

Registered Nurses' Perspectives on End-of-Life Care Across Diverse Hospital Settings: A Cross-Sectional Survey

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Abstract

End-of-life care is provided in various healthcare settings beyond specialized palliative units, underscoring the need to identify barriers and promote safe, high-quality care. This study sought to assess nurses' attitudes toward end-of-life care and to identify both hindering and supportive factors influencing such care in multi-profile hospitals across Eastern Europe. A descriptive, correlational design was applied using a cross-sectional survey of 1,320 registered nurses from seven hospitals in Lithuania. Across all hospital types, nurses highlighted the importance of ensuring patient safety, delivering effective care, and addressing spiritual needs at the end of life. Major obstacles reported included expressions of anger from family members, relatives' limited understanding of nursing care, lack of time for patient communication, insufficient knowledge to support bereaved families, disregard for nurses' input, and physicians' reluctance to discuss diagnoses while providing overly positive prognoses. Facilitating factors that improved end-of-life care included participation in relevant training, engagement in volunteer work, and active family involvement. Nurses identified patients' spiritual needs as their top priority at the end of life. Family-related issues remain major barriers, while physician–nurse dynamics continue to significantly influence care quality.

Keywords: End-of-life care, Registered nurses, Barriers, Facilitators

Introduction

According to the National Cancer Institute, end-of-life (EOL) care refers to the support provided to individuals approaching death who have ceased curative treatment. It involves addressing patients' and families' physical, emotional, social, and spiritual needs. As a key aspect of palliative care, EOL care focuses specifically on individuals nearing the final stage of life [1]. Palliative care, viewed as a fundamental human right, seeks to preserve health and dignity. Professionals working in this field possess specialized skills in managing symptoms and offering emotional, spiritual, cultural, and practical assistance, particularly in complex cases [2]. While many healthcare professionals—including nurses, physicians, and allied health workers—believe that EOL care is best delivered in palliative units or hospitals with adequately trained staff [2], in practice, such care occurs in a variety of clinical environments. This diversity underscores the need to identify barriers to EOL care and to ensure patients receive safe, high-quality services regardless of setting [3]. Nurses are central to EOL care delivery, and their competence, attitudes, and preparedness are vital for ensuring compassionate, patient- and family-centered care [4, 5]. Both palliative and EOL care also aim to improve patients' and caregivers' quality of life by providing practical and emotional support tailored to individual needs [6]. Nurses' perceptions of death and their readiness to deliver EOL care significantly shape the quality of care provided to terminal patients [7]. Attitudes toward dying are influenced by cultural norms, societal values,

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religion, and personal beliefs [8]. Experiencing patient death can provoke anxiety and emotional discomfort among nurses, which may negatively affect their care. A nurse's communication with dying patients often reflects their underlying attitudes, highlighting the importance of adequate professional training for both nurses and physicians. Since death can occur in any clinical setting, comprehensive EOL training should be an essential part of every nurse's education [9].

Previous research has shown that a majority of nurses experience uncertainty and distress when communicating with dying patients. Sasahara *et al.* found that 92% of nurses struggled to assist patients expressing anger or fear about death, and 91% were unsure how to respond when patients initiated conversations about dying [10]. Similar findings have been reported across various cultural contexts, where many nurses felt emotionally unprepared and insufficiently trained to handle EOL discussions [8, 11, 12]. As a result, communication with terminal patients was often described as emotionally taxing, leading some nurses to avoid such interactions [13].

Studies further indicate that demographic factors, work experience, and previous education can influence nurses' attitudes toward EOL care. Greater exposure to dying patients and longer clinical experience have been associated with more confidence and a more positive approach to caring for terminally ill individuals [14–17]. Given the critical role of nurses in end-of-life settings, it is essential to explore their attitudes and preparedness for EOL care within multi-profile hospitals and to develop strategies that help improve communication, readiness, and overall quality of care for patients in the terminal phase.

