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End-of-Life Acceptance in Hemodialysis Patients: A Conceptual Analysis

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LITERATURE REVIEW

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ABSTRACT

End-of-life (EOL) acceptance is a crucial but underexplored concept among patients with end-stage renal disease (ESRD) undergoing hemodialysis. This study aimed to analyze and clarify the concept of EOL acceptance in hemodialysis patients using Walker and Avant's eight-step method. These patients often face progressive physical deterioration and limited life expectancy, making psychological, emotional, and spiritual readiness to confront death a fundamental component of care. However, the term "EOL acceptance" lacks conceptual clarity and consistency in nursing practice. A comprehensive literature review was conducted using PubMed, CINAHL, and Scopus databases, targeting studies published between 2014 and 2024. The keywords used included 'end-of-life,' 'terminal care,' 'death acceptance,' 'dying acceptance,' 'hemodialysis,' 'end-stage renal disease,' and 'terminal care nursing'. The analysis identified three attributes of EOL acceptance: psychological readiness to face death, integration of existential and spiritual meaning, and proactive decision-making toward dignified dying. Supporting factors include awareness of terminal illness, therapeutic communication, and psychosocial-spiritual support. The identified consequences are emotional peace, enhanced family preparation, and improved quality of life. This analysis delineates a conceptual framework for EOL acceptance, enabling nurses to assess and support patients facing terminal illness effectively. It also provides a foundational framework for developing assessment tools and nursing interventions to improve person-centered EOL care for individuals with ERSD.

Key Messages:

- End-of-life acceptance among patients with end-stage renal disease (ESRD) undergoing hemodialysis is an underdefined yet critical concept, necessitating conceptual clarity to guide nursing practice and patient care strategies.
- The defining attributes of end-of-life acceptance in patients with end-stage renal disease (ESRD) undergoing hemodialysis include psychological readiness, spiritual integration, and proactive decision-making, which collectively shape how patients approach dying with dignity.

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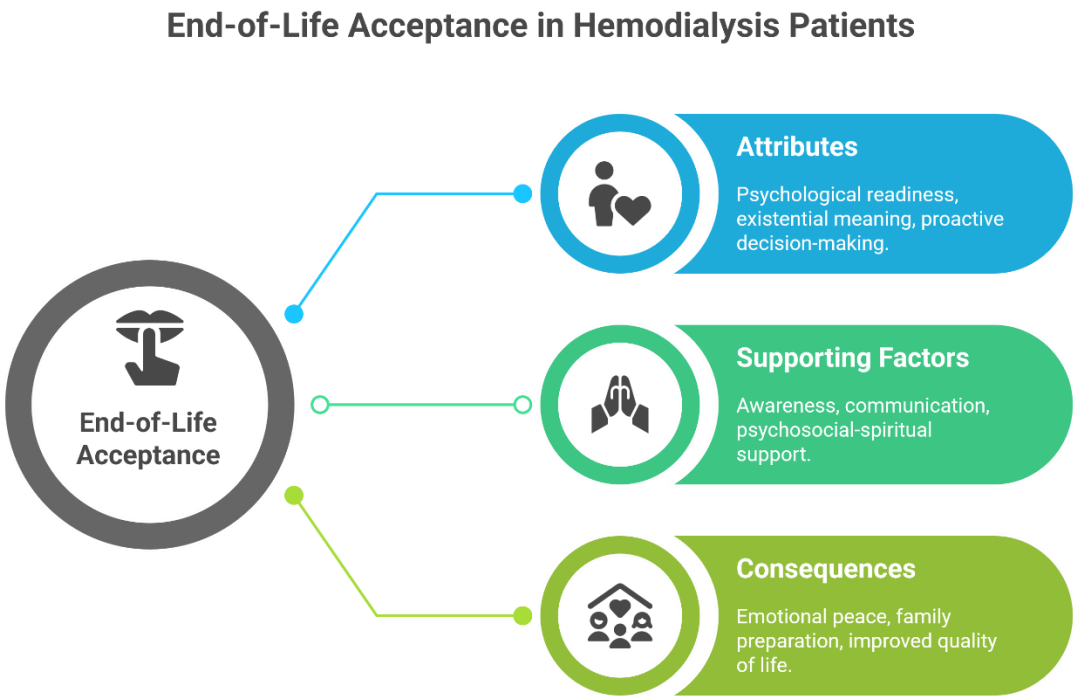
GRAPHICAL ABSTRACT



INTRODUCTION

Chronic kidney disease (CKD) is a global public health challenge, affecting more than 850 million people and contributing to a significant burden of disability and morality worldwide (1,2). Global prevalence data showing that more than 4.9 million people worldwide undergo renal replacement therapy, with hemodialysis being the most common modality", along with "recent studies reporting survival rates of hemodialysis patients, where competing risks in patient outcomes and associated risk factors influencing survival in ESRD populations were identified (3,4). Patients on long-term dialysis often endure repeated hospitalizations, fatigue, cardiovascular complications, and psychosocial stress that severely impact quality of life (5,6). Despite the predictable decline in function and high mortality risk comparable to many cancers, discussions about the end-of-life remain under-addressed in routine nephrology care (7,8).

Nurses, who are present throughout the illness trajectory, play a vital role in caring for patients with end-stage renal disease (ESRD). They are often the first to detect emotional distress, initiate conversations about future care preferences, and provide the psychosocial and spiritual support patients need when facing terminal decline (9,10). However, one significant barrier to providing such care is the absence of a clear understanding of how patients process and accept their impending death. Many patients continue to undergo aggressive dialysis even when it no longer aligns with their values, not simply because of clinical misunderstandings, but due to unresolved psychological or spiritual resistance to death (7,11).

The inner resistance is linked to what is referred to as "end-of-life (EOL) acceptance," a process whereby individuals acknowledge the inevitability of death, reach emotional reconciliation, and prepare to shift their focus from curative to comfort-based care (12–14). EOL acceptance differs significantly from resignation, which implies hopelessness and passivity, or denial, which represents avoidance of reality (9,10,15,16). True acceptance is an active, meaning-making process, often shaped by personal values, relational dynamics, and spiritual beliefs. Research shows that patients who achieve acceptance are more likely to engage in advance care planning, avoid unnecessary interventions, and experience greater peace and dignity in the dying process (3,16,17).

Nevertheless, the concept of EOL acceptance remains poorly defined and inconsistently applied in nephrology nursing. Most guidelines, including those from the Kidney Disease: Improving Global Outcomes (KDIGO) Controversies Conference on Supportive Care in end-stage renal disease (ESRD), acknowledge the

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need for palliative care integration but do not elaborate on the psychological constructs that facilitate meaningful transition at the end of ilfe (2,18,19). Existing studies often conflate EOL acceptance with related but distinct concepts such as death anxiety, spiritual well-being, or grief. Without a standardized conceptualization, nurses lack a reliable framework to assess and support acceptance, resulting in fragmented care and missed opportunities to affirm patient dignity (3,20–22).

Cultural and religious factors add further complexity. In many Asian contexts, discussion about death are considered inappropriate, and families may avoid open communication with dying patients, believing it to be disrespectful or emotionally harmful (3,23–26). Beliefs about divine will, karma, or the afterlife shape patients' attitudes toward suffering and influence whether death is perceived as defeat or transition. These perspective can either promote or hinder acceptance, depending on how they are integrated into care (3,20–22).

The limited understanding of the concept end-of-life acceptance, particularly among patients undergoing hemodialysis, underscores the need for further clarification. This understanding is crucial so that nurses can accurately identify the characteristics of acceptance, differentiate it from other emotional responses, and provide responsive and culturally appropriate interventions. This study uses the Walker and Avant concept analysis method to investigate the main characteristics, requirements, outcomes, and empirical markers of end-of-life acceptance in order to meet these needs. The results of this study are expected to serve as the foundation for the creation of assessment instruments and nursing interventions that promote holistic and respectable end-of-life care.

METHODS

This study used a concept analysis design, which adheres to the eight steps Walker and Avant developed (27). This methodical approach was chosen for its efficacy in clarifying complex or inconsistently defined concepts that are integral to nursing science. The main focus of this analysis is the concept of end-of-life acceptance, which is increasingly relevant in the context of chronic illness and palliative care. This study employed Walker and Avant's eight-step concept analysis method. A comprehensive literature search was conducted in PubMed, CINAHL, and Scopus databases to identify relevant studies published between 2014 and 2024.

Literature Search Strategy

A comprehensive literature search was conducted in PubMed, CINAHL, and Scopus databases using the keywords 'end-of-life,' 'terminal care,' 'death acceptance,' 'dying acceptance,' 'hemodialysis,' 'end-stage renal disease,' and 'terminal care nursing', focusing on studies published between 2014 and 2024.

Articles were included if they (1) involved adult populations with CKD or on hemodialysis; (2) discussed emotional, psychological, spiritual, or existential dimensions of dying or death acceptance; and (3) had relevance to nursing or interdisciplinary palliative care involving nurses, physicians, psychologists, and spiritual care providers. Exclusion criteria comprised non-English publications, pediatric studies, commentaries, and non-peer-reviewed sources.

A total of 2,634 articles were retrieved. After removal of duplicates, 2,018 titles and abstracts were left for screening. After review, 115 full-text articles were assessed, and 43 were deemed eligible for inclusion. These consisted of qualitative studies, theoretical papers, and conceptual reviews. All articles were systematically extracted and charted into a concept matrix, focusing on definitions, key attributes, antecedents, consequences, and related empirical indicators.

Data Extraction and Analysis

A conventional thematic analysis was employed to identify and categorize defining attributes, antecedents, and consequences across the reviewed studies. Two reviewers with clinical and academic expertise in nephrology and palliative care nursing independently conducted the process. Disagreements about coding or interpretation were discussed until a consensus was reached. The collected data were subsequently organized according to the stages of Walker and Avant's conceptual analysis framework. The aim of this process was to formulate a conceptual definition of end-of-life acceptance and to explore

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practical approaches for its measurement and application in the clinical management of patients with advanced renal disease.

Walker and Avant's Eight-Step Concept Analysis Process

This concept analysis adhered to the eight systematic steps established by Walker and Avant (27). This framework effectively assesses, clarifies, and advances concepts that lack consistent definition in nursing practice and healthcare. The main point of the analysis was the idea of accepting death, which was locked at in great detail in the context of patients on hemodialysis. This demographic typically encounters intricate emotional and spiritual challenges, alongside a constrained prognosis. In order to preserve the integrity and practical significance of the concept definition within the context of holistic palliative nursing care, each phase of the methodology was executed in a systematic, stringent, and contemplative manner..

Step 1: Select a Concept

The initial phase of the concept analysis process involves selecting concepts for comprehensive examination. This study centers on the concept of end-of-life acceptance, a subject often examined in nephrology and palliative care, yet it remains devoid of a standardized operational definition in both clinical practice and research. Patients on long-term hemodialysis often have a short life expectancy and experience physical deterioration over time. It is uncommon to find a systematic explanation for the behavioral, spiritual, and psychological processes that influence how people perceive and react to the imminence of death. The assessment and support processes offered by health professionals are hampered by this ambiguity, underscoring the pressing need to promote more targeted, compassionate, and evidence-based nursing practice.

Step 2: Determine the Aim or Purpose of the Analysis

The purpose of this concept analysis is to investigate and elucidate what end-of-life acceptance means for patients with end-stage renal disease (ESRD) undergoing hemodialysis. Finding key characteristics, antecedent, consequences, and empirical references from its conceptual structure is the primary goal. In order to support the clinical assessment process, create more meaningful therapeutic communication, and create nursing interventions that are sensitive to patients' end-of-life needs, the analysis's findings should provide a strong theoretical basis. This study helps to improve the quality of holistic, transformative, and patient-centered end-of-life care by methodically defining the concept's boundaries and contents.

Step 3: Identify All Uses of the Concept

Tracing different reference source to investigate the differences in meaning of the term under study is the first step in elucidating the concept. In order to provide a more comprehensive and contextual understanding, it is crucial to avoid reducing meaning that originates from a single scientific field. Consequently, research is undertaken utilizing dictionaries, thesauruses, and scientific literature from diverse disciplines, including sociology, psychology, nursing, medicine, theology, and bioethics. The objectives of this interdisciplinary inquiry are to discern various applications of the term "end-of-life acceptance" and to elucidate the dimensions of meaning that may be obscured in its usage. In the realm of clinical nursing, the results of this study represent the initial phase in formulating a robust and operational conceptual definition (27).

The lexical definition of acceptance is the willingness to accept something that is offered or given. This concept has arisen in psychology as an adaptive mechanism through which individuals consciously acknowledge and accept immutable realities, such as a terminal diagnosis or the proximity of death. In this context, acceptance denotes an integrative process that embodies the achievement of existential acceptance and emotional equilibrium, rather than a disposition of capitulation or despondency. Acceptance in medical practice, especially in end-of-life care, is frequently linked to the patient's readiness to shift from curative treatment to hospice or palliative care. This change shows that the treatment has some limits and that the focus is now on improving the focus is now on improving the patient's comfort, dignity, and quality of life (28,29).

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In the spiritual and religious world, accepting death is often seen as a way to submit to God's will or as a way to understand the unavoidable cycle of life. In palliative care, a patient's serene disposition regarding their terminal illness, engagement in personally significant activities such as legacy work, or participation in religious and ritualistic practices that honor the conclusion of life exemplify their acceptance of the end-of-life. This concept is also discussed in the context of advanced care planning, dying with dignity, and comprehensive psychospiritual preparation as integral components of the end-of-life transition. So, acceptance of the end-of-life a sign of emotional readiness, personal spirituality, and making conscious choices about the dying process. This, in turn, improves the dignity and quality of life in the last stage of human existence (30,31).

