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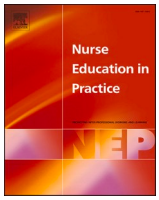

Knowledge and training among nursing students regarding the conspiracy of silence in palliative care: A participatory action research

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ABSTRACT

Aim: To develop and implement specific training based on the knowledge and management of conspiracy of silence among nursing students.
Background: Conspiracy of silence refers to the concealment of information from a patient on the family's request, under the influence of a paternalistic culture that seeks to protect the patient.
Design: Participatory action research.
Methods: Was conducted in the following stages: reconnaissance (focus groups); planning, action and observation (theoretical sessions); and reflection (analysis of care plans). The focus group consisted of six fourth year and eight second-year students. The intervention was conducted with 42 s-year students and a total of 93 s-year students participated in the resolution of the clinical case. The study was conducted between October 2022 and June 2023 at the Faculty of Nursing, University of Valencia. For data analysis, the process described by Carrillo et al. (2011) was followed, involving coding and the creation of categories and subcategories.
Results: The focus group deficiencies were detected in the students' learning of palliative care competence, breaking bad news and the conspiracy of silence (reconnaissance stage). Therefore, an intervention was conducted to reinforce these knowledge areas, specifically addressing the conspiracy of silence (planning, action and observation stages). The resolution of the case showed how students with training approached the situation more comprehensively, including the family and proposed activities that were consistent with managing the situation (reflection stage).
Conclusions: An active feedback process was successfully established, where the students' feedback helped create specific training on oncological palliative care and provided the students with tools to manage the conspiracy of silence. The results underscore the importance of providing students with training in palliative care and managing conspiracy of silence, through therapeutic communication training, active training or enhancing emotional intelligence. This training is essential for cultivating the attitudes and skills required to deliver high-quality palliative care.

1. Introduction

Palliative care was defined by the International Association of Hospice and Palliative Care, as "active holistic care of individuals across all ages with serious health-related suffering due to severe illness and especially of those near the end of life," received from the patient's family and their caregivers (Radbruch et al., 2020). This involves early identification, assessment and treatment of physical, spiritual and psychosocial problems (WHO (World Health Organization), 2014). The need for palliative care is growing because of increased life expectancy, inadequate care and increased social awareness (Espinar Cid, 2019).

Communication between patients, healthcare professionals and families is a fundamental part of palliative care (Ibañez-Masero et al., 2019). When this communication is impaired, conflicts such as the "conspiracy of silence" emerge (Fernandez, 2016; Lemus-Riscanevo et al., 2019). Conspiracy of silence is a phenomenon where family members and healthcare professionals agree to not tell patients the truth about their diagnosis, prognosis and/or severity (Bermejo et al., 2013; Cejudo-López et al., 2015; Lemus-Riscanevo et al., 2019). The authors differentiate between adaptive conspiracy of silence (when the patient chooses to be unaware of the information) and maladaptive conspiracy of silence (when the patient is deprived of autonomy, denying their right

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to know the truth) (Bermejo et al., 2013; Cejudo-López et al., 2015; Moreno-Mulet et al., 2018).

The causes of conspiracy of silence include the influence of culture, filled with taboos that shape society (Ayers et al., 2017; Cheng et al., 2021; Ibañez-Masero et al., 2019; Lope and Díaz, 2019; Serrano-Gemes et al., 2021) and the patient's family's attitude, because they are the first recipients of information and decide whether to proceed with concealing the truth (Ayers et al., 2017; Cejudo López et al., 2015; Cejudo-López et al., 2020; Ibañez-Masero et al., 2019; Serrano-Gemes et al., 2021). Likewise, nursing staff point out two contributing factors: fear of the patient's negative reactions to learning the truth about their prognosis/diagnosis (Ayers et al., 2017; Ibañez- Masero et al., 2019; Lope and Díaz, 2019; Stavroula Georgaki, 2002) and their own fear, both of becoming too involved in the patient's situation and of lacking preparedness to handle such sensitive situations.

BACKGROUND

The future of palliative care (PC) is inextricably linked to the education and training of current students and future professionals. However, the absence of standardized regulations governing their education remains a significant barrier (Gallastegui et al., 2022; Testoni et al., 2023; Valenzuela et al., 2020; Willemsen et al., 2021). Despite the increasing recognition of PC within the Bologna Process framework in Spain, it continues to receive minimal attention in nursing curricula (Chover-Sierra and Martínez-Sabater, 2020; Rubio et al., 2020). There is a pressing need to enhance education and training in palliative care, as emphasized by both students and institutions (Nilsson et al., 2022; Schenell et al., 2023; Ziwei et al., 2023).

In contrast, the issue of the conspiracy of silence reveals an even more pronounced scarcity of training and research. Multiple studies highlight the necessity of training nursing students and professionals in managing the conspiracy of silence and delivering bad news (Agnese et al., 2022; Rayan et al., 2022; Wahyuni et al., 2023). Furthermore, conducting research to improve clinical practice in this area (Agnese et al., 2022).

In response to these challenges, we conducted the following study with the objective of developing and implementing specialized training programs focused on the knowledge and management of the conspiracy of silence among nursing students. This initiative aims to bridge the gap in current educational frameworks and equip future healthcare professionals with the necessary skills to handle sensitive situations effectively

2. Methods

2.1. Design

A participatory action research design was chosen to create training tailored to the knowledge acquired during nursing education. Participatory action research is a method where researchers and participants work together to discover and address the actual needs of participants using a democratic approach, proposing a change in practice and allowing for the development of emerging theories (Baum et al., 2006). It is a potentially useful and widely used tool in education (Colmenares, 2012) and is increasingly gaining popularity in healthcare, specifically in nursing research (Abad et al., 2010). This study followed the steps proposed by Kemmis and McTaggart (1992). These stages include reconnaissance, planning, action, observation and reflection.

2.2. Participants

In the reconnaissance and planning stages, nonprobabilistic purposive convenience sampling was used (Otzen and Manterola, 2017). Inclusion criteria were established to obtain a heterogeneous focus group and the following criteria were applied: students in their second and fourth year of their nursing degree at the University of Valencia, aged over 18, of both sexes, who entered university through different access routes (EBAU (Evaluation of the Baccalaureate for Access to the University), over 25, other university degrees, or higher-level vocational training) and who had provided informed consent to participate in the research. These selection criteria were chosen based on their representation of the predominant access pathways for nursing students at University of Valencia. In relation to the course, the second year was selected due to its initiation of clinical practice, while the fourth year was chosen for its culmination, facilitating the inclusion of students with varying levels of patient contact experience.

The students were reached out to through their course professor, who facilitated their contact with the researchers via email.

Subsequently, during the action, observation and reflection periods, two out of the four second-year nursing groups were involved.

2.3. Action plan and data collection

The study was conducted between October 2022 and June 2023 at the Faculty of Nursing, University of Valencia. Fig. 1 provides a schematic representation of the stages, actions undertaken, and data gathered.

2.3.1. Stage 1: Reconnaissance

In the first period, an extensive literature search was conducted to understand the current status of conspiracy of silence. In addition, the first focus group was conducted with second-year students to assess their existing knowledge on the topic. Subsequently, a second focus group was conducted with fourth-year students to observe their acquisition of knowledge of conspiracy of silence at the end of their studies. The script used for these focus groups is detailed in Table 1. Prior to the final focus groups, a pilot test was conducted.

Semi-structured interviews were conducted along with field notes and direct observations by the researcher during group sessions with nursing students, facilitating discussion of the topics and free contributions from the participants. The principal investigator led the focus groups, bringing with experience in qualitative research and specialized knowledge in palliative care (Master's degree in oncological nursing). It is important to note that she had no prior relationship with any of the participants in the groups, with the goal of fostering participant openness.

Audio and video from both meetings were recorded for subsequent transcription. The sessions were held in a classroom at Faculty X, purposefully equipped with ample lighting, a circular table and integrated recording capabilities (invisible to the participants). Prior to participating in the focus group, the interviewer briefed attendees on the study's objectives, stages and recording process, ensuring their consent.

2.3.2. Stage 2: Planning

In the second stage, an action plan was created, developing a one-hour training session that addressed all the needs expressed by the nursing students during the focus groups. The engagement and findings from the focus group sessions provided the cornerstone for shaping the development of the session.

2.3.3. Stage 3: Action and observation

The action and observation phases were further divided into two phases. First, the principal investigator carried out a one-hour training session was delivered, supported by visual presentations, to second-year students in a single group. This session occurred in the group's regular classroom. Following this session, a question-and-answer session was held to address the doubts that arose during the theoretical session. Support guides and email addresses were provided to expand the knowledge and express needs. Field notes were continuously taken, and student reactions were observed. The input offered by students during the training session directed the crafting of the case proposal.

Second, a clinical case representing the situation of conspiracy of silence in an oncology patient was presented to all second-year students.

