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NURSES' EXPERIENCES AND PERCEIVED CHALLENGES IN COMMUNICATING WITH PATIENTS AND FAMILIES DURING PALLIATIVE CARE: A QUALITATIVE STUDY

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Abstract

Effective communication is a crucial element of palliative nursing care, particularly when patients and families are struggling with uncertainty, emotional discomfort, evolving care goals, and complicated informational requirements. The purpose of this study was to evaluate nurses' experiences of communication with patients and their families in palliative care, and to identify perceived barriers of communication in such situations. A qualitative phenomenological research design was adopted to acquire an in-depth understanding of nurses' lived experiences and viewpoints Ten registered nurses with direct experience of caring for patients receiving palliative care were selected for the study using purposive sampling. Semi-structured interviews were conducted individually with participants using a researcher-developed guide. The guide included open-ended questions with pertinent probing questions. Interview data were analyzed using Braun and Clarke's reflexive thematic analysis, which involved systematic familiarization with transcripts, coding, theme creation and refinement, and interpretation of trends across participants' accounts. The research revealed four key themes: managing emotionally sensitive communication; managing family, cultural and religious factors; communication within the framework of organizational restrictions; and developing nurses' preparedness and professional support. Nurses stressed the need of active listening, empathy, emotional presence and realistic hope in communication with patients and families. But hurdles were severe, including family rejection and conflicting expectations, cultural and religious issues, hard workload, restricted privacy, ambiguous professional duties, uneven interdisciplinary communication, and inadequate formal

training. The study showed that both individual nursing competence and a supportive clinical environment are necessary for effective palliative-care communication. It is recommended that healthcare institutions provide structured palliative communication education, simulation-based training, mentorship, clear interdisciplinary communication protocols, sufficient opportunities for private conversations, and emotional debriefing and professional support for nurses. Developing these areas may increase nurses' confidence in communicating and encourage compassionate, culturally relevant, patient and family-centered palliative care.

INTRODUCTION

Palliative care is an integrated approach to health care that aims to improve the quality of life of people with serious or life-limiting disease and their families. Unlike care that is largely focused on treating sickness, palliative care targets a broader spectrum of medical, psychological, social, emotional and spiritual needs. Communication is integral to this multidimensional approach because patients and families frequently require information that is complex, struggle with uncertainty, desire involvement in decision-making, and need to adapt to changes in the goals of treatment (Lashari, Umrani & Buriro, 2021). Communication in palliative contexts is so much more than the delivery of medical knowledge; it demands empathy, active listening, emotional presence, respect for individual choices and sensitivity to how patients and families view sickness, hope, suffering and the future (Bukhari, et al., 2023). Communication barriers and lack of individualized attention have been recognized as major issues for patients and families receiving palliative and end-of-life care across their care continuum (Kallis et al., 2025). Patients receiving palliative care have also identified the significance of being appropriately informed and participating in decisions about their care, illustrating that communication is crucial to maintaining autonomy and dignity when faced with a serious disease (Nankundwa et al., 2025). Because of the persistent and direct interaction with patients and their families, nurses play a particularly essential role in palliative-care communication (Lashari, Umrani & Buriro, 2021). Physicians may focus on communication of diagnosis, prognosis, and treatment options. Nurses frequently spend time with patients pre- and post-such discussions, clarify information within their professional scope, observe emotional responses, answer questions and provide reassurance and psychosocial support (Bukhari et al., 2023). Therefore, patients may reveal fears, uncertainties, spiritual concerns, family problems and preferences to nurses that they may not reveal during formal medical appointments. Studies on rapport between nurses and patients at the end of life reveal that significant nurse–patient relationships are founded on trust, emotional connection, attentive presence, and personalized engagement (Chang & Jeong, 2025). Communication must be seen as inherent to nursing care and not as an additional activity of an interpersonal nature. Good communication provides nurses with an opportunity to develop a culture where patients feel listened to, valued and safe to raise sensitive issues.

Communication in palliative care is difficult in nature, yet important. Topics of conversation can include disease progression, changes in treatment goals, worsening health, burden of symptoms, loss of independence, uncertainty, death and dying (Lashari et al., 2018) . Nurses may have to answer questions that may not have clear or certain answers whilst trying to keep a person's hope up and not give false reassurance. Communication in life-limiting disease often takes place in an atmosphere of continuous uncertainty, as Grant and Johnson-Koenke (2024) highlighted, and nurses may need to enable patients to interpret changing information and unclear outcomes. Peerboom et al. (2024) highlighted the value of creating an environment of open communication, making use of understandable language, recognizing patients' needs and preferences, and adapting communication to the situation. They observed that effective end-of-life communication required nurses to do so. The findings suggest that in palliative nursing communication clinical judgment, interpersonal sensitivity and the ability to respond flexibly to individual circumstances are required (Lashari et al., 2018).The emotional nature of these discussions presents further obstacles for nurses. Patients may sense fear, anxiety, despair, anger, hopelessness or have trouble accepting their situation. Nurses may feel sadness, uncertainty, emotional attachment or worry of

saying the wrong thing. A recent qualitative study of nurses working with terminally ill patients showed that conversations about death were determined by the disease's development, patients' communication readiness, family members' expectations, nurses' ability to communicate, and their emotional experiences (Batı et al., 2026). In that study, nurses found that communication skills and professional expertise were critical for managing such talks well. This shows that effective communication in palliative care requires not only technical communication abilities, but also emotional readiness. Nurses need to be able to be empathic and emotionally available, while keeping appropriate professional boundaries and managing their emotional responses to pain and loss (Lashari et al, 2018).

