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# Physicians' perceptions of end-of-life decision-making in the adult intensive care unit: A qualitative study

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**Background.** End-of-life (EOL) decision-making in the intensive care unit (ICU) is a complex and ethically demanding process requiring the integration of medical judgement, ethical principles and emotional sensitivity. Physicians initiate and lead these decisions, particularly in determining the appropriateness and limits of life-saving interventions. In South Africa (SA), systemic challenges, such as communication barriers and resource limitations, further complicate these decisions. There is limited research exploring physicians' perspectives on EOL decision-making in adult ICUs.

**Objective.** To explore physicians' perceptions of EOL decision-making in an adult ICU in SA.

**Methods.** An exploratory, descriptive qualitative design was used. Semi-structured interviews were conducted with nine purposively sampled physicians from a multidisciplinary adult ICU in a Johannesburg tertiary hospital. Data were transcribed verbatim and analysed using inductive thematic analysis.

**Results.** Three major themes emerged: collaborative decision-making, communication with families and emotional detachment v. burden. The decision to limit life-sustaining treatment is a complex and collaborative process that requires effective communication with patients' families. However, emotional responses, including detachment and burden, arose when navigating the decision-making process.

**Conclusions.** EOL decision-making in ICUs is complex and emotionally demanding for physicians, shaped by ethical dilemmas and communication challenges. Addressing these challenges is vital to creating a more supportive environment for healthcare professionals. This study emphasises the importance of clearer interprofessional collaboration, particularly between nurses and physicians, in the decision-making process.

**Keywords**: physician, perception, end-of-life, decision-making, intensive care unit

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**Contribution of study**

This study provides novel evidence on physicians' perceptions of end-of-life decision-making in South African intensive care units. The findings highlight the need for enhanced emotional support, continuing education in end-of-life care, and early integration of palliative care principles into undergraduate medical and nursing curricula to strengthen clinicians' preparedness for ethically complex decision-making.

End-of-life (EOL) decision-making in adult intensive care units (ICUs) is a complex and emotionally demanding process.[1] Physicians must navigate medical uncertainty, ethical dilemmas and emotional distress while maintaining patient-centred care. As ICUs increasingly manage critically ill patients with limited chances of recovery, physicians are required to make difficult decisions about the initiation, continuation or withdrawal of life-sustaining treatment.[2,3]

Physicians often experience moral distress when making these decisions, as they balance considerations of beneficence, non-maleficence, patient autonomy and resource constraints.[2,3] Determining medical futility can be particularly challenging in cases with uncertain clinical trajectories, leading to variability in clinical decision-making and inconsistencies in care.[4] Ethical tensions may arise among healthcare professionals and patients' families regarding the appropriateness of continued treatment.

Although effective communication with patients' families is central to EOL care, communication barriers, cultural expectations and family disagreements about prognosis and treatment goals may hinder timely and compassionate decision-making.[5,6] Poor communication may increase psychological distress for both families and clinicians and contribute to conflict or delayed withdrawal of treatment.[5,6] In addition to these clinical and ethical complexities, EOL decision-making takes a significant emotional toll on physicians. The responsibility of initiating or participating in decisions to withhold or withdraw life-sustaining treatment has been associated with burnout, moral injury and long-term psychological distress.[1,7] The emotional burden of such

decisions may conflict with expectations of professional detachment and objectivity.

Although the importance of EOL decision-making in ICU settings is well recognised, there is limited understanding of physicians' perceptions in this domain, especially within resource-constrained settings such as South Africa (SA).[8] Contextual realities include the burden of disease, limited ICU beds, high patient volumes and constrained palliative care resources, which further compound the emotional and ethical demands on ICU physicians.[9,10] There is thus a need for local evidence to inform supportive strategies, clinical guidelines and interprofessional collaboration in EOL care.

This study explores physicians' perceptions of EOL decision-making in an adult ICU. By examining the ethical, emotional and communicative dimensions of these decisions, it aims to inform interventions that enhance support for physicians and improve the quality of EOL care in SA ICUs.

