**DEATH MANAGEMENT. REGIONAL DOCTORS’ AND NURSES’ ATTITUDES AND BELIEFS. ΤΗΕ CASE OF A DISTRICT HOSPITAL OF GREECE**

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# ABSTRACT

**Introduction:** Doctors and nurses, daily interacts with dying patients. Studies have shown that the attitudes of doctors and nursing stuff towards death, affect the quality of care.

**The aim** of this study was to investigate the attitudes of doctors and nurses of a district hospital of Greece towards death management.

**Material and methods:** In this survey participated 202 doctors and nurses. An anonymous, self-administered questionnaire was used to collect data. It contained questions recording socio-demographic data and the questionnaire Death Attitude Profile-Revised. The statistical analysis was performed with the IBM SPSS Statistics version 19.

**Results:** The participants with lower educational level had a greater "fear of death" in comparison with those with higher one. Physicians and nursing stuff with professional experience more than 7 years, had a greater "fear of death" compared to their colleagues with less experience. Nurses had a greater "fear of death" but they accepted death more than doctors. Doctors and nurses who worked in clinical settings and they were in contact with dying patients more frequently, accepted death more than their colleagues who worked in wards that they didn’t come along with terminal patients. Also the discussion with patients and with other colleagues of the department about death reduced the "fear of death".

**Conclusions:** Death affects both doctors and nurses. It is necessary to run groups for psychological support of both doctors and nurses who work with the dying patient. Achieving and maintaining good communication between them is important to achieve the best quality of care for the dying patient.

**Key words:** death, attitudes, perceptions, patients, doctors, nurses.

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**Relieving Care**

Final stage patients are often elderly people who are alone and thus more sensitive. It is common for these patients to live the rest of their lives facing serious problems. These problems relate to the relief of the symptoms and they pose difficulty to the cover of their needs since the life-threatening diseases affect the physical as well as the social, psychological and spiritual health of the patients and their families. These are the needs that Relieving Care covers[1,2,3].

According to the International Health Organization, with the term Relieving Care we refer to the approach which makes the life of the patients and their families better, dealing with problems that relate to a life-threatening disease[4].These problems are only solved through the immediate identification, right evaluation and confrontation of the pain and the physical, psychological, social, and spiritual symptoms.

Relieving or Supporting Care must be provided to every single patient regardless of the diagnosis, scientific field or expertise aiming at both the improvement of life quality and provision of a dignified death[5]. Nowadays, of course, there is some quality in death thanks to the existence of technological means which help and maintain life[6,7]. End-of-life Care or Relieving (Comforting) Care covers an extended time period of up to 2 years, during which the patient, family, doctors and nurses are aware of the fact that life is about to come to an end[8].

The values that govern Relieving Care are autonomy, dignity, life quality, the relationships between the patient and doctors and nurses, positive attitude towards life and death, communication, sensibility and information of the society, interdisciplinary approach and support in the mourning process. These principles are found in all modern structures of treatment, such as hospices, treatment at home, day care units, hospitals, even Intensive Care Units that are run in various countries, individually or combined[9].

In these places, medical and nursing staff (doctors, nurses, visiting doctors, physiotherapists, pharmacists, dieticians) are responsible for providing care. As it is expected, relations with patients who are at the last stage of an incurable disease create emotional load to the employees[10]. Therefore, death affects the psychology of doctors and nurses who treat people suffering from incurable diseases and have developed a close relationship with the sick person [11]**.**

Death embodies the end, separation and loss. No matter how it is explained, even if it is perceived through the perspective of after-death life and possible reunion with the beloved, loss which relates to death is painful for those who stay back because their lives are affected and changed dramatically[5].

Each patient affects the staff in a different way. When there is a long-lasting and close relationship and when the identification is intense (because of age, characteristics, lifestyle, perception of life), then mourning for doctors and nurses is intense. Through this procedure doctors and nurses are asked to explain the fact of a death, the course towards death and their contribution to the provided care. Moreover, doctors and nurses have to seek and find the necessary support in order to continue to offer[5].

