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Death Management. Regional Nurses and Doctors' Attitudes and Beliefs: The Case of a District Hospital in Greece

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Abstract

Nurses and physicians, daily interact with dying patients. Studies have shown that the their attitudes towards death, affect the quality of care. The aim of this study was to investigate these attitudes in a Greek district hospital towards death management.
In this survey 202 nurses and doctors participated. An anonymous, self-administered questionnaire was used to collect data, containing questions recording socio-demographic data and Scale Death Attitude Profile-Revised. The statistical analysis was performed with the IBM SPSS Statistics version 19. Participants with lower educational level had a greater "fear of death" in comparison with those with higher one. Nursing staff and physicians 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". Death affects both nurses and doctors. It is necessary to run groups for psychological support of both of them, 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.

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1 Introduction

Terminal 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 Palliative Care covers [1,2,3].

According to the World Health Organization, with the term Palliative Care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual [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.

2 Background

Relieving or Supporting Care should be provided to each 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, the technological equipment has helped to preserve life [6,7]. End-of-life Care or Palliative (Comforting) Care covers an extended time period of up to 2 years. During this period, the patient, family, nurses and medical staff come familiar with the sense of the end of life[8].

The values that govern Palliative Care are autonomy, dignity, life quality, the relationships between the patient and health professionals, 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].

Effect of death in nurses' and doctors' emotional state

In these places, nursing and medical staff (physiotherapists, pharmacists, dieticians) is 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 carers [10]. Therefore, death affects the psychology of health professionals who treat people suffering from incurable diseases and have developed a close relationship with the sick person [11,12, 13,14,15].

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 nurses and physicians is intense. Through this procedure, they are asked to explain the fact of a death, the course towards death and their contribution to the provided care. Moreover, nurses and doctors have to seek and find the necessary support in order to continue to offer [5].

However, when deaths are repeated and frequent, they 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 [16].

Most studies about burn out show that death is one of the most stressful experiences for nursing and medical staff. It has been proved that traumatic experiences in the health domain connected with incidents such as death, abuse and destruction make them susceptible to indirect trauma and tiredness due to compassion. Compassion fatigue 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 nurses and doctors [17].

They 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 [17].

However, bereavement of nurses and doctors, is often overridden by both society and working staff. This happens due to the wrong impression that they 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[17, 5].

Not all deaths have the same impact on nursing and medical staff. 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 [18, 19]. 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 nurses and doctors' experience [5].

Kalish claims that death affects doctors and nursing staff in a different way [16,20]. 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, nurses 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. Nursing staff is 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 nursing staff avoids facing their own death [16, 21].
Nurses and doctors develop defensive mechanisms and adopt specific behaviors 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 [16, 22].

3 Methodology

3.1 Purpose of the Study

The purpose of this study is to present nurses' and doctors' attitudes and beliefs towards death management at a Greek Regional Hospital and also defines the factors that affect their attitudes and opinions. Factors which were analyzed were personal (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 nurses and doctors' education with regard to the dying patient and on the other hand management of nursing and medical staff who treat dying patients.

3.2 Description of the Study

Two hundreds two health professionals (nursing staff and physicians) took part in this study, aged 18 to 67 years old. Response rate was approximately 100%. All participants gave written consent. They were given to complete a 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 nursing staff and physicians.

3.3 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 literature review 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 nurses and doctors working at two Units of a Greece Regional Hospital was used.

3.4 Collecting Facts

For the collection of data, an anonymous questionnaire was used. The first part contained socio-demographic questions and while the 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 et al and there is a use permit.
In particular, the questionnaire firstly recorded the basic demographic characteristics of nurses and physicians, such as 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.

3.5 Statistical Analysis

Descriptive indexes of the variables were used and analyzed. 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 doctors' and nurses' relationships with the dying patients. In addition, a special questionnaire with 32 suggestions was used to form nurses and doctors behavior 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 subscale that had been formed, the average subscale was calculated dividing by the number of suggestions that constitute the subscale. Five different subscales became evident. Particularly, these subscales 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 nurses and doctors' attitude towards death based on the 5 subscales 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.

3.6 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 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.

4 Results

4.1 Demographic Facts

Two hundreds two people, aged 18-67 years old, took part. 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 (%)**
Sex		
Female	135	66.8
Male	67	33.2
Age		
18 – 30	45	22.6
31 – 50	134	67.3
51 – 67	20	10.1
2. **Familystatus**		
Single	76	37.8
Married	114	56.7
Divorced	7	3.5
Widowed	4	2.0
LevelofEducation		
Secondary	60	29.9
TechnologicalInstitution	57	28.4
University	64	31.8
Post-GraduateDegree	10	5.0
Ph. D	10	5.0
YearsofExperience		
<1	16	8.2
1 – 7	77	39.3
8 – 15	41	20.9
>15	62	31.6
Job		
Doctor	67	33.2
Nursingstaff	135	66.8
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
Office of nursing service	3	1.5
Years of Experience in the Department		
<1	50	25.3
1 – 7	105	53.3
8 – 15	22	11.2
>15	20	10.2

We could see below the analysis of the answers given by the participants (both nurses and doctors) about the frequency of contact with a dying patient. 71.35% interact with one or no such patient every week. 22.1% says that they get in contact with 2-5 dying patients every week and 5.5% says 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% feels that this training is adequate to deal with death and dying patients (Table 2).

Table 2: Questions concerning contact with the dying patient and training for death management

Questions	**Frequency**	**Percentage (%)**
How many times a week can get in contact with a patient who eventually dies?		
None or 1	142/199	(71.35)
2 - 5	44/199	(22.1)
6 - 10	11/199	(5.5)
>10	2/199	(1.0)
Have you received any specific training in your school about the administration of the death?		
No	102/202	(50.5)
Yes	100/202	(49.5)
I feel that the education I received for the management of death prepared me enough to deal with death and people who die.		
No	143/202	(70.8)
Yes	59/202	(29.2)

Cronbach's Alpha is presented below for checking the reliability of the various subscales

obtained as described above. Table 3 shows that the reliability indicator for all subscales (except the "Neutral Attitude to Death") is over 80%. This indicates very good reliability. The lower reliability of the "neutral toward death" that reaches 60% possibly is due to the large variability of participants' responses to these questions (Table 3).

Table 3: Results of the reliability for the 5 subscales

Subscale	**Cronbach's Alpha**	**Number of Questions**
FearofDeath	0.831	7
AvoidanceofDeath	0.867	5
NeutralattitudetowardsDeath	0.594	5
AcceptanceofDeath	0.888	10
DeathasLiberation	0.884	5

Table 4 presents the descriptive characteristics of the 5 subscales. We should note that the distribution of "neutral towards Death" shows slight asymmetry. The other subscales are normally distributed (Table 4).

Table 4: Basic statistical data and variation regarding the 5 subscales towards death

Subscales	**AverageValue**	**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 significant difference of the average "fear of death" among participants with different positions ($t= 2.107$, $p= 0.036$). More specifically, doctors tend to be more undecided regarding "fear of death" subscale compared to nursing staff. In addition, there is a statistically significant difference concerning the average "acceptance of death" subscale among participants of different positions ($t= 3.217$ & $p= 0.002$). Doctors tend to "disagree moderately" regarding "acceptance of death" compared to nursing staff, who appear to be more undecided. Moreover, participants with higher educational level (70,1% University) appeared to "accept death" better than others(29,9% high school). Additionally, nurses and doctors who work in wards "accept death" better than others who do not work in wards. On the other hand, concerning the rest of the subscales, there is no statistically significant difference regarding the average behavior of health professionals of different positions ($p > 0.05$) (Table 5).

Table 5: Results of the differences between the 5 subscales regarding attitudes towards death and work position.

Subscales	**Mean (SD) Doctor (n= 67)**	**Nurse (n=135)**	**StatisticalControl[1]**
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 in dependent samples
*statistically important result at level of statistical importance 5%

In table 6, we can see the results of the correlation between the different subscales concerning death management and the open discussion with patients about death. Statistical test shows that there is a statistically significant difference of the average "fear of death" subscale, depending on whether they are discussing openly with the patients or not (t=2.645 & p=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 subscale "fear of death". Moreover, there is a statistically significant difference of the average behavior concerning "avoidance of death", depending on whether they are discussing openly with the patients (t=2.162 & p=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 subscale "avoidance of death". However, as for the other subscales, there seems to be no statistically significant correlation (p > 0.05).

Table 6: Results between the subscales of attitude towards death and the open discussion with the patients about death

Subscale	**Mean (SD) No (n= 142)**	**Yes (n=59)**	**Statistical Control[1]**
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

[1]t-test for in dependent samples
*statistically significant result at level of statistical importance 5%
SD= Standard Deviation

In table 7, we can see the results of the correlation between the subscales and the discussion with colleagues concerning an incident of death at their department. After applying statistical test, we can see a statistically significant differentiation of the average subscale "avoidance of death", depending on whether participants discuss an incident of death at their department (t=2.881 & p=0.005< 0.05). In particular, the doctors and nursing staff 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 subscale "death as liberation", depending on whether they are discussing a death with their colleagues (t=3.303 & p= 0.001< 0.05). More specifically, it appears that those participants who do not discuss such issues tend to have higher scores in the subscale "death as liberation". However, as for the other subscales, there seems to be no statistically important correlation (p> 0.05). As a result, discussing with colleagues plays an important role in the differentiation of their attitude towards death.

Table 7: Results between the subscales of attitude towards death and the discussion with colleagues about an incident of death at their workplace

Subscale	**Mean (SD)** **No (n= 141)**	**Yes (n=60)**	**Statistical Control[1]**
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*

[1]t-test for independent samples
*statistically important result at level of statistical importance 5%
SD= Standard Deviation

In table 8, we can see the results of the correlation between the different attitudes towards death and the relief they feel after discussing. After applying statistical test, we get a 'borderline' statistically significant differentiation of the average attitude "fear of death", depending on whether they feel relieved after the discussion or not (t=1.925 & p = 0.05). In particular, doctors and nurses who feel relieved tend to have higher scores in the subscale "fear of death". As for the other subscales, there seems to be no statistically significant correlation (p> 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 8: Results of the differences between the subscales of attitude towards death and the relief after the discussion

Subscale	**Mean (SD)** **No (n= 108)**	**Yes (n=34)**	**Statistical Control[1]**
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

[1]t-test for independent samples
*statistically significant result at level of statistical importance 5%
SD= Standard Deviation

Table 9 shows a statistically important correlation with "fear of death" and "acceptance of death" subscales. This means that the participants with a higher score in the "fear of death" subscale tend to be negatively affected if they do not discuss with their colleagues (r= -0.251 & p= 0.053). Similarly, the participants with a higher score in the subscale "acceptance of death" tend to be negatively affected if they do not discuss the issue of death with their colleagues (r= -0.321 & p= 0.012< 0.05). On the other hand, there is no evident important result concerning the other subscales (p> 0.05). Therefore, there is evidence that the attitude of doctors and nursing staff towards death has a correlation with the discussion of the issue.

Table 9: Results of the differences between the subscales of attitude towards death and the relief without discussion

If you do not discuss, to what extent does it affect you negatively?	**Correlation Subscale r**	**Statistical Control[2]**
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

[2]Spearman
*statistically significant result at level of statistical importance 5%

Table 10 shows the way to relieve feelings after an incident of death while table 11 shows the way death affects personal life of nurses and doctors.

Table 10: The way to relieve feelings after an incident of death

	Way to relieve feelings after an incident of death					Total
	Keep isolated (%)	I avoid talking to colleagues (%)	I cry to burst out (%)	I think about in my home (%)	I totally do not care (%)	
Doctor	3(5.5)	4(7.4)	0	38 (70.3)	9 (16.6)	54
Nurse	10 (10.6)	9 (9.5)	4 (4.2)	59 (62.7)	12 (12.7)	94
Total	13 (8.7)	13 (8.7)	4 (2.7)	97 (65.5)	21 (14.1)	148
	Value					
Pearson Chi-Square	46.328					
Likelihood ratio	28.365					
Linear-by-Linear	0.060					
Nominal by Nominal Phi	0.559					
Cramer's V	0.280					

Table 11: Differences between doctors and nurses regarding the way death affects their personal life

	How it affects your personal life such incident							Total
	Absolutely (%)	Verymuch (%)	Moderate (%)	Nocare (%)	Just a little (%)	A little (%)	Notatall (%)	
Doctor	1 (1.8)	6 (11.1)	17(31.4)	1 (1.8)	14 (25.9)	9 (16.6)	6 (11.1)	54
Nurse	3 (3.1)	14(14.7)	25(26.3)	1 (1.05)	20 (21)	19 (20)	13 (13.6)	95
Total	4 (2.6)	20(13.4)	42(28.1)	2 (1.3)	34 (22.8)	28(18.7)	19 (12.7)	149
	Value							
PearsonChi-Square	25.145							
Likelihoodratio	23.287							
Linear-by-Linear	0.112							
NominalbyNominal Phi	0.409							
Cramer's V	0.183							

5 Discussion

This study aimed to investigate the attitudes of nurses and doctors in a Greek district hospital towards death management in order to identify their ideas about death. We, also,

tried 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, factors that affect attitudes of nursing and medical nursing staff 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, nurses and doctors 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 [23]. 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 short experience had a negative attitude towards death. In addition, Dunn et al 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 [24]. These findings are also supported by other studies [25, 26, 27, 28],
Regarding position (nurse, doctor) in this study, nursing staff had a more positive attitude towards death compared to doctors. These results are in agreement with those of Papadatou et al [29]. 16 individuals from nursing staff 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, nursing staff openly expressed their sadness and their understanding was more intense [29]. 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 nursing staff on the bio-psychosocial level. These findings agree with the study of Vejlgaard et al, according to which nursing staff showed a more positive attitude towards comforting care compared to doctors. Furthermore, the attitudes of doctors and nursing staff who worked in the community were more positive than the attitudes of doctors and nursing staff who worked in hospitals [30].
Participants 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, nursing staff of a higher educational level could provide more specialized care and this made them more confident [31]. Furthermore, Baylor et al, Mallory et al and Dunn et al are confirmed. Nursing staff who had received better university education had a more positive attitude towards death [32, 33, 24].
Doctors and nursing staff 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. There is evidence that position probably plays an important role in the differentiation of the behavior towards death. Carr and Merriman compared the attitudes of nursing and medical staff who worked at Palliative 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 [35, 36].
Finally, as it was proven in this study, that discussion about death either with patients or with colleagues seems to positively affect doctors and nurses' attitudes. Particularly, those

who discussed the issue of death with patients or colleagues tend to front "fear of death" better than others. 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 [29, 37]. 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 [38]. According to Chapman, nursing staff have to be prepared technically and also equipped with communication skills [39]. As a result, discussion with patients about death plays a significant role in the differentiation of their attitude towards death.

The results of this study help to define the characteristics of doctors and nursing staff that have to do with their attitude towards a dying patient. The findings show that the demographic facts, working positions 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.

6 Suggestions

Through the study of literature, we reached the conclusion that the positive attitude of health professionals towards the dying patients contributes to quality treatment [40, 41]. On the basis of the conclusions from the previous part, we make some important suggestions for nurses and doctors to help them have a positive attitude towards death.

Psychological support groups. Nursing and medical staff 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 nurses and doctors in wards with many deaths. Working on research programs, 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 nurses and doctors of all levels may improve readiness and positive attitude of personnel towards death. Realization of psychological needs 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 nursing staff 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 qualifications to deal with the several intense emotional reactions at work. It is important for doctors, nursing staff 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.

7 Limitations of the Study

The small sample and collection of data only from two units of one hospital require for studies on a larger scale. In other words, more studies that use bigger samples and a cross-section of nursing and medical 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.

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