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# Motivations behind end-of-life care: a qualitative study of Iranian nurses' experiences

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## Abstract

**Background** Providing high-quality end-of-life care is currently a paramount health priority. Given that the standard of care is intrinsically linked to nurses' motivations, it is becoming too imperative to explore the contributing factors. Consequently, this study was undertaken to elucidate the experiences of Iranian nurses regarding their motivation for delivering end-of-life care.

**Methods** This research is a qualitative, descriptive inquiry employing conventional content analysis, carried out at two governmental hospitals in Gorgan, northern Iran, from February to July 2023. 12 nurses were purposefully selected to participate in the study, ensuring maximal diversity. The data were collected through semi structured interviews and analyzed using Graneheim and Lundman's five-step method. The coding process was facilitated by the use of MAXQDA version 10 software. To establish rigor, the four criteria outlined by Guba and Lincoln were applied.

**Results** the participants included eight women and four men with an average age of  $39.6 \pm 6.31$  years. The data analysis yielded five main categories and fifteen subcategories. The main categories were: "The Foundations of professional care in nursing", "Core Drivers in Optimal End-of-Life Care", "Family Involvement in End-of-Life Care", "Incorporating Spiritualism in Care" and "Dominant motivational Issues Within the Caregiving Atmosphere".

**Conclusions** This study delineates the experiences that influence the provision of end-of-life care from the perspective of Iranian nurses. Innate traits such as empathy and a passion for nursing, in addition to nurses' moral compass and spiritual beliefs, serve as pivotal motivational stimuli. Leveraging these findings can be instrumental in shaping healthcare practices and policies to enhance the quality of end-of-life care.

**Keywords** Palliative care, Motivation, End of life, Qualitative research, Iran, Health policy

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## Background

The growing global population of elders, coupled with the increased prevalence of cancer and chronic conditions, has resulted in a skyrocketing number of terminally ill patients requiring hospitalization and long-term care services [1] end-of-life care has become a global concern [2] because 80% of people over the age of 65 have at least one or two chronic diseases. In Iran, 65.6% of all deaths occur among elderly people over 60 years old [3] cancer is the second most common chronic noncontagious disease and the third most common cause of death among Iranians [4].

Despite the recognition of hospice care as the gold standard for end-of-life treatment [5], the reality is that most patient deaths occur in acute care hospital settings [6]. In Iran, 60% of all deaths occur in hospitals [7]. Patients with life-threatening diseases at the end of their lives suffer from physical discomfort in addition to a wide range of psychosocial and spiritual concerns [8]. Therefore, the demand for end-of-life care and the need to provide services in the hospital environment is increasing [9]. This care is provided during the last 6 to 12 months of the patient's life [3] and is focused on supportive treatments and interventions for physical, spiritual, social, and emotional well-being [10]. Nurses are vital members of the end-of-life care team [9] nurses shoulder critical responsibilities in ensuring the well-being of patients and their families [11], for instance: active participation in the decision-making processes of patients [2], supporting the comfortable and dignified death of patients [12], and playing the role of a facilitator to create cooperation between the health team and the patient's family [13], to ensure the provisions of comfort-based care instead of treatment-based care and finally playing a professional role to ensure the end of the patient's life in an environment with peace, respect and with their beloved ones [14].

However, end-of-life care providers confront several challenges in delivering quality care which can be quite excruciating for both patients and providers, they frequently involve intense emotional stress, pressure, and complex moral decision [15]. Furthermore, nurses are compelled to strike a delicate equilibrium, managing their internal emotional reactions to patient distress while performing their duties both as professional caregivers and as compassionate human beings [16].

The concept of palliative and end-of-life care represents a relatively new approach within the Iranian health [11] system, one that necessitates a significant cultural shift for Iranian patients [17]. Despite the policy of the Ministry of Health to improve the quality of care and reduce cost of services in community-based care, in Iran's health system, less attention is given to end-of-life care in health care centers [18, 19], which does not meet the needs of

patients [20]. Most patients at the end of their lives spend their last moments in oncology and intensive care units. In these environments, nurses actively care for dying patients, even if they are not formally trained to care for such patients. The Iranian nursing curriculum does not include theoretical and practical training in end-of-life care or palliative care [19]. In the Afsharzadeh et al. study, the knowledge of care providers such as physicians and nurses was moderate [11]. However, in Aghaei et al.'s study, nurses' knowledge about end-of-life care was low and more than half of the nurses expressed that they did not receive enough training to provide this care [21]. In general, Iranian nurses have a positive attitude towards end-of-life care [22].

A study in Malaysia classified the most important facilitators of providing end-of-life care into two categories. Facilitators related to health professionals, such as: a greater number of nurses, training of nurses in the field of end-of-life care, interdisciplinary cooperation and stopping unnecessary invasive treatments, and facilitators related to the organization, such as: attendance of religious experts in the care team and the development of guidelines in the field of end-of-life care and the transfer of end-of-life care at home [9]. Additionally, in a review study, the presence of effective communication, family participation in end-of-life care, and personal values of health professionals, and the existence of specialized were identified as facilitators of better end-of-life care [23]. Many theories have been used to explain motivation at work, such as needs theory (Maslow 1954; Herzberg et al. 1959), expectancy theory (Vroom 1964), equity theory (Adams 1965), and goal-setting theory (Campbell and Richard 1976) [24]. However, there is no single theory that comprehensively describes motivation. For example, Herzberg's theory, states that there are two factors that affect the motivation of people in an organization: hygiene and motivator factors. Hygiene factors are related to the job context or external aspects of employees and are known as extrinsic motivations. Motivator factors are related to job content and are labeled as intrinsic motivation [25]. Although this theory is related to motivation, it draws attention to satisfaction and dissatisfaction in terms of salary as motivation and not nursing practice [26]. Therefore, models and theories of work motivation do not specifically address the motivation for care and are therefore not suitable for use in this field.

At present, the delivery of compassionate, person-centered, and high-quality end-of-life care is a paramount concern of healthcare professionals [27]. Additionally, insights into these motivations can assist nursing managers devising and implementing effective strategies to further motivate their nursing teams [24]. Since The existing theories of health employees have not specifically addressed their care motivation and are not suitable

for use in this field. Because care is often considered separate from different forms of work and also, the literature review has shown that the studies conducted in this field have mostly focused on the knowledge and attitude and facilitators of end-of-life care. According to the paucity of published research on this specific subject, motivations of nurses providing end-of-life care and considering the fact that qualitative research can illuminate the experiences encountered across different societies, this study seeks to elucidate the experiences of nurses concerning their motivations for providing end-of-life care.

## Methods

### Design

The current study is rooted in qualitative research methodology and utilized conventional content analysis for data interpretation, adhering to the consolidated criteria for reporting qualitative research (COREQ) (Supplementary file 1) [28]. Content analysis is particularly adept at reflecting divergent views and elucidating complex issues, allowing for the meaningful interpretation of concepts and methods [29]. The conventional approach employed in this research abstains from preconceived categorizations, instead immersing researchers fully into the data to extract fresh insights and understanding [30]. Our objective was to explore nurses' experiences and motivations regarding the provision of end-of-life care.

### Sample and setting

The study was carried out from February to July 2023 in the specific setting of Iran's healthcare system, and the study took place in two government hospitals in Gorgan, in the north of Iran. We purposefully sampled twelve nurses—ten of them were from the ICU, one of them was from the CCU, and one was from the oncology department, based on specific inclusion criteria. These criteria encompassed possessing a minimum of a bachelor's degree in nursing, at least two years of work experience, voluntary participation, expressive ability, and practical

experience in end-of-life care. Participants could voluntarily withdraw from the study, but no withdrawals occurred post consent. We ensured a diverse representation of participants with regard to age, gender, education, and work experience (Table 1).

### Data collection

An interview guide was developed and the research team evaluated the questions in terms of ambiguity and appropriateness of the objectives. The revised questions were used by the researchers and It was uploaded as a supplementary file (supplementary file 2). The data were collected using an in-depth semi-structured interview held in a quiet place in the participants' workplace. The interviews were conducted by the first author(ZR), a 40-year-old female PhD candidate, and corresponding author (KH Y), a 50-year-old female associate professor at Golestan University of Medical Science.

