Cogitare Enfermagem

ORIGINAL ARTICLE

Translation and validation of the Frommelt Attitude Toward Care of the Dying Scale - Form B*

HIGHLIGHTS

1. FATCOD-B was translated, validated and adapted to Brazilian Portuguese.
2. Physicians' and nurses' preparedness in the face of human finitude.
3. Cronbach's alpha coefficient of 0.81; high internal consistency.
4. Content Validity Index higher than the recommended minimum.

Thalita Felsky dos Santos [1]
Maria Helena Lenardt [1]
Vitor Last Pintarelli [2]
João Alberto Martins Rodrigues [1]
Clovis Cechinel [1]

ABSTRACT

Objective: To translate and cross-culturally adapt the Frommelt Attitude Toward Care of the Dying Scale - Form B into Brazilian Portuguese and to assess its content validity and internal consistency. **Method:** A methodological study developed in online format during 2021 and 2022 with participation of experts in the topic of "death" and sworn translators from Brazil. It involved the following stages: Translation; Synthesis; Back-translation; Review by an experts' committee; Pre-test; and Final version. **Results:** After the translation process, internal consistency was verified using Cronbach's alpha reliability coefficient, which reached 0.81. The overall Content Validity Index was 88.27, higher than the minimum required for acceptability. **Conclusion:** The Brazilian version of the Frommelt Attitude Toward Care of the Dying Scale - Form B Scale presented sufficient metrics to be applied in Brazil. Use of the scale will contribute to increasing visibility regarding the issue of death and assistance to dying patients.

DESCRIPTORS: Validation Study; Translation; Death; Health Assessment; Health Personnel.

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[1] Universidade Federal do Paraná, Programa de Pós-graduação em Enfermagem, Curitiba, PR, Brasil.
[2] Universidade Federal do Paraná, Departamento de Clínica Médica, Curitiba, PR, Brasil

INTRODUCTION

Addressing death is a taboo, considering that talking about the subject matter implies realizing one's own finitude. However, death is part of health professionals' routines, and it is essential to discuss its process and prepare to deal with its nuances[1].

The global scenario indicates that health courses need to increase the number of academic disciplines that teach about death and grief and how to communicate hard news. By expanding information on these topics, health professionals will gain knowledge that goes beyond the technical-scientific realm[2].

In Brazil, health education is focused on curing diseases. Incorporated into healthcare, technological developments along with scientific advances have favored health professionals' "ideal" to fight against death[3], which is seen as a failure on their part, generating anguish, frustration and impotence[4]. For historian Philippe Ariès, adequate training in terminal diseases provides cheerful and dignified moments in this last life stage[5].

Death can generate anxiety and trauma for those who experience it. Caring for people with terminal diseases and witnessing their death can lead to depression and burnout in nurses[6]. Combined with non-preparedness to deal with this population group, frequent contact between health professionals and these patients and their families leads to a reduction in the quality of the care provided[7].

Few tools have been developed to assess medical and nursing professionals' attitudes toward caring for terminally-ill patients. The Frommelt Attitude Toward Care Of the Dying Scale - Form B (FATCOD-B) scale is used to assess health professionals' comfort/discomfort in caring for terminally-ill patients and is applied to test the effectiveness of end-of-life training programs[8].

FATCOD-B was developed by nurse Katherine Helen Murray Frommelt in 1989. It is used to assess the attitudes of nurses and other health professionals regarding the care of terminally-ill patients and their families. It consists of 30 Likert-type items with the following answer options: "Strongly Disagree", "Disagree", "Uncertain", "Agree" and "Strongly Agree". Items 1, 2, 4, 16, 18, 20, 21, 22, 23, 24, 25, 27 and 30 are positive assertions (from 1 for "Strongly Disagree" to 5 for "Strongly Agree") whereas the others are negative (from 1 for "Strongly Agree" to 5 for "Strongly Disagree"). Thus, the total score varies between 30 and 150, with higher values reflecting more positive attitudes[9–11].

