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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 □ve-step method. The coding process was facilitated by the useof 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 ± 6.31 years. The data analysis yielded □ve main categories and □fteen 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 in□uence 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 □ndings 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

e 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 su er from physical discomfort in addition to a wide range of psychosocial and spiritual concerns [8]. ere-fore, the demand for end-of-life care and the need to provide services in the hospital environment is increasing [9]. is 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 digni ed 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 nally 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].

e concept of palliative and end-of-life care represents a relatively new approach within the Iranian health [11] system, one that necessitates a signi cant 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. e 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 classi ed 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 eld 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 eld of end-of-life care and the transfer of end-of-life care at home [9]. Additionally, in a review study, the presence of e ective communication, family participation in end-of-life care, and personal values of health professionals, and the existence of specialized were identi ed 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 a ect 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]. erefore, models and theories of work motivation do not speci cally address the motivation for care and are therefore not suitable for use in this eld.

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 e ective strategies to further motivate their nursing teams [24]. Since e existing theories of health employees have not speci -cally addressed their care motivation and are not suitable

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

Methods

Design

e 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 le 1) [28]. Content analysis is particularly adept at re ecting divergent views and elucidating complex issues, allowing for the meaningful interpretation of concepts and methods [29]. e 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

e study was carried out from February to July 2023 in the speci c setting of Iran's healthcare system, and the study took place in two government hospitals in Gorgan, in the north of Iran ry. 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 speci c inclusion criteria. ese 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. e revised questions were used by the researchers and It was uploaded as a supplementary le (supplementary le 2). e data were collected using an in-depth semi-structured interview held in a quiet place in the participants' workplace.

e interviews were conducted by the rst 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(±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 con rmed this, as no further novel information emerged. All interviews were digitally recorded with consent.

Data analysis

e data were analyzed via the ve-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. ese units were distilled into labels, later combined into subcategories, and nally 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
Sa□yeh	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 con rmability [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 con rm 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 veri ability was ensured through accurate, direct quotations from interviews. Con rmability was preserved by keeping a careful record that includes the original notes, transcription and analysis.

Findings

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

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

Innate empathy

e ndings 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 identi cation 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 e ective 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. ree 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

rough the insights gathered from nursing professionals, it was identi ed that the foundational principles and values, intrinsic to the nursing vocation played a signi cant role in fostering motivation to care. is primary category is divided into four subcategories: "Focused interaction and e ective communication", "Knowledge-Based Approach to End-of-Life Care" and "Conscientiousness in Care".

Focused interaction and e ective communication

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

e 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 in uenced by scienti c knowledge and evidence. In addition to the experiences they gain during their professional activities, nurses should also be familiar with the latest scienti c evidence.

e participants conveyed that a nurse's competence, grounded in knowledge and evidence-based practice, can bolster self-con dence and foster more e cacious care.

Re ecting 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

e 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. is 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. e 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. is 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

e study's results indicate that a family's understanding and acceptance of the patient's treatment trajectory can positively in uence 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. ey tend to become irritable in response to the services provided to their loved ones. is is not the case for families of patients with chronic conditions. [Hamid]*

Compassion with family

e 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 e orts, 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. ese experiences fell into three subcategories: "**Hope and Diligence in Sustaining Patient Life**", "Re ection 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 signi cance 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 living person, one who still harbors the hope for recovery. [Hamid]*

Re ection 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

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

> *e 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.: ey 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. is sensation is profoundly heartening. [Maryam]*

Dominant motivational issueswithin the caregiving atmosphere

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

Caregiving tension

e study's ndings revealed that factors such as colleagues' negative reactions, insu cient resources and facilities, the demanding nature of end-of-life care, and

managerial neglect could demotivate caregivers. Sima noted the impact of neglect:

> *e system plays a substantial role. At times, our system works erodingly, induced by a neglectful management style. ey 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. is 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:

> *ere 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]*

e 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 ndings

e principal nding of this study revolves around the motivational factors that in uence Iranian nurses in the provision of end-of-life care. e study identi ed ve key motivators for care: "Foundations of professional care in the essence of the nurse", "Core Drivers in Optimal End-of-Life Car", "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 theirValues instilled through family upbringing, innate empathy, and individual capabilities in care function as motivators for providing end-of-life care. e 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] ese inherent traits shape nurses' interactions with patients and in uence 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]. eir 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. is study highlights the upbringing values imparted by the family as in uential motivators. Sociologists regard the family as a powerful mean for transmitting values [35]. rough 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]. ey nd a sense of gratefulness in their end-of-life care experiences. is 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 ndings from this study pertain to the Core Drivers of Optimal End-of-Life Care, which encompasses concepts such as, focused interaction and e ective communication, knowledge-based and conscience-driven

care. Nurses mentioned in their experiences that they tried to establish e ective 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 e ective 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]. e experiences of the nurses in this study showed that they increased their self-con dence 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. e 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. ey 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 signi cantly 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. Sarıkahya 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 signi cance within Iranian culture. E orts were made to mitigate these limitations as much as possible, enabling increased visitation and considering that it might be the patient's nal interaction with their family, which served as a compelling motivator for delivering family-centered care.

Another motivating factor identi ed 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]. e 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 livies 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]. e signi cance of adherence to religious and ethical convictions in in uencing professional conduct is well-recognized [34]. Research by Sastrawan highlighted that religious values are a source of motivation and an in uencing 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 con dence in their capabilities and resilience in the face of challenges [49]. Despite encountering numerous di - culties due to shortages within Iran's healthcare system, nurses persevere in providing end-of-life care. e 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 re ection 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. rough this dedication, nurses attain a sense of personal excellence.

Another nding of this research is Dominant motivational issues Within the Caregiving Atmosphere. e 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 sta , lack of communication and cooperation between health care providers were identi ed as barriers to providing optimal end-of-life care [9]. In Iran, a major challenge within the health system is the shortage of nursing sta . Nurses

operating in an environment plagued by sta ng de cits experience increased stress and workload. Compounded by low remuneration, inadequate resources, and insu - cient supervision [50], these conditions can lead to sub-optimal 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. ey 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].

is 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. is can be achieved by supporting nursing sta and crafting motivational interventions that account for individual di erences, while preserving intrinsic motivation.

Limitations

e current study is not without its limitations. e experiences reported herein may be representative of a subset of Iranian nurses' perspectives and might not translate across di erent sociocultural milieus. is particular constraint potentially impacts the broader applicability of the ndings. Consequently, consideringthe complexity and signi cance 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

is study is a pioneering qualitative investigation into the motivational experiences of Iranian nurses in the provision of end-of-life care. e ndings 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 a r-mative caregiving atmosphere s, act as driving forces for delivering end-of-life care. e 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. ese e orts 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 nal approval of the nal 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 con dentiality 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, con dentiality, 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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