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Experience of Chinese intensive care unit nurses in resuscitating terminally ill patients: An Ethnographic study

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Research Article

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Abstract

Objective

To explore the inner experience of intensive care unit nurses in resuscitating terminally ill patients under the cultural background of traditional Chinese ideas.

Methods

A field survey was conducted on intensive care unit nurses using the focused ethnographic research method. Using purposive sampling method, 14 intensive care unit nurses were selected as the research subjects, and participatory observation, semi-structured interviews, and informal interviews were conducted. The data was analyzed using the Spradley's ethnographic analysis method.

Results

A total of 4 themes and 16 subthemes were extracted: (a) Ethical decision making and execution pressure (Helplessness and moral Dilemma under cultural conflict; The execution pressure of ineffective recovery; Role tension in agency decision-making); (b) Realistic difficulties faced in resuscitate efforts (Family members have strong emotional reactions; Family members grievance and question medical staff; The psychological pressure brought by communication; The dual dilemma of personnel shortage and filial piety pressure; Perception of life and emotional tearing sensation; Career value challenge under the expectation of filial piety); (c) Positive self growth in resuscitate efforts (Professional competence and self-efficacy enhancement; Optimization and improvement of communication methods; Team collaboration and peer support; Reduced compassion and relief towards the blame from family members); (d) Hope for support (Support for staffing resuscitate personnel; Resuscitate equipment support; Emotional understanding and psychological support).

Conclusions

In the context of Chinese culture, intensive care unit nurses experience complex and profound inner experiences while resuscitating terminally ill patients. Understand the complexity of Confucian filial piety and ethics, and construct a holistic nursing model that balances cultural values, patient dignity, and nurse professional well-being to address ethical dilemmas in Chinese intensive care units.

Introduction

The intensive care unit (ICU) is a department in hospitals that focuses on the treatment of critically ill patients. Patients are often in critical condition, have high uncertainty in prognosis, and are often in a state of being unable to make independent decisions. The diagnosis, treatment, and care of patients are

mostly led by their family members, making the ICU one of the most concentrated medical scenarios for end-of-life decision-making, cultural conflicts, and nurse professional pressure[1]. Nurses, as the executors of clinical work in the ICU, are fully involved in communication, disease notification, end-of-life care, and other work. They are the direct bearers of medical decision-making and ethical conflicts, and their professional experience and psychological state are easily influenced by the attitude of family members towards treatment.

In Chinese traditional culture, filial piety is regarded as one of the most important virtues for offspring[2]. The concept of filial piety has been deeply integrated into the value system and behavioral logic of the people, becoming the core standard for judging the moral conduct of children in society. Under the influence of this concept, family members of patients often show a strong willingness to seek treatment when their family members are ill. In addition, some family members have limited understanding of death. They often consider the presence of heartbeat as if the patient is still alive[3, 4]. Compared to the cultural environment in the West, death education in China started relatively late, which to some extent affects the rational understanding of death in the cultural environment[5]. This persistent attitude towards life, coupled with the pressure of public opinion when giving up treatment[6], may them often have high expectations of medical staff, hoping that they will do their best to resuscitate the patient's life.

However, in reality, in some cases, reducing or avoiding ineffective resuscitate measures can not only effectively reduce the waste of medical resources, but also improve the quality of patient death to a certain extent, allowing patients to pass away in a more peaceful and dignified manner in the final stage of life[6]. The current modern critical care medical system follows the rational principle of putting quality of life first, with patient prognosis, quality of life, and rational utilization of medical resources as the core diagnosis and treatment basis, advocating rational medical concepts such as palliative care[7]. At the same time, family members' high expectations for medical outcomes, lack of understanding of medical decisions, and negative emotions arising from ineffective resuscitation can easily lead to communication barriers between nurses and patients, legal disputes, and verbal conflicts. It often brings heavy work pressure to ICU nurses, even in the face of hopeless resuscitate, nurses still need to continue to invest energy and remain physically and mentally exhausted for a long time[8], which may put medical staff in a moral dilemma and make it difficult to find the appropriate balance between respecting family members' wishes and adhering to medical principles.In the legal and cultural context of China, giving up treatment is highly likely to trigger a series of thorny ethical conflicts[6]. When focusing on the special medical scenario of ICU, the promotion and implementation of abandoning treatment face many difficulties[6].

