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Final year nursing students' perceptions of end-of-life care: A qualitative study

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ABSTRACT

Objective: To explore senior nursing students' perceptions of end-of-life care through qualitative inquiry. **Method:** The study sample consisted of 18 nursing students who had completed their clinical practices, selected through a purposive sampling method. A qualitative research design was employed. Data were collected through face-to-face, in-depth focus group interviews conducted by the researchers, and content analysis was utilized for data evaluation. **Results:** Three overarching themes were identified: Planning End-of-Life Care, Outcomes of End-of-Life Care, and Dying with Dignity. These themes were supported by 10 categories and 17 codes. Students emphasized the importance of holistic assessment, symptom management, emotional support, family involvement, and maintaining dignity during the dying process. **Conclusion:** Students perceived end-of-life care as a multidimensional process integrating physical, psychological, social, and ethical components. They reported challenges in communication, emotional management, and responding to cultural and spiritual needs. Strengthening nursing curricula by incorporating simulation-based training, role-playing, and experiential learning is recommended to enhance students' readiness for end-of-life care. These educational approaches may better prepare students to provide compassionate, dignified, and culturally sensitive care to individuals at the end of life.

Keywords: Nursing students, terminal care, attitude to death, qualitative research

Son sınıf hemşirelik öğrencilerinin yaşam sonu bakıma ilişkin algıları: Nitel bir çalışma

ÖZET

Amaç: Bu çalışma, son sınıf hemşirelik öğrencilerinin yaşam sonu bakımına ilişkin algılarını nitel bir yaklaşımla incelemeyi amaçlamıştır. **Yöntem:** Nitel araştırma deseniyle yürütülen çalışmanın örneklemini, amaçlı örnekleme yöntemiyle seçilen ve klinik uygulamalarını tamamlamış 18 hemşirelik öğrencisi oluşturmuştur. Veriler araştırmacılar tarafından gerçekleştirilen yüz yüze derinlemesine odak grup görüşmeleri ile toplanmış; analizde içerik analizi yöntemi kullanılmıştır. **Bulgular:** Analiz sonucunda Yaşam Sonu Bakımının Planlanması, Yaşam Sonu Bakımının Sonuçları ve Onurlu Ölüm olmak üzere üç tema; bu temalara bağlı 10 kategori ve 17 kod belirlenmiştir. Öğrenciler holistik değerlendirme, semptom yönetimi, duygusal destek, aile katılımı ve hastanın onurunun korunması gibi unsurları vurgulamıştır. **Sonuç:** Öğrenciler yaşam sonu bakımını fiziksel, psikolojik, sosyal ve etik boyutları içeren çok yönlü bir süreç olarak değerlendirmiştir. İletişim, duygusal güçlüklerle baş etme ve kültürel–manevi gereksinimlere yanıt verme konularında zorlandıklarını ifade etmişlerdir. Bu nedenle hemşirelik eğitim programlarında simülasyon temelli eğitimlerin, rol canlandırma uygulamalarının ve deneyimsel öğrenme yöntemlerinin daha fazla kullanılması önerilmektedir. Bu yaklaşımlar, öğrencilerin yaşam sonu bakımında daha duyarlı, saygılı ve bütüncül bakım sunma becerilerini güçlendirebilir.

Anahtar kelimeler: Hemşirelik öğrencileri, terminal dönem bakımı, ölüme karşı tutum, niteleyici araştırma

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INTRODUCTION

End-of-life care is a holistic approach to care that aims to meet the physical, mental, and spiritual needs of patients and their families.[1] In this critical phase, nurses assume core clinical responsibilities such as the effective management of symptoms, ensuring patient comfort, facilitating the stabilization of emotional fluctuations, and preserving individual autonomy. In addition, nurses undertake a multidimensional and ethical role that includes supporting patients in achieving a dignified end of life and providing psychological support to family members during the bereavement process.[1-3] The quality of nursing care is directly associated with professionals' level of preparedness for this process and the perceptions they develop.[4] The perceptions of nursing students who are still in the stage of developing their professional identity regarding end-of-life care hold strategic importance in predicting how they will shape their future professional roles and manage this sensitive process.[5]