Research context

In Lithuania, palliative care is delivered across multiple settings, including healthcare institutions, day centres, and patients' homes. It involves comprehensive care for individuals suffering from incurable and progressive illnesses. Depending on patient and family needs, a multidisciplinary team—typically consisting of a physician, nurse, social worker, psychologist, and other healthcare professionals—provides the necessary support. The concept of palliative care was formally introduced in Lithuania in 2006 through the National Cancer Control and Prevention Programme. Legal regulation of end-of-life (EOL) care began in 2007, when official procedures for palliative care delivery were established. That same year, the National Health Insurance Fund (NHIF) introduced contractual frameworks governing palliative care provision, which specified referral criteria, service procedures, and professional standards (e.g., a team of at least three specialists including a doctor, nurse, and social worker; a minimum list of required equipment; and minimum consultation times for home visits) [18].

In 2012, the government approved a set of requirements outlining the standards for supportive treatment and nursing services, which subsequently guided EOL care provision. Nevertheless, advance care planning—such as preparing a living will or discussing care preferences with patients and families—has not become common practice in Lithuania. Conversations about EOL priorities are often considered sensitive or even avoided. Consequently, healthcare professionals frequently bear the moral responsibility for making crucial EOL decisions. Furthermore, effective intersectoral collaboration in healthcare remains limited in Lithuania. Although the significance of cross-sectoral cooperation for population health is widely recognized, practical mechanisms for implementing it have only recently begun to develop [19–21]. Strengthening multidisciplinary and intersectoral collaboration is essential not only for improving EOL services but also for enhancing the overall quality and safety of healthcare. The present study therefore aimed to assess nurses' attitudes toward EOL care and to identify both barriers and facilitating behaviors influencing care delivery in multi-profile hospitals in Eastern Europe.

Materials and Methods

Research design

This study employed a descriptive, cross-sectional, correlational design.

Sample

Participants included registered nurses (RNs) from various specialties—surgical, therapeutic, and intensive care—working in seven major municipal multi-profile hospitals across Lithuania. Of approximately 22,500 RNs in the country, about 2,560 were employed in these hospitals. Based on sample size calculations (95% confidence level, 5% margin of error), a minimum of 378 participants was required [22]. To compensate for potential non-response, a larger sample of 1,310 nurses was recruited. This group of RNs also served as the sampling pool for another related study [23]. Eligible participants were those actively working day, night, or mixed shifts during the study period. Nurses on maternity leave, annual leave, or medical leave were excluded from participation.

Instruments

Nurses' preparedness and attitudes toward EOL care were measured using the *Questionnaire of Helps and Obstacles in Providing End-of-Life Care to Dying Patients and Their Families* [24]. This instrument, previously validated and tested for reliability by the authors [25], used a Likert-type scale ranging from 1 (“no help/not an obstacle”) to 5 (“extremely helpful/extremely large obstacle”). The questionnaire also collected demographic data,

including age, gender, employment type, workplace, and years of experience. The reliability coefficient (Cronbach's alpha) for the scale was 0.86, indicating strong internal consistency. Comparable versions of this questionnaire have been employed in studies conducted in Lithuanian oncology departments and intensive care units in Spain and the United States [25–27].

Data collection

From September to November 2017, one of the study authors personally distributed questionnaires to nurses across the participating hospitals. A total of 1,320 questionnaires were handed out, and 1,180 were returned. After screening for completeness, 1,055 were found suitable for analysis, resulting in a response rate of 79.9%.

Data analysis

Data were processed and analyzed using *SPSS Statistics for Windows, Version 19.0* [28]. Only fully completed questionnaires were included. Descriptive statistics were used to determine the means and standard deviations of key variables within a 95% confidence interval. The threshold for statistical significance was set at $p \leq 0.05$.

Ethical considerations

The research protocol was reviewed and approved by the Bioethics Committee of the Lithuanian University of Health Sciences (Approval No. BE-2-27). Hospital authorities were informed about the study's objectives before data collection began. Verbal informed consent was obtained from all participants after explaining the purpose of the research and the voluntary nature of participation; this consent process was approved by the ethics committee. Nurses were free to withdraw at any time without consequences. Participant anonymity and confidentiality were safeguarded, and findings were presented in aggregate form only.

Results and Discussion

Sample characteristics

Table 1 summarizes the sociodemographic characteristics of the 1,055 registered nurses (RNs) included in the study. Participants had an average age of 45.8 years (SD = 9.9) and an average of 23.4 years (SD = 11.1) of professional experience. Most respondents were married (63.3%, $n = 668$), worked part-time (74.5%, $n = 786$), and were assigned to mixed shifts (67.9%, $n = 716$). Nearly half of the nurses (46.9%, $n = 495$) had graduated from medical college. In terms of department distribution, 49% ($n = 516$) were employed in internal medicine, 32.6% ($n = 344$) in surgery, and 18.4% ($n = 195$) in intensive care.

Table 1. Sample Characteristics.

Characteristic	Total (N = 1,055)	Kaunas (n = 102)	Klaipėda (n = 97)	Panevėžys (n = 278)	Alytus (n = 86)	Marijamp olė (n = 67)	Vilnius (n = 155)	Šiauliai (n = 270)
	N (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Age, years								
≤ 44 years	349 (33.1)	30 (29.4)	26 (26.8)	85 (30.6)	11 (12.8)	15 (22.4)	79 (51.0)	103 (38.1)
45 to 50 years	374 (35.5)	38 (37.3)	30 (30.9)	100 (36.0)	32 (37.2)	32 (47.8)	49 (31.6)	93 (34.4)
≥ 51 years	332 (31.5)	34 (33.3)	41 (42.3)	93 (33.5)	43 (50.0)	20 (29.9)	27 (17.4)	74 (27.4)
Educational Preparation								
Higher University Education	115 (10.9)	15 (14.7)	21 (21.6)	24 (8.6)	3 (3.5)	6 (9.0)	27 (17.4)	19 (7.0)
College	940 (89.1)	87 (85.3)	76 (78.4)	254 (91.4)	83 (96.5)	61 (91.0)	128 (82.6)	251 (93.0)
Department/Unit								
Surgery Department	344 (32.6)	27 (26.5)	31 (32.0)	79 (28.4)	17 (19.8)	24 (35.8)	79 (51.0)	87 (32.2)
Intensive Care Department	195 (18.5)	14 (13.7)	16 (16.5)	53 (19.1)	18 (20.9)	8 (11.9)	44 (28.4)	42 (15.6)

Internal Medicine	516 (48.9)	61 (59.8)	50 (51.5)	146 (52.5)	51 (59.3)	35 (52.2)	32 (20.6)	141 (52.2)
Shift								
Morning	209 (19.8)	21 (20.6)	13 (13.4)	61 (21.9)	10 (11.6)	9 (13.4)	32 (20.6)	63 (23.3)
Night/Afternoon Shift	130 (12.3)	21 (20.6)	0 (0)	36 (12.9)	6 (7.0)	18 (26.9)	9 (5.8)	40 (14.8)
Mixed (Morning, Afternoon, Night)	716 (67.9)	60 (58.8)	84 (86.6)	181 (65.1)	70 (81.4)	40 (59.7)	114 (73.5)	167 (61.9)
Years of Experience in Nursing								
0 to 5	114 (10.8)	16 (15.7)	14 (14.4)	25 (9.0)	0 (0)	2 (3.0)	20 (12.9)	37 (13.7)
6 to 15	143 (13.6)	12 (11.8)	7 (7.2)	33 (11.9)	3 (3.5)	4 (6.0)	38 (24.5)	46 (17.0)
16 to 25	273 (25.9)	25 (24.5)	15 (15.5)	75 (27.0)	18 (20.9)	19 (28.4)	50 (32.3)	71 (26.3)
26 to 31	272 (25.8)	22 (21.3)	24 (24.7)	76 (27.3)	31 (36.0)	26 (38.8)	33 (21.3)	60 (22.2)
> 31	253 (24.0)	27 (26.7)	37 (38.1)	69 (24.9)	34 (39.5)	16 (23.9)	14 (9.0)	56 (20.7)

Registered nurses' attitudes toward end-of-life care

Findings from the study indicated that registered nurses (RNs) across all three hospital departments prioritized the delivery of safe, effective, and compassionate care for patients nearing the end of life. Nurses also highlighted the significance of addressing patients' spiritual needs, emphasizing the right to a dignified and pain-free death.

