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# Between culture and care: nurses' experiences of end-of-life communication in Ghana

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## Abstract

**Background** Communicating at the end-of-life (EOL) requires deep sensitivity and adherence to strong ethical principles that respect the dignity, rights, and values of patients and their families. However, many nurses find this task emotionally challenging, especially in settings with limited training and strong cultural taboos about death. In Ghana, little is known about how nurses experience and manage these conversations in everyday clinical practice. This study explored nurses' experiences communicating with families at the end of life.

**Methods** This study adopted an interpretivist qualitative design to explore the experiences of nurses at a district hospital in the Volta Region of Ghana. The Consolidated Criteria for Reporting Qualitative Research (COREQ) guided the study. Twenty registered nurses with at least two years of clinical experience participated in in-depth, semi-structured interviews. Data were analysed inductively using Braun and Clarke's reflexive thematic analysis approach. The research team engaged in continuous reflexive practice to ensure analytic rigor.

**Results** Three major themes were identified: (1) emotional and psychological challenges of breaking bad news, (2) coping mechanisms and professional obligations, and (3) institutional and cultural barriers to effective communication. Nurses described sadness, fear, and hesitation when informing families about death or poor prognosis, but they still viewed it as a core professional duty. Coping strategies included information gathering, teamwork, and personal faith. Communication was largely informal, with limited guidance or training. Cultural beliefs about death, family blame, and lack of privacy or institutional support further complicated interactions.

**Conclusion** Strengthening training, developing institutional guidelines, and incorporating cultural understanding into communication practices could help nurses deliver end-of-life care with greater confidence and support.

**Relevance to clinical practice** Communication during the end of life must be done correctly to convey the correct meaning of the message to the client and family. The findings will enable other nurses to identify with the experiences shared in this article and how to cope in such situations.

**Keywords** End-of-life communication, Nurses' experiences, Ghana, Qualitative study, Palliative care, Cultural beliefs

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## Patient or public contribution

Health care providers from a different facility tested the interview guide to ensure clarity of the questions.

## What does this paper contribute to the broader global clinical community?

- During end-of-life care, nurses face emotional, cultural, and institutional challenges
- Cultural taboos around death and limited resources within the hospital further constrained open communication. Nurses often lack structured guidance, institutional support, and formal training in communicating with families.
- Despite these challenges, nurses relied on personal faith, teamwork, and self-developed coping strategies to fulfil their duties compassionately.
- Findings show that institutional policies need to provide clear guidelines and psychological support mechanisms to help nurses navigate these sensitive interactions.
- Encouraging open dialogue about death and dying within healthcare settings can gradually shift cultural attitudes.

## Background

Globally, about 56.8 million people die annually, and nearly 60% of these deaths require palliative care [1]. Nurses play a central role in providing such care, not only through clinical support but also by facilitating communication between patients, families, and physicians [2]. End-of-life communication is a multifaceted process that may involve ongoing discussions about prognosis, goals of care, and symptom management, as well as more acute conversations such as the delivery of bad news during periods of clinical deterioration or at the time of death, reflecting the complex communication needs inherent in care for people with life-limiting conditions [3]. It is an integral part of nursing care that supports patients and families during critical moments.

Effective end-of-life communication has been shown to reduce family distress and enhance decision-making [4]. However, many nurses worldwide feel unprepared for this task, and more than half of palliative care nurses report insufficient training [5]. End-of-life communication is inherently ethical, as it requires nurses to navigate tensions between professional obligations and sociocultural expectations, particularly in relation to core principles such as autonomy, veracity, beneficence, and confidentiality, which are often complex to apply in practice [6, 7]. While high-income countries have increasingly introduced structured communication training programs [8], very few hospitals in sub-Saharan Africa provide such training [9]. Even where protocols such as the SPIKES model are available, studies show that nurses still experience emotional exhaustion and moral uncertainty when navigating the grief, denial, or anger of families [10].