Communication is further hampered by the fact that palliative care rarely involves simply the patient and healthcare professional but family members are often crucial to the care process. Families can be caregivers, activists, interpreters, information searchers and take part in decision making (Lashari et al., 2018). Their expectations and information demands may not always match those of the patient. Family members may be experiencing anticipatory sadness, denial, anxiety, ambiguity or trouble in accepting worsening and thus they may seek repeated reassurance or new information from healthcare providers. In a qualitative research of family caregivers, Gonella et al. (2023) found that families' communication with nursing staff during the course of treatment was substantially associated with family caregivers' experiences of involvement, readiness and continuity of care. More recent work on communication preferences in palliative care suggested that caregivers and health care professionals appreciated clear, timely, compassionate and comprehensive communication, while health care professionals also encountered practical constraints in providing the desired level of communication (Mathe et al., 2025). These findings show that nurses need to concurrently meet the particular needs of patients and the informational and emotional concerns of families.Communication in palliative care is also influenced by cultural, religious and societal issues. Patients and families vary in their desires for frank discussion of deterioration, prognosis, limitations of treatment, death and future care. In some settings, immediate disclosure may be preferable while in others families may play a protective role and prefer that painful information is not disclosed at all or is communicated gradually to the patient. Spiritual and religious beliefs can influence how people interpret disease, pain, hope, recovery, and death. Thus, a one-size-fits-all approach to communicating may not meet the needs of all patients or families. Nurses must be able to notice these disparities and adapt their communication, rather than assume on the basis of culture or religion alone. This means being sensitive to the individual's preferences, while at the same time maintaining dignity, respect and guaranteeing that they are appropriately included in decision-making.

Quality of communication is also affected by healthcare-system and organizational factors. Meaningful interactions involve time, privacy, continuity and coordination among health experts. However, clinical settings often involve competing obligations, workload, interruptions, staffing pressures and little opportunity for uninterrupted talks. Families may be getting information from a variety of providers, and conflicting or confusing signals can lead to uncertainty and decreased faith in the healthcare team. A countrywide research of bereaved families in palliative care units indicated that families appreciated clear and direct communication and deemed information from both physicians and nurses to be valuable, highlighting the necessity for collaborative communication among professional groups (Maeda et al., 2025). Thus, to improve palliative communication, it is necessary to improve not just the skills of individual nurses, but also to create organizational circumstances for consistent, coordinated, and patient- and family-centered communication.Professional preparation is of special importance because communication skills do not usually develop organically through ordinary clinical exposure. Nurses may have been generally trained in therapeutic communication but still feel unprepared to undertake conversations about death, prognosis, existential concerns, family conflict or uncertainty. Batı et al. (2026) concluded that professional preparation and communication competence were crucial to nurses' experiences of dealing with terminally ill patients, and nurses underlined the value of proper training and skill. Likewise, the synthesis by Chang and Jeong (2025) concluded that rapport with patients approaching end of life is established through complicated relational processes rather than information sharing alone. The findings imply a need for nursing education that includes experiential approaches such as simulation, role-play, reflective practice, mentorship, and guided exposure to challenging topics. Such training might

allow nurses to communicate effectively and to be attentive to the particular emotional and informational needs of patients and families.

Although current research has grown to accept communication as part of the palliative nurse's role, the qualitative experience of nurses interacting with both the patient and their family concurrently still need examination. Previous research has identified trust, individualized communication, family involvement, emotional preparedness, cultural sensitivity, professional competence, and interdisciplinary collaboration as important, but these elements may be perceived differently in various healthcare settings and sociocultural contexts. Qualitative inquiry is particularly well suited to the study of such experiences as it allows nurses to explain the meanings, emotions, relational challenges and contextual aspects involved in communication exchanges that cannot be fully represented by numbers alone. Therefore, the present study addressed **nurses' experiences and perceived barriers in communication with patients and families during palliative care**. Understanding these experiences may assist to uncover practice-based communication barriers and inform nursing education, institutional support, interdisciplinary collaboration, and culturally sensitive initiatives to promote compassionate and patient- and family-centered palliative care.

Problem statement

Effective communication is a vital element of palliative nursing care, as patients and families confronting life limiting illness need more than clinical knowledge; they also need emotional reassurance, explanation of goals of care, and opportunity to articulate fears, values, and preferences. Because of their ongoing presence at the bedside, nurses are ideally placed to provide this support and yet communication in palliative care continues to be difficult, especially when it involves prognosis, deterioration, uncertainty, limitations of treatment, spirituality or death. Research has shown that nurses can face role ambiguity in goals-of-care communication and often express wanting more communication training and professional assistance (Wittenberg et al., 2024). Problems when nurses caring for patients moving from curative to palliative care are not involved in important discussions, do not have enough information, or then have to deal with patients' existential and emotional worries have also been described (Nilsson & Hommel, 2024). Family expectations, cultural norms, emotional suffering, and preferences for disclosure further complicate communication and affect the ways in which information is shared. Studies with patients and relatives have identified the need of effective palliative communication, including tailored, sensitive and intelligible information, and how communication failures can raise uncertainty and distress (Engel et al., 2023). Comparable findings have been seen in research with pediatric oncology nurses, demonstrating a disconnect between the ideals of compassionate communication and the realities of clinical contexts, emphasizing the significance of improved communication preparation and organizational support (Özdemir Koyu et al., 2023).

