrate that this normalization does not diminish its emotional impact. Instead, nurses develop a dual awareness in which death is both accepted and experienced as emotionally challenging, particularly in sudden, young, or pandemic-related cases.^{2,23}

Repeated exposure to death was found to initiate a process of transformation, moving from emotional burden and helplessness toward acceptance, resilience, and professional maturity. This aligns with the concept of adaptive transformation, highlighting that exposure to distress can simultaneously generate vulnerability and growth.^{24,25} Importantly, this process is not linear and varies across individuals and contexts.

The coexistence of emotional strain and personal growth underscores nurses' active engagement in meaning-making. Beyond the clinical context, death experiences were shown to influence nurses' personal lives, shaping their emotional awareness, relationships, and life perspectives, supporting the view of death as an existential as well as a clinical experience.⁶

Coping with death emerged as a multidimensional, context-dependent process encompassing both adaptive strategies (e.g., spirituality and meaning-making) and maladaptive responses (e.g., avoidance or substance use).^{4,18} However, individual coping alone was insufficient to manage cumulative emotional burden. In this regard, the lack of institutional support was identified as a critical factor, with insufficient psychological and organizational support contributing to burnout and emotional strain.^{19,20}

Professional experience further shaped coping processes, with less experienced nurses emphasizing distress and uncertainty, and more experienced nurses demonstrating greater acceptance and meaning-making, indicating the role of experiential learning in adaptive coping.⁸

Overall, the findings suggest that nurses' experiences of death constitute an interconnected process involving confrontation with death, transformation, and the influence of coping resources and institutional support. By integrating these dimensions, this study extends existing literature and offers a process-oriented framework that may inform future research and the development of supportive interventions in intensive care settings.

This study has several limitations that should be considered when interpreting the findings. First, participants had varying levels of professional experience (2–27 years), which may have contributed to differences in perceptions and experiences related to patient death. Although this variation enriched the diversity of perspectives, some experience-specific nuances may not have been explored in equal depth. Second, the study was conducted with nurses working in general and internal intensive care units within a specific geographical and institutional context in Türkiye. Therefore,

the transferability of the findings to different clinical, cultural, or healthcare settings should be considered with caution.

Additionally, data were collected through online interviews, which may have limited the observation of certain non-verbal expressions and interpersonal interactions during the interview process.

Conclusion

This study demonstrates that intensive care nurses experience patient death as a multidimensional and emotionally challenging process that influences both their professional and personal lives. The findings indicate that repeated exposure to death may lead not only to emotional burden and burnout but also to adaptation, meaning-making, and professional growth over time. In this context, strengthening institutional support systems such as psychological counseling, peer support, supervision, and end-of-life care education appears essential to support nurses' well-being and coping capacities. The study contributes to the literature by providing a process-oriented understanding of nurses' experiences with patient death and may guide the development of supportive interventions in intensive care settings.

Conflict of Interest

The authors declare no conflicts of interest.

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Author Contributions

B.B.Ç., Y.Ç., D.K.M., G.K.Ö.: Concept and design; Data analysis and interpretation; Drafting of the manuscript; B.B.Ç., Y.Ç.: Data collection; Literature Review; Critical revision; B.B.Ç.: Publication process. All authors approved final and accountability for the work.

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