In Africa, cultural and religious beliefs greatly influence end-of-life (EOL) communication [11, 12]. This hinges on the ethical principle of cultural and spiritual sensitivity. In many communities, discussions about death are considered taboo, making it difficult for nurses to navigate their professional duties alongside family expectations [13]. However, nurses often experience tension between the ethical principle of veracity and sociocultural expectations that discourage direct disclosure about dying and death [14]. In Ghana, death is often viewed as psychologically overwhelming, which makes open conversations about dying particularly difficult [11]. Families may see terminal illness as caused by spiritual factors, complicating acceptance of biomedical explanations [15]. Nurses often feel uncomfortable delivering bad news, citing cultural restrictions and a lack of institutional support [16]. Unlike high-income countries, where structured training, debriefing, and interdisciplinary teamwork are common, nurses in Ghana usually rely on experiential learning, resilience, or informal peer and spiritual support to manage emotional stress [8, 11, 17].

Systemic barriers further compound these challenges. Heavy workloads, shortages of palliative care units, and limited institutional protocols undermine consistent communication with families [18]. Legal and educational gaps also contribute to uncertainty, as many nurses report minimal formal preparation for EOL communication and limited knowledge of the legal frameworks guiding end-of-life decisions [6, 19].

At the institutional level, nurses working in district hospitals, which are government institutions, face these cultural and systemic barriers directly, often without formal training or structured support mechanisms [20]. District-level facilities typically lack specialist palliative care teams or formal coping structures, leaving frontline nurses to navigate communication independently while managing their own emotional well-being [15, 16]. Within this context, end-of-life communication often becomes most salient during periods of irreversible clinical deterioration and at the time of death, when nurses are required to communicate with family members about dying, death, and the delivery of bad news. Despite the critical role nurses play in supporting families during this period, little is known about how Ghanaian nurses, particularly those at the district level, experience and cope with the emotional, cultural, and institutional challenges of EOL communication while maintaining ethical principles. This study, therefore, explored the experiences of nurses in communicating with families at the end of life. at a district government hospital in Ghana.

## Methods

### Study design, setting, sampling technique, and participants

This study adopted an interpretivist qualitative design using Reflexive Thematic Analysis (RTA) as outlined by Braun and Clarke [21]. An interpretivist approach assumes that knowledge is socially constructed and shaped through interactions between participants and researchers. This approach was appropriate for exploring how nurses make sense of end-of-life communication within their cultural, institutional, and ethical contexts. Rather than seeking essentialised "lived experience," the study aimed to examine patterned meanings and shared interpretive practices in nurses' accounts of end-of-life communication [22].

In Ghana, most district-level facilities serve as a referral centre for surrounding rural and peri-urban communities (Central Tongu District [23]). The hospital provides general medical, surgical, and emergency services but operates with limited human and material resources, which makes end-of-life communication both frequent and emotionally demanding. The study focused on nurses working in wards where EOL communication commonly occurs, including the medical, surgical, and emergency units, to ensure relevance of the interpretive focus of the study.

A purposive sampling technique was used to recruit nurses with direct experience in EOL communication. Eligible participants were registered nurses employed with a minimum of two years' clinical experience and who had directly participated in end-of-life care or delivered difficult news to patients' families. Nurses on extended leave or those without direct involvement in EOL communication were excluded. Sampling adequacy was guided by the principle of information power. During the analytic process, the research team observed increasing stability in the coding structure, convergence in participants' accounts, and no emergence of substantially new interpretive insights. When successive interviews primarily deepened rather than expanded the existing thematic structure, the team considered the data set to have reached sufficient analytic depth. Therefore, twenty nurses were recruited for the study ($N = 20$).

### Data collection tools and procedure

Data were collected using a semi-structured interview guide (Appendix A) developed through discussions with experienced nurses regarding the study objectives and by reviewing existing literature on EOL communication. The guide was reviewed by two PhD holders with expertise in qualitative research (L.A.O and P.Y.A.A) to ensure clarity and alignment with study objectives. The guide was pretested with two nurses from a different hospital who met the inclusion criteria but were not part of the final sample. They helped refine some of the terminology to improve clarity. Feedback from the pretest informed refinement of question wording and flow to enhance sensitivity and comprehension. The Consolidated Criteria for Reporting Qualitative Research (COREQ) guided the study.