At present, research on the occupational stress and ethical dilemmas of ICU nurses mainly focuses on universal aspects such as work intensity and nurse patient communication, neglecting the cultural roots of Chinese Confucian filial piety culture. Ethnographic research can focus on local cultural contexts, delve into the medical behaviors and nursing needs of specific cultural groups, and reveal the impact of situational factors on nursing work[9]. It is an adaptive research method for analyzing such cultural and

medical conflicts. In summary, the Confucian filial piety culture and the strong willingness of family members to receive treatment, shaped by various reasons, have become important local cultural factors affecting the professional experience, mental health, and career development of ICU nurses in China. Therefore, this study takes ICU as the investigation field, based on the traditional Chinese filial piety culture background, and adopts ethnographic research methods to explore the impact of family members' ultimate willingness to treat on ICU nurses' work experience, providing practical basis for optimizing the ICU practice environment, resolving local conflicts, and improving the critical care humanistic nursing system.

Methods

Design

This study adopts an ethnographic research design, due to the emphasis on long-term and in-depth observation and participation of cultural groups in natural environments in ethnographic research[9], it is suitable for understanding nursing practices in specific cultural contexts. The Confucian filial piety in this study, as a deep cultural structure, permeates into the treatment decisions of family members and the professional practice of nurses. Therefore, this study focuses on phenomena within the specific cultural unit of ICU, aiming to gain a deeper understanding of how ICU nurses shape their rescue experience for end-stage patients in the context of Chinese culture.

Setting and Participant

The data collection work was carried out in the ICU ward of a tertiary comprehensive hospital in Liaoning Province, China. The hospital has a large scale and a large number of ICU inpatients, making it the department with the highest frequency of end-of-life resuscitate and possessing rich research contexts. Therefore, this hospital was chosen as the research site.

By using purposive sampling and following the principle of maximum differentiation, to ensure the diversity in participants' age, gender, education, and years of work experience. The inclusion criteria include (1) Having obtained the nursing professional certificate.(2) Working in the ICU. (3)Nurses with resuscitation experience. Exclusion criteria include (1) Student nurses. (2) Nurses who were not on duty during the study period.

Researcher role

The interviewer is a female nursing graduate student who has obtained the English CET-6 and nursing qualification certificate, and has received systematic training in qualitative research methodology. And has a dual identity as a student nurse and a researcher from November 2025 to January 2026. The identity of a nurse helps to gain a deeper understanding of the scene and gradually establish a trusting

relationship with the nurses. And in the process of data collection, the researcher clearly informed the nurses that I am currently a researcher, and the answers to the interview will not have any impact.

Data Collection: Participatory observation

Researchers conducted a 3-month participatory observation of ICU nurses in the natural setting of the ICU ward, delving into their nursing work through repeated descriptive observation, focused observation, and selective observation. Complete field notes within 24 hours after observation.

Data Collection: Semi-structured interview

The researcher was the main research instrument. Based on the research purpose and literature review, the research team discussed and drafted a preliminary interview outline. Three participants were selected for pilot interviews, and combined with the results of the pilot interviews, experts in the relevant field jointly discussed and further revised the outline. The final content is as follows: 1. What are your main experiences and feelings of resuscitate since working in the ICU? 2.What did you gain from the resuscitate experience? 3.What is the collaboration style between you and your colleagues when resuscitating patients? 4. Have you noticed in your work that some family members have a strong willingness to treat terminally ill patients, and what impact has this had on the resuscitate work? 5. How do you feel after successfully or unsuccessfully resuscitating terminally ill patients?

Before conducting the interview, the researcher introduces the interview process to the research subjects and records it with their consent. The first author conducted semi-structured interviews in a face-to-face manner in the nurse duty room. Another researcher observed and recorded nonverbal information such as the participant's tone, facial expressions, and changes in body movements in detail, and questioned or supplemented key content if necessary.