Although communication is increasingly recognized as a core nursing ability, gaps persist in understanding the nurses' experience of communicating with patients and families in palliative care. Qualitative evidence suggests that nurses must continually reconcile cultural expectations, family-centered decision-making, emotional fragility, professional boundaries and the need to sustain hope while presenting tough facts (Pei et al., 2026). Nurses caring for patients with life-threatening diseases have also described communication as being culturally and emotionally complicated, needing more preparation for challenging interactions (Dönmez et al., 2026). At the same time, families using palliative services still experience a need for easy, consistent, and coordinated communication with healthcare professionals. Fragmented communication can lead to confusion, uncertainty, and distress (Martinsen et al., 2025; Weetman et al., 2025). These results suggest that communication problems cannot be reduced to individual nursing abilities but are embedded in interpersonal, cultural, family, professional and organizational contexts. However, there is still a lack of context-specific qualitative research on how nurses experience these interactions and what problems they have when speaking with palliative-care patients and their families at the same time. Therefore, it is important to explore nurses' experiences and perceived communication challenges to identify practice-based barriers and inform culturally sensitive communication education, professional support, and institutional strategies for enhancing patient and family-centered palliative nursing care.

Research Objectives

1. To explore nurses' experiences of communicating with patients and their families during palliative care.
2. To identify the perceived challenges nurses encounter while communicating with patients and families during palliative care.

Research Questions

1. What are nurses' experiences of communicating with patients and their families during palliative care?
2. What challenges do nurses perceive while communicating with patients and families during palliative care?

Literature Review

Communication is acknowledged as one of the core elements of successful palliative nursing care, as patients with a serious or life-limiting illness often suffer uncertainty, fear, shifting care priorities and complicated informational and emotional requirements. Nurses are well positioned to participate in this process, because they are always there, which gives them the opportunity to form therapeutic relationships with patients and to contact them on a regular basis with family members. Effective palliative communication is more than the provision of clinical information; it is active listening, empathy, emotional support, clarification, collaborative decision-making and recognition of individual choices. Williams (2023) underlined the value of transparent, truthful, kind and emotionally sensitive communication for the patients and families approaching the end of life. Similarly, O'Kane et al. (2023) reviewed palliative nursing practices in intensive care settings and found that increased communication and support for patients and families were critical components of successful palliative nursing. The findings also indicated that nurses needed to be well prepared and trained to carry out this function effectively.

The therapeutic relationship between nurses and patients is particularly important for patients with progressive or life-limiting illness. Nurses can talk to patients about worries and uncertainties, existential issues, family duties, spirituality and preferences for future care. Such conversations may occur spontaneously as part of ordinary care duties and hence require nurses to identify opportunities for meaningful interaction. Communication may also be emotionally difficult when patients ask for information regarding prognosis, limitations of treatment, deterioration, or death. Nurses are therefore expected to integrate their professional expertise with interpersonal sensitivity and emotional awareness. Giachello et al. (2026) reviewed communication approaches used in palliative nursing and found that structured communication tools such as conversation guides, question-prompt approaches, protocols, and electronic resources could aid in patient participation, expression of care preferences, and emotionally supportive conversations. The authors, however, noted that successful implementation depended on adequate nurse education and institutional support. This implies that successful palliative communication depends on both the individual's communication competence and the therapeutic context in which communication occurs.

An additional important facet of communication in palliative care is the family members. They frequently serve as caregivers, advocates, partners in decision making, and emotional support. Relatives may also suffer worry, anticipatory sadness, doubt, denial or trouble recognizing decline and this may disrupt their interactions with healthcare providers. Pun et al. (2023) highlighted in an integrated review of family roles in end-of-life communication that families can play a significant role in information exchange and decision-making, particularly in family-centred cultural contexts. Family members may serve as a communication bridge, but disparities between patient desire and family expectations may sometimes create discord over disclosure and treatment options. Nurses consequently need to arrange communication carefully so that they may honor family participation without compromising patient's preferences, dignity and autonomy.

Emerging research that incorporates a family perspective emphasizes the value of effective communication. Boakye et al. (2026) studied family caregivers' impressions of palliative-care consultations

for nursing-home residents and highlighted the significance of family members in palliative decision-making and communication. The qualitative findings support the notion that palliative-care encounters should include family caregivers as active collaborators, rather than passive recipients of information. Family involvement is especially important in cases where patients have little capacity for independent communication. For nurses this means that they have to interact with patients and families concurrently while taking into account that each group may have varying levels of comprehension, expectations and emotional readiness. These findings are directly relevant to nursing practice as nurses are often still available to families after formal consultation and may thus be expected to clarify facts, respond to concerns and offer emotional reassurance.

When people are newly introduced to, or referred to, palliative-care services, the communication needs of patients and caregivers may also alter. Misunderstanding of the nature of palliative care can produce fear and can lead patients or relatives to equate the referral immediately with death or discontinuation of treatment. Saab et al. (2025) employed a descriptive phenomenological method with patients receiving specialist palliative care and their caregivers and found that first views of palliative-care referral were often associated with death. Importantly, participants recognized compassion, empathy, hope, privacy, tailored communication, proper timing, and gradual provision of information as important components of good communication. Clear and clear explanations were also identified to be helpful to allow individuals to understand and accept palliative-care referral. These findings underscore the importance of customizing communication to the level of preparation of patients and families rather than using a one-size-fits-all strategy.

Organizational and professional variables also contribute to communication challenges. Nurses may lack the time to engage in lengthy conversations because of workload, competing clinical demands, interruptions, or staffing limits. Role ambiguity may also arise when nurses are unclear about how much they should say concerning prognosis, treatment decisions or deterioration, especially when communication roles are not explicitly shared among the health care team. Gamzaeva (2025) analyzed communication via a palliative-care hotline and found that emotional support, pain-related counsel and clear information were prevalent needs among patients, while families needed help navigating resources and controlling anxiety. It is important to point out that the hurdles to communication were time constraints, aggressiveness and confusing distribution of professional tasks. The study stressed the need for nurses to improve their psychological and communication competence, and recommended that effective communication involves organizational clarity and personal interpersonal skill.