Although they possess conceptual similarities, several scholars in the domain of death and end-of-life studies have articulated the notion of end-of-life acceptance in various manners. Kumar (2022) defines acceptances as "a person's ability to accept the reality of his or her own death, often accompanied by a sense of peace and emotional closure." Neimeyer (2025) connects it to the patient's readiness to openly discuss the prognosis, set care objectives, and articulate preferences for the final resting place. Dönmez, Yilmaz and Helvaci (2021) assert the authentic acceptance constitutes an active process characterized by profound awareness, a quest for meaning, and emotional maturity, distinguishing it from mere passive resignation. These three perspectives suggest that accepting death is a complex psychospiritual construct that encompasses existential connections to the significance of life and death, alongside cognitive and affective regulation.

This concept is often associated with other terms, including emotional closure, dignified dying, peaceful acceptance, and death preparedness. Even though people sometimes use these words to mean the same thing, they don't fully describe how complicated it is to accept death. The notion of end-of-life acceptance entails a holistic amalgamation of behavioral, spiritual, cognitive, and emotional components that are frequently not delineated individually in these terminologies. Consequently, it is essential to distinguish these concepts within a more extensive conceptual framework to prevent the oversimplification of acceptance as merely being emotionally or physically prepared for death; instead, it should be regarded as a dynamic process encompassing self-awareness, meaning, and a thorough adjustment to impending death.

The term "end-of-life acceptance" is commonly employed across multiple disciplines to describe an individual's internal journey of reconciling, processing, and preparing themselves for the conclusion of their life. This idea includes being aware of yourself, being mentally calm, being spiritual, and making well-thought-out and intentional decisions. Acceptance is described in dictionaries as "a mental and emotional agreement to a situation." In clinical practice, end-of-life acceptance is evidenced by patient decision reflecting a readiness to cease curative treatment, genuine verbal expressions, and an openness to shift towards palliative care. It is important to understand the different ways this idea can be understood and expressed in order to come up with a complete and contextual definition. This is especially true in nursing and nephrology services that aim to improve the quality of life for terminally ill patients.

Step 4: Determine the Defining Attributes

The literature review identified three primary attributes that define end-of-life acceptance: psychological readiness, spiritual and existential integration, and active participation in end-of-life decision-making (24,33). These three attributes constitute a comprehensive conceptual framework and illustrate the dynamics of end-of-life acceptance, particularly among hemodialysis patients. Psychological readiness reflects the emotional acceptance of the inevitability of death; spiritual and existential integration signifies a deep understanding of the meaning of life and death, while proactive decision-making indicates self-control in determining the direction of care based on the patient's values. All three serve as a foundation for understanding end-of-life acceptance as a multidimensional process that can be used as a basis for developing more clinically and contextually sensitive nursing assessments and interventions.

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Psychological Readiness

Psychological readiness refers to a person's emotional ability to consciously face death without showing denial, avoidance, or active resistance. This attribute reflects an individual's capacity to accept the reality of death while achieving an emotional resolution to the closure of their life. Patients who are psychologically prepared generally show inner peace, reduced anxiety about death, and acceptance of their terminal condition as an inevitable part of the life cycle (3). In hemodialysis patients, this can be recognized by their willingness to accept the diagnosis realistically, which reduces the desire for heroic medical procedures and allows them to begin focusing on meaningful relationships or spiritual aspects of life. Psychological readiness enables individuals to find peace during the dying process, thereby enhancing the overall quality of the end-of-life experience.

Spiritual and Existential Integration

Spiritual and existential integration reflects an individual's ability to find meaning, direction, or a form of transcendence in the face of life and the prospect of death. This attribute is not limited to religious beliefs but also encompasses non-religious spiritual awareness, such as a belief in an afterlife, a connection to divine power, or a sense of connectedness to the universe and the broader existence (34). Patients who reach this stage may engage in practices such as prayer, reflecting on life, and practicing forgiveness and apologies, or participate in symbolic rituals that mark the completion of life. In many cultures, especially in Asia, this process is greatly affected by traditional beliefs, ancestral spirituality, and the values that the community shares. For hemodialysis patients, spiritual integration manifests as an attitude of gratitude, acceptance of divine timing, or a conviction that their suffering possesses profound existential significance. These qualities help patients get over their fear of death and make room for more inner peace and acceptance (24,35,36).