Data Collection: Informal interviews

While conducting participatory observation and semi-structured interviews with nurses, with their consent, researchers also engage in informal conversations during their free time. The sense of restraint during formal interviews is eliminated through daily private conversations. Nurses are allowed to express their true thoughts in a relaxed state, and field notes from informal interviews are added on the same day after the conversation ends. Thus improving the richness and authenticity of research data.

Data analysis

The data analysis and data collection work are carried out synchronously. Researchers organize interview recordings and on-site observations into written materials, number each participant, and repeatedly read the written materials. To ensure the accuracy and reliability of the analysis, two researchers conducted coding work separately and jointly developed preliminary coding. During this

process, researchers continuously reflect on potential biases, their own positions, emotional responses, and potential impacts on data collection and interpretation, in order to avoid imposing subjective biases on participants' experiential narratives. Resolve differences in a timely manner through continuous discussion. Finally, summarize and organize the core cultural themes. In addition, researchers conducted member checking by inviting respondents to review whether the topic reflected their intended meaning.

Rigor

In the research design phase: The researchers conducted a systematic literature review to clarify the methodological positioning of this study and avoid duplication or deviation of research questions. Before the formal field work began, the researchers familiarized themselves with the department's work pace, personnel structure, and established preliminary trust relationships with nurses. At the same time, pilot interviews were conducted, and then modified the interview outline based on the interview results and research group discussion results to determine the final interview outline, ensuring that the interview outline can cover the questions of this study and create favorable conditions for the development of formal field work.

In the data collection stage: Researcher, as both student nurse and researcher, gain a deep understanding of the working environment of ICU nurses. The data collection is conducted through a combination of observation, semi-structured in-depth interviews, and informal interviews to ensure the credibility of the research. In terms of observation data collection, researchers immediately record after the observation is completed to ensure the immediacy and completeness of the observation records.The interview location is generally chosen in the lounge to ensure that the room is quiet, comfortable, and undisturbed, and to proceed smoothly. During the interview, do not interrupt the interviewee's response and provide appropriate responses if necessary. And record the interviewee's movements, facial expressions, and make interview notes.

In the data analysis stage: After the interview, two researchers promptly transcribed and

reviewed the interview data and maintained an open and inclusive attitude, constantly

reflecting on whether their personal values and identities had any potential interference or

impact on the research results.

Results

Participant Characteristics

A total of 14 participants were included in this study. After interviewing the 11th participant, the collected information has reached theme saturation without any new themes appearing[10]. The age range of these participants is 22 to 49 years old, with 11 females and 3 males. They are all ICU nurses

with work experience ranging from 1 to 27 years. Among the 14 participants, 12 have the bachelor's degree.The demographic characters of the participants have been presented in Table 1.

Table 1
Demographic characteristics of the participants

ID	Age (years)	Gender	Degree of education	Working years	Position
1	47	Female	Bachelor’s degree	27	Associate Chief Nurse
2	42	Female	Bachelor’s degree	19	Supervising Nurse
3	33	Female	Bachelor’s degree	13	Supervising Nurse
4	26	Female	Bachelor’s degree	1	Nurse
5	23	Female	Associate degree	1	Nurse
6	49	Female	Bachelor’s degree	23	Associate Chief Nurse
7	44	Female	Bachelor’s degree	17	Associate Chief Nurse
8	43	Female	Bachelor’s degree	20	Supervising Nurse
9	38	Female	Bachelor’s degree	13	Senior Nurse
10	28	Female	Bachelor’s degree	8	Supervising Nurse
11	29	Male	Bachelor’s degree	6	Senior Nurse
12	37	Male	Bachelor’s degree	12	Supervising Nurse
13	39	Female	Bachelor’s degree	15	Supervising Nurse
14	22	Male	Associate degree	1	Nurse

Key themes

Table 2 shows the themes and subthemes formed based on the interview results.

