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Perceptions of Death and Attitudes Related to Death with Dignity of Health Professionals and Caregivers

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ABSTRACT

Purpose: This descriptive research was conducted to determine the death perceptions and attitudes of healthcare professionals and caregivers.

Method: As a data collection tool; descriptive characteristics form, "Attitudes Towards Death Scale", "Attitudes Evaluation Scale Towards Respectable Death Principles" were used. Data of the study; Analyzed using t test, one-way ANOVA.

Results: The average score of health professionals on the Attitudes Towards Death Scale is 4,3±1,2 and the average score of caregivers is 4,4±0,7. The average score of health professionals on the Attitude Scale towards Dignified Death Principles is 3,9±1,0 and the average score of caregivers is 3,4±1,4. Perceptions of health professionals' Attitudes Towards Death and Principles of Dignified Death; It was found that it was affected by having children, education, and the previous loss of a relative, and caregivers were affected by the frequency of thinking about death and their level of education. It was determined that there was a positive, moderate relationship between the Escape Acceptance dimension, which is one of the sub-dimensions of the Health Professionals' Attitudes Towards Death Scale, and the Attitude Towards Respectable Death Principles ($p<0.05$). It was determined that there was a positive, moderate relationship between the sub-dimensions of the Caregivers Attitudes Towards Death Scale, Fear of Death and Avoidance of Death, Neutral Acceptance and Approach Acceptance, and the Attitude Towards Respectable Death Principles of the Escape Acceptance dimensions ($p<0.05$).

Conclusion: Educational activities regarding death are recommended for healthcare professionals who provide care and treatment, as well as for relatives who care for patients.

Key words: attitude to death, palliative care, caregivers

ÖZET

Amaç: Tanımlayıcı nitelikteki bu araştırma, sağlık çalışanları ve bakım verenlerin ölüm algılarını ve tutumlarını belirlemek amacıyla yapılmıştır.

Yöntem: Veri toplama aracı olarak; tanıtıcı özellikler formu, "Ölüme Karşı Tutum Ölçeği", "Saygın Ölüm İlkelerine İlişkin Tutumları Değerlendirme Ölçeği" kullanılmıştır. Araştırmanın yapılabilmesi için etik kurul izni, kurumlardan yazılı izin, katılımcılardan yazılı veya sözel izin alınmıştır. Çalışmanın verileri; t testi, tek yönlü ANOVA kullanılarak analiz edilmiştir.

Bulgular: Sağlık profesyonellerinin Ölüme Karşı Tutum Ölçeği puan ortalamaları 4,3±1,2 bakım vericilerin puan ortalaması 4,4±0,7'dir. Sağlık profesyonellerinin Saygın Ölüm İlkelerine İlişkin Tutum Ölçeği puan ortalaması 3,9±1,0 bakım vericilerin puan ortalaması 3,4±1,4'tür. Sağlık profesyonellerinin Ölüme Karşı Tutum ve Saygın Ölüm İlkