Caring for individuals at the end of life in a curative care unit: Privileges and heartbreaks

By Marie-Laurence Fortin and Louise Bouchard

Abstract

The objective of this study was to describe the experience of caring for individuals at the end of life by five nurses working in curative care units. Semi-structured interviews were conducted to gain a better understanding of the meaning nurses give to this experience. The analysis of results, based on Giorgi's phenomenological method (1997), highlighted a central meaning: it is a human experience fraught with paradoxes where the bedside nurse feels both privileged to be accompanying these individuals at the end of their lives and torn between the medical priority given to curative care and the lesser priority given to palliative care. This study offers relevant options for nurse managers wanting to improve these nurses' work environment and the quality of care for individuals at the end of life.

In today's Western society, death has lost the familiar character it still possessed in the middle of the 20th century (Ariès, 1975). In today's society, death mainly takes place in the hospital, and very few of the individuals nearing the end of life ever access palliative care (Lambert & Lecompte, 2002; Dongois, 2003). In Canada, experts estimate that nearly 10% of terminally ill cancer patients receive palliative care, while in Quebec, this number is between 5% and 10% (Lambert & Lecompte). The vast majority of these patients die in curative care units where the overarching philosophy builds more upon the cure of disease, technological efficacy and the prolongation of life than on the sacred nature of death, the alleviation of suffering and the well-being of individuals at the end of their lives (Fillion, Fortier & Goupil, 2005; Dechêne, Dion, & Gratton, 2004; Ferrell & Coyle, 2002). As the majority of people die in curative care units of hospitals, and since nurses are the professionals who deliver end-of-life care and spend the most time with these patients, it is vital to wonder how nurses live this supportive care experience.

As reported in the literature, nurses working in curative care units demonstrate a high level of anxiety and helplessness in relation to patients nearing the end of their lives when compared to nurses working in a palliative care context (Brockopp, King, & Hamilton, 1991; Thompson, 1985; Frommelt, 1991). However, they tend to have a more favourable attitude toward caring for patients at the end of life when they have more frequent contact with them (Rooda, Clements, & Jordan, 1999; Hare & Pratt, 1989). Other studies show that nurses caring for individuals at the end of life in medical-oncology units have a significantly higher level of occupational stress and burnout than nurses taking care of this population in palliative care units (Plante, 1993; Bram & Katz, 1989). The lack of professional support, and the absence of initial and continuing training for end-of-life care, as well as the difficulty of caring for two different patient populations within one unit not governed by a palliative care philosophy are the main reasons behind these results (Plante). Work overload, philosophical differences regarding care between nurses and physicians, and the time they must devote to administrative work are the stressors nurses perceive in their work with individuals at the end of life (Kulbe,

2001). Other stress factors add further to the work of nurses caring for this population: the anguish or anger of patients misinformed about their prognosis, the numerous requests from anxious families, the therapeutic relentlessness practised with end-of-life patients, and the impossibility of saying goodbye to them due to lack of time (Gray-Toft & Anderson, 1986). While they are very useful, these few documented studies are based on theoretical models and pre-defined concepts by the researchers, which leaves little room for the nurses' opinions on their experience of caring for individuals at the end of life in a curative care environment.

As far as we know, in 2005, the year this study was conducted, there were only two studies that had explored the experience of nurses caring for individuals at the end of life in a curative care context: the phenomenological studies of Hopkinson (2002) and of Rittman, Rivera, and Godown (1997). The results of the first study completed in the United Kingdom indicate that nurses felt stressed by time constraints and the feeling they had not done all that was possible for their patients at the end of life, which resulted in frustration, anger and a feeling of helplessness. The second study conducted with American oncology nurses reports that they perceived it a privilege to give the supportive care and attention to individuals nearing the end of their lives since it is provided at a significant period of their lives. Two other qualitative studies are worth mentioning for the relevance of their results, but they pertain to a different context. A phenomenological study carried out in Sweden by Berterö (2002) explored the lived experience of homecare nurses working with individuals at the end of life. They described the experience as an opportunity to meet challenges, establish close links with the patients and their families and develop a sense of professional independence in relation to managing diverse care situations. They also reported experiencing frustrations with respect to the belief that they had not provided the care they would have liked to due to lack of time and the lack of recognition by their employer for the complexity of the work related to end-of-life care. Finally, Davies, Clarke, Connaughty, Cook, MacKenzie, McCormick and colleagues (1996) undertook a qualitative study about nurses working with terminally ill children suffering from chronic diseases. They ascertained that these nurses experienced moral distress when they were faced with internal conflicts and had to choose between respecting medical directives and providing care centred on quality of life; between expressing sad emotions and

Soigner des personnes en fin de vie dans une unité de soins curatifs : privilèges et déchirements

Abrégé

Cette étude a pour but de décrire l'expérience de prendre soin de personnes en fin de vie pour cinq infirmières œuvrant dans des unités de soins curatifs. Des entrevues semi-structurées ont été réalisées afin de mieux comprendre la signification que ces infirmières donnent à cette expérience. L'analyse des résultats, basée sur la méthode phénoménologique de Giorgi (1997), a fait ressortir cette signification centrale : une expérience humaine, teintée de paradoxes, où l'infirmière soignante se sent à la fois privilégiée d'être présente auprès de ces personnes en fin de vie et déchirée entre les priorités médicales accordées aux soins curatifs et le peu de place accordée aux soins palliatifs. Cette étude offre des avenues pertinentes aux gestionnaires de soins soucieux d'améliorer le contexte de travail de ces infirmières et la qualité des soins dispensés aux personnes en fin de vie.

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maintaining a “more professional” attitude, i.e., not cry, not get emotionally involved and be strong. According to Davis and colleagues (1996), nurses also experienced feelings of frustration and helplessness whenever the medical team did not take their opinion into account in decision-making processes.

The lack of knowledge and paucity of recent studies on the topic of the nurses’ experience in caring for individuals at the end of life in curative care units constitute the main incentive for conducting this study. The few results yielded by qualitative studies describe this experience as difficult, complex, fraught with professional challenges and frustrations, an experience that deserves to be studied more thoroughly.

Methodology

A phenomenological approach was selected for this qualitative study in order to better describe and understand the meaning assigned to the experience of caring for individuals at the end of life by nurses working in curative care units at a Montreal university health centre. This methodological approach aims to understand a phenomenon rather than explaining it or trying to identify variables enabling its prediction (Sadala & Adorno, 2002). As a philosophical and empirical approach, phenomenology focuses on the meaning given to a lived experience based on the individual’s consciousness of it, i.e., its perception and its context. It considers the individual’s subjective world from the narration of his or her experience (Giorgi, 1997; Oiler, 1982; Omery, 1983).

Following ethics committee approval and approval of the hospital health centre where the study was to take place, the research student (the first author for this article) proceeded with the recruitment of participating nurses in a university health centre providing adult care in the Montreal area. The requirements for participation were as follows: 1) to be a nurse with a permanent position in a unit; 2) to belong to a medical ward where medical treatments are aimed at recovery and where death is a regular occurrence, i.e., about one death per week; 3) to have cared for at least one individual nearing the end of life within the preceding three months.

Five nurses were recruited, all working full-time and having delivered care to between six and 10 individuals at the end of life in the three-month period prior to the interview. The participants were between 23 and 30 years old, had between two and five years of work experience in the type of curative care unit required for the study. Among the participants, two had completed college training while the other three had received university training. The care unit was composed of a team of resident physicians that was replaced every 45 days. Consequently, nurses had to frequently adapt to new medical teams. In this unit, resident physicians and nurses did not receive any training specifically related to palliative care. No palliative care standards were available to nurses. Lastly, most of the patients at the end of life were cared for in two- or four-bed hospital rooms.

After obtaining written consent from the nurses, semi-structured interviews were carried out by the student researcher. These lasted from 45 to 90 minutes and centred around general questions such as, “Tell me about an experience where you had to care for an individual at the end of life in your unit...” and, “What was most significant for you in this experience?” Each nurse was also asked to complete a questionnaire designed to collect sociodemographic data. The data were collected over a six-week period.

Giorgi’s (1997) data analysis method itself based on Husserl’s (1859-1938) philosophical foundations was used to obtain a better understanding of the phenomenon in question. The interviews were analyzed following the five major steps described by this author: completing and transcribing the interviews; reading the data multiple times to identify the stories’ global meaning; compiling sentences and groups of terms expressing a common idea to create meaning units; organizing the raw data and restating it in the language of the discipline; identifying the essential structure of the concretely-lived experience through synthesis of the results, for purposes of communication to the scholarly community.

According to Giorgi (1997), authenticity and credibility criteria help ensure scientific rigour. Credibility means that the results match the reality. This is achieved by diversifying the selection of participants and having the phenomenon recognized by experts. Another way of achieving credibility is to use the interviews until full redundancy of the collected data is achieved. The student researcher is aware that the limited number of nurses could not ensure both the diversity and redundancy of all collected data, as expected in phenomenological studies. However, that number proved sufficient to bring out the essence, themes and sub themes that covered common interpretations in the experiences the nurses had lived through. Lastly, the results were compared to those of scientific authors associated with the area under study and discussed with the research supervisor who has expertise in oncology nursing.

Authenticity means that the results correspond accurately to the experience as lived by the study participants and bracketing is used to meet this requirement. This exercise required the student researcher to formulate in advance and in writing her preconceptions related to the phenomenon under study, to try and become aware of them and keep them in mind while carrying out the interviews and data analysis. The authenticity criteria are also obtained by reading the interview transcripts multiple times and validating the student researcher’s analysis results with those of her research supervisor (Cara, 2002). The latter read and analyzed all of the interview transcripts in order to determine the sub themes related to the participants’ experiences. The results of her analysis were compared to those of the student researcher and discussed with her.

Results

Synthesizing the themes and sub themes obtained through the analysis of the interviews allows us to illustrate the experience of nurses taking care of individuals¹ at the end of life in curative care units as follows: it is a human experience, fraught with paradoxes where the bedside nurse feels both privileged to be accompanying these individuals at the end of their lives and torn between the medical priority afforded to curative care and the lesser priority given to palliative care. These themes and sub themes are illustrated in Table One and described thereafter.

Living a privileged experience by providing supportive care and attention to individuals at the end of life

In all of the collected testimonies, it is clear that nurses live privileged moments and derive several positive aspects from this care experience with individuals at the end of life. Caring for these

Table One. Essence—themes and sub themes—for the phenomenon under study

<ul style="list-style-type: none"> • Living a privileged experience by providing supportive care and attention to individuals at the end of life 	<ol style="list-style-type: none"> 1. Be able to practise nursing according to its humanist foundations 2. Have the opportunity to reflect and learn about death, life, oneself and nursing practice
<ul style="list-style-type: none"> • Living an agonizing experience because so little room is given to palliative care in the care unit 	<ol style="list-style-type: none"> 1. Feel little supported by the medical team 2. Bear the weight of decisions compromising professional ethics 3. Feel helpless and poorly equipped to deal with patients’ suffering

individuals enables them to reaffirm who they are and what they were trained for: nursing according to its humanist foundations where the patients and their needs are at the very core of the care and where nurses have an opportunity to exercise their human relations skills such as listening and compassion. They feel re-energized by the opportunity to make a real difference in these individuals' lives.