All interviews occurred face-to-face and in Persian and lasted 40 to 60 min with a mean of  $45(\pm 5.78)$  min. Interviews were scheduled according to participants' preferences for time and location.

General questions initially established rapport and gauged participants' understanding of end-of-life care. Subsequent inquiries delved deeper into the study's aims, ensuring a comprehensive expression of experiences. Data saturation was deemed achieved after interviewing ten participants. Two additional interviews confirmed this, as no further novel information emerged. All interviews were digitally recorded with consent.

### Data analysis

The data were analyzed via the five-step content analysis method of Granheim and Landman [29]. Transcription was promptly performed after each interview, followed by repeated readings for full comprehension. Each text was then broken down into semantic units for coding purposes. These units were distilled into labels, later combined into subcategories, and finally elevated to main

**Table 1** Demographic characteristics of the study participants

Participant Pseudonym	Age	Gender	Education	Work Experience	Marital Status	Life style	Ward	Shift
Hamid	42	male	Bsc in Nursing	22	Married	With husband	ICU	Morning& Evening
Sahar	40	female	Bsc in Nursing	16	Single	With parents	ICU	Rotation
Mohammad	43	male	Bsc in Nursing	20	Married	With husband	ICU	Rotation
Neda	38	female	Bsc in Nursing	8	Married	With husband	ICU	Rotation
Kamran	26	male	Bsc in Nursing	2	Married	With husband	Oncology	Rotation
Samaneh	44	female	Bsc in Nursing	21	Married	With husband	ICU	Rotation
Maryam	42	female	Bsc in Nursing	18	Married	With husband	CCU	Rotation
Asieh	43	female	Bsc in Nursing	19	Married	With husband	ICU	Rotation
Soheila	33	female	Bsc in Nursing	9	Married	With husband	ICU	Rotation
Safiyeh	46	female	Bsc in Nursing	21	Married	With husband	ICU	Fixed Morning
Reza	32	male	Bsc in Nursing	10	Single	Alone	ICU	Rotation
Sima	47	female	Bsc in Nursing	23	Married	With husband	ICU	Fixed Morning

categories, with consensus by all authors. MAXQDA version 10 software [31] was utilized for data management and analysis.

Trustworthiness

Trustworthiness was established according to Guba and Lincoln’s criteria: credibility, dependability, transferability, and confirmability [32]. Techniques such as prolonged data engagement, allocating adequate time to data collection and analysis, and member checking contributed to credibility. For member checking, the interviews were read several times by the research team, and after coding, the interviews were checked with two of the participants, and they were asked to confirm the accuracy of the text. To ensure dependability, two independent researchers were involved in analyzing the data and discussing the results until they reached a consensus. Transferability was supported by detailed descriptions of the research process, and verifiability was ensured through accurate, direct quotations from interviews. Confirmability was preserved by keeping a careful record that includes the original notes, transcription and analysis.

Findings

Twelve nurses—comprising eight women and four men with an average age of 39.6±6.31 years and an average work experience of 15.75±6.79 years—participated in this study. They shared their experiences and motivations related end-of-life care. Through the analysis, 488 primary codes were extracted, resulting in the identification of nurses’ motivations for end-of-life care structured across five main categories and fifteen subcategories (see Table 2).

Foundations of professional care in the essence of the nurse

Iranian nurses have actively identified inherent characteristics within themselves that serve as motivational factors in their provision of end-of-life care. According to the participants’ experiences, these characteristics include “a fascination with care and a sense of value”, “Values instilled through family upbringing”, “innate empathy” and” individual capacity to care”.

A fascination with care and a sense of value

The participants expressed that their love and interest in nursing serve as significant motivating factors, with some, citing a longstanding passion for the profession since their childhood. One participant emphasized the importance of entering the nursing profession driven by love, stating, “When I embarked on this career, it was solely driven by love. Not everyone can become a nurse,” [Sima].

Moreover, the nurses expressed a sense of worth, capability, and a feeling of being chosen due to their caregiving role.