Communication in palliative care is also affected by cultural norms and the way that patients and families conceptualize sickness, hope, pain, and decision-making. In some family-centred settings relatives may take responsibility for obtaining information, or attempt to protect patients from upsetting information. Pun et al. (2023) emphasized the significant importance of family members on end-of-life communication and showed how culturally entrenched family roles might mediate the negotiation of information and decisions. These circumstances can create ethically complex situations for nurses when family preferences conflict with patients' rights or expressed requests. When communicating in a culturally responsive manner, nurses need to evaluate each circumstance separately, rather than assume all patients or families of a same cultural background will have the same preferences.The literature reviewed shows that successful communication in palliative care is a multimodal nursing obligation that involves therapeutic connections, emotional support, information exchange, family engagement, cultural sensitivity and interprofessional coordination. However, issues exist in relation to nurses' communication ability, role clarity, time restrictions, emotional demands and professional preparation. Williams (2023) pointed to ongoing issues with the patient and family experience of compassion and understanding in end-of-life communication, and Giachello et al. (2026) reported that structured communication strategies require specific training and organizational support before they can be successfully embedded in nursing practice. Overall, the literature suggests that communication problems cannot be understood simply as a deficit in the communication skills of individual nurses, but are affected by the interaction of patient needs, family expectations, cultural values, professional obligations and healthcare environments.

Current evidence gives useful insights for palliative communication, but more qualitative exploration of nurses' experience is needed. Much of the literature available is focused on specific contexts,

communication treatments, end-of-life decision making, or patient and family perspectives and not on nurses' experiences of communication with **patients and families throughout palliative care**. The nurses' perspective can illuminate practical problems of emotional ambiguity, family conflict, sensitive issues of culture, professional boundaries, and organizational limits that may not be revealed by quantitative assessment alone. Thus, the present qualitative study aimed to analyze nurses' experiences of communication with patients and families during palliative care and to identify the problems they faced. Such evidence can be used to develop communication training, nursing education, clinical procedures, and organizational strategies to enhance compassionate, patient- and family-centered palliative care.

Research Methodology

Research design

The study used a qualitative phenomenological design to evaluate nurses' experiences and perceived problems in interacting with patients and their families within the framework of palliative care. The qualitative technique offered a rich comprehension of participants' experiences, perceptions, feelings and meanings within their clinical situation . Detailed accounts of nurses' communication experiences were obtained through individual face-to-face interviews. Data obtained were examined using Braun and Clarke's reflexive thematic analysis which included familiarization with the data, coding, formulation and refinement of themes and interpretation of findings.

Sampling Technique

Purposive sampling technique was employed to recruit registered nurses with direct experience caring for patients undergoing palliative care and talking with their families. Participants were recruited based on pre-determined inclusion criteria so that they could provide extensive accounts of relevance to the aims of the research. Registered nurses with direct palliative care expertise in key clinical areas including cancer, intensive care and medical units were eligible for participation. The study involved 10 registered nurses who fulfilled the eligibility requirements

Research Instrument

Data collection was guided by a researcher-developed semi-structured interview guide based on the research objectives and relevant literature on communication in palliative nursing care. The interview guide included open-ended questions about nurses' experiences communicating with patients and families, emotionally sensitive conversations, family expectations, cultural and religious influences, perceived communication barriers, organizational challenges, preparedness, and support needs. Probing questions were used where appropriate to seek clarification and urge participants to elaborate on their experiences. Interviews were audio-recorded with permission and complemented by field notes to assist in correct transcription and thematic analysis.

Ethical Consideration

All the ethical guidelines according to BERA framework were followed. The participants were advised of the purpose and methods of the study and written informed consent was obtained before to each interview. Participation was voluntary and participants were advised of their right to refuse to answer any question or to quit from the study at any time without penalty. The research findings maintained confidentiality and anonymity by using participant identification codes (P1, P2, P3, etc.) instead of recording participants' names. Audio recordings, interview transcripts and other data from the research were stored securely and were accessible only to the research team. Given the delicate nature of experiences related to palliative care, interviews were conducted in a polite manner and participants were allowed to halt or stop the interview if they encountered emotional discomfort.

Data Analysis

Braun and Clarke's reflexive thematic analysis was employed for analyzing the qualitative data collected through semi-structured interviews. Interview transcripts were read, processed and grouped into meaningful patterns. Major themes and sub-themes were constructed to represent nurses' experiences and

perceived problems in communication with patients and families during palliative care.Four major themes and eight related sub-themes emerged from the analysis of interview accounts. The themes identified were nurses' experiences of emotionally sensitive communication, the importance of families and sociocultural views, organizational hurdles to effective communication, and the need for nurses to be better prepared and supported professionally. The themes and sub-themes are provided below.

