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Knowledge Regarding Palliative Care Among Staff Nurses Working in Oncology Units

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ABSTRACT

Palliative care represents a critical and often underappreciated dimension of oncology nursing, aiming to improve the quality of life of patients diagnosed with life-threatening conditions, particularly cancer. Recognised by the World Health Organization as an essential element of comprehensive healthcare, palliative care encompasses physical, psychological, social, and spiritual dimensions of patient care and support. Staff nurses working in oncology units occupy a frontline position in delivering such care, yet studies consistently reveal significant gaps in their knowledge, skills, and training.

This review article explores the concept and principles of palliative care, the specific roles of oncology nurses, barriers to effective care delivery, and the importance of structured education and training. The paper synthesises an extensive body of literature to identify key challenges and recommend evidence-based strategies for improving palliative care competency among oncology nurses. The findings underline that structured education programmes, mentorship, and institutional support are vital for closing knowledge gaps and ensuring compassionate, dignified end-of-life care.

Furthermore, this review highlights the significant disparities in palliative care provision globally, with particular attention to the situation in low- and middle-income countries such as India, where the burden of cancer-related mortality is disproportionately high and palliative care infrastructure remains underdeveloped. The review concludes with a comprehensive set of evidence-based recommendations for nurse educators, clinical leaders, and policymakers committed to advancing palliative care nursing practice.

Keywords: Palliative care, oncology nursing, knowledge, symptom management, end-of-life care, oncology units, nurse education, cancer care.

1. INTRODUCTION

Palliative care has emerged as one of the most vital yet frequently under-resourced areas in modern healthcare. Defined by the World Health Organization as an approach that improves the quality of life of patients and their families facing life-threatening illness through the prevention and relief of suffering (WHO, 2020), palliative care encompasses far more than simple pain management. It involves a holistic philosophy that addresses physical, emotional, social, and spiritual needs of both the patient and the family unit, recognising that individuals are more than the sum of their symptoms and that dying is a profound human experience deserving of comprehensive, compassionate care. In oncology settings, where patients routinely face diagnoses with uncertain prognoses and treatment regimens that are often aggressive and side-effect laden, the need for skilled palliative nursing care is particularly acute (Paice et al., 2016).

Research indicates that more than 10 million new cancer cases are diagnosed globally each year, and a significant proportion of these patients require palliative interventions at various stages of their illness trajectory (National Cancer Institute, 2021). Nurses who work in oncology wards are in a unique position to:

- Assess symptoms and implement direct comfort measures.
- Provide necessary psychological support to distressed individuals.
- Facilitate seamless communication between patients, families, and the interdisciplinary team.

Yet despite their proximity to patients and their central role in care delivery, oncology nurses frequently report feeling inadequately prepared to address the complex palliative needs of their patient population. This preparedness gap has direct implications for the quality of care that patients receive, particularly in relation to pain management, communication about prognosis, and psychological support during the dying process (Dahlin, 2015).

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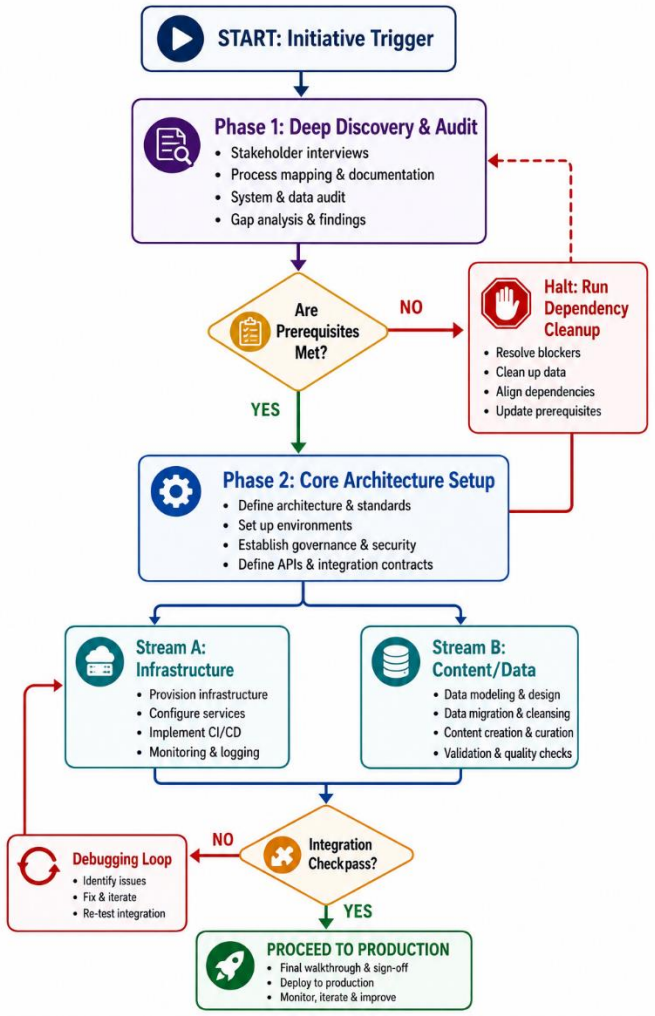


Figure 1: The Deep-Dive Operational & Execution Architecture

Underlying Factors of the Knowledge Gap

Despite the recognised importance of palliative care, numerous studies have highlighted a persistent gap in nurses' knowledge and preparedness to deliver this care effectively. This gap is attributed to a variety of factors including:

- Inadequate undergraduate nursing curricula.
- Limited clinical exposure to dedicated palliative settings.
- Institutional barriers and resource constraints.
- Cultural and attitudinal challenges regarding mortality.

Addressing these gaps requires not only educational interventions but also systemic changes in how healthcare institutions value and prioritise palliative care as a legitimate and indispensable component of oncology practice. It requires a shift in professional culture that moves away from the conflation of palliative care with abandonment or therapeutic failure and towards an understanding of it as an affirmation of the full human dignity and worth of every patient (Twycross, 2019).

This review article provides a comprehensive analysis of the current state of palliative care knowledge among oncology staff nurses. It draws from an extensive body of literature to explore key themes including the conceptual framework of palliative care, the multifaceted role of nurses, barriers to care provision, ethical and psychosocial dimensions, and evidence-based recommendations for training and education. By synthesising knowledge from diverse global contexts and integrating perspectives from clinical practice, nursing education, and health policy, this review seeks to contribute to the ongoing professional dialogue about how best to prepare oncology nurses for the profound and rewarding challenge of palliative care delivery (Lynch et al., 2013).

2. CONCEPT OF PALLIATIVE CARE

The concept of palliative care has evolved considerably since its origins in the hospice movement of the 1960s, pioneered by Dame Cicely Saunders in the United Kingdom. Initially associated exclusively with the terminal phase of illness, contemporary palliative care is now understood as a continuum of support that

should ideally begin at diagnosis and continue through curative treatment, survivorship, and, when necessary, end-of-life care (Connor, 2017).

This evolution reflects a broader understanding that suffering is not confined to the dying process but is present throughout the illness experience and that the relief of this suffering is a legitimate and urgent clinical priority at every stage of disease management. The concept of "total pain," introduced by Dame Cicely Saunders, elegantly captures the multidimensional nature of suffering experienced by patients with serious illness, encompassing physical, emotional, social, and spiritual components that must all be addressed for care to be truly effective (Twycross, 2019).

WHO Holistic Framework The WHO definition recognises that palliative care affirms life and regards dying as a normal process (WHO, 2020). It neither hastens nor postpones death but focuses on providing relief from pain, dyspnoea, nausea, and other distressing symptoms. Crucially, it integrates psychological and spiritual care and offers a support system to help patients live as actively as possible until death, as well as helping families cope during the patient's illness and in bereavement (Ferrell & Coyle, 2015). This definition has been widely endorsed by national and international nursing bodies as providing the most appropriate framework for understanding and practising palliative nursing care, and it underpins the competency frameworks and educational standards that guide palliative nurse education globally (American Nurses Association, 2016).

Integration with Active Oncology Treatments

In oncology, palliative care often runs in parallel with disease-modifying treatments such as chemotherapy, radiotherapy, and targeted therapies. Research by Temel and colleagues demonstrated that early integration of palliative care into the management of metastatic non-small cell lung cancer not only improved quality of life and mood but also resulted in longer median survival compared to standard care alone (Journal of Clinical Oncology, various issues). This landmark finding has catalysed a paradigm shift in oncology towards earlier and more systematic integration of palliative approaches, challenging the previously dominant model in which palliative care was initiated only after all curative options had been exhausted. Early palliative care integration is now endorsed by major oncology organisations as a standard of care for patients with advanced disease (Paice et al., 2016).