The FATCOD-B scale is originally written in English and requires translation, adaptation and cross-cultural validation at the national level to be used in Brazil; these processes were carried out in this study[12].

The objective of this study was to translate and cross-culturally adapt the Frommelt Attitude Toward Care of the Dying Scale - Form B into Brazilian Portuguese and to assess its content validity and internal consistency.

METHOD

This methodological study for semantic validation and cultural adaptation of the FATCOD-B scale was conducted during 2021 and 2022. Methodological studies focus on the development, validation and evaluation of methodological tools or strategies[13].

A number of inclusion criteria were established for the study participants. Translator 1 (TRANS 1): at least 18 years old; being a health professional and having knowledge about the construct assessed; speaking Brazilian Portuguese as their native language; and being fluent in English. Translator 2 (TRANS 2): at least 18 years old; being a professional in a field other than health (naïve translator); having no knowledge about the construct assessed, in order to reflect non-academic language; speaking Brazilian Portuguese as their native language; and being fluent in English. For back-translators 1 and 2 (BT 1 and BT 2), the inclusion criteria were defined as being at least 18 years old, having English as their native language and being fluent in Brazilian Portuguese.

The study was structured with the following stages: Translation (I), Synthesis (II), Back-translation (III), Review by an experts' committee (IV), Pre-test (V) and Final version (VI)[14-15].

Data collection was initiated with the FATCOD-B translation by the translators, who generated versions T1 and T2. In the synthesis, TRANS 1 and TRANS 2 created a version called T 1-2, according to the stages described below.

Two translators took part in stage I. Both of them worked independently and translated the scale into Brazilian Portuguese. TRANS 1's translation was called T1, while TRANS 2's version was named T2. The translation process took place exclusively online, with communication between the translators and authors via e-mail and cell phones.

In stage II, the translators held an online meeting with the researchers as observers. The 30 questions included in the FATCOD-B scale were discussed and the synthesis version called T1-2 was created after due consensus.

North American back-translators (BT 1 and BT 2) took part in stage III. Both of them received version T1-2 and individually formulated back-translated versions into English, called BT1 (by BT 1) and BT2 (by BT 2).

Stage IV (Review by an experts' committee) had the participation of a nursing professional, a researcher in the topic of death, a nursing professional with expertise in translation and cross-cultural validation of scales, a physician specialized in Palliative Care, TRANS 1, TRANS 2, BT 1, BT 2, a professional with a Language degree in Portuguese-English and translator 3 (TRANS 3) replacing TRANS 2 (who was unable to continue participating due to personal problems). The participants received the original version of the FATCOD-B scale, T1, T2, T1-2, BT1 and BT2, in addition to the reports corresponding to these versions, with explanations about the translation, back-translation and synthesis processes, as well as due reasons for the choice of words in the aforementioned stages.

After analyzing all the documents, the experts' committee members created a version of the FATCOD-B scale that was applied in stage V.

A total of 75 physicians and 12 nurses affiliated to the Geriatrics and Gerontology Brazilian Society (*Sociedade Brasileira de Geriatria e Gerontologia*, SBGG) took part in stage V. The participants received an invitation from the SBGG mailing list that contained

a Google Forms link with the sociodemographic questionnaire and the FATCOD-B scale to be answered.

The Beaton et al. (2000) framework suggests between 30 and 40 participants for sample size. A probability sampling method was chosen in this study, obtaining 75 physicians and 12 nurses in the Pre-test stage. Stratified sampling was used, as the population of interest was subdivided into groups. According to Manzato and Santos (2012), when sampling does not take into account the existence of these subgroups, results may be produced that are influenced by sample imbalance[16].

The sociodemographic questionnaire was adjusted based on the one created by Frommelt, which consisted of the following variables: gender, age, religion, profession, questions about previous education on dying and death, previous experience in caring for people with terminal diseases, previous experience with losses, and current experience with the death of a loved one. Adjustments were made so that the questionnaire would be more appropriate to the Brazilian reality. There are several religious denominations in our country. Therefore, it was decided to add the "Spiritist", "Afro-Brazilian", "Agnostic" and "Atheist" options. There were also changes in professional training, as there is no High School Equivalence or High School Diploma in Brazil, for example. It was decided to maintain "Residency", "Master's degree" and "PhD" in the question about other training.

