

# End-of-Life Care: Attitudes & Preferences

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## Introduction: Defining Attitudes toward End-Of-Life Care

Attitudes toward **End-Of-Life Care (EoL)** represent complex cognitive and affective schemas that individuals, families, and societies hold regarding the processes, decisions, and quality of care received when death is imminent or anticipated due to serious illness. These attitudes are fundamental in shaping the trajectory of care, influencing choices ranging from aggressive curative treatments to comfort-focused palliative interventions. Understanding these deeply held beliefs is critical for psychological research, clinical practice, and public policy, as they determine how suffering is managed, dignity is preserved, and the final stages of life are experienced. These attitudes are not static; they evolve based on personal experiences, medical prognosis, cultural norms, and the perceived quality of the healthcare system itself. Furthermore, societal attitudes often reflect underlying anxieties about mortality, technological overuse, and the perceived failure of medicine to conquer death, contributing to profound psychological stress for all involved stakeholders.

The psychological framework underlying EoL attitudes encompasses a spectrum of dimensions, including beliefs about pain management, the acceptability of palliative sedation, the value placed on longevity versus quality of life, and perceptions of personal control during the dying process. A crucial distinction exists between attitudes focused on prolonging life at all costs and those prioritizing comfort, autonomy, and a peaceful death. These dispositions often manifest in preferences for or against specific interventions, such as mechanical ventilation, cardiopulmonary resuscitation (CPR), or artificial nutrition and hydration. The strength and clarity of these attitudes significantly impact the effectiveness of **Advance Care Planning (ACP)**, serving as the bedrock upon which legally binding documents and verbal directives are constructed. When attitudes are ambiguous or conflicting, the burden of decision-making shifts heavily onto surrogate decision-makers, frequently leading to moral distress and protracted ethical conflicts within the family unit and with the medical team.

Examining EoL attitudes requires an interdisciplinary approach, drawing from psychology, sociology, medical ethics, and anthropology. Psychologists are particularly interested in the concepts of terror management theory, which posits that coping with the existential threat of death influences health behaviors and decision-making, and the impact of cognitive biases, such as optimism bias, which may lead individuals to underestimate their need for EoL preparations. Moreover, the emotional component of these attitudes--fear, hope, denial, and acceptance--plays a powerful, often subconscious, role in determining behavioral responses to serious illness diagnoses. A comprehensive understanding of these psychological underpinnings is essential for developing interventions that facilitate open communication, reduce emotional barriers, and align patient care with their authentic values and preferences during the vulnerable period preceding death.

## Psychological Determinants of EoL Attitudes

Individual attitudes toward the end of life are profoundly shaped by internal psychological states, past experiences, and personality characteristics. One major determinant is the level of **death anxiety** an individual possesses. High levels of death anxiety often correlate with a preference for aggressive, life-prolonging treatments, regardless of the quality of life implications, as these interventions symbolize resistance against mortality. Conversely, individuals who have integrated the reality of death or have successfully navigated previous grief experiences may exhibit greater acceptance and a stronger inclination toward palliative measures that focus on comfort and dignity. The mechanism through which personality traits operate is also significant; for instance, individuals scoring high on neuroticism may experience elevated stress and difficulty making definitive EoL choices, while those high in conscientiousness are often more proactive in completing advance directives and communicating their wishes clearly to loved ones and clinicians.

Locus of control is another critical psychological variable influencing EoL attitudes. Patients with an internal locus of control, who believe they have significant influence over their health outcomes and life decisions, are generally more likely to engage actively in shared decision-making and exert their autonomy in selecting treatment paths. They often prioritize detailed communication and clarity regarding prognosis and intervention efficacy. In contrast, those with an external locus of control, believing fate, powerful others, or chance determines outcomes, may be more passive, deferring complex decisions entirely to physicians or family members. This external orientation can sometimes lead to treatments that do not align with the patient's underlying, unarticulated values, simply because they feel less empowered to challenge medical authority or the momentum of the healthcare system.