From a nursing perspective, understanding the concept of palliative care involves recognising that it is not a synonym for withdrawal of treatment or giving up, but rather a proactive and compassionate mode of care that seeks to maximise wellbeing at every stage (Matzo & Sherman, 2019). Nurses who hold a clear conceptual understanding of palliative care are better equipped to:

1. Advocate for their patients effectively.
2. Challenge misconceptions among colleagues and families.
3. Deliver care that is strictly aligned with patient preferences and values.

This conceptual clarity also supports nurses in resisting institutional pressures that may inadvertently marginalise palliative interventions in favour of aggressive curative treatments that offer limited benefit but significant burden in the context of advanced disease. Nurses grounded in a strong conceptual framework can serve as powerful advocates for a more balanced and patient-centred approach to oncology care (Lynch et al., 2013).

3. PRINCIPLES OF PALLIATIVE CARE

The principles that guide palliative care practice provide a normative framework for nursing interventions in oncology settings. These principles, as articulated by major international bodies, assert that palliative care must be patient-centred, family-inclusive, and interdisciplinary in its approach (WHO, 2020).

Key Guiding Principles

- **Patient-Centred Customization:** Care must be tailored to the individual needs, preferences, and cultural background of each patient. This requires nurses to engage in thorough and compassionate assessments that go beyond physical symptoms to include psychological distress, social concerns, and existential suffering. Patient-centred care means actively eliciting patients' values and goals and ensuring that all clinical decisions are made in alignment with these preferences, respecting the unique personhood of each individual even when they can no longer communicate their wishes directly (Dahlin, 2015).
- **Open and Honest Communication:** Nurses play an indispensable role in facilitating conversations about prognosis, treatment options, and end-of-life preferences. Research by Matzo and Sherman (2019) underscores that effective communication is one of the most powerful tools a palliative care nurse possesses, enabling patients to make informed decisions and feel genuinely heard and respected. Communication skills training has therefore become a cornerstone of palliative nursing education, with programmes such as ELNEC (End-of-Life Nursing Education Consortium) providing structured

frameworks for developing these essential competencies. Studies evaluating such programmes have consistently demonstrated significant improvements in nurses' confidence, knowledge, and reported practice following participation (Ferrell et al., 2015).

- **Non-Abandonment and Equity:** Patients and families must know that they will not be left alone in their suffering, regardless of the clinical trajectory. This requires nurses to maintain continuity of care, to be present during moments of crisis, and to facilitate referrals to specialist palliative care services when needed (Kuebler, Berry & Heidrich, 2018). Non-abandonment is not merely a matter of physical presence but encompasses emotional attentiveness, professional commitment, and the willingness to bear witness to suffering and dying without retreating into clinical detachment or false reassurance. Equally important is the principle of equity, which demands that palliative care be accessible to all patients irrespective of age, diagnosis, socioeconomic status, or geographic location, recognising that disparities in access to quality end-of-life care constitute a serious ethical failure within healthcare systems (Connor, 2017).
- **Interdisciplinary Collaboration:** No single professional can address all the complex needs of a palliative care patient. Effective palliative care requires a team-based approach involving physicians, nurses, social workers, chaplains, physiotherapists, and psychologists working in coordination to deliver seamless, comprehensive care (American Nurses Association, 2016). Within this interdisciplinary framework, nurses occupy a uniquely central position, as they spend the greatest amount of time with patients and families and are therefore best placed to monitor changes in condition, identify unmet needs, and communicate across the team. Research consistently demonstrates that strong interdisciplinary collaboration improves outcomes for palliative care patients, including better symptom control, higher family satisfaction, and fewer unnecessary hospitalisations near the end of life (Lynch et al., 2013).

4. ROLE OF NURSES IN ONCOLOGY UNIT

Staff nurses in oncology units are the primary point of contact for patients undergoing cancer treatment and those receiving palliative interventions. Their role is multidimensional and encompasses clinical, educational, psychosocial, coordinative, and advocacy functions (American Nurses Association, 2016).

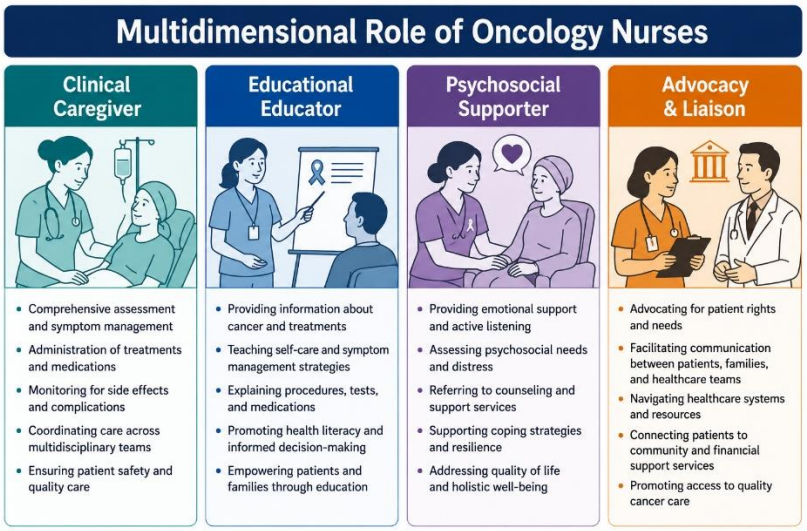


Figure 2: Multidimensional Role of Oncology Nurses in Cancer Care

1. Clinical Caregiver

Clinically, oncology nurses are responsible for assessing and managing complex symptom burdens including pain, fatigue, nausea, dyspnoea, and delirium. They administer chemotherapy and other medications, monitor for adverse effects, and implement evidence-based comfort measures. This clinical role demands a high level of technical competence alongside the interpersonal sensitivity to recognise when a patient's experience of illness extends beyond what pharmacological management alone can address, requiring a more holistic and person-centred intervention (Paice et al., 2016).

2. Patient and Family Educator

Beyond clinical tasks, oncology nurses serve as patient educators, providing individuals and families with the knowledge they need to manage symptoms at home, recognise early warning signs, and understand the goals of their treatment plan. Ferrell and Coyle (2015) emphasise that effective patient education improves self-efficacy, reduces anxiety, and enables more meaningful participation in care decisions. This educational role becomes especially critical in palliative settings where patients and families must often learn to navigate

complex emotional terrain alongside practical care tasks, such as managing a syringe driver, administering subcutaneous medications, or recognising the signs of approaching death. Nurses who deliver this education with clarity, sensitivity, and cultural awareness make an enormous difference to families' sense of preparedness and control during an inherently distressing time.

3. Psychosocial Supporter

The psychosocial dimension of oncology nursing is equally significant. Nurses are uniquely positioned to identify psychological distress, facilitate referrals to mental health professionals, and provide empathic presence during moments of grief and existential crisis (Matzo & Sherman, 2019). They often serve as the emotional anchor for patients who may feel overwhelmed by their diagnosis and prognosis.

Research published in the *Indian Journal of Palliative Care* highlights that patients frequently cite nursing care as the most consistently supportive aspect of their illness experience, underscoring the profound impact nurses have on subjective wellbeing. This psychosocial function requires nurses to possess not only empathy and compassion but also the professional resilience and self-care strategies necessary to sustain these qualities over the course of a demanding career in oncology nursing (Kuebler, Berry & Heidrich, 2018).

4. Patient Advocate and Coordinator

Nurses also play a critical advocacy role, ensuring that patients' rights to informed consent, dignity, and self-determination are upheld. They are often the first to notice when a patient's expressed preferences are not being honoured, and they must be equipped with the confidence and communication skills to advocate effectively within interdisciplinary team meetings (Kuebler, Berry & Heidrich, 2018). This advocacy role extends to the systemic level, with experienced oncology nurses well-placed to champion policy changes that improve palliative care access and quality within their organisations and the broader healthcare system.

Finally, as coordinators of care, nurses manage the complex logistics of palliative interventions across multiple settings, ensuring that patients receive continuity of care as they transition between inpatient units, outpatient clinics, and home care environments (Connor, 2017).

5. IMPORTANCE OF KNOWLEDGE IN PALLIATIVE CARE

Adequate knowledge is a prerequisite for the delivery of high-quality palliative care. Studies consistently demonstrate a positive correlation between nurses' palliative care knowledge and the quality of outcomes experienced by patients, including better symptom control, higher patient satisfaction, and more frequent discussions about advance care planning (Connor, 2017).

In contrast, knowledge deficits have been associated with under-treatment of pain, poor communication about prognosis, and failure to recognise deterioration and initiate appropriate comfort measures. The consequences of inadequate palliative care knowledge are therefore not merely academic but directly translate into unnecessary suffering for patients and families who deserve better. Addressing knowledge deficits is accordingly a matter of both professional ethics and patient safety (Ferrell & Coyle, 2015).