In stage VI, the Brazilian version of the FATCOD-B scale (FATCOD-BB) (APPENDIX) was finalized by the researchers after checking its validation and internal consistency.

Contacts with the participants were made via e-mail and three online meetings in which the main researcher took part as observer. The first one was held between TRANS 1 and TRANS 2, when the 30 translated items of the FATCOD-B scale were discussed, reaching consensus on the synthesis version. In the second meeting, the committee members assessed the semantic, idiomatic, cultural and conceptual equivalences. In the third meeting, the Pre-test version of the scale was approved by the committee.

For data analysis, the answers given by the Pre-test participants were organized in Microsoft® Excel. The participants' characteristics were evaluated using descriptive statistics techniques, and the answers were calculated considering frequencies, percentages and confidence intervals for proportion.

For each question on the FATCOD-B scale, Content Validity Indices (CVIs) were calculated to determine whether the instrument content was a faithful reflection of the construct[17]. Regarding internal consistency, Cronbach's alpha was used, which provides this measure in a single test[18].

The mean agreement values and standard deviations found in all questions of the FATCOD-B scale were calculated and the general metrics for the questions were presented. The analyses were performed using the R.4.1.2 and R.4.2.2 programming languages, with the assistance of a statistician.

Due permission from the author of the scale was obtained for translating, validating and cross-culturally adapting the FATCOD-B scale into Brazilian Portuguese. The research project was approved by the Human Research Ethics Committee belonging to the Health Sciences Sector of the Federal University of Paraná under opinion number 5,339,069.

RESULTS

Table 1 shows that 57.4% of the participants were up to 45 years old, with 66.7% women, 55.2% Catholics and 73.6% indicating their religious beliefs as exerting some influence on their attitude toward death.

In all, 31% of the respondents had attended some course on dying and death, 96.6% had cared for terminally-ill patients and their families and 33.3% had previous experience with losses involving their own family members. Death of a person that was not a relative was experienced by 39.1%, with 83.9% not dealing with any losses at the time of the survey and 6.9% experiencing the death of a loved one.

Table 1 – Distribution of the sociodemographic characteristics corresponding to the physicians and nurses affiliated to the Geriatrics and Gerontology Brazilian Society that took part in the Pre-test. Curitiba, PR, Brazil, 2024

(continue)

Characteristics	n†	% (95% CI)‡
1. Age		
23-27 years old	1	1,1 (0,2; 6,2)
28-35 years old	19	18,4 (11,6; 27,8)
36-45 years old	39	37,9 (28,5; 48,4)
46-55 years old	20	17,2 (10,7; 26,5)
56-59 years old	7	8,0 (4,0; 15,7)
60+ years old	15	17,2 (10,7; 26,5)
2. Gender		
Female	72	66,7 (56,2; 75,7)
Male	29	33,3 (24,3; 43,8)
3. Religion		
Afro-Brazilian	2	2,3 (0,6; 8,0)
Agnostic	10	10,3 (5,5; 18,5)
Atheist	7	4,6 (1,8; 11,2)
Catholic	52	55,2 (44,7; 65,2)
Spiritist	11	9,2 (4,7; 17,1)
Protestant	14	5,7 (2,5; 12,8)
Others	5	12,6 (7,2; 21,2)
4. My religious beliefs and their influence on my attitudes toward dying and death		
No influence	20	21,8 (15,2; 33,0)
Little influence	23	23,0 (16,2; 34,3)
Strong influence	51	50,6 (42,4; 63,4)
No answer	7	6,9

Tabela 1 – Distribution of the sociodemographic characteristics corresponding to the physicians and nurses affiliated to the Geriatrics and Gerontology Brazilian Society that took part in the Pre-test. Curitiba, PR, Brazil, 2024 (conclusion)