However, when deaths are repeated and frequent, doctors and nursing staff experience bereavement overload that makes them more susceptible to professional exhaustion. Multiple losses do not give them the time to digest and accept them. As a result, they suppress their feelings and so they cannot deal with such a big amount of experiences[12].

Most studies about professional exhaustion show that death is one of the most stressful experiences for doctors and nurses. It has been proved that traumatic experiences in the health domain connected with incidents such as death, abuse and destruction make doctors and nursing staff susceptible to indirect trauma and tiredness due to compassion. Compassion tiredness or secondary traumatic stress is the natural consequence of care provision to people who are in pain, suffering or hurt and it forms the cost of care for doctors and nurses[13].

Doctors and nursing staff take care of people whose health is threatened and is many times lost because of a serious illness. A patient’s death is loss for them since they form a psychological-sentimental bond with their patient and they may display similar symptoms to those of the relatives. Sometimes, a patient’s deteriorating health can cause a need to cry, sorrow, difficulty in concentration, anger, guilt, stress, tiredness or weakness and inability to cope with the demands at work [13].

However, doctors and nurses’ bereavement is often overridden by both society and working staff. This happens due to the wrong impression that doctors and nurses have been taught not to have personal needs, reactions and emotions when they treat a sick person. Even in the cases in which they are affected, they have to feel obliged to control their feelings in order not to be exposed in front of their colleagues and themselves. In this way, the only thing they do is that they do not realize the pain they are experiencing. As a result, they do not receive the necessary support that should be given to all people who face serious illness and patients’ death[13, 5].

Not all deaths have the same impact on doctors and nurses. Each patient causes different impact based on their characteristics, way of life, and idea of life and age[14,5].In developed countries, death is no longer common among babies and young children. It is related to chronic illnesses and has to do with the elderly [14,15]. The death of an older person caused by a chronic illness is more easily accepted than the death of a younger person in a car accident. In the first case, besides age, chronic medical treatment offers psychological preparation. Mourning starts when the sick person is dying .This course is gradual and is based on clinical and paraclinical tests and doctors and nurses’ experience[5].

Kalish claims that death affects doctors and nurses in a different way[12,16]. The reason is that doctors usually focus on the medical treatment and so they take death as a personal failure. For this reason, they get involved in a series of fruitless efforts aiming at the extension of time, not quality of life for the dying person. When their efforts are proven pointless they keep themselves at a distance because they believe that their omnipotence is questioned and at the same time they feel weak, angry and depressed and they face vanity.

On the contrary, nursing staff tend to be orientated towards the general care of the sick people and they support them in the different stages of their illness. As a result, they get to know each other, they bond and as a consequence, nurses are affected by the deterioration of the patient’s state. Many times, there is a noticeable clash between their efforts to provide care and at the same time their need to keep distances in order to protect themselves from the intense and painful feelings caused by the oncoming death. The reason is actually that nurses avoid facing their own death[12, 17].

Doctors and nurses develop defence mechanisms and adopt specific behaviours so that they can control stress associated with death. But when these mechanisms are constantly and invariably used, they tend to become obstacles in the communication and care provision. Some examples of such behaviors and mechanisms are:

* Refusal
* Rationalisation
* Projection.
* Transfer
* Humour
* Game of chances
* Constant hyperactivity or unceasing speech[12, 18].

1. **Methodology**
   1. **Purpose of the study**

The purpose of this study is to present doctors’ and nurses’ attitudes and beliefs towards death management at a Regional Hospital of Greece and also define the factors that affect their attitudes and opinions. The factors which were analysed were personal factors (age, job, workplace, education, their idea of death) and factors which have to do with exposure to death (clinical experience, frequency of deaths at work). Working with facts led to the formation of suggestions which include on the one hand measures concerning doctors and nurses’ education with regard to the dying patient and on the other hand management of doctors and nurses who treat dying patients.