# Methods

## Study design

An exploratory, descriptive qualitative design was employed to gain an in-depth understanding of physicians' perceptions of EOL decision-making in the adult ICU of a tertiary hospital in Johannesburg, SA. This approach was appropriate given the complexities associated with EOL decisions, which required further exploration of physicians' decision-making processes, communication strategies and perceived barriers to providing optimal patient care. The design facilitated a rich exploration of how physicians navigate prognostic uncertainty, ethical dilemmas and interactions with patients' families within the ICU context.

## Study setting and sample

Purposive sampling was used to recruit participants from an 18-bed multidisciplinary adult ICU at an academically affiliated hospital in Johannesburg. Eligible participants were physicians with direct experience in managing critically ill and dying patients and who were actively involved in EOL care, including decision-making processes. Inclusion criteria required that participants were working in the ICU at the time of the study, were willing to share their views, had at least five years of clinical experience, had provided EOL care and had made or contributed to decisions to withhold or withdraw life-sustaining treatment. Participants were selected based on their ability to offer rich, experience-based insights into EOL decision-making in the ICU context.

## Data collection tools and procedures

Data were gathered through individual, face-to-face interviews conducted between March and April 2022. Ethical clearance was obtained from the hospital's Ethics Committee, and written permission to conduct the study was granted. Verbal permission was also obtained from the ICU consultant and unit manager, and the study purpose and procedures were explained to them prior to recruitment.

Participants were approached during routine ward rounds and case reviews. Each potential participant received a copy of the study information letter following these interactions. Those who expressed interest and willingness to participate provided written informed consent prior to the interview. Interviews were scheduled at times and locations convenient to participants. All interviews were conducted in a quiet physician's restroom adjacent to the ICU, as preferred by the participants, and took place during their ICU shifts.

Interview sessions lasted between 45 and 60 minutes. Data collection continued until thematic saturation was reached, with no new information emerging. Field notes were taken during and after interviews to capture contextual details. All interviews were audio-recorded and transcribed verbatim to ensure accuracy and preserve the richness of the data.

## Data analysis

All audio-recorded interviews were transcribed verbatim and analysed using MAXQDA Plus 2020 (VERBI Software, Berlin). Braun and Clarke's thematic analysis method was applied to guide a systematic and iterative process of data interpretation.[11] The primary researchers independently read the transcripts multiple times to develop a deeper understanding of the narratives and engage with the data. Field notes were incorporated to enhance contextual interpretation. Transcripts were imported into MAXQDA to facilitate coding. Initial codes were generated inductively from the data by identifying recurring patterns and meaningful text segments across the transcripts. These codes were then reviewed and grouped based on conceptual similarities, resulting in the development of preliminary themes. Related codes that further explained specific aspects of the themes were organised into subthemes.

Themes and subthemes were iteratively reviewed in relation to the full data set to ensure coherence and consistency. The research team collaborated to refine and finalise the themes. To enhance the credibility and rigour of the analysis, a third researcher with qualitative expertise independently reviewed and coded selected transcripts. The final themes and subthemes were derived through consensus and are represented with supporting quotations to illustrate key findings.

## Trustworthiness

To enhance the rigour of the study, Ahmed's pillars of qualitative research trustworthiness were applied.[12] Multiple strategies were used to ensure credibility, including prolonged engagement with participants in their natural clinical setting, which enabled the researcher to build rapport and gain contextual understanding. Member checking was conducted during interviews by summarising participants' responses in their own words to confirm the accuracy of interpretations.

Dependability was ensured through a clearly documented and transparent research process. All interviews were audio-recorded and transcribed verbatim immediately following data collection. A detailed audit trail was maintained, documenting methodological decisions, coding steps and theme development to allow independent review of the analytic process.

Confirmability was strengthened by involving an experienced qualitative researcher as a co-coder during data analysis. Independent coding and collaborative discussions reduced the potential for researcher bias, supporting a balanced interpretation of the findings.

To support transferability, a rich description of the study design, research setting, sampling criteria and participant characteristics is provided, enabling readers to assess the relevance and applicability of the findings to other similar contexts.