Characteristics	n†	% (95% CI)‡
My lack of religious beliefs and its influence on my attitudes toward dying and death		
No influence	23	23,0 (52,9; 84,7)
Little influence	8	5,7 (7,9; 35,6)
Strong influence	3	3,4 (3,7; 27,2)
No answer	67	66,3
6. Profession		
Nurse	12	13,8 (8,1; 22,6)
Physician	75	86,2 (77,4; 91,9)
7. Training		
Residency	45	50,6 (50,3; 72,4)
Master's degree	21	16,1 (12,1; 30,4)
PhD	15	14,9 (11,0; 28,8)
No answer	20	19,8
8. Previous education on dying and death:		
I took some course	27	31,0 (22,3; 41,4)
I didn't take any specific course, but the topic was covered in others.	57	65,5 (55,1; 74,7)
No previous information about dying and death was presented.	3	3,4 (1,2; 9,7)
9. Previous experience in caring for people with terminal diseases:		
I've already cared for terminally-ill patients and their families.	84	96,6 (90,3; 98,8)
I have no previous experiences.	3	3,4 (1,2; 9,7)
10. Previous experience with the loss of someone close to me:		
Close family members	29	33,3 (24,3; 43,8)
No previous experience	24	27,6 (19,3; 37,8)
Other significant person	34	39,1 (29,5; 49,6)
11. Current experience:		
I currently have a loved one who is terminally-ill (life expectancy of one year or less).	8	9,2 (4,7; 17,1)
I'm witnessing the death of a loved one in advance.	6	6,9 (3,2; 14,2)
I'm not dealing with any imminent loss at this time.	73	83,9 (74,8; 90,2)

† = Number of patients; ‡ = Percentage of patients (95% confidence interval);
Source: The authors (2024)

Table 2 presents the minimum Cronbach's alpha reliability coefficient, which totaled 0.81 considering all items. Likewise, calculated using the Content Validity Index and the standard deviations of all questions on the FATCOD-B scale, the mean agreement between the evaluators can be observed. The two items with the highest mean agreement were the following questions: "*Os cuidados devem ser estendidos à família da pessoa em fase final de vida*" (4.71) and "*As famílias precisam de suporte emocional para aceitar as mudanças de comportamento da pessoa em fase final de vida*" (4.67). The overall CVI obtained in the research was 88.27, a value that is higher than the minimum required for acceptability.

Table 2 –Content Validity Index, Cronbach's alpha coefficient, Mean and Standard Deviation corresponding to agreement for the questions included in the Frommelt Attitude Toward Care of the Dying Scale - Form B. Curitiba, PR, Brazil, 2024

(continue)

Items	CVI†	Alpha‡	Mean	SD§
1. Cuidar da pessoa em fase final de vida é uma experiência que vale a pena.	91,95	0,81	4,48	0,80
2. A morte não é o pior que pode acontecer para uma pessoa.	93,1	0,81	4,39	0,81
3. Eu ficaria desconfortável em falar sobre a morte que se aproxima com a pessoa em fase final de vida.	86,21	0,81	3,97	1,05
4. O cuidado com a família do paciente deve continuar durante todo o período de luto.	96,55	0,81	4,59	0,56
5. Eu não gostaria de cuidar de uma pessoa em fase final de vida	94,25	0,80	4,16	0,82
6. Os cuidadores que não são da família não devem ser aqueles que vão falar sobre morte com a pessoa em fase final de vida.	94,25	0,82	4,28	0,98
7. Eu ficaria estressado com o tempo necessário para cuidar de uma pessoa em fase final de vida.	74,71	0,80	3,67	1,20
8. Eu ficaria abalado quando a pessoa em fase final de vida sob meus cuidados perdesse a esperança de melhorar.	77,01	0,80	3,79	1,28
9. É difícil construir uma relação próxima com a pessoa em fase final de vida.	94,25	0,81	4,36	0,88
10. Há momentos em que a morte é bem-vinda pela pessoa em fase final de vida.	89,66	0,81	1,67	0,66
11. Quando um paciente pergunta "estou morrendo?", acredito ser melhor mudar de assunto para algo mais alegre.	100	0,81	4,36	0,59
12. A família deve estar envolvida no cuidado físico da pessoa em fase final de vida.	68,97	0,82	2,07	0,97
13.Eu não gostaria de estar presente quando a pessoa de quem estou cuidando falecesse.	94,25	0,80	4,21	0,90
14. Tenho receio de me tornar amigo de uma pessoa em fase final de vida.	97,70	0,81	4,30	0,76

