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Original research article

Social and emotional determinants of death anxiety in the context of health care

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Abstract
Introduction: Health care professionals (HCPs) often meet terminal patients in the course of their work, which potentially poses psychological and existential challenges. The identification of individual and social factors associated with fear of death (FoD) is crucial for prevention.
Objective: The objective of the study was to explore the psychological and social variables related to FoD levels among HCPs.
Methods: In a quantitative, cross-sectional study, the Multidimensional Fear of Death Scale was applied (N = 500). Data were analysed with Mann–Whitney, Spearman's, and Kruskal–Wallis tests.
Results: The mean FoD score was 129.76 points. There was no significant difference in MFODS scores between religious and non-religious participants (U = 30349.50; p = 0.632), and no significant correlation between working conditions and MFODS scores (ρ = 0.071; p = 0.114). However, there was a significant negative correlation between psychological strain and the FoD score (ρ = –0.301; p < 0.001). Fear levels differed significantly according to the extent of communication about death (H = 29.46; p < 0.001).
Conclusion: FoD is mainly influenced by emotional strain and communication opportunities, while religiosity and working conditions alone have no significant effect on its level. Psychological support related to the terminal stage and promoting open communication about death may serve as important protective factors for HCPs.

Keywords: Communication; Emotional strain; Fear of death; Religion; Working conditions

Introduction

Fear of death is one of the oldest and most fundamental forms of human existential anxiety, stemming from becoming aware of finiteness, the unknown, and the potential loss of control. Several theories emphasise its nature and consider it a type of anticipatory mode of "being-in-the-world", which results from becoming aware of the limits of one's existence (Beshai and Naboulsi, 2004). Psychoanalytic approaches emphasise the role of defence mechanisms, while existential perspectives associate the confrontation with death with questions of life's meaning and authenticity. Cultural embeddedness shapes the meanings ascribed to the experience of death and the ways in which it can be processed by the individual. While a universal phenomenon, how it is experienced depends greatly on personal experiences, societal norms, and the work environment. Among HCPs, who see actual death as part of their work as helpers, this experience has significant psychological weight and relevance. The frequency and the way HCPs see death at work vary. When it happens occasionally, it may result in some emotional strain, but the psychological burden's intensity is especially high where death is experienced directly, as an unavoidable part of patient care. Attitudes towards death and the related emotional reactions have a substantial effect on how professionally the helper role is realised and how the mental well-being of HCPs is maintained (Pessin et al., 2015). Mental strain may be extremely high when contact with death is not only a professional situation but also an experience with internal emotional involvement (Tornøe et al., 2015). According to the literature, long-term professional interaction with terminal patients may lead to psychological phenomena such as secondary traumatisation and compassion fatigue, with symptoms like intrusive thoughts, irritability, and avoidance showing patterns typical of posttraumatic stress (Karaoglu et al., 2021; Kegye, 2021).

The various aspects of FoD, such as the fear of physical destruction, loss of control, pain, or the unknown, may be present in the work of HCPs. These emotional reactions may contribute to anxiety, mental exhaustion and burnout, which

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are critical for individual psychological adaptation and for the quality of patient care (Alhusamiah and Zeilani, 2025; Lu et al., 2024). Attitudes towards death are not only relevant in care situations where death is ever-present, but also in professional environments where the issue of death is not prominent, yet it implicitly affects helpers' attitudes (Long et al., 2023; Zana et al., 2014). The professional competence and emotional control expected from HCPs often repress subjective reactions to experiencing death. Becoming aware of one's mortality, especially through repeated losses, is emotionally straining, yet it often happens invisibly in the context of one's professional role (Clare et al., 2022).

The examination of death anxiety (DA) and related psychological factors is theoretically relevant and has practical implications for HCPs' ability to cope with psychological strain and maintain the people-centred quality of care. This is particularly important because of the complexity of death experiences and the significance of their individual and professional processing.