A statistically significant variation was observed among RNs from different departments regarding their attitudes toward working with terminally ill patients. Surgical nurses, compared to those in internal medicine and intensive care, more frequently expressed the need for psychological support to manage the emotional challenges of EOL care ($M = 4.20, p = .009$). They also showed a stronger belief that family members should have unrestricted access to visit patients both in terms of timing and duration ($M = 4.16, p < .001$).

Conversely, nurses working in internal medicine departments more often emphasized that patients should not be continuously sedated throughout their final days ($M = 3.69, p < .001$). Meanwhile, intensive care nurses reported feeling the most psychologically equipped to handle the emotional and ethical complexities associated with end-of-life situations ($M = 3.67, p = .011$) (Table 2).

Table 2. RN attitudes toward patient care at the end-of-life depending on the department.

Row No.	Statement	Surgical Department (n = 344)	Intensive Care Department (n = 195)	Internal Medicine Department (n = 516)	p-value
		M (SD)	M (SD)	M (SD)	
1	The patient should continue to receive all interventions to prevent pressure sores	4.66 (0.59)	4.73 (0.53)	4.68 (0.51)	0.331 ^c
2	The patient is entitled to a dignified and painless death	4.62 (0.60)	4.69 (0.54)	4.67 (0.56)	0.392 ^c
3	The patient should always be given the opportunity to receive last rituals that are appropriate to the religious and spiritual beliefs of the patient and their family	4.60 (0.58)	4.62 (0.62)	4.60 (0.58)	0.839 ^c
4	The patient should be cared for in the privacy of a private room	4.55 (0.60)	4.56 (0.67)	4.54 (0.63)	0.659 ^c
5	During EOL care, oro/endotracheal suction should be continued to maintain the airway of the patient	4.45 (0.60)	4.44 (0.67)	4.42 (0.60)	0.629 ^c

6	Healthcare professionals working with patients with extremely serious conditions and frequent deaths need psychological help	4.20 (0.79)	4.05 (0.83)	4.01 (0.89)	0.009 ^c
7	The family and friends of the patient should be permitted to visit at any time, day or night	4.16 (1.04)	3.28 (1.25)	4.04 (1.09)	< 0.001 ^c
8	It is advisable for a patient suffering from an incurable disease to be given the optimum amount of painkillers, despite the fact that this would accelerate his death	4.14 (0.78)	4.21 (0.76)	4.20 (0.78)	0.419 ^c
9	Patients have the right to refuse treatment, even though this would result in their death	3.87 (0.93)	3.86 (0.97)	3.95 (0.91)	0.354 ^c
10	Some patients may be excluded from their treatment and nursing decisions because of doubts about their ability to assess the situation	3.86 (0.78)	3.92 (0.80)	3.83 (0.83)	0.481 ^c
11	Talking with doctors about solving end-of-life problems in a patient has a positive effect on nurses' job satisfaction	3.76 (0.94)	3.91 (0.86)	3.73 (0.98)	0.128 ^c
12	During EOL care, the patient should continue to receive fluids to maintain hydration	3.72 (1.04)	3.87 (1.04)	3.70 (1.03)	0.126 ^c
13	Nurses have sufficient knowledge of their patients to make an informed decision about what they want	3.67 (0.97)	3.62 (0.97)	3.71 (1.01)	0.393 ^c
14	Interviews with the patient's family about solving the patient's end-of-life problems have a positive influence on nurses' job satisfaction	3.64 (1.00)	3.66 (0.95)	3.59 (1.01)	0.730 ^c
15	Patient consciousness should not be permanently suppressed by sedation	3.52 (1.01)	3.27 (1.06)	3.69 (1.01)	< 0.001 ^c
16	You feel psychologically prepared to deal with critical care issues	3.49 (1.01)	3.67 (1.05)	3.66 (0.97)	0.011 ^c
17	Nurses must respect the patient's wishes, even if they are contrary to their own beliefs	3.32 (1.01)	3.29 (1.09)	3.32 (1.06)	0.941 ^c
18	The family and friends of the patient should be permitted to visit the patient at the bedside without a restriction on the number of family members and friends	2.92 (1.19)	2.63 (1.17)	2.91 (1.24)	0.006 ^c