Additionally, providing end-of-life care was associated with a sense of personal fulfillment. As expressed by a participant, “Delivering end-of-life care brings a sense of fulfillment. This sensation motivates me to provide the best possible care for my patients” [Soheila].

Values instilled through family upbringing

The participants identified the values, beliefs, and perspectives instilled by their families as effective motivators in their approach to caregiving. One participant cited the impactful role of familial guidance, stating, “When I chose this profession, my family provided encouragement. My parents consistently emphasized the importance of

Table 2 Categories and subcategories extracted from the content analysis

Categories	Subcategories
Foundations of professional care in the essence of the nurse	A fascination with care and a sense of value Values instilled through family upbringing Innate empathy Individual capacity to care
Core Drivers in Optimal End-of-Life Care	Focused interaction and effective communication Knowledge-Based Approach to End-of-Life Care Conscientiousness in Care
Family Involvement in End-of-Life Care	Acceptance and Challenges Faced by the Patient’s Family Compassion with Family
Incorporating Spiritualism in Care	Hope and Diligence in Sustaining Patient Life Reflection of Care Consequences in Life Trust-Oriented Belief in End-of-Life Care Nurse’s Spiritual Beliefs
Dominant motivational issues s Within the Caregiving Atmosphere	Caregiving Tension Positive Environmental & Organizational Motivation

*empathizing with patients, urging me to regard them as my own family.*" [Reza].

Another participant reflected on the enduring influence of familial values, noting, *"The values that have evolved into beliefs and certainties for me within my family have significantly shaped my approach to caregiving"* [Neda].

### **Innate empathy**

The findings demonstrated that the participants, utilizing their inherent capabilities and capacities, such as understanding the patient's critical condition, considering compassion and kindness in care and identification with the patient to be motivational factors in end-of-life care. In fact, they believe that apart from the usual professional care, nurse should use empathy to better understand patient's conditions at the end of life. Moreover, a participant highlighted the personal relevance of empathizing with patients, stating, *"I regularly think about the fact that one of my parents or loved ones could have been on this bed instead of this patient. I will take care of this patient in the same way as I like my loved ones to be taken care of"* [Sima].

### **Individual capacity to care**

Participants indicated that effective end-of-life care requires nurses with considerable physical and psychological resilience. One participant described their endurance, stating, *"I and other nurses must have enough power. Be strong. Three patients were arrested at the same time during the night. We had to manage all three patients simultaneously with a small number of nurses. Facing these emergency situations and being able to control things requires a special ability that we have acquired over time."* [Mohammad].

### **Core drivers in optimal end-of-life care**

Through the insights gathered from nursing professionals, it was identified that the foundational principles and values, intrinsic to the nursing vocation played a significant role in fostering motivation to care. This primary category is divided into four subcategories: "Focused interaction and effective communication", "Knowledge-Based Approach to End-of-Life Care" and "Conscientiousness in Care".

#### **Focused interaction and effective communication**

The participants endeavored to discern the patients' care requirements while attentively considering their physical and mental well-being, aiming to cultivate an effective rapport and to engender a sense of worthiness in patients during end-of-life care.

The study highlighted the importance of communication with unconscious patients. One participant shared:

*Regardless of the patient's consciousness, I take measures to communicate with them. For instance, I would explain upcoming procedures, whether it is enteral feeding, suction, or changing their bedding. I recall a patient who showed no visible reaction. However, upon speaking to her, and later to her mother about her condition, it was clear to me that the patient perceived our conversation.* [Soheila]

Furthermore, another participant commented:

*I reassure the patient by saying, 'Know that you are not alone; everyone here is focused on you, making you the center of our attention.'* [Maryam]

### **Knowledge-based approach to end-of-life care**

End-of-life care requires skills that are influenced by scientific knowledge and evidence. In addition to the experiences they gain during their professional activities, nurses should also be familiar with the latest scientific evidence. The participants conveyed that a nurse's competence, grounded in knowledge and evidence-based practice, can bolster self-confidence and foster more efficacious care.

Reflecting on this one nurse remarked, *"Because I regularly read the latest scientific articles on end-of-life care, I have the knowledge that physicians rely on my knowledge and expertise, which in turn enhances my self-assurance"* [Reza].

### **Conscientiousness in care**

The experiences of the participants indicated that nurses are fully committed to delivering the highest level of care, particularly during end-of-life situations where they are acutely aware of the devastating consequences of any oversight.

*I do all the necessary care for the patients in the face of severe distress. This makes me feel good about my conscience that I did everything I had to do for my patient.* [Asieh]

### **Family involvement in end-of-life care**

Family is the cornerstone of Iranian culture and society, so family members are essential in delivering end-of-life care, which is often facilitated by nurses. The practitioners involved in this study also endeavored to address the needs of the family, not just those of the patients, during the provision of end-of-life care, adopting a family-oriented strategy in their care plans. This thematic category comprised two subcategories: "Acceptance and Challenges Faced by the Patient's Family" and "Compassion with Family".

### **Acceptance and challenges faced by the patient's family**

The study's results indicate that a family's understanding and acceptance of the patient's treatment trajectory can positively influence nurses' delivery of care. Conversely, agitation and the projection of familial anxiety onto the patient can dramatically impact the caregiving process.

One participant remarked:

*When the family of my patient is unprepared regarding the disease's nature and progression, it adds to my concern and agitation. They tend to become irritable in response to the services provided to their loved ones. This is not the case for families of patients with chronic conditions. [Hamid]*

### **Compassion with family**

The participants endeavored to extend kindness and compassion to the patient's family during the provision of end-of-life care.

*You are beset with the sense that it might be the last time you're seeing a patient, perhaps the last opportunity for them to hear a loved one's voice. [Soheila]*

In their efforts, they also sought to cultivate positive memories for the family members. In this regard, one participant said:

*Families often feel neglected in medical settings; we tend to focus solely on the patient. Even as the patient approaches the end of life, we should endeavor to ensure that the family doesn't carry away negative memories from the nurse. [Sahar]*

### **Incorporating spiritualism in care**

Participants incorporated their spiritual beliefs into the provision of end-of-life care. These experiences fell into three subcategories: "**Hope and Diligence in Sustaining Patient Life**", "Reflection of Care Consequences in Life" "Trust-Oriented View of End-of-Life Care" and "Nurse's Spiritual Beliefs".

#### **Hope and diligence in sustaining patient life**

During care delivery, nurses endeavored to maintain patient's hope for recovery, often using encouraging language at the patient's bedside. Furthermore, the nurses underscored the significance of the moments during end-of-life care, approaching them with a sense of reverence and a commitment to prolonging the patient's life as much as possible. A nurse explained:

*I make a conscious effort to leave hopeful messages by the patient's bed and never view the patient as merely at the terminal stage. I regard them as a liv-*

*ing person, one who still harbors the hope for recovery. [Hamid]*

### **Reflection of care consequences in life**

Participants expressed the sentiment that the energy expended on the patient reciprocates in their life.

*When I work with love and dedicate time, I receive many positive returns in my life and see many problems resolved. In line with the law of karma, love given in one place returns to another. [Maryam]*

### **Trust-oriented belief in end-of-life care**

The participants believed that the patient represented divine trust in their care and that they were duty-bound to honor this trust. One participant conveyed this obligation:

*The care I provide is with the intention of fulfilling God's entrusted duty to the best of my ability. [Maryam]*

### **Nurses' spiritual beliefs**

Participants felt that their spiritual beliefs profoundly impacted their approach to end-of-life care, equating the manner in which they cared for patients to a life test. They regarded the constant presence of God as both an observer and a companion providing unseen aid during the care process:

*I frequently sense God's guiding hand directly and feel His comforting presence above my head and that of the patient. This sensation is profoundly heartening. [Maryam]*

### **Dominant motivational issues within the caregiving atmosphere**

The caregiving atmosphere in end-of-life care contains elements that can either motivate or deter nurses' enthusiasm for care delivery. This dimension encompassed two subcategories: 'Caregiving Tension' and 'Positive Environmental & Organizational Motivation.'