Table 2 –Content Validity Index, Cronbach's alpha coefficient, Mean and Standard Deviation corresponding to agreement for the questions included in the Frommelt Attitude Toward Care of the Dying Scale - Form B. Curitiba, PR, Brazil, 2024 (continue)

Items	CVI†	Alpha‡	Mean	SD§
15. Eu sentiria vontade de fugir quando a pessoa efetivamente morresse.	96,55	0,80	4,29	0,70
16. As famílias precisam de suporte emocional para aceitar as mudanças de comportamento da pessoa em fase final de vida.	96,55	0,81	4,67	0,64
17. À medida em que um paciente se aproxima da morte, o cuidador que não é da família deve afastar-se emocionalmente do paciente.	100	0,81	4,30	0,63
18. As famílias devem se preocupar em ajudar o familiar em fase final de vida a aproveitar ao máximo o tempo que lhe resta.	82,76	0,81	4,28	0,91
19.A pessoa em fase final de vida não deve ter o poder de tomar decisões sobre seu cuidado físico.	96,55	0,81	4,08	0,65
20. As famílias devem manter o ambiente o mais normal possível para o familiar em fase final de vida.	66,67	0,82	3,71	1,13
21. Para a pessoa em fase final de vida, é bom falar sobre os seus sentimentos.	88,51	0,81	4,40	0,77
22. Os cuidados devem ser estendidos à família da pessoa em fase final de vida.	98,85	0,81	4,71	0,48
23. Os cuidadores deveriam permitir que os horários de visitas para as pessoas em fase final de vida sejam flexíveis.	93,10	0,81	4,53	0,74
24. A pessoa em fase final de vida e sua família devem ser os responsáveis por tomar decisões.	78,16	0,82	3,95	1,07
25. O vício em medicamentos para dor não deve ser um motivo de preocupação ao lidar com pessoas em fase final de vida.	80,46	0,80	4,18	1,25
26. Eu me sentiria desconfortável se entrasse no quarto de uma pessoa em fase final de vida e a encontrasse chorando.	77,01	0,81	3,71	1,28
27. Pessoas em fase final de vida devem receber respostas honestas a respeito de sua condição de saúde.	86,21	0,81	4,36	0,71
28. Esclarecer as famílias sobre morte e o processo de morte não é de responsabilidade do cuidador que não é da família.	93,10	0,81	4,33	0,97
29. Familiares que permanecem próximos à pessoa em fase final de vida frequentemente interferem com os trabalhos profissionais prestados ao paciente.	65,52	0,82	3,11	1,26

Table 2 –Content Validity Index, Cronbach's alpha coefficient, Mean and Standard Deviation corresponding to agreement for the questions included in the Frommelt Attitude Toward Care of the Dying Scale - Form B. Curitiba, PR, Brazil, 2024 (conclusion)

Items	CVI†	Alpha‡	Mean	SD§
30. Os cuidadores que não são da família podem ajudar os pacientes a se prepararem para a morte.	95,40	0,81	4,39	0,58

† = Content Validity Index; ‡ = Cronbach's alpha coefficient; § = Standard Deviation

Source: The authors (2024)

Table 3 shows the sum of the FATCOD-B mean values, which was 121 points, with a standard deviation of 0.68.

