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REVIEW

Palliative care and nursing attitudes: keys to dignified end-of-life care

Cuidado paliativo y actitudes de enfermería: claves para una atención digna al final de la vida

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ABSTRACT

Introduction: end-of-life care gained increasing relevance in the face of population aging and the increase of chronic diseases. The WHO estimated that the need for palliative care would double by 2060, highlighting the importance of the role of nurses in end-of-life care. However, deficiencies in academic training and inappropriate attitudes were identified that limited the quality of such care.
Development: this review addressed fundamental concepts such as dying patient, death, palliative care and attitude. The most common attitudes towards the end of life were described: fear, denial, avoidance and acceptance. Scales used to measure these attitudes were also analyzed, such as the FATCOD, the Collet-Lester and the Revised Profile of Attitudes Toward Death (PAM-R), validated in various countries. It was found that nursing staff attitudes were influenced by cultural, educational and personal factors. In addition, barriers to empathic care were identified, such as fear of death and lack of adequate tools during professional training.
Conclusions: it was concluded that nursing staff attitudes were determinant in the quality of palliative care. The review showed the need to strengthen emotional and ethical training from undergraduate level, incorporating valid assessment tools. The role of the nurse was not only focused on physical care, but also on emotional and spiritual accompaniment. Encouraging positive attitudes from the training allowed providing a more humane and dignified care at the end of life.

Keywords: Palliative Care; Attitudes; Nursing; Terminal Patient; Professional Training.

RESUMEN

Introducción: la atención al final de la vida cobró creciente relevancia ante el envejecimiento poblacional y el aumento de enfermedades crónicas. La OMS estimó que la necesidad de cuidados paliativos se duplicaría hacia 2060, destacando la importancia del rol del personal de enfermería en la atención de pacientes terminales. Sin embargo, se identificaron deficiencias en la formación académica y actitudes inapropiadas que limitaron la calidad de dicha atención.
Desarrollo: esta revisión abordó conceptos fundamentales como paciente moribundo, muerte, cuidado paliativo y actitud. Se describieron las actitudes más comunes ante el final de la vida: miedo, negación, evitación y aceptación. También se analizaron escalas utilizadas para medir estas actitudes, como la FATCOD, la Collet-Lester y el Perfil Revisado de Actitudes hacia la Muerte (PAM-R), validadas en diversos países. Se encontró que las actitudes del personal de enfermería estuvieron influenciadas por factores culturales, educativos y personales. Además, se identificaron obstáculos que dificultaron una atención empática, como el temor a la muerte y la falta de herramientas adecuadas durante la formación profesional.
Conclusiones: se concluyó que las actitudes del personal de enfermería fueron determinantes en la calidad del cuidado paliativo. La revisión evidenció la necesidad de fortalecer la formación emocional y ética desde el pregrado, incorporando herramientas de evaluación válidas. El rol del enfermero no solo se centró en el cuidado físico, sino también en el acompañamiento emocional y espiritual. Fomentar actitudes positivas desde la formación permitió brindar una atención más humana y digna al final de la vida.

Palabras clave: Cuidados Paliativos; Actitudes; Enfermería; Paciente Terminal; Formación Profesional.

INTRODUCTION

Population aging and the increase in chronic noncommunicable diseases have led to a significant growth in the demand for palliative care worldwide.[1,2,3,4] According to the World Health Organization (WHO), it is estimated that by 2060, this need will double, becoming a priority for health systems.[1,6,7,8] In this context, nursing staff are central in providing comprehensive care to patients at the end of life, focusing on the individual and their family.[9,10,11,12]

However, several studies show that significant barriers still limit quality care in these contexts. Among the most relevant are deficiencies in academic training and the lack of appropriate attitudes to accompany the dying process.[13,14,15] These deficiencies affect the ability of nursing professionals to provide humane, empathetic, and competent care in hospital and community settings.[2,16,17]

The attitude of healthcare personnel toward death and terminal patients is a determining factor in the quality of palliative care.[18,19,20] Multiple factors influence these attitudes, such as academic training, professional experience, personal beliefs, and cultural context. Therefore, it is essential that initial nursing training promotes competencies that allow students to acquire technical knowledge and develop a deep understanding of the human dimension of the dying process.[21,22]

Despite the importance of the subject, there are still gaps in the literature regarding the specific attitudes of nursing professionals toward the care of terminally ill patients, as well as the tools used to assess these attitudes.