The psychological process of coping with a terminal illness diagnosis significantly modulates attitudes toward care options. Denial, a common initial defense mechanism, often results in resistance to discussing EoL preferences or engaging in ACP, delaying crucial preparations until a crisis point is reached. As patients move through stages of acceptance, their focus typically shifts from fighting the disease to maximizing remaining quality of life, leading to more favorable attitudes toward hospice and palliative care services. Furthermore, the concept of **perceived burden**--the patient's belief about the emotional, physical, and financial toll their illness imposes on their family--can dramatically alter their care preferences. Some patients may opt for less resource-intensive care or even hasten death indirectly to alleviate perceived suffering of their loved ones, highlighting the deep interplay between individual psychology and relational dynamics in EoL decision-making.

## The Role of Cultural and Religious Frameworks

Cultural and religious traditions exert a profound and often decisive influence on attitudes toward death, dying, and medical intervention at the end of life. These frameworks provide individuals with

meaning-making structures that define what constitutes a "good death" and prescribe appropriate behaviors regarding medical technology usage. For example, in many Western cultures influenced by Christian traditions, there is a strong emphasis on the sanctity of life, which can translate into attitudes favoring maximum life-prolongation efforts, viewing the cessation of treatment as morally questionable. Conversely, some Eastern philosophies, such as certain Buddhist traditions, emphasize detachment and acceptance of natural processes, potentially leading to greater openness toward non-aggressive, comfort-focused care and viewing death as a natural transition rather than a medical failure.

Religious beliefs specifically dictate attitudes toward critical interventions like pain medication, hydration, and the withdrawal of life support. For instance, some faith traditions prohibit the active hastening of death, thereby complicating decisions related to physician-assisted dying or terminal sedation, even when suffering is intractable. Furthermore, certain cultural groups place greater emphasis on **familial collectivism** over individual autonomy. In these contexts, the attitude of the family unit, often represented by the eldest or most respected member, may supersede the expressed wishes of the dying patient. This collective decision-making model contrasts sharply with the Western legal emphasis on individual autonomy, creating potential conflicts when healthcare providers attempt to adhere strictly to advance directives or patient self-determination principles.

The influence of culture extends beyond theological doctrine to encompass communication styles and the expression of grief. Attitudes toward discussing death openly vary widely; in some cultures, discussing prognosis or EoL decisions directly with the patient is considered taboo, harmful, or a harbinger of bad luck, leading to a pattern of **protective non-disclosure** by the family and physician. This avoidance significantly impacts the patient's ability to articulate their own preferences, thereby limiting their autonomy and potentially leading to care that contradicts their true desires. Effective EoL care requires cultural humility from providers, demanding they understand and respect these diverse attitudes regarding disclosure, authority, and the appropriate setting for the dying process, which may range from a high-tech hospital unit to the patient's home surrounded by extended family.

## Communication and Decision-Making Challenges

Effective communication is the linchpin of aligning EoL attitudes with actual care received, yet numerous psychological and systemic barriers impede this process. A primary challenge stems from the inherent difficulty physicians face in delivering bad news, often leading to ambiguous language, overly optimistic prognoses, or the avoidance of explicit discussions about death and dying. This medical reluctance is often reciprocated by patients and families who harbor a deep-seated fear of confronting mortality, resulting in a mutual conspiracy of silence that prevents clear articulation of preferences. When communication is poor or delayed, attitudes based on

misunderstanding or unrealistic expectations proliferate, increasing the likelihood of aggressive, unwanted interventions in the final hours of life, which is often contrary to what patients would have chosen had they been fully informed.

The complexity of medical information further complicates the alignment of attitudes and care. Patients and families often struggle to comprehend the probabilistic nature of treatment outcomes, leading to distorted attitudes toward the potential benefits of interventions like chemotherapy or surgery late in the disease course. They may cling to hope for a cure, even when statistically improbable, delaying the shift toward palliative care goals. Clinicians must employ skilled communication techniques, such as empathetic listening and framing information in terms of values and goals rather than just procedures, to bridge this knowledge gap. The psychological safety provided by a trusting relationship allows patients to explore their fears and articulate preferences that might otherwise remain hidden due to fear of disappointing their family or their medical team.