Table 3 - Overall metrics for the Frommelt Attitude Toward Care of the Dying Scale - Form B questions. Curitiba, PR, Brazil, 2024

Metric	Minimum	Maximum	Sum of the mean values	Mean of the mean values	Standard deviation of the mean values
Value	1,67	4,71	121	4,04	0,68

Source: The authors (2024)

DISCUSSION

The original scale was translated from the source language to the target one. Both versions presented similar content, despite small variations in choice of words and sentence structure for each translator.

In the synthesis stage, the translated versions were compared and any and all discrepancies were adjusted. The translators discussed the most appropriate options for each translated item in order to formulate a single synthesis version, as recommended by a number of authors in the field[19].

In line with methodological recommendations, the back-translated versions were similar to each other despite variations in vocabulary and sentence structure. Furthermore, the original version of the scale was compared to the resulting translations to ensure that the translated versions were adequate[20].

Throughout the analyses, all FATCOD-B questions were checked for semantic, idiomatic, cultural and conceptual equivalence and improvement suggestion were made. Some words and/or phrases triggered greater discussion. In the "Addiction to pain relieving medication should not be a concern when dealing with a dying person" question, translated as "*O vício em medicamentos para dor não deve ser um motivo de preocupação ao lidar com pessoas em fase final de vida*", the word "addiction" was questioned countless times. According to the content validation guidelines, the experts chose "*vício*" over "*adição*" after observing that it is understood by 12-year-old children[17].

The Pre-test version was used to assess comprehension and acceptability of the scale. It was considered adequate because it encompassed a population from different parts of the country, reflecting the existence of multiple cultural, professional and academic aspects of the interviewees, in agreement with other studies for the translation and cross-cultural adaptation of scales[21-22].

The Pre-test internal consistency was verified using Cronbach's alpha coefficient and the value obtained demonstrated quality and reliability of the results obtained in the scale questions, considering all its items[13,18,23]. Likewise, the Content Validity Index reached an overall value higher than the minimum recommended for acceptability[17].

The professionals aged ≤45 years old had more informed opinions on the fact of softening the topic of death in front of terminally-ill patients and on the feeling of wanting to run away at the moment of a patient's death. These results are discordant with a study that applied FATCOD-B to Chilean nurses, which showed that the older the age, the more positive the professionals' attitudes toward terminally-ill patients[24].

Religion proved to be one of the factors associated with the physicians' and nurses' attitudes toward death. Depending on the scale questions, there were changes in the answers when comparing the group of Christians, non-Christians and those professing no religion; on the other hand, religion did not interfere with the results in other questions. It is noteworthy that religion can affect decision-making in end-of-life care[25].

The physicians and nurses affiliated to the SBGG had positive attitudes toward death and dying, given that the FATCOD-BB score was 121 ± 0.68. This value was higher than the one obtained in a study conducted in Italy (115.20 ± 7.86)[26], but lower than the score of a Swedish study (125.5 ± 8.2)[27].

In the current study, the loss experience promoted changes in the physicians' and nurses' attitudes toward their terminally-ill patients, diverging from a study conducted in Italy, Spain and England, where the answers to the FATCOD-B scale were not influenced by personal grief[28].

The importance of this research goes beyond translating, adapting and validating FATCOD-B into Brazilian Portuguese, as the scale can help health professionals deal with terminal situations. It can be applied to identify professionals with greater aptitude for working with terminally-ill patients and to assess professional attitudes before and after end-of-life training.

FATCOD-BB will be useful in structuring academic disciplines on the topic of dying and death. Professional preparedness can reduce burnout syndrome, anxiety and depression among professionals that deal with end-of-life issues. In this way, society benefits from better professional qualifications and, consequently, more qualified treatments.

Some setbacks arose during this research, such as difficulties finding back-translators that would participate in the experts' committee stage and health professionals with English proficiency in their Lattes CVs. There was limited participation of physicians and nurses in the Pre-test online stage, with consequent loss of participants.

CONCLUSION

Based on the methodology and results presented, it can be concluded that the FATCOD-B scale was translated, validated and cross-culturally adapted to Brazilian Portuguese, in addition to presenting high content validity and internal consistency values.