* 1. **Description of the study**

202 individuals took part in this study, aged 18 to 67. They were given a complete questionnaire consisting of two parts. In the first part the basic demographic characteristics were recorded and questions about death management were included. In the second part a number of suggestions (options) regarding different attitudes towards death were included. These suggestions helped to form 5 different behavior patterns concerning death management, which characterize the degree of agreement or disagreement among doctors and nurses.

* 1. **Planning**

It is a cross sectional analytical study which took place from July 2012 to March 2013.

In order to complete this study, a comprehensive bibliographical study had already been completed. This was used to complete the thesis. There was a linguistic restriction in the collection of bibliographical references. Published articles in Greek and English were selected. To realize this study, a sample of doctors and nurses working at the two Units of a Regional Hospital of Greece was used.

* 1. **Collecting facts**

For the collection of data, an anonymous questionnaire was used. Its first part contained socio-demographic questions and its second part contained the Death Attitude Profile-Revised (DAP-R) questionnaire by Wong, PTP Peker GT & Gesser G. The questionnaire has been adapted in Greek by Malliarou and Colleagues and there is a use permit.

In particular, the questionnaire firstly recorded the basic demographic characteristics of doctors and nurses, in other words their age, work position, workplace, level of education, attitude towards death and factors regarding exposure to death (clinical experience, death frequency at work). The purpose of the study was explained to the participants, as well as the fact that their participation is optional, anonymous and confidential. Furthermore, no facts could be used in other studies or for other purposes.

**1.5 Statistical Analysis**

The descriptive indexes of the variables were used and analysed. Moreover, the basic statistical data and variation were used as well as the frequencies in order to describe the demographic characteristics and the questions about death management training and training concerning the relationships of doctors and nurses with the dying patients. In addition, a special questionnaire with 32 suggestions was used to form doctors and nurses’ behaviour profiles towards death.

In order to study the hypotheses of this project, several specific suggestions from the whole questionnaire were used to form the behavior profile towards death. All answers got the same marking so that high rates could indicate high degree of agreement in the scale. Then, for every factor (profile) that had been formed, the average profile was calculated dividing by the number of suggestions that constitute the profile. Five different behavior profiles (factors) became evident. Particularly, these profiles have to do with “fear of death”, “avoidance of death”, “neutral attitude towards death”, “acceptance of death” and the idea that “death is liberation”.

The study of doctors and nurses’ attitude towards death based on the 5 profiles mentioned above, considering the demographic facts, death management training and their relationship with the patients, was carried out using a parametric test that compares average (mean) values of two independent samples (t-test) and analysis of variation in one direction (ANOVA). Finally, the non-parametric correlation factor Spearman r was calculated.

The “p-value” that are mentioned are based on bilateral controls. Those with a price lower than 0.05 were considered statistically important results. IBM SPSS Statistics version 19 software was used for the purposes of the statistical analysis.

* 1. **Etiquette**

Prior to the conduct of the study, documents were sent to the Board of each hospital to allow the study at their workplace. In the document, the names of researchers, the research institution, the purpose and form of the study and the way in which facts would be used were mentioned ensuring anonymity of participants and confidence regarding facts. Finally, a written permit was given by the Board of Governors and the Scientific Board of the Regional Hospital in Greece.

This study followed the fundamental principles of a research. More specifically, all information concerning the participants was strictly confidential. Fact security and participants’ anonymity were ensured and the results that followed were exclusively used for the purposes of this study.

**2. RESULTS**

**2.1 Description of the facts concerning the whole sample**

**2.1.1 Demographic facts**

202 people aged 18 to 67 took part. 33.2% of the participants were men and 66.8% were women. 22.6% of the sample were of age 18 to 30, 67.3% were of age 31 to 50 and 10.1% over 50. The majority of the participants (56.7%) were married while 37.8% were single, 3.5% divorced and 2% widowed.