Interviews were conducted by the first and second authors (a male, BSc, and a female, PhD, respectively) face-to-face in private spaces within the hospital to ensure confidentiality and comfort. The first author's prior experience as an intern nurse in the hospital facilitated not just access and rapport but also shaped participants' disclosures and positioning. Some participants appeared to emphasize professional competence and ethical commitment, possibly reflecting perceived evaluative dynamics. The rapport and trust from participants, often enabled more open discussion of emotionally sensitive encounters. At the same time, the research team remained attentive to the possibility that participants might emphasize professional competence in their accounts, and reflexive discussions were used to critically examine how such dynamics shaped interpretation. A reflexive journal documented assumptions, emotional responses, and interpretive decisions. Regular team discussions were conducted to interrogate divergent readings and challenge taken-for-granted interpretations. This process strengthened analytic depth and transparency.

Participants were approached directly by the researcher, with support from hospital management; participation was voluntary. Each participant was informed that the data being collected is intended to improve communication and not to penalize anyone. They were reassured that their identities would remain anonymous and that the audio recording would be kept secure. Each interview lasted between 45 and 60 min and was audio-recorded with participants' consent. Field notes were taken to capture non-verbal cues and contextual details. The interviewers maintained a nonjudgmental stance and encouraged participants to describe their experiences freely. Data collection continued purposively until information power was achieved.

### Data management and analysis

All audio-recorded interviews were transcribed verbatim, and the transcripts were compared with the original recordings and field notes to ensure completeness and accuracy. The NVivo software was used to manage data. Data were analysed using Braun and Clarke's [21] six-phase reflexive thematic analysis. Analysis was iterative and interpretive rather than mechanical. Coding focused on meaning-making practices, emotional positioning, and ethical negotiations. Themes were developed through recursive engagement with data and team-based

**Table 1** Demographic summary of interview participants

| Participant | Position/Rank | Ward or Unit | Years of Experience |
|---|---|---|---|
| 1 | Principal Nursing Officer | Female Ward | 9 years |
| 2 | Senior Staff Nurse | Female Ward | 5 years |
| 3 | Senior Nursing Officer | Male Ward/ART Unit | 11 years |
| 4 | Staff Nurse | Female Ward | 3 years |
| 5 | Nursing Officer | Male Ward | 10 years |
| 6 | Senior Staff Nurse | Emergency Ward | 6 years |
| 7 | Principal Nursing Officer/Ward In-Charge | Female Ward | 12 years |
| 8 | Senior Staff Nurse | Emergency Ward | 4 years |
| 9 | Senior Nursing Officer | Emergency Ward | 14 years |
| 10 | Senior Nursing Officer/Ward In-Charge | Male Ward | 10 years |
| 11 | Senior Staff Nurse | Female Ward | 4 years |
| 12 | Staff Nurse | Emergency Unit | 3 years |
| 13 | Deputy In-Charge (SNO) | Accident & Emergency Unit | 4 years |
| 14 | Senior Nursing Officer | Female Ward | 12 years |
| 15 | Senior Nursing Officer | Emergency Unit | 10 years |
| 16 | Nursing Officer | Emergency Unit | 7 years |
| 17 | Nursing Officer | Female Ward | 5 years |
| 18 | Principal Nursing Officer | Administrative (formerly clinical) | 11 years |
| 19 | Senior Paediatric Nurse | NICU | 9 years |
| 20 | Senior Nursing Officer | Children's Ward | 11 + years |

interpretive dialogue. Reflexivity was treated as constitutive of analysis rather than a procedural add-on.

The principal investigator kept a reflexive journal to document personal biases, assumptions, and reactions, ensuring that interpretations remained grounded in participants' perspectives. Themes were reviewed iteratively and refined through constant comparison with the raw data. Rich descriptions and illustrative quotations were retained to enhance credibility and provide a nuanced understanding of the nurses' experiences.