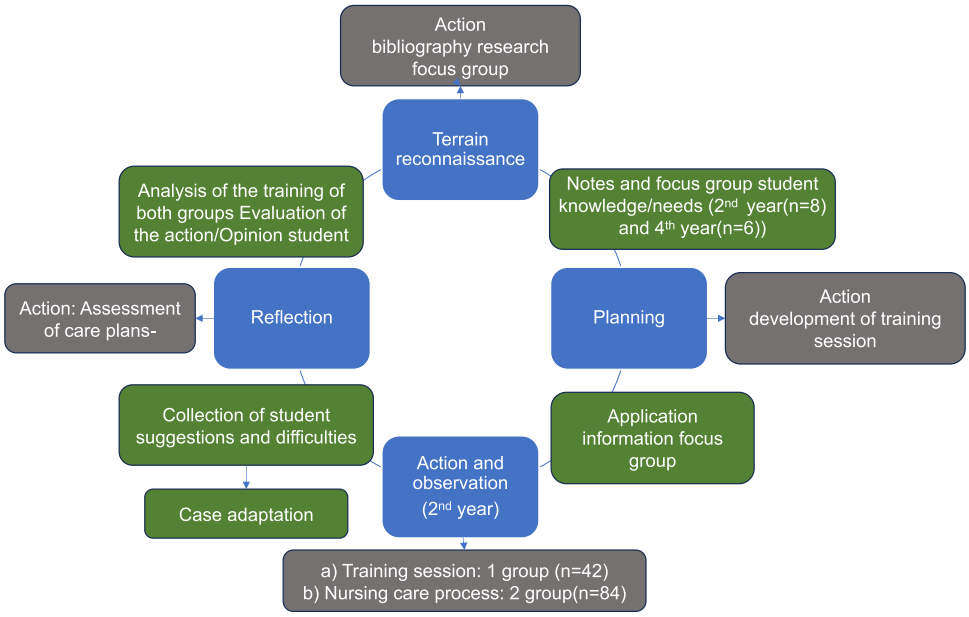

Fig. 1. Stages (blue), actions (grey) and data gathered (green).

Table 1
Focus Group Questions.

	Dash Questions
Opening Questions	Why did you choose to study nursing? What do you think of the degree regarding the knowledge taught? What do you know about oncology and caring for cancer patients? What kind of training have you received for providing care to people with cancer?
Central Questions *Palliative Care Conspiracy of silence*	What do you know about palliative care? How would you care for a patient in their final days? What training have you received for caring for and communicating with individuals and families facing end-of-life situations? If you were facing a situation where death is imminent, would you prefer to know and have all the information? If it were a loved one in that situation, would you handle it the same way? What is your understanding of the concept of the conspiracy of silence? What training have you undergone to manage scenarios where the truth about a patient's condition is withheld from them while the family is aware of the impending death? Have you encountered such a situation previously, and how would you respond if faced with it again?
Nursing care process	How would you evaluate the existence of a conspiracy of silence in an individual and their surroundings? What strategies does nursing employ to address this situation? Which specific tools from the NANDA, NOC, and NIC taxonomies are you familiar with for providing care in these situations?
Closed questions	Are you ready to provide care in palliative care situations and manage instances involving the conspiracy of silence? How would you prefer to be prepared for training in palliative care and handling situations involving the conspiracy of silence? How do you feel after completing this activity?

In groups of 6–7 people, students were required to resolve the case following the Nursing Care Process (NCP) and the NANDA, NIC and NOC taxonomies, integrated into the activities during instruction on the subject "Methodological Foundations of the Nursing Profession." During this activity, data were extracted from the clinical cases. This session was led by the usual course instructor.

2.3.4. Stage 4: Reflection

This stage involved the evaluation of the care plan proposed for the clinical case. The results of the second-year students who attended the theoretical session were compared with cases solved by a group without training. The second course was chosen because of its accessibility and because it was the first year that they carried out clinical practice with patients.

Specifically, the diagnoses and/or collaboration issues, objectives, interventions and activities proposed in the plan were assessed.

2.4. Data analysis

The data collected during the reconnaissance phase were transcribed verbatim to initiate the five phases of the analysis as described by Carrillo et al. (2011), a process that remained iterative throughout. Atlas ti, a software tool that compiles, stores and segregates data, was used.

