Review Article

Critique of the Peaceful End-of-Life Theory Using Meleis' 2012 Approach

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Abstract

Background: Providing a peaceful end of life while preserving dignity is a fundamental goal of nursing care. The Peaceful End-of-Life Theory (PELT) offers a middle-range theoretical framework to guide holistic nursing care for terminally ill patients. Despite its broad application, this theory has not yet been systematically critiqued using Meleis' theory analysis framework. **Materials and Methods:** This study presents a theoretical discussion employing a structured critique based on Afaf Meleis' (2012) theory analysis framework. The structural and functional components of PELT—including its concepts, assumptions, propositions, inner dimensions, clarity, consistency, practical, educational, and research utility, as well as empirical support—were systematically examined. The primary source of analysis was the original theory article by Ruland and Moore (1998), supported by relevant theoretical and empirical literature. **Results:** The analysis identified PELT as a coherent and internally consistent middle-range theory that effectively links nursing interventions to holistic patient outcomes such as pain relief, comfort, dignity, peace, and closeness to significant others. However, several limitations were noted, including insufficient operational guidance for prioritizing interventions, challenges in measuring culturally sensitive concepts such as peace and comfort, and systemic barriers to implementation such as nursing shortages and misalignment with diagnosis-focused reimbursement systems. **Conclusions:** Although PELT provides a valuable conceptual framework for guiding end-of-life nursing care, its effective application requires further development of context-specific clinical guidelines, culturally sensitive and validated assessment tools, and supportive health policies that acknowledge the interdisciplinary and resource-intensive nature of palliative care. Addressing these gaps may enhance the theory's practical applicability and contribute to more equitable and dignified end-of-life care across diverse settings.

Keywords: *Hospice care, nursing theory, terminal care, theory analysis*

Introduction

The increasing elderly population and the rise of incurable diseases have made end-of-life care essential in nursing.[1] Death is inevitable, and everyone wishes to face it with dignity, fulfilling their final wishes while surrounded by loved ones.[2] The World Health Organization (WHO) defines end-of-life care as interventions designed to improve the well-being of patients and their families in challenging situations.[1] The goal of such care is to alleviate suffering and provide holistic support during the dying process, while avoiding futile treatments that merely prolong life without benefit.[2]

Patients experiencing significant pain may struggle to say goodbye, fulfill final wishes, or maintain autonomy. This reality underscores the critical need to recognize and honor the individuality of each dying person.[2] A key theoretical framework for addressing this need is the Peaceful End-of-Life Theory (PELT) by Ruland and Moore which offers guidance for nurses to improve end-of-life care.[3] While this theory has been previously evaluated using frameworks by Fawcett[4] and Chinn and Kramer,[1] it has not yet undergone a structured analysis through the lens of Meleis' approach. Meleis' framework provides a comprehensive critique by examining a theory's description, origins, internal dimensions, and the relationship between its structure and function.[5]

A rigorous critique of PELT using Meleis' criteria is vital. It enables healthcare professionals to refine their approach to holistic care, effectively integrating the emotional, physical, and spiritual needs of

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patients, especially those seeking spiritual comfort. This analysis can reveal gaps to inform nursing education, helping future providers deliver more compassionate care. Furthermore, it can aid in formulating coherent clinical guidelines and policies to ensure equitable, high-quality end-of-life care for all. Therefore, this study aims to critique the PELT through Meleis' analytical framework to deepen understanding and enhance its practical application in nursing practice, education, and research.

Materials and Methods

This study is a theoretical discussion employing a structured critique based on Afaf Meleis' (2012) theory analysis framework. The selection of this framework was based on its comprehensive and systematic nature, designed to evaluate nursing theories through an examination of both their structural components and their functional utility. The analysis centered on the foundational publication of the PELT—the 1998 article by Ruland and Moore titled "Theory Construction Based on Standards of Care: A Proposed Theory of the Peaceful End of Life." To contextualize the theory's development and application, a subsequent review of scholarly literature that referenced, applied, or discussed PELT was also conducted. This research was performed from April to December 2023. This methodology is consistent with prior research that has utilized Meleis' framework for theory critique, notably in analyses of theories such as Orem's.[6]

