REVIEW ARTICLE

A Systematic Literature Review on ICU Nurses' Experience and Family Interactions during Death and Dying from an Islamic Perspective

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ABSTRACT

The growing complexity of death and dying in Intensive Care Units highlights nurses' critical role, particularly concerning family interactions and spiritual needs from an Islamic perspective. However, there is a gap in understanding the nuances of these interactions, how nurses can best facilitate them, and how potential conflicts arising from differing interpretations of religious beliefs may impact care; this area remains underexplored. This systematic literature review aims to synthesize existing studies on ICU nurses' experiences with critically ill patients during death and dying, focusing on Islamic perspectives or spiritual care, employing a qualitative synthesis approach. The Scopus database was used to retrieve relevant documents published between 2005 and 2024. The review followed PRISMA guidelines for identification, screening, exclusion, and inclusion. Qualitative, quantitative, mixed-method studies, and review articles were included, with only qualitative papers appraised using the Joanna Briggs Institute's criteria. Initially, 378 records were identified. After removing unavailable files and screening, 113 titles and abstracts were assessed. Of 84 reports reviewed for eligibility, 68 were excluded, leaving 14 studies that met the inclusion criteria for the final review. This review emphasizes the crucial need for better training, policies, and institutional support for ICU nurses. Such measures would enable them to manage the complexities of culturally sensitive care for family members during loved ones' death and dying. Implementing standardized guidelines addressing Islamic perspectives can significantly improve care quality and patient-family satisfaction.

Keywords:
Critical care, spiritual care, nurses, Islamic perspective, death and dying

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INTRODUCTION

Critical care nurses face challenges in integrating Islamic cultural and religious values into their practice, especially during death and dying. They work closely with patients to provide essential care, with the goal of end-of-life care, ensuring patients' final moments are peaceful, dignified, and comfortable.[1] However, achieving this goal can be difficult due to challenges in the critical care environment, such as burnout out which may lead to psychological problems for the nurses involved.[2] Nurses also face obstacles like doctors being overly optimistic about patient recovery and families not fully understanding life support measures, making communication and decision-making harder.[3] It is a common occasion for a critical care nurse to experience different kinds of emotions during caring, including sadness, anger, and frustration, as they try to provide compassionate care in emotionally charged situations.[2,4] For newer nurses, experiences such as anticipating death, witnessing the transition from life to death, supporting the family during these moments, and continuing with their duties afterwards can be incredibly challenging.[5,6]

The importance of addressing the Islamic perspective in end-of-life care is particularly pronounced due to documented cultural practice gaps and known misalignments with standard Western ICU procedures. Islamic values emphasize kindness and compassion, influencing nurses' approach in culturally diverse settings and enhancing the healthcare experience for all involved, emphasizing the importance of compassion until the end.[7]

However, healthcare providers often demonstrate a lack of knowledge regarding the specific needs and beliefs of Muslim patients and their families concerning end-of-life care, indicating a critical gap in cultural competence training for nurses. Issues regarding organ donation are also frequently mentioned, as they usually affect patients in the process of death and dying. It includes the ethical decision made by the family member and the patients themselves. Studies on death and dying processes in Islamic countries are limited due to a focus on Western contexts, indicating a lack of studies on Islamic or spiritual practices in hospital settings for nursing patients.[5]

In Islamic contexts, cultural and religious values further shape these dynamics of death and dying, often diverging from conventional hospital protocols. Practices like Qur'anic recitations, *Shahadah* (declaration of faith), and continuous family presence at the bedside are integral to ensuring a dignified death and dying and are deeply valued. Yet, these core Islamic practices can often conflict with, or be hindered by, standard ICU procedures and hospital restrictions, as evidenced during periods like the COVID-19 pandemic.[8,9] Furthermore, specific issues such as organ donation, embalming, and autopsy frequently present ethical dilemmas for Muslim families and healthcare providers due to differing religious interpretations and traditional post-mortem practices.[10] The reliance on life-sustaining technologies for religious reasons, even against clinical advice, also highlights potential areas of conflict in ICU settings.[11] Critically, spiritual care, though essential and valued in Islamic traditions, often remains neglected for critically ill Muslim patients, despite the proven benefits of Islamic spiritual practices as non-pharmacological interventions.[12]

Studies on death and dying processes in Islamic countries are limited due to a focus on Western contexts, indicating a lack of studies on Islamic or spiritual practices in hospital settings for nursing patients.[13,14] This significant gap in existing literature and the scarcity of high-quality evidence underscore the need for further research in this area.[13,14] This systematic review aims to address this critical gap by synthesizing existing studies to understand ICU nurses' experiences in dealing with critically ill patients during death and dying, specifically focusing on Islamic perspectives and spiritual care. This exploration is vital for developing culturally sensitive care models that respect and incorporate the unique values of Muslim patients and their families.

METHODS

Search strategies

This review exclusively used Scopus as its data source, valuing its high-quality, consistent, and reliable data for accurate trend and citation analysis. Scopus was chosen over other databases for its comprehensive coverage, structured information, and robust analytical tools, making it the ideal primary source for the review, which involved a detailed keyword search. The study selection process involved Scopus screening articles based on availability and relevance, assessing suitability, and selecting studies on ICU nurses' experiences, spirituality, family interactions, and death and dying, ensuring the most relevant and eligible studies were included for the systematic review.