### Ethical considerations

The Ghana College of Nurses and Midwives Academic Board granted permission for the study; however, ethical approval was obtained from the Institutional Review Board (IRB) at Kwame Nkrumah University of Science and Technology, Kumasi. After detailed explanations of the study's purpose, voluntary participation, and right to withdraw at any point without penalty, written informed consent was obtained from all participants.

**Table 2** Themes and sub-themes

| THEMES | SUB-THEMES |
|---|---|
| 1. Emotional and psychological challenges in breaking bad news | a. Emotional burden and discomfort<br>b. Fear of family reactions |
| 2. Professional responsibility and relational coping practices | a. Sense of professional duty<br>b. Preparation and information gathering<br>c. Collaborative approach<br>d. Managing emotions |
| 3. Structural and cultural constraints shaping communication | a. Lack of formal training and guidelines<br>b. Cultural and spiritual beliefs<br>c. Institutional and resource limitations<br>d. Institutional and resource limitations |

Confidentiality and anonymity were ensured through coded identifiers and password-protected data storage that was accessible only to the research team. Considering the sensitive nature of EOL communication, emotional support mechanisms were made available. Participants could pause or terminate the interview at any point, and referrals to counselling services were offered when necessary.

### Methodological Rigour

To ensure trustworthiness, Guba and Lincoln's [24] criteria of credibility, transferability, dependability, and confirmability were applied. Credibility was strengthened through member checking, whereby transcripts and emerging themes were returned to participants to verify accuracy and resonance with their experiences. Thick descriptions of the setting and participants supported transferability. Dependability and confirmability were established through an audit trail documenting analytical decisions, reflexive notes, and peer debriefing sessions with academic supervisors.

## Results

### Participant demographics

A total of 20 nurses participated in the study, representing a range of clinical settings, ranks, and years of professional experience. Participants included staff nurses, senior staff nurses, nursing officers, senior nursing officers, principal nursing officers, and a deputy ward in-charge. Their years of experience ranged from 3 to more than 14 years, with representation across female, male, children's, emergency, and specialized units such as the ART unit and NICU. Table 1 provides a summary of participant demographics.

Three analytically grounded themes were identified: Emotional Labour, Professional Duty, and Institutional Constraints. See from Table 2 the themes as they emerged from the data: (1) Emotional and psychological challenges in breaking bad news, (2) Professional responsibility and relational coping practices, and (3) Structural and cultural constraints shaping communication. Each

theme included several sub-themes that reflected the nuanced experiences of nurses in the study.

### Theme 1: Emotional and psychological experiences of breaking bad news

This theme captures how nurses experienced end-of-life communication as emotionally demanding relational work involving anticipatory anxiety, moral responsibility, and emotional self-regulation.

Participants described internal negotiations between professional duty and emotional vulnerability. They described breaking bad news as emotionally difficult and personally distressing. Across interviews, nurses repeatedly spoke about feeling anxious, scared, unsettled, or emotionally unprepared when tasked with communicating death or severe deterioration to families. These emotional reactions were not limited to new nurses but were also expressed by those with several years of experience. Participants also indicated that these feelings often emerged before the conversation took place and, for some, lingered afterward.

#### *Emotional burden and discomfort*

Nurses described the act of breaking bad news as "difficult," "scary," and emotionally heavy. Several participants used language that suggested an internal struggle before initiating these conversations, including feelings of nervousness, uncertainty, and emotional strain.

> *"It is mostly difficult for me. It is more like a burden on me. So mostly when I am about to do it, I feel so anxious… am I going to do it right?" (P1).*
> *"Death in itself is scary. To be in a position where you must inform someone about losing a loved one is not always easy." (P16).*
> *"I feel my heart racing every time I have to tell a family that their loved one has passed." (P4).*
> *"Even after years on the ward, I sometimes feel like I'm not prepared emotionally." (P9).*

#### *Fear of family reactions*

In addition to their own emotional discomfort, participants frequently expressed concern about how families would respond to bad news. Nurses described anticipating negative reactions, including blame, disbelief, and physical or verbal confrontation. This anticipation contributed to heightened tension during these encounters.