During the planning stage, an immersion into the data was carried out by meticulously reading each line and extracting initial "notes" and general ideas about the meaning of the text, which would assist in the coding process. Subsequently, data with similar meanings were grouped into codes, which were then further grouped into categories and subcategories, some of which were established in advance, whereas others emerged inductively. This process was conducted by two researchers and a third consultant to resolve points of disagreement. The two researchers engaged in multiple readings of the transcription, independently suggesting categories and subcategories. Subsequently, the three evaluators convened to scrutinize the proposed categories/subcategories. The third reviewer carefully reviewed both the transcription and the categories posited by the other researchers. They strengthened the categories initially delineated by the two researchers and contributed to the nomenclature of categories and subcategories, addressing minor semantic discrepancies. The data were then classified into agreed-on categories and subcategories. Data saturation was achieved during the analysis of the focus groups when both principal investigators identified redundancy in the participants' responses, obviating the need to extend the study to a third focus group (Saunders et al., 2018).

The data collected in the care plans were analyzed in the reflection stage, reflecting the differences and similarities between both groups, both in the diagnosis stage (NANDA) and in planning with the objectives (NOC) and chosen interventions (NIC), with a similar process described by Carrillo et al. (2011).

2.5. Ethical considerations

This study was approved by the Research Ethics Committee of the University of Valencia (code 2519250). Prior to participation, written informed consent was provided, which was explained orally, along with the option to withdraw consent at any time.

All data were coded to ensure anonymity, including transcription coding from the focus group sessions and the anonymous submission of care plans. Participants were briefed on the transcription and coding process to ensure anonymity, with the assurance that audio and video recordings would be deleted after transcription. The entirety of the study's data were stored on a solitary computer safeguarded by a password.

Throughout, it was ensured that participation was voluntary and free from any form of coerción. The care plan was not assessable and no student was obligated to participate.

3. Results

3.1. Terrain recognition and planning (Focus groups)

Two focus groups were conducted with students from the nursing faculty at the University of Valencia. The first group comprised eight second-year students (duration 1,03 h) and the other comprised six fourth-year students (duration 1,19 h), totaling 14 participants during the terrain recognition phase. Participants' characteristics are presented in Table 2. All the students who were invited via email participated in the study. Prior to commencing the definitive focus groups, a pilot test was administered among fourth-year students. Of the 6 students invited, only 2 attended.

After analyzing the interviews from both groups, three main categories were identified: palliative care, communication of bad news and the conspiracy of silence. These encompassed various subcategories (Fig. 2). Additionally, Table 3 shows the most representative quotes from each subcategory.

3.2. Planning

After obtaining information from the focus groups, training based on the following points was proposed: basic concepts of palliative care, the concept of the conspiracy of silence and their performance as nursing personnel with the use of the NANDA, NOC and NIC taxonomy, for both the patient and family.

Table 2
Characteristics of the participants.

Focus Group/ Duration	Participants	Sex	Age	Other university degree	University access
Group 1 (2nd course)	S 1	M	22	No	EBAU
	S 2	W	29	Yes	University title
	S 3	M	27	Yes	University title
	S 4	W	36	No	Acces for people over 25 years old
	S 5	W	19	No	EBAU
	S 6	M	22	No	EBAU
	S 7	W	19	No	EBAU
	S 8	W	23	No	EBAU
Group 2 (4th course)	S 9	W	29	No	Higher training cycle
	S 10	W	22	No	EBAU
	S 11	W	24	No	EBAU
	S 12	M	32	Yes	University Title
	S 13	W	21	No	EBAU
	S 14	W	21	No	EBAU

(M: man; W: women; EBAU: Baccalaureate evaluation for university Access)

3.3. Reflection (Clinical case resolution)

Differences were found when analyzing the care plans resolved by second-year students who had received training (n = 42) compared with the group that did not received the training session (n = 51). Total 93 participants. Table 4 presents the results of the study.

4. Discussion

4.1. Palliative care competence

During students' university studies, palliative care training was unnoticeable. Students lack theoretical and practical knowledge in this field and are unable to visualize the real work involved in palliative care, leading to a perception distant from reality. On the one hand, fourth-year students who have already completed practical training fear facing this service in the future and lack the ability to confidently handle and cater to patients with these needs correctly. On the other hand, students who have only completed two years imagine palliative care as abstract, based on the good deeds and personalities of each professional, even doubting the existence of theoretical foundations for palliative care.

The results reinforce the need to deepen our knowledge of palliative care during university studies. This need was previously observed when comparing studies by Chover-Sierra et al. (2017), Hökkä et al. (2022) and Valenzuela et al. (2020), revealing that students who had received university training on PC generated a higher success rate in response than professionals who had only received basic training, showing a 20.9 % difference between the two groups.

Proposed are evidence-supported educational initiatives aimed at improving the instruction of palliative care. These initiatives encompass heightened emotional readiness to navigate patient-family-team interactions, facilitated through active methodologies such as case resolution (Durojaiye et al., 2023), role-playing (Laranjeira et al., 2021), or clinical simulation (Yoong et al., 2024).