Proactive End-of-Life Decision-Making

Proactive end-of-life decision-making means that the patients is aware of and actively involved in making choices about their care that are in line with their values and preferences during the last stages of life. This encompasses involvement in advance care planning (ACP), appointment of a medical proxy, determination of a preferred place of death, and clear articulation of preferences concerning resuscitation and life support (24). These traits are very important for making sure that patients' autonomy is respected and that invasive procedures that could cause harm or suffering are kept to a minimum. In hemodialysis practice, patients at this stage frequently consult with their medical team regarding the optimal timing to discontinue dialysis therapy, redirect attention to symptom management, or opt for hospice care. Proactive decision-making shows that a person is mature enough to accept that they will die soon and is trying to keep their dignity and self-control while they die in a peaceful and meaningful way (20,28).

Step 5: Construct a Model Case

A case model is a perfect example of a concept because it has all of the defining features that make it what it is. This case exemplifies a definitive representation or paradigmatic instance that elucidates the parameters and fundamental nature of the concept under examination (27). A case model is presented to enhance the comprehension of end-of-life acceptance in hemodialysis patients, thoroughly encompassing the three principal attributes: psychological readiness, spiritual and existential integration, and active participation in end-of-life decision-making.

Mr. Raka, who was 73 years old, had been receiving regular hemodialysis for eight years because of his end-stage renal disease. In recent months, his clinical condition had shown a progressive decline, and doctors told him and his family that his prognosis was poor. Responding calmly to this, Mr. Raka stated that he had lived a full life and calmy accepted his terminal condition. He told the nurses that he did not want any additional aggressive medical interventions or future hospitalization.

Mr. Raka actively requested meetings with the palliative care team to plan for comfort-based care at home. He had open discussions with his children about his end-of-life preference, including pain management, spiritual support, and his refusal of resuscitation. He drafted an advance care directive and

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formally designated his eldest son as his medical decision-maker. Although his children initially responded with emotional distress, Mr. Raka reassured them by saying “Death is a part of life. I am ready when that time comes.” He also requested visits from a spiritual advisor and spent time reminiscing with his family. He prayed and thought about his life every night which he said helped him find peace within himself. A few weeks later, Mr. Raka arrived in his last moments of life. He was surrounded by his family, free of pain, and his family and medical team all said he died peacefully and with dignity.

The story of Mr. Raka as a whole shows the three main traits of accepting death. His acceptance of the terminal prognosis and his ability to face death calmly show that he is psychologically ready. His connection to transcendental values, religious practice, and thinking about of life shows spiritual and existential integration. At the same time, proactive decision-making is shown by open communication, writing down medical preferences, and being aware of and involved in planning for end-of-life care.

All of these dimensions are shown through specific actions, words, and a purposeful and meaningful attitude toward life. This case exemplifies end-of-life acceptance, illustrating that this process not only enables patients to preserve autonomy and dignity in the presence of death but also improves the quality of the end-of-life transition, offering emotional solace for the grieving family.

Step 6: Construct Borderline, Related, and Contrary Cases

Construct a contrary case

Assert that a contrary case is an example that fails to embody the concept under examination and facilities comprehension by omitting all definitional characteristics. Such cases are important in the concept clarification process because they illustrate conceptual boundaries by presenting a situation where not all key qualities are met. The following is a counterexample that describes a patient who does not exhibit any of the essential elements of end-of-life acceptance (27).

Mr. Deni is a 68-year-old man with end-stage renal disease who has been on hemodialysis for the past six years. Recently, his physician informed him that his condition was deteriorating and suggested initiating conversations about end-of-life care. However, Mr. Deni rejected the information, insisting that he would not die and would live many more years. He refused to allow the healthcare team to speak to his family and demanded continuation of complete treatment, including ICU support if needed. In contrast to Mr. Raka, who approached the end of his life with acceptance and calmness, Mr. Deni became agitated and resistant when asked about his preferences for future care. His denial—expressed in the statement, ‘Do not talk to me about death—I am not going anywhere’—illustrates the absence of end-of-life acceptance and underscores the variability in patients’ psychological and emotional responses to terminal illness.

This case does not reflect any of the defining attributes of end-of-life acceptance. Mr. Deni displays psychological denial, lacks spiritual integration, and avoids any form of proactive decision-making. As such, it serves as a contrary case that contrasts with the ideal of end-of-life acceptance.

Construct a related case

Related cases are similar to the concept under study but do not include all defining attributes. They may overlap with associated ideas such as spiritual well-being, resilience, or readiness to die, but they are not full exemplifications of the concept.

Mrs. Yani is a 70-year-old woman with chronic kidney disease who has recently transitioned to hemodialysis. She is devout and often speaks about her faith, stating that she trusts God's will and is not afraid of death. Although she demonstrates strong spiritual well-being and talks about the afterlife with serenity, she avoids discussing medical decisions. She has not appointed a healthcare proxy or expressed any preferences for end-of-life care. When asked about her wishes if her condition worsens, she replies, "God will take care of everything."