1. Be able to practise nursing according to its humanist foundations

All interviewed nurses expressed that the experience of caring for individuals at the end of life in their curative care unit gave them the opportunity to deliver care in accordance with a care model applying the fundamental values of the nursing profession. While the medical team distances itself from individuals at the end of life, as it can no longer save them, nurses want to seize this opportunity to fully apply their caregiving and communication skills, thus demonstrating the holistic approach to the patient. Some abilities such as listening, empathy and human presence come to the fore and take their full meaning in these supportive care experiences, as indicated by Sophie, Anne and Maude's remarks.

"I found that these experiences with individuals at the end of life gave me the opportunity to develop these strengths, to have psychosocial interactions with both patients and their families, which I don't have as regularly with patients in more critical situations. It is a great opportunity to address spiritual and psychosocial aspects, which are more significant... and all these, are wonderful opportunities... It is a privilege to be with them [...] I came to be in a medical care unit without really choosing it and I found because I can do this (provide supportive care at the end of life), I now have a real preference for it." (Sophie)²

"Basically, what makes my work, what I find rewarding, really, it's that. It's helping, to be able to help the family and the patient in... the experience" (Anne)

"I think it's very rewarding work. You give a lot of yourself, but you get a lot out of it too, I find. It's like a privilege, at times, to be caring for individuals at the end of life." (Maude).

In contrast with the more technical care required by the unit's regular population, the study participants discover the specific nature of the supportive care and attention necessary for these individuals and realize the difference they can make in their lives, as well as the impact they can have on what the experience will be like for these patients. They feel useful, appreciated and valued for their work with individuals at the end of life.

"Because you can see the difference that it makes. [...] You see that... what you have done remains with them. At least, you are doing work that has an impact on some people.[...] I think that palliative care may be the moment when nurses are appreciated the most because the physicians are not always there, plus they see that you can make a difference with the level of comfort.[...] I think that we are really useful." (Maude)

"It's the opportunity to have interesting communications and explore the spiritual and psychosocial dimensions, as opposed to the technical stuff, like blood transfusions, for example, which is not as interesting to me. So, that's why it is more significant, it has more to do with the psychosocial... all the interpersonal relations, communication, coping, hopes and fears, uncertainty, all that, it's ... great opportunities." (Sophie)

2. Have the opportunity to reflect and learn about death, life, oneself and nursing practice

For the five nurses in this curative care unit, palliative care offers opportunities to learn about themselves and reflect on life and death.

Caring for an individual at the end of life is considered an extremely meaningful and formative experience because it deals with the very basis of life, its fragility and finitude. This type of care gives them the opportunity to think about and reflect upon the human condition, the meaning of life and the rationale for their professional practice. At one point or another, all were sensitive to the great questions regarding the universality of death.

"Experiences with patients at the end of life make me think, something that does not happen with the other patients. I reflect on nursing practice, on my beliefs, on... the way we practise our profession in general, our role as nurses and... [...] on me, my beliefs and also on the way we collaborate with patients, their families and the other professionals." (Sophie)

"I think that for me, for my own development, it was super positive because I felt like the pivotal force that could... bring people to communicate and say OK, that's it. My responsibilities were clearly demonstrated to me. What my goal was, what I do in life, in my professional life. That's the essence, I think." (Anne)

"Learning from the people, from the vision they're going to have of their illness, it makes you realize that... [...] these patients succeed in touching me, in making me search within myself, in making me aware that in the end... all that I considered a big deal... what seemed to me like a tragedy, in the end... it makes me see things differently [...] I learn a lot, I find, about myself, with these patients, they help me realize some things, they talk to you a lot about their lives and... it's nearly a life lesson." (Julie)

Living an agonizing experience because so little room is given to palliative care in the care unit

All participating nurses stressed how little room was given to palliative care in their curative care unit. Palliative care is perceived as being marginalized compared with curative care. As reported by the nurses, activities focusing on supportive attention, helping relations and support to the individual at the end of life and their loved ones are not being recognized within the unit. Nurses feel they can't allocate the necessary amount of time to provide quality care to these individuals. The time they should devote to them is often lessened in order to meet the needs of acute care patients. All of these problems tend to make this a frustrating and agonizing experience for nurses who believe that these end-of-life individuals do not receive the quality of care to which they are entitled.