Nursing students' perception of end-of-life care begins to take shape gradually from the moment they start their undergraduate education. Their perceptions of end-of-life care may be influenced by the courses they take during their education, their clinical experiences, and their personal values.[6,7] In the absence of adequate training and practical experience in end-of-life care, students may feel inadequate in the care process and have difficulty in providing effective support to patients.[5]

In a study conducted by Bahçeli et al. in 2022, it was reported that nurses had difficulty in caring for patients in end-of-life care units, and the reason for this was the lack of training on this subject.[8] Uysal et al. (2019) stated that education is important for nursing students to improve their care skills for dying patients and their families and more opportunities should be provided.[9] According to a study, students who completed End-of-Life Nursing Education Consortium (ELNEC) training during their undergraduate education reported feeling comfortable and competent in providing end-of-life care after graduation.[6] In this context, including more end-of-life care topics and practices in the nursing education process may contribute to students becoming more competent and equipped in this field. Therefore, it is important to integrate end-of-life care topics into nursing education programs and to determine students' perceptions of end-of-life care in terms of curriculum development and improvement.

In the literature, studies on nursing students' perceptions of end-of-life care are limited. As a result of a study conducted with 71 undergraduate students, Colley found that the experience of caring for a dying patient increased students' self-confidence.[7] In another study conducted with nursing students, students emphasized that knowledge and practice skills are important to ensure good death. In a study conducted with senior students using a descriptive qualitative design, it was stated that end-of-life care was not sufficiently included in the education and that end-of-life care education was necessary to prevent students from experiencing difficulties after graduation.[10] Adequate consideration of end-of-life care in nursing education can make students more aware of overcoming the difficulties they will encounter in their professional life, coping with ethical dilemmas, and communicating effectively with patients and their families.[11] However, many students have limited involvement in end-of-life care processes in their clinical experiences and therefore may feel inadequate in this area. In line with this information, the aim of the study is to determine the perceptions of nursing students on end-of-life care using qualitative methods and to provide a basis for future studies. Therefore, this study aims to explore the perceptions of senior nursing students regarding end-of-life care through a qualitative lens, providing a comprehensive understanding of their experiences and establishing a foundation for future educational strategies.

METHOD

Study Design

This study was conducted using a qualitative research approach with a phenomenological design. Phenomenology places a strong emphasis on the subject as interpreted through the individual's perspective.[12] In this study, the phenomenon is defined as the lived experiences and perceptions of senior nursing students regarding end-of-life care during their clinical practice. A descriptive phenomenological approach was preferred to deeply explore and understand how these students make sense of providing care to terminal patients in a real-world clinical setting.

Setting and Participants

The study population consisted of 56 senior nursing students enrolled in the faculty of health sciences. A purposive sampling method was employed to select participants who could provide rich information regarding the phenomenon. In this context, maximum variation sampling, a type of purposive sampling, was utilized to ensure diversity in terms of gender and previous clinical experience in different units, thereby reflecting a broader range of perspectives.

Inclusion criteria were as follows: being a final year nursing student (1), having completed clinical practice in a fully equipped hospital (2), volunteering for the study (3), and speaking and understanding Turkish (4). Although 22 students initially expressed interest, the final sample consisted of 18 nursing students who met the inclusion criteria. Data collection was terminated

when no new themes or insights emerged from the interviews, indicating that the data had reached a point of redundancy.

Data Collection Tools

Data were collected using the "Sociodemographic Characteristics Form" and the "Semi-structured Interview Form.

Sociodemographic Characteristics Form: This form was designed by the researchers to collect baseline information, including age, gender, previous experience in end-of-life care, and the clinical units where students completed their practice.