The analytical process followed the five sequential stages prescribed by Meleis. The initial stage involved a thorough description of the theory, where its core structural elements—including underlying assumptions, central concepts, and relational propositions—were identified and delineated, alongside its functional focus. The second stage comprised an analysis of the theorist's background, the paradigmatic origins of the theory, and its inner dimensions such as its logical structure, purpose, and scope. In the third stage, a critical evaluation was undertaken, applying specific criteria from Meleis, including assessments of the theory's clarity, internal consistency, simplicity versus complexity, its diagrammatic representation, and its practical, educational, managerial, and research utility. The fourth stage focused on evaluating the theory's empirical support and validation by synthesizing findings from existing research that has tested or utilized PELT. The final stage integrated the insights from the preceding steps to formulate a conclusive synthesis of the theory's strengths and limitations, leading to targeted recommendations for its future development and application.[7]

Ethical considerations

The authors certify that this theoretical analysis did not involve human subjects or primary data collection; therefore, patient consent was not applicable. The research protocol was formally approved by the Ethics Committee of Shahrekord University of Medical Sciences (Ref. ID: IR.SKUMS.REC.1404.022).

Results

The findings of this analysis are presented in accordance with Meleis' (2012) framework and reflect the outcomes of a systematic theoretical critique of the PELT. The results are organized into four main areas: [1] structural and functional components, [2] analysis of concepts and theory, including theorist background, paradigmatic origins, and inner dimensions, [3] critical evaluation of clarity, consistency, diagram, utility, and external components, and [4] assessment of empirical testing and theoretical support.[7]

Description of structural and functional components

Meleis states that theory analysis's descriptive phase involves identifying structural components (assumptions, concepts, and propositions) and functional components defining the theory's focus.[7] Analysis reveals PELT as a middle-range theory primarily composed of relational propositions linking nursing interventions to patient outcomes.

Table 1 summarizes PELT's structural and functional components, presenting key metaparadigm concepts, major concepts, assumptions, and propositions and illustrating how each contributes to a peaceful end-of-life experience. PELT revolves around five core concepts: absence of pain, comfort, peace, closeness to significant others, and dignity.[3] All propositions are relational, connecting specific nursing actions—pain and comfort management, emotional support, and family involvement—to patient outcomes. Table 1 also details each concept's nature (primitive/derived, abstract/concrete) and differentiates between explicit and implicit underlying assumptions. These propositions create testable hypotheses reflecting the theorists' assumptions about nursing actions' role in achieving a peaceful end of life.[3] These propositions form the basis for testable hypotheses and reflect the theorists' assumptions regarding the role of nursing actions in achieving a peaceful end of life.[3] PELT's five core concepts include absence of pain, comfort, dignity and respect, peace, and closeness to significant others.[3] Pain was defined as the absence of sensory and emotional experiences associated with tissue damage, and its relief is achievable through pharmacological and nonpharmacological interventions.[3] However, the theory text lacks further conceptual elaboration of pain.

Functional analysis indicated that PELT focuses on the patient while explicitly incorporating family members and significant others into the care process. Nursing actions, such as pain and comfort management, nutrition, relaxation, and emotional support, were identified as central mechanisms through which nurses facilitate peaceful end-of-life experiences.[3,7]

Table 1: Analysis of the metaparadigm, major concepts, and key elements of the PELT by Meleis (2012)