4.2. Communication of bad news

Similarly, when dealing with the communication of bad news, students had a clear idea of how they would like it to be if they themselves or their relatives were the protagonists. They advocated for the patient to make the decision, although not all of them had practiced this approach in their family experiences. In fact, studies support the idea that patients, in most cases, want to be informed about their poor prognosis (Friedrichsen et al., 2011; Kuosmanen et al., 2021). However, when students put themselves in the shoes of professionals who deliver this type of news, they had doubts about how to do so and proposed only passive support and physical contact as actions. This corroborates findings from prior studies (Chover-Sierra and Martínez-Sabater, 2020; Ferri et al., 2021).

They also found the process more challenging if it involved a young adult or child. Nevertheless, in this field, communication should be a strong point for the nursing staff. Therapeutic communication should be practiced (Fernandez, 2016), following the recommendations of the Spanish Society of Palliative Care guide and other palliative care experts (SECPAL, 2002; Povedano et al., 2014), as comprehensive care encompasses not only biological and technical aspects, but also emotional and spiritual aspects. For this purpose, it should be offered starting from universities training in therapeutic communication (Fernandez, 2016; Pereira et al., 2023) to ensure familiarity with strategies like SPIKES (Pereira et al., 2023), Tell me more, or Ask-Tell-Ask (Bumb et al., 2017; Dermani et al., 2020;)