Core Domains of Knowledge

Knowledge in palliative care encompasses several specific domains:

- **Clinical Knowledge:** Related to systemic symptom assessment and management.
- **Pharmacological Knowledge:** Regarding analgesics, equianalgesic dosing, and other palliative medications.
- **Psychosocial Knowledge:** About grief, loss, coping mechanisms, and family dynamics.
- **Ethical/Legal Knowledge:** Pertaining to end-of-life decision-making and advance directives.

Nurses who are deficient in any of these domains may inadvertently compromise the quality of care they provide. For example, a nurse with limited pharmacological knowledge may be hesitant to administer adequate doses of opioid analgesics due to unfounded fears of hastening death or causing addiction, resulting in unnecessary patient suffering. Equally, a nurse lacking psychosocial knowledge may fail to identify depression or complicated grief in a patient or family member, missing a critical opportunity for early intervention and support (Dahlin, 2015).

Managing Evolving Clinical Complexity

The importance of palliative care knowledge is further amplified by the increasing complexity of the oncology patient population. Advances in cancer treatment have led to longer survival times but also to more complex symptom profiles and more protracted illness trajectories (National Cancer Institute, 2021). Nurses must therefore be equipped with current, evidence-based knowledge to manage an evolving range of palliative needs across a diverse patient population. This includes knowledge of newer pharmacological agents and delivery systems, updated evidence on non-pharmacological symptom management strategies, and an understanding of how technological advances in cancer treatment are reshaping the palliative care landscape. Continuous professional development is therefore not optional but an essential component of professional practice for all oncology nurses (Paice et al., 2016).

Institutional investment in palliative care education is therefore not merely a professional development activity but a patient safety imperative. Organisations such as the WHO and the American Nurses Association have issued clear directives calling for the integration of palliative care competencies into basic and continuing nursing education (WHO, 2020; ANA, 2016). These directives reflect an international consensus that no nurse who works with seriously ill patients should be without the fundamental knowledge and skills required to provide compassionate, competent palliative care. Achieving this standard will require sustained commitment from nursing schools, clinical institutions, professional bodies, and governments, all working together to create an educational environment that truly prepares nurses for the realities of palliative oncology practice (Lynch et al., 2013).

6. NEED FOR THE STUDY

Despite the growing recognition of palliative care as an essential component of oncology nursing, research consistently reveals that many staff nurses lack the knowledge and competencies necessary to deliver this care effectively. A systematic review conducted by the *European Journal of Oncology Nursing* identified that a significant proportion of oncology nurses reported inadequate training in palliative care, particularly in areas such as pain management, communication of bad news, and cultural sensitivity in end-of-life care (European Journal of Oncology Nursing, various studies). These findings point to a pressing need for studies that assess the current state of palliative care knowledge among oncology nurses and identify the specific areas requiring educational intervention, so that resources can be targeted most effectively and improvements in care quality can be achieved as efficiently as possible (Twycross, 2019).

The Contextual Urgency in India

In the Indian context, the need for such research is particularly acute. India bears a disproportionately high burden of cancer-related mortality, with a significant proportion of patients presenting at advanced stages of disease when palliative interventions become the primary focus of care (*Indian Journal of Palliative Care*, various issues). Yet palliative care remains a relatively nascent field in India, with limited integration into nursing curricula and healthcare systems.

Studies conducted in Indian oncology settings have found that nurses frequently feel ill-equipped to manage complex palliative scenarios, citing:

- Lack of structured, hands-on training.
- Poor interdisciplinary communication.
- Insufficient institutional support as key barriers (Connor, 2017).

The cultural context of India, with its diverse religious traditions, familial care norms, and complex attitudes towards death and dying, presents unique challenges for palliative care delivery that require contextually appropriate research and educational responses.

The need for this study is also driven by the imperative to generate context-specific evidence that can inform the development of targeted educational programmes for oncology nurses in India and similar low- and middle-income settings. Generic palliative care training modules, while valuable, may not adequately address the cultural, linguistic, and resource-related challenges that characterise oncology nursing in these contexts. Evidence generated from studies conducted in Indian oncology settings is essential for designing training programmes that are not only evidence-based but also culturally resonant and practically applicable within the constraints of resource-limited healthcare environments (Dahlin, 2015).

Finally, the need for this study is underscored by the growing imperative to move towards person-centred, value-congruent care models across all aspects of oncology practice. The global shift towards patient-centred care, supported by international frameworks such as the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases, creates an urgent context for enhancing nurses' palliative care knowledge and practice. Studies that rigorously assess and document knowledge levels, identify specific deficits, and evaluate the effectiveness of educational interventions contribute directly to this broader agenda and help build the evidence base that is necessary to drive systemic change at institutional, national, and international levels (Lynch et al., 2013).

7. OBJECTIVES

The study is structured around several distinct, measurable objectives aimed at evaluating and improving the current framework of oncology nursing:

1. To assess the level of knowledge regarding palliative care among staff nurses working in oncology units.
2. To determine the association between selected demographic variables (such as age, years of experience, and educational qualification) and the level of palliative care knowledge demonstrated.
3. To identify the specific domains of palliative care in which knowledge deficits are most pronounced among oncology nurses.

4. To explore the perceived barriers to the provision of effective palliative care in oncology settings (Ferrell & Coyle, 2015).
5. To recommend evidence-based educational strategies for improving palliative care competencies among oncology staff nurses, drawing on best practices identified in the international literature and adapting these to the specific needs and constraints of the local context.

By systematically examining these dimensions, the study contributes to the growing body of evidence that supports the development of targeted, contextually appropriate educational interventions for oncology nurses in diverse healthcare settings (Connor, 2017). This recommendation objective is particularly important given the significant practical implications of the study for nurse education, institutional policy, and ultimately for the quality of care received by patients with advanced cancer (WHO, 2020). Taken together, these objectives provide a comprehensive framework for understanding the current state of palliative care knowledge in oncology nursing and for charting a course towards meaningful improvement in knowledge, competence, and ultimately in patient and family outcomes.

8. REVIEW OF LITERATURE

The literature on palliative care knowledge among oncology nurses is extensive and spans multiple countries and healthcare contexts. In a landmark study, Ferrell and Coyle (2015) surveyed over 2,000 oncology nurses in the United States and found that while the majority expressed a commitment to palliative care principles, a significant proportion reported inadequate formal training in symptom management, communication, and ethical decision-making. The authors concluded that palliative care content must be more systematically integrated into undergraduate and postgraduate nursing curricula to ensure that all nurses entering oncology practice possess the foundational competencies required. This finding has been replicated across numerous subsequent studies in diverse international settings, suggesting that inadequate palliative care preparation in undergraduate nursing education is a global rather than a country-specific challenge.

In a systematic review of palliative care education in nursing, Matzo and Sherman (2019) analysed 45 studies published between 2000 and 2018 and identified several recurring themes:

- Nurses generally reported positive attitudes towards palliative care but lacked confidence in their clinical skills.
- Knowledge of opioid pharmacology and pain assessment was particularly deficient.
- Interdisciplinary training was identified as a critical facilitator of improved practice.

The review highlighted that simulation-based learning and mentorship programmes were among the most effective educational interventions, producing sustained improvements in both knowledge and clinical confidence. These findings have important implications for the design of palliative care education programmes, suggesting that passive, didactic approaches are less effective than interactive, experiential learning modalities (Dahlin, 2015).

Global Inequities and the Indian Context

Connor (2017), in the *Global Atlas of Palliative Care at the End of Life*, examined palliative care provision across 136 countries and found stark inequities in the availability and quality of palliative nursing education. The Atlas noted that in many low- and middle-income countries, including India, palliative care is not yet integrated into national health policies or nursing educational standards, resulting in chronic shortfalls in nurse competency (Connor, 2017). This global inequity in palliative care preparedness is compounded by resource constraints that limit the availability of specialist palliative care teams, essential medicines including opioid analgesics, and educational infrastructure. Addressing these structural barriers requires not only educational investment but also broader health system strengthening and policy reform at national and international levels.

Within the Indian context, research published in the *Indian Journal of Palliative Care* has documented persistent knowledge gaps among oncology nurses, particularly in relation to opioid analgesic administration, psychological support for dying patients, and communication of terminal prognosis to families. These gaps are compounded by cultural taboos around death and dying, which can make it difficult for nurses to initiate frank conversations about end-of-life preferences (*Indian Journal of Palliative Care*, various issues). A study by Kuebler, Berry, and Heidrich (2018) similarly noted that cultural competence is an often-overlooked dimension of palliative care education that must be explicitly addressed in nursing training programmes. These findings collectively underscore the need for culturally sensitive, context-specific approaches to palliative care education in Indian and similar settings (Paice et al., 2016).

9. METHODOLOGY

This review employed a systematic and comprehensive approach to synthesise existing literature on palliative care knowledge among oncology nurses. Electronic databases including PubMed, CINAHL, Medline, Cochrane Library, and Google Scholar were searched using a combination of MeSH terms and

keywords including *palliative care, oncology nursing, end-of-life care, knowledge, staff nurses,* and *symptom management*.