	Definition	Analysis
Metaparadigm concepts		
Person	Ruland and Moore's theory posits that the journey toward the end of life is a personal experience, where nursing care plays a vital role in ensuring that patients have a tranquil experience.	Abstract Variable Primitive
Health	Health is addressed through the lens of achieving a peaceful end of life, which encompasses physical comfort, emotional well-being, and the absence of pain. The article discusses various outcome indicators related to health such as not being in pain and experiencing comfort and dignity.	Abstract Nonvariable Derived
Nursing	Nursing actions and interventions that support patients in achieving a peaceful end of life.	Abstract Nonvariable Derived
Environment	The context in which care is provided, including the physical and emotional atmosphere contributes to a peaceful end of life.	Concrete Variable Derived
Major concepts		
"Not being in pain"	No sensory and emotional experience associated with actual or potential tissue injury.	Primitive Concrete Variable
" Experience of comfort"	Comfort includes preventing, monitoring, and relieving discomfort, promoting relaxation, facilitating rest, ensuring satisfaction, and avoiding complications	Derived Concrete Variable
"Being at peace"	Feeling calm, harmonious, and content, free from anxiety and fear	Primitive Abstract Variable
"Closeness to significant others"	The sense of connection to other individuals who matter	Derived Concrete Variable
"Experience of dignity"	Feeling respected and valued as a person. The concept of value is a key aspect of the idea. For a dying patient, it means respect and equality without compromising integrity or values. Improved through family involvement, treating patients with empathy and respect, considering their preferences	Abstract Variable Primitive
Assumptions		
Nurses can observe and interpret cues that reflect the patient's experience of being or not being in a peaceful state and appropriately intervene. This also applies in instances when the patient is not able to communicate verbally.		Explicit
Nursing care for a patient plays a major role in making this a peaceful experience.		Explicit
It was presumed that a person's approach to the end of life is a highly personal experience.		Implicit
Statements		
"Monitoring and administering pain relief and applying pharmacologic and non-pharmacologic interventions contribute to the patient's experience of not being in pain"		Relational
"Preventing, monitoring, and relieving physical discomfort, facilitating rest, relaxation, and contentment, and preventing complications contribute to the patient's experience of comfort".		Relational
" Including the patient and significant others in decision-making regarding patient care, treating the patient with dignity, empathy, and respect, and being attentive to the patient's expressed needs, wishes, and preferences contribute to the patient's experience of dignity and respect".		Relational
"Providing emotional support, monitoring and meeting the patient's expressed needs for anti-anxiety medications, inspiring trust, providing the patient and significant others with guidance in practical issues, and providing physical presence of another caring person if desired contribute to the patient's experience of being at peace".		Relational
"Facilitating the participation of significant others in patient care, attending to significant other's grief, worries, and questions, and facilitating opportunities for family closeness contribute to the patient's experience of closeness to significant others or persons who care"		Relational
"The patient's experiences of not being in pain, comfort, dignity, and respect, being at peace, and closeness to significant others or persons who care contribute to the peaceful end of life".		Relational Deterministic

PELT=Peaceful End-of-Life Theory

Analysis of concepts and theory (the theorist, paradigmatic origins, and inner dimensions)

The second step involves analyzing concepts and theory (The Theorist, Paradigmatic origins, and Inner dimensions).[7] In this theory, concepts are defined both theoretically and practically, but they vary in abstraction levels.

The Theorist: Cornelia Ruland and Shirley M. Moore developed the PELT. Ruland, director of the Center for Nursing Research at the University of Bergen, holds degrees from Haukeland School, the University of Oslo, and Case Western Reserve University, where she earned her Ph.D. Her award-winning research centers on shared decision-making and patient-centered chronic illness management.[8] Moore, a Professor at Case Western Reserve University's School of Nursing, possesses nursing degrees and a research background in cardiac recovery, emphasizing the importance of theory development, particularly for doctoral students.[8]

Paradigmatic origins: The analysis revealed that PELT originated in a Norwegian university hospital context, where nurses identified a lack of structured clinical guidelines for terminal cancer care.[3] The theory is grounded in Donabedian's structure–process–outcome model, which is derived from general systems theory.[9] In this framework, nursing interventions (process) influence patient outcomes such as pain relief, comfort, peace, dignity, and relational closeness within a defined care structure.[8] Donabedian's model has been widely applied in health services research.[10-13] In addition, Brandt's preference theory and Kolcaba's Comfort Theory informed the emphasis on fulfilling patient desires and addressing holistic needs at the end of life.[8]

Inner dimensions: Based on Meleis' criteria, PELT demonstrates identifiable inner dimensions, including logical, purpose, context, abstractness, and method.[7] The theory was developed through both inductive and deductive processes, drawing on clinical experiences and empirical knowledge. It was designed to be applicable across various end-of-life contexts, including oncology, chronic illness, and crisis situations such as the COVID-19 pandemic. The analysis showed that PELT conceptualizes end-of-life care as a nonhierarchical continuum, in which all components are interconnected and collectively contribute to peaceful dying.[7]

Critical analysis: Structure, function, and external evaluation

In the third step, the theory was critically analyzed with an emphasis on the relationship between structure and function. This evaluation included subcategories such as clarity, consistency, simplicity versus complexity, tautology/teleology, theory diagrams, the circle of contagion, practical utility, educational relevance, management applicability, and research implications, along with external components.[7]