Theme 1: Handling Emotionally Sensitive Communication

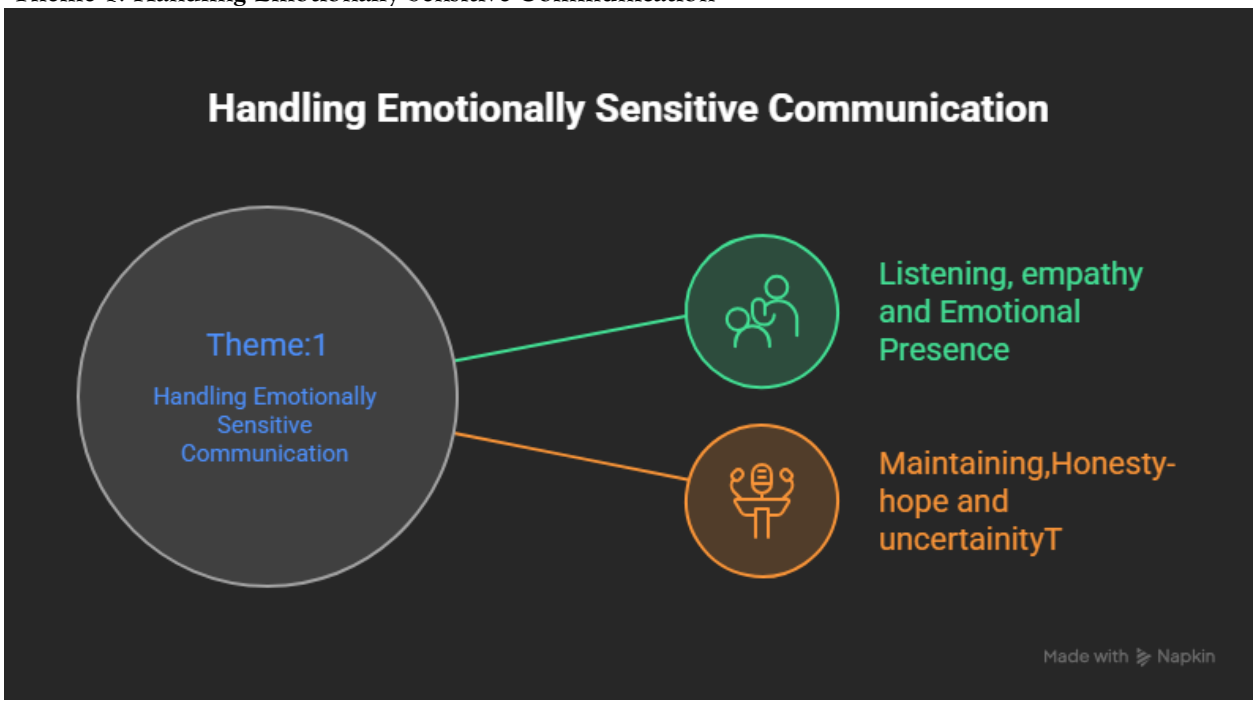


Fig 1: Graphical Representation of Theme 1

Sub-theme 1.1: Listening, empathy and emotional presence

Therapeutic communication in palliative care is not just an exchange of clinical information, but requires active listening, empathy, emotional presence, sensitivity and recognition of patients' concerns. The importance of listening was mentioned by participants frequently as one of the most significant parts of their contacts with patients with serious disease. Sometimes, their testimonies show, patients needed a chance to voice anxiety, uncertainty, family worries and emotional suffering more than they required a fast answer. Nurses consequently considered that their being there and being prepared to listen was a part of compassionate care in palliative nursing.

P1:I find talking to palliative-care patients emotionally exhausting but also rewarding. I feel that many patients want someone to listen to their fears and worries, not just to provide clinical information.

P4:With experience I have learnt that listening is often more important than talking. Often patients want to talk about anxiety, family worries, unfinished obligations and uncertainty.

Participants' experiences suggest that good palliative communication is relational, not just factual. The emphasis on listening, tranquility, stillness and emotional acknowledgment reveals how nurses establish psychologically safe environments in which patients are able to express concerns that may not emerge during ordinary clinical contacts. This view is in line with Stenman et al. (2025), who found that nurses in specialist palliative care sought meaningful and supportive connections by engaging in confidential talks. Their following ethnographic work has shown in greater detail how confidence in the nurse-patient communication is built dynamically through frequent interpersonal contacts (Stenman et al., 2026). Similarly, recent studies in pediatric palliative care suggest that compassionate nursing communication enhances family confidence and coping during critical illness (Özdemir et al., 2026).

P8: I try to be calm, respectful and realistic. I validate emotions instead of trying to change immediately the way the person feels.

Collectively these experiences illustrate that communication in palliative care is a sort of therapeutic presence where the spoken word is not the only important aspect of communication but also listening, empathy, appropriate silence and emotional acknowledgment. Participants seemed to understand that they could not always resolve patients' anxiety or doubt but could offer a space where these feelings may be expressed non-judgmentally. Thus, compassionate presence was seen as an important quality of nurses' communication with patients in palliative care.

Sub-theme 1.2: Maintaining Honesty, Hope, and Uncertainty

One particularly sensitive area of palliative-care communication was finding a balance between conveying realistic facts and maintaining hope. Nurses faced circumstances where patients explicitly asked them about their prognosis, the potential of healing or deterioration. Such interactions put nurses in a difficult position, as they wanted to react honestly without unnecessarily upsetting patients or stepping outside their professional duty in communicating. This process was made more difficult by uncertainty, since patients sometimes wanted definitive answers when definitive results could not be given.

P2: One big problem is answering inquiries regarding prognosis. Sometimes patients ask directly if they are dying, or if treatment will cure them.

P4: It is hard to balance honesty with hope. Patients have the right to be told the truth but information has to be given sensitively.

These views highlight the ethical and emotional complexities of communicating about serious disease. Nurses were making decisions not just about what information to share, but also about timing, emotional preparation, professional boundaries, and the possible effect of knowledge on hope. Likewise, Aghaei et al. (2026) found a strategy of communicating tough realities that included evaluating family preparation, choosing the optimal timing, sustaining true compassion, and providing emotional relief. Recent qualitative studies also indicates that uncertainty regarding decision-making and the quality of information are major problems for patients and caregivers receiving palliative cancer care (Rabben et al., 2025). In addition, communication gaps, poor communication skills and ambiguity of professional duties were reported as major obstacles in nursing care at the end of life (Taheri-Ezbarami et al., 2026).