Table 2
The themes and subthemes

Themes	Subthemes
(a) Ethical decision making and execution pressure	Helplessness and moral Dilemma under cultural conflict
	The execution pressure of ineffective recovery
	Role tension in agency decision-making
(b) Realistic difficulties faced in resuscitate efforts	Family members have strong emotional reactions
	Family members grievance and question medical staff
	The psychological pressure brought by communication
	The dual dilemma of personnel shortage and filial piety pressure
	Perception of life and emotional tearing sensation
	Career value challenge under the expectation of filial piety
(c) Positive self growth in resuscitate efforts	Professional competence and self-efficacy enhancement
	Optimization and improvement of communication methods
	Team collaboration and peer support
	Reduced compassion and relief towards the blame from family members
(d) Hope for support	Support for staffing resuscitate personnel
	Resuscitate equipment support
	Emotional understanding and psychological support

Theme 1: Ethical decision making and execution pressure

Helplessness and moral Dilemma under cultural conflict

Family members often expect medical staff to do their utmost to provide treatment out of deep care and filial piety towards their relatives. When family members are informed their relatives' death, the bond of familial affection makes it difficult for them to let go of their grief, and sometimes even difficult to accept this cruel reality. The difficulty of letting go of this emotion has plunged the family into deep pain. Faced with such strong emotional appeals, nurses deeply understand that they cannot refuse. Even when faced with medical conditions that have no hope of treatment, it is difficult to go against the wishes of family members.

I just feel that it's still the filial piety of family members, that they can't bear to give up on their relatives. Ah, that's how I feel (Participant 3)

They also know about it, but it's just the kind of emotions that family members have. They can't let go, but in fact, the doctors have repeatedly explained that it's meaningless. (Participant 7)

The execution pressure of ineffective recovery

In clinical practice, some resuscitate measures are no longer beneficial to patients and may even cause waste of medical resources. ICU resources are limited, but family members often insist on implementing certain ineffective resuscitate measures due to emotional factors, which conflicts with the professional judgment of medical staff based on the condition. Faced with strong demands from family members, medical staff find it difficult to refuse directly.

I have had a patient who underwent cardiopulmonary resuscitation for over two hours, well, (the family members) did not give up. (We) are aware that (the patient) cannot be resuscitated, and then waste some manpower and material resources. Our manpower, material resources, and financial resources will actually be wasted, but the family members do have that intention. We cannot say that we have violated the will of the family members. We still need to resuscitate them. Since every family member refuses to give up, we need to resuscitate them. (Participant 8)

Role tension in agency decision-making

When the strong will of family members is inconsistent with the professional judgment of the medical team, nurses often face questioning from family members when making decisions. Although these decisions are based on the best interests of the patient and medical standards, family members may develop resistance due to their inability to accept them. If family members are dissatisfied with the decision results, it can easily lead to medical disputes.

To be honest, sometimes we all know in our hearts that resuscitate is meaningless, but if we don't resuscitate, the family will definitely question you. Once the patient dies, the family will sue you in return, leading to legal disputes.(Participant 1)

Theme 2 Realistic difficulties faced in resuscitate efforts

Family members have strong emotional reactions

Family members often have strong emotional reactions when facing resuscitate results. When the resuscitate is successful and the family is immersed in joy, this emotion is easy to handle. However, when resuscitate fails, family members are usually emotionally agitated.

If it's successful, of course the family members will be quite happy. If they can't be resuscitated, the emotions of the family members must be quite agitated.(Participant 6)

Family members grievance and question medical staff

In some failed resuscitate cases, family members sometimes vent their grievances on medical staff and even seriously question their abilities and levels. This intense emotional fluctuation also brings tremendous psychological pressure to nurses. Nurses need to maintain their professional calmness while comforting the emotions of their families, which is undoubtedly a highly challenging task.

There's definitely pressure because of the family's strong desire to resuscitate the patient. We're afraid that if we can't resuscitate them, the family member might react very strongly emotionally and direct their anger and resentment at the medical staff, possibly with harsh words or other behaviors. (Participant 6)

Family members do express doubts, such as questioning the treatment plan, questioning nursing measures, emotional agitation, and verbal agitation. Well, there will be. (Participant 9)

Family members will be very agitated, and their language can become quite agitated. Well, sometimes they question whether we've done everything we should have. (Participant 10)

The psychological pressure brought by communication

When facing patients with low hope of successful resuscitate, how nurses communicate with their families and inform them of possible outcomes becomes a highly challenging task. Nurses need to respect the family's right to know while avoiding excessive panic, which is a difficult and complex task that requires nurses to possess excellent communication skills and resilient psychological qualities.