The search was limited to peer-reviewed articles published in English between 2000 and 2024, and additional grey literature including WHO reports, policy documents, and nursing association guidelines was also reviewed. Database searches were supplemented by manual screening of reference lists from identified key articles and targeted searching of relevant specialist journals including *Palliative Medicine, the Journal of Pain and Symptom Management,* and the *Indian Journal of Palliative Care* (Matzo & Sherman, 2019).

Table 1: Study Selection Criteria

Criteria	Inclusion Criteria	Exclusion Criteria
Participants	Qualified nurses in oncology or palliative care settings.	Focuses exclusively on physician or allied health practices.
Outcomes	Knowledge, attitudes, or practices related to palliative care.	Opinion pieces or essays without empirical clinical data.
Design	Quantitative, qualitative, or mixed-methods studies.	Non-peer-reviewed or unverified programmatic literature.

Both quantitative and qualitative study designs were included, reflecting recognition that a comprehensive understanding of palliative care knowledge requires both measurement of knowledge levels and exploration of the contextual factors that shape knowledge development and application in clinical practice. Mixed methods studies were particularly valued for their capacity to integrate these complementary perspectives (Ferrell & Coyle, 2015).

Data Extraction and Synthesis

Relevant data were extracted from each included study using a standardised data extraction form capturing information on study design, sample size and characteristics, setting, measurement instruments, key findings, and recommendations. A narrative synthesis approach was used to integrate findings across studies, with particular attention to areas of convergence and divergence in the evidence base. Where quantitative data were available, descriptive statistics and effect sizes were noted to provide a sense of the magnitude of knowledge deficits and educational gains associated with different interventions (Ferrell & Coyle, 2015).

The quality of included studies was assessed using appropriate appraisal tools, including the Newcastle-Ottawa Scale for observational studies and the Cochrane Risk of Bias tool for randomised controlled trials, ensuring that conclusions were drawn from methodologically sound research (Dahlin, 2015).

The overall synthesis was informed by a conceptual framework integrating the WHO definition of palliative care, the competency frameworks issued by major nursing bodies including the American Nurses Association and the International Council of Nurses, and the ecological model of health behaviour, which emphasises the importance of individual, interpersonal, organisational, community, and policy-level factors in shaping healthcare practice (American Nurses Association, 2016). This multilevel framework ensured that the review considered not only individual nurse knowledge but also the broader contextual factors that enable or constrain the application of that knowledge in clinical settings, thereby generating recommendations that are relevant at multiple levels of the healthcare system (Lynch et al., 2013).

10. PAIN MANAGEMENT

Pain is the symptom most commonly associated with advanced cancer and the one that patients and families fear most. Effective pain management is therefore a cornerstone of palliative nursing care in oncology settings. The WHO pain relief ladder, introduced in 1986 and updated in subsequent guidelines (WHO, 2020), provides a stepwise framework for pharmacological pain management that has been widely adopted in palliative care practice.

Staff nurses must be proficient in applying this framework, which involves escalating analgesic therapy from non-opioid agents through weak opioids to strong opioids based on the severity of pain. This proficiency requires not only theoretical knowledge of the ladder but also practical skills in pain assessment using validated tools, understanding of equianalgesic dosing principles, and the clinical judgement to anticipate and manage opioid side effects (Kuebler, Berry & Heidrich, 2018).

Deficiencies and the Impact of Opiophobia

Despite the availability of evidence-based pain management guidelines, studies consistently reveal that pain is poorly managed in oncology settings, often due to deficiencies in nursing knowledge (Kuebler, Berry &

Heidrich, 2018). Common knowledge gaps identified in the literature include:

- Unfamiliarity with equianalgesic dosing conversions.
- Inadequate assessment of pain intensity using validated visual or numerical scales.
- Reluctance to administer opioids due to fears of respiratory depression or addiction.
- Limited knowledge of adjuvant analgesics such as corticosteroids, anticonvulsants, and antidepressants (Journal of Clinical Oncology, various articles).

"Opiophobia," defined as the irrational fear of opioid analgesics, has been consistently identified as a major barrier to adequate cancer pain management and appears to be particularly prevalent among nurses who have received limited palliative care education. Overcoming this barrier requires targeted educational interventions that provide accurate information about the safety profile of opioids when used appropriately and challenge the myths that sustain opiophobic attitudes (Twycross, 2019).

Role of Non-Pharmacological Interventions

Non-pharmacological pain management strategies, including relaxation techniques, heat and cold application, positioning, and psychological support, are also within the nursing scope of practice and have been shown to complement pharmacological approaches (Matzo & Sherman, 2019). However, surveys of oncology nurses have found that many are not routinely using or teaching these strategies, again pointing to gaps in knowledge and training.

The integration of non-pharmacological approaches into pain management plans requires nurses to possess a broad repertoire of skills and the clinical confidence to use them appropriately in combination with pharmacological interventions. Research suggests that nurses who receive training in complementary pain management strategies not only expand their clinical toolkit but also experience greater job satisfaction and a stronger sense of professional efficacy in caring for patients with complex pain needs (Paice et al., 2016).

Improving oncology nurses' pain management knowledge requires a multipronged educational approach that addresses both pharmacological and non-pharmacological dimensions and actively challenges the myths and misconceptions that contribute to under-treatment. Educational programmes should incorporate case-based learning scenarios that confront nurses with realistic pain management challenges, simulation exercises that practise both assessment and intervention skills, and reflective practice activities that help nurses examine and revise their attitudes towards opioid analgesics (Ferrell & Coyle, 2015).

Assessment of pain management knowledge using validated instruments such as the *Nurses' Knowledge and Attitudes Survey Regarding Pain* (NKASRP) provides a useful baseline and outcome measure for such programmes, enabling educators to track knowledge gains and tailor content to address identified deficits. Regular audit of pain management practices in oncology units, with feedback to nursing staff, creates an organisational culture of continuous improvement (Dahlin, 2015).

11. SYMPTOMS MANAGEMENT

Beyond pain, patients with advanced cancer experience a constellation of distressing symptoms that significantly impair quality of life. These include fatigue, dyspnoea, nausea and vomiting, cachexia, constipation, delirium, and oral complications, among others. Comprehensive symptom management is therefore a core competency for oncology nurses working in palliative settings, requiring knowledge of both pharmacological and non-pharmacological interventions (Ferrell & Coyle, 2015).

Effective symptom management begins with systematic assessment using validated tools such as the Edmonton Symptom Assessment System (ESAS) or the Palliative Care Outcome Scale (POS), which enable nurses to identify and quantify the range of symptoms experienced by each patient and track changes over time. Failure to conduct systematic symptom assessments is a major contributor to symptom under-treatment and represents a fundamental knowledge gap that educational programmes must address (National Cancer Institute, 2021).

Managing Highly Prevalent Symptoms

- **Cancer-Related Fatigue:** Fatigue is one of the most prevalent and debilitating symptoms experienced by cancer patients, yet it is also one of the most frequently under-assessed and under-treated. Studies have found that many nurses lack the knowledge to distinguish between disease-related fatigue and treatment-related fatigue, or to implement evidence-based interventions such as activity pacing, sleep hygiene advice, and energy conservation strategies (National Cancer Institute, 2021). The management of cancer-related fatigue requires a holistic assessment that considers contributing factors including anaemia, malnutrition, psychological distress, sleep disturbance, and concurrent medications, as well as the patient's functional status and personal goals. Nurses who possess this comprehensive understanding are better equipped to develop individualised management plans.

- **Dyspnoea and Breathlessness:** Dyspnoea is a source of intense distress for many palliative patients but is often poorly managed due to nurses' unfamiliarity with the pharmacological options available, including opioids and benzodiazepines, or anxiety about their use.
- **Nausea and Vomiting:** Management is complicated by multiple potential causes, including disease progression, chemotherapy, opioid side effects, and psychological factors. Nurses must be capable of conducting systematic assessments to identify the likely aetiology and select the most appropriate antiemetic strategy (*Indian Journal of Palliative Care*, various issues). This aetiological approach requires deep knowledge of pathophysiology alongside clinical mentorship.
- **Constipation and Bowel Dysfunction:** Constipation, a near-universal side effect of opioid analgesia, must be anticipated and prevented rather than managed reactively; nurses play a key role in monitoring bowel function and initiating prophylactic laxative therapy in accordance with local protocols (Kuebler, Berry & Heidrich, 2018).
- **Delirium:** Affecting a significant proportion of patients in advanced stages, delirium presents unique challenges requiring knowledge of both its assessment and management (including non-pharmacological strategies like reorientation, environmental modification, and family involvement). Studies have highlighted that nurses' knowledge of delirium in palliative care is often limited, resulting in missed diagnoses and suboptimal management, with significant negative consequences for patients and their families (Matzo & Sherman, 2019).