## Ethical considerations

The study obtained ethical approval from the Human Research Ethics Committee (ref. no. M210229) and the study hospital (ref. no. GP_202107_010). Verbal permission was also obtained from the ICU consultant, nursing manager and unit manager prior to data collection. Written informed consent was obtained from all participating physicians before conducting interviews and audio-recordings. Participants were provided with an information sheet outlining the study's purpose,

procedures and ethical safeguards. Confidentiality and anonymity were assured, and no names or identifying details were included in the transcripts or final report. Participation was voluntary, and participants were informed of their right to withdraw from the study at any stage without penalty.

# Results

A total of nine physicians participated in the study. All were registered medical practitioners with clinical experience ranging from 6 to 15 years. At the time of the study, participants had between 6 months and 7 years of ICU experience. Two participants were ICU consultants. The sample comprised six males and three females, with ages ranging from 30 to 41 years. All interviews were conducted in English.

Thematic analysis of the data revealed three main themes and six subthemes reflecting physicians' perceptions of EOL decision-making in the adult ICU. These themes are presented in Table 1 and are elaborated below, supported by direct quotations to illustrate key insights.

**Table 1. Themes and subthemes**

| Theme | Subtheme |
|---|---|
| Collaborative decision-making | Process-oriented |
| | Exclusion of nurses |
| Communication with families | Importance of clear communication |
| | Challenges in maintaining consistency |
| Emotional detachment v. burden | Emotional detachment |
| | Emotional burden |

## Theme 1: Collaborative decision-making

This theme captures physicians' perspectives on the decision-making process during treatment withdrawal and EOL care in the adult ICU. Two subthemes emerged: 'process-oriented' and 'exclusion of nursing staff'.

### Subtheme 1: Process-oriented

Participants described decisions regarding the withdrawal of life-sustaining treatment as a process involving several steps undertaken over time. As head of the ICU team, the consultant was typically responsible for making the final EOL decision. However, collaborative discussions within the team, as well as involvement of the patients' family, informed decisions regarding the best approach to the withdrawal process and subsequent EOL care.

'Most of these decisions to not escalate or to withdraw are taken over time. I will have to discuss with the other senior colleagues … It is a process.' (Participant 8)

'It is a multidisciplinary sort of type of decision. You will need to involve the family. You need to involve your colleagues … It's a collective decision.' (Participant 2)

'Those decisions get made usually by the critical care consultants.' (Participant 3)

EOL discussions centred on patients' chances of survival and quality of life. Factors such as age, comorbidities and clinical scoring systems, including the Acute Physiology and Chronic Health Evaluation (APACHE) and Sequential Organ Failure Assessment (SOFA) scores, were used to inform EOL decision-making.

'We look at the patient's comorbidities, patient's age, what is the initial pathology, the initial problem, the diagnosis, the outcome, is it a poor diagnosis … We did our SOFA score, APACHE score and frailty index.' (Participant 9)

### Subtheme 2: Exclusion of nursing staff

Despite the collaborative nature of EOL decision-making, participants expressed that the attending consultant was responsible for the final decision, and that nurses were often not involved in the decision-making process or related discussions.

'It often does not involve us discussing with the nurses. It is a decision that is made and then it is relayed.' (Participant 2)

'They help us a lot … I think from a decision-making process that aren't too involved.' (Participant 3)

'The ones that I have been involved [in] … Not in the discussion to not escalate treatment … [From] what I've seen, nurses are not involved.' (Participant 4)

## Theme 2: Communication with families

This theme relates to the exchange of information between participants and patients' families during the withdrawal of life-sustaining treatment and EOL care in the ICU. Two subthemes emerged: 'importance of clear communication' and 'challenges in maintaining consistency'.

### Subtheme 1: Importance of clear communication

Participants emphasised the importance of informing patients' families about changes in the treatment plan and providing clear and consistent information during treatment withdrawal and EOL care. They noted that it was essential for families to understand the process and be involved in decision-making throughout.

'You explain to them what is happening, where we are, what are the organs that are failing … What we are anticipating, what might happen.' (Participant 8)

'They need to understand where we are, why we're making that decision.' (Participant 6)

### Subtheme 2: Challenges in maintaining consistency

Despite the importance of clear communication, participants mentioned challenges in maintaining consistency during treatment withdrawal and EOL care. Factors such as differing family reactions and perspectives and delays in physician communication contributed to these difficulties.

'You're not always speaking to the same person … Information gets different stories, the story changes.' (Participant 4)

'The family isn't necessarily here for the whole process or the patient's hospital stay ... Important decision that needs to be discussed is definitely missed.' (Participant 7)

'There is a bit of a disconnect between a consultant telling the treating doctor, and the treating doctor and nurse.' (Participant 1)

## Theme 3: Emotional detachment v. burden

The data generated a third theme: emotional detachment v. burden. This theme captures participants' feelings and reactions during EOL decision-making and their subsequent involvement in EOL care in the adult ICU. It is elaborated through the subthemes 'emotional detachment' and 'emotional burden'.

### Subtheme 1: Emotional detachment

Some participants reported feeling detached when making delicate decisions in the ICU, indicating that they were able to make EOL decisions without allowing their emotions to influence their judgement.

> 'I often see it in the best interest of the patient. So, I'm at peace with those decisions.' (Participant 1)

> 'I do not struggle with those decisions. I have not felt a particular emotion where I felt it was unfair or I felt particularly sad.' (Participant 5)

> 'I have got no regret that I have made a decision to say [do] not escalate.' (Participant 7)

### Subtheme 2: Emotional burden

In contrast, some participants expressed the emotional demands of participating in EOL decision-making, highlighting the intensity of the emotions involved.

> 'It's never an easy thing to tell a family that we cannot offer the family member further care.' (Participant 3)

> 'There is part of you that is sad about it, you feel sad for the patient and for the family.' (Participant 4)

> 'It's always almost heartbreaking that we try to do our best to make a patient progress further, but there's no better outcome.' (Participant 9)

## Discussion

The study explored physicians' perceptions of EOL decision-making in the adult ICU. Three key themes emerged: collaborative decision-making, communication with families and the balance between emotional detachment and burden. To our knowledge, this is the first SA study to explore physicians' perceptions of EOL decision-making in the adult ICU. These findings offer critical insight into the complex and ethically demanding nature of EOL care in resource-constrained, culturally diverse settings. They highlight the urgent need for palliative care education and the integration of core palliative care principles into ICU practice, particularly in the context of EOL care. The findings also underscore the relevance of core palliative care principles, including interdisciplinary teamwork, a commitment to neither hasten nor postpone death and a patient- and family-centred approach aligned with global movements toward universal health coverage (UHC).

### Collaborative decision-making

EOL decision-making in the ICU was described as a collaborative yet physician-led process. Consistent with international studies, decision-making is typically stepwise and involves input from both the healthcare team and families.[1,13,14] The goal is to make informed decisions aligned with the patient's wishes and values, while also considering their clinical condition and prognosis.[14,15] A fundamental principle of effective palliative care is that no single discipline can adequately address the complexity of EOL care.[14,16,17] Instead, an interdisciplinary team approach should include physicians, nurses, social workers, spiritual leaders and allied health professionals working together to deliver patient- and family-centred care that effectively addresses medical, psychosocial and spiritual needs.[16,17] Interdisciplinary collaboration, adequate preparation and teamwork are imperative for a co-ordinated EOL decision-making process.[14,15]

The present study identified limited interdisciplinary collaboration, with nurses rarely involved in initiating or contributing to EOL decisions. Similar findings have been reported in some low- and middle-income countries, where hierarchical structures and cultural norms position physicians as the primary decision-makers.[18,19] This physician-dominant approach contrasts with practices in Europe, Australia and New Zealand, where nurses are actively engaged in EOL decision-making.[20,21] The exclusion of nurses may reflect poor communication, insufficient EOL care training, personal beliefs and hierarchical healthcare systems that are predominantly physician-centric.[1,22,23] Additional contributing factors may include communication barriers, unclear scopes of practice, a lack of guidelines defining nurses' roles in EOL care and limited physician understanding of the unique role nurses play in EOL decision-making.[8,18]