Used Kruskal Wallis Test

Registered nurses' attitudes toward barriers and facilitating behaviors in providing end-of-life care

The analysis of barriers perceived by registered nurses (RNs) revealed several recurring challenges in delivering effective end-of-life (EOL) care. In the first group of barriers—those rated with an average score above 4—nurses across all departments identified managing angry family members ($p = .004$) and relatives' inadequate understanding of nursing care (NS) as major obstacles. Intensive care nurses, in particular, more frequently reported difficulties with family members and friends who repeatedly called the ward to inquire about the patient's condition instead of consulting the designated contact person ($M = 4.02, p = .034$). They also highlighted disagreements among family members regarding the most appropriate care for the patient as a significant hindrance ($M = 3.90, p = .046$).

In the second cluster of barriers, with mean scores ranging from 3.5 to 4.0, nurses most often pointed to family members' insufficient knowledge of the patient's condition and the limited time available to discuss patients' end-of-life wishes as substantial challenges.

The third group of barriers, with average scores below 3.5, included issues such as nurses' limited knowledge in communicating with bereaved families, the lack of acknowledgment of nurses' professional opinions, and physicians' avoidance of discussing the diagnosis or their tendency to present overly optimistic assessments of the patient's prognosis. Differences among departments in this category were not statistically significant (**Table 3**).

Table 3. RN attitudes to potential barriers in ensuring patient care at end-of-life depending on the department.

Row No.	Statement	Surgical Department	Intensive Care Department	Internal Medicine Department	p-value
		(n = 344)	(n = 195)	(n = 516)	
		M (SD)	M (SD)	M (SD)	
1	The patient's relatives having inadequate understanding of the situation interfere with the nurses' duties	4.16 (0.73)	4.09 (0.75)	4.18 (0.72)	0.319 ^c
2	Nurses have to deal with angry patient's family members	4.04 (0.86)	4.05 (0.87)	4.18 (0.87)	0.004 ^c
3	Family has no access to psychological help after being informed about the patient's diagnosis	3.97 (0.91)	4.04 (0.89)	3.86 (1.04)	0.217 ^c
4	Usually there is no time for conversations with patients about their wishes concerning end-of-life decisions	3.95 (0.85)	3.89 (0.87)	4.00 (0.87)	0.150 ^c
5	Family members or friends regularly call for a nurse in order to find out about the patient's condition instead of addressing an informed family member	3.83 (0.87)	4.02 (0.85)	3.83 (0.92)	0.034 ^c
6	Very often, the patient's family members disagree on which treatment is most appropriate	3.80 (0.81)	3.75 (0.89)	3.83 (0.85)	0.449 ^c
7	The patient's family members disagree on what kind of care is the most adequate	3.72 (0.87)	3.90 (0.78)	3.85 (0.87)	0.046 ^c
8	The lack of nursing knowledge on how to treat the patient's grieving family	3.42 (0.99)	3.33 (0.99)	3.26 (1.06)	0.125 ^c
9	The nurse's opinion on immediate patient care is not welcome, valued, or discussed	3.40 (1.09)	3.46 (1.08)	3.39 (1.11)	0.770 ^c
10	Physicians are too optimistic about the patient's survival prospects during conversations with the patient's family members	3.27 (0.99)	3.19 (0.97)	3.25 (1.03)	0.627 ^c
11	Physicians are evasive and avoid conversation with the patient and/or family members	3.09 (1.10)	2.91 (1.07)	3.08 (1.14)	0.251 ^c

Used Kruskal Wallis Test

Facilitating factors in providing end-of-life care

Data regarding factors that could enhance end-of-life (EOL) care are summarized in **Table 4**. Across all departments, registered nurses (RNs) consistently identified family education on caring for seriously ill patients as a key facilitator that would ease the nurses' workload and improve care quality. Likewise, respondents from surgical, internal medicine, and intensive care units emphasized that participation in EOL care training programs, engagement in volunteer activities, and active involvement of patients' families would all contribute positively to the delivery of effective and compassionate EOL care. Differences among the three groups of nurses were not statistically significant.

Table 4. Factors facilitating end-of-life care for patients depending on the department.