12. COMMUNICATION SKILLS

Effective communication is arguably the most important competency in palliative care nursing. The ability to communicate with compassion, honesty, and sensitivity enables nurses to establish therapeutic relationships with patients and families, facilitate advance care planning conversations, deliver difficult news, and support individuals through profound grief and existential distress (Matzo & Sherman, 2019).

However, communication in palliative settings is also among the most challenging aspects of clinical nursing practice, and research consistently identifies it as an area of significant knowledge and skill deficit. Nurses frequently report feeling unprepared to initiate or respond to difficult conversations about prognosis and dying, and this discomfort can lead to avoidance behaviours that deprive patients and families of the honest, compassionate communication they need to make informed decisions and prepare emotionally for what lies ahead (Dahlin, 2015).

Structured Frameworks for Breaking Bad News

Breaking bad news is a communication task that oncology nurses are frequently called upon to perform or support, yet formal training in this area remains inconsistent across nursing programmes. The SPIKES protocol, widely cited in the palliative care literature, provides a structured framework for delivering difficult information in a sensitive and patient-centred manner (*Journal of Clinical Oncology*, various articles):

- **S** - Setting Up the Interview
- **P** - Assessing the Patient's Perception
- **I** - Obtaining the Patient's Invitation
- **K** - Giving Knowledge and Information
- **E** - Addressing the Patient's Emotions
- **S** - Strategy and Summary

Training in this and similar communication frameworks has been shown to improve nurses' confidence and competence in having difficult conversations. However, theoretical knowledge of communication frameworks is insufficient on its own; nurses also require opportunities to practise these skills in safe environments, receive constructive feedback, and reflect on their communication behaviours (Ferrell & Coyle, 2015).

Active Listening and Handling Cultural Interventions

Active listening is another communication skill of particular importance in palliative nursing. Patients who are facing death often need space to express fears, regrets, and hopes, and nurses must be equipped to be fully present in these conversations without feeling the need to offer premature reassurance or redirect the discussion to clinical matters (Connor, 2017). Reflective listening skills, the capacity to tolerate silence, and the ability to respond to emotional cues with empathy and authenticity are all competencies that can and should be explicitly taught and practised as part of palliative care nursing education. Research demonstrates that nurses who receive training in reflective listening and emotional presence report significantly greater confidence, as well as lower levels of compassion fatigue and burnout (Twycross, 2019).

Communication with families in palliative settings presents additional complexities, including the management of conflicting preferences between patients and family members, the facilitation of family meetings involving multiple stakeholders, and the provision of culturally sensitive communication to

families from diverse backgrounds (Kuebler, Berry & Heidrich, 2018). In many cultural contexts, including in India, family members may take a central role in decision-making about treatment and may request that information about prognosis be withheld from the patient, creating ethical tensions that nurses must be prepared to navigate with skill and sensitivity.

Educational programmes must therefore address not only the technical aspects of difficult communication but also the ethical and cultural dimensions that shape communication in diverse palliative care settings, equipping nurses to adapt their approaches while maintaining their core commitment to patient dignity and autonomy (Lynch et al., 2013).

13. ETHICAL AND LEGAL ISSUES

The ethical dimensions of palliative care are numerous and complex, and oncology nurses must be equipped to navigate them with confidence and competence. Key ethical principles relevant to palliative nursing include autonomy, beneficence, non-maleficence, and justice (American Nurses Association, 2016).

The Ethical Balance

Respecting patient autonomy requires nurses to support informed consent, advance care planning, and the right of patients to refuse treatment, even when the nurse's clinical judgement might favour a different course of action. Balancing beneficence and non-maleficence can be particularly challenging in situations involving the administration of analgesic doses that may theoretically hasten death in a terminally ill patient, a scenario governed by the ethical principle of double effect (Twycross, 2019). Nurses who lack a clear understanding of this principle may refuse to administer appropriate doses of analgesics, thereby causing avoidable suffering in a misguided attempt to avoid harm.

Advance Care Planning (ACP)

Advance care planning (ACP) is an area of growing importance in oncology palliative care and one in which nurses play an increasingly prominent role. ACP involves structured conversations between patients, families, and healthcare providers about future care preferences, including:

- Resuscitation status (DNR orders).
- Preferred place of death (home vs. hospice).
- The use or withdrawal of life-sustaining treatments (Ferrell & Coyle, 2015).

Research indicates that patients who have engaged in ACP experience less aggressive end-of-life interventions, higher satisfaction with care, and greater congruence between their preferences and the care they receive (*European Journal of Oncology Nursing*, various studies). Despite these clear benefits, advance care planning conversations remain insufficiently common in oncology settings, partly due to nurses' lack of knowledge and confidence in initiating and conducting such discussions, and partly due to institutional cultures that implicitly discourage frank discussion of prognosis and end-of-life preferences.

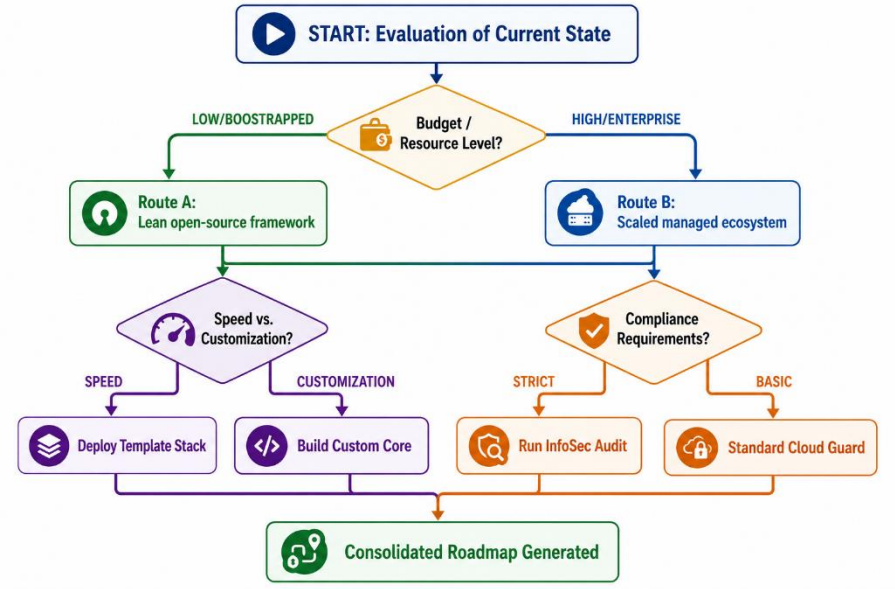


Figure 3: The Comprehensive Multi-Tiered Decision Matrix

Legal Context and Distributive Justice

Legal considerations in palliative nursing include familiarity with relevant legislation governing advanced directives, euthanasia, and physician-assisted dying, which vary significantly between jurisdictions. In India, the Supreme Court ruling in the *Common Cause* case (2018) recognised the right to passive euthanasia and the validity of advance medical directives, creating new legal and ethical responsibilities for nurses working

in palliative settings (*Indian Journal of Palliative Care*, various issues). Nurses must therefore be knowledgeable about the legal framework in their jurisdiction and understand how it interacts with their professional ethical obligations, enabling them to support patients in exercising their legal rights while practising within the boundaries of their professional role.

The ethical principle of justice demands that palliative care resources and expertise be distributed equitably, ensuring that all patients with advanced cancer have access to high-quality symptom management, psychosocial support, and dignified end-of-life care regardless of their social circumstances, geographic location, or cultural background (Connor, 2017). Oncology nurses have an important role in identifying and addressing inequities in palliative care access within their organisations, advocating for vulnerable patients who may be at risk of receiving substandard care, and contributing to broader efforts to eliminate disparities in end-of-life care quality. This advocacy role requires nurses to be informed about the structural determinants of palliative care access and to be prepared to challenge institutional policies and practices that perpetuate inequitable care (American Nurses Association, 2016).

14. PSYCHOSOCIAL CARE

Psychosocial care is a fundamental component of holistic palliative nursing and encompasses support for the psychological, emotional, social, and existential needs of patients and their families. The psychosocial impact of a cancer diagnosis is profound and multifaceted, including anxiety, depression, adjustment disorders, grief, fear of death and dying, and disruption of family roles and relationships (Matzo & Sherman, 2019).

Nurses who are equipped with psychosocial care competencies are better able to identify distress, provide supportive interventions, and facilitate referrals to specialist psycho-oncology services when needed. Validated screening tools such as the Hospital Anxiety and Depression Scale (HADS) and the Distress Thermometer enable nurses to systematically assess psychosocial distress and ensure that patients with significant psychological needs are identified and supported (Paice et al., 2016).