P 10: It is difficult when patients ask questions that do not have a definite answer. It is a skill to give hope without false reassurance.

The findings thus show that successful palliative communication does not need nurses to choose between total optimism and harsh disclosure. Participants indicated a more complex process of retaining realistic hope in the midst of clinical uncertainty. Their reports emphasize the importance of compassionate truth-telling, professional clarity, and sensitivity to patients' emotional readiness. It seems that one of the most complicated communication skills necessary in palliative nursing practice is the juggling of these competing needs.

Theme 2: Navigating Family, Cultural and Religious Pressures

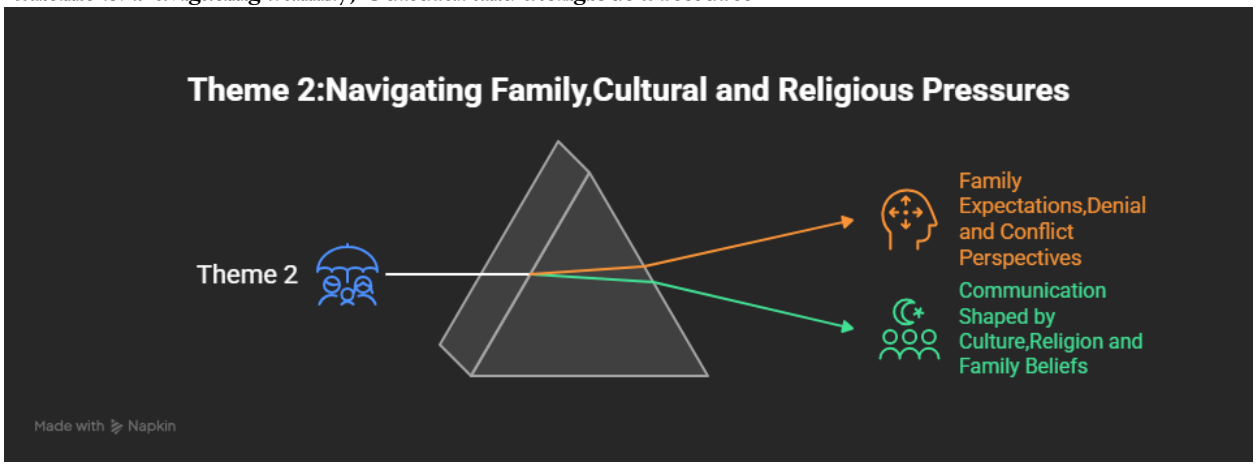


Fig 2: Graphical Representation of Theme 2

Sub-theme 2.1: Family Expectations, Denial and Conflicting Perspectives

The communication of palliative care was crucial to families. Nurses said families needed knowledge, reassurance and emotional support, while also dealing with dread, sadness, denial and ambiguity. Communication was especially hard when families had excessive expectations for recovery, were divided within themselves, felt furious or sought clear answers from nurses. The narratives of the participants showed family communication as an important but often challenging feature of palliative nursing.

P1: Denial is prevalent. Some relatives have expectations of recovery even if the patient's condition is quite poor.

P5: Managing false expectations is challenging. Some relatives think that necessarily going on with every conceivable treatment will lead to recovery.

These comments mirror the fact that nurses often work at the intersection of clinical realities and family expectations. Family denial or excessive expectations should not be automatically viewed as resistance, but rather may be reflective of emotional anguish, anticipatory sadness, uncertainty, or difficulty accepting decline. At the end of life, communication with families entails assessing family readiness, slowly communicating difficult realities, compassionate language, and emotional comfort (Aghaei et al., 2026). Similarly, studies with advanced cancer patients and family caregivers showed quality information and strong communication as the foundation for meaningful involvement in palliative decision-making (Rabben et al., 2025). Recent data in pediatric palliative care also suggests significant emotional and caregiving costs for families and a crucial role for nurses in fostering coping and help-seeking (Özdemir et al., 2026).

P 8: Conflict can arise when relatives or the healthcare team disagree with the treatment decisions.

In conclusion, family-centered communication was recognized as a core role of nursing and a possible source of interpersonal complexity. Nurses have to be able to identify the feelings of families, but also to apply professional limits and protect the interests of the patient. The findings point to the need for planned opportunities for families to get consistent information, ask questions, voice concerns, and be able to participate appropriately in discussions about care.

Sub-theme 2.2: Communication shaped by culture, religion and family beliefs

Cultural and religious beliefs affected patients' and families' views on sickness, suffering, prognosis, hope, and palliative care. Participants mentioned spirituality as a significant source of consolation but identified cases when family beliefs precluded forthright discussion of deterioration. In some instances, families opted to make decisions together or asked that patients be spared from grave information. Nurses had to choose between respect for culture and family norms and ideals of patient centered communication and autonomy.

P 1: Some relatives want to protect the patient from knowing all the details of the sickness for fear of destroying hope.

P 7: Family involvement is strong in our context. Decisions are often collective rather than individual, so nurses need to communicate with patient and relatives.

These stories illustrate that palliative communication cannot be divorced from the sociocultural setting in which sickness is lived. Family-centered cultures may stress group decision making, protection of vulnerable patients, and hope, whereas professional frameworks may stress individual autonomy and disclosure. Similarly, Aghaei et al. (2026) observed that sociocultural and religious norms may favor substantial family participation and slow or indirect disclosures in end-of-life communication. Similarly, Taheri-Ezbarami et al. (2026) found that cultural and religious barriers are some of the variables leading to communication problems for nurses, patients and families. These findings underscore the need for culturally sensitive communication that investigates each patient and family's preferences rather than relying on predefined assumptions.

P 10: Cultural and religious values affect the understanding of illness, suffering and death. Respecting these is important in establishing trust.

The findings highlight the need for sensitivity rather than standardization in culturally appropriate palliative communication. Nurses should be aware that religious belief can be a significant resource for coping and that family structures can have a profound effect on the receipt of information and the making

of decisions. Good practice therefore requires respect for cultural and spiritual values, with due respect for patient wishes, dignity and autonomy.

Theme 3: Communication within organizational constraints



Fig 3: Graphical Representation of Theme 3

Sub-theme 3.1. Workload, Staffing and Limited privacy

The nurses' ability to communicate well was heavily affected by organizational settings. Participants reported a number of difficulties to having meaningful interactions including workload, personnel shortages, competing clinical tasks, interruptions and lack of privacy. Palliative communication generally needs time, concentration and a private location. Nurses observed working situations where acute clinical obligations often took precedence over longer interactions with patients and family.

P1: The workload is a big problem. When you have a few patients that need attention at the same time it is difficult to spend enough time to have sensitive conversations.

P2: The major barriers are heavy workload, limited staff and no private space to discuss family matters

These statements suggest that communication problems cannot be attributed only to the interpersonal skills of individual nurses. Even a nurse with sufficient communication skills may not be able to provide continual emotional support while looking after several patients or is constantly interrupted by urgent clinical duties. High workload was one of the hurdles that affected nurses' communication with patients and families in a 2025 nursing communication intervention. The study indicated that clinically relevant education might increase communication confidence and competence (2025). Similarly, Omidi et al. (2025) examined ICU nurses' perspectives of palliative care and stressed the need for sufficient nursing competences and supporting settings to provide successful palliative care. More recently, high workload and stress were elements of fragmented interdisciplinary care and communication issues found by Taheri-Ezbarami et al. (2026).

P9: The work is heavy so we sometimes hurry our conversations.

These findings suggest that high-quality palliative communication is dependent not just on nurses' willingness to communicate but also on whether hospital surroundings enable them to communicate. Improved patient- and family-centered palliative care may consequently require adequate staffing, protected communication time, private settings and acknowledgment of communication as genuine

professional practice. So, individual communication training should be complemented by organizational improvement.

3.2 Subtheme: Fragmented interprofessional communication and unclear role

Another key organizational challenge was communication among the multi-disciplinary team. Participants reported confusion about what information nurses were allowed to give, particularly about prognosis and treatment options. They also pointed to the likelihood that patients and families could receive conflicting signals from various members of the team. This inconsistency can lead to uncertainty, anxiety and a decrease in trust, and leave nurses wondering about their communication duties.

P2: I don't know how much to explain sometimes.

P5: Communication consistency between doctors and nurses is very important, because contrary information increases family anxiety.

The participants' worries indicate that the communication between the patient and the family is inseparable from the communication between healthcare providers. Nurses spend a lot of time at the bedside and may be asked questions following a discussion with the physician. Not knowing the limits of their profession, however, can erode their confidence in answering. However, Taheri-Ezbarami et al. (2026) acknowledged interrelated issues such as inadequate professional communication, ambiguous role definitions, physician-centered frameworks, and communication gaps with patients and families. Rabben et al. (2025) also observed that although high-quality information is important for shared decision-making in palliative cancer treatment, the involvement of nurses to decision-making can be ambiguous. These results corroborate the participants' calls for multidisciplinary communication coordination and explicit professional roles.

P9: Communication is a team approach of multiple disciplines, not leaving the unpleasant conversation to one professional.

The findings suggest, then, that successful palliative communication should be understood as a team effort rather than an isolated nursing task. Clear responsibilities for communication, interdisciplinary family meetings, shared paperwork, and consistency between nurses and physicians may help to decrease confusion and build trust with patients and families. So, contact with patients and their families can also improve.

Theme 4: Enhancing Nurses' Preparedness and Professional Support

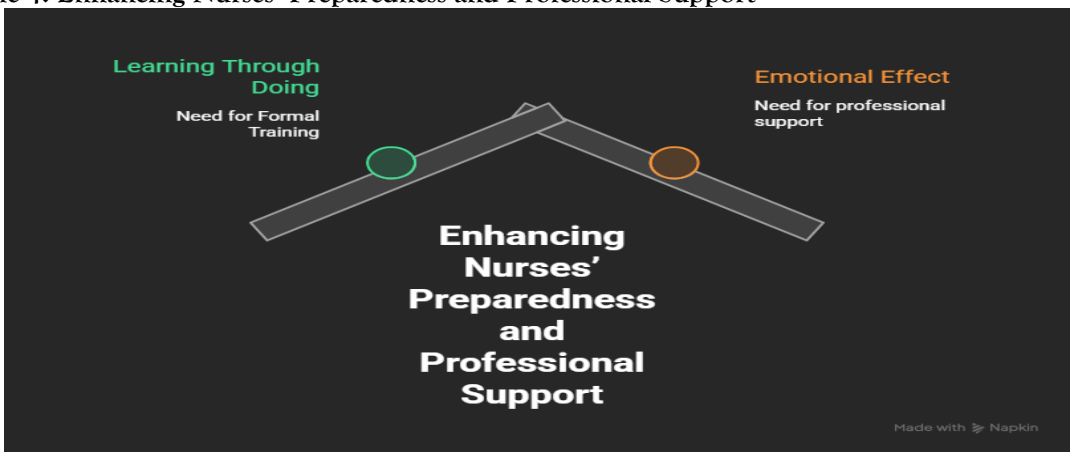


Fig 4: Graphical Representation of Theme 4

Sub-theme 4.1: Learning Through Doing and Need for Formal Training

There was large difference among participants in their perception of their preparedness to engage in palliative communication. Generally, the more experience a nurse had, the more confident they felt, with less experienced nurses often reporting feeling doubtful, especially in relation to questions involving deterioration, prognosis and death. Some participants said that they gained communication skills informally through observation, senior colleagues and frequent clinical exposure, rather than through formalized palliative-care instruction.