Changes in the quality of teaching about death and dying should be encouraged. To this end, strategic planning and training of health professionals are necessary. It is recommended to employ FATCOD-BB for continuing education on these topics in health services.

Using FATCOD-BB will promote increased visibility of the issue of death and assistance to dying patients; it will also help health professionals understand their feelings and the difficulties related to this specific type of care and contribute to improving quality of the assistance provided to these patients.

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APÊNDICE
VERSÃO BRASILEIRA DA FATCOD-B *SCALE* (FATCOD-B-B)

Nos itens a seguir, o propósito é entender como cuidadores que não são da família se sentem em relação a certas situações nas quais estão envolvidos com pacientes. Todas as afirmativas dizem respeito a cuidar de pessoa em fase final de vida e/ou sua família. **Onde há referência a paciente em fase final de vida, considere que se refere à pessoa que é considerada terminalmente doente e tem seis ou menos meses de expectativa de vida.** Favor circular a afirmativa que corresponde a seus sentimentos pessoais sobre a atitude ou situação apresentada. Favor responder a todas as 30 afirmativas da escala.

1 - Cuidar da pessoa em fase final de vida é uma experiência que vale a pena.
Discordo totalmente Discordo Não concordo nem discordo Concordo Concordo totalmente

2 - A morte não é o pior que pode acontecer para uma pessoa.
Discordo totalmente Discordo Não concordo nem discordo Concordo Concordo totalmente

3 - Eu ficaria desconfortável em falar sobre a morte que se aproxima com a pessoa em fase final de vida.
Discordo totalmente Discordo Não concordo nem discordo Concordo Concordo totalmente

4 - O cuidado com a família do paciente deve continuar durante todo o período de luto.
Discordo totalmente Discordo Não concordo nem discordo Concordo Concordo totalmente

5 - Eu não gostaria de cuidar de uma pessoa em fase final de vida.
Discordo totalmente Discordo Não concordo nem discordo Concordo Concordo totalmente

6 - Os cuidadores que não são da família não devem ser aqueles que vão falar sobre morte com a pessoa em fase final de vida.
Discordo totalmente Discordo Não concordo nem discordo Concordo Concordo totalmente

7 - Eu ficaria estressado com o tempo necessário para cuidar de uma pessoa em fase final de vida.
Discordo totalmente Discordo Não concordo nem discordo Concordo Concordo totalmente

8 - Eu ficaria abalado quando a pessoa em fase final de vida sob meus cuidados perdesse a esperança de melhorar.
Discordo totalmente Discordo Não concordo nem discordo Concordo Concordo totalmente

9 - É difícil construir uma relação próxima com a pessoa em fase final de vida.
Discordo totalmente Discordo Não concordo nem discordo Concordo Concordo totalmente

10 - Há momentos em que a morte é bem-vinda pela pessoa em fase final de vida.
Discordo totalmente Discordo Não concordo nem discordo Concordo Concordo totalmente

11 - Quando um paciente pergunta "estou morrendo?", acredito ser melhor mudar de assunto para algo mais alegre.
Discordo totalmente Discordo Não concordo nem discordo Concordo Concordo totalmente

12 - A família deve estar envolvida no cuidado físico da pessoa em fase final de vida.
Discordo totalmente Discordo Não concordo nem discordo Concordo Concordo totalmente

13 - Eu não gostaria de estar presente quando a pessoa de quem estou cuidando falecesse.
Discordo totalmente Discordo Não concordo nem discordo Concordo Concordo totalmente

14 - Tenho receio de me tornar amigo de uma pessoa em fase final de vida.
Discordo totalmente Discordo Não concordo nem discordo Concordo Concordo totalmente

15 - Eu sentiria vontade de fugir quando a pessoa efetivamente morresse.
Discordo totalmente Discordo Não concordo nem discordo Concordo Concordo totalmente