We can understand the feelings of many family members, but there may be some difficulties in communication, which can also cause us a lot of psychological and work pressure. (Participant 9)

The dual dilemma of personnel shortage and filial piety pressure

Under the influence of Confucian filial piety culture, there is a contradiction between the cultural expectations of family members and the actual manpower allocation in the ICU.Due to the highly unpredictable changes in the condition of terminally ill patients, the existing nursing workforce often cannot meet the culturally amplified medical needs when dealing with emergency resuscitation needs due to the limited number of staff. The shortage of manpower has increased the workload and psychological pressure of medical personnel, which is further amplified under the influence of filial piety.

There isn't enough manpower, it's very urgent, and there isn't enough manpower yet. And then the collaboration process becomes even more urgent. Well, sometimes during night shifts or sudden emergencies, not all personnel may be present (Participant 2)

Perception of life and emotional tearing sensation

The strong expectations of family members make ICU nurses not only face the fragility and unpredictability of life itself when rescuing terminally ill patients, but also endure intense emotional tearing between the "filial piety demands of family members" and the "terminal reality of medicine". For

some special patients, nurses develop a complex emotion of awe, regret, and powerlessness towards life, while also replicating the sadness and despair of the patient's family, generating strong empathy.

I would feel very sorry, life is very fragile. (Participant 10)

It may be a bit more complicated, or for example, the patients may have hospitalized there for a long time and then developed some feelings for them, and then passed away (Participant 11)

From the bottom of my heart, I feel quite regretful. There used to be a 6-year-old child who was hit by a car in a car accident. At that time, well, it was quite a few years ago. I administered the injection to him, and I felt very reluctant. Even when his family members cried, I cried too. (Participant 7)

If the resuscitate is successful, I feel very happy, especially if the patient is young and has fewer underlying diseases. If they are resuscitated, I will feel a great sense of achievement and feel that it is good to help this person resuscitate their life. But if they can't be resuscitated, I will also feel quite disappointed, thinking that the patient is quite young and suddenly passing away. It will also be quite disappointing. (Participant 8)

Career value challenge under the expectation of filial piety

In medical practice, in some cases, the situation is very serious, and even with full resuscitate efforts, it cannot meet the expectations of the family. There is a huge gap between cultural expectations and medical reality. At this moment, nurses feel that their professional values have been severely impacted. They cannot resuscitate the patient or persuade the family. A sense of powerlessness and moral dilemma surged in their hearts

Success is definitely enjoyable, but when it comes to failure, sometimes I feel uncomfortable. But this kind of thing is not something that a nurse can do. The patient cannot be resuscitated, so there is no way (Participant 2)

Actually, for some patients, (resuscitate) has no meaning at all, but their families are saying, 'Oh, I beg you to come and resuscitate him.' Actually, it doesn't make any sense at all, but from the bottom of our hearts, we feel like we're powerless to turn things around. (Participant 7)

Theme 3: Positive self growth in resuscitate efforts

Professional competence and self-efficacy enhancement

When nurses successfully complete resuscitation in high-pressure situations, their hearts are filled with a sense of achievement, which not only stems from technical success, but also contains a deep value confirmation of "responding to the filial piety expectations of family members". Make them deeply feel the meaning of their work and become more confident in their professional abilities. At the same time, in the process of recovery work, nurses often face strong willingness from family members for treatment, even anger, questioning, and blame, faced with this pressure, they transform it into positive and uplifting motivation.

I feel a sense of achievement when I successfully resuscitate the patient. (Participant 7)

There will be a great sense of achievement and satisfaction (when I successfully resuscitate the patient), so to speak. (Participant 3)

Well, there may be pressure, but turn it into motivation. (Participant 11)

Optimization and improvement of communication methods

In ICU nursing work, when faced with strong emotional fluctuations caused by grief and anxiety, as well as doubts about medical decisions and nursing measures, ICU nurses will actively explore effective communication methods and skills to gain the trust of patients' family members.