Clarity and Consistency: The analysis indicated that PELT demonstrates internal consistency between its assumptions, concepts, and propositions. Concepts were used consistently throughout the theory and aligned with both theoretical and operational definitions.[3,7] The absence of physical and psychological suffering was identified as a prerequisite for comfort, which in turn contributes to inner peace. According to Meleis, this alignment supports construct and content validity.[7]

Teleological, Tautological, and Diagrammatic Features: PELT was found to avoid tautology, as it employs clear definitions without redundant or circular reasoning.[7] Regarding its purpose, the theory exhibits partial teleological characteristics, as it emphasizes the desired outcomes of peaceful end-of-life care rather than specifying detailed pathways for achieving them.[7] Furthermore, the theory diagram visually represents the relationships among key concepts and nursing interventions and was congruent with the textual descriptions, thereby supporting comprehension of the theory.[3,7]

Circle of Contagion: The PELT originated in a Norwegian university hospital to address the lack of guidelines for terminal cancer care.[3] Since then, PELT has been widely adopted in various settings, including hospitals, hospices, home care, and intensive care units, for clinical practice, education, management, and research. Its cross-cultural relevance is demonstrated by empirical applications in Europe, Asia, the Middle East, and Latin America.[14-17] Early adoption was facilitated by theorists grounding the theory in clinical standards, while subsequent studies and palliative care initiatives have sustained its use and expansion.[7]

Practical Utility: The practical utility of the PELT was evaluated in terms of its applicability to real-world nursing practice, clarity of implementation, relevance across nursing domains, cost considerations, and alignment with the nursing process.[7] The analysis indicated that PELT provides a clear and clinically relevant framework for palliative care, emphasizing respect, comfort, and dignity for terminally ill patients and their families. Advances in medical science have extended the duration of end-of-life care, increasing the need for structured guidance. PELT supports healthcare professionals—particularly nurses—in identifying and interpreting signs of dying, facilitating peaceful end-of-life experiences even when patients are unable to communicate verbally.[18-20] PELT outlines five essential elements of end-of-life care—absence of pain, comfort, dignity and respect, peace, and closeness to significant others—which guide practice, education, research, and management.[8] Its relevance to patient classification systems has been explored through comparative analyses of palliative care models, highlighting

the Hex COM and IDC-Pal systems as providing detailed representations of patient complexity.[21]

Educational Utility: Palliative care and pain management education in nursing is enhanced through the integration of programs like the End-of-Life Nursing Education Consortium (ELNEC), a national and international project. ELNEC, including its Pediatric program with a perinatal/newborn module since 2003 and a dedicated perinatal palliative care module added in 2021, educates nursing students, practicing nurses, and specialists.[22,23] Furthermore, nurses in pain management courses can pursue certifications such as Nursing Assistant (CHPNA), Registered Nurse (CHPN), Advanced Practice Registered Nurse (ACHPN), and Pediatric Nurse Practitioner (CHPPN) from the Hospice and Palliative Credentialing Center.[24]

Management Utility: PELT's administrative utility lies in its ability to guide organizational implementation, establish quality control, align nursing missions, and support patient classification systems.[7] Management practices have utilized PELT to develop standards of care, quality indicators, and clinical guidelines for end-of-life care across settings. For example, Ruland and Moore used PELT to create a standard of care for terminally ill patients in home care,[3] and others have developed quality indicators for end-of-life and palliative care.[25,26] PELT also informs the definition and measurement of quality outcomes for nursing home residents who died.[27] A computerized system facilitates the implementation and evaluation of care standards, ensuring alignment between patient symptoms/preferences and counseling.[28]

Practical guidance for physicians managing common symptoms in dying patients (pain, dyspnea, delirium, etc.) is available.[29] The WHO provides a fact sheet defining palliative care, outlining its importance, target populations, access strategies, and key statistics regarding its impact on health and human rights.[30] The Better Health Channel offers an overview of end-of-life and palliative care, detailing its providers, delivery locations, and benefits for those with life-limiting illnesses.[31] The Royal Australian College of General Practitioners outlines the roles of general practitioners in palliative and end-of-life care, including terminal care plans, post-death care, and bereavement support.[32] The UK's National Health Service offers guidance on end-of-life care, planning, coping with grief and loss, and finding support.[33]