Inclusion criteria are: i) Articles encompassing qualitative studies and mixed-method studies. However, only qualitative and mixed method papers were appraised as it is more suitable for this topic of interest; ii) Articles published in English only; iii) Studies in the ICU setting; iv) Studies related to spiritual care, religion, or the Islamic perspective; v) Articles published between 2005 and 2024; and vi) Studies pertaining to nurses and family interaction.

The exclusion criteria are: i) Articles only consisting of abstracts; ii) Studies that are outside the scope of the topic; and iii) Studies involve nursing students.

Identify Relevant Studies

Search Results

The study followed PRISMA guidelines as explained in Figure 1 below.

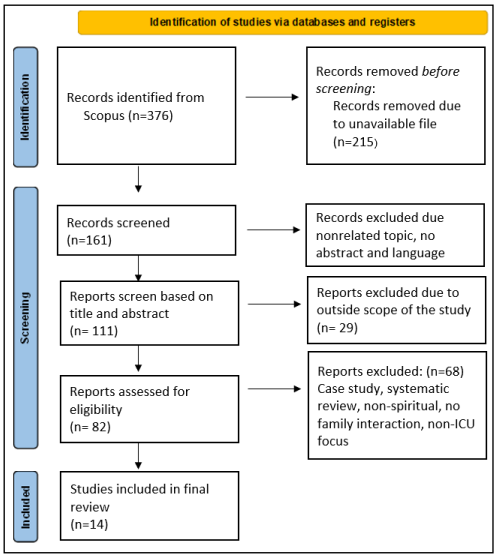

Figure 1: PRISMA flow diagram of the documents search, selection process, and reason for exclusion.

Critical Appraisal of the Sources of Evidence

Critical appraisal of papers was conducted using the JBI tool. Table I summarizes the methodological quality of included studies, allowing researchers to identify strengths and weaknesses against standardized criteria quickly. Each row specifies a research study by author(s) and publication year. Column headers represent individual criteria from a specific JBI Critical Appraisal Checklist. "Y" signifies the study met the criterion, indicating strength; "UC" means it was unclear if the criterion was met due to insufficient reporting; and "N" indicates the study did not meet the criterion, suggesting a methodological weakness or risk of bias.

Table I: JBI Quality appraisal for qualitative studies

Author (year of publication)	Individual Criteria from a Specific JBI Critical Appraisal Checklist.									
	C1	C2	C3	C4	C5	C6	C7	C8	C9	C10
Mani, (2024)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Sadeghi et al., (2016)	Y	Y	Y	Y	Y	Y	UC	Y	Y	Y
Betriana & Kongsuwan (2019)	Y	Y	Y	Y	Y	Y	UC	Y	Y	Y
Adistie et al., (2020)	Y	Y	Y	Y	Y	U C	UC	Y	Y	Y
Lima & Rosa (2008)	Y	Y	Y	Y	Y	Y	N	Y	Y	Y

In this review, the author critically appraises only qualitative data because the review was done for several justifiable reasons. Firstly, the alignment with the research question is key, as qualitative studies are best suited for exploring experiences, perceptions, meanings, or processes, and for answering "what," "how," or "why" questions. Secondly, such an appraisal is part of a qualitative evidence synthesis or systematic review, which specifically aims to synthesize qualitative findings to enhance their credibility and transferability or to complement systematic reviews of clinical trials. Lastly, the review will serve as a complementary role, providing qualitative insights to inform policy and practice without necessarily integrating quantitative measures of effectiveness or prevalence. For a comprehensive explanation of each criterion, refer to Table II, which presents the JBI Critical Appraisal Checklist.

Table II: Checklist of JBI critical appraisal

CRITE	QUESTION
C1	Is there congruity between the stated philosophical perspective and the research methodology?
C2	Is there congruity between the research methodology and the research question or objectives?
C3	Is there congruity between the research methodology and the methods used to collect data?
C4	Is there congruity between the research methodology and the representation and analysis of data?
C5	Is there congruity between the research methodology and the interpretation
C6	Is there a statement locating the researcher culturally or theoretically?
C7	Is the influence of the researcher on the research, and vice versa, addressed?
C8	Are participants, and their voices, adequately represented?
C9	Is the research ethical according to current criteria, or for recent studies, and is there evidence of ethical approval by an appropriate body?
C10	Do the conclusions drawn in the research report flow from the analysis or interpretation of the data?

Data Extraction

The standardized data extraction chart included the following information for each study: Author's year, country, study design, objectives, recruitment, and main findings, as shown in Table III.

RESULTS

Theme 1: Cultural and Spiritual Sensitivities Islamic Principles and End-of-Life Spiritual Support

Islam, the world's second-largest religion, teaches that death is a divine will and an inevitable transition to the afterlife.[15] Islamic traditions emphasize the connection between death and faith, requiring families to honour religious practices through presence, prayer recitation, and ensuring a peaceful passing in accordance with Islamic

Table III: Summary of the selected articles

No	Author (Year), Country	Design (Data Collection Method)	Phenomenon of Interest	Recruitment	Main findings
		Title: Bridging cultural gaps in end-of-life care: the experiences of international charge nurses in Saudi Arabia			
1	**Mani (2024), Saudi Arabia**	• Qualitative descriptive design • Semi-structured interview • Interview guide	To understand the unique cultural and religious considerations that shape end-of-life care practices within the Islamic context.	Eight participants who are international ICU charge nurses from different countries.	• The Weight of Unspoken Truths • Clashing Worldviews • The Family's Agony • The Burden on Nurses • Bridging the Divide • A Call for Change • The Importance of Family Presence • Honouring Faith in Absence: Peaceful and Compassionate Passings
		Title: The life meaning of the parents of the critical patient			
2	**Lima & Rosa (2008), Salvador**	• Qualitative approach • Semi-structured interview	To understand the life meaning of critical patients' relatives, in view of the Tragic Triad: guilt, suffering, and death; to identify the contents of these individuals' life meanings, based on Existential Analysis.	10 interviews were conducted, and only six of them were selected based on the content criteria.	• The existential void: unveiling the relatives' concrete situation. • The suffering: unveiling the relatives' gravity and the unconscious God • Guilt: being guided by responsibility • Death: unveiling moments of reflection • Meaning of life: unveiling the eternal file • Assistance to the critical patients' relatives: unveiling the ICU as a health care space.
		Title: Spiritual Needs of Families with Bereavement and Loss of an Infant in the Neonatal Intensive Care Unit: A Qualitative Study			
3	**Sadeghi et al., (2016), Iran**	• Exploratory qualitative study • Semi-structured interview	To explore the spiritual needs of Iranian families at the end of their baby's life and through bereavement, from families' and professional health care providers' perspectives in the NICU.	25 participants (15 interviews with family members and 10 interviews with professionals).	• Belief In a Supernatural Power • The Need for Comfort of The Soul • Preserving the Human Dignity of the Newborn.
		Title: Grief reactions and coping strategies of Muslim nurses dealing with death			
4	**Betriana & Kongsuwan (2019), Indonesia**	• Qualitative phenomenological approach • Individual interview	To describe the grief reactions and coping strategies of Muslim intensive care nurses in dealing with the death of patients.	14 ICU nurses participated. Three were male and 11 were female.	• Reactions of grief • Factors influencing grief reactions • Coping strategies
		Title: The Needs of Children with Terminal Illness: A Qualitative Study			
5	**Adistie et al., (2020), Indonesia**	• Qualitative descriptive study • Focus group and in-depth interview	To examine the needs of children with terminal illness from the perspective of nurses and parents.	15 nurses from paediatric ward, PICU and NICU. 11 parents of children with terminal illness.	• Biological needs in children with terminal disease • Psychological needs in children with terminal illness • Social needs in children with terminal illness • Spiritual needs in children with terminal illness
		Title: The Dying Process and Death of Patients with Covid-19: A Reflection In The Light of Spirituality			
6	**Silva et al., (2020), Brazil**	• Reflective article	To reflect on the dying process and death of patients with Covid-19 in the light of spirituality.	Not applicable	Understanding the sense of spirituality on the part of health professionals, in search of support for dying patients and bereaved families, is important, as spirituality can be a potential factor of integration and harmonization of interpersonal relationships.
		Title: Perinatal and Paediatric Issues in Palliative and End-of-Life Care from the 2011 Summit on Compassionate Care			
7	**Youngblut & Brooten (2012), United States**	• Review paper	To convey a summary of research on infant/child ICU death and parent experiences, needs, and responses used to stimulate discussion of perinatal and paediatric palliative/EOL care issues and to provide recommendations for future research and clinical practice generated by those attending this session.	Not applicable	• Family/Parent Needs and Responses • Palliative and EOL Care Issues • Communication Issues • Communication between • Health Care Delivery System
		Title: The Investigation of Death Anxiety and Spiritual Well-Being Levels of Family Members of Patients Admitted to the Intensive Care Unit			
8	**Görücü and Arslan (2024), Turkey**	• Quantitative • Descriptive correlational • Face-to-face interview and survey	To investigate the death anxiety (DA) and spiritual well-being (SWB) levels of first-degree family members of patients hospitalized in the intensive care unit (ICU).	308 family members who came to visit family members treated in the ICU.	In this study, a positive and significant correlation was found between the DA levels and SWB levels of the family members. According to this result, as family members' DA increases, their spiritual needs also increase.
		Title: Religious and spiritual support in the conception of nurses and families of critical patients: a cross-sectional study			
9	**Santos et al., (2021), Brazil**	• Exploratory and descriptive, cross-sectional • Quantitative study	To assess the religious and spiritual support in critical care according to the conception of patients' family members and nurses.	22 nurses participated, 11 from hospital A and 11 from hospital B. Regarding family members, there were 34 from ICU A and 27 from ICU B (n=56).	Nurses and family members recognized religious/ spiritual support as significant to the process of caring for critically ill patients, even though professional qualification is required for greater integration of this support in daily intensive care.
		Title: Intensive Care Registered Nurses' Role in Bereavement Support			
10	**Kurian et al., (2014), United States**	• Quantitative • post-test-only survey design	To ascertain ICU registered nurses' (RNs') current practice and beliefs about bereavement care, their role in bereavement support, and interest and education related to bereavement.	A total of 110 RNs working in the MICU (n=28), TSICU (n=39), NICU (n=29), and CCU (n=14).	Most of the nurses agreed with items indicating it is the nurses' role to provide bereavement support to relatives. Almost half (46%) indicated they have not had sufficient education, training, and experience with bereavement care. The ICU nurses who had received bereavement program training more strongly agreed that nurses should be involved in initiating and maintaining contact with newly bereaved families.

cont'd

		Title: How do intensive care clinicians ensure culturally sensitive care for family members at the end of life? A retrospective descriptive study			
11	**Brooks et al., (2022), Australia**	• Quantitative • Descriptive study utilising a retrospective medical record audit	To examine whether clinicians provided culturally sensitive care for family members of patients from culturally diverse backgrounds who died in an intensive care unit.	430 records used to analyse.	Despite the culturally diverse patient population, findings show that details about culturally sensitive end-of-life care are rarely documented. Comprehensive documentation is required of how clinicians assess patient and family member cultural wishes and preferences, in conjunction with how clinicians attempt to address these cultural needs.
		Title: Families' needs of critical care Muslim patients in Saudi Arabia: A quantitative study			
12	**Al-Mutair et al., (2018), Saudi Arabia**	• Quantitative study • A cross-sectional survey designs. • Self-administered questionnaire.	To identify the needs of families of adult intensive care unit (ICU) patients in Saudi Arabia as perceived by family members and healthcare providers.	176 family members and 497 intensive health care providers were recruited from eight adult mixed medical-surgical ICUs.	Family members and health care providers ranked assurance, information and cultural and spiritual needs as the most important, and support and proximity as least important.
		Title: "The Patient Is Dying, Please Call the Chaplain": The Activities of Chaplains in One Medical Center's Intensive Care Units			
13	**Choi et al. (2015), United States**	• Quantitative • Retrospective cross-sectional study	To describe the prevalence, timing, and nature of hospital chaplain encounters in the ICU	Among a total of 4169 admissions to adult ICUs over six months, 248 patients (5.9%) had documented chaplaincy care during their index ICU stay.	Chaplain visits are uncommon and generally occur just before death among ICU patients. Communication between chaplains and physicians is rare. Chaplaincy service is primarily reserved for dying patients and their family members rather than providing proactive spiritual support. These observations highlight the need to better understand challenges and barriers to optimal chaplain involvement in ICU patient care.
		Title: How Should Intensive Care Unit Nurses Organize End-of-life Care? A Mixed-methods Study			
14	**Jung et al., (2024), South Korea**	• Mixed-methods study • Focus group interviews and focus group interviews	To explore intensive care unit nurses' perceptions of end-of-life care and to identify strategies for improving patient comfort in the intensive care unit.	Focus group = 12 ICU nurses, Questionnaire 95 ICU nurses	• Focus group: • End-of-life care units: Connection with family and patients • Combining acute critical care with end-of-life care • Physical care: Physical care at the boundary between life and death with dignity • Linking spiritual/social/ psychological well-being to end-of-life care • Environmental considerations that dying patients deserve Questionnaires: The primary components of end-of-life care for ICU nurses in the FGI were centred around "comforting" and "connecting." The participants said that they aimed to provide comfort to patients by connecting them with their families, spiritual beliefs, social networks, and their life experiences, helping patients organize their thoughts and accept death without feeling isolated. These priorities were set in the context of the challenges faced in providing end-of-life care within the ICU's broader scope of care.

teachings. In Islam, both the dying and the deceased are treated with respect and dignity, and families often request healthcare providers to uphold these values.[16] Religious practices like Qur'anic recitation and prayer also provide spiritual comfort, as many Muslims believe that spiritual guidance is necessary to help a person die peacefully and in a state of faith.[16,17] Nurses are crucial in meeting spiritual needs while balancing medical responsibilities, navigating cultural sensitivities, and respecting religious beliefs without interfering with patient care.[16] For Muslim families, faith serves as a coping mechanism, helping them find comfort and strength during the process of death and bereavement.[18] Healthcare providers can foster a compassionate and spiritually sensitive environment by addressing religious needs while upholding medical ethics and Islamic traditions.

Spirituality plays a crucial role in supporting patients and families during death and bereavement.[19] A study found that spiritual and cultural needs are among the top three priorities for families.[20] However, research has mainly focused on patients, with less attention given to the families' spiritual needs.[21] Families of dying patients face heightened fear and emotional distress, making spiritual support crucial, especially in high-stress situations like the COVID-19 pandemic.[22] Factors influencing this need include employment status, income level, marital status, having children, and education level.[21] Many families view spirituality as a source of hope, believing in miracles or divine intervention for their loved ones.[23] Despite its importance, spiritual guidance is sometimes overlooked, particularly for children with terminal illnesses.[17] Providing spiritual support, whether through chaplaincy services or personalized care, helps address families' emotional and existential needs.[19] Critically ill patients receive frequent chaplain visits, while nurses, who form

close bonds with patients, often take the lead in providing spiritual care.[, 25] Families actively seek spiritual care from healthcare providers, believing that receiving religious guidance brings them peace.[16] Nurses play a key role in facilitating spiritual care by offering small yet meaningful gestures, such as providing a Qur'an to Muslim families.[18] They also invite religious leaders for additional support, helping patients feel closer to their Creator, though some families may decline such services.[18,25,26] Nurses are encouraged to incorporate spiritual interventions to support both patients and families.[22] Even after a patient's death, families require continued emotional support, including empathy, follow-up contact, and counselling.[27] Recording family wishes, including body handling and burial preferences, helps honour cultural and spiritual needs.[26] For Muslim families, respectful and careful handling of the body is a key aspect of spiritual care, helping to reduce stress and anxiety.[20]

Theme 2: Challenges occur during Grief and Coping

Family struggles

Families of critically ill patients often face intense emotional struggles, including anxiety, guilt, and existential distress, sometimes blaming themselves for their loved one's condition.[23] In the ICU, uncertainty about the patient's prognosis and exclusion from the care process often intensify families' distress. Denial is common, with families sometimes insisting that doctors and nurses do everything possible, even when the outcome is inevitable.[18,26] Communication gaps between medical staff and families can increase anxiety. While withholding information may respect cultural sensitivities, it can also erode trust and leave families feeling uninformed.[18] The emotional toll of these situations varies, but studies suggest that strong social support can help families cope better and even experience personal growth after grief.[13] Religious beliefs help families cope, as many see their loved one's illness as a test from God, finding solace in Qur'anic recitation and prayer.[16] Islam values patience (*sabr*) and discourages excessive mourning, which can emotionally challenge Muslim nurses supporting grieving families.[15] The level of grief experienced by families is influenced by demographic factors such as gender, employment status, income level, and past experiences with loss.[21] Recognizing these factors helps healthcare providers offer personalized support, ensuring families feel heard and included.

Nurse coping

ICU nurses face emotional strain from repeated patient deaths and family pressure, impacting their health, compassion, and care quality delivered.[18] Grief responses vary, with some showing detachment, empathy, or guilt, while others grieve privately.[8] Among nurses, factors like patient age, postpartum cases, and family involvement shape their grief, which ICU nurses manage through prayer and peer support to remain effective.[15] Muslim nurses, despite their Islamic values and personal faith, require structured support systems and training to effectively manage their emotional well-being.

Communication needs

Effective communication between healthcare providers and families is crucial in reducing stress and grief during the dying process. Transparent and empathetic communication helps families feel informed, supported, and involved in their loved one's care.[25] Nurses prioritize patient and family connections through active communication, but language barriers can hinder understanding, leading to miscommunication and distress.[26,27] Healthcare providers should ensure families are included in decision-making and kept well-informed about the patient's condition.[17,18] This involvement helps alleviate fear and uncertainty, making families feel more valued and reassured.[18] For those facing language difficulties, hospitals should provide translators or technology-based translation tools to ensure smooth and accurate communication.[18,26] This is particularly important when cultural expectations affect a family's understanding of medical care and end-of-life decisions.[27] Interestingly, in cases involving sick children, parents sometimes withhold medical information from them to protect them from emotional distress, which can complicate the communication process.[17] To address these challenges, healthcare institutions should continuously develop and improve communication tools to ensure effective dialogue between providers and

families.[18] Open discussions about religious and cultural beliefs foster trust, understanding, and comfort among families, reducing feelings of isolation and providing support to medical staff.[16,17] Chaplains and healthcare workers may face communication gaps due to differing perceptions of spiritual care needs, potentially hindering collaborative efforts.[24] Addressing these barriers to communication is essential in providing holistic, compassionate, and patient-centred care for both patients and their families.

Theme 3: Holistic and Family-Centred Care

Physical care

Nurses prioritize physical comfort and dignity during death and dying, especially in Islamic settings, ensuring care within a culturally and religiously sensitive framework. It stated that many nurses focus on meeting the patients' needs as well as providing them with emotional and spiritual support.[18] The example of basic physical care is the pain management from the nurses who received optimal infection prevention when hospitalized.[17,25] Nurses are also required to provide comfort as much as they can, as it can help to alleviate the suffering.[18]

Emotional care

Emotional care extends to both patients and their families, emphasizing the need to create a supportive environment, as there was distress on both sides.[22] For families, reassurance and acknowledgment of their grief are vital, while patients benefit from compassionate care that helps them accept death peacefully. Nurses often encourage the family members to be with the patient by their side, believing it to be the comfort the patients need.[17,18] This is including as act of visiting the sick relatives, as it is highly encouraged in Islamic teaching. It was stated that doing the emotional care shows respect for them, emotionally, spiritually, and psychologically.[18,20] During death and dying, nurses provide detailed patient information, especially for children, and encourage support through humour and treating them as sick individuals.[10] Nurses provide emotional support to patients by displaying family photos, making meaningful remarks, and organizing hospital programs to help them cope with sadness and fear.[25]

Training gaps

Nurses often report insufficient training in death and dying, particularly in addressing the spiritual and cultural needs of families.[19,28] The study highlights the significance of structured education programs on bereavement care and cultural competence in ICU nurses to enhance patient care and support.[18] It also highlights the need for resources and support mechanisms to acknowledge and address the emotional toll, as without support, nurses may experience burnout.[18]

Maqasid Al-Shariah: Guiding Islamic Perspectives on Death and Dying

The ethical considerations in Islamic healthcare are deeply rooted in *Maqasid al-Shariah*, which prioritize the preservation of life, intellect, faith, mind, and progeny.[29] Islam also emphasizes the integration of spirituality in health to maintain balance in the body, mind, and soul.[30] Islamic medical ethics emphasize truthfulness and trustworthiness in diagnosing patients, balancing patient autonomy with communal well-being.[29] This is particularly evident in Saudi medical settings, where family participation is emphasized to preserve emotional well-being and uphold *tawakkul* (reliance on God) in critical situations. This ethical framework ensures healthcare decisions consider both individual rights and family involvement.[29]

Additionally, Islamic spiritual care is crucial in modern healthcare, addressing physical, mental, psychological, emotional, and religious well-being.[30] Integrating spirituality and religion into patient care promotes holistic healing, comfort, and coping mechanisms in hospital settings. Engaging in prayer can help divert the mind from pain and promote relaxation through bodily movements.[30] Healthcare providers must practice spiritual care as a professional duty, respecting patients' values and beliefs, enhancing patient and family comfort.[30]

Islamic bioethics addresses ethical concerns in end-of-life decision-making, particularly regarding patient autonomy

and family roles. Physicians face dilemmas balancing truth-telling and psychological preparedness.[31] The integration of *Maqasid al-Shariah* in medical ethics ensures ethical, spiritually aware, and patient-centred healthcare, addressing both physical and metaphysical well-being.[31] This framework enables Muslim healthcare providers to navigate complex decisions while adhering to Islamic principles of justice, mercy, and public welfare.

DISCUSSION

The findings of this review highlighted the critical role of ICU nurses in managing the cultural and spiritual needs of patients and families during the death and dying process in Islamic contexts. Nurses serve as advocates, ensuring that the beliefs and values of Muslim patients and their families are respected and integrated into end-of-life care.[18] The approach to culturally sensitive ICU care emphasizes the importance of promoting a peaceful and dignified passing through key Islamic practices like Qur'anic recitation, *Shahadah,* and family presence, which provide spiritual and emotional comfort during a patient's final moments.[16,17] These rituals not only ease the patient's transition but also offer solace and closure to grieving families. Many Muslims find faith to be a source of strength during bereavement, believing in God's healing power and divine wisdom.[16]

However, a significant gap identified in this review is the lack of institutional guidelines addressing Islamic cultural and spiritual needs. Without formal policies, nurses are often left to rely on personal judgment or improvised approaches, leading to inconsistencies in care quality.[18,26] Nurses in ICU settings often engage with religious leaders for spiritual care, but may struggle due to a lack of awareness or training. Culturally tailored policies and standardized training programs are crucial for equitable and high-quality care. The review also highlights the emotional and psychological burden on ICU nurses providing care. Repeated exposure to grief and loss, coupled with the responsibility of supporting families in distress, can lead to stress, compassion fatigue, and burnout.[15,18] Nurses face challenges in dealing with young patients, denial-inducing families, and culturally sensitive cases, causing professional grief as they form emotional bonds with patients, making their deaths deeply affecting.[15]

ICU nurses in Islamic settings cope through prayer, faith, and religious practices for emotional strength, while peer support provides comfort through shared experiences.[8] ICU nurses experience burnout due to limited organizational support. Institutions should offer counselling, debriefing, and peer support to boost resilience. Cultural expectations and communication challenges further complicate care. Families of critically ill patients often experience heightened anxiety and stress, especially when faced with uncertainties about their loved one's condition.[16] In Islamic settings, illness is seen as a test of faith, leading families to seek spiritual reassurance and emotional support from healthcare providers, but communication gaps can exacerbate these challenges.[18,23] A lack of clear and empathetic communication regarding treatment options and prognosis can lead to frustration and mistrust, increasing the emotional strain on both families and nurses.

Some healthcare providers avoid discussing death and dying matters, fearing the topic is too sensitive or inappropriate.[18] Language barriers, cultural misunderstandings, and inadequate training in culturally sensitive communication complicate interactions in ICUs. Improving communication can be achieved through interpreters, translation technology, and cultural liaisons. Healthcare providers must also find a balance between cultural sensitivity and evidence-based medical practices, such as addressing traditional remedies like honey and oil for wound care while ensuring patient safety and medical efficacy.[18] Families in denial may struggle to accept a loved one's condition, often insisting on further medical interventions even when recovery is unlikely.[18] Effective communication not only reduces family distress but also eases the emotional burden on nurses, fostering a more supportive care environment.[18]

Holistic care is essential in death and dying management, addressing physical, emotional, and spiritual needs. While pain management is crucial, spiritual and emotional support are equally important in ensuring a dignified and compassionate death.[18] ICU nurses play a pivotal role in

this approach by facilitating religious rituals, involving chaplains, and providing spiritual care.[18,24] Many nurses lack training in cultural and religious aspects, making them unprepared to provide comprehensive spiritual care. Implementing educational programs on cultural competence, bereavement support, and spiritual care could equip nurses with the necessary skills.[18] These programs would not only boost nurses' confidence but also ensure that care practices align with the spiritual and cultural values of patients and families.

In summary, this discussion synthesizes the critical insights gleaned from the systematic review concerning the complex interplay between Islamic principles, spiritual care, and end-of-life experiences within Intensive Care Units. The findings underscore the indispensable role of ICU nurses in navigating cultural and spiritual sensitivities during the death and dying process for Muslim patients and their families.

A central theme emerging from the review is that Islamic traditions consider death an inevitable divine will and a transition to the afterlife. This foundational belief dictates a profound emphasis on honouring religious practices, including presence, prayer recitation, and ensuring a dignified passing in accordance with Islamic teachings. Both the dying and the deceased are to be treated with utmost respect and dignity, a value that families frequently ask healthcare providers to uphold. Religious acts such as Qur'anic recitation and prayer are not merely rituals but vital sources of spiritual comfort, believed to facilitate a peaceful and faith-affirming death. Faith itself serves as a crucial coping mechanism for Muslim families, providing strength and solace during bereavement. Nurses, therefore, hold a pivotal position in addressing these spiritual needs while balancing their medical duties, respecting diverse beliefs, and avoiding interference with patient care.