Regarding education, 29.9% of the individuals had a Senior High School certificate, while most individuals had a University degree. More specifically, 28.4% were graduates of Technological Institutions, 31.8% University graduates, 5% holders of a post-graduate degree and the rest 5% holders of a Ph.D.

Regarding the years of experience, 8.2% worked for less than a year, 39.3% for 1-7 years, 20.9% for 8-15 years and 31.6% for over 15 years.

As for positions, 66.8% of the individuals were nurses and 33.2% doctors. The individuals came from many different departments. Most of the individuals worked in the Pathology Clinic (22.8%), Surgery Clinic (19.8%) and Emergency Department (13.9%). Concerning years of experience in the specific positions, 25.3% had worked for less than a year, 53.3% for 1-7 years, 11.2% for 8-15 years and 10.2% for over 15 years.

All the demographic details mentioned above are fully presented in Table 1.

**Table 1: Descriptive statistical facts regarding the demographic characteristics of the 202 participants of this survey.**

|  |  |  |
| --- | --- | --- |
| **Demographic facts** | **Frequency** | **Percentage (%)** |
| 1. **Sex** |  |  |
| Female | 135 | 66.8 |
| Male | 67 | 33.2 |
| 1. **Age** |  |  |
| 18 – 30 | 45 | 22.6 |
| 31 – 50 | 134 | 67.3 |
| 51 – 67 | 20 | 10.1 |
| 1. **Family status** |  |  |
| Single | 76 | 37.8 |
| Married | 114 | 56.7 |
| Divorced | 7 | 3.5 |
| Widowed | 4 | 2.0 |
| 1. **Level of Education** |  |  |
| Secondary | 60 | 29.9 |
| Technological Institution | 57 | 28.4 |
| University | 64 | 31.8 |
| Post-Graduate Degree | 10 | 5.0 |
| Ph. D | 10 | 5.0 |
| 1. **Years of Experience** |  |  |
| <1 | 16 | 8.2 |
| 1 – 7 | 77 | 39.3 |
| 8 – 15 | 41 | 20.9 |
| >15 | 62 | 31.6 |
| 1. **Job** |  |  |
| Doctor | 67 | 33.2 |
| Nurse | 135 | 66.8 |

|  |  |  |
| --- | --- | --- |
| 1. **Department** |  |  |
| Surgery Clinic | 40 | 19.8 |
| Orthopedic Clinic | 9 | 4.5 |
| Urology Clinic | 10 | 5.0 |
| Pathology Clinic | 46 | 22.8 |
| Maternity Clinic | 8 | 4.0 |
| Cardiology Clinic | 10 | 5.0 |
| Pediatric Clinic | 5 | 2.5 |
| Physiotherapy | 1 | 0.5 |
| Microbiology Clinic | 3 | 1.5 |
| Pulmonary Clinic | 1 | 0.5 |
| Anesthesiology Clinic | 2 | 1.0 |
| Ophthalmology Clinic | 1 | 0.5 |
| Dialysis Unit | 14 | 6.9 |
| Emergency Department | 28 | 13.9 |
| Outpatients’ Department | 9 | 4.5 |
| Blood Donation | 2 | 1.0 |
| Social Welfare | 3 | 1.5 |
| Branch Clinics | 2 | 1.0 |
| Nursing Department | 3 | 1.5 |
| 1. **Years of Experience in the Department** |  |  |
| <1 | 50 | 25.3 |
| 1 – 7 | 105 | 53.3 |
| 8 – 15 | 22 | 11.2 |
| >15 | 20 | 10.2 |

**Questions concerning contact with the dying patient and training for death management.**

We can see below the analysis of the answers given by the participants about the frequency of contact with a dying patient. 71.4% interact with one or no such patient every week. 22.1% say that they get in contact with 2-5 dying patients every week and 6.5% say they are in contact with 6 or more dying patients every week. 49.5% of the participants answered that they had received special training concerning death management when they studied. However, only 29.2% feel that this training is adequate to deal with death and dying patients.