A significant decision-making challenge arises when patients lose decisional capacity. The attitudes of surrogate decision-makers--often spouses or adult children--become paramount, introducing potential conflicts between the patient's previously expressed wishes (if known) and the surrogate's own emotional needs or attitudes toward prolonging life. Studies repeatedly show that surrogates often overestimate the patient's desire for aggressive care, driven by guilt, hope, or a psychological need to feel they "did everything possible." This discrepancy highlights the critical importance of timely, clear, and documented communication of EoL attitudes through **Advance Directives**, ensuring that the patient's voice, even when silent, guides the decisions made on their behalf, thereby mitigating the moral distress experienced by surrogates.

## Attitudes of Healthcare Providers vs. Patients and Families

The attitudes held by healthcare providers significantly influence the quality and direction of EoL care, sometimes creating friction with the attitudes of patients and their families. Physicians and nurses, trained in the ethos of healing and life preservation, often struggle psychologically when shifting their focus from curative efforts to comfort care. This professional attitude can manifest as "therapeutic obstinacy," where providers continue aggressive treatments long after they cease to offer meaningful benefit, driven by a fear of litigation, professional obligation, or an internalized sense of failure. This provider attitude frequently clashes with patient and family attitudes that prioritize relief from suffering and dignity over marginal extensions of life, leading to feelings of alienation and mistrust within the care relationship.

Discrepancies in attitudes often revolve around the definition and timing of palliative care. While patients and families increasingly view palliative care favorably as a means of symptom management and quality-of-life improvement, providers sometimes view it strictly as care reserved

for the actively dying, delaying referral until the final weeks or days. This delay limits the psychological and physical benefits that early palliative intervention provides, reinforcing the negative societal attitude that palliative care equals "giving up." Furthermore, healthcare provider attitudes toward resource allocation and futility play a role; providers must balance the ethical obligation to provide beneficial care with the recognition that certain treatments are medically non-beneficial, creating moral dilemmas when family attitudes strongly demand continued intervention based on hope or denial.

Training and psychological support are crucial for shaping constructive provider attitudes. When clinicians receive specialized education in communication skills, pain management, and ethical decision-making regarding EoL, they are better equipped to integrate patient and family values into care plans. The concept of **moral resilience** is increasingly recognized as vital for providers, enabling them to navigate the emotional burden of witnessing suffering and death without resorting to defensive practices or developing compassion fatigue. Aligning provider attitudes with patient-centered values requires institutional support, clear policies on defining futility, and fostering an environment where open discussion about mortality is considered a standard, necessary component of high-quality medical practice.

## Ethical Dilemmas and the Concept of Autonomy

Attitudes toward EoL care are inextricably linked to core ethical principles, particularly **autonomy**, beneficence, non-maleficence, and justice. The principle of autonomy--the patient's right to self-determination--is central in many Western legal and ethical frameworks, dictating that competent adults have the right to refuse any medical treatment, even if that refusal leads to death. Attitudes that strongly favor autonomy support the patient's right to make choices that align with their personal values, even if those choices seem medically irrational or emotionally difficult for family members and providers to accept. This includes attitudes toward refusing life support, stopping dialysis, or electing palliative sedation to manage refractory symptoms.

However, attitudes regarding autonomy often collide with the principles of beneficence (acting in the patient's best interest) and non-maleficence (doing no harm). This conflict is highly visible in discussions surrounding **Physician-Assisted Dying (PAD)** or euthanasia. Attitudes supporting PAD emphasize the ultimate expression of autonomy and the relief of suffering (beneficence), arguing that a compassionate society allows individuals to control the timing and manner of their death when faced with unbearable, irreversible suffering. Conversely, attitudes opposing PAD often stem from religious sanctity-of-life doctrines or professional ethics codes that prohibit physicians from intentionally causing death (non-maleficence), viewing it as an unacceptable breach of trust and professional duty.