#### **Caregiving tension**

The study's findings revealed that factors such as colleagues' negative reactions, insufficient resources and facilities, the demanding nature of end-of-life care, and managerial neglect could demotivate caregivers. Sima noted the impact of neglect:

*The system plays a substantial role. At times, our system works erodingly, induced by a neglectful management style. They scrutinize you for minor*



*issues but overlook a thousand achievements, forcing you to justify even the smallest mistakes.*

Additionally, one participant cited heavy workloads and lack of resources as contributing to caregiving tension:

*Faced with elements beyond my control, such as the environment, the patients' conditions, shortages of equipment, and the need to assist colleagues during busy shifts, I am often compelled to unwillingly adjust my priorities. [Neda]*

#### **Positive environmental & and organizational motivations**

Certain elements within the care environment, such as team support and patient gratitude, were cited motivational for nurses. One participant recalled:

*I cared for a patient who, though not completely oriented, recognized and appreciated the care provided. This was evident in his smile and the sense of satisfaction in his gaze, an acknowledgment that deeply touched me. [Sahar]*

In addition, organizational factors such as the understanding of upstream managers and the support of managers when unwanted errors occur were involved in motivating nurses to provide better care. Another participant highlighted this issue:

*There are other items as well, but maybe they are less important, for example, when my child is sick, the organization and managers understand me, instead of forcing me to say that you must come and do a shift. [Samaneh]*

The encouraging role of managers was also noted:

*Recognition in departmental seminars by managers can be highly motivating. For instance, our department being acknowledged for effective work in a specific area gives me a significant boost. [Soheila]*

## **Discussion**

### **Most important findings**

The principal finding of this study revolves around the motivational factors that influence Iranian nurses in the provision of end-of-life care. The study identified five key motivators for care: "Foundations of professional care in the essence of the nurse", "Core Drivers in Optimal End-of-Life Care", "Family Involvement in End-of-Life Care", "Incorporating Spiritualism in Care" and "Dominant motivational issues Within the Caregiving Atmosphere".

### **Interpretation and comparison with previous studies**

One of the emergent themes from this study concerns the professional care foundations entrenched within the nurses' essence. Participants revealed that their values instilled through family upbringing, innate empathy, and individual capabilities in care function as motivators for providing end-of-life care. The nurses not only demonstrated a keen interest in caring for others but also felt a sense of worth from their caregiving roles. In this regard, Kuntarti et al. stated that the caring personality of a nurse is a basic foundation for providing professional care and patient satisfaction in nursing care [33]. These inherent traits shape nurses' interactions with patients and influence their caregiving performance. Nurses endowed with social and emotional personality traits possess professional vitality and are adept at discerning patients' needs, thereby enhancing the quality of nursing care provided. Nurses with these attributes are often expected to accept greater responsibilities, exhibit greater levels of patience, intelligence, and motivation, and maintain a more robust work conscience [34]. Their altruistic nature and empathic inclination compel them to take more vigorous responsibility for patient care. Moreover, these nurses typically eschew a routine approach to care in regard to end-of-life situations. Rather, they strive to deliver optimal care. This study highlights the upbringing values imparted by the family as influential motivators. Sociologists regard the family as a powerful mean for transmitting values [35]. Through informal family education which is woven into daily life, a system of values and beliefs is instilled and can later become a driving force for nurses to deliver superior end-of-life care. Furthermore, the opportunity to assist others, serves as a motivational factor for nurses, with those selecting the profession from a deep-seated desire to serve demonstrating heightened motivation [36]. Chan Liu et al.'s study revealed that nurses who commit to end-of-life care often cultivate new mental attitudes such as courage, calmness, and passion [37]. They find a sense of gratefulness in their end-of-life care experiences. This study indicates that nurses derive a sense of value, blessedness, and merit from engaging in end-of-life care, fueling their enthusiasm to excel in this challenging but rewarding domain.