Mainly communicating with the family members, using more professional medical and nursing methods to communicate with them, and making them trust us. (Participant 9)

Team collaboration and peer support

Under the expectations amplified by filial piety and the pressure of insufficient personnel. The teamwork ability among nurses is constantly improving to meet the technical needs of resuscitation tasks and better respond to resuscitation efforts.

The charge nurse can help, and then call other nurses in the same group. Well, each doctor can try to call as many people as possible to cooperate with the resuscitate and ensure the safety of the patient's life as much as possible (Participant 2)

It's based on the patient's different urgent and critical conditions, and then, well, I know what medication should be used accordingly, so I have a better understanding of this aspect. Then various resuscitate skills, such as cardiopulmonary resuscitation, will be more perfected and understood. (Participant 5)

If there is resuscitate during work, everyone will help each other. That is to say, if there is a resuscitate situation for a patient who is not under one's own management, everyone will arrive at the bedside where the patient is being resuscitated as soon as possible, and then cooperate by handing over various things, injecting medication, recording various things, and collaborating at the same time (Participant 6)

Reduced compassion and relief towards the blame from family members

When the resuscitate is successful, nurses and their families feel happy together, but when the resuscitate fails, nurses and their families also fall into grief. Sometimes, when the resuscitate results are not satisfactory, family members sometimes blame the nurse. However, as working experience

accumulate, after long-term clinical practice and self reflection, this emotional fluctuation gradually creates a sense of peace among nurses, they gradually became able to view family blame with a sense of relief.

At that moment, I feel a bit regretful, but we have encountered many of them, so I gradually adjusted myself and can adapt. (Participant 3)

The verbal blame, blame it, it's not our fault. We will do our best to do this thing well, which is worthy of our work. (Participant 8)

Theme 4 Hope for support

Support for staffing resuscitate personnel

In some special situations such as night shifts or hospitalization with a large number of patients, the number of personnel involved in the resuscitate process may be relatively insufficient, which may lead to an increase in the workload and internal pressure of medical staff or affect the results of the resuscitate.

It may be one person on duty, but occasionally in such resuscitate situations, there may not be enough personnel. (Participant 6)

Resuscitate equipment support

Equipping medical personnel with advanced equipment such as cardiopulmonary resuscitation machines can significantly reduce their physical load when facing high-intensity and challenging resuscitation work, allowing them to focus more on precise operations and communication with family members, and improve the efficiency and quality of resuscitation.

The hospital's support is to provide us with some resuscitate equipment that can reduce the physical strength of the nurse Sometimes (nurses) help with cardiopulmonary resuscitation, and now we also have cardiopulmonary resuscitation machines that can reduce the workload (of nurses). (Participant 6)

Emotional understanding and psychological support

Engaged in high-intensity and high-pressure resuscitate work for a long time, ICU nurses work in a high-intensity and high-pressure environment. In this situation, healthcare workers crave emotional support and understanding. They are eager to implement a flexible scheduling system, so that they can take appropriate breaks during busy work breaks and continue to devote themselves to work with a more full mental state.

Hospitals provide care to doctors and nurses, well, psychologically. (Participant 7)

Flexible scheduling at work allows us to relax and rest both physically and mentally. (Participant 9)