4.3. Conspiracy of silence

Regarding the conspiracy of silence, students were unaware of its

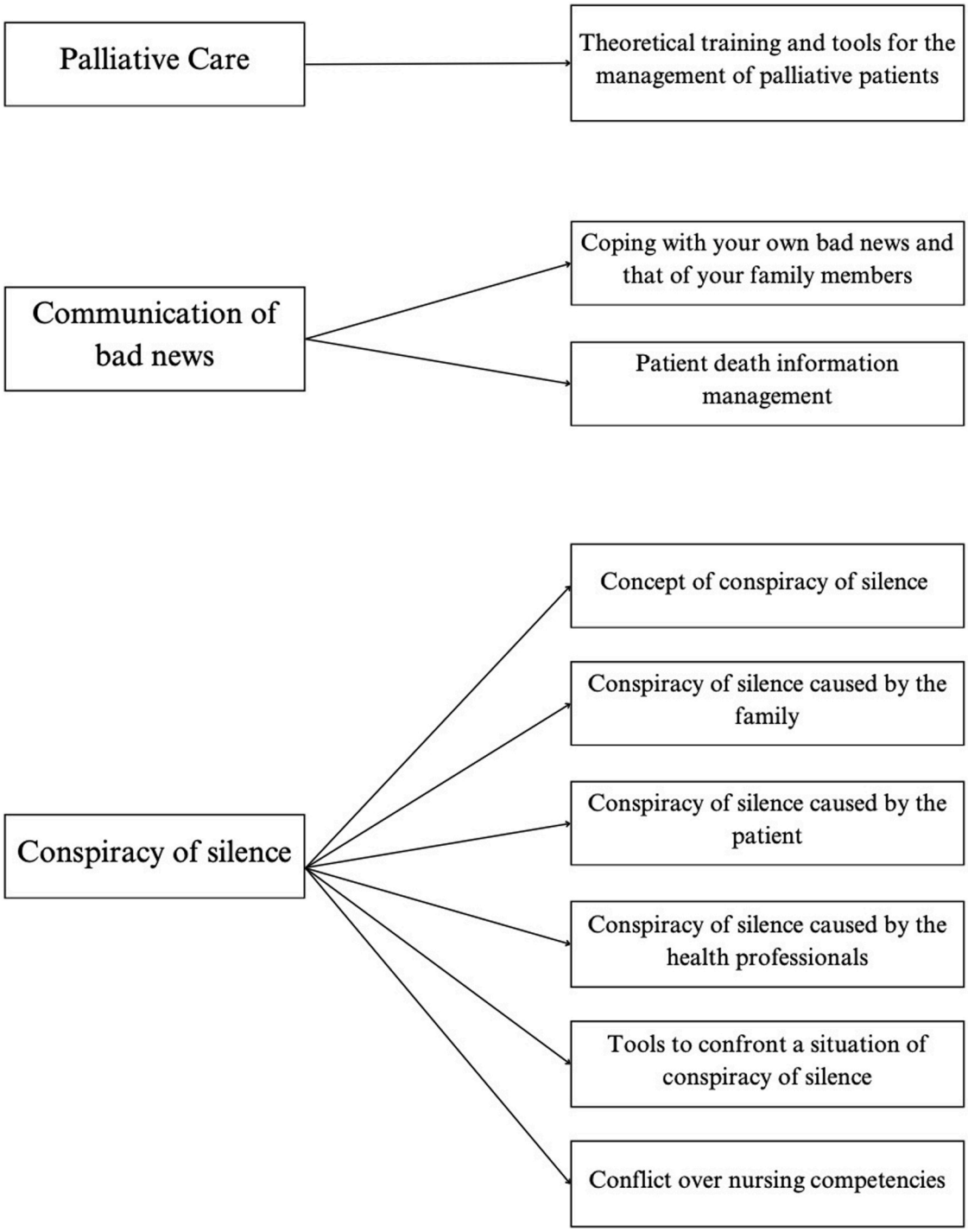

Fig. 2. Category tree, focus group results.

meaning, with only one providing a definition that differed significantly from the real meaning of conspiracy of silence. It is true that after explaining the concept, most participants stated they were familiar with conspiracy of silence situations, either through personal experience or clinical practice. They described situations of conspiracies of silence with different points of origin, coinciding with the three main elements described in the literature (Domínguez Eguizábal, 2020). Students spoke about how the responsible doctor first addresses the family to convey news about the patient's prognosis and/or diagnosis and it is the family that decides whether to hide the truth. However, there are cases where the doctor tries to disguise bad news by subtly presenting the information and leaving the interpretation of the data to the patient and their family. In this manner, conspiracy of silence originates from healthcare professionals, as they are not entirely clear and leave room for information to be misunderstood. Lastly, adaptive silence is also mentioned (Bermejo et al., 2013), where the patient decides not to know their situation and prefers to delegate the reception of information about their health status to their families.

Regarding how students would act in a conspiracy of silence situation, two main conclusions arise, primarily because of the lack of training in handling this phenomenon and its implications. First, the students did not have a clear understanding of the nursing staff's role and many of them combined the responsibilities of doctors and nurses. They freely discuss rights, duties and ethical principles, forming a

Table 3
Subcategories and quotes.

Theoretical training and provision of tools for the management of PCs	"…palliative care is actually something that is the order of the day, but it is a bit of a taboo subject, everyone knows that it exists, but no information is given about it either." (S2) "They tell me that my first contract is in palliative care or oncology and ugh, I don't know how to tell you, maybe I would prefer to be last in the bag and not work. Let's see, in the end you learn, but the first few days you have to have a terrible time because you don't have tools…" (S14) "I just don't know to what extent we can say that this is right or wrong, it will depend on the person in front of me." (S4)
Coping with your own bad news and that of your family members	"I don't like people looking out for me, that is, that person who knows if they are protecting me? Ask me and I will tell you if it is for my protection or not." (S2) "I mean, I think that knowing what you are facing, in my opinion, is a help, but I also understand that ignorance is a help for others." (S12) "But I have never stopped to sit down with him and tell him, look, this is happening to you, you are like this, and you have this prognosis, because I think knowing it will affect him more than not knowing it." (S13)
Patient death information management	"…the only thing you can do is ask them if they need something, let them know you are there, but little else can be done in those situations." (S6) "…if it's an older person, that's fine, but what about 40 years old, 50 years old? child? The thing is, if you're in children's oncology, I know, it's a world apart. I think it would be difficult." (S2) "Right now, you get physical contact, a pat on the shoulder, sooner than a sentence." (S10)
CS concept	"Avoid certain topics that are taboo or even practices that are not the most appropriate, not only in terms of techniques, when communicating with the patient. That is, things that stop being done or are ignored and that we all know but that no one raises their voice, or no one explains, because in the end it is a reality, which is hidden. " (S12)
CS caused by family	"…to what extent does your family have a decision about your health? I mean, before asking you they are asking your family…" (S5) "The doctor explained to them that if he wanted them to tell my grandfather, and they decided, look, we're not going to tell him, that whatever he has left, he should have the best time possible, that he shouldn't suffer, and that's it." (S3)
CS caused by healthcare professionals	"…the doctor tries to tell him: "nothing's wrong, he's just grown a little bit." And then I see the report and of course you realize that things are not going well for him." (S13)
CS caused by patient	"…in my case it was the other way around… my grandfather was sick and didn't tell anyone." (S8) "Just for the sake of not bothering others, older people are very like that, they don't want to tell you their problems, they don't want to worry you too much." (S12)
Tools to confront a situation of conspiracy of silence	"I see it a little like that, I mean, with the training I have right now, I would never approach that situation." (S11) "You put me there and I can be as I am, but what do I say? What do I tell the family?" (S7) "I wouldn't have a clue and now I'm afraid to start practices and that situation will happen, because I don't know how to act." (S5)
Conflict over nursing competencies	"The conspiracy of silence is illegal, it is illegal." (S4) "Man, we are talking about ethical principles, right? I think they take precedence over anything, if not, why are they there? I skip the doctor, if ethical principles are above the doctor, right?" (S2) "…we are a little limited in the fact that we cannot give diagnoses per se, we cannot give the news to the family member that they are going to die." (S10) "… Health education is the responsibility of the nurse, how can it be that you cannot explain to a patient what is happening to them? So that he understands her illness, or so that the family member understands." (S10)