Semi-structured Interview Form: The interview questions were developed by the researchers based on a comprehensive review of the relevant literature to explore students' perceptions in depth.[8,10,11] The draft form was evaluated by three independent experts in the field of nursing education and qualitative research to ensure content validity. Based on their feedback, the final version of the form consisted of the following questions:

- How would you define end-of-life care?
- Which care practices are involved in the care of a patient at the end of life?
- What are the emotional impacts of caring for a patient in pain and suffering at the end of life?
- What do you think are the positive and negative aspects of end-of-life care? Can you explain?
- What do you think nurses should do to ensure that the patient at the end of his/her life continues his/her last days in a dignified, respectful, and peaceful way?
- What are the factors affecting end-of-life care practices?

Data Collection Procedure

The data were collected by researchers using face-to-face in-depth focus group interview technique. The first researcher, who has extensive training in qualitative methodology and several published qualitative studies, served as the moderator. The second and third researchers completed asynchronous online training programs on qualitative research and focus group interview techniques prior to the study. During the sessions, the second researcher acted as an observer, while the third researcher was responsible for the technical management of the audio recording process. Before the interview, the students were informed about the place and time of the interview. The interviews were conducted in the meeting room of the university where the students were studying. It was ensured that the hall where the interview would be held was arranged in a table and chair arrangement where students could see each other and sit comfortably. The students were informed that audio recordings would be made during the interview and that this audio recording would only be listened to by the researchers and would not be shared with any person, institution or organization. After all this information, semi-structured in-depth focus group interviews lasting approximately 60 minutes were conducted.

Data analysis

The audio recordings obtained as a result of the interviews were listened to one by one and transcribed verbatim on computer. By listening to the audio recordings repeatedly, the natural flow of the interviews was evaluated, and word errors were prevented. The data were analyzed by content analysis method used in qualitative research. Content analysis is a hierarchical system in which each piece of data is coded with one or more words. To increase the reliability of the data analysis, the researchers worked independently of each other in creating codes, categories and themes.

In the first stage, the text was divided into small units. At this stage, care was taken to preserve the main/basic meaning. In the next step, a code list of meaningful units was created and the code lists prepared by the two authors were compared. The next steps of the analysis were based on the code list agreed upon by the researchers. Similar and different categories were compared and grouped. In the next step, two or more categories were brought together to form themes explaining the experience. In the last step, the researchers came together and analyzed the themes one by one. Three themes were identified and they reached consensus on categories and codes. The COREQ guide was used for reporting.

Table 1. Sociodemographic characteristics of nursing students (n= 18)

Characteristics	Categories	n (%)	Mean (SD)
Age (years)			22.49 (2.39)
Gender	Female	14 (77.8)	
	Male	4 (22.2)	
Previous participation in end-of-life care	Yes	9 (50.0)	
	No	9 (50.0)	
Clinical practice departments	Internal units	8 (32.0)	
	Surgical units	15 (60.0)	
	Intensive care units	2 (8.0)	

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RESULTS

Table 1 shows the socio-demographic characteristics of the students. The mean age of the participants was 22.49 years. The majority of the participants consisted of female students (77.8%). Regarding their previous clinical experience, 50% of the students (n=9) had prior involvement in end-of-life care processes. In terms of their clinical practice departments, most students gained experience in surgical units (60%).

In the study, three themes (Planning End-of-Life Care, Outcomes of End-Of-Life Care and Dying with Dignity), a total of 10 categories in line with the themes and 17 codes related to the categories were determined (Table 3). The 18 students included in the study were referred to as 'STUDENT 1, STUDENT 2, STUDENT 3...' to ensure confidentiality.