Discussion

Influenced by the traditional Confucianism of filial piety in China, or insufficient understanding of the condition, family members often insist on implementing certain treatment measures that are not beneficial or even harmful to the patient, which conflicts with the decisions made by nurses based on professional judgment. Even if nurses have made ethical decisions, they may still face many difficulties and risks during the execution process. Meanwhile, in the context of Confucian Familism culture, the model of shared decision making between medical staff and patients is weakened, and medical staff usually discuss treatment plans with the patient's family members rather than the patient themselves, which is different from the emphasis on the patient's right to independent information in Western culture[11]. Research shows that 34.4% of ICU nurses consider unrealistic expectations for treatment from family members as an important source of stress[2]. 72% of Chinese doctors believe that obtaining a do not attempt resuscitation (DNAR) poses significant difficulties[12]. At present, China has not yet introduced relevant special laws. Although most large-scale hospitals have ethics committees, they typically do not directly participate in the ethical decision-making process for terminally ill patients[6]. Therefore, when medical staff terminate meaningless resuscitate based on professional judgment, they may face social public opinion pressure and even be questioned for medical accidents, murder, or violating professional ethics of saving the dying[6]. This reality dilemma leads medical staff to be forced to continue treatment even when they realize that resuscitate is meaningless, due to concerns about ethical and legal risks.Therefore, the principle of "selecting patients who may benefit from intensive care" in the Chinese ICU admission guidelines is difficult to truly implemen[13]. At the practical level, the establishment of ethical and legal norms can provide institutional guarantees for terminating meaningless resuscitate; strengthen death education for family members, popularize end-of-life care related knowledge in advance, help family members make rational decisions at appropriate times[14], not only alleviate their grief after death, but also make it easier for them to accept nursing goals that are in line with reality[15].

The attitudes and beliefs of family members are important sources of pressure faced by ICU nurses in the process of resuscitating terminally ill patients. The specific manifestation is that family members find it difficult to let go of their emotions towards their relatives, have high expectations for the resuscitate results. When the resuscitate results are not satisfactory, family members often find it difficult to accept the fact that their relatives have passed away, and their hearts are filled with disappointment and pain, leading to strong emotional reactions, including verbal berating, questioning of medical staff, and even venting their inner dissatisfaction on nurses. Previous studies have shown that workplace violence is very common among Chinese nurses, with ICU nurses being particularly

prominent. 77.7% of ICU nurses have experienced workplace violence[16], 63.65%-71.8% of nurses have experienced non physical violence[17, 18], and 82% of nurses reported that the perpetrators was patient's family members[18]. The main reasons for this phenomenon include dissatisfaction with the treatment results, discrepancies between actual efficacy and expectations, and poor communication between medical staffs and patients[18, 19]. Faced with such situations, nurses not only have to bear enormous psychological pressure, but also need to patiently explain and communicate to eliminate misunderstandings from patients' family members Related studies have also found that compared to doctors, the communication style between nurses and family members has a more significant impact on their emotions[20]. Long term exposure to workplace violence can lead to psychological health problems such as post-traumatic stress disorder and depression among ICU nurses, which in turn can affect their family life, social functioning, and job satisfaction[19, 21]. In response to the above issues, it is recommended that ICU nurses actively learn communication skills to deal with angry and grieving family members, and invite family members to participate in prognosis discussions in advance[22, 23].

The patients admitted to the ICU ward have critical and rapidly changing conditions, and resuscitate work often needs to be carried out in a very short period of time. However, in special situations such as night shifts or a large number of patients, the personnel involved in resuscitate often find it difficult to meet actual needs. This shortage of personnel not only significantly increases the workload of medical staff, keeping them in a high-intensity work state for a long time, but also brings enormous psychological pressure. Related studies have shown that 59.4% of Chinese ICU nurses experience high levels of occupational burnout, 78.0% report high levels of stress, and 32.0% experience severe depressive symptoms[24]. Insufficient staffing and excessive workload have become key factors leading to nurse fatigue[25]. And may have adverse effects on patient treatment outcome[26, 27].

Despite facing numerous difficulties and pressures, ICU nurses have generally demonstrated a positive self-awareness of reflection and growth after multiple resuscitates. They are able to optimize team task allocation and collaboration abilities, so as to transform difficulties into valuable experience and cope with subsequent challenges more calmly. Time is tight during the resuscitate process, and team interaction is the core element of teamwork. Efficient and multidisciplinary coordination under time pressure has a significant impact on patient prognosis[28]. The retrospective mechanism in clinical work helps promote the reflective ability and feedback skills of team members, enabling nurses to continuously optimize resuscitate processes and improve patient outcomes[29].At the same time, nurses are actively exploring effective communication methods to establish patient trust. It is worth noting that ICU nurses are often able to transform various pressures faced during resuscitate into motivation for progress.