Figure 4: Components of Holistic Psychosocial Care in Oncology and Palliative Settings

Bereavement and Caregiver Support

Grief and bereavement support is a particularly important aspect of psychosocial care that extends beyond the patient's death to encompass support for family members in the weeks and months following bereavement. The *Indian Journal of Palliative Care* has published several studies demonstrating the high prevalence of complicated grief among caregivers of cancer patients in India, and the important role that nurses play in identifying risk factors and providing early bereavement support (*Indian Journal of Palliative Care*, various issues).

However, nurses' capacity to deliver this support is often limited by inadequate training, high workloads, and a lack of institutional structures for bereavement follow-up. Establishing formal bereavement care pathways within oncology services, supported by trained nursing staff and specialist bereavement counsellors, represents an important step towards ensuring that families receive the support they need following the death of a loved one.

Spiritual and Existential Care

Spiritual and existential care represents the dimension of psychosocial nursing that is perhaps most frequently neglected, yet it is one that patients with life-limiting illness consistently identify as critically important. Existential distress, characterised by fears about the meaning and purpose of life, concerns about legacy, and anxiety about what lies beyond death, is highly prevalent in palliative patients and has been

associated with poorer quality of life and increased psychological suffering (Connor, 2017).

Nurses need not be spiritual care specialists to address existential concerns; simple acts of presence, attentive listening, and facilitation of spiritual practices can make a profound difference to patients' sense of wellbeing and dignity. However, nurses do need to develop sufficient self-awareness and emotional courage to enter into conversations about spiritual and existential matters without retreating into the safety of purely clinical discourse.

The social dimensions of the palliative care experience, including concerns about financial security, family relationships, housing, and social isolation, are equally important aspects of holistic nursing assessment. Social workers are key members of the palliative care interdisciplinary team and should be available to provide specialist support for patients with complex social needs. However, nurses are often the first to identify social concerns and must be equipped with the knowledge and skills to conduct basic social needs assessments and make timely referrals (Kuebler, Berry & Heidrich, 2018). Research consistently shows that unmet social needs are associated with poorer psychological wellbeing, lower quality of life, and greater difficulty coping with illness, underscoring the importance of proactive social needs assessment as a routine component of holistic palliative nursing care in oncology settings (Lynch et al., 2013).

15. BARRIERS TO PALLIATIVE CARE

Multiple barriers impede the delivery of high-quality palliative care by oncology nurses, and understanding these barriers is essential for designing effective interventions.

1. Organisational and Systemic Barriers

Organisational barriers are among the most pervasive and include high patient-to-nurse ratios, inadequate staffing levels, and insufficient time for nurses to engage in the kind of holistic, relationship-centred care that palliative nursing requires (Kuebler, Berry & Heidrich, 2018). The physical environment of many oncology wards, with shared rooms and limited privacy, can also make it difficult to have sensitive palliative conversations or provide adequate emotional support. Healthcare system factors including lack of specialist palliative care teams, limited availability of essential palliative medicines, and inadequate community support services further constrain nurses' ability to deliver optimal palliative care, particularly for patients wishing to die at home (Connor, 2017).

2. Knowledge and Educational Barriers

Knowledge and educational barriers are equally significant. Palliative care remains inadequately represented in many undergraduate nursing curricula and continuing education programmes (WHO, 2020). As a result, many nurses enter oncology practice without the foundational knowledge and skills required to deliver effective palliative care.

Access to specialist palliative care education and training, including courses offered by national palliative care organisations, remains limited in many settings, particularly for nurses working in rural or under-resourced areas. The ELNEC project, which has trained thousands of nurses internationally in palliative care competencies, represents one of the most successful responses to this educational gap, but its reach remains insufficient relative to the global need (Ferrell & Coyle, 2015).

3. Attitudinal and Cultural Barriers

Attitudinal and cultural barriers can be particularly challenging to address. In many cultures, including in India, death is a taboo subject that is rarely discussed openly, and both healthcare professionals and families may collude in avoiding conversations about prognosis and end-of-life preferences (*Indian Journal of Palliative Care*, various issues). Nurses who share these cultural norms may find it especially difficult to initiate advance care planning discussions or to be honest with patients about the limits of curative treatment. Additionally, institutional cultures that prioritise curative interventions over comfort care can create an environment in which nurses feel that palliative care is seen as a low-priority or defeatist endeavour, undermining their motivation to develop and apply palliative care competencies (Twycross, 2019).

4. Personal and Emotional Barriers

Personal and emotional barriers also play a role in limiting nurses' engagement with palliative care. Nurses who have not had the opportunity to reflect on their own attitudes towards death and dying, or to develop personal coping strategies for dealing with the emotional demands of palliative care, may experience high levels of distress, compassion fatigue, and burnout that compromise their capacity to provide empathic, skilled care (Matzo & Sherman, 2019).

Educational programmes that incorporate reflective practice, self-care strategies, and emotional support alongside clinical and communication skills training are more likely to produce nurses who are not only knowledgeable but also emotionally resilient and sustainable in their palliative care practice. Recognising and addressing the personal and emotional dimensions of palliative nursing is therefore an essential component of comprehensive palliative care education at all levels (Dahlin, 2015).

16. TRAINING AND EDUCATION

Education and training represent the most powerful levers for improving palliative care knowledge and practice among oncology nurses. A robust body of evidence supports the effectiveness of a range of educational interventions, from formal academic programmes and workshops to simulation-based learning, case-based discussions, and clinical mentorship (Matzo & Sherman, 2019). The key is to ensure that educational content is grounded in evidence-based practice, culturally relevant, and aligned with the specific learning needs and practice contexts of oncology nurses. A needs assessment approach, which identifies the specific knowledge and skill gaps of the target group before designing educational interventions, is most likely to produce programmes that are relevant, engaging, and impactful (Paice et al., 2016).

Curriculum Restructuring Strategies

- **Undergraduate Curricular Integration:** Undergraduate nursing programmes have a fundamental responsibility to integrate palliative care content throughout the curriculum rather than confining it to a single module. Core competencies that should be addressed include pain and symptom assessment and management, communication skills for difficult conversations, psychological support for patients and families, ethical and legal frameworks, cultural competence, and interdisciplinary teamwork (American Nurses Association, 2016). Clinical placements in palliative care settings, including hospices, should be a required component of undergraduate nursing education to ensure that students gain direct experience of palliative care practice before graduation. Evidence from programmes that have incorporated mandatory palliative care placements demonstrates significant improvements in students' knowledge, attitudes, and self-efficacy in relation to palliative care, with sustained effects on their subsequent practice as qualified nurses (Lynch et al., 2013).
- **Postgraduate and Continuing Professional Development:** At the postgraduate level, specialist palliative care nursing programmes provide in-depth preparation for advanced roles in this field. However, such programmes are not available in all settings, and the majority of oncology nurses will need to develop their palliative care competencies through continuing professional development activities. WHO and nursing bodies such as the ANA have recommended that all nurses who work with seriously ill patients should have access to regular, high-quality palliative care education, and that organisations should allocate dedicated time and resources for this purpose (WHO, 2020). Online learning platforms have expanded access to palliative care education, enabling nurses in remote and resource-limited settings to access high-quality content that was previously unavailable to them, though this requires active strategies to ensure that online learning is applied and embedded in clinical practice.

Modern Pedagogical Modalities

Simulation-based learning has emerged as a particularly promising approach to palliative care education, offering nurses the opportunity to practise complex clinical and communication skills in a safe environment before applying them in real clinical settings (*European Journal of Oncology Nursing*, various studies). Standardised patient scenarios involving breaking bad news, managing an acute pain crisis, or conducting a family meeting have been shown to improve both knowledge and confidence among participants, with gains sustained at follow-up assessments.

Mentorship programmes, in which experienced palliative care nurses provide ongoing guidance and support to less experienced colleagues, have also demonstrated effectiveness in translating educational knowledge into sustained improvements in clinical practice, representing a cost-effective and contextually embedded approach to palliative care professional development (Ferrell & Coyle, 2015).

17. CULTURAL SENSITIVITY IN PALLIATIVE CARE

Cultural competence is an integral dimension of palliative care nursing that is often insufficiently addressed in educational programmes. India's diverse population encompasses a wide range of religious traditions, languages, and cultural norms relating to illness, death, and dying, all of which have profound implications for how palliative care is experienced and delivered (*Indian Journal of Palliative Care*, various issues). Hinduism, Islam, Christianity, Sikhism, and other religious traditions each provide distinctive frameworks for understanding the meaning of suffering and death, and nurses who are aware of these frameworks are better equipped to deliver care that is spiritually sensitive and culturally congruent. Cultural competence in palliative nursing requires more than factual knowledge of religious beliefs and practices; it demands a capacity for genuine curiosity and respectful engagement with the unique cultural identity of each patient and family (Kuebler, Berry & Heidrich, 2018).