Objective

The objective of the study was to explore the profession-specific and personal determinants of FoD. Variables that may affect attitudes towards death, along with individual experiences and the specificities of the work environment, were included. The study analysed religiosity, the assessment of working conditions, the psychological burden of dying, and the role of death-related thinking and communication.

Materials and methods

Study design

This was a quantitative, cross-sectional study, with electronic data collection between November 2024 and May 2025. The survey was administered via the Google Forms platform and distributed among HCPs through institutional channels, professional mailing lists (e.g., the Hungarian Hospice-Palliative Association), and social media networks. The target population was nurses and doctors.

Participation was voluntary and anonymous, and tracing the identity of the respondents was not possible. Data processing was compliant with current data protection regulations. Compliance with the rights of the participants and with ethical norms was ensured in every stage, in line with the principles laid down in the Declaration of Helsinki.

The Scientific and Research Ethics Committee of the Medical Research Council approved the study (resolution BM/24869-1/2024). Leaders of Hungarian university clinical centres gave their consent to data collection in official statements of acceptance, and the institutional and regional research ethics committees granted the required authorisations.

Sample

Our database consisted of 500 valid, completed surveys, all with responses to all items of the measurement tool. Data from respondents in the sample were comprehensively processed. The inclusion of the whole sample contributed to the stability of the results and strengthened the internal validity of the conclusions. The sample size was justified by prior statistical considerations: it was deemed sufficient to detect a medium effect size (with 80% statistical power).

Measurement tools

The unit of the survey that we compiled recorded the subjects' sociodemographic characteristics.

Fear of death was measured with the Multidimensional Fear of Death Scale (MFODS), the Hungarian version of which was validated by Zana et al. (2006) at the Semmelweis University. The survey consists of 42 items, operationalising eight different dimensions of FoD (Zana et al., 2006). Respondents used a five-point Likert scale (1 = fully agree, 5 = fully disagree) to assess the statements. Following the author's instructions, data were processed with reverse scoring, where lower scores indicated a higher FoD level. In the study sample, the internal consistency of the scale was excellent (Cronbach $\alpha = 0.89$).

Before application, a pilot study was conducted on a small sample ($N = 20$) to check the comprehensibility and structural coherence of the modular tool. The applicability of the measurement tool was confirmed by the feedback, and it was proven to be appropriate for the research objectives.

Statistical analysis

The data were processed using SPSS Statistics 29.0 software. When preparing the input structure, we converted the items with reversed scale and calculated the total MFODS score for every respondent. According to the results of the Shapiro–Wilk tests, the data did not meet the criteria of normality, so nonparametric tests were applied in the analyses.

Dichotomous variables were compared with the Mann–Whitney U test, while the correlation between continuous variables and the MFODS score was analysed with Spearman's rank correlation. Descriptive statistics are presented as medians and interquartile ranges [IQR]. The effect of nominal variables with three or more categories was analysed with a Kruskal–Wallis test. A p-value < 0.05 was considered statistically significant.

Results

The sample of 500 was heterogeneous in terms of gender, age, and qualifications. The gender distribution of respondents was 431 (86.2%) women and 69 (13.8%) men. 82 respondents (16.4%) were under the age of 30, 105 (21.0%) were between 30 and 39, 123 (24.6%) were between 40 and 49, and 190 (38.0%) were over 50.

According to marital status, 259 respondents (51.8%) were married, 89 (17.8%) were unmarried, 86 (17.2%) lived in a domestic partnership, 54 (10.8%) were divorced, and 12 (2.4%) were widow(er)s.

175 (35.0%) respondents lived in county seats, 135 (27.0%) in small towns, 112 (22.4%) in the capital, and 78 (15.6%) in villages or farms.

As for qualifications, 199 respondents (39.8%) had secondary level nursing qualifications (OKJ: National Qualifications Framework), 150 (30.0%) had college degrees (BSc), 45 (9.0%) had university degrees (MSc), and 3 (0.6%) had PhD degrees. In addition, 103 respondents (20.6%) were doctors.