> *"Families blame us, especially when they do not expect the death. It is draining." (P2).*
> *"The woman wanted to beat me that day… I had to run away." (P16).*
> *"Sometimes families refuse to accept what I am telling them, and it makes me so tense." (P5).*

### Theme 2: Professional responsibility and relational coping practices

Nurses described breaking bad news as a task they were expected to perform as part of their professional role, even when it caused emotional discomfort. Alongside this sense of responsibility, nurses described different ways they tried to manage the task, including preparing themselves, involving others, and finding moments to regulate their own emotions after difficult encounters.

#### *Sense of professional duty*

Nurses repeatedly stated that they felt obligated to carry out these conversations, regardless of how emotionally difficult they were. Some participants described this responsibility as unavoidable, especially those in senior or supervisory roles.

> *"We are humans… but the job must be done." (P8).*
> *"Personally, I felt that way, but I do not have a choice… if your staff cannot do it, then it falls on you because you are the 'in-charge'." (P13).*
> *"Even when I dread it, I know I must inform the family because it is my responsibility." (P3).*

#### *Preparation and information gathering*

Some participants described preparing themselves before initiating these conversations. This preparation involved reviewing patient information and gradually engaging families before death occurred. Nurses explained that this process helped them feel more confident and better able to respond to questions.

> *"…Usually, before the person passes on, we engage the families on the prognosis… I build on what they already know." (P2).*
> *"I check the patient file thoroughly and think about how to explain things without causing panic." (P11).*

#### *Collaborative approach*

Participants described involving others in the process of breaking bad news, including colleagues, doctors, and religious figures. They explained that this made the process easier and provided additional forms of support for families.

> *"We include some other team members, medical doctors and others to assist." (P9).*
> *"Sometimes there is a need to bring in some people who will help you break the news… due to their religious beliefs." (P6).*
> *"I often call on senior nurses or a chaplain to be present during these discussions." (P12).*

#### *Managing emotions*

Participants described how they tried to manage both the emotional reactions of families and their own feelings. Some nurses explained that they allowed families to express their emotions freely. Others described stepping away afterward to regain emotional composure before continuing their duties.

> *"We just allowed them to express themselves… You cannot stop them from crying." (P1).*
> *"After I break the news, I go inside the nurse's station … relax myself for a while… and then I move on." (P10).*
> *"I take a few moments in the staff room to compose myself before attending to other patients." (P7).*

### Theme 3: Structural and cultural constraints shaping communication

Participants described several external factors that made breaking bad news more difficult. These included the absence of formal training, limited institutional support, heavy workloads, and culturally shaped beliefs about death. Nurses explained that these conditions influenced how, when, and where they communicated with families.

#### *Lack of formal training and guidelines*

Most participants reported that they had not received formal education or structured training on how to break bad news or communicate at the end of life. Instead, they described learning through observation, trial and error, and personal experience.

> *"Although I have not received any formal education or training on that… I think that is one of the biggest challenges." (P6).*
> *"Formal training? No… school does not even give you that adequate training." (P12).*
> *"I had to learn on the job by watching senior nurses handle these situations." (P8).*

#### *Cultural and spiritual beliefs*

Participants explained that cultural and spiritual interpretations of illness and death affected how families received information. Some families preferred traditional or religious explanations over direct biomedical communication, complicating the nurses' role.

> *"They attribute most death to spiritual causes… they want to take the person to prayer camps or shrines." (P6).*
> *"Even if you are 120 years old and you die, people will say somebody has killed you." (P11).*
> *"Some families refuse to accept the prognosis and prefer consulting traditional healers first." (P5).*

#### *Institutional and resource limitations*

Participants also described how hospital conditions affected their ability to communicate effectively. They mentioned the absence of formal procedures, lack of privacy, and heavy workloads as major challenges.