Other findings from this study pertain to the Core Drivers of Optimal End-of-Life Care, which encompasses concepts such as, focused interaction and effective communication, knowledge-based and conscience-driven care. Nurses mentioned in their experiences that they tried to establish effective communication with patients. Regardless of the patient's level of consciousness, they were aware of their listening capacity, and they were careful not to use desperate words. With their effective communication, they try to remind the patients that they are important. Good communication with the patient is

a key factor in providing end-of-life care to patients [38]. Nurses' communication with dying patients requires skills such as listening and nonverbal observation to guide end-of-life communication with patients, and nurses should also be able to choose words and verbal communication skills appropriately [39]. The experiences of the nurses in this study showed that they increased their self-confidence by updating their care knowledge because it made physicians trust their knowledge. Toode et al. also reported that acquiring professional knowledge and having learning opportunities, such as interacting with physicians, are motivational factors [36].

Conscientiousness emerged as another subcategory that plays a critical role in end-of-life care motivation. The nurses in this study listened to their inner voice while providing end-of-life care and tried to provide the best end-of-life care they can because if they had any negligence, there wouldn't be a second chance to compensate. Jasemi et al. have previously noted that conscientiousness not only boosts professional performance but also incentivizes the delivery of high-quality care [40]. Voultsos et al. reported that some participants continued to provide care that was even called futile. They stated reasons such as having a sense of empathy, valuing human life and experiencing end-of-life care for their loved ones [41].

An additional insight from this study is the role of family in end-of-life care. In this study, the participants tried to accept the challenges that the patient's family creates in providing end-of-life care as a part of end-of-life care and dealing with patients' families with compassion to avoid being neglected. In this regard, Paterson and Maritz stated that the behavioral and emotional patterns of families in end of life situations can be significantly different. Families express emotions such as grief, denial, and displaced anger, so nurses often have to respond to these emotionally driven behaviors [42]. Various studies have emphasized the need to support the family with different strategies, such as providing the opportunity for the family to be with the patient [42, 43]. Additionally, the family's feeling of satisfaction with the way patients are cared, and receiving positive feedback from the family regarding their satisfaction with professional performance, was a motivational role for the participants in this study. Sarikahya et al. also reported receiving positive feedback from the patients and their relatives as individual motivational factors for providing end-of-life and palliative care [44].

In the context of Iran, visitation policies in ICU departments are notably restricted, usually scheduled and limited in number [45], often leading to the marginalization of the family's role., the participants recognized the family's significance within Iranian culture. Efforts were made to mitigate these limitations as much as possible, enabling increased visitation and considering that

it might be the patient's final interaction with their family, which served as a compelling motivator for delivering family-centered care.

Another motivating factor identified in this study concerns the spiritual beliefs of nurses as they provide end-of-life care. Hope is one of the concepts related to spirituality [46]. The participants tried to maintain hope in patients while providing end-of-life care. Guedes has emphasized that nurturing hope in palliative care extends beyond professional duty; it is a moral imperative that forms the foundation of all nursing actions [47]. In addition, it is necessary to perceive the pervasive nature of uncertainty in the lives of people that are dealing with advanced diseases. By seeing hope in them and shifting the focus of the conversation from "loss of life" to "life with hope", the person-centered practices can be improved [48]. The significance of adherence to religious and ethical convictions in influencing professional conduct is well-recognized [34]. Research by Sastrawan highlighted that religious values are a source of motivation and an influencing factor on the quality of nursing services [35]. In Iran, the presence of religious convictions has been cited as a key motivator for nurses, fostering confidence in their capabilities and resilience in the face of challenges [49]. Despite encountering numerous difficulties due to shortages within Iran's healthcare system, nurses persevere in providing end-of-life care. The strong religious and spiritual beliefs underpin the Iranian society serve not only as a motive for a positive and valuable attitude towards caregiving but also as a means for nurses to seek a reflection of these values in their personal lives. By investing maximum love and energy in their caregiving roles and feeling a sense of divine presence, they exhibit a steadfast commitment to the care of those who are ill and dying. Through this dedication, nurses attain a sense of personal excellence.