While physicians typically lead EOL decisions, patients and families in SA and other African contexts often draw on *ubuntu* ethics, which prioritise compassion, dignity, interconnectedness and collective involvement of family and community.[24-26] This ethical orientation underscores the need for EOL discussions to extend beyond physicians to include nurses, patients, families and their communities.[26] The *ubuntu* ethical framework promotes culturally sensitive, holistic and patient- and family-centred care, recognising that a good death is a shared experience rather than a solitary journey.[25,26] Strengthening team-based approaches in SA may not only improve care outcomes but also align with the palliative care principle that dying is a shared human experience requiring co-ordinated, compassionate support.[16]

While physicians prioritise family needs and consensus, nurses often act as patient advocates and emotional liaisons for families.[20] They help clarify necessary information for families, act as intermediaries between physicians and families and provide emotional and spiritual support.[22,27,28] This reflects the principles of patient- and family-centred care, where nurses' proximity to patients and families positions them to advocate for dignity and personhood at EOL.[27,28] Nurses are trained professionals and essential members of the multidisciplinary team. Excluding such a crucial role player in EOL care may jeopardise the experience of both patients and their families. Recognising and leveraging these complementary roles is essential for integrated, compassionate EOL care.[28]

Early and formal inclusion of nurses in this setting may improve care continuity, family satisfaction and clinical outcomes. Furthermore, strengthening interdisciplinary practice supports UHC's commitment to equity and quality by ensuring that patients and families receive co-ordinated and comprehensive care.[29] Applying patient- and family-centred care principles in EOL settings may facilitate collaboration among ICU teams, patients and their families.[30] The findings suggest an urgent need for hospital management to investigate the extent of interdisciplinary co-operation, particularly between nurses and physicians, during EOL care.

### Communication with families

Effective EOL communication with families was described as central to successful decision-making. Physicians noted that clear, consistent and transparent communication helped families feel informed and involved. This aligns with the literature indicating that effective communication reduces conflict, prepares families for bereavement and facilitates alignment with patient values.[13,18,29] Palliative care principles emphasise that open, culturally sensitive communication is essential for patient- and family-centred care, as it upholds dignity, honours preferences and supports shared decision-making.[16,17,30] Consistent, respectful and inclusive communication also helps families understand the EOL care trajectory and reduces the risk of complicated grief following bereavement.[6,29,31]

Poor, ineffective or absent EOL communication, however, may lead to stress, dissatisfaction and conflict among families and the healthcare team.[13,29] It may also contribute to delayed transition to palliative care, unnecessary aggressive treatment and burnout among healthcare providers. These delays may unintentionally prolong suffering, thereby conflicting with the palliative care principle of neither hastening nor postponing death.[16] Timely, compassionate communication enables a more natural dying process while avoiding futile interventions.[13]

As shown in this study, communicating with different members of a single family may lead to inconsistent EOL communication. Previous studies have shown that certain family attitudes and behaviours may act as barriers to effective EOL care.[32,33] To ensure consistent and effective communication, this study suggests early identification of a designated family spokesperson responsible for care-related communication, especially during EOL care. This may help reduce inconsistencies in communication.

During EOL discussions, language preferences, timing of communication and family background should be considered. Patients' and families' religious, cultural and ethnic backgrounds directly affect EOL communication and decision-making.[6,29] Unfortunately, healthcare providers working in ICUs often lack formal training in EOL communication. This study therefore suggests implementing continuous professional development programmes and formal education in EOL decision-making and care for ICU teams. Embedding structured communication training within interdisciplinary education may ensure that all team members are equipped to engage in meaningful conversations with families.[14,33] This not only improves patient and family experience but also reflects UHC's goal of delivering people-centred health services that are respectful and responsive to community values.[28,30] Effective EOL communication requires the involvement of a multidisciplinary team, patients and families.