This case shows a patient with spiritual and existential integration, but not psychological readiness or proactive decision-making. Mrs. Yani is emotionally calm and appears spiritually prepared, yet she avoids engaging in concrete planning. Therefore, this case is related to end-of-life acceptance but does not contain all its defining attributes.

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Construct a borderline case

Borderline cases display some, but not all, of the concept's defining attributes. They help demonstrate partial manifestations and support clarification of conceptual boundaries.

Mr. Umar is a 74-year-old man who has been on hemodialysis for eight years. After a recent hospitalization, he was told that his overall prognosis was poor. Mr. Umar expressed understanding of his condition and told the nephrologist that he "was ready to go if it is time." He requested that unnecessary hospital visits be avoided and shared his wish to pass away at home. However, he has not yet completed any formal documents such as an advance directive, and he avoids bringing up the topic with his children because he "does not want to make them sad."

This case reflects psychological readiness and a level of decision-making but lacks full spiritual-existential articulation and formal planning. Mr. Umar accepts his situation and demonstrates peacefulness, but still avoids open communication with his family and documentation of care preferences. Therefore, this is a borderline case close to full acceptance but missing one or more critical components.

Step 7: Identifying Antecedents and Consequences

Identify Antecedents

According to Zeydani et al. (27), antecedents are conditions or events that must be present before a concept can emerge in its entirety. Based on the result of the literature review, several antecedents underlie the formation of end-of-life acceptance in hemodialysis patients, encompassing psychological, interpersonal, and contextual aspects. These factors play a crucial role in facilitating the acceptance process and providing direction for the health team in developing the right support approach.

1. Awareness of terminal conditions and delivery of prognosis: The patient's understanding that the disease they are facing is irreversible and limits life expectancy is a primary prerequisite. Honest and transparent communication from health workers is often the trigger for this awareness.
2. Therapeutic and empathetic communication form clinicians: The way information about prognosis and treatment options is conveyed significantly determines the extent to which patients can accept the reality of the end-of-life. Supportive and non-threatening dialogue will increase trust and openness.
3. Emotional and spiritual support from family and social networks: A warm, respectful, and empathetic support system helps patients cope with emotional distress and strengthens feelings of being accepted and not alone in facing death.
4. Past experience with death, dying, or end-of-life care: People who have been with a loved one through a terminal illness or seen a dignified death are usually better able to accept the fact that they will die.
5. Cultural and religious acceptance of death discussions: Social norms and spiritual beliefs that see death as a normal part of life, not as a failure or taboo, help people accept it.
6. Access to palliative care and advance care planning (ACP) services: Structured programs that focus on end-of-life needs give patients the chance to think about non-curative care goals and get ready for death.
7. Being ready to think about explore existential issues: Before acceptance, people often go through a period of self-reflection in which they face their fears, look for meaning in life, and think about theirs about their legacy.

These antecedents collectively constitute the conceptual framework for the evaluation of end-of-life acceptance. If one or more of these factors are absent, it may impede terminally ill patients' acceptance of their condition, potentially resulting in denial, avoidance, or extended emotional distress.

Identify Consequences

Characterize consequences as the events or effects that transpire subsequent to the realization of a concept. In the context of end-of-life acceptance, numerous studies demonstrate that patients who attain acceptance frequently experience a variety of advantageous effects across psychological, spiritual, interpersonal, and clinical dimensions. Patients aren't the only ones affected by these; families, healthcare providers, and the overall quality of end-of-life care are also greatly affected(27).

1. Emotional peace and psychological resolution: Patients who accept the end-of-life usually feel less anxious, scared, and emotionally troubled, and they are more-calm when they talk about death and

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interact with others.
2. More people are planning ahead for their care: People who have come to terms with their situation are more likely to share their wishes for life-sustaining measures, choose medical representatives, and write legal or spiritual documents.
3. A better quality of dying: Acceptance lets patients spend their last days with more meaning, comfort, less pain, and more respect for their dignity.
4. Better family readiness for grief: When the patient shows acceptance, it can help the family get ready emotionally and logistically, which lowers the chance of prolonged or pathological grief.
5. Fewer unnecessary medical procedures: When people accept their illness, they often stop using aggressive treatments and instead focus on how to deal with their symptoms. This makes healthcare resources more logical and useful.
6. Improved spiritual health and inner peace: Patients who know they are going to die are more likely to do spiritual things like pray, meditate, or make amends, which help them find peace in their lives.
7. More satisfaction with care and communication: Acceptance fosters a collaborative relationship with the medical team, improves mutual understanding, and results in care that is consistent with the patient's values and life goals.