Table 3. Themes, categories and codes related to students' perceptions of end-of-life care

Themes	Categories	Codes
Theme 1: Planning End-of-Life Care	Category1.1: Attributed Meanings	Code 1.1.1 Palliative care Code 1.1.2 Terminal period Code 1.1.3 End Stage disease Code 1.1.4 Dying patient care Code 1.1.5 Comfortable death
	Category 1.2: Practices	Code 1.2.1 Hygiene practices Code 1.2.2 Psychological support Code 1.2.3 Treatment practices and pain relief Code 1.2.4 Education for patient relatives Code 1.2.5 Fulfilling last wishes Code 1.2.6 Spiritual care
	Category 1.3: Influencing Factors	Code 1.3.1 Patient's previous life Code 1.3.2 Attitude of the patient and relatives Code 1.3.3 Equipment inadequacy Code 1.3.4 Nurse's approach
Theme 2: Outcomes Of End-Of-Life Care	Category 2.1: Compassion Fatigue Category 2.2: Sadness Category 2.3: Burnout Category 2.4: Spiritual Satisfaction	
Theme 3: Dying with Dignity	Category 3.1: Togetherness with Family Category 3.2: Making Death Feel Imminent Category 3.3: Ethical Concerns	 Code 3.3.1. Avoiding invasive procedures Code 3.3.2. Non-Intervention

Theme 1: Planning end-of-life care

Students expressed their statements about planning end-of-life care. These statements were grouped under the theme of planning end-of-life care. Based on the statements of the students, first three categories and then these categories were divided into codes within themselves.

Category 1.1: Attributed meanings

This category was created based on students' perceptions of end-of-life care. When the students were asked to define end-of-life care, the answers were as follows: care given to palliative patients (n=4), care of terminal patients (n=4), care of the patient in the last stage of life (n=5), care given to the dying patient (n=3) and ensuring a comfortable death (n=4). Codes are given below.

Code 1.1.1. Palliative care

STUDENT 1: Specifically, palliative comes to my mind. I thought that the patients in palliative care are at the last stage in terms of their lives and they are hospitalized there in the ward.

STUDENT 14: I think of the palliative service of the hospital. I think of pre-death patients whose pain is more severe, and care is at a higher level.

Code 1.1.2. Terminal period

STUDENT 2: Terminal period patients come to my mind.
STUDENT 6: I think we should ask how we can provide the best psychological care for terminal patients.

Code 1.1.3. End stage disease

STUDENT 7: In line with what I saw in the lectures, the end of life shows that there is no hope of medical treatment and that the disease is in its end stages.
STUDENT 18: End-of-life care, the care of the patient in the end stage of their illness comes to mind.

Code 1.1.4. Dying patient care

STUDENT 10: Care aimed at preparing patients for death.
STUDENT 17: It is defined as the care given to patients who have tried everything medically and now enter the stage of death when we can no longer get a return from the patient.

Code 1.1.5. Comfortable death
STUDENT 6: I think we should ask how we can give the best psychological care to patients in the terminal period.
STUDENT 8: I define it as fulfilling their last wishes.
STUDENT 17: It is the care that allows patients to live more painlessly

Category 1.2: Practices
This category was created based on students' experiences about the practices in end-of-life care and their experiences about these practices. In end-of-life care, students stated that patients were cared for personal hygiene practices (n=5), patients were supported psychologically (n=4), medication was given to relieve pain (n=4), relatives were educated about the patient's condition (n=4), patients' last wishes were fulfilled (n=3) and spiritual care was provided (n=2). Codes and examples of students' statements regarding the answers given are given below.

Code 1.2.1 Hygiene practices
STUDENT 7: When I was doing my internship in intensive care, some of the patients there were terminal patients. We were giving perineal care and oral care to those patients.
STUDENT 5: In terms of hygiene, we should treat the patient as if he/she will continue his/her normal life and provide care in that direction. If the patient, who is already psychologically depressed, experiences a lack of hygiene, he thinks that he is getting closer to death. Therefore, it is necessary to provide the best care.

Code 1.2.2. Psychological support
STUDENT 2: In addition to drug treatment, it is to support patients emotionally in terms of making their wishes because it is before death.
STUDENT 6: I think we should ask how we can provide the best psychological care for terminal patients.

Code 1.2.3. Treatment practices and pain relief
STUDENT 3: When I think of terminal period patients, I think of intensive care patients and bedsores that occur in patients. Therefore, wound care came directly to my mind.
STUDENT 5: Drug treatment of end-of-life patients for pain, not for treatment.