Table 4
Care plan results.

	TRAINING GRUP A(n=42)	NO TRAINING GRUP B (n=51)
Nursing diagnosis (NANDA)	1: Dysfunctional family processes (00063) 2,5,7,8: Death anxiety (00147) 2: Risk of family identity deterioration syndrome (00284) 3,9: Disabling family coping (00037) 3: Chronic grief (00137) 6: Spiritual suffering (00066) 6: Family identity deterioration syndrome (00283) 8: Willingness to improve decision making (000184)	1: Impotence r/c inadequate knowledge to handle a situation and inadequate interpersonal relationships (00125) 1: Decision conflict (00083) 2,5,6,7: Dysfunctional family processes (00063) 4,9,11: Death anxiety (00147) 4,7: Committed family coping (00037) 5: Discomfort r/c inadequate control over the situation (00214) 8: Poor knowledge (00126) 9,12: Hopelessness (00124) 10: Deterioration of resilience (00210)
Nursing Outcomes Classification (NOC)	1, 8: Dignified death (1307) 1: Quality of life (2000) 1: Adaptation of the main caregiver to the patient's admission to a social health center (2200) 3: Relationship between primary caregiver and participant (2204) 3: Acceptance of health status (1300) 5: Anxiety level (1211) 6: Self-esteem (1205) 7: Decreased worry (1210) 8: Family support during treatment (20609) 8: Participation in health decisions (1606)	1: Decision making (0906) 1,4,5: Acceptance: health status (1300) 1,5,9,12: Dignified death (1307) 2,7: Social climate of the family (2601) 3: Situational low self-esteem (00120) 4: Knowledge: cancer management (1833) 4: Coping with family problems (00074) 5. Emotional balance (1204) 6: Family integrity (2603) 11,12: Fear self-control (1404)
Nursing Intervention Classification (NIC)	1,3: Family support (7140) 3,7,8: Emotional Support (5270) 5: Care in agony (5260) 8: Decreased anxiety (5820) 8: Support in decision making (5250)	1,2,3,6,7: Declare the truth to the patient (5470) 1: Advice (5240) 2,7,10: Facilitate grief (5290) 3,11: Emotional Support (5270) 4: Support for the main caregiver (7040) 4: Decreased anxiety (5820) 5: Active listening (4920) 9: Decreased anxiety (5820) 10: Improve coping (5230)

combination of these concepts without clearly defining each. They stressed the obligation of healthcare professionals to respect patients' rights and did not consider interdisciplinary teamwork, indicating that

nurses should act independently.

The findings may be influenced by the existence of the hidden curriculum as part of the learning process in the nursing profession (Raso et al., 2019). The hidden curriculum can be defined as "Values, dispositions and social and behavioral expectations that brought rewards in school for students" (Kentli et al., 2009). Therefore, societal perceptions or educators' beliefs about nursing competencies and end-of-life care could influence students' perspectives.

This aspect was also analyzed by Cejudo-López (2020), wherein nurses confused the principle of autonomy with the patient's privacy, justifying their actions regarding conspiracy of silence under the principle of beneficence, without considering that they also violate the principle of non-maleficence. If they hide information from a patient or provide it without consent, they will inadvertently harm the patient. This means that they do not act in line with the recommendations of authors advocating respect for these principles, particularly towards the end of life (Varelius, 2006; Pérez, 2006).

Second, the participants expressed a general feeling of ignorance and uncertainty regarding the event. They did not feel prepared to handle conspiracies of silence because they had never been trained to do so. They claimed that they would not know how to handle a conversation with either the patient or their family, even developing a fear of having to deal with it in their clinical practice. Moreover, they believe that their positive intentions and willingness to learn are insufficient. Similarly, students themselves are requesting tools to manage their emotions and develop competencies such as empathy and social skills, a conclusion already supported by existing literature (Wang et al., 2022). However, the nursing curriculum primarily emphasizes training in physiological care, neglecting the spiritual and emotional dimensions (Chover-Sierra and Martínez-Sabater, 2020). Therefore, it is advisable to incorporate training in emotional intelligence to better equip students in addressing the psychosocial aspects of palliative care (Kang and Choi, 2020; Yoong et al., 2023).

