UFSM
REUFSM
REVISTA DE ENFERMAGEM DA UFSM
ISSN 2179-7692
OPEN ACCESS

Rev. Enferm. UFSM, v.15, e16, p.1-21, 2025 •
Submission: 08/30/2024 • Acceptance: 08/20/2025 • Publication: 10/13/2025

Original article

Nursing students' perceptions and coping in end-of-life situations

Percepções de acadêmicos de enfermagem frente à terminalidade de vida e a morte

Percepciones de los estudiantes de enfermería ante la terminalidad de la vida y la muerte

Luis Eduardo Oliveira dos Passos[I], Silvana Bastos Cogo[II], Aline Ost dos Santos[III], Carolina Heleonora Pilger[IV], Vanúzia Sari[II], Graciela Dutra Sehnem[II]

[I] Empresa União Assistencial, Passo Fundo, Rio Grande do Sul, Brazil
[II] Universidade Federal de Santa Maria, Santa Maria, Rio Grande do Sul, Brazil
[III] Universidade Federal de Rio Grande, Rio Grande, Rio Grande do Sul, Brazil
[IV] Universidade Federal do Rio Grande do Sul, Porto Alegre, Rio Grande do Sul, Brazil

Abstract

Objective: to understand nursing students' perceptions, feelings, and coping strategies when caring for patients at the end of life. **Method:** qualitative, descriptive-exploratory study. From June to November 2021, semi-structured interviews were conducted with 15 nursing students. Data were analyzed using discursive textual analysis. **Results:** three categories emerged: (1) Nursing students' perceptions and feelings about patients' death and dying in end-of-life care; (2) Nursing students' coping strategies when caring for patients at the end of life and at the time of death; and (3) Teaching about death and end of life in undergraduate nursing education. **Conclusion:** nursing curricula should include teaching on compassionate communication and the management of suffering and end-of-life symptoms. Providing emotional support and teaching coping strategies can better prepare students for end-of-life care.

Descriptors: Students, Nursing; Education, Nursing; Death; Attitude to Death; Terminal Care

Resumo

Objetivo: compreender as percepções, os sentimentos e as estratégias de enfrentamento adotadas por acadêmicos de Enfermagem diante da terminalidade da vida e da morte dos pacientes. **Método**: pesquisa qualitativa, descritivo-exploratória. Entre junho e novembro de 2021, realizaram-se entrevistas semiestruturadas com 15 acadêmicos de Enfermagem. Os dados foram submetidos à análise textual discursiva. **Resultados**: emergiram três categorias: percepções e sentimentos dos acadêmicos de Enfermagem sobre a morte e o morrer de pacientes em terminalidade de vida; estratégias de enfrentamento dos acadêmicos diante da terminalidade de vida e da morte de um paciente; o ensino sobre a morte e a terminalidade de vida na graduação de enfermagem. **Conclusão**: a formação acadêmica deve incluir o ensino de comunicação compassiva e o manejo do sofrimento e de sintomas terminais. É fundamental oferecer apoio emocional e ensinar estratégias de enfrentamento aos estudantes para prepará-los melhor para o cuidado na terminalidade de vida.

Descritores: Estudantes de Enfermagem; Educação em Enfermagem; Morte; Atitude Frente à Morte; Assistência Terminal

Resumen

Objetivo: comprender las percepciones, los sentimientos y las estrategias de afrontamiento adoptadas por los estudiantes de Enfermería frente a la terminalidad de la vida y la muerte de los pacientes. **Método**: investigación cualitativa, de carácter descriptivo y exploratorio. Entre junio y noviembre de 2021 se realizaron entrevistas semiestructuradas con 15 estudiantes de Enfermería. Los datos fueron sometidos a análisis textual discursivo. **Resultados**: surgieron tres categorías: percepciones y sentimientos de los estudiantes de Enfermería acerca de la muerte y el proceso de morir de pacientes en situación de terminalidad; estrategias de afrontamiento empleadas por los estudiantes ante la terminalidad de la vida y la muerte de un paciente; y la enseñanza sobre la muerte y la terminalidad de la vida en la formación de grado en enfermería. **Conclusión**: la formación académica debe incluir la enseñanza de la comunicación compasiva y del manejo del sufrimiento y de los síntomas terminales. Es fundamental ofrecer apoyo emocional y enseñar estrategias de afrontamiento a los estudiantes para prepararlos mejor para el cuidado en la terminalidad de la vida.

Descriptors: Estudiantes de Enfermería; Educación en Enfermería; Muerte; Actitud Frente a la Muerte; Cuidado Terminal

Introduction

End of life is a term in palliative medicine used to describe the final stage of a person’s life when a debilitating medical condition or life-limiting illness is present.[1] Care, which includes helping patients and their loved ones prepare for the inevitable, focuses on comfort and the relief of suffering. Death is an inevitable biological event; it also has social, religious, and philosophical dimensions. Witnessing another person’s death, especially during direct end-of-life care, is a relatively common experience for health professions students, particularly nursing students.[2] However, for contemporary society, death and issues related to it have been perceived with discomfort and associated with a negative connotation, often seen as a sign of failure in medicine.[3]

In clinical settings, when witnessing an end-of-life situation and the uniqueness of the experience that accompanies it, many students and professionals feel unprepared to provide care and struggle to process their own feelings or to attend to those expressed by others.[4-5] At times, when faced with the impending death of some of the patients under their care, students confront the difficult task of prioritizing life-sustaining care for other patients over those who require a good and timely death.