Code 1.2.4. Education for patient relatives
STUDENT 4: I consider it caring for the patient and the patient's relatives rather than medication. I consider it as providing training to the patient and the patient's relatives in terms of both support and care, rather than medication at this stage, which has reached the last stage of life.
STUDENT 5: Since the behavior of the patient's relatives will also affect the patient, we should prepare the relatives for this situation

Code 1.2.5. Fulfilling last wishes
STUDENT 7: It is the care in which the last wishes of the patient are met, and the last days are spent well.
STUDENT 8: If patients have a last request, we can fulfill it.

Code 1.2.6. Spiritual care
STUDENT 1: We can provide support to the patient with a dimension of faith.
STUDENT 7: We can fulfill religious rituals in line with the patient's request.

Category 1.3: Influencing factors
Students think that end-of-life care depends on the patient's previous life (n=2), the attitude of the patient and relatives (n=4), equipment inadequacy (n=2) and the approach of the nurses (n=3).

Code 1.3.1 Patient's previous life
STUDENT 17: Personality traits, the patient's background affect. The emotions I feel can change according to the patient's lifestyle. Unfortunately, I cannot feel the same for a criminal patient and a patient whose life has been difficult.
STUDENT 18: I agree with Student 17. Bad or good events that the patient has experienced in the past affect our care as they shape our feelings towards the patient and our prejudice.

Code 1.3.2 Attitude of the patient and relatives
STUDENT 5: I think that the patient's approach to us, our relations with the patient's relatives affect us in a good way. The patient's behavior also affects.
STUDENT 16: Negative behaviors of patients and their relatives towards healthcare professionals affect care.

Code 1.3.3 Equipment inadequacy
STUDENT 12: The adequacy of hospital equipment is also important. It affects end of life care.
STUDENT 13: I agree with Student 12. If the supply of materials is not sufficient, the treatment will be ineffective.

Code 1.3.4 Nurse's approach
STUDENT 5: If the nurse shows a good approach while caring for the patient, the patient's motivation increases.
STUDENT 10: As end-of-life care affects nurses, the care given to other patients is also affected. A nurse who is psychologically affected may reflect this in interactions with other patients.

THEME 2: Outcomes of end-of-life care
This theme was created based on the students' responses to the outcomes of end-of-life care. Then, the theme was discussed and divided into 4 categories as 'compassion fatigue, spiritual satisfaction, burnout and sadness'. Some of the students' statements related to these categories are given below.

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Category 2.1: Compassion fatigue
This category was created based on the experiences of students (n=5) in end-of-life care.
STUDENT 12: Since we are in a hospital environment, we get used to the process. For example, I work in the emergency room and the patient's death does not affect me anymore. I can say that I am used to this process. If I see it outside, I feel sad, but I do not have the same feeling in the hospital environment.
STUDENT 15: I agree with my friends. I came across this situation a lot during hemodialysis. At first, I was affected a lot, I was devastated, but as time passed, I got used to this process. I can also call it compassion fatigue.

Category 2.2: Sadness
This category was created based on the emotional experiences of students (n=6) in end-of-life care.
STUDENT 7: I cannot help showing my emotions. I also affect my environment. It makes me feel bad.
STUDENT 17: I feel sad not because the patient died but because I will never see him/her again. I feel sad for the relatives of the patient because it will be a difficult situation for them.

Category 2.3: Burnout
This category was formed when students (n=6) expressed that they experienced burnout in end-of-life care.
STUDENT 14: When an individual is in pain, although we apply treatment, the unrelenting pain wears us out nurses. This situation exhausts us psychologically because we cannot do anything else other than treating.
STUDENT 13: I am experiencing what we call compassion fatigue. It wears me out a lot to see that although we treat a patient who is in pain and suffering, it does not work and we cannot do anything else.