Objective

To review the available scientific evidence on the attitudes of nursing staff toward the care of patients at the end of life, identifying the factors that condition them, the most commonly used instruments for measuring them, and the implications for professional training and clinical practice.

DEVELOPMENT

Theoretical framework

Definitions

Dying patient

Defined as "a person who will die within six months despite medical therapy; the last two weeks of life are considered the final stage".[3,23,24]

A dying patient is a person who has different needs from other people. As time passes, the disease of a terminal or dying patient progresses, making the moment of death more predictable due to the complications that arise during the terminal stage.[4,25,26]

Palliative care

Palliative care is an interdisciplinary approach focused on patients with advanced or terminal illnesses and their families. Its objectives are to provide quality of life and relief from suffering through overall control of symptoms and respect for values and beliefs.[5,27,28]

Palliative care refers to actions aimed at improving the quality of life of individuals and their families, who also experience what it means to live with life-threatening illnesses. These actions include pain prevention, relief, communication, and emotional support.[1,29,30]

Death

This refers to when the vital organs collapse, causing all bodily functions to cease. This can happen suddenly, caused by acute illnesses, accidents, or terminal illnesses.[6,31,32,33]

According to Avalos, to define death, it is essential to specify that it is considered the biological cessation of functions that previously defined human vitality, such as brain and cardiovascular activity and the total loss of respiratory patterns.[7,34,35,36]

Law 1733 of 2014, Consuelo Devís Saavedra Law

Palliative care is provided to people with chronic, terminal, and irreversible illnesses to manage symptoms such as pain, among others. This care requires a multidisciplinary and family-centered approach throughout the disease. "The goal of palliative care is to achieve the best possible quality of life for the patient and their family".[8,37,38,39]

Attitude

Attitude is a psychological construct that allows behavioral tendencies to be mobilized through cognitive, emotional, and rational components. In this sense, it is essential to emphasize that attitude mobilizes human beings in their style of thinking and acting. Therefore, attitudes imply that our responses can be constructive or unfavorable, considering the context, values, and beliefs.[9,40,41,42]

Attitudes toward the end of life

After a person is born, the path to death also begins to be irreversible; death is a natural and irreversible phenomenon.[10,43,44] Today's culture does not accept death and does not know how to deal with it. When we talk about dying patients, we need to understand that these are people who are living the last moments of their lives.[11,45,46]

Terminally ill patients are patients who are going through the process of dying. This phase can be delayed by a few hours or extended for months. During this time, those affected experience unpleasant symptoms and emotional and cognitive reactions, depending on the process of the disease they are suffering from and their imminent death.[11]

When faced with death, humans experience different emotions that cause them to adopt different attitudes, including acceptance, denial, and/or avoidance.[12,47,48]

Fear is a reaction humans have to the process of death, influenced by feelings of fear, uncertainty, pain, and distress, both in the person and their family in a palliative situation.[13,49,50]

Denial: this is a typical response of people who are undergoing a stressful situation that involves all dimensions of the human being: physical, psychological, and social.[13,51,52]

Avoidance: this is the stance of denial in the face of death and everything it encompasses.[13,53,54]

Acceptance: "a state of calm associated with the understanding that death and other losses are natural phenomena in human life".[13,55,56]

Scales that measure attitudes toward death

The scales that have been used to measure attitudes toward death are described in the following table (table 1).

Table 1. Scales of attitudes toward death

Name, author	Purpose of thescale	Items and subscales
The Collet-Lester scale was created by Jessica Collet and David Lester in 1969.[14]	Differentiating between fear and death.	It has 28 items on a scale of 6 to 1. Fear of one's own death, fear of the death of others, fear of the process of dying, and fear of the process of others dying.[15]
The Revised Profile of Attitudes Toward Death Scale (PAM-R). It was developed by Gesser, Wong, and Reker in 1988.[12]	Measuring the attitudes of professionals toward people in palliative care and their dying process.[12]	The scale has 32 items ranging from 1 to 7, from strongly disagree to strongly agree. Its dimensions are: acceptance and approach, fear of death, avoidance of death, acceptance of escape, and neutral acceptance.[16]
La escala Frommelt Attitude Toward Care of the Dying Scale (FATCOD) fue diseñada por la investigadora Katherine Frommelt en 1989.[17]	Assess nurses' attitudes toward caring for terminally ill patients and their families.[17]	The scale consists of 30 items with Likert responses ranging from 1 to 5. Fifteen items are worded positively (questions 1, 2, 4, 10, 12, 16, 18, 20, 21, 22, 23, 24, 25, 27, and 30), while the other 15 are worded negatively. The possible scores range from 30 to 150; the higher the score, the more positive the attitudes toward caring for the dying patient. Twenty questions assess nurses' attitudes toward terminally ill patients and 10 assess attitudes toward the families of terminally ill patients.[18]