There is also a lack of clinical and emotional support to cope with such an event. These gaps contribute to less humanized end-of-life care and to resistance to acknowledging or making sense of loss, suffering, sadness, fear4, and grief.

Academic training generally focuses on health promotion, the prevention and treatment of health conditions, and the rehabilitation and management of chronic noncommunicable diseases with an emphasis on sustaining life. This scenario perpetuates professional gratification centered on cure, creating stigma toward palliative care and end-of-life care, which can generate negative feelings among professionals and affect their mental health, ultimately leading to illness.[6]

Although there is no single way to act in the face of the end of life and the process of death and dying, the approach of death is a phenomenon that elicits reactions and, for this very reason, can impose an emotional burden on the health care team, particularly on nursing professionals, affecting their functioning. It is, therefore, essential to provide these professionals with psychological and emotional support and to attend to organizational and environmental factors that can support the management of death and dying.[7]

Professionals must be urgently prepared to deal with patients' end of life and death while also receiving support and care during this experience. Academia needs to create educational spaces that address these aspects from undergraduate through graduate education; this approach should be grounded in research on students' attitudes toward these experiences, the feelings they arouse, and the interventions that promote compassionate and assertive attitudes.[7]

Understanding nursing students' perceptions of end-of-life care and patient death can foster the development of pedagogical strategies that encourage meaningful, collaborative, and solution-oriented reflection. Although national[8-11] and international[12-14] investigations point to the need to incorporate palliative care and end-of-life care into health curricula, such approaches are not always translated into effective educational practices.[15] A new perspective on this topic can help fill these educational gaps and provide guidance to enhance its integration into curricula more sensitively and critically, aligned with students' actual needs.

Based on these premises, this study addresses the following research question: What are nursing students' perceptions, and how do they approach caring for patients at the end of life and at the time of death? It aims to understand nursing students' perceptions, feelings, and coping strategies in the face of patients' end of life and death.

Method

This qualitative, descriptive, and exploratory study recruited participants through convenience sampling. Eligible participants were students enrolled in the 7th–10th semesters of an undergraduate nursing program at a public university in the Southern Region of Brazil, whose standard curriculum comprises ten semesters. Students on medical leave or any other type of leave during the data collection period were excluded.

The inclusion criteria were defined under the hypothesis that longer clinical experience would provide more frequent contact with patients at the end of life and greater exposure to death and dying, thereby enhancing the study's representativeness.

Data were collected through semi-structured interviews that addressed: the meaning of death; feelings or thoughts evoked by the word "death"; emotions experienced while caring for patients at the end of life and during the process of death and dying; how clinical classes address care for patients at the end of life; how the topic of "death and dying" is addressed in undergraduate education; strategies suggested for addressing end of life in the curriculum and the recommended semesters for doing so; meanings attributed to death across age groups; and coping strategies adopted during care at the end of life and at the time of death.

Data collection occurred from June to November 2021 in an online format due to the COVID-19 pandemic. The interviewer was a male nursing student trained in semi-structured interviewing and with a personal interest in the topic. No pilot testing or repeat interviews were conducted. The interview questions were developed by the principal investigator, a PhD in Nursing whose research area focuses on the process of death and dying, and by a master's student in Nursing, drawing on prior studies from the research group and on scientific evidence.

The students' contact information was obtained from the program office. Initially, an email was sent to the four cohorts introducing the study, its objectives, and the risks and benefits of participation. Interested students were identified, and a second invitation was sent to their personal email addresses to confirm participation and schedule the interview. For those who did not respond to the emails, one additional contact attempt was made via private messages on social media. Of the 45 students contacted, 15 agreed to participate and 30 did not respond; nonresponse was interpreted as refusal. There were no dropouts in subsequent phases.

Interested students received the Informed Consent Form (ICF) via Google Forms. After they agreed to participate, the interviews were scheduled and conducted virtually via Google Meet, with only the participant and the researcher present. All sessions were video-recorded and transcribed verbatim in Microsoft Word to ensure data fidelity. Transcripts were not returned to participants for comments or corrections. The interviews had a mean duration of 10 minutes.

No qualitative data management software was used to assist with the analysis. Data analysis followed the four steps of discursive textual analysis.[16] In the first step, corresponding to disassembling the text, the information was examined and unitized, then broken down and later regrouped based on similarities to create textual units of the phenomenon under study. In the second step, relationships were established to form categories by combining similar characteristics identified in the data collected.[16]

In the third step, termed “capturing new emergent,”[16] a metatext was constructed from the analysis of sets of categories and subcategories, allowing theorization of the phenomenon under study. Producing the metatext is a learning process that begins with deconstructing and fragmenting the corpus, followed by a self-organized process of reconstruction, which generates new understandings. This self-organization constitutes the fourth and final element of discursive textual analysis, which seeks to transform chaos and disorder into new, creative ways of understanding the phenomenon.[16]

This study adhered to all ethical principles applicable to research involving human participants, in accordance with the National Health Council guidelines. The Research Ethics Committee of the host higher education institution approved it (approval No. 4,650,120; CAAE: 45326921.6.0000.5346). To preserve anonymity, the letter “P” followed by an Arabic numeral reflecting interview order (e.g., P1–P15) identified participants.