Despite the clear importance of spirituality, the review highlights significant challenges and gaps in current practice. Healthcare providers, including nurses, often demonstrate a lack of specific knowledge regarding the end-of-life needs and beliefs of Muslim patients and their families, pointing to a critical deficit in cultural competence training. This lack of understanding can lead to conflicts with standard ICU procedures, hindering deeply valued Islamic practices such as continuous family presence, Qur'anic recitations, and the Shahadah. Ethical dilemmas surrounding issues like organ donation, embalming, and autopsy further complicate care, often stemming from differing religious interpretations. While spiritual care is profoundly valued in Islamic traditions, it frequently remains overlooked for critically ill Muslim patients, despite its proven benefits as a non-pharmacological intervention.

The findings advocate for healthcare providers to foster compassionate and spiritually sensitive environments by actively addressing religious needs within the bounds of medical ethics and Islamic traditions. Nurses play a key role in facilitating spiritual care through gestures like providing a Qur'an and inviting religious leaders for additional support, though some families may decline such services. Critically ill patients benefit from chaplain visits, and nurses, due to their close patient bonds, often lead in providing spiritual care.

RECOMMENDATIONS

Future research should focus on Islamic perspectives in ICU end-of-life care, focusing on the cultural and spiritual needs of Muslim patients and families. Comparative studies between Islamic and non-Islamic settings could provide insights into how cultural differences impact care practices and patient outcomes. Culturally tailored training programs for ICU nurses are essential, covering bereavement support, spiritual care, and effective communication. Further investigation into institutional support mechanisms, such as counselling and peer support groups, is needed to manage the emotional burden of repeated patient deaths. Standardized guidelines integrating Islamic principles should be developed for culturally sensitive care.

LIMITATIONS

The review has limitations, including its reliance on a single database (Scopus) for literature search, which may have limited the scope of findings, and its inclusion of only English-language articles, potentially introducing

language bias and excluding studies conducted in non-English-speaking Islamic countries. Reviewing only qualitative papers may have caused incompleteness and a limited scope of evidence however, the decision to focus exclusively on qualitative studies, is valid for research questions aiming to explore experiences, perceptions, or meanings.

CONCLUSIONS

This review examines the experiences and difficulties faced by ICU nurses caring for dying Muslim patients. Nurses manage emotional, ethical, spiritual, and cultural complexities, providing both medical and spiritual support for patients, families, and themselves, which is a good practice to enhance the quality of care delivered. Family involvement and spiritual practices are crucial for patient comfort, yet nurses encounter communication barriers, a lack of spiritual care training, and support from the organizations. Therefore, improved training, policies, and support systems are needed. Culturally sensitive practices and better institutional support can enhance the end-of-life experience for patients and families, aligning with Malaysia Madani's vision.

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CONFLICT OF INTEREST

The authors declares no conflict of interest.

REFERENCES

1. Suprayitno E, Setiawan I. Nurses' roles in palliative care: an Islamic perspective. Belitung Nurs J. 2021;7:50–4. doi:10.33546/bnj.1254.
2. Al-Ab IA, Mohammad SY, Ameen DA. Experiences and emotions of critical care nurses toward dealing with patients and their families in the process of withdrawal of life-sustaining treatments. Egypt J Health Care. 2024;15:180–90. doi:10.21608/ejhc.2024.386594.
3. Alanazi MA, Shaban MM, Ramadan OME, et al. Navigating end-of-life decision-making in nursing: a systematic review of ethical challenges and palliative care practices. BMC Nurs. 2024;23:705. doi:10.1186/s12912-024-02087-5.
4. Iglesias MEL, Pascual C, Vallejo RB. Obstacles and helpful behaviours in providing end-of-life care to dying patients in intensive care units. Dimens Crit Care Nurs. 2013;32:99–106. doi:10.1097/dcc.0b013e3182808429.
5. Borhani F, Hosseini SH, Abbaszadeh A. Commitment to care: a qualitative study of intensive care nurses' perspectives of end-of-life care in an Islamic context. Int Nurs Rev. 2013;61:140–7. doi:10.1111/inr.12079.
6. Botes M, Mabetshe L. Family presence during patient acute deterioration: a survey of nurses' attitudes and reflection on COVID-19 in an African setting. Afr J Emerg Med. 2022;12:259–63. doi:10.1016/j.afjem.2022.04.012.
7. Khalid DS. End of life care: the Islamic perspective. Int J Hum Caring. 2019;23:254–9. doi:10.20467/1091-5710.23.3.254.
8. Isgandarova N. "When Someone is Dying, We Prefer….": COVID-19 and The Challenges to Muslim Health Care Choices. J Relig Health. 2021;60:3846-3860. doi:10.1007/s10943-021-01438-6.
9. Mahmoud S, Moughrabi S, Khasawneh WF. Dying in Isolation: An Islamic Perspective on End-of-Life Care During COVID-19. J Relig Health. 2022;61:148-164. doi:10.1007/s10943-021-01435-9.
10. Zainuddin Z, Qudsy SZ, Cahyani N, Hasan M, Asrori I. Muslims Resistance to Health Protocols in COVID-19 Funeral: A Study of Islamic Law. Int J Islam Bus Ethics. 2022;7:209-224. doi:10.30603/ijibe.v7i2.2741.
11. Khan I, Saad AB. Death Be Not Proud: A Commentary on Muslim Acceptance of Death in the Intensive Care Unit. J Palliat Med. 2021;24:1511-1512. doi:10.1089/jpm.2021.0186.
12. Rababa M, Al-Sabbah S. The use of Islamic spiritual care practices among critically ill adult patients: A systematic review. J Hosp Palliat Nurs. 2023;25:E187-E194. doi:10.1097/NJH.0000000000000969.
13. Abdullah R, Al-Omari AA, Al-Zoubi H, Al-Sabbah S,