In terms of work experience, 74 respondents (14.8%) worked less than 5 years, 84 (16.8%) worked 5–10 years, 92 (18.4%) 11–20 years, and 250 (50.0%) over 20 years in health care.

266 (53.2%) respondents said they were religious, and 234 (46.8%) said they were not. Table 1 shows the distribution of the sociodemographic data.

Table 1. Sociodemographic characteristics of the sample (*N* = 500)

Variable and category	*N*	(%)
Gender		
female	431	(86.2)
male	69	(13.8)
Age		
<30 years	82	(16.4)
30–39 years	105	(21.0)
40–49 years	123	(24.6)
≥50 years	190	(38.0)
Marital status		
unmarried	89	(17.8)
divorced	54	(10.8)
married	259	(51.8)
in a domestic partnership	86	(17.2)
widow(er)	12	(2.4)
Place of residence		
capital	112	(22.4)
county seat	175	(35.0)
small town	135	(27.0)
village/farm	78	(15.6)
Qualifications		
Secondary level nursing qualification (OKJ)	199	(39.8)
BSc in nursing	150	(30.0)
MSc in nursing	45	(9.0)
PhD in nursing	3	(0.6)
Doctor	103	(20.6)
Work experience		
<5 years	74	(14.8)
5–10 years	84	(16.8)
11–20 years	92	(18.4)
≥20 years	250	(50.0)
Religiosity		
religious	266	(53.2)
not religious	234	(46.8)

Note: N – absolute frequency; % – percentage

The mean of the total MFODS score was M = 129.76 (SD ± 25.71), scores ranged from 62 to 195, the median value was 130, and the interquartile range was 37.25. Although the distributional characteristics were approximately symmetrical (g1 = –0.05; g2 = –0.39), the Shapiro–Wilk tests indicated non-normality; therefore, nonparametric procedures were applied. The overall FoD level was moderate in the sample. The mean cumulated score on the MFODS scale was 139.34 for doctors and 127.28 for nurses; based on the reverse interpretation of the scale, this indicates a lower DA level among doctors. The difference between the two groups in the total MFODS score was statistically significant (U = 14857.0; $p < 0.001$), with a medium effect size (Cliff's δ = –0.273), indicating that nurses exhibited a higher overall level of death anxiety. The dimensional analysis revealed variability across the MFODS factors. Medium effect sizes emerged in "Fear of the dying process" (δ = –0.186), "Fear of the dead" (δ = –0.256), "Fear of the unknown" (δ = –0.232), "Fear of conscious death" (δ = –0.279), and "Fear for the body after death" (δ = –0.280), whereas "Fear of annihilation" (δ = –0.082), "Fear for significant others" (δ = –0.090), and "Fear of premature death" (δ = –0.057) showed only small differences between the groups.

According to the factor-level analysis, the highest FoD level in the sample was in the dimension of fear of premature death (M = 11.12), followed by fear for significant others (M = 11.80), fear of being destroyed (M = 13.34), and fear of the dying process (M = 14.60). The fear of the unknown was at a similar level (M = 14.62), followed by the fear of conscious death (M = 19.14). The lowest level of fear was associated with contact with the corpse (M = 21.29) and with the fear of the body after death (M = 23.86). These two factors showed the highest mean scores, which – on this scale – indicate lower levels of fear. The results indicate that FoD in respondents is primarily linked to interpersonal losses and existential threats, while contact with the corpse caused less fear.

The comparison of the two subsamples along the dimensions analysed showed higher mean scores among doctors, indicating a lower FoD level. Table 2 shows the factor scores for FoD among doctors and nurses, according to the original structure of the dimensions of the scale.