Consequently, in this context where the care unit's mandate is to "cure", nurses feel torn between their desire to deliver quality relational care to individuals at the end of life and their desire to deal with the medical emergencies associated with the "acute" condition of their other patients. They feel they must give greater importance to the various tests, examinations and treatments reserved for the latter, who are always first on the list of priorities. Thus, they observe that the vast majority of the time, end-of-life care is deemed secondary and is neglected by the care team.

"It is frustrating because we have acute patients in our unit who require a lot of attention. And I wanted to devote more of my attention to a female patient (nearing the end of her life) because I knew her family had a hard time accepting her diagnosis, that she was going to die soon and I wanted to stay with them so that they had more time, but I had... other things to do. I could not. I had to take care of the other patients. So it's hard, it's... frustrating." (Maude)

"The time I had to give them was not what I would have liked to give them. On the other hand, I am the one who feels guilty afterwards; I'll say to myself, 'This gentleman is one of my priorities,' but I also have patients who are unstable and whom I must treat." (Julie)

1. From here on, unless stipulated otherwise, the term "individual" also includes family members.

2. Each of the verbatim excerpts from the interviews is followed by a first name. The fictitious first names Sophie, Maude, Julie, Anne and Caroline were assigned to the nurse participants.

"Our floor is... medical, that's it. So you deal with what presses the most. When you have palliative care patients, it is obvious that you must help them turn and position them properly, however.... However one would like to do it every two hours, but at times, it's not realistic." (Caroline)

1. *Feel little supported by the medical team*

In a medical context that does not support them, nurses must go to great lengths to be able to offer adequate supportive care and attention to their patients at the end of life. The curative and "interventionist" attitude that prevails among the medical team makes it difficult for nurses attempting to deliver supportive care and attention to patients nearing the end of life and their loved ones and preparing them for their impending death. The experience is all the more difficult because of the goals of care for individuals at the end of life; choices regarding their resuscitation status and communication related to their prognosis are either ambiguous or poorly defined. Supportive care and attention for individuals nearing the end of their lives is simply not recognized as a care priority.

In such a context, the family suffers from not understanding the reason behind the move from curative to palliative care. Various fears and uncertainties around the medical situation shatter the trust relationship and cause suffering and pain for individuals at the end of life and their families, which sometimes causes them to react by demanding more attention. This situation can be a tough challenge for nurses.

"The resident did not even want to come into the room with me to see the patient and her family [...] that's not at all a priority for them. The 'no code' individual does not get the same attention as the others..." (Sophie)

"Professionally speaking, it infuriates me [...] People who are dying, one stops treating them or at least dealing with them on floors like these. I find that physicians do not take the time to do it (announcing the prognosis). And often we're not even forewarned. So you enter the room and everybody's been crying and you're the last one to know. [...] That's what transpires from what I've seen, an announcement is made over a countertop. I hardly see anything positive in keeping palliative patients in a unit like ours." (Julie)

The lack of support is particularly noticeable when it's time to alleviate the pain experienced by individuals at the end of life. All nurses interviewed for the study stated they were frequently forced to be insistent with the resident physicians to get appropriate medications for pain and other symptoms. The time the nurse has to take to convince the physicians, and the latter's resistance to prescribing certain drugs are sources of immense frustration.