This series of consequences emphasize of promoting and-of-life acceptance in clinical practice, especially among hemodialysis patients who frequently encounter disjointed care and ambiguity regarding the end-of-life. Understanding and recognizing these consequences enables healthcare provider to assess the impact of acceptance and design interventions that promote dignity, calm, and value-centered care.

RESULTS

The concept of end-of-life acceptance is analyzed by examining its attributes, antecedents, consequences, and empirical referents. Through the systematic application of Walker and Avant's conceptual analysis framework, this study provides an in-depth understanding of the clinical relevance of the concept. The main objective of this analysis is to elaborate the conceptual meaning of end-of-life acceptance so that it can be integrated appropriately in future theory development, especially in the context of palliative care and chronic disease management in hemodialysis patients. The multidisciplinary literature analysis yielded three main attributes: psychological readiness, spiritual and existential integration, and proactive end-of-life decision-making. Across the synthesized literature, three core attributes consistently emerged as central to defining end-of-life (EOL) acceptance: psychological readiness, spiritual and existential integration, and proactive end-of-life decision-making. Model, borderline, contrary, and related cases were then presented to illustrate the boundaries of the concept. Each case analysis was reviewed to explicitly refer back to these attributes, noting which were present or absent. These three components form a conceptual framework that reflects the complexity and multidisciplinary dimensions of end-of-life acceptance (37,38).

The related cases discussed in this analysis demonstrate closeness to end-of-life acceptance, but do not fully reflect all of the key attributes. Some terms that are often associated with this concept—such as death readiness, resignation, spiritual well-being, dignified dying, and emotional surrender—describe certain dimensions of the end-of-life experience, but do not contain the entire conceptual structure that defines acceptance. For example, one case demonstrated spiritual peace, but did not reflect active engagement it end-of-life planning or complete psychological resolution. This highlights the importance of differentiating between true end-of-life acceptance and other forms of representation that are similar in terminology but essentially different (39,40).

Understanding these conceptual differences is essential for health care provider to appropriately identify, document, and intervene with end-of-life acceptance in clinical practice. A comprehensive description of the attributes, antecedents, and consequences of these concepts has been systematically summarized in Table 1 to support more focused, humanistic, and patient-centered theoretical apllications and nursing practices.

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Table 1. Summary of the End-of-Life Acceptance in Hemodialysis Patients: A Concept Analysis (Attributes, Antecedents, and Consequences)

Attributes	Antecedents	Consequences
a. Psychological readiness: emotional openness and reduced denial b. Spiritual and existential integration: peace, meaning, and transcendence c. Proactive end-of-life decision-making: active participation in planning	a. Awareness of terminal illness and prognosis b. Therapeutic and honest communication by clinicians c. Family and social support (emotional and spiritual) d. Previous experience with death, dying, or caregiving e. Cultural and religious openness to talk about death f. Availability of palliative care and ACP services g. Patient's readiness to engage in reflection and dialogue	a. Emotional peace and psychological resolution b. Greater involvement in advance care planning c. Improved quality of dying experience d. Strengthened family preparedness for death e. Reduction in futile or aggressive treatments f. Enhanced spiritual well-being and inner harmony g. Better healthcare resource utilization and satisfaction

DISCUSSION

EOL acceptance is a foundational concept in improving the quality of dying and care planning for patients with life-limiting conditions, particularly those undergoing long-term hemodialysis (3,8,41). It encompasses a psychological, spiritual, and behavioral shift from resisting death to embracing it as a natural and inevitable part of the human experience (17,25). This concept is highly relevant in CKD populations, where life is often prolonged through dialysis, but without necessarily enhancing quality or comfort at the terminal stage (24,42).

Understanding and defining EOL acceptance enables healthcare professionals, especially nurses, to support patients in making decisions that reflect their values, preferences, and dignity (4,23). In hemodialysis patients, EOL acceptance is linked to their readiness to transition from life-extending interventions toward comfort-focused and person-centered care (3,19,43). This study identified three primary characteristics: psychological readiness, spiritual and existential integration, and proactive end-of-life decision-making. These traits demonstrate that accepting death is not a passive resignation but an active, conscious, and constructive approach to confronting the reality of mortality. This acceptance shows that the person is thinking deeply about what life means and is actively working on choosing a course of care that fits with their values, which gives them a sense of peace and comfort (18,22,44).

Cultural dimensions substantially influence the understanding and implementation of end-of-life acceptance (1,4). In Western cultures, acceptance is often characterized by autonomy in decision-making and early involvement in advance care planning. In contrast, Eastern cultures or collectivistic societies generally facilitate the acceptance process collectively within the family, emphasizing spiritual surrender and the preservation of social harmony (2,45). In Indonesia, open conservations about death are often seen as taboo and even thought to speed up death, which can make it harder to make quick decisions (46). In this context, nurses act as important, sensitive, and understanding cultural facilitators who can handle end-of-life communication well by respecting the belief and values of each person and their family. Given these cultural nuances, nurses may require specialized training in communication strategies that use indirect language or metaphors to open EOL discussions in a respectful manner. (12,16).