Results

Fifteen undergraduate nursing students participated in the study, aged 21–49 years; by sex, 14 were female and one was male. At the time of data collection, 11 were enrolled in the 7th semester, one in the 8th, and three in the 10th semester. Three participants had completed the elective course titled "The process of death and dying: a new perspective on death and life," offered by the university; the remaining students (n = 12) had not.

When asked about their religious affiliation, six participants reported having no specific religion, five identified as Catholic, two as Protestant, one as Lutheran, and one as agnostic.

Analysis of the interviews identified three categories regarding the study topic: (1) Nursing students' perceptions and feelings about patients' death and dying in end-of-life care; (2) Nursing students' coping strategies when caring for patients at the end of life and at the time of death; and (3) Teaching about death and end of life in undergraduate nursing education.

Nursing students' perceptions and feelings about patients' death and dying in end-of-life care

From the perspective of nursing students, the end of life and death carry a range of meanings rooted primarily in students' unique life experiences.

> *It is the end of a cycle. It depends a lot—for each person it will mean something different. I personally think death is the end of your mission on earth. (P10)*

This reference to a mission highlights that each student's spirituality and religious beliefs shape—at least to some extent—how they ascribe meaning to death and dying.

> *Because of my religion, my faith, I see death as something that happens, that is necessary, and that there is something beyond this life—but it is something we will all go through. (P5)*

Some participants view death as a natural stage in the life cycle—something everyone will inevitably face—interpreting it both as the close of a cycle and as an event imbued with transcendence and a sense of mysticism.

> *Death is a passage. We came here to earth, we spend some time, and when we die we will have another, more spiritual experience, and we will carry the memories we acquired in this life. (P12)*
> *Death is a process of passage, whether from this life to another or simply leaving this life. (P8)*

Death was also described as a source of relief that eases suffering and affords rest to patients facing extremely debilitating, disabling, and painful illnesses.

> *For me, in some cases death is relief, because there is so much suffering. (P3)*
> *Sometimes it is rest—it depends on the context. It can feel like a sentence; other times it gives meaning to life. I think we can interpret death in many ways; depending on the context, it can take on different facets. (P2)*

Another theme that emerged was the ever-present nature of the end of life and death in the lives of nursing students and practitioners throughout their careers.

> *I try to think of death as a friend who accompanies us throughout life. (P1)*

When understood from this perspective, the end of life can even give meaning to existence—for both those who provide care and those who receive it—even though it represents a definitive and irreversible condition.

Regardless of their views, a wide range of feelings was elicited as students witnessed the physical, mental, and emotional deterioration that accompanies patients' end of life and the process of death and dying among some of those under their care. The physical and symbolic losses experienced by these patients and their loved ones also generated varied feelings, including anguish, sadness, pain, fear, and a sense of relief. In many cases, empathy toward the patient's experience and the suffering of family members acted as a catalyst for these emotions.

> *Sadness, pain, anguish—especially when it is someone close. And I think that when we are faced with someone who is in the process of dying, it is impossible not to be moved, to try to put ourselves in the place of those family members and feel their sadness and their pain. (P4)*

For some students, a sense of powerlessness was added to the sadness and pain already experienced, particularly when they faced unfavorable prognoses with no disease-modifying treatments available.

> *Sadness—just bad feelings—from seeing that person like that and knowing that nothing more can be done. (P6)*

Findings indicated that, for a subset of students, caring for people who are dying and for their loved ones is not always easy or gratifying. Enduring end-of-life situations—when they become time-bound, concrete, and urgent—can be especially challenging. Here, "to support" should be understood both as offering support to others and as inwardly bearing the emotional and psychological weight of care.

> *There is sadness, because it is very difficult to deal with death; it is very difficult to accept that people are dying [...]. (P11)*

In certain circumstances, difficulty in dealing with another person's death was linked to not knowing how to offer support—what to say or how to care for someone at the end of life—even when that person is at peace with their diagnosis and prognosis. For some interviewees, accepting the death of someone who appears "alive and happy" can be even more complex and painful.

> *I have a problem with not knowing what to say, how to act; maybe I am prone to behaving in ways that are not called for, because sometimes the person is at the end of life and they are fine, happy, fulfilled—they have accepted it—and I wouldn't know how to deal with someone like that, but it's a process. (P2)*

At this point, death was seen as more acceptable and less distressing when it involved individuals with severely deteriorated clinical states, recognized by the students as being in active dying. For these patients, death was not only expected but also, in a certain sense, desired. In this scenario, some interviewees reported redirecting their attention and emotions to bereaved family members. Perceiving the grief and pain of others generated feelings of compassion, sympathy, and empathy.

> *I always think more about the family, because the patient is there in a state of suffering; as students, we can see that they are reaching the end of life, but there are family members who will keep living. I feel impacted—moved—by the situation. (P5)*

Evidently, patients' end of life and death, and the grief of their loved ones, stirred a diversity of feelings and emotions among students, at times constituting a stressor that required them to adopt coping strategies.

Nursing students' coping strategies when caring for patients at the end of life and at the time of death

Each student confronts patients’ end of life and death in a personal way, shaped by prior exposure to stressors; perceptions of death and dying; how the topic has been addressed throughout their life; personality traits; and the uniqueness of each experience.

The coping approaches identified in this study included problem-focused strategies (e.g., analyzing the experience), emotion-focused strategies (e.g., praying or crying), and social support–seeking strategies (e.g., talking with others); these often co-occurred and were mutually reinforcing. Defensive behaviors, such as distancing or withdrawal, were also observed.

For some students, pausing to reflect—and recognizing that all necessary care had been provided—helped them accept that death was a plausible outcome, despite the emotional difficulty of providing care during the end of life and the process of death and dying.

> *That feeling of having provided good care—when I thought about everything that happened, I realized the care provided had been the most appropriate, that there had been no negligence or delay. That ends up bringing comfort; it doesn’t leave a sense of guilt, and we can move forward more at ease. (P12)*

Notably, participants did not always recognize right away that their coping responses were helping them manage the situation. For some interviewees, recognizing these strategies as forms of coping occurred only after a period of emotional distress. In other words, awareness that such approaches could foster professional resilience was often delayed.

> *[...] I was deeply shaken throughout the day; I am not quite sure what I used to cope, but I began to think that what could be done had been done—that there was nothing else to do. So I started to accept it. (P6)*

Other interviewees found support in belief in a higher power, faith, and religious and spiritual practices, using these beliefs to regulate the emotional responses triggered by patients’ end of life and death under their care.

> *[...]religion helps me a lot—I’m a devout Catholic. I believe in God, and I think all health professionals need some source of comfort to cope with this; personally, I cope through my religion—I pray every day. (P10)*

Seeking social support within their networks, especially through conversations and shared reflection, was also identified as an effective strategy to mitigate potential negative effects associated with patients' end of life and death. This support was key to navigating these experiences. Examples included talking with classmates and receiving support from peers who had gone through similar situations.

> *I talked with students who were further along in the program and shared what I'd been through. (P5)*

Some interviewees also cited personal characteristics and specific behavioral strategies as coping resources that helped minimize or relieve the internal demands generated by the stressor.

> *When I'm feeling those feelings (pain/sadness), I try to talk to someone or go for a run—you know when you just take off running; I go out to shake it off. (P1)*
> *I cry—I'm a crier; I cry about everything. Crying helps me let out what's distressing me, but crying is all I do. That's how I get relief; we don't really know how to relieve it. But I've learned that when I cry, I feel better. (P3).*

Teaching about death and end of life in undergraduate nursing education

When reflecting on their preparation to care for patients at the end of life and at the time of death, participants indicated that the topic has been treated superficially and insufficiently in undergraduate education. They emphasized that their training did not equip them with the knowledge and skills needed to care appropriately for people at the end of life and for bereaved family members.

> *[...]We had a few courses that touched on the topic superficially, but I think these issues should be worked on more in our undergraduate program, because it will be very important for us as future nurses. That way we would graduate better prepared to face this kind of situation. (P9)*

Some students reported feeling unsure about the stance to adopt, the actions to take, and the words to use when caring for people at the end of life and their family members. This distress tended to intensify with pediatric patients. Practical exposure to end-of-life situations or to family bereavement was infrequent for the interviewees, occurring only sporadically, even in the final semesters of the program.

> *I think this is missing in the undergraduate program, because it is still very much a taboo for us to talk about death and even about grief. Of course I haven't had many experiences with death, but if you told me that a given patient is at the end of life, I wouldn't know how to approach and talk with them, or what to say to the family—and even less so if it is a child. (P7)*

Given the limited practical exposure and the superficiality of discussions on the subject, some students expected to acquire this knowledge only after graduation, through day-to-day practice.

> *I think it's talked about very little; I think most students are not prepared to deal with death. I think we'll learn only after we graduate, in practice. (P11)*

In this context, participants highlighted the need for academia to develop a teaching and learning process that addresses theoretical, technical, psychological and emotional, and communication aspects of end of life, death, dying, and bereavement. They also expressed the desire for these topics to accompany students throughout their education—from the beginning to the end of the program—discussed and supported from multiple perspectives, across different stages of the life course, and by a diverse group of faculty members. This support becomes even more important as students begin their clinical placements.

> *From the very first time we go to clinical placements, we start by providing basic care, but we don't know what might happen, because one day I may be in a placement caring for a person and the next day receiving the news that they have died. That's why I believe it should be addressed from the first placements onward. (P9)*
>
> *I think discussions about death and dying should be embedded across all contexts. We tend to see it as a separate elective course, but it is present in all areas—we may encounter people at the end of life when working in primary care, not necessarily in the hospital. I think this topic should be addressed by all faculty. (P12)*

From some students' perspective, although having at least one course in the undergraduate curriculum devoted to death, dying, and end of life is important, a single course would not provide adequate preparation for care in these circumstances or for bereavement care. A stand-alone course would also be insufficient to effectively foster the adoption of coping strategies in this domain. One interviewee remarked that, in this specific respect, the responsibility for preparing to face the end of life and the first deaths of patients falls on each student. He noted that, if needed, students should seek psychological support to deal with these experiences.

> *Now we have this elective course that will help students a lot to understand this process—and I say partially, because faculty bring it up across the courses we take and prepare us by warning that this will happen, but sometimes there isn't deeper guidance; it's up to the student to take the initiative—preparing psychologically when needed—and, at times, to seek support from a psychologist to learn how to face all this. (P5)*

One suggestion for teaching and learning was to address end of life, death, and dying gradually throughout the program, using clinical cases in which the outcome involves the patient's death. The aim is to promote ongoing reflection on these topics across all stages of the human life course.

> *When we work with cases during courses, I think it's a way to make things clearer in our minds. For example, how a child's dying unfolded—how many days they were hospitalized, how many times the nurse or student had contact with them. And I think we should be direct about this point, making room for it in course sessions. (P5)*

Overall, the findings indicate weaknesses in undergraduate training with respect to care at the end of life, death, and bereavement. The accounts point to the need for a continuous, integrated approach that prepares students not only technically but also emotionally and in communication. These results underpin the reflection that follows regarding the meanings attributed to death and the limitations identified in the teaching and learning process for these topics.

Discussion

The understanding of death as a passage, the completion of a mission, or the closing of a cycle common to all reveals a continuum between life and death—one that goes beyond the strictly biological dimension traditionally attributed to the phenomenon and reaches symbolic, metaphysical, and spiritual dimensions. By moving away from purely biological definitions, participants related death to their personal experiences and acknowledged the right of the person in their care to preserve their uniqueness in this process. This perspective invites reflection on the extent to which such a broadened understanding may (or may not) support care that goes beyond the physical body, encompassing the emotional, spiritual, and symbolic dimensions of the person at the end of life.

For the interviewees, viewing the end of life and death as a natural event—through symbolism, religious beliefs, or the spiritual dimension—may have mitigated possible anguish and the existential suffering that accompanies living with these circumstances. This idea of a cyclical process, transcendence, and a sense of mysticism converges with findings from Brazilian studies that examined death and dying among students in nursing,[3,17–18] medicine,[19] and psychology,[20] as well as among patients at the end of life and their family members.[21]

However, conceiving death as part of the life cycle also implies, indirectly, an assumption that there are moments when its occurrence is more appropriate. The findings of this study indicate that the end of life and death are more often accepted when they occur at older ages or in the context of disabling illnesses associated with intense symptoms. This perception is corroborated by an investigation with Chilean nursing students, which identified the deaths of young people or children as more challenging than the deaths of older people, considered an expected end. The sudden or early death of children and young people was complicated for these students to accept.[18]

Conversely, if death is understood as a means of relieving suffering imposed by illness, it is necessary to ask to what extent care provided to patients at the end of life may have resulted in a futile prolongation of the dying process, adding further layers of suffering. Perhaps even more concerning is the possibility that, in the face of a patient's end of life and dying process, suffering is the only perceptible feature. Has academia truly taught students to assess and palliate distressing symptoms? Have patients had the right to access palliative care? Have nursing students had the opportunity to practice caring for people at the end of life, who are dying, and for their family members?

A meta-synthesis of 20 articles that sought to describe the available evidence on nursing students' experiences in caring for patients at the end of life and their family members showed that students did not necessarily consider that their patients might die while they were providing care. They were more likely to accept the death of those they cared for than had been assumed. Students' negative emotions were more closely associated with an inability to relieve distressing symptoms, communicate effectively, and comfort these patients than with fear of the patients' death.[5]

Undergraduate education appears to have provided insufficient preparation for relieving end-of-life symptoms and inadequate training in compassionate communication. Instead, students often rely on intuition or personal/family experiences when caring for and communicating with people at the end of life and their family members. The findings of this study confirmed this difficulty among students, which may have contributed to feelings of sadness, powerlessness, distress, and fear—or even to the impression that only death could bring relief of the patient’s suffering and the rest they desired. These emotions were also expressed in other studies with health professions students.[2,17,22–23]

Accordingly, strengthening students’ skills in managing end-of-life symptoms, in end-of-life care, and in communication during end-of-life and bereavement situations is a practical way to reduce negative feelings during these experiences. This may also improve students’ coping strategies.[5]

“Coping” can be understood as the set of cognitive and behavioral strategies that individuals use to deal with situations perceived as stressful or challenging.[24] Conversely, a sense of inability or limitation in the face of a patient’s process of death and dying may translate into grief for the student.[23]

Faculty, advisors, and supervisors should provide clinical and emotional support, as well as prepare students for contact with patients at the end of life, particularly in terms of the psychological and emotional demands that will arise from such encounters. This is important not only for future professional practice but also because, typically, it is during supervised clinical practice and internships that students first experience the death of a patient, often without sufficient competence to manage crises.[7]

Nevertheless, the findings of this study indicate that discussions of end of life, death, and dying within academic settings have been superficial and insufficient to develop the competencies required for care in such circumstances. The essentially theoretical character and lack of cross-curricular integration limited the topic to a few courses and to specific points in the program, failing to span all stages of the life course. Other studies share this understanding in health degree programs.[5,15,17,19]

It is essential to restructure undergraduate curricula to expand knowledge, care resources, and coping strategies used in caring for people at the end of life, during death, and in bereavement. Dedicated courses in thanatology and palliative care should be integrated into curricula.

Creating spaces for discussion, reflection, active listening, and the sharing of knowledge and experiences with students is also necessary.[4] Sharing experiences with peers, faculty, and clinical preceptors—and, in specific cases, with psychologists—will enable students to receive psychological and practical support for care in end-of-life contexts. This perspective will reduce anguish and ease feelings of inadequacy.[5] Sharing experiences with classmates and reflecting on their experiences were coping strategies reported in this study.