The FATCOD scale measures six specific dimensions that should be emphasized during the educational preparation of health students, which are: Fear/Discomfort, Family Care, Communication, Family as Caregiver, Relationship, and Active Care.[19]

Countries with validation of the FATCOD scale

This scale has been widely used. The results obtained in several countries are described below.

Studies conducted in Japan found that the first factor, FATCOD I (positive attitudes toward caring for dying patients), was internally consistent.

(Cronbach's α) of 0,73, while the second factor, FATCOD II (perceptions of patient- and family-centered care), had an α value of 0,65. The internal consistency for the total FATCOD-Form BJ was 0,85.[20] On the other hand, in another study, Cronbach's α was 0,91, and the intraclass correlation in the test-retest was 0,94.[21,57,58]

When using the FATCOD scale for studies in China, Cronbach's alpha coefficient was 0,790. The overall content validity index was 0,92.[22,59,60] In Egypt, the reliability of the scale has been established several times. The Pearson coefficient was 0,94.[23]

Two studies were found in Turkey, the first of which determined that Cronbach's α value of the scale was 0,73. Cronbach's alpha value in this study was 0,93.[24] The following study showed that the FATCOD scale was also subjected to reliability analysis, showing that Cronbach's coefficient varied between 0,605 and 0,800 for the factors. Cronbach's alpha value was 0,783.[25]

The validity of the FATCOD scale in Sweden showed that values below 0,08 were considered satisfactory. The average variance extracted (AVE) and composite reliability (CR) were calculated to fit the measurement model. Values above 0,5 (AVE) and above 0,7 (CR) indicate good convergent validity. Reliability was measured using internal consistency (Cronbach's α), where Cronbach's α values were higher.[26,61,62]

In Italy, Cronbach's α was 0,68 for the entire scale, 0,72 for factor I, 0,68 for factor II, 0,71 for factor III, and 0,11 for factor IV.[27] The study conducted in Spain shows Cronbach's alpha for factor I to be 0,73, while for factor II, it was 0,65. The internal consistency for the total form was 0,85.[28,63,64]

In addition, the present method "has been validated and used in Mexico in its Spanish version, with a Cronbach's alpha reliability of 0,87 in this population".[29] It is a valid and reliable measure of patients' end-of-life experiences in the United States, with an alpha coefficient of 0,98.[17] Finally, the study conducted in Chile shows "a Cronbach's α of 0,80 and significant criterion validity when compared to other scales".[9,65,66]

The role of nursing in caring for the dying patient

Nurses who work with patients at the end of their lives and are more exposed to the entire life cycle process face situations that can generate conflicts and changes in attitudes toward patient care and self-care, all based on their own experience. These attitudes help us organize, direct, and regulate the actions of individual and group healthcare professionals, many of whom experience emotions such as fear and dread of death.[12,67,68]

When it comes to emotional support and accompaniment, nurses provide a measure of adaptive support, applying different communication, outreach, and assistance strategies to meet the needs of family members. Nurses create environments where family members can express their doubts and feelings, creating a good relationship between the patient and the family and allowing them to express their feelings and reflect during the end-of-life process.[30]

The role of nurses at the end of life is broad and consists of several processes. The first is to be present, listen, provide comfort, and minimize pain and suffering. The second is to clarify concerns to family members and patients about the decisions made by healthcare personnel for the patient's improvement, well-being, and peace of mind. The third encompasses the patient's final journey toward death. The nurse provides full support to the family, allowing them to express their emotions and feelings so that the patient can have a peaceful end of life.[31]

Nursing is a vocation, care, love, responsibility, commitment, and humanity. Nurses are firmly committed to patients and their families until the end. In addition to providing care and attention, nurses also show emotion when patients die because they adopt them as family members. The appropriation of care makes nurses sensitive to the different situations and emotions that patients go through. However, the care and interventions nurses provide do not always meet the needs of patients and their families, so a commitment is made to ensure that patients have a humane end of life.[32,69]