The case model in this analysis illustrates a condition of complete acceptance, demonstrated by emotional serenity, spiritual reconciliation, and thorough involvement in end-of-life planning. These results align with prior research indicting that patients who attain acceptance generally exhibit increased readiness, enhanced tranquility, and an improved quality of the dying process (47–49). In contrast, related and borderline cases only demonstrate partial aspects of the concept, such as expressions of peace or acknowledgment of prognosis, but do not demonstrate active involvement in decision-making—thus distinguishing them form the more comprehensive conceptual meaning of end-of-life acceptance (50–52).

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The antecedents of EOL acceptance, including awareness of prognosis, clinician communication, and family support, affirm the importance of early, transparent, and compassionate dialogue between patients and care teams (5,17,53). These conditions help patients move beyond denial and toward psychological and spiritual resolution (3,4). The consequences of EOL acceptance, such as emotional peace, reduced suffering, increased involvement in advance care planning, and improved family preparedness, support previous studies highlighting acceptance as a facilitator of quality end-of-life outcomes (19,32).

Additionally, empirical referents such as the Death Attitude Profile-Revised (DAP-R), Peace, Equanimity, and Acceptance in the Cancer Experience (PEACE) Scale, and Spiritual Well-Being Scale (SWBS) offer practical tools to identify the presence of EOL acceptance (28,54). However, these instruments were not explicitly developed for hemodialysis patients, indicating a clear need for contextual tool development to ensure cultural and clinical validity in nephrology populations. Future research should focus on developing and validating a culturally-adapted instrument to measure EOL acceptance specifically within the Southeast Asian hemodialysis population (1,2).

This analysis makes a significant contribution in refining the concept of end-of-life acceptance by developing a structured understanding framework regarding its core dimensions. These findings not only expand the theoretical foundation but also have relevant practical implications for the development of interventions, clinical assessments, and education in the context of palliative nephrology nursing (24,41). Promoting end-of-life acceptance is believed to reduce the frequency of disproportionate medical interventions while improving the quality of the dying experience, which is centered on the values and dignity of the individual. Furthermore, clarifying the concept of EOL acceptance contributes to the refinement of existing nursing theories, particularly those related to palliative care, chronic illness management, and culturally competent care (28,54).

However, this analysis has several limitations that need to be taken into account. The reliance on secondary literature may limit the depth of understanding of the contextual dynamics and subjective experiences of patients, particularly in culturally diverse settings. All of the studies included in this review involved adult populations with end-stage renal disease (ESRD) receiving hemodialysis, in accordance with the first inclusion criterion. Therefore, the findings are specific to the nephrology context and reflect the experiences of patients for whom hemodialysis is the mainstay treatment for ESRD (28,54). Nevertheless, Walker and Avant's systematic approach, used in this study, provides a strong methodological foundation, thereby ensuring consistency, clarity, and precision in conceptual exploration (27).

In conclusion, encouraging end-of-life acceptance in hemodialysis patients has high strategic value, both clinically, ethically and emotionally. Nurses and multidisciplinary teams can use the attributes and empirical referents identified through this analysis to assess patient readiness, support reflective communication process, and design care that respects life while preparing for a dignified and meaningful death.

CONCLUSION

There are notable differences in how the concept of end-of-life acceptance is understood and implemented among hemodialysis patients across various clinical and cultural contexts, particularly in Southeast Asia and Indonesia. These differences underscore the importance of futter exploring the cultural, spiritual, and relational aspects of this concept. More research is needed to better understand the local and religious views that affect how patients feel and what they decide to down when they are near the end of their lives.

This study clarifies the conceptual frameworks of end-of-life acceptance in hemodialysis care, emphasizing three key dimensions: psychological readiness, spiritual and existential integration, and proactive involvement in decision-making. This new way of thinking can help us figure out how well nursing intervention and ways of talking to patients with end-stage renal disease help them die peacefully and with dignity. Using this idea makes advance care planning better, cuts down on unnecessary medical procedures, prepare families ready for loss, and makes the dying process better. In addition to strengthening the theoretical basis, this concept also has the potential to serve as a framework for preparing person-entered and culturally sensitive care practices, particularly in nephrology and palliative

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service. Thus, end-of-life acceptance is not only a clinical goal but also an ethical and humanistic reflection in caring for patients at the end-of-life.

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CONFLICTS OF INTEREST

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