Familial Decision-Making Frameworks

The role of the family in decision-making and care provision is particularly significant in Indian and many other non-Western cultural contexts. In these settings, the family rather than the individual patient may be the

primary decision-making unit, and major clinical decisions, including decisions about disclosure of diagnosis and prognosis, may be understood as the prerogative of the family rather than the patient alone.

Nurses working in these contexts must be able to navigate the resulting ethical tensions thoughtfully and flexibly, respecting cultural norms while maintaining their professional commitment to patient dignity and informed consent (Connor, 2017). This navigation requires not only cultural knowledge but also advanced communication skills, ethical reasoning capacity, and the ability to facilitate conversations that honour both individual and family perspectives.

Resolving Linguistic Inequities

Language barriers present additional challenges for culturally sensitive palliative care in linguistically diverse settings. In India, where hundreds of languages and dialects are spoken, ensuring that patients receive clear, accurate information about their diagnosis, prognosis, and treatment options in a language they can fully understand is a fundamental nursing responsibility (Dahlin, 2015). The use of professional interpreters, where available, is recommended over reliance on family members for interpretation, as family members may inadvertently censor or modify information in ways that compromise patient autonomy and informed consent. Nurses must advocate for adequate interpreter services within their organisations and develop strategies for delivering compassionate, comprehensible communication in the absence of professional interpretation services.

Educational programmes designed to develop cultural competence in palliative nursing must go beyond didactic content delivery to incorporate experiential learning activities that challenge nurses to examine their own cultural assumptions and develop genuine cross-cultural empathy. Narrative approaches, including the use of patient stories and reflective writing, have been shown to be particularly effective in promoting cultural self-awareness and perspective-taking among nursing students and qualified nurses (Matzo & Sherman, 2019). Partnerships between nursing programmes and community organisations representing diverse cultural groups can provide valuable opportunities for nurses to engage directly with patients and families from different backgrounds, developing the cultural understanding and relational skills that are essential for culturally competent palliative care practice in diverse settings.

18. DISCUSSION

The literature reviewed in this article consistently highlights a significant gap between the palliative care knowledge that oncology nurses possess and what is required to deliver high-quality care to patients with advanced cancer. This gap is evident across multiple domains including pain and symptom management, communication, psychosocial care, and ethical decision-making, and is influenced by a complex interplay of individual, educational, organisational, and cultural factors (Connor, 2017; Ferrell & Coyle, 2015). The consistency of these findings across diverse international contexts suggests that inadequate palliative care preparation is a systemic problem rooted in fundamental gaps in nursing education and institutional support, rather than a reflection of individual nurses' lack of commitment or compassion. This systemic framing has important implications for how interventions are designed and where responsibility for improvement is located within healthcare systems.

Addressing Opiophobia through Supervised Mentorship

A particularly striking finding across the reviewed literature is the persistence of opiophobia among nursing staff. Despite decades of evidence demonstrating the safety and efficacy of opioid analgesics for cancer pain, many oncology nurses continue to harbour unfounded fears about respiratory depression, addiction, and hastening death that lead to inadequate pain management (Kuebler, Berry & Heidrich, 2018). Addressing this issue requires not only educational interventions but also institutional culture change and supportive supervision that empowers nurses to administer analgesics confidently and in accordance with best practice guidelines.

The role of specialist palliative care nurses in modelling confident, evidence-based analgesic practice and providing mentorship to ward-based colleagues is likely to be particularly important in shifting clinical culture around opioid administration in oncology settings (Twycross, 2019).

Localizing Educational Frameworks

The discussion also highlights the need for contextually appropriate palliative care education in low- and middle-income countries including India. Educational programmes developed in high-income Western contexts may not adequately address the cultural, linguistic, and resource-related challenges faced by nurses in these settings. There is a clear need for collaborative research between palliative care educators, clinical nurses, and policymakers to develop and evaluate palliative care education models that are fit for purpose in diverse global contexts (*Indian Journal of Palliative Care*, various issues). This collaborative approach should draw on the expertise of nurses themselves in identifying the specific educational needs of their professional community and the barriers they face in applying palliative care knowledge in their clinical

contexts.

The discussion further reveals the need for a more integrated approach to palliative care delivery that positions it as an integral component of oncology care from the point of diagnosis rather than a service that is initiated only at the end of life. The evidence supporting early palliative care integration, including improved quality of life, reduced symptom burden, and in some cases improved survival, provides a compelling clinical and ethical argument for redesigning oncology care pathways to ensure that palliative approaches are systematically incorporated alongside disease-modifying treatments (Paice et al., 2016). This requires not only changes in clinical practice but also a cultural shift in how oncology healthcare professionals, patients, and the broader public understand the relationship between cancer treatment and palliative care, challenging the false dichotomy that positions curative and palliative approaches as mutually exclusive options.

19. FINDINGS

The synthesis of reviewed literature yields several key findings regarding palliative care knowledge among oncology nurses:

- **Widespread Deficits:** Knowledge deficits are widespread and affect nurses at all levels of experience and qualification, though the specific nature of these deficits varies with individual background and practice context (Ferrell & Coyle, 2015).
- **Pain Management and Opiophobia:** Pain management knowledge is consistently identified as one of the most deficient areas, with under-treatment of cancer pain representing a major ongoing challenge in oncology settings globally. The persistence of opiophobia as a driver of inadequate pain management despite decades of educational efforts suggests that addressing this issue requires more than information provision and must engage with the attitudinal and cultural factors that sustain opiophobic beliefs among nursing staff (Kuebler, Berry & Heidrich, 2018).
- **Communication Vulnerabilities:** Communication skills, particularly the ability to initiate and conduct conversations about prognosis, advance care planning, and end-of-life preferences, are consistently rated as areas of significant uncertainty and discomfort among oncology nurses (Matzo & Sherman, 2019).
- **Attitudinal Triggers:** Attitudinal and cultural factors play an important role in shaping both the knowledge nurses seek and the care practices they adopt. Nurses who hold positive attitudes towards palliative care and who perceive it as a meaningful and rewarding aspect of their professional role are more likely to engage in self-directed learning and to deliver high-quality palliative care. Positive attitudes appear to be fostered by direct clinical experience in palliative care settings, mentorship from experienced palliative care nurses, and exposure to reflective practice approaches that invite nurses to examine the personal significance of their work with dying patients (Dahlin, 2015).
- **Multimodal Gains:** Educational interventions, particularly those that are multimodal, sustained over time, and embedded within a supportive clinical environment, are effective in improving palliative care knowledge and practice (*European Journal of Oncology Nursing*, various studies). The evidence suggests that single, one-off educational events produce short-term gains in knowledge that are not always sustained in practice, and that sustained improvements require ongoing educational support combined with changes in the clinical environment that enable nurses to apply their new knowledge.
- **Institutional Context:** Institutional and organisational factors, including staffing ratios, access to specialist support, and workplace culture, have a profound influence on nurses' ability to apply palliative care knowledge in practice, highlighting the need for systemic as well as individual-level interventions (Connor, 2017).
- **Specialist Integration:** The integration of specialist palliative care nurses into oncology teams is associated with improved outcomes for patients and families, as well as with increased palliative care knowledge and confidence among ward-based nursing staff. Specialist palliative care nurses who function as clinical educators, role models, and consultants within oncology units represent a highly effective strategy for bridging the gap between formal educational preparation and clinical practice, providing the just-in-time learning and professional support that nurses need to deliver high-quality palliative care in real clinical settings (Paice et al., 2016).
- **Family Partnerships:** Family-centred care approaches that explicitly include family members as partners in palliative care delivery are associated with better outcomes for patients and families alike, and nurses play a central role in facilitating this family-centred approach through their daily interactions with patients and their carers (Lynch et al., 2013).

20. RECOMENDATIONS

Based on the review of literature, the following evidence-based actions are recommended:

1. Educational and Academic Frameworks

- Palliative care content should be systematically integrated throughout undergraduate nursing curricula, with mandatory clinical placements in palliative care settings to provide direct experiential learning (WHO, 2020).
- All oncology nurses should have access to regular, structured continuing professional development in palliative care, with institutions allocating dedicated time and resources for this purpose (American Nurses Association, 2016).
- Simulation-based learning should be incorporated into palliative care education programmes to develop communication and clinical skills in a safe and supportive environment (Matzo & Sherman, 2019).

These recommendations collectively represent a minimum standard for palliative care preparation that should be enshrined in nursing education policy and institutional continuing education frameworks at national and international levels.