ICU nurses often experience complex emotional changes after experiencing failed resuscitation and family blame and questioning. In the early stages, there is often a strong empathetic response due to excessive emotional investment, feeling the fragility of life; as emotional involvement deepens, there may be emotional tearing and a sense of powerlessness; after experiencing such situations for a long time, an adaptive state will gradually form. This finding is highly consistent with Figley's Compassion

Fatigue Theory Model[30]. But this study further reveals the duality of "habituation" as a career survival strategy. Traditional theories often emphasize the negative effects of "fatigue", however, empathy itself is also a core source of guilt, when empathy is excessive or biased, it may lead to pathogenic guilt beliefs[31]. In addition, when emotional regulation strategies are insufficient, continuous exposure to painful situations can lead to compassion fatigue and emotional exhaustion[32]. Therefore, there is a fundamental difference between "regulated empathy" and "excessive emotional involvement"[32]. A cross-sectional survey of 992 Chinese clinical nurses conducted by Zhang et al. showed that nurses with higher empathy abilities are more likely to experience compassion fatigue[33]. And compassion fatigue can further lead to occupational burnout and decreased self-care ability[34]. Based on this, this study suggests that "habituation" may be an adaptive protective mechanism. Related studies have found that inquiry-based stress reduction interventions can significantly improve ICU nurses' awareness of death and reduce interpersonal problems[35]. Therefore, nursing managers should pay attention to the mental health of ICU nurses, and effectively alleviate negative emotions through strengthening death education and psychological counseling. At the same time, nurses should also learn to regulate their emotions and handle negative emotions properly after experiencing resuscitate failures, in order to face work and life in a better state.

Therefore, ICU nurses should support each other and work together to tackle difficulties in their work. Nursing management personnel should reasonably allocate resuscitate personnel to ensure sufficient participation in emergency situations, in order to improve the success rate of resuscitate and ensure the safety of patients' lives. Secondly, in terms of device configuration, auxiliary devices such as mechanical chest compression device can effectively reduce the physical exertion of nurses, allowing them to devote more energy to key resuscitate processes and comprehensively improve resuscitate efficiency[36]. Finally, a flexible scheduling system should be implemented and necessary emotional support should be provided to help nurses balance work and life, alleviate psychological stress, and thereby improve job satisfaction[37]. In summary, through multidimensional support such as optimizing resuscitate personnel, improving device configuration, and building emotional support systems, not only can the efficiency and quality of resuscitate work be improved, and the safety of patients' lives be guaranteed, but also the physical and mental health of medical staff can be effectively promoted, and their work enthusiasm can be stimulated.

Conclusion

This study used an ethnographic research method to explore the psychological experiences of 14 ICU nurses during the process of resuscitating terminally ill patients under the background of Confucian filial piety culture in China. Research has found that nurses undergo complex internal changes after resuscitating terminally ill patients, it includes multiple dilemmas intertwined with culture and ethics, practical difficulties faced in rescue practices, proactive response and adjustment strategies, and an urgent need for systematic support. The research results can help nursing managers gain a deeper understanding of nurses' true feelings during the resuscitate process, and develop an integrated care model that combines filial piety and dignity, and provide targeted psychological attention, ultimately

ensure the cultural values, quality of death and mental health of nurses, and promote the healthy and stable development of the nursing team.

Limitation

This study is a single center design and only includes data from one tertiary hospital, with limited sample representativeness. Multi center research can be conducted in the future to further enhance the credibility of the results.

Declarations

Ethics statement

This study has been approved by the Ethics Committee of Tieling Central Hospital, under approval number 2025-39.

Declaration of competing interest

The authors report no conflict of interests in this work.

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Author Contribution

Zhu Han: Writing – original draft, Methodology, Investigation, Formal analysis, Data curation,Conceptualization.Li Wang: Writing –review & editing, Supervision, Methodology, Formal analysis, Data curation, Conceptualization.

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Data availability statement

Research data will be shared with reasonable requests.

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