Another finding of this research is Dominant motivational issues Within the Caregiving Atmosphere. The Caregiving Tension reported by participants is often attributed to an excessive workload and negative interactions within the healthcare system, factors that can diminish their motivation to provide end-of-life care. In Daw Hussin et al. 's study, a lack of nursing staff, lack of communication and cooperation between health care providers were identified as barriers to providing optimal end-of-life care [9]. In Iran, a major challenge within the health system is the shortage of nursing staff. Nurses operating in an environment plagued by staffing deficits experience increased stress and workload. Compounded by low remuneration, inadequate resources, and insufficient supervision [50], these conditions can lead to suboptimal performance. Additionally, the lack of systemic support for palliative care in Iran presents another



significant hurdle [51], resulting in diminished motivation and dishearten among nurses providing end-of-life care.

Participants mentioned positive environmental and organizational factors as other motivators for end-of-life care. They described the managers' supporting roles as a motivating factor. Gagnon and Duggleby stated that organizational factors are a part of the work environment that is not under the control of nurses, and there is a need for managerial and organizational support for the importance of nurses' work in end-of-life care [52]. In a quantitative study, an inverse relationship between organizational support and burnout among palliative care nurses was shown [53]. Patients' gratitude serves as an uplifting force within the caregiving atmosphere. Aparicio noted that gratitude from patients acts as an incentive for health professionals, fostering continued service marked by dedication, love, and competence [54]. In the Ramadan study, a positive relationship between motivational factors in nurses and patient satisfaction was reported [55].

This study has examined the experiences of nurses with respect to their motivations for providing end-of-life care, yielding rich, detailed data that could serve as a foundation for future action research studies. An understanding of the motivational factors that drive nurses in delivering end-of-life care can assist policymakers in enhancing care quality. This can be achieved by supporting nursing staff and crafting motivational interventions that account for individual differences, while preserving intrinsic motivation.

### Limitations

The current study is not without its limitations. The experiences reported herein may be representative of a subset of Iranian nurses' perspectives and might not translate across different sociocultural milieus. This particular constraint potentially impacts the broader applicability of the findings. Consequently, considering the complexity and significance of motivation in end-of-life care, further qualitative research is warranted. Investigations into the perspectives of nurses in diverse healthcare settings, insights from nursing administrators, and viewpoints of other healthcare professionals could deepen our understanding of this phenomenon. Such research would contribute to a more nuanced appreciation of the dynamics at play and, in turn, strengthen the overall body of evidence in this domain.

### Conclusion

This study is a pioneering qualitative investigation into the motivational experiences of Iranian nurses in the provision of end-of-life care. The findings revealed that a diverse array of factors, including nurses' spiritual beliefs,

intrinsic traits such as empathy and a devotion to nursing, conscientiousness, and experiences with an affirmative caregiving atmosphere, act as driving forces for delivering end-of-life care. The insights gained from this research can assist healthcare professionals and policymakers in acknowledging the variability of motivational factors among individuals. Subsequently, they can craft targeted interventions, which might include support programs such as counseling for nurses to enhance motivation. These efforts are anticipated to lead to an improvement in the quality of end-of-life care.

### Abbreviations

COREQ Consolidated Criteria for Reporting Qualitative Research  
ICU Intensive Care Unit

### Supplementary Information

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Supplementary Material 1

Supplementary Material 2

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### Author contributions

All the authors (ZR, Kh Y, and Gh M) were actively involved in this project. ZR and Kh Y undertook the data collection; the data analysis was carried out by Kh Y and Gh M. ZR composed the initial draft of the manuscript, while the revision of the draft was undertaken by Kh Y and Gh M. All authors have reviewed the manuscript critically and have granted their final approval of the final version to be published.

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### Data availability

The data are available upon reasonable request to the corresponding author, subject to the signing of relevant confidentiality agreements and in accordance with ethical standards and decisions made by the ethics committee.

### Declarations

#### Ethical approval

This study honored the ethical framework of the Declaration of Helsinki and received approval from the Ethics Committee of Golestan University of Medical Sciences, Gorgan, Iran (IR.GOUMS.REC.1401.458). Potential participants were thoroughly briefed on the objectives of the study, their rights, consent, confidentiality, and voluntary participation guarantees before consenting and agreeing to the recording of their interviews. Informed consent was obtained from all participants. All procedures were designed to uphold privacy and utilize data solely for research purposes.

#### Consent for publication

Not applicable.

#### Competing interests

The authors declare no competing interests.

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