It will likewise be useful to promote specific programs that support the development of communication competencies and emotional skills throughout academic training and beyond.[25] Clinical simulation activities can be particularly beneficial in this regard.

Furthermore, educational institutions should, where possible, include psychological support or student support groups as a complementary practice to training in these contents.[26] Professionals trained in coping or psychology can contribute to teaching competencies related to care at death, dying, and bereavement care.[20] They can also deliver interventions for students that foster the expression of emotions in these experiences and healthy coping with patients' end of life and death.[27] After all, it is inevitable that a patient's death and dying will entail some degree of suffering for caregivers and for those being cared for (patients and family members).

Although academia and health institutions cannot control the specific clinical circumstances in which students encounter death or end-of-life care, promoting exposure to such situations during clinical practice is crucial. When properly supported and guided, this experience can have a profound pedagogical impact on the development of the competencies needed for care in these moments;[28] as well as on learning effective coping strategies (problem-focused and social-support-seeking). Demystifying the end of life is essential to promoting a culture that discourages self-blame and moves away from the view of death as a failure of care.

Open dialogue and support can help students navigate these situations with competence and empathy. When students receive appropriate support and have opportunities to reflect on their experiences, potential negative aspects associated with this process—such as feelings of inadequacy, exclusion, and role conflict—are mitigated.[28]

This approach will help students build their resilience. Ultimately, the challenge is to strengthen the ability to share in another person's pain without compromising one's own well-being.[29]

It is also worth noting that coping strategies focused solely on emotion—such as religiosity and crying, as mentioned in this study—may be insufficient to prevent compassion fatigue when caring for patients at the end of life and in the process of death and dying.

With adequate preparation, however, students will feel able to "be there," accompanying the patient, looking them in the eye without fear, with love, and with deep gratitude to the patient and their family. This learning process not only enriches the relationship with the patient but also strengthens their appreciation for life itself—of all that it offers and teaches through these experiences.[30]

Learning to view death and dying through the lens of care is also crucial for developing open, compassionate conversations with patients at the end of life and their family members. This includes eliciting and understanding the patient's wishes, preferences, and needs, ensuring the patient's voice is heard even when verbal expression is no longer possible. Recognizing and validating the other's experience is fundamental to tailoring and improving the end-of-life care plan. That recognition begins with the health professional, who must cultivate the ability to perceive both the other and themselves.

The main limitations of this study include the use of non-probability sampling and the restriction of data collection to a single public higher-education institution, which limits the generalizability of the findings to other contexts and institutions. In addition, data collection occurred during the COVID-19 pandemic, which temporarily disrupted social and educational interactions. Therefore, the findings and interpretations may not be generalizable; however, they enrich the existing body of research by complementing other investigations with similar results.

This study has practical implications, as it corroborates similar studies and highlights gaps in curricula and in nurse training, particularly regarding the content and approach to end-of-life care, death, and bereavement. The findings are relevant to both nursing education and the health field as a whole, as they highlight the need for both curricular and pedagogical revision.

Building inter- and transdisciplinary partnerships—including with programs such as psychology and other health disciplines—can help create broader opportunities for discussion, reflection, and the sharing of experiences related to death, dying, and bereavement care. In addition, collaboration with experts in coping can support the development of alternatives and support mechanisms that help students cultivate effective coping skills when facing patients' end of life and death under their care.

Future research should: evaluate the impact of clinical simulation strategies on end-of-life care, end-of-life symptom control, communication in end-of-life situations, and bereavement care with respect to students' knowledge, skills, and attitudes; assess health professions students' attitudes toward death before and after specific educational and/or support interventions, using a validated scale; and understand the coping strategies students use when caring for patients at the end of life and explore how these strategies relate to the concept of death they hold.

Conclusion

The findings of this study show that nursing students ascribe varied meanings to patients' end of life and death, grounded in their personal experiences. The most frequently reported perspectives included death as a phenomenon with a spiritual or religious dimension—characterized by transcendence and a sense of mysticism—as part of a natural cycle, or as a means of relieving illness-related suffering. While providing care at the end of life and at the time of death, students reported a range of emotions, including pain, sadness, distress, fear, powerlessness, insecurity, sympathy, and empathy.

The interviewed students used a range of coping strategies, including emotion-focused strategies (such as religiosity and crying), problem-focused strategies (such as reflecting on the experience), and social support–seeking strategies (such as conversations with peers and mentors). These approaches were used to navigate the complex experiences associated with caring for people at the end of life and their family members.

The study also revealed perceived fragility and insecurity in user embracement, communication, and care for patients at the end of life or in active dying, as well as for family members in bereavement (anticipatory/pre-loss or post-loss). According to participants, the undergraduate nursing program at the study institution primarily addresses the topic at a conceptual and theoretical level, albeit superficially and insufficiently. A lack of cross-curricular integration confines the topic to a few courses and specific points in the program, with limited pedagogical impact on developing the technical, emotional, and communication competencies needed for care at the end of life, during death and dying, and in bereavement.