**Results for the total of factors**

|  |  |  |
| --- | --- | --- |
| **Profile** | **Cronbach’s Alpha** | **Number of Questions** |
| Fear of Death | 0.831 | 7 |
| Avoidance of Death | 0.867 | 5 |
| Neutral attitude  towards Death | 0.594 | 5 |
| Acceptance of Death | 0.888 | 10 |
| Death as Liberation | 0.884 | 5 |

**Basic statistical data and variation regarding the 5 profiles towards** **death**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Profile** | **Average Price** | **Standard Deviation** | **Minimum** | **Maximum** |
| Fear of Death | 4.4 | 1.33 | 1 | 7 |
| Avoidance of Death | 4.1 | 1.51 | 1 | 7 |
| Neutral attitude  towards Death | 5.6 | 0.83 | 1 | 7 |
| Acceptance of Death | 3.5 | 1.21 | 1 | 7 |
| Death as Liberation | 3.2 | 1.57 | 1 | 7 |

First of all, there is a statistically important differentiation of the average “fear of death” profile among participants with different positions (t-test= 2.107 & p-value= 0.036< 0.05). More specifically, doctors tend to be more undecided regarding “fear of death” profile compared to nurses. In addition, there is a statistically important difference concerning the average “acceptance of death” profile among participants of different positions (t-test= 3.217 & p-value= 0.002< 0.05). Doctors tend to “disagree moderately” regarding “acceptance of death” compared to nurses, who appear to be more undecided. On the other hand, concerning the rest of the profiles, there is no statistically significant difference regarding the average behavior of health professionals of different positions (p-value> 0.05). Consequently, there is evidence that position probably plays an important role in the differentiation of the behavior towards death.

**Table 3. Results of the statistical correlation between the 5 profiles regarding doctors and nurses’ attitudes towards death and work position.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Mean Price (SD)** | | |
| **Profile** | **Doctor**  **(n= 67)** | **Nurse**  **(n=135)** | **Statistical Control¹** |
| Fear of Death | 4.1 (1.34) | 4.5 (1.31) | t= 2.107  p= 0.036\* |
| Avoidance of Death | 4.0 (1.58) | 4.1 (1.48) | t= 0.310  p= 0.757 |
| Neutral Attitude towards Death | 5.7 (0.71) | 5.6 (0.88) | t= 0.479  p= 0.322 |
| Acceptance of Death | 3.1 (1.34 ) | 3.7 (1.08) | t= 3.217  p= 0.002\* |
| Death as Liberation | 3.0 (1.55) | 3.3 (1.58) | t= 0.960  p= 0.161 |

¹ t-test for independent samples

\*statistically important result at level of statistical importance 5%

In table 4, we can see the results of the correlation between the different profiles concerning death management and the open discussion with patients about death. Statistical control shows that there is a statistically significant difference of the average “fear of death” profile, depending on whether they are discussing openly with the patients or not (t=2.645 & p-value=0.009< 0.05). In particular, it seems that those who do not openly discuss the issue of death with the patients tend to have a higher score in the scale “fear of death”. Moreover, there is a statistically important differentiation of the average behavior concerning “avoidance of death”, depending on whether they are discussing openly with the patients (t=2.162 & p-value=0.032< 0.05). In other words, the doctors and members of the nursing staff who do not talk with the patients about death tend to have a higher score in the scale “avoidance of death”. However, as for the other profiles, there seems to be no statistically significant correlation (p-value> 0.05). As a result, discussing with patients about death plays an important role in the differentiation of their attitude towards death.