> *"There are no laid-down procedures here to guide us, so everyone just does what they think is best at that moment." (P14).*
> *"The workload is too much, and sometimes you cannot even find the time to sit down with the family properly." (P7).*
> *"We often have to break the news in crowded wards with no privacy, which makes it very stressful." (P3).*

## Discussion

This study explored the experiences of nurses at a district hospital as they communicated with families at the end of life. Findings illustrate how ethical principles were enacted situationally within cultural and organizational contexts. They highlight three broad areas: the emotional and professional realities of communication, coping and support strategies, and barriers that shape how these interactions unfold. While many of the experiences mirror those reported globally, several context-specific features stand out, particularly the reliance on informal approaches and the influence of cultural and spiritual beliefs.

Nurses in this study described the emotional weight of breaking bad news, bearing in mind the principle of truth-telling, often reporting sadness, anxiety, and hesitation. These experiences align with reports from other countries where nurses face significant emotional strain during end-of-life communication [6, 25, 26]. As in other contexts, participants emphasized that the emotional burden often extended beyond the hospital setting, affecting their personal well-being. Additionally, some nurses in this study described communication with families as a non-negotiable part of their professional duty. Following the ethical principles of veracity, confidentiality and fidelity, nurses in this study tried to maintain effective communication at the end of life. They stated that this was not an easy task considering family expectations as well as their professional vulnerability and institutional constraints. This corroborates the findings from Rayan et al. [27], who explained that nurses perceive end-of-life discussions as a moral and professional responsibility, even when emotionally difficult. This may be because nurses recognise communication with families as an integral part of quality, ethical care rather than an optional add-on [28]. This sense of obligation reflects how professional norms in nursing often prioritise emotional endurance and self-regulation, sometimes at the expense of personal vulnerability [29].

However, significant differences emerged in the Ghanaian setting. Unlike high-income countries, where structured protocols such as SPIKES are commonly used to guide communication [10, 30], nurses in this study relied heavily on informal and reactive approaches. They often learned by observing senior colleagues rather than through formal training programs. This is similar to the outcomes of Rayan et al.'s [27] study in Jordan, which reported that 72.5% did not receive any training on end-of-life communication. This reliance on improvisation reflects systemic gaps in communication training in Ghana [16, 20]. It is further complicated by cultural norms in Ghana that discourage direct conversations about death [31]. The challenge of ensuring cultural and spiritual sensitivity and telling the truth was a dilemma for most nurses, considering the community where they found themselves. This is because in many Ghanaian communities, death is not only a biological event but a deeply social and spiritual occurrence, often associated with moral, ancestral, or supernatural interpretations [32]. Therefore, knowing the perception surrounding speaking about death within the community and the need to communicate at this crucial moment in the life of a patient and family brought emotional stress to these nurses. These findings suggest that while the emotional burden and sense of duty are universal, the absence of structured training and the presence of cultural taboos create additional challenges for Ghanaian nurses.

Participants described a range of coping strategies that helped them manage the stress of end-of-life communication. Preparation, such as reviewing patient records and engaging families in advance, helped build confidence and made conversations more manageable. Similar strategies have been reported elsewhere, where preparation is associated with more effective communication and reduced stress [33, 34]. Nurses also emphasised collaboration with colleagues, doctors, and, notably, religious leaders. This teamwork helped to share the emotional burden and provided families with holistic support. Informal peer support and personal strategies, such as stepping away briefly after a difficult encounter, were also common, echoing findings from recent studies that highlight the value of collegial support and self-care practices in helping healthcare professionals manage the emotional demands of end-of-life communication [25, 34]. These strategies illustrate that coping was not only individual but also relational and socially embedded, relying heavily on communal forms of support rather than formal institutional mechanisms.

What stands out in the Ghanaian context is the strong role of religion and spirituality. Nurses described involving clergy or other spiritual figures when families expressed strong religious beliefs, both to ease their own stress and to help families cope. This reflects the central role of spirituality in Ghanaian understandings of illness and death, as noted by Osei et al. [11] and Dartey et al. [5]. In contrast to high-income countries, where structured debriefing or counselling services are often available [35], Ghanaian nurses appear to compensate for the lack of institutional support with communal and faith-based approaches [11]. Spiritual engagement served not only as emotional support but also as a culturally legitimate way of making sense of death, legitimising loss, and restoring social meaning [32].

Nurses identified several barriers that hindered effective communication, many of which are consistent with global literature. The most prominent was the lack of formal training and guidelines, with participants noting that they had learned primarily on the job. Similar gaps have been reported elsewhere [5, 36],however, in high-income settings, some formal frameworks exist to guide practice. The absence of structured training leaves nurses to depend on observation and instinct, which contributes to inconsistencies and reactive communication.

Nurses' commitment to truth-telling was frequently negotiated in practice when families appeared emotionally unprepared to receive information about impending death. In such situations, participants described delaying explicit disclosure or involving senior colleagues or clergy, reflecting a contextualised interpretation of beneficence and cultural sensitivity. Participants further described hostile family reactions, ranging from denial and blame to overt aggression. These responses are consistent with global findings that families often struggle to process bad news [37, 38], but the level of aggression reported in this study appears particularly pronounced, with some nurses facing verbal threats or physical confrontation. Such experiences not only intensified emotional stress but also discouraged nurses from taking on communication responsibilities.

Families frequently attributed death to supernatural causes rather than biomedical explanations, a finding consistent with Osei et al. [11], who observed similar patterns in Ghana, and Paterson & Maritz [12]. who reported that families in African palliative settings often interpret terminal illness through spiritual or supernatural beliefs. Nurses reported that this forced them to balance truth-telling with cultural sensitivity, often improvising to avoid conflict. This negotiation reflects a broader ethical tension between Western biomedical norms of transparency and local moral systems that prioritise harmony, protection from emotional harm, and spiritual coherence [39]. Additionally, institutional constraints further complicated ethical practice. Similarly, ethical tensions were linked to family blame or aggression, cultural interpretations of death, lack of institutional protocols and absence of privacy in hospital wards in the study setting. These findings highlight ethics as embedded within

organizational structures rather than individual decision-making alone.

### Implications for policy

The findings of this study underscore the need for institutional policies that support nurses in end-of-life communication. Hospitals should develop clear guidelines and standard operating procedures for delivering bad news, addressing family reactions, and involving multidisciplinary teams in end-of-life care. Such policies could formalize collaboration between nurses, physicians, spiritual leaders, and social workers, ensuring consistent and culturally appropriate communication. Additionally, policies should mandate mechanisms for emotional and professional support, such as debriefing sessions, peer mentoring, or counselling services, to reduce emotional exhaustion and moral distress among nurses. Ensuring adequate staffing and creating private spaces for sensitive conversations are also essential policy priorities.

### Implications for education

This study highlights gaps in formal preparation for nurses regarding end-of-life communication. There is a clear need for structured educational programs that combine theoretical knowledge with practical skills, including role-play, simulations, and case-based learning. Training should cover core ethical principles such as autonomy, veracity, beneficence, and confidentiality, as well as culturally and spiritually sensitive communication strategies relevant to Ghanaian communities. Integrating such education into nursing curricula and continuing professional development programs can equip nurses with the confidence and competence to manage emotionally challenging situations. Targeted workshops on coping strategies, emotional regulation, and family engagement can further enhance professional readiness and resilience in end-of-life care.

### Implications for clinical protocols

Clinical protocols must reflect both ethical standards and the realities of care in Ghanaian district hospitals. Protocols should guide the structured involvement of multidisciplinary teams, ensuring collaboration with doctors, nurses, spiritual leaders, and social workers during end-of-life discussions. They should also integrate cultural considerations, balancing truth-telling with sensitivity to family beliefs and community norms. Clear documentation practices, including recording the content of communications and family responses, can provide continuity of care and reduce miscommunication. Protocols should also specify supportive measures for nurses, such as scheduled reflection or debriefing periods, to maintain well-being and professional performance.