These findings suggest that undergraduate nursing education should more effectively integrate teaching on compassionate communication with patients at the end of life and their family members, as well as the management of suffering and end-of-life symptoms. It is essential to provide emotional support to students and teach effective coping strategies to prepare them for the complexity of end-of-life care. Implementing these improvements will not only enrich academic training and promote students' well-being but also improve the quality of care delivered to patients and their families at the end of life and at the time of death.

References

1. Cordeiro FR, Oliveira SG, Giudice JZ, Fernandes VP, Oliveira AT. Definiciones para "cuidados paliativos", "final de vida" y "enfermedad terminal" en oncología: scoping review. Enfermería (Montev En Línea). 2020;9(2):205-28. doi: 10.22235/ECH.V9I2.2317.

2. Santos GKN, Oliveira LC, Fonseca MRA, Sousa DA, Lima PAL, Barros LM. O medo da morte e do morrer em estudantes da área da saúde. Psicol Pesqui (Online). 2022;16(1):1-20. doi: 10.34019/1982-1247.2022.v16.30075.

3. Medeiros DS, Melo MCSC, Souza RCM, Salimena AMO. Conhecimentos e significados da morte para discentes de enfermagem. Rev Bras Pesqui Saúde. 2020;22(2):89-95. doi: 10.47456/rbps.v22i2.19965.

4. Hey AP, Tonocchii RC, Agudo AT, Garraza TS, Szczypior DM, Massi GAA. Perceptions about the role of nurses in people at the end of life. Rev Enferm UFSM. 2021;11:e21. doi: 10.5902/2179769243525.

5. Wang Y. Nursing students' experiences of caring for dying patients and their families: a

systematic review and meta-synthesis. Front Nurs. 2019;6(4):261-72. doi: 10.2478/FON-2019-0042.

6. Lopes MFGL, Melo YST, Santos MWCL, Oliveira DAL, Maciel AMSB. Vivências de enfermeiros no cuidado às pessoas em processo de finitude. Rev Ciênc Plur. 2020;6(2):82-100. doi: 10.21680/2446-7286.2020v6n2ID18828.

7. Cybulska AM, Żołnowska MA, Schneider-Matyka D, Nowak M, Starczewska M, Grochans S, et al. Analysis of nurses attitudes toward patient death. Int J Environ Res Public Health. 2022;19(20):13119. doi: 10.3390/ijerph192013119.

8. Gonçalves RG, Oliveira LPBA, Silva CJA, Elias TMN, Nogueira ILA, Menezes RMP. Palliative care in nursing training: higher education course coordinators' perception. Rev Bras Enferm. 2023;76(3):e20220222. doi: 10.1590/0034-7167-2022-0222.

9. Minosso JSA, Martins MMFP, Oliveira MAC. Palliative care in undergraduate nursing education: a mixed-methods study. Referência. 2022;6(1):1-8. doi: 10.12707/rv21060.

10. Ribeiro BS, Coelho TO, Boery RNSO, Vilela ABA, Yarid SD, Silva RS. Ensino dos cuidados paliativos na graduação em enfermagem do Brasil. Enferm Foco [Internet]. 2019 [acesso em 2025 set 08];10(6):131-6. Disponível em: https://enfermfoco.org/wp-content/uploads/articles_xml/2357-707X-enfoco-10-06-0131/2357-707X-enfoco-10-06-0131.pdf.

11. Sarmento WM, Araújo PCB, Silva BN, Silva CRDV, Dantas RCO, Véras GCB, et al. Formação acadêmica e qualificação profissional dos enfermeiros para a prática em cuidados paliativos. Enferm Foco. 2021;12(1):33-9. doi: 10.21675/2357-707X.2021.v12.n1.3805.

12. Hökkä M, Lehto JT, Kyngäs H, Pölkki T. Finnish nursing students' perceptions of the development needs in palliative care education and factors influencing learning in undergraduate nursing studies - a qualitative study. BMC Palliat Care. 2022 Mar 23;21(1):40. doi: 10.1186/s12904-022-00915-6.

13. Hökkä M, Pölkki T, Lehto JT. Nursing students' views of the content of palliative care in undergraduate education and their self-assessed palliative care competence-a nationwide cross-sectional study. J Palliat Care. 2022 Jul;37(3):434-42. doi: 10.1177/08258597221084445.

14. Pereira SM, Hernández-Marrero P, Pasman HR, Capelas ML, Larkin P, Francke AL. Nursing education on palliative care across Europe: Results and recommendations from the EAPC Taskforce on preparation for practice in palliative care nursing across the EU based on an online-survey and country reports. Palliat Med. 2021 Jan;35(1):130-41. doi: 10.1177/0269216320956817.

15. Dominguez RGS, Freire ASV, Lima CFM, Campos NAS. Palliative care: challenges for teaching in the perception of nursing and medical students. Rev Baiana Enferm. 2021;35:e38750. doi: 10.18471/rbe.v35.38750.

16. Morais R, Galiazzi MC. Análise textual discursiva. 3 ed. rev. ampl. Ijuí (RS): Unijuí; 2020. eBook.

17. Alvim ALS, Almeida ALO, Santos KC, Oliveira LKC, Silva NR. Morte e o processo de morrer na visão dos discentes de enfermagem. J Health NPEPS [Internet]. 2021 [acesso em 2023 set 15];6(1):302-13. Disponível em: https://periodicos.unemat.br/index.php/jhnpeps/article/view/5010.