**Table 4. Results of the statistical correlation between the profiles of attitude towards death and the open discussion with the patients about death.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Mean Price (SD)** | | |
| **Profile** | **No**  **(n= 142)** | **Yes**  **(n=59)** | **Statistical Control¹** |
| Fear of Death | 4.5 (1.24) | 4.0 (1.44) | t= 2.645  p= 0.009\* |
| Avoidance of Death | 4.2 (1.47) | 3.7 (1.57) | t= 2.162  p= 0.032\* |
| Neutral Attitude towards Death | 5.6 (0.85) | 5.6 (0.79) | t= 0.407  p= 0.684 |
| Acceptance of Death | 3.5 (1.17) | 3.4 (1.30) | t= 0.644  p= 0.520 |
| Death as Liberation | 3.3 (1.60) | 3.1 (1.52) | t= 0.579  p= 0.507 |

¹t-test for independent samples

\*statistically significant result at level of statistical importance 5%

In table 5, we can see the results of the correlation between the different profiles and the discussion with colleagues concerning an incident of death at their department. After applying statistical control, we can see a statistically important differentiation of the average behavior profile “avoidance of death”, depending on whether participants discuss an incident of death at their department (t=2.881 & p-value=0.005< 0.05). In particular, the doctors and nurses who do not discuss with their colleagues at their department tend to have higher scores in the scale “avoidance of death”. Furthermore, there is a significant differentiation of the average behavior concerning the profile “death as liberation”, depending on whether they are discussing a death with their colleagues (t=3.303 & p-value= 0.001< 0.05). More specifically, it appears that those participants who do not discuss such issues tend to have higher scores in the scale “death as liberation”. However, as for the other profiles, there seems to be no statistically important correlation (p-value> 0.05). As a result, discussing with colleagues plays an important role in the differentiation of their attitude towards death.

**Table 5. Results of the statistical correlation between the profiles of attitude towards death and the discussion with colleagues about an incident of death at their workplace.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Mean Price (SD)** | | |
| **Profile** | **No**  **(n= 141)** | **Yes**  **(n=60)** | **Statistical Control¹** |
| Fear of Death | 4.4 (1.14) | 4.4 (1.41) | t= 0.487  p= 0.627 |
| Avoidance of Death | 4.5 (1.24) | 3.9 (1.59) | t= 2.881  p= 0.005\* |
| Neutral Attitude towards Death | 5.6 (0.89) | 5.6 (0.81) | t= 0.734  p= 0.657 |
| Acceptance of Death | 3.6 (1.10) | 3.5 (1.25) | t= 0.338  p= 0.603 |
| Death as Liberation | 3.8 (1.41) | 3.0 (1.59) | t= 3.303  p= 0.001\* |

¹t-test for independent samples

\*statistically important result at level of statistical importance 5%

In table 6, we can see the results of the correlation between the different attitudes towards death and the relief they feel after discussing. After applying statistical control, we get a ‘borderline’ statistically important differentiation of the average attitude “fear of death”, depending on whether they feel relieved after the discussion or not (t=1.925 & p-value= 0.05). In particular, doctors and nurses who feel relieved tend to have higher scores in the scale “fear of death”. As for the other profiles, there seems to be no statistically important correlation (p-value> 0.05). Therefore, the relief after a discussion may play a role in the differentiation of the attitude towards death. At the same time, the correlation factor regarding doctors and nurses’ attitude towards death and the negative effect in the case when they do not discuss was calculated. Table 20 shows a statistically important correlation with “fear of death” and “acceptance of death” scales. This means that the participants with a higher score in the “fear of death” profile tend to be negatively affected if they do not discuss with their colleagues (r= -0.251 & p-value= 0.053). Similarly, the participants with a higher score in the profile “acceptance of death” tend to be negatively affected if they do not discuss the issue of death with their colleagues (r= -0.321 & p-value= 0.012< 0.05). On the other hand, there is no evident important result concerning the other profiles (p-value> 0.05). Therefore, there is evidence that the attitude of doctors and nurses towards death has a correlation with the discussion of the issue.