Al-Qadri A. Preferences and Experiences of Muslim Patients and Their Families in Muslim-Majority Countries for End-of-Life Care: A Systematic Review and Thematic Analysis. J Pain Symptom Manage. 2020;60:1223–38.e4. doi:10.1016/j.jpainsymman.2020.06.032.

14. Piracha NZ, Al-Omari AA, Al-Zoubi H, Al-Sabbah S, Al-Qadri A. Muslims and End-of-Life Healthcare in Non-Muslim Majority Nations: A Systematic Literature Review. J Pain Symptom Manage. 2024;67:e299–e312. doi:10.1016/j.jpainsymman.2024.01.004.
15. Betriana F, Kongsuwan W. Grief reactions and coping strategies of Muslim nurses dealing with death. Nurs Crit Care. 2019;25:277–83. doi:10.1111/nicc.12481.
16. Sadeghi N, Hasanpour M, Heidarzadeh M, Alamolhoda A, Waldman E. Spiritual needs of families with bereavement and loss of an infant in the neonatal intensive care unit: a qualitative study. J Pain Symptom Manage. 2016;52:35–42. doi:10.1016/j.jpainsymman.2015.12.344.
17. Adistie F, Lumbantobing VBM, Maryam NNA. The needs of children with terminal illness: a qualitative study. Child Care Pract. 2019;26:257–71. doi:10.1080/13575279.2018.1555136.
18. Mani ZA. Bridging cultural gaps in end-of-life care: the experiences of international charge nurses in Saudi Arabia. BMC Nurs. 2024;23:643. doi:10.1186/s12912-024-02514-7.
19. Santos PM, Rodrigues KS, Pinheiro LA, et al. Religious and spiritual support in the conception of nurses and families of critical patients: a cross-sectional study. Rev Esc Enferm USP. 2021;55:e20200508. doi:10.1590/1980-220x-reeusp-2020-0508.
20. Al-Mutair AS, Plummer V, Clerehan R, O'Brien A. Families' needs of critical care Muslim patients in Saudi Arabia: a quantitative study. Nurs Crit Care. 2013;19:185–95. doi:10.1111/nicc.12039.
21. Görücü S, Gürol Arslan G. The investigation of death anxiety and spiritual well-being levels of family members of patients admitted to intensive care unit. J Caring Sci. 2024;13:20–6. doi:10.34172/jcs.2024.33069.
22. Silva M da CQ, Vilela ABA, Boery RNS, Silva RS. The process of dying and death of patients with COVID-19: a reflection in the light of spirituality. Cogitare Enferm. 2020;25. doi:10.5380/ce.v25i0.73571.
23. Lima AB, Rosa D de OS. The life meaning of the parents of the critical patient. Rev Esc Enferm USP. 2008;42:539–45.
24. Choi PJ, Curlin FA, Cox CE. "The patient is dying, please call the chaplain": the activities of chaplains in one medical center's intensive care units. J Pain Symptom Manage. 2015;50:501–6. doi:10.1016/j.jpainsymman.2015.05.003.
25. Jung HJ, Kim D, Chang SO. How should intensive care unit nurses organize end-of-life care? A mixed-methods study. J Korean Acad Fundam Nurs. 2024;31:112–22. doi:10.7739/jkafn.2024.31.1.112.
26. Brooks LA, Manias E, Bloomer MJ. How do intensive care clinicians ensure culturally sensitive care for family members at the end of life? A retrospective descriptive study. Intensive Crit Care Nurs. 2022;73:103303. doi:10.1016/j.iccn.2022.103303.
27. Youngblut JM, Brooten D. Perinatal and pediatric issues in palliative and end-of-life care from the 2011 Summit on the Science of Compassion. Nurs Outlook. 2012;60:343–50. doi:10.1016/j.outlook.2012.08.007.
28. Kurian MJ, Daniel S, James A, et al. Intensive care registered nurses' role in bereavement support. J Hosp Palliat Nurs. 2014;16:31-9. doi:10.1097/njh.0000000000000018.
29. Alfahmi MZ. Justification for requiring disclosure of diagnoses and prognoses to dying patients in Saudi medical settings: a Maqasid Al-Shariah-based Islamic bioethics approach. BMC Med Ethics. 2022;23:79. doi:10.1186/s12910-022-00808-6.
30. Baig N, Isgandarova N. Exploring Islamic spiritual care: what is in a name? Religions. 2023;14:1256. doi:10.3390/rel14101256.
31. Akdeniz M, Yardımcı B, Kavukcu E. Ethical considerations at the end-of-life care. SAGE Open Med. 2021;9:20503121211000918. doi:10.1177/20503121211000918.