The ethical landscape is further complicated by societal attitudes toward resource allocation.

Justice requires that scarce healthcare resources be distributed fairly. Attitudes that favor aggressive, high-cost interventions for patients with minimal chance of recovery raise ethical questions about the equitable distribution of resources that could benefit patients with better prognoses or be used for preventative care. The psychological attitude that "everything must be done" often ignores the economic and societal costs associated with technologically intensive EoL care, prompting ongoing policy debates about the societal responsibility to fund treatments deemed futile by clinical consensus. Navigating these ethical dilemmas requires a sophisticated understanding of how individual and collective attitudes shape both personal medical choices and broader public health policy.

## Impact of Advance Care Planning on Attitudes

**Advance Care Planning (ACP)** serves as a critical process designed to formalize and align individual attitudes toward EoL care with future medical treatment. The act of engaging in ACP, which involves discussing future care preferences and documenting those wishes, is itself a psychological intervention that positively influences attitudes. Studies show that individuals who complete ACP documents report lower levels of death anxiety, higher self-efficacy regarding healthcare decisions, and a greater sense of peace concerning their future care trajectory. This proactive engagement transforms passive worry into active preparation, making the topic of dying less abstract and more manageable.

The primary mechanism through which ACP impacts attitudes is by shifting the focus from crisis management to values clarification. ACP encourages individuals to explore what gives their life meaning--their personal definition of quality of life--and to articulate the trade-offs they are willing to accept regarding treatment side effects, cognitive impairment, and dependence. By defining these core values, individuals develop clearer, more stable attitudes toward specific interventions. For example, a patient who values cognitive function above all else will likely develop a strong negative attitude toward treatments that carry a high risk of permanent brain damage, regardless of their life-prolonging potential. This clarity reduces the psychological burden on both the patient and their loved ones when decisions must be made under stress.

Despite its benefits, attitudes toward ACP itself remain mixed. Many people maintain a procrastinatory attitude, believing they are too young or too healthy to need planning, or harbor a superstitious belief that planning for death might hasten it. Healthcare systems must address these psychological barriers by normalizing ACP, framing it as a standard component of preventative wellness rather than an obligation reserved solely for the terminally ill. Successful ACP implementation relies on creating a supportive environment where trained facilitators can gently guide individuals and families through these sensitive conversations, ensuring that documented attitudes accurately reflect the patient's evolving values and goals throughout the course of their life and illness.

## Future Directions and Improving EoL Care Attitudes

Future efforts to improve EoL care must focus heavily on shaping more constructive and realistic public attitudes toward death and dying. This requires systemic changes in how mortality is addressed in public discourse and medical education. One key direction involves integrating palliative care principles earlier in the disease trajectory, moving away from the binary attitude that care is either curative or palliative. Promoting the attitude of **concurrent care**--where palliative interventions run alongside disease-modifying treatments--helps patients and families accept comfort measures without feeling they have abandoned hope or treatment.

Education plays a crucial role in shifting attitudes. For the general public, educational campaigns must demystify hospice and palliative care, emphasizing their focus on living well until the end, rather than simply managing the final moments. For healthcare professionals, training must prioritize empathy, communication skills, and ethical reflection to combat professional attitudes of detachment or therapeutic obstinacy. Furthermore, addressing the psychological distress and burnout experienced by providers is vital, as provider well-being directly impacts their capacity to engage compassionately and effectively in difficult EoL conversations, ultimately shaping patient and family attitudes toward the care process.

Finally, leveraging technology and policy changes can solidify positive attitudes. Utilizing digital platforms to facilitate ACP conversations and documentation can increase accessibility and uptake. Policy interventions, such as making EoL discussions reimbursable and mandatory components of serious illness care, signal institutional validation of these critical conversations. Ultimately, improving attitudes toward EoL care is a societal imperative, requiring a collective shift toward valuing dignity, autonomy, and quality of life across the entire continuum of care, ensuring that the final chapter of life is managed with compassion, respect, and alignment with the individual's deepest wishes.