4.4. Knowledge acquisition

After analyzing the results of the clinical cases resolved by the students, it was observed that most detected a communication problem, regardless of whether they received training in palliative care and conspiracy of silence. However, each group interpreted the situation differently, leading to the assignment of different NANDA diagnoses. Most participants used only one diagnosis: anxiety in the face of death (GA2,5,7,8 and GB4,9,11). It is noteworthy that the group that received training focused their diagnoses on the family (five out of the eight groups), considering it as the origin of the problem and, therefore, addressing the situation from this perspective. As for the group that did not receive training, six out of the 12 groups also approached the problem as familial, but diagnoses focused on the patient herself were more predominant, labeling the issue as hopelessness (GB9,12), powerlessness (GB1), or discomfort (GB5). This might be due to the emphasis during the training session that in palliative care, one should work holistically not only with the patient but also with the family (Ibañez-Masero et al., 2019; SECPAL, 2002).

As a result of the diversity of diagnoses, students proposed various outcomes to achieve NOC (Moorhead et al., 2018). It is true that there were no major differences between the groups with or without training, but what was observed was that the students perceived the need for comfort and visualized it as an objective to resolve it. It is worth noting that on reviewing the NOC taxonomy, there are no objectives that perfectly describe the conspiracy of silence, possibly explaining why students chose such disparate indicators. This may indicate a challenge in addressing the concept of the conspiracy of silence within existing standardized nursing outcomes, contributing to the varied selection of indicators by the students (Moorhead et al., 2018).

Regarding the interventions (NIC) (Butcher et al., 2018) and activities chosen by the students, it is important to highlight that there was indeed a difference between the students who received the training when comparing the actions proposed by the participants in the focus group and the case resolution. In the case resolution, the students addressed the patient's emotional aspect and supported her family, suggesting activities for the patient to express her feelings and concerns and encouraging her to articulate her priorities and wishes. This contrasts with the responses during the interview, when they perceived telling the truth to the patient as the best option, without considering much else. The latter approach was proposed by most students who did not receive training (GB 1,2,3,6,7), as their priority is to support the patient in decision-making, provide guidance and enhance coping. However, although they identified the problem, they failed to comprehensively address the situation. Therefore, the results of this study would reinforce the conclusions of various studies asserting that training future nursing professionals in communication skills, palliative care and phenomena such as conspiracy of silence is beneficial (Chover-Sierra et al., 2017; Povedano et al., 2014). It also highlights the pervasive global need to implement this in undergraduate education, as spoken by experts, which is highly necessary (Smith et al., 2018; Vindrola-Padros et al., 2018).

4.5. Limitations and strengths

This study was conducted with a specific student body; therefore, these results may differ from those obtained when studying another sample, for example, one where palliative care training is already incorporated into the curriculum or students acquire while working through different learning methodologies. Additionally, it would be interesting to repeat this study with palliative care unit nurses to observe how their experiences influenced the management of conspiracy of silence.

In relation to the strengths of this study, it significantly contributes to the sparse literature on the conspiracy of silence. By employing participatory action research, it establishes a valuable precedent for other researchers to emulate, thereby enhancing the success of their own training and investigations. This study contributes to bridging the gap between training, research, palliative care and the conspiracy of silence in nursing science.

5. Conclusions

An active feedback process was established, wherein students' knowledge helped create specific training for oncological palliative. Participatory action research made it possible to identify the true needs of students, confirming their limited knowledge and the need to implement this knowledge in the current nursing degree curriculum. The training session offered students a broader perspective, emphasizing care plans that consider both the patient and the family. The findings prompt reflection, given that a one-hour training session has already shown efficacy in addressing care plans involving a conspiracy of silence. Hence, integrating mandatory theoretical-practical training in palliative care, workshops, therapeutic communication training and enhancing emotional intelligence in the curriculum would effectively bridge the current gap in managing challenging situations, particularly those involving conspiracy of silence.

It is urgent for universities to train new generations of professionals so that they are well-prepared and capable of facing conspiracy of silence situations with the necessary attitudes and aptitudes to offer comprehensive biological, psychological, social and spiritual care.

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Marta Terrón-Pérez: Writing – review & editing, Supervision, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Julia Carrió-Fito:** Writing – original draft, Methodology, Investigation, Formal analysis, Data curation, Conceptualization.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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