P2: As far as I am concerned, I have not had formal training in palliative communication. Most of my knowledge I have gained from senior nurses and clinical experience.
P6: University education is taught basic communication skills, but not enough practice for these situations.
The stories suggest that there may be a gap between general communication training and the specific skills needed for palliative dialogs. Nurses may know the concepts of therapeutic communication but feel unprepared when patients ask straightforward questions about prognosis or families exhibit significant emotional responses. In a 2025 study of a multimodal training intervention, nurses stated they first felt insufficiently prepared for end-of-life communication, but subsequently reported increased confidence and competence after targeted education. Stenman et al. (2025) also found that palliative nurses build personal and professional ways to approach confidential talks via practice and reflection. Recent research from Pakistan also reveals ongoing gaps in nurses' understanding and communication on palliative care, reinforcing the need for focused professional education (Hassan et al., 2025; Mulazim et al., 2025).
We need to support them as new nurses, we can't expect them to manage difficult conversations by themselves. (P6)
The results show that experience is important for communicating confidence, but that formal preparation cannot replace for it. Nurses can transfer theoretical communication ideas into clinical practice through formal education including role-play, simulation, case discussion, supervised practice and mentoring. Special consideration should be given to junior nurses who may find themselves involved in emotionally tough palliative conversations before they have developed adequate experiential confidence.

Sub-theme 4.2: Emotional effect and need for professional support
Nurses also suffered an emotional weight while dealing with very ill patients and concerned families. Participants perceived palliative communication as useful, but emotionally draining. They recognized that nurses could be affected psychologically by repeated exposures to suffering, decline, family sadness and unpleasant conversations. Their stories indicated that nurses were expected to provide emotional support to others but did not have much opportunity to process their own emotional experiences.
P1: Psychological support is also needed for nurses as we are under constant pressure from attending to critically ill patients and upset families.
P9: Communication can be gratifying when patients feel safe to share their worries, but it can also be emotionally draining.
These descriptions show that emotional effort is inherent in palliative nursing communication. Nurses often need to keep their own feelings under check, while projecting a calm, reassuring presence for patients and families. Omidi et al. (2025) point out that palliative care presents complicated challenges for ICU nurses and requires specific professional competencies to serve patients and their families. Aghaei et al. (2026) also portrayed challenging information transmission as a nursing role with complicated emotional aspects and the need for compassionate and culturally aware engagement. Moreover, Taheri-Ezbarami et al. (2026) recognized stress and lack of supportive structures as issues influencing nurses providing end-of-life care. Collectively, these findings suggest that supporting nurses' mental health should be part of organizational initiatives to improve palliative care.
P8: Nurses require time to debrief after emotionally challenging cases. We support patients and families but staff mental health is sometimes forgotten.
Finally, the emotional demands of palliative communication are not limited to individual interactions but might accrue over time. Experiences of participants highlight the necessity for supportive mechanisms such as clinical debriefing, peer support, mentorship, reflective practice and accessible psychological help. Emotional health of nurses may not only assist the staff, but also maintain compassionate patient-centered communication in palliative care settings.

Conclusion
In summation, communication between nurses and patients and their families in palliative care is a difficult and emotionally demanding part of nursing practice. Good communication was seen by nurses as including much more than the transfer of clinical knowledge, and requiring active listening, empathy,

emotional availability, and respect and understanding of the concerns of patients and their families. The findings indicated specific problems with discussing prognosis, responding to inquiries regarding deterioration, preserving realistic hope and handling ambiguity. Family expectations, denial, opposing opinions, and cultural and religious beliefs also affected communication. Therefore, nurses had to negotiate honest communication with emotional sensitivity, recognizing the patients' wishes and the significant role of families in palliative care decision-making.

The study also revealed that good palliative-care communication is affected not only by individual competency but also by organizational and professional settings. Heavy workload, insufficient staffing, lack of private space, ambiguous roles for professional communication, and inconsistent multidisciplinary communication hampered nurses' capacity to have meaningful conversations with patients and families. In particular, less experienced nurses acknowledged a need for further training in handling emotionally charged talks, whereas more experienced nurses stressed the value of learning through clinical exposure and supervision. Hence, to improve palliative-care communication, systematic education, simulation-based training, interdisciplinary teamwork, straightforward communication protocols, mentorship, and emotional support for nurses are required. Meeting these needs may foster nurse confidence and communication competency, and result in more compassionate, culturally responsive, patient and family oriented palliative care.

Recommendations

- Structured communication training should be provided to nurses, focusing on difficult conversations, prognosis-related concerns, emotional support, and communication with distressed patients and families during palliative care.
- Simulation-based learning and role-play should be incorporated into nursing education and continuing professional development to strengthen nurses' confidence in handling sensitive palliative-care conversations.
- Interdisciplinary communication protocols should be established to promote consistent information-sharing among nurses, physicians, and other healthcare professionals and minimize conflicting messages to patients and families.
- Culturally and spiritually sensitive communication practices should be promoted to ensure that patients' and families' cultural values, religious beliefs, preferences, and decision-making practices are respected during palliative care.
- Organizational and emotional support for nurses should be strengthened through adequate staffing, protected time and privacy for sensitive conversations, mentorship, peer support, and debriefing following emotionally challenging palliative-care situations.

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