Category 2.4: Spiritual satisfaction
This category was created based on the statements of some of the students (n=4) that they felt spiritual satisfaction after providing end-of-life care.
STUDENT 1: When I see the patients, I remember death and think how worthless my salary is. It makes me feel good spiritually. STUDENT 4: Seeing that death is near adds religious positivity.
STUDENT 5: As I receive prayers from patients, I feel the spiritual satisfaction of the profession, and I feel happy and I say that I am glad I chose the profession.

THEME 3: Dying with dignity
Students made some suggestions for dignified death. Based on these suggestions, 3 categories were formed as “Togetherness with Family, Making Death Feel Imminent, Ethical Concerns.”

Category 3.1: Togetherness with family
Some of the students (n=5) stated that it is better for end-of-life care patients to spend time with their loved ones in order to say goodbye peacefully.
STUDENT 16: I think it is more appropriate for him to wait for death in a more peaceful way with his loved ones at home.
STUDENT 14: I find it logical that the patient should stay in care homes such as hospices and die more peacefully by creating a home environment rather than staying in a palliative service. The hospital environment is not a good environment for this situation. Individuals do not have the opportunity to spend time with their loved ones in a good way.

Category 3.2: Making death feel imminent
Most of the students (n=15) think that end-of-life care patients and their relatives should be made to feel that the patient is approaching death and should be prepared for this situation.
STUDENT 5: I think that the patient should not be made to feel that he/she is in the last stage of life.
STUDENT 2: The patient is somewhat aware of his/her condition, although not completely. If we treat the patient as if he/she will not die because he/she does not think that he/she will live for 10-20 years, if we give false hope, the patient may feel bad thinking that he/she has been deceived. Instead of acting as if this situation does not exist, it is necessary to prepare the patient and his/her relatives for possible situations.

Category 3.3: Ethical concerns
The majority of the students (n=16) had ethical concerns about whether or not to practice on the patient in end-of-life care. Two codes were identified under this category. The codes and sample statements related to the codes are given below.

Code 3.3.1. Avoiding invasive procedures
STUDENT 7: Giving constant stimuli to patients can cause wear and tear in patients.
STUDENT 13: Invasive interventions performed on every patient at the end of death affect the patient negatively. Because it becomes open to infection. It accelerates the coming of death more and can cause it to pass faster.

Code 3.3.2. Non-Intervention
STUDENT 17: I do not support euthanasia, but I think that some patients should stop intervening. When I look at it from the patient's point of view, I think in this direction, but when I think from the point of view of the patient's relatives, I may have different thoughts because it is an open-ended issue.
STUDENT 13: I have heard that a patient diagnosed with stomach cancer will not be intervened in any complicated situation. I think it is unethical not to intervene.

DISCUSSION

In the study, depending on the theme of planning end-of-life care, the category of attributed meanings and the codes of palliative care, terminal period, end stage disease, dying patient care and comfortable death were determined in this category. When the studies on end-of-life care are examined in the literature, it is seen that they are frequently associated with the concepts of palliative care and terminal period.[2,13-15] Dignity therapy in end-of-life care by Cuveas et al. (2021) drew attention to death with dignity by emphasizing that humanitarian approaches are a necessary intervention in dealing with pain and distress at the end of life. In our study, it was found that nursing students associated these concepts with end-of-life care.[16] Therefore, it is thought that senior nursing students learn these subjects in the courses during their undergraduate education and reinforce this knowledge with practice in clinical education.

Another category under the first theme is “Practices”. In this category, codes titled “Hygiene Practices, Psychological Support, Treatment Practices and Pain Relief, Education for Relatives, Fulfilling Last Wishes” and “Spiritual Care” were created. Nursing care is very important in the care of an individual at the end of life. Especially the students' statements about the fulfillment of the last wishes of the patients and spiritual care support may explain that they do not see end-of-life care only as a physical care. In several studies conducted with nursing students, it was determined that there were statements about the importance of fulfilling the last wishes of dying patients and spiritual care.[17,18] This shows that students do not ignore holistic care in patient care.