18. Sandoval SÁ, Vargas MAO, Schneider DG, Magalhães ALP, Brehmer LCF, Zilli F. Death and die in the hospital: a social, spiritual and ethical look of students. Esc Anna Nery. 2020;24(3):e20190287. doi: 10.1590/2177-9465-EAN-2019-0287.

19. Couceiro FBL, Bonini LMM, Afférri C, Imada HN, Nictheroy LM, Silva RA. A percepção da morte e do morrer por estudantes de medicina. Diálogos Interdisciplinares [Internet]. 2019 [acesso em 2023 set 15];8(10):1-13. Disponível em: https://revistas.brazcubas.br/index.php/dialogos/article/view/821.

20. Ramos VC, Cirino AAOG. Concepções sobre a morte e o morrer entre estudantes de psicologia. Estud Interdiscip Psicol. 2020;11(1):26-48. doi: 10.5433/2236-6407.2020v11n1p26.

21. Sartor SF, Mercês NNA, Torrealba MNR. Significados da morte para adultos com câncer assistidos em um hospital oncológico do Brasil. Enferm Actual Costa Rica [Internet]. 2022 [acesso em 2023 set 22];42:13-26. Disponível em: https://docs.bvsalud.org/biblioref/2023/03/1384849/enfermerian42art13.pdf.

22. Andrade PCST, Gomes AMT, Spezani RS, Nogueira VPF, Barbosa DJ, Bernardes MMR, et al. Social representation of death for nursing Students. Cogitare Enferm. 2021;26:e71628. doi: 10.5380/ce.v26i0.71628.

23. Cattâneo LP, Vitali MM, Ferraz F, Soratto J. Atuação dos acadêmicos dos cursos da saúde frente ao processo de morte e morrer nos cenários de prática assistencial. Saúde Redes. 2021;7(1):39-49. doi: 10.18310/2446-4813.2021v7n1p39-49.

24. Folkman S, Lazarus RS. An analysis of coping in a middle-aged community sample. J Health Soc Behav. 1980;21(3):219-39. doi: 10.2307/2136617.

25. Ferreira JC, Pereira AP, Bonamigo EL. Difficulty communicating the patient’s death to family members. Rev Bioét. 2022;30(1):36-44. doi: 10.1590/1983-80422022301504PT.

26. Hernández Ramírez MJ, González-Martí EY, Fuentes Rodríguez AM, Carranza López SA, Compeán Padilla V, Guerrero Castañeda RF. Lived experience of first contact with death in nursing students' clinical prácticum. Enfermería Glob. 2022;21(65):116-39. doi: 10.6018/eglobal.483631.

27. López Encina ME, Vega Vega PA, Carrasco Aldunate P, González Briones XG, Abarca González E, Rojo Sánchez L, et al. Estrategias del equipo de salud para afrontar la muerte de niños y adolescentes con câncer. Rev Cuba Enferm. 2022 [acceso en 2023 sep 16];38(2):e4624. Disponible en: http://scielo.sld.cu/scielo.php?script=sci_arttext&pid=S0864-03192022000200005.

28. Novais SAL, Aguiar AR, Sousa AR, Almeida M, Raposo M. Atitudes dos estudantes de enfermagem perante a morte e os cuidados em fim de vida. Referência. 2021;5(6):e20111. doi: 10.12707/rv20111.

29. Jilou V, Duarte JMG, Gonçalves RHA, Vieira EE, Simões ALA. Fatigue due to compassion in health professionals and coping strategies: a scoping review. Rev Bras Enferm. 2021;74(5):e20190628. doi: 10.1590/0034-7167-2019-0628.

30. Palomar Gallardo MC, Romero Palomar M, Pérez García E, Romero Palomar MI. Educar para la vida y la muerte a los estudiantes de Enfermería: “del miedo al amor”. Enfermería (Montev En Línea). 2020;9(1): 65-81. doi: 10.22235/ech.v9i1.2167.

Authorship contribution

1 – Luis Eduardo Oliveira dos Passos

Nurse, postgraduate – luiseduardopassos31@gmail.com
Research conception and/or development and/or manuscript writing; Review and approval of the final version

2 – Silvana Bastos Cogo

Nurse, Doctor, Professor – silvana.cogo@ufsm.br
Research conception and/or development and/or manuscript writing; Review and approval of the final version

3 – Aline Ost dos Santos
Nurse, PhD student – alineostdossantos@gmail.com
Review and approval of the final version

4 – Carolina Heleonora Pilger
Nurse, PhD student – carolinapilger@gmail.com
Review and approval of the final version

5 – Vanúzia Sari
Corresponding author
Nurse, PhD student – vanu.sari@gmail.com
Research conception and/or development and/or manuscript writing; Review and approval of the final version

6 – Graciela Dutra Sehnem
Nurse, Doctor, Professor – graciela.sehnem@ufsm.br
Review and approval of the final version

Scientific Editor: Eliane Tatsch Neves
Associate Editor: Rodrigo Guimarães dos Santos Almeida

How to cite this article

Passos LEO, Cogo SB, Santos AO, Pilger CH, Sari V, Sehnem GD. Nursing students’ perceptions and coping in end-of-life situations. Rev. Enferm. UFSM. 2025 [Access at: Year Month Day]; vol.15, e16:1-21. DOI: https://doi.org/10.5902/2179769288803