**Table 6.**  **Results of the statistical correlation between the profiles of attitude towards death and the relief after the discussion.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Mean Price (SD)** |  |  |
| **Profile** | **No**  **(n= 108)** | **Yes**  **(n=34)** | **Statistical Control¹** |
| Fear of Death | 3.9 (1.55) | 4.5 (1.34) | t= 1.925  p= 0.050\* |
| Avoidance of Death | 3.6 (1.51) | 4.0 (1.60) | t= 1.389  p= 0.167 |
| Neutral Attitude towards Death | 5.6 (0.69) | 5.5 (0.84) | t= 0.992  p=0.323 |
| Acceptance of Death | 3.5 (1.07) | 3.5 (1.31) | t= 0.032  p= 0.975 |
| Death as Liberation | 2.7 (1.54) | 3.1 (1.60) | t= 1.283  p= 0.202 |
| **If you do not discuss, to what extent does it affect you negatively?** | **Correlation Factor r** | | **Statistical Control²** |
| Fear of Death | -0.251 | | p= 0.053\* |
| Avoidance of Death | -0.190 | | p= 0.146 |
| Neutral Attitude towards Death | 0.198 | | p= 0.129 |
| Acceptance of Death | -0.321 | | p= 0.012\* |
| Death as Liberation | -0.219 | | p= 0.092 |

¹t-test for independent samples

²Spearman

\*statistically significant result at level of statistical importance 5%

**Discussion**

This project aimed at examining the doctors and nurses’ attitudes concerning death management, in order to identify their ideas about death, to define the way they handle their emotions and the stress relating to their own death and express the needs to deal with the fear and anguish that death brings about.

To serve this purpose, the factors that affect doctors and nurses’ attitudes were studied. These factors were personal ones (age, post, workplace, education, notion of death) and factors that relate to exposure to death (clinical experience, death frequency at work).

According to the results of this analysis, a conclusion is drawn. **Working experience, position, education level, frequency of contact with dying patients and discussion with patients as well as with colleagues about death** play an important role in the diversification of attitudes.

In particular, doctors and nurses with the most **working experience** seemed to have a positive attitude towards death, as it is also confirmed by the study conducted by Gabrera et al [19]. In this particular study, the nursing staff from Guillermo Grant Benavente de Conception (HGGB) Hospital and Las Higueras de Talcahuano (HT) took part. According to the study, 69.43% of the participants of a younger age and with little experience had a negative attitude towards death. In addition, on the basis of Dunn et al study, which examined 57 nurses, participants who thought that death was a way out of a painful reality and had more years of experience faced death in a positive way compared to their colleagues with less working experience[20]. These findings are also supported by other studies, which show a positive connection between experience and treatment of dying patients. These studies were conducted by Stoller, Payne et al, Irvin, Roman et al. [ 21, 22, 23, 24].

Regarding position (doctor, nurse) in this study, nurses had a more positive attitude towards death compared to doctors. These results are in agreement with those of Papadatou et al [25]. 16 nurses and 14 doctors who treated children with cancer participated in this study. The idea of loss and the reactions of mourning of both groups were compared. According to the study, nurses openly expressed their sadness and their understanding was more intense [25]. Moreover, they received their colleagues’ support while doctors had to suppress their feelings. Clearly, each group had received different training concerning approaching patients. In other words, doctors focused on the biological level while nurses on the biopsychosocial level. These findings agree with the study of Vejlgaard et al, according to which nurses showed a more positive attitude towards comforting care compared to doctors. Furthermore, the attitudes of doctors and nurses who worked in the community were more positive than the attitudes of doctors and nurses who worked in hospitals[26].

The individuals with a higher education (university education) 70.1% compared to high school graduates 29.9% showed greater “acceptance of death”. These conclusions seem to agree with those of De Kock. According to them, nurses of a higher educational level could provide more specialized care and this made them more confident[27]. Furthermore, Baylor et al, Mallory et al and Dunn et al are confirmed. Nurses who had received better university education had a more positive attitude towards death[28, 29, 20].