"I did not really feel supported by the medical team, not at all. The physicians in charge such as the senior ones should come in and see how things are with the family [...] they did not want to talk at all to the family. They could go see them, see if they have any questions, see how they are doing... Then it took half an hour after he died for the physicians to come see him to pronounce him dead! [...] There's nothing. There's no support, I find! [...] Even, at times, when one suggests they give scopolamine (a drug that is used to dry up secretions), for someone who is drowning in his own secretions, and the physicians are so reticent to prescribe it. They're afraid to do it..." (Maude)

"With the doctors too [...] your patient is dying, he's in pain, and so you go see them, and tell them I have such a medication to give him and there's no relief. And they reply to me: 'Let's see, he is taking enough as it is, I won't prescribe any more, it's going to be too much.' Professionally speaking, it makes me furious!" (Julie)

"For sure there is the traditional morphine phobia both with the patients and the physicians. That resistance... is frustrating. And how many arguments there are on pain management, for example!" (Anne)

2. *Bear the weight of decisions compromising professional ethics*

As they do their utmost to support their patients and prepare them for their last moments, nurses must apply treatments or care that result from decisions sometimes infringing on their professional ethics. Some of the participating nurses report they already had to resuscitate patients who they said could derive no benefit from the intervention. They then see the medical team relentlessly working on a deceased patient and must even participate in these resuscitation attempts they deem futile. Some of the participants in our study also mentioned various interventions and tests such as blood sample collections and x-rays performed on patients nearing the end of their lives, which they said added to the pain they experienced. Sometimes these various medical practices were even perceived as amounting to torture. In addition, the nurses see themselves as torn between advocating for patients and maintaining a good relationship with the medical team and members of the family.

"That, too, is something difficult at the end of life, the resuscitation code, no resuscitation code. The eternal debate. This is terrible when the doctors say 'No, there is nothing to be done and we are not going to be issuing a code'. The family ends up resigning itself, OK, no choice, he is going to be a 'no code'. And, at the time the cardiopulmonary arrest occurs and the family is at bedside, they panic and say 'Do something, do something!' then is it resuscitation code or no resuscitation code? That's hell [...] they panic or change their minds, they feel really bad... It's hard... [...] One time, we ended up doing a no code patient." (Anne)

"There are times when it doesn't make any sense. [...] When the patient is terminal. And there are family members who really believe that something can be done and instead of making him comfortable and helping him... but no, we're there to puncture, but there is no vein because he's all swollen up. At this stage, it's torturing more than anything else. It's not palliative; you're torturing him..." (Caroline)

"And it's always the balance between... what the patient wants, what the family wants and what nurses and physicians think is best... to alleviate the pain, but the family wants the patient to be alert and you know that the patient is in pain and so you're always... [torn]. Me, I never want to see that the families... they don't trust you." (Sophie)

3. *Feel helpless and poorly equipped to deal with patients' suffering*

All participants felt helpless when confronted with the physical or psychological suffering of individuals at the end of life and with the mystery and inevitability of death. Even when everything possible had been done, they were still upset by human suffering. Nurses live through trying moments, as they witness how much suffering some individuals endure at the end of life, some of whom are perceived as impossible to relieve completely.

"But the patient was never comfortable, or so very rarely. And even after being with him, reassuring him and trying to position him properly and giving him medications... You would leave the room, take three steps and he would start screaming again. It was horrible. It's horrible, you know, to care for someone and not being able to do anything, anything significant for the patient, it's something you hope you'd never get to see as a nurse and as a... human being, too!" (Sophie)

"At times you feel... helpless! Because you tell yourself ... I want to do something! [...] Each time I would go in the room, it was a tremendous amount of suffering. What can I possibly do to make him comfortable?!" (Caroline)

The participants in the study contend they are poorly prepared to deal with the various situations surrounding end-of-life care. They say they did not receive any training regarding palliative care both during their basic training and their hospital training. On top of feeling their inability to manage various specific symptoms, nurses state they are not comfortable communicating with patients nearing the end of their lives and their families.

"At school, we never really did that. When I did my rotations, I never did any in palliative care... I never had to do any, I never thought about doing that. So... when I lived through my first experiences, it was really... overwhelming, because there was a lot of suffering, as the patient had dyspnea... and I truly did not know what to do." (Sophie)

"I feel I don't yet have optimal communication skills. I'm a little... sometimes I am afraid of asking questions, that I may not use the right words. [...] I have not yet sufficiently developed my skills in... communication; anyway, it's... it's difficult." (Anne)

"You want to assess your patient's pain, but we ourselves don't know. I don't even know the exact difference between giving 2mg of morphine subcutaneously and giving 2mg of morphine intravenously. I find that we're not equipped to deal with palliative care patients in this unit." (Julie)

Discussion

The study results are, up to a point, similar to those of other studies. Rittman, Rivera and Godown (1997), Byrne and McMurray (1997) and Wallerstedt and Andershed (2007) report that nurses' experiences had positive aspects when caring for individuals at the end of life. Hopkinson (2002), and Wallerstedt and Andershed (2007) describe the priority given in curative care units to this type of care as opposed to palliative care. Our study supports the results of research by Oberle and Hughes (2001), and Wotton, Borbasi and Redden (2005) on the physicians' reluctance to prescribe certain drugs to patients at end life, and by Jacobs and collaborators (2002), McGrath and collaborators (1999), Oberle and Hughes (2001), and Vachon (1987) on communication issues between nurses and physicians; on the feeling of helplessness and lack of knowledge in the specific area of palliative care (Fillion et al., 2005; McGrath et al., 1999; Frommelt, 1991; Georgaki et al., 2002; Oberle & Hughes, 2001; Plante, 1993), and on the hardships experienced by nurses in relation to curative interventions performed on patients at the end of life (Gray-Toft & Anderson, 1987; Jacobs et al., 2002; Wotton et al., 2005). However, our study deserves to be recognized for gathering all these data in a single study and concerning nurses working exclusively on a curative care unit. We don't pretend it covered everything about the experiences lived by these nurses. Our study will need to be conducted again with a greater number of nurses and in more diverse curative care units such as intensive care, surgical care and emergency care units. Moreover, the mutually validating statements made by the five recruited participants who had cared for between six and 10 patients nearing the end of life in the three months preceding the interviews, are perceived as enabling a greater understanding of this lived experience. All of the nurses reported both favourable and unfavourable elements.

Even though the nurses had more to say about the problems and hardships associated with providing palliative care in their curative care unit, they did not underestimate the fulfillment they derive from caring for individuals nearing death and their families. This research revealed that this type of care could be a source of inspiration, reflection and gratification. When taking care of individuals at the end of life, in the middle of their hectic daily work, the interviewed nurses are still able to stop and take the time to communicate with the people under their care. They state that the delivery of supportive care and attention to these individuals in their last moments on Earth helped them reflect on what's essential, on life's intrinsic values and on the importance of the humanist foundations of caring that can make the difference in people's lives. They appreciate being able to offer holistic care to individuals at the end of life and their families and allow themselves moments of compassion, sensitivity and concern for others. They say they can find again the sense of humanity that had pushed them in some way toward the nursing profession. Some of the study participants were able to apply their creativity and professional independence all along the process they went through with these unique experiences. Those results are partially reflected in some studies that identified the sense of privilege the nurses derived from

providing supportive care and attention to individuals at the end of life (Rittman et al., 1997; Wallerstedt & Andershed, 2007).