In the category of influencing factors, our study identified specific themes such as the patient's previous life history, the attitudes of the patient and their relatives, equipment inadequacy, and the nurse's professional approach. While literature often emphasizes systemic issues like workload and staffing[4,19] studies specifically focusing on end-of-life care highlight more nuanced barriers. Research in this field suggests that cultural beliefs, ethical dilemmas, insufficient palliative care training, and the emotional burden of facing death are the primary factors hindering the quality of terminal care.[1,10] In line with this, our findings resonate with specialized literature regarding the impact of patient and family dynamics. The students’ emphasis on the patient's past life and family behaviors as significant factors suggests that psychosocial and relational dimensions are perceived as more dominant in end-of-life care than in routine clinical practice. This focus indicates that students are not merely performing task-oriented care but are profoundly affected by the emotional and interpersonal complexities inherent in the dying process.

In the study, nursing students stated that end-of-life care can affect nurses emotionally both positively and negatively. Four categories, namely compassion, burnout, sadness, and spiritual satisfaction, were identified in relation to the theme of outcomes of end-of-life care. Some studies have indicated that students experience physical and cognitive effects such as negativity in thought processes, nightmares, nausea and loss of appetite, insomnia after patient deaths.[2,11,18,20] Similar to our findings, research indicates that when students perceive themselves as providing a 'good death' and supporting a patient's dignity, they experience a sense of meaning-making and spiritual peace, which mitigates the risk of burnout.[20,21] Therefore, the care of patients approaching death and dying causes psychological, physiological, mental and social effects on students.

Death with dignity refers to the management of end-of-life care in accordance with human dignity, respecting the identity and choice of the individual. In the study, students emphasized the concept of death with dignity. Death with dignity refers to the management of end-of-life care in accordance with human dignity, respecting the identity and choice of the individual. A systematic review examining nursing students' end-of-life care experiences in palliative care settings reported that students are sensitive to the concept of a dignified death.[14] In another study, nursing students stated that patients were neglected by nurses and family members during the end-of-life care process.[17] Similar to our findings, Sandoval et al. (2020) found that students defined end-of-life care as the control of symptoms and avoidance of unnecessary invasive interventions to complete the dying process with dignity.[21] The results of this and other studies show that developments in science and technology make it possible to take measures to prolong or sustain the life of individuals. This may raise ethical issues.

CONCLUSION

In this study, it was observed that students attributed different meanings to end-of-life care and emphasized the importance of nursing in this process. It was also understood that care provided during the final stage of life is influenced by emotional factors such as spiritual satisfaction, compassion fatigue, burnout, and sadness. Identifying the perceptions of senior nursing students, who are the future healthcare professionals, regarding end-of-life care is crucial in terms of improving palliative care practices, incorporating end-of-life care into the nursing education curriculum, and ensuring that students gain experience in this area during clinical training.

Developing students' skills in establishing effective communication, building empathetic relationships with patients and families, and being sensitive to cultural and spiritual differences should also be integral parts of

the education process. In this context, it is recommended that simulation-based training and role-playing methods be used more frequently.

Although nursing is the profession most commonly associated with patient care, end-of-life care requires a multidisciplinary approach. Therefore, conducting similar studies within other healthcare disciplines is also recommended. Furthermore, it is believed that conducting both quantitative and qualitative research with healthy and ill individuals regarding end-of-life care will contribute significantly to enhancing caregivers' empathy, communication skills, and overall quality of care.

Ethical considerations

Written permission dated 09.12.2023 and E-26428519-050.99-109059 was obtained from the ethics committee unit of a university to conduct the study. The research was conducted in accordance with the Principles of the Declaration of Helsinki. Prior to the focus group interviews, participants were informed about the study's objective, their roles in the process, and the use of audio recording devices. At the same time, students were informed by the researchers that they had the right to participate in the study or withdraw from the study at any time. To ensure confidentiality and data security, all electronic data were stored in password-protected files accessible only to the research team. All research data will be securely stored for a period of five years following the completion of the study, after which it will be permanently destroyed by deleting electronic files.

Author Contributions
Study idea/design: FT, EE
Data collection: FT, EE, FY
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