Table 2. MFODS factor values of doctors and nurses (*N* = 500)

MFODS factors	Doctors (*N* = 103) factor score mean (sum of factor scores)	Nurses (*N* = 397) factor score mean (sum of factor scores)
Fear of the dying process	2.68 (16.10)	2.37 (14.21)
Fear of the dead	3.84 (23.02)	3.47 (20.84)
Fear of being destroyed	3.49 (13.95)	3.29 (13.18)
Fear for significant others	2.08 (12.46)	1.91 (11.62)
Fear of the unknown	3.12 (15.62)	2.87 (14.36)
Fear of conscious death	3.72 (18.60)	3.47 (17.33)
Fear for the body after death	3.31 (19.84)	3.08 (18.49)
Fear of premature death	3.75 (14.98)	3.48 (13.93)

Note: N – absolute frequency; Lower MFODS scores = higher fear of death

The most prominent differences were associated with the bodily aspect of death: fear of the dead (doctors: 3.84 vs. nurses: 3.47; difference: 0.37), fear of the dying process (doctors: 2.68 vs. nurses: 2.37; difference: 0.31), fear of premature death (doctors: 3.75 vs. nurses: 3.48; difference: 0.27), and fear of conscious death (doctors: 3.72 vs. nurses: 3.47; difference: 0.25). These are aspects of DA related to bodily and physiological aspects, and these are more often present in the everyday work of nurses.

Religious beliefs and FoD

Of the respondents, 266 (53.2%) identified themselves as religious, while 234 (46.8%) reported being non-religious; these proportions were 55.3% and 52.1% among doctors and

nurses, respectively. The FoD levels of these groups were compared using the Mann–Whitney *U* test, based on the total MFODS score. The median FoD score for the religious group was 131.50 [111.75–150.00], and for the non-religious group 131.00 [118.00–146.00]. The difference between the groups was not statistically significant ($U = 30349.50$; $p = 0.632$). Table 3 presents the descriptive statistics of the MFODS scores according to religiosity.

Table 3. Descriptive and comparative statistics of the total MFODS score across religiosity groups (*N* = 500)

Group	*N*	Median	IQR	Minimum	Maximum	*U*	*p*-value
Religious	266	131.50	111.75–150.00	43	197	30349.50	0.632
Not religious	234	131.00	118.00–146.00	67	177		

Note: N – sample size; IQR – interquartile range; *U* – Mann–Whitney test; Lower MFODS scores = higher fear of death

This result suggests that religious identity is not a determining factor in FoD levels within this sample. The study did not address the more complex dimensions of religiosity; therefore, further research is needed to explore the role of spiritual protective factors.

Working conditions and fear of death

Respondents assessed their working conditions on a scale of 1 to 10, with 1 being the worst and 10 the best. The median score for perceived working conditions was 7.00 [6.00–8.00], indicating the level of fear of death was 130.00 [111.25–149.00]. Values given for working conditions ranged across the whole scale, from 1 to 10, with doctors having a somewhat better assessment than nurses, with a median of 8.00 [6.00–8.00] and 7.00 [6.00–8.00]. The FoD scores ranged from 62 to 195.

The correlation between the two variables was analysed using Spearman's rank correlation. Although a positive trend was observed, the association between the subjective assessment of working conditions and FoD was not statistically significant (Spearman $\rho = 0.071$; $p = 0.114$), indicating that in this sample the relationship was not meaningful. Table 4 shows the descriptive statistics of working conditions and FoD.

Table 4. Descriptive statistics and correlation between working conditions rating and total MFODS scores (*N* = 500)

Variable	*N*	Median	IQR	Minimum	Maximum	ρ	*p*-value
Working conditions	500	7.00	6.00–8.00	1	10	0.071	0.114
MFODS total score	500	130.00	111.25–149.00	62	195		

Note: N – sample size; IQR – interquartile range; ρ – Spearman; Lower MFODS scores = higher fear of death

Interpreting the results, we can conclude that the subjective assessment of working conditions is not a significant predictor of FoD levels. When analysed by profession, the same pattern was observed among doctors (Spearman $\rho = 0.048$; $p = 0.629$) and nurses (Spearman $\rho = 0.068$; $p = 0.175$). This is consistent with conceptual approaches that suggest FoD primarily develops through intrapsychic and existential factors, previous experience, and emotional processing patterns, rather than through general assessments of working conditions.