Research Implications: involve evaluating the theoretical propositions considered (central or peripheral), the research aim (validation or interpretation), and the use of theory in testing propositions or interpreting findings, including explicit theoretical assumptions factored into the methodology.[7] For example, Kennedy's 2016 study highlighted the impact of patient dignity at the end of life. Patient dignity, a central tenet of the PELT, was validated in this study, which also sought effective factors in end-of-life care.[34] Similarly, another study explored dignity in palliative care, emphasizing its importance alongside significant others and using the PELT to test its propositions.[35]

External Components (Values and Social Significance): External values and social significance were also examined, questioning whether the nurse's role aligns with societal perceptions and expectations.[7] PELT's assumptions were uncovered and described, defining its assumptions as the first step. Nursing interventions, like pain alleviation, trust-building, and respecting autonomy, align with societal expectations. Public perception of nurses corresponds with the theory's roles, emphasizing comfort and respect. Ruland and Moore's values, focused on pain relief and compassionate care for terminally ill patients, reflect the nursing profession's commitment to patient well-being and rights. This theory holds social significance, improving the quality of life for terminally ill patients across diverse healthcare settings.

Evaluation of theory testing and support

In the fourth step, we evaluated theory testing and support, focusing on the utility of nursing theory, the relevance of propositions from various fields to nursing, and the testing of nursing concepts and propositions through interpretation.[7] Medium-range theories fulfill the testability criterion when specific tools and statistical techniques are employed to observe and measure the validity of their claims. Additionally, the criterion of empirical adequacy requires that a theory's propositions are coherent and supported by empirical evidence, which is established through a systematic review of the relevant studies. Ruland and Moore emphasize the significance of ongoing refinement and advancement of the theory.[3]

PELT is a prescriptive theory that includes relational propositions defining the connections between terms and concepts. Based on existing evidence, PELT was used to develop a model for holistic palliative care for patients with sickle cell anemia.[36-38] In Thailand, Kongsuwan and Locsin referenced this theory as beneficial for creating a framework to identify key obstacles to quality end-of-life care in ICUs.[14] Additionally, multiple studies have examined the challenges that family members face at the end of a loved one's life across various care settings and how these challenges differ.[39-41]

Recent research has applied PELT in various contexts. A qualitative study by Munkombwe in 2020, for example, explored the connection between pain management and communication with family. The findings revealed that positive interactions can help reduce patient pain, emphasizing the need for specialized training in nonpharmacological pain and palliative care for nurses.[42] Another study focused on ICU nurses' experiences with end-of-life care for COVID-19 patients, demonstrating the

practical and current application of the theory.[15] Moreover, organizations like Comfort and Peace Hospice have been established to provide end-of-life care, with nursing care plans made available on their websites.[15,43-48]

The theory is supported by Rahemi *et al*.'s[49] 2023 work, "End-of-life Care Planning for People of Various Age Categories," which introduced the End-of-life Care Planning (EOLCP) framework. This framework comprehensively addresses individuals based on their health conditions, age (young, middle-aged, and elderly), and geographical setting (urban and rural). PELT has also been the basis for the development of the model and program of palliative care and end-of-life for patients with dementia,[16] women with myocardial infarction,[50] children,[51] cystic fibrosis,[52] and newborns.[17] Furthermore, a cognate protocol derived from the End-of-life Symptom Management Order protocol emerged from this theory. This specialized protocol addresses terminally ill patients with refractory pain and includes stipulations for nonresuscitation.[53] A study conducted in 2022 by Xia Li utilized the NP-PECI instrument to assess nurses' performance and attitudes toward caring for dying patients. The study concluded that PELT offers a theoretical framework and guidelines for clinical nursing practice, which is essential for enhancing the quality of palliative care.[54]

Another aspect of theory evaluation is the level of support the theory receives. This includes the extent of its backing, the presence of a committed audience, and an identifiable community of researchers who apply the theory in their work and various contexts.[7] The Worldwide Palliative Care Alliance is an international NGO focused on advancing hospice and palliative care globally by promoting affordable, high-quality services.[55] The International Association for Hospice and Palliative Care shares a similar mission, aiming to alleviate health-related suffering through online training for healthcare professionals and funding for attendance at relevant events to enhance care in communities.[56]