End-of-life theory

Within the nursing discipline, there is a theoretical position proposed by Ruland & Moore, "whose fundamental objective is to achieve a dignified and peaceful death, based on five fundamental outcomes: absence of pain, experience of well-being, experience of dignity and respect, state of tranquility, and closeness to loved ones".[33]

The fundamental outcomes highlighted by Ruland and Moore are:

Absence of pain: it is important to understand patients' perceptions of the end-of-life experience, which includes being free from physical suffering. Pain is a particular sensation characterized by sensory or emotional discomfort.[33]

Experience of well-being is defined as a total state of satisfaction, well-being, relief, and relaxation.[33]

Experience of dignity and respect: this is the value and ethical principle of autonomy and respect for those who are terminally ill, who must be treated and respected as autonomous beings.[33]

State of tranquility: feelings of tranquility include serenity, calm, peace, absence of anxiety, and no actions that cause unease or discomfort. Being calm encompasses physical, psychological, and spiritual dimensions.[33,70]

Proximity to loved ones: proximity is the action of being closely connected to people you care about; it

involves a close connection that includes physical or emotional support.[33]

About Ruland and Moore's theory of a peaceful end of life, few articles were found that show its application or reference to people at the end of life or with terminal illnesses. However, in a study conducted in Thailand in 2009, which aimed to explore how intensive care nurses promoted a peaceful end of life in their patients, they evaluated how they created and promoted care environments so that patients did not feel pain but rather expressed comfort by providing them with dignity and respect.[34,71]

As mentioned above, over the years in southern Thailand, a phenomenological study was conducted in which interviews were conducted with Buddhist families who had experienced the death of loved ones in intensive care units. They mentioned five qualities that in some way defined what a peaceful death is, where the main idea was that death was a natural process of life and that we should be at peace, seeking mental tranquility in order to grieve without pain, that it is always better to be in the company of our family members and not go through this process alone. Moreover, most importantly, they do not live with regrets.[35,72]

In another review, a study conducted in Taiwan in 2009 was found, which aimed to evaluate the ethical dilemmas that arise in intensive care units, where patient mortality is a daily experience, which means that the practice of good end-of-life care is not optimal or beneficial. They mentioned that to provide quality care, autonomy, palliative care, ethics, and justice must be considered, characteristics that are as important as providing pharmacological treatment and life support to those in care.[36,73]

On the other hand, in 2002, Kirchhoff sought to describe how a terminally ill patient in the intensive care unit can be given a peaceful death, considering that these areas of hospitals and clinics are not considered good places to die. He mentions that a peaceful death must go hand in hand with a good death in order to reduce suffering for both the patient and the family, taking into account quality standards and holistic care.[37]

CONCLUSIONS

End-of-life care represents one of the most significant challenges for the nursing profession, not only because of its clinical complexity but also because of the profound emotional, ethical, and human burden it entails. This review has shown that nursing professionals' attitudes toward dying patients directly influence the quality of care provided. These attitudes, far from secondary elements, act as determinants of the practical, empathetic, and dignified support patients require in their final days.

One of the key findings is that the attitude of nursing staff is strongly influenced by factors such as academic training, personal experiences, cultural context, and religious beliefs. Evidence shows that when these variables are not adequately addressed during training, obstacles such as fear, avoidance, and denial of death arise. These attitudes hinder patient-centered care and can affect the professional and the patient's family.

Likewise, the importance of valid and reliable tools for assessing nursing staff attitudes toward death and palliative care is highlighted. Scales such as the FATCOD, the Revised Profile of Attitudes Toward Death (PAM-R), and the Collet-Lester scale allow for the identification of critical aspects in professional preparation and facilitate effective educational interventions. These tools have been validated in various international contexts, reinforcing their usefulness for comparative research and curriculum improvements.

Another fundamental aspect addressed in this review is the role of nurses as key figures in the emotional and spiritual support of dying patients. Beyond clinical care, nurses represent a constant presence that provides comfort, communicates difficult decisions, and helps families navigate the grieving process. To fulfill this role effectively, professionals must develop communication skills, ethical sensitivity, and an attitude of acceptance toward death as a natural part of life.

Ultimately, fostering positive attitudes toward the end of life through university education and ongoing clinical practice will enable the training of professionals who are technically competent and emotionally prepared to provide high-quality palliative care. Education in human values, reflective practice, and institutional support are essential pillars for achieving a dignified and humane death for those facing the end of life.

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CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

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