Psychological strain and FoD

Respondents evaluated the emotional impact of dying they experience when providing patient care. They also assessed the psychological strain associated with dying on a scale of 1 to 10, where 1 indicated the lowest and 10 the highest level of emotional involvement. The median score for psychological burden was 6.00 [4.00–8.00], suggesting that most respondents experience a moderate level of psychological burden from contact with dying patients. The distribution is slightly left-skewed (skewness = –0.23), i.e., most of the answers are in the higher value range.

To analyse the correlation between psychological strain and the FoD level, we used Spearman's rank correlation. For the MFODS scale measuring FoD, the median score was 130.00 [111.25–149.00], which indicates a moderate FoD level for the overall sample. We found a statistically significant, negative correlation between emotional strain and FoD ($\rho = –0.301$; $p < 0.001$). Table 5 shows the associated statistical indicators.

Table 5. Descriptive statistics and correlation between psychological strain and MFODS scores (*N* = 500)

Variable	*N*	Median	IQR	Minimum	Maximum	ρ	*p*-value
Psychological strain	500	6.00	4.00–8.00	1	10	–0.301	<0.001
MFODS total score	500	130.00	111.25–149.00	62	195		

Note: N – sample size; IQR – interquartile range; ρ – Spearman; Lower MFODS scores = higher fear of death

The negative Spearman coefficient indicates that the stronger the psychological reaction triggered by dying, the lower the respondent's MFODS score, i.e., the higher the FoD level. When analysed by profession, this correlation was stronger among doctors ($\rho = –0.324$, $p < 0.001$) than among nurses ($\rho = –0.270$, $p < 0.001$). This finding supports the theoretical assumption that FoD is linked to direct contact with terminal patients, suggesting that personal involvement may be a relevant predictor of FoD intensity.

Thinking about death and the possibility of death-related communication

Two questions were aimed at exploring mental and social attitudes towards death: one about the frequency of thinking about death, with three answers, and one about the possibility of communication about death within the family, which used a scale of 1 to 4. The effect of the two variables on the MFODS scores was analysed with a Kruskal–Wallis test, with results reported as medians and interquartile ranges.

According to the frequency of thinking about death, there was no statistically significant difference in FoD levels (H = 2.49; p = 0.288). For those choosing the answer "I think about it often", "I think about it sometimes", and "I never think about it", the median MFODS scores were 125.00 [108.00–140.00], 125.00 [111.00–136.00], and 129.00 [118.00–140.00], respectively. This suggests that thinking about death more often does not in itself lead to systematic changes in FoD levels. Table 6 shows the statistical characteristics of the MFODS scores associated with the specific answers.

Table 6. FoD level based on statistical analysis according to the frequency of thinking about death (*N* = 500)

Variable	*N*	Median	IQR	Minimum	Maximum	H	*p*-value
Often	197	125.00	108.00–140.00	74	171		
Sometimes	281	125.00	111.00–136.00	82	182	2.49	0.288
Never	22	129.00	118.00–140.00	108	159		

Note: N – sample size; IQR – interquartile range; H – Kruskal–Wallis; Lower MFODS scores = higher fear of death

The assumption that the frequency of thinking about death alone is not a sufficient factor for FoD was confirmed. In this regard, emotional processing methods and the content of thoughts may be more relevant qualitative factors.

Differences in FoD levels according to the possibility of communication within the family were analysed with a Kruskal–Wallis test. The analysis showed a strong, significant difference between the four categories (H = 29.46; p < 0.001), which can be interpreted as a tendency: the possibility of more open communication was associated with lower levels of FoD. Descriptive data showed that FoD gradually decreased as communication became increasingly open. The highest FoD level was observed among those who "cannot talk about it at all", with a median MFODS score of 113.50 [101.75–142.25]. This was followed by participants who answered "sometimes", with a median of 126.50 [107.00–141.25], and those who answered "often", with a median of 130.00 [114.25–154.25]. The lowest level of FoD was found among participants who could talk about death "anytime", with a median of 138.00 [122.00–154.00]. This substantiates that communication without taboos may be a protective factor and help the processing of FoD. Table 7 presents the median [IQR] MFODS scores according to the possibility of family communication about death, as well as the overall pattern of differences between the groups.