Another form of support for nursing theory is through conceptual analysis and studies grounded in experiences. Philip Austin's review highlighted the significance of peace in palliative care, emphasizing its role in acceptance and chronic disease management for better survival outcomes. The study also investigated the connection between peace dimensions and spiritual wellness.[57] A qualitative study in 2012 established a framework to assist physicians in guiding patients toward attaining inner peace, which can help them find tranquility in the face of their illnesses.[58]

Discussion

Meleis' framework reveals that the PELT comprises relational propositions linking nursing actions to patient outcomes, enabling testable hypotheses and positioning PELT as a middle-range theory. PELT posits that pain relief, comfort, dignity, peace, and connection with loved ones collectively facilitate a peaceful end of life. However, this multifaceted structure complicates empirical validation due to the difficulty of simultaneously measuring its numerous interrelated constructs. Nevertheless, PELT effectively connects abstract concepts to clinical outcomes, culminating in the holistic assertion that freedom from suffering combined with meaningful connection fosters a peaceful end of life. Overall, this theoretical coherence represents a central strength of PELT while simultaneously introducing methodological complexity.

While this flexibility supports individualized care, the absence of sequential or necessary and sufficient propositions can reduce clarity in complex or resource-limited settings where clinical prioritization is essential. In particular, limited guidance on outcome sequencing—such as the timing of pain relief relative to psychosocial or relational interventions—may hinder practical application, especially for novice nurses. Thus, greater operational clarity could enhance the theory's usability in real-world clinical contexts.

Further analysis indicates limited conceptual depth regarding foundational constructs such as pain, which appears to be treated as a universally understood phenomenon. This assumption overlooks the subjective and culturally variable nature of pain, comfort, and peace, as these experiences are shaped by individual factors such as age, culture, and personal history (e.g., cultural norms surrounding pain expression or personal experiences such as pregnancy). Consequently, these concepts, while theoretically distinct, often blur in end-of-life care and operate along a continuum that forms an individualized definition of well-being. Although this fluidity aligns with holistic care principles, it poses challenges for conceptual clarity, measurement, and consistent application across diverse populations and clinical settings.

Although PELT emphasizes the nurse's central role in end-of-life care, it insufficiently addresses contextual determinants essential for individualized practice, including financial constraints, cultural and religious beliefs, education, age, and gender.[59] Systemic barriers further limit implementation. For example, nurse shortages in Iran often prioritize basic physical care, restricting nurses' ability to address the psychosocial dimensions central to PELT. A major structural challenge is the theory's misalignment with diagnosis-based reimbursement systems such as diagnosis-related groups (DRGs), which are frequently underfunded and inconsistent in palliative care contexts.[60-62]

Evidence from Germany demonstrates that DRG-based reimbursement creates a financing gap for inpatient palliative care because primary diagnoses poorly reflect actual care costs.[60] Moreover, DRGs fail to capture the

complex psychosocial and spiritual needs of palliative patients,[62-64] for whom symptom burden and functional status may be more appropriate indicators than diagnosis alone.[62] This mismatch is particularly problematic in under-resourced low- and middle-income countries with high palliative care needs.[61] The rigidity of DRG systems also undermines the individualized care central to PELT,[60,62] further compounding financial and organizational constraints. These structural limitations reveal a disconnect between PELT's holistic philosophy and current health financing models.

Despite these challenges, growing evidence supports palliative care models aligned with PELT principles. Home-based palliative care has been shown to improve quality of life, increase the likelihood of dying at home, and reduce healthcare utilization, although evidence regarding symptom control and cost-effectiveness remains limited.[64] Overall, palliative care is generally more cost-effective than standard care.[64] In addition, web-based educational interventions highlight the importance of palliative care knowledge for nurses caring for seriously ill children.[65,66]

Ruland and Moore[3] emphasize the importance of a "pleasant environment," encompassing both physical surroundings and relationships between patients and significant others, as a core element of peaceful end-of-life care. Their standards, derived from empirical evidence and expert consensus, guide effective interventions and theory development in areas where research-based knowledge remains limited.[3] From a paradigmatic perspective,[7] PELT aligns with end-of-life care's emphasis on respecting patient preferences[8] and shares common goals with Kolcaba's Comfort Theory, which has demonstrated practical value across diverse populations and clinical settings.[67-73] In this regard, expert clinical experience remains essential for refining peaceful end-of-life care indicators.

Despite its strengths, PELT faces several challenges, including difficulties in measuring nursing care effectiveness, the omission of explicit spiritual dimensions—particularly relevant for patients with beliefs such as the Day of Judgment—and high resource demands. Conceptual clarity is inconsistent, as some nursing interventions lack precise definitions, potentially confusing nurses operating under different scopes of practice.[7] Uncertainty regarding independent nursing interventions and regulatory requirements further underscores the need for validated and culturally sensitive measurement tools for concepts such as comfort, peace, and health.[7]

The large number of key concepts within PELT, each subject to individual interpretation, complicates measurement and often necessitates multiple assessment instruments. Although validated tools exist for pain, fatigue, and quality of life, instruments addressing cultural and spiritual dimensions of end-of-life care remain limited.[7] High patient loads further restrict nurses' capacity to provide psychological and spiritual support. Moreover, PELT's broad definitions of emotional support, trust-building, and guidance complicate implementation. While integrating non-nursing professionals and traditional medicine specialists may enhance care, such approaches increase costs and require effective interdisciplinary collaboration. The central caregiving role of families also expands nurses' educational responsibilities, further intensifying practice demands.

Despite extensive discussion in the literature, comprehensive end-of-life care as defined by PELT's contagion circle and utility remains inconsistently implemented in hospital settings, resulting in gaps in nursing support.[5,7] Although the theory originated in Norway, it has achieved broad international dissemination and has informed hospice and palliative care programs worldwide.[74] In Iran, both the importance of palliative care and barriers to its implementation have been widely documented.[74,75] In Colombia, PELT has contributed to the development of comprehensive neonatal and perinatal palliative care programs and the promotion of evidence-based practice.[17] Similarly, studies from the Philippines during the COVID-19 pandemic highlight nurses' experiences in providing compassionate end-of-life care, further supporting the theory's cross-cultural relevance.[15]

Dying is a deeply personal and culturally influenced experience shaped by beliefs, customs, spirituality, geography, and worldview, all of which affect preferences for medical interventions, place of death, and attitudes toward dying.[76-78] Understanding and respecting these cultural dimensions is essential for facilitating peaceful and dignified end-of-life care. Although theoretical diagrams enhance conceptual understanding, the PELT diagram could be strengthened by emphasizing the progressive relationship among pain relief, comfort, and peace, and by aligning dignity more explicitly with family involvement.[7] Current limitations include overly general interventions lacking concrete examples and conceptual overlap among core outcomes. Addressing these issues would enhance the diagram's educational and practical value.

Overall, while PELT demonstrates clear relevance for nursing education and practice, it lacks measurable outcomes, sufficient empirical testing, and operational specificity. Its broad scope, high implementation costs, unclear role boundaries, and resource constraints limit feasibility across settings. Future refinement should focus on developing contextually appropriate assessment tools, competency-based educational models, interdisciplinary collaboration, specialized classification systems for end-of-life care, comprehensive clinical guidelines, and systematic evaluation of feasibility across diverse cultural contexts.[7]

Conclusion

This study provided a structured critique of the PELT using Meleis' (2012) analytical framework. The analysis

confirms PELT's value as a coherent, middle-range theory that successfully links nursing interventions to holistic patient outcomes, offering a clear and socially significant framework for end-of-life care. Its strengths lie in its conceptual clarity, internal consistency, and broad utility across educational, managerial, and research domains.

However, the critique also identifies critical areas for refinement. A primary limitation is the operational gap between the theory's well-defined concepts and their practical application. The lack of detailed guidance on intervention prioritization, coupled with the under-specification of complex, culturally nuanced concepts like "peace" and "comfort," challenges consistent implementation. Furthermore, the theory's empirical validity requires strengthening through the development and use of standardized, multicultural measurement tools. Real-world feasibility is often constrained by systemic barriers such as nursing shortages, misalignment with rigid reimbursement models (e.g., DRGs), and the high resource demands of holistic palliative care.

To enhance PELT's applicability and impact, future efforts must focus on: [1] developing context-specific, competency-based educational and clinical guidelines; [2] creating validated assessment instruments sensitive to cultural and individual variability in end-of-life experiences; and [3] advocating for healthcare policies and classification systems that recognize and support the complex, interdisciplinary nature of quality end-of-life care. By addressing these gaps, PELT can evolve to more effectively guide equitable, dignified, and peaceful care for all individuals at the end of life, both in routine practice and during public health crises.

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Conflicts of interest

Nothing to declare.

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