## Emotional detachment v. burden

Physicians reported varied ewmotional responses to EOL decisions. Some adopted a stance of emotional detachment to maintain objectivity, while others experienced significant emotional strain and moral distress. These findings mirror global evidence that, due to the complexity of EOL decisions and associated ethical responsibilities, physicians may adopt emotional detachment to enable objective decision-making, maintain professionalism and focus on patient care in emotionally charged situations.[34,35]

Ethical dilemmas, concerns about legal liability, family dynamics and a lack of standardised institutional protocols for EOL decisions may contribute to emotional detachment, as physicians often prioritise procedural correctness over emotional engagement.[34,35] Detachment may serve as a coping mechanism and personal protective strategy to manage the emotional burden of impending patient death, moral distress and occupational burnout.[36,37] However, emotional detachment may contribute to burnout and job dissatisfaction, which may compromise the ability to provide compassionate care. A core principle of palliative care is the recognition of the emotional toll of caring for dying patients and the need to support healthcare professionals accordingly.[16,29] Interdisciplinary teamwork, mentorship and peer support may reduce moral distress and foster resilience, which is essential for sustaining compassionate practice.[32,33] This underscores the need to create a supportive decision-making environment through enhanced interprofessional collaboration and communication. It is also important to address role ambiguity and communication challenges within the healthcare team, particularly among nurses and physicians, as this may help reduce emotional detachment and improve job satisfaction.

This study also found that EOL decision-making was emotionally burdensome and straining for physicians. Previous studies support this, highlighting feelings of guilt, sadness, grief and moral distress.[3,38] Ethical tensions between acting in the patient's best interests and concerns about legal consequences often lead to moral distress and burnout.[39] Balancing compassion and empathy while making ethically complex decisions further intensifies emotional burden. Palliative care's emphasis on accepting death as a natural process provides an ethical framework for navigating these dilemmas, helping clinicians balance the avoidance of futile treatment with the principle that death should not be hastened.[16,40] Similarly, ethical principles such as autonomy, beneficence and non-maleficence guide physicians in providing compassionate and ethically sound care during EOL decision-making.[16,17,40] These principles offer reassurance that decisions are grounded in respect for the natural course of life. Collectively, these findings emphasise the value of integrating palliative care principles into EOL decision-making and care.

Furthermore, the degree of emotional strain and moral distress appeared to vary according to physicians' experience, autonomy and involvement in EOL decisions.[41,42] More experienced clinicians seemed better equipped to navigate these challenges, suggesting that clinical exposure and training contribute to emotional resilience. Physicians who had received formal EOL education and training reported greater coping ability, reinforcing the need for structured and continuous professional development in EOL care.[43,44] Integrating such training within UHC frameworks would ensure equitable access to high-quality palliative care education for all healthcare providers, thereby improving system-wide capacity to deliver compassionate, patient- and family-centred care.[16,28,30] Regular workshops and in-service training are therefore essential to upskill ICU physicians, and EOL care should be integrated into undergraduate medical and nursing curricula from the early stages of training.

## Limitations of the study

While this study provides valuable insights into physicians' perceptions of EOL decision-making, several limitations should be acknowledged.

First, the study was conducted in a single multidisciplinary ICU at an academic referral hospital, which may limit the transferability of the findings to other ICU settings, including private and non-academic hospitals. Future research should include multiple adult ICUs across different hospitals and provinces to capture a broader range of perspectives.

Second, the qualitative design does not allow for statistical generalisation, although the findings may offer a useful foundation for subsequent research and practice improvement in similar contexts.

Finally, data collection took place during the later stages of the COVID-19 pandemic, a period marked by clinical strain and staffing challenges. Many physicians were under significant pressure, which affected participant recruitment and the scheduling of interviews.

# Conclusion

EOL decision-making in ICUs is a multifaceted and emotionally charged process, encompassing ethical, clinical and communication challenges. This study highlights the need for ongoing education and training in EOL care to equip physicians with the competencies required to navigate these complexities. Establishing structured avenues for debriefing and psychological support may further safeguard the emotional wellbeing of ICU physicians.

The findings underscore the importance of early integration of palliative care principles and services within the ICU to support timely and compassionate decision-making. Interdisciplinary communication and collaboration, particularly between physicians and nurses, are vital to improving the consistency and quality of EOL care. Institutional efforts are needed to examine and enhance collaboration among healthcare professionals involved in EOL decision-making. These efforts will promote a more inclusive, co-ordinated and compassionate approach to EOL care.

**Data availability statement.** The data used in this study are available from the authors upon reasonable request.

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