2. Clinical and Institutional Practice

- Specialist palliative care nurses should be available in all oncology units to provide clinical mentorship, role modelling, and consultation for nursing staff (Ferrell & Coyle, 2015).
- Institutions should conduct regular audits of palliative care practice and use findings to inform targeted educational interventions at the individual and team level (Kuebler, Berry & Heidrich, 2018).
- Cultural competence training should be an explicit component of palliative care education to equip nurses to deliver sensitive, respectful care to patients from diverse backgrounds (*Indian Journal of Palliative Care*, various issues).
- National health policies should mandate the integration of palliative care into cancer care services and establish clear standards for palliative nursing education and practice (Connor, 2017).

These recommendations span multiple levels of the healthcare system, recognising that sustainable improvements in palliative care quality require action at the level of individual educational programmes, clinical institutions, professional bodies, and health policy (Lynch et al., 2013).

3. Research and Policy Directions

- Research investment in palliative care nursing education should be increased, with a particular focus on developing and evaluating contextually appropriate educational interventions for low- and middle-income settings where the need is greatest and the evidence base is most limited (Dahlin, 2015).
- Collaborative research partnerships between nursing schools, clinical institutions, and palliative care organisations in high- and low-income countries should be established to facilitate knowledge exchange and capacity building across diverse contexts.
- International nursing organisations including the International Council of Nurses should develop and disseminate global competency frameworks for palliative nursing that can be adapted to local contexts and used to standardise educational expectations and clinical practice standards (Paice et al., 2016).

These frameworks should be developed with the active participation of nurses from diverse global settings to ensure that they are relevant and applicable across the full range of healthcare environments in which palliative nursing is practised.

4. Workplace Culture and Support

Healthcare organisations should actively cultivate a workplace culture that recognises palliative care as an essential component of comprehensive cancer treatment and values it as a core clinical competency for all oncology nurses. Such a culture must move beyond viewing palliative care solely as end-of-life management and instead integrate it throughout the continuum of cancer care, beginning from diagnosis and continuing through treatment, survivorship, or terminal stages. Establishing this culture requires strong leadership commitment to palliative care as an organisational priority, including the incorporation of palliative care principles into institutional mission statements, policies, clinical guidelines, and quality improvement initiatives. Leaders within healthcare institutions should ensure that oncology nurses receive adequate educational opportunities, protected training time, and access to evidence-based resources that strengthen their confidence and competence in symptom management, psychosocial care, communication, and ethical decision-making (Twycross, 2019).

In addition to educational investments, healthcare organisations must provide adequate staffing levels and manageable nurse-to-patient ratios that allow nurses sufficient time to engage meaningfully with patients and families. Palliative nursing care requires not only technical competence but also emotional presence, therapeutic communication, and continuous assessment of physical, psychological, social, and spiritual needs. When nurses are overwhelmed by excessive workloads or staffing shortages, opportunities for compassionate interactions, emotional support, and holistic care may be significantly reduced. Therefore, administrators should prioritise workforce planning strategies that support continuity of care and reduce

burnout among oncology nurses. Recognition and reward systems for excellence in palliative nursing practice, including professional advancement opportunities, awards, and performance incentives, can further motivate nurses to maintain high standards of compassionate and patient-centred care (Twycross, 2019). Healthcare institutions should also establish structured peer support systems, mentorship programmes, clinical supervision models, and reflective practice forums within oncology units to strengthen nurses' emotional resilience and professional development. Caring for patients with advanced cancer often exposes nurses to repeated experiences of suffering, grief, ethical dilemmas, and death, which may contribute to compassion fatigue, emotional exhaustion, and moral distress if appropriate support is lacking. Regular opportunities for debriefing, interdisciplinary case discussions, and guided reflective practice can help nurses process difficult clinical experiences, share coping strategies, and enhance collaborative learning. Senior nurses and palliative care specialists can serve as mentors to less experienced staff, fostering confidence and promoting the application of palliative care principles in everyday clinical practice. Such supportive professional environments not only improve nurses' wellbeing but also contribute to greater job satisfaction, staff retention, and improved quality of patient care (American Nurses Association, 2016).

Finally, healthcare leaders must recognise that improving palliative care quality requires sustained organisational commitment rather than isolated educational interventions. Policies supporting nurse wellbeing, continuing professional development, emotional support, and evidence-based practice should be continuously evaluated and strengthened. Investment in supportive workplace environments enables nurses to translate their palliative care knowledge into consistent, compassionate, and effective clinical practice. By addressing the organisational conditions necessary for high-quality palliative nursing care, healthcare systems can create environments in which patients with advanced cancer experience greater dignity, comfort, emotional support, and quality of life during serious illness and at the end of life. Such organisational commitment ultimately benefits not only patients and families but also the nurses who provide this demanding yet profoundly meaningful care (American Nurses Association, 2016).

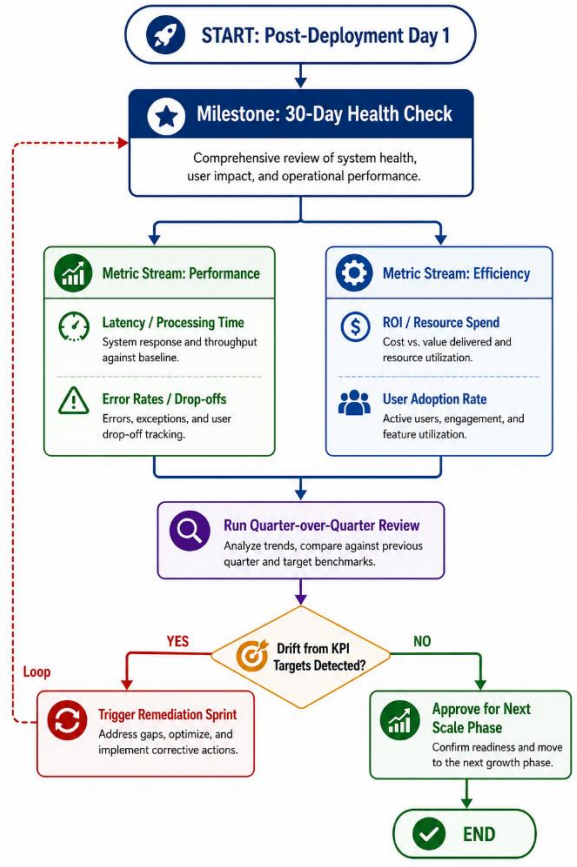


Figure 5: The Long-Term Governance, Audit, & Maintenance Lifecycle

CONCLUSION

This review has demonstrated that palliative care knowledge among oncology nursing staff remains a critical area of concern, with significant gaps identified across multiple domains including pain and symptom management, communication, psychosocial and spiritual care, ethical decision-making, and cultural competence. These gaps are not simply the result of individual nurse deficiencies but reflect systemic failures in nursing education, institutional prioritisation, and healthcare policy at the national level.

Addressing them requires a comprehensive and multi-level response that encompasses curriculum reform, continuing education, clinical mentorship, organisational culture change, and policy advocacy (WHO, 2020; Ferrell & Coyle, 2015). The evidence reviewed confirms that knowledge and competence in palliative care are not innate qualities but skills that can be taught, developed, and refined through appropriate educational experiences and supportive clinical environments.

Every patient with advanced cancer deserves to receive care that is compassionate, dignified, and technically excellent. Meeting this standard requires nurses who are not only clinically skilled but also emotionally resilient, ethically informed, and culturally sensitive. Achieving this vision will require sustained investment in palliative care nursing education at all levels, supported by institutional leaders, policymakers, and the broader nursing profession. The moral case for this investment is clear and compelling: the relief of suffering at the end of life is one of the most fundamental responsibilities of any healthcare system, and the nurses who bear the greatest part of this responsibility deserve the preparation and support necessary to fulfil it with competence and compassion (Connor, 2017; Matzo & Sherman, 2019).

Future research should focus on developing and rigorously evaluating palliative care education programmes that are contextually adapted for diverse settings, particularly in low- and middle-income countries where the need is greatest but resources are most constrained. Such research has the potential to generate transformative improvements in the quality of life and death experienced by millions of patients with advanced cancer and their families (Connor, 2017). Additionally, implementation science approaches that examine not only whether educational interventions work but how and under what conditions they are most effective will be essential for translating research findings into sustained improvements in clinical practice. The ultimate measure of success in palliative care education is not nurses' scores on knowledge assessments but the quality of the care that patients and families experience at the most vulnerable and meaningful moments of their lives (Paice et al., 2016).

In conclusion, the vision of a healthcare system in which every patient with advanced cancer receives expert, compassionate palliative care is achievable, but it will require coordinated action across multiple levels of the healthcare system over a sustained period of time. Nurses are central to this vision, and equipping them with the knowledge, skills, and support they need to realise it is one of the most important investments that healthcare institutions and policymakers can make. The evidence reviewed in this article provides both a clear diagnosis of the current state of palliative care knowledge in oncology nursing and a roadmap for the educational and systemic changes required to close the gap between the care that patients currently receive and the care they deserve (Dahlin, 2015; Lynch et al., 2013).

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