Our study also highlighted the heartbreaks experienced by nurses who feel they must give their top priority to clinical interventions and curative treatments at the expense of the comfort care and psychosocial care and attention required by patients nearing the end of their lives. Nurses feel especially disappointed by the lack of support from some physicians with regard to the importance that should be given to caring for individuals at the end of life. Some of these physicians are reluctant to prescribe analgesics and go as far as refusing to enter a patient's room. In our study, nurses stated that oftentimes the care plan is vague as the members of the team have not clearly discussed the goals of care and prognosis both between themselves and with the family. Moreover, nurses are sometimes the last to be informed of what the patients know about their illness and their prognosis. In these conditions, it is extremely difficult for nurses to take care of the patients and their significant ones, especially when they turn to nurses to obtain nurturing or information. This difficult situation is further exacerbated by a feeling of helplessness and a marked lack of knowledge in this specific area of care, as highlighted in several other studies (Fillion et al., 2005; McGrath et al., 1999; Frommelt, 1991; Georgaki et al., 2002; Oberle & Hughes, 2001; Plante, 1993). Moreover, the nurses who participated in this study witness therapeutic inflexibility in situations and are sometimes forced to take part in them, all of which makes them truly uncomfortable. A few studies mention the hardships experienced by nurses in relation to curative interventions performed on patients at the end of life (Gray-Toft & Anderson, 1987; Jacobs et al., 2002; Wotton et al., 2005). However, the lack of support from physicians to integrate palliative care practices in a curative care unit is hardly noted in the literature.

The results of our study invite reflection upon the place given to death in the context of acute care where the prevailing philosophy of technical omnipotence equates death with a lost battle and the abandonment of the patient, thus leaving little room for palliative care. According to our results, our study's curative care unit does not constitute an ideal place for dying, nor a place where a human being can get closer to their family and give meaning to their life and imminent death. It's also worth mentioning that the nurses in our sample did not stress the lack of nursing resources or the organizational problems and work condition issues that influence the nurses' work nowadays. The rotation of medical teams, as it occurs in care units such as the one studied here, can adversely affect the effectiveness of communication between nurses and physicians, and the continuing relationship with the client and their family. These contextual elements may explain some of the results obtained in this study such as the readiness—and ensuing frustration—to take care of the most urgent cases to the detriment of individuals at the end of life, as felt by the nurses. At the time the study was conducted, the lack of training and the absence of policy regarding palliative care in the health centre in question could also have contributed to the hardships the nurses experienced. One can also presume that resident physicians are as torn as the nurses in such a context and that their avoidance of individuals at the end of life and their sometimes equivocal decisions are not necessarily a result of bad faith. Further research is recommended to better explain the contextual elements of palliative care as currently practised in curative care units.

Recommendations

This study sought to better understand what nurses experience when they care for individuals at the end of life in a curative care unit. The gathered data underline both their love for human contact and the source of their suffering at work. According to our results, nurses should be able to express and share what they have to say about their care experience with individuals nearing the end of their lives. They also cast a light on the need for training on end-of-life care provided within curative care units in which 90% of patients die according to the latest provincial statistics. Some universities are now offering a

course on end-of-life care in their basic curriculum, as well as a micro program at the master's level. However, we believe that this training should also be offered in the hospital centres where nurses are working, as they don't all have access to university studies. This training on end-of-life care should include, among other things, a component on ethics and on interprofessional communication as they specifically relate to end of life. We noted that nurses experience distress in connection with choices and decisions linked to treatments intended for individuals at the end of life.

It is important for health care settings to value and support nurses who provide support care and attention to these individuals. We recommend that head nurses and directors of nursing recognize and value the work performed by nurses with individuals at the end of life in acute care contexts and adjust their tasks by considering the psychosocial and spiritual work they must accomplish. A precise care plan should be created as soon as possible after the patient has been

admitted. The medical team and nursing team should discuss together the care priorities for each of the patients, especially for those who are going to be transitioning from curative care to palliative care. Furthermore, it seems critical that unit head nurses ensure adequate collaboration and efficient communication between nurses and physicians. Since this study ended, a palliative care clinical nurse specialist position has been established at this hospital, which will boost support for the bedside nurses and promote the development of particular skills in this area. More and more nurses will be experiencing supportive care and attention situations with individuals at the end of life whatever their work setting, as palliative care units are unable to meet the demand associated with an ageing population. It seems relevant to properly understand what nurses are going through and to give them the required resources in order to not only improve the quality of end-of-life care provided in Quebec's health care establishments, but also their quality of life at work. 🍀

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