### Strengths and limitations

This study provides an in-depth understanding of how nurses in a district-level hospital in Ghana experience and manage end-of-life communication. A major strength lies in its focus on a context that is often underrepresented in the literature, where cultural norms and limited institutional support strongly shape care delivery. The use of subjective experiences and interpretations approach allowed rich and authentic narratives to emerge, giving voice to nurses who frequently face emotional and ethical challenges in silence. The nurses had the opportunity to describe what their construction of meaning was to communication at the end-of-life. The inclusion of participants from multiple wards, including emergency, medical, and surgical units, enhanced the diversity and transferability of the findings within similar hospital settings.The use of reflexive thematic analysis enabled the identification of patterned meanings across nurses' accounts while acknowledging the interpretive role of the research team.

However, the study also has some limitations. It was conducted in a single district hospital, which may limit the transferability of the findings to other regions or higher-level facilities with different resources and organizational structures. Self-reporting during interviews could have introduced social desirability bias, as participants may have downplayed mistakes or negative emotions. Additionally, cultural sensitivity around discussions of death may have constrained how openly some participants spoke about their experiences. Despite these limitations, the study offers valuable insights that can inform the development of training programs and institutional policies to improve end-of-life communication in similar contexts.

### Conclusion and recommendations

This study highlighted the emotional, cultural, and institutional challenges nurses face when communicating with families during end-of-life care. Nurses recognise these interactions as a core part of their professional role, yet often lack structured guidance, institutional support, and formal training. Cultural taboos around death and limited resources within the hospital further constrained open communication. Despite these challenges, nurses relied on personal faith, teamwork, and self-developed coping strategies to fulfil their duties compassionately.

To strengthen end-of-life communication, hospitals should prioritise continuous education and structured training that equips nurses with communication and emotional management skills. Institutional policies should also provide clear guidelines and psychological support mechanisms to help nurses navigate these sensitive interactions. Encouraging open dialogue about death and dying within healthcare settings can gradually

shift cultural attitudes and improve the quality of care for patients and families. Further research involving other cadres of health professionals and different levels of hospitals could deepen understanding and guide the development of context-specific interventions.

### Relevance to clinical practice

The findings show that it is not rare for nurses to have emotional and psychological challenges when communicating, especially with clients' families at the end of life. The study emphasises the need for regular training to address pertinent issues such as communication at the end of life.

Strategies adapted by these nurses could be a cue to enable others to handle the effects on their mental well-being.

## What this study adds:

- Most nurses learn how to communicate on end-of-life issues during practice. This aspect of nursing needs more demonstration and emphasis on the ethical principles and how to navigate dilemmas during training.
- Death is a complex subject to talk about in some cultures; however, nurses must find a way around it in the process of caring for patients and families.
- Nurses as caregivers are not immune to emotions during end-of-life communications; however, they must adhere to the ethical principles such as cultural and spiritual sensitivity, veracity, autonomy, beneficence and fidelity.

### Abbreviations

EOL End-of-Life
ART Antiretroviral Therapy
NICU Neonatal Intensive Care Unit
SNO Senior Nursing Officer
PNO Principal Nursing Officer
RN Registered Nurse

## Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12910-026-01437-z.

Supplementary Material 1.

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### Authors' contributions

P.A. and P.Y.A.A. conceived the study. P.Y.A.A. supervised the work. L.A.O. provided expert guidance. W.O.K., P.A. and P.Y.A.A. drafted the initial manuscript. All authors contributed to and read the final manuscript.

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### Data availability

The data supporting the findings of this study are available from the corresponding author upon reasonable request.

## Declarations

### Ethics approval and consent to participate

The study adhered to the Declaration of Helsinki. Ethical approval for this study was obtained from the Ghana College of Nurses and Midwives Academic Board and the Institutional Review Board of the Kwame Nkrumah University of Science and Technology (KNUST IRB) (Approval Number: CHRPE/AP/210/25). Written informed consent was obtained from all participants after providing detailed explanations of the study's purpose, voluntary participation, and right to withdraw at any point without penalty. Confidentiality and anonymity were maintained through coded identifiers and password-protected data accessible only to the research team. Given the sensitive nature of end-of-life communication, emotional support mechanisms were made available, allowing participants to pause or terminate the interview at any time. Referrals to counselling services were offered when necessary.

### Consent for publication

Not applicable.

### Competing interests

The authors declare no competing interests.

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## Publisher's Note