Row No.	Statement	Surgical Department	Intensive Care Department	Internal Medicine Department	p-value
		(n = 344)	(n = 195)	(n = 516)	
		M (SD)	M (SD)	M (SD)	
1	Teaching families how to act with a dying patient	4.08 (0.79)	4.15 (0.65)	4.18 (0.67)	0.343 ^c
2	End-of-life patient care training	3.97 (0.80)	3.97 (0.67)	4.06 (0.75)	0.066 ^c
3	Auxiliary personnel helping the nurse with the patient's care	3.74 (0.86)	3.66 (0.90)	3.80 (0.93)	0.130 ^c
4	Having one family member be the designated contact person for all other family members regarding information about the patient	3.66 (1.05)	3.87 (0.92)	3.75 (1.03)	0.131 ^c
5	The family of the patient who appreciates your work in caring for a patient with a serious condition	3.61 (0.91)	3.58 (0.86)	3.55 (0.99)	0.736 ^c

6	Nurse talking with patient about their feelings and thoughts about death	3.47 (0.93)	3.60 (0.88)	3.49 (0.97)	0.263 ^c
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Used Kruskal Wallis Test

The quality of end-of-life (EOL) care largely depends on nurses' attitudes toward death and dying. In this study, registered nurses (RNs) emphasized the importance of addressing patients' spiritual needs, reflecting a holistic perspective on EOL care. Similar findings have been reported in other studies, which note that patients in terminal stages face not only physical discomfort but also spiritual and existential distress, often seeking to discuss these concerns with nurses or other healthcare professionals [29, 30]. Spirituality, as a component of holistic nursing, is crucial in helping patients find meaning and peace at the end of life. However, much of EOL care in practice still focuses mainly on symptom control rather than comprehensive holistic support [31, 32]. The present study's results suggest that nurses recognized the necessity of integrating both safe and effective medical care with respect for patients' dignity, pain-free death, and spiritual or religious practices.

Understanding the behaviors that facilitate EOL care helps illuminate the barriers nurses encounter in practice. Previous research has shown that the most common obstacles involve patients' families—particularly those who express anger, denial, or unrealistic expectations—and certain physician behaviors [26, 33, 34]. Similarly, in this study, nurses across all departments identified communication difficulties with patients' relatives and their reluctance to accept terminal prognoses as major impediments. Another significant challenge reported was the lack of time to discuss patients' wishes and preferences for end-of-life treatment. The heavy workload of nurses, especially when attending to the physical needs of severely ill patients, often leaves insufficient time for emotional and spiritual care.

EOL decisions—such as continuing or discontinuing life-sustaining interventions—should be guided by clinical considerations and the patient's values, yet these decisions remain culturally and ethically complex [11, 12]. Physicians play a decisive role in initiating or terminating treatment; however, many nurses in this study reported that their opinions regarding direct patient care were often ignored or undervalued. Earlier research noted that physicians in Northern and Central Europe were more likely to engage ICU nurses in EOL discussions compared with those in other regions, including North America, Japan, and Brazil [35]. The persistence of hierarchical dynamics and differing professional attitudes can therefore impede collaboration and reduce the overall quality of EOL care [24]. Findings from this study confirm that nurses continue to experience marginalization in EOL decision-making, contributing to both patient dissatisfaction and professional frustration among nurses.

When identifying factors that could improve EOL care, nurses highlighted the need for family education on caring for seriously ill patients, as well as the involvement of volunteers and social workers to support nursing staff. Allowing families adequate time to say goodbye, helping them accept the dying process, and providing emotional support were also viewed as essential to enhancing care quality [36, 37]. Such measures not only ease the psychological burden on nurses but also promote a more compassionate and collaborative EOL environment.

Conclusion

Nurses' perspectives on EOL care may vary depending on their clinical setting. Across departments, addressing patients' spiritual needs was recognized as a primary aspect of quality care at the end of life. Nonetheless, several barriers persist—most notably those related to family dynamics and communication, as well as challenges arising from physician–nurse relationships. To improve the quality of EOL care, key areas for focus include: (1) educating and engaging families in the care process, (2) strengthening collaboration and mutual respect between nurses and physicians in EOL decision-making, and (3) creating supportive work environments that reduce emotional strain for both healthcare providers and family members

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