Table 7. MFODS results and group comparisons according to the possibility of communication with family (*N* = 500)

Category	*N*	Median	IQR	Minimum	Maximum	H	*p*-value	D–B
Not at all (1)	30	113.50	101.75–142.25	70	175	29.46	<0.001	1 < 3†, 4
Sometimes (2)	222	126.50	107.00–141.25	62	186			2 < 4
Often (3)	80	130.00	114.25–154.25	74	191			>1
Anytime I feel the need (4)	168	138.00	122.00–154.00	65	195			>1, 2

Note: N – sample size; IQR – interquartile range; H – Kruskal–Wallis; D–B – Dunn–Bonferroni *post hoc* test; Lower MFODS scores = higher fear of death; † – marginally significant

To explore the differences, Dunn–Bonferroni pairwise comparisons were performed across six possible group pairs. Table 7 presents only those combinations showing significant differences in MFODS total scores (1 < 3, 4; 2 < 4). The comparison between the "not at all" group (1) and "often" group (3) approached significance [p(corr)] = 0.054), indicating a marginally significant difference. The "not at all" group (1) also scored significantly lower than the "anytime" (4) group [p(corr)] < 0.003), while the "sometimes" group (2) scored significantly lower than the "anytime" (4) group [p(corr)] < 0.003).

In summary, participants who could talk about death "anytime" showed significantly lower fear of death than those reporting "not at all" or "sometimes", and the "often" group showed a marginally lower level than the "not at all" group.

These findings support theoretical models interpreting fear of death in both intrapsychic and sociocultural contexts. Open communication about death may help alleviate anxiety, particularly among those frequently exposed to death in their work.

Discussion

We explored the social and psychological correlations of FoD in a sample of 500 participants. Our results show that FoD varied around an average level, with broad individual differences.

No significant correlation was found between religiosity and FoD, confirming that it is not religious identification but the depth of spiritual beliefs that can serve as a protective factor. This aligns with theories stating that it is not religiosity but its level of internal integration that affects existential anxiety (Jong, 2021). In our study, no in-depth analysis was carried out on religiosity; however, international findings and research exploring Central European cultural differences suggest that the frequency of religious practice or the use of spiritual coping strategies may significantly affect death anxiety. Therefore, these factors may represent important areas for future studies aiming at a deeper understanding of the development of fear of death (Kollár, 2024; Kolman et al., 2003). No correla-

tion was found between the assessment of working conditions and FoD levels, suggesting that fear is influenced less by overall workplace comfort than by specific psychological strains. The complex phenomenon of FoD is affected not only by the external environment but, to a greater extent, by personal cognitive, emotional, and symbolic processes. Researchers at the University of Michigan showed that in decreasing DA, the key is resilience, the acceptance of the finiteness of life, and the stability of identity (Lehto and Stein, 2009). The work environment can be examined in various ways, not just as a general background factor. Taking its stress exposure effects into consideration (such as work overload, seeing death repeatedly, and the lack of mental support) it may increase FoD among HCPs (Nia et al., 2016).

Significant correlation was found between FoD and psychological strain: the stronger the emotional reaction triggered by death, the higher the DA level was among respondents. This shows that emotional strain experienced when caring for patients is not only a work psychology issue but also has an existential meaning, and, without mental health support, may lead to increased psychological risk in the long term. This is substantiated by empirical studies: among emergency nurses, as resilience decreased, the DA level increased, especially when emotional strain increased (El-Ashry et al., 2025).

Our findings suggest that frequent reflection on death does not necessarily result in stronger FoD, indicating that other psychological factors also impact how anxiety is experienced. A Turkish study had similar findings, confirming that FoD among HCPs is correlated not with the relative frequency of thoughts about death, but with its interpretation in terms of content and emotions (Karaoglu et al., 2021).

Open family communication tended to be associated with lower fear levels, supporting the idea that reducing the taboo around discussions of death may serve as a protective factor. Conversations about death are often indirect or limited to practical matters, which may hinder shared coping and sustain higher FoD. Consistent with our findings, age-appropriate family dialogue can support cognitive reframing and emotional processing. Therefore, we recommend including family-focused, culturally sensitive communication training in health care education and continuing professional development. Our results also align with international findings showing that communication about death without taboos, and training that supports it, improve HCPs' attitudes toward death and may reduce the psychological effects of DA (Nia et al., 2016).

Defence mechanisms resulting from anxiety (e.g., denial, avoidance) may hinder end-of-life communication. Experience also suggests that generally the insufficiency of targeted training and later of ongoing support increases the incidence of unfavourable responses. Among caregivers, a potential manifestation of this is an aversive attitude towards communication about death, resulting from anxiety, which presents itself as a negative avoidance strategy (defence mechanisms like repression, denial, avoidance, etc.) (Helembai, 2021). This phenomenon also highlights that the psychological dimensions of clinical work are at least as important as the physical factors. The subjective (self)care diagnosis of these professionals is a prerequisite for the development of the practice of person-centred care, which may be achieved through patient counsellig and which also has implications for patient satisfaction. Unprocessed anxiety in nurses leads to emotional fatigue and probably has a negative effect on the quality of care (Helembai, 2019; Helembai et al., 2025).

Conclusion

The research results substantiate the complex social-emotional nature of fear of death. An attitude based on respect for human dignity can be effectively supported if human factors are considered.

Hospice trainings preparing participants for caring for terminal patients have a holistic, dignity-based approach, and the implementation and teaching of such an approach is worth considering. In hospice trainings, educational content is open and focuses particularly on communication and the continuous processing of death-related fears. This may be one reason why people working in hospice care have a measurably more accepting attitude towards communicating about death and related experiences.

The practical significance of the results lies in their potential application in the continuing education of HCPs, particularly in communication with terminal patients and managing FoD. Furthermore, they may contribute to developing psychological support programmes and improving the quality of palliative care.

Based on the findings, a review of the educational process and training content is recommended for those preparing for this profession. Just as understanding patient behaviour is essential, professionals providing end-of-life care should also have the opportunity to prepare for the conscious interpretation and management of their own emotional responses.

The study has limitations, including the causal uncertainty of the cross-sectional design and potential biases associated with self-reported measures. Voluntary participation may have led to self-selection bias, while social desirability and the lack of control over online completion could also have affected response reliability. As an online survey, participant identity could not be verified and completion conditions could not be standardised, which may have introduced additional errors despite our quality checks. Finally, the sample was culturally homogeneous and drawn from Hungary, which limits the generalisability of the findings.

Author contributions

The concept and design of the study were developed by (*ND*), the measurement tools were developed by (*ND*), the expert review was conducted by (*IV* and *KH*), data was collected by (*ND*), data analysis was performed by (*ND*), and the manuscript was written by (*ND*). The manuscript was critically reviewed and professionally revised by (*IV* and *KH*).

The authors hereby certify that they read the final version of the manuscript in its entirety, fully agree with its content, and gave their consent for it to be submitted and published.

Submission declaration

The authors declare that the manuscript has not been published and is not currently under review at another journal. All authors have read and approved the final version of the manuscript and give their consent for it to be submitted to the Kontakt Journal.

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Ethical statement

The study was approved by the Scientific and Research Ethics Committee of the Medical Research Council (ETT TUKEB, resolution no. BM/24869-1/2024). Chairs of Hungarian university clinical centres gave their consent to data collection in statements of approval. The study was compliant with all ethical norms adopted by the scientific community.

Conflict of interest

The authors hereby declare that they have no conflict of interest concerning the research.

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