16 - As famílias precisam de suporte emocional para aceitar as mudanças de comportamento da pessoa em fase final de vida.
Discordo totalmente Discordo Não concordo nem discordo Concordo Concordo totalmente

17 - À medida em que um paciente se aproxima da morte, o cuidador que não é da família deve afastar-se emocionalmente do paciente.
Discordo totalmente Discordo Não concordo nem discordo Concordo Concordo totalmente

18 - As famílias devem se preocupar em ajudar o familiar em fase final de vida a aproveitar ao máximo o tempo que lhe resta.
Discordo totalmente Discordo Não concordo nem discordo Concordo Concordo totalmente

19 - A pessoa em fase final de vida não deve ter o poder de tomar decisões sobre seu cuidado físico.
Discordo totalmente Discordo Não concordo nem discordo Concordo Concordo totalmente

20 - As famílias devem manter o ambiente o mais normal possível para o familiar em fase final de vida.
Discordo totalmente Discordo Não concordo nem discordo Concordo Concordo totalmente

21 - Para a pessoa em fase final de vida, é bom falar sobre os seus sentimentos.
Discordo totalmente Discordo Não concordo nem discordo Concordo Concordo totalmente

22 - Os cuidados devem ser estendidos à família da pessoa em fase final de vida.
Discordo totalmente Discordo Não concordo nem discordo Concordo Concordo totalmente

23 - Os cuidadores deveriam permitir que os horários de visitas para as pessoas em fase final de vida sejam flexíveis.
Discordo totalmente Discordo Não concordo nem discordo Concordo Concordo totalmente

24 - A pessoa em fase final de vida e sua família devem ser os responsáveis por tomar decisões.
Discordo totalmente Discordo Não concordo nem discordo Concordo Concordo totalmente

25 - O vício em medicamentos para dor não deve ser um motivo de preocupação ao lidar com pessoas em fase final de vida.
Discordo totalmente Discordo Não concordo nem discordo Concordo Concordo totalmente

26 - Eu me sentiria desconfortável se entrasse no quarto de uma pessoa em fase final de vida e a encontrasse chorando.
Discordo totalmente Discordo Não concordo nem discordo Concordo Concordo totalmente

27 - Pessoas em fase final de vida devem receber respostas honestas a respeito de sua condição de saúde.
Discordo totalmente Discordo Não concordo nem discordo Concordo Concordo totalmente

28 - Esclarecer as famílias sobre morte e o processo de morte não é de responsabilidade do cuidador que não é da família.
Discordo totalmente Discordo Não concordo nem discordo Concordo Concordo totalmente

29 - Familiares que permanecem próximos à pessoa em fase final de vida frequentemente interferem com os trabalhos profissionais prestados ao paciente.
Discordo totalmente Discordo Não concordo nem discordo Concordo Concordo totalmente

30 - Os cuidadores que não são da família podem ajudar os pacientes a se prepararem para a morte.
Discordo totalmente Discordo Não concordo nem discordo Concordo Concordo totalmente

*Cuidador que não é da família é qualquer pessoa, profissional ou não, que esteja cuidando do doente em fase final de vida sem ser seu familiar. Últimos 4 dígitos do número de seu CPF:_____. O preenchimento e devolução deste questionário serão interpretados como consentimento em ser participante de pesquisa neste estudo. Seu anonimato é garantido.

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Corresponding author:
João Alberto Martins Rodrigues
Universidade Federal do Paraná
Av. Pref. Lothário Meissner, 632, Bloco Didático II, 3° andar – Jardim Botânico
morgadinho70@hotmail.com

Role of Authors:

Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work - **dos Santos TF, Lenardt MH, Pintarelli VL, Rodrigues JAM, Cechinel C.** Drafting the work or revising it critically for important intellectual content - **dos Santos TF, Lenardt MH, Pintarelli VL, Rodrigues JAM, Cechinel C.** Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved - **dos Santos TF, Lenardt MH, Pintarelli VL, Rodrigues JAM, Cechinel C.** All authors approved the final version of the text.

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