Doctors and nurses who work in wards with frequent deaths show greater acceptance of death, probably because of the fact that death is interwoven with the nature of their job. This result is also confirmed by Carr and Merriman. In the study, they compared the attitudes of doctors and nurses who worked at Relieving Care hospices and of health professionals who worked at a hospital[30]. The results showed that people working at hospices treated dying patients more easily than their colleagues who worked at a hospital, where contact with dying patients is not so frequent. In addition, the studies of Albett et al and Ali M. et al had the same results [31, 32].

Finally, as it was proven in this study, discussion about death either with patients or with colleagues seems to positively affect doctors and nurses’ attitudes. Discussion with colleagues, examined by Papadatou et al, as well as discussion between doctors and patients, examined by Wenrich et al, have proven that in the communication process with dying patients the following points play a significant role: honest and direct discussion with the dying person, willingness to talk about death, announcing bad news with sensitivity ,listening to the patients’ problems, encouraging patients to ask questions and displaying sensitivity when patients are ready to talk about death[25, 33]. As we can also see in the study of Costello, a good death is characterized by open communication with the dying person and their family, aiming at relieving their pain, and also by every patient’s dignity and respect for their acceptance of death[34].According to Chapman, nurses have to be prepared technically and also equipped with communication skills [35].

The results of this study help to define the characteristics of doctors and nurses that have to do with their attitude towards a dying patient. The findings show that the demographic facts, working conditions and relationships between colleagues are defining factors of their behavior. Therefore, we can have a better understanding of their attitudes if we take these factors into account.

**Suggestions**

Through the study of bibliography, we reach the conclusion that the positive attitude of health professionals towards the dying patients contributes to quality treatment [36, 37]. On the basis of the conclusions from the previous part, we make some important suggestions for doctors and nurses to help them have a positive attitude towards death.

*Psychological support groups*. Doctors and nurses can share their feelings and ideas about illness, death, life. They can seek alternative ways to handle difficult cases, discuss the successful operations that can boost their self-confidence, understand their reactions and cope with the painful experiences. Psychologists should create such groups in hospitals and wards with an increased number of deaths. There, all health professionals will be able to express their feelings and discuss with other colleagues, go deep into the values of life and accept the difficulties of their profession so as to avoid “professional tiredness”. Multiformity at work (enrichment), where possible, could decrease professional exhaustion, which is experienced by doctors and nurses in wards with many deaths. Working on research programmes, teaching, taking on administrative duties and many more can offer the staff a way out of the stressful environment.

*Introduction of pre-death care for doctors and nursing staff of all levels* may improve readiness and positive attitude of personnel towards death. Knowledge of psychology could help understand the reactions of a sick person, their family and members of the staff and contribute to the effective communication and support.

*Good communication between nurses and doctors* is necessary in order to ensure information about the patient’s health and the approach that they have to follow in communication and consulting, since that depends on the nature and progress of the disease.

*Education at pre-graduate level* regarding death management in order to provide doctors and nursing staff with all the necessary equipment to deal with the several intense emotional reactions at work. It is important for doctors, nurses and the rest of the staff to get training on communication and basic psychological knowledge before they work with patients. In this way, interpersonal relationships will help face the patient in a better way. In addition, it is necessary to introduce the idea of the end of life and comforting care in the syllabus of students in Medical and Nursing Schools, in order to improve their attitude towards dying patients and the care they offer them and their families.

**Weaknesses of the study**

The small sample and collection of data only from two units of one hospital ask for studies on a larger scale. In other words, more studies that use bigger samples and a cross-section of doctors and nursing staff need to be carried out. We need facts from hospitals that offer treatment to patients with chronic ailments and from pediatric clinics as well. In this way, the attitudes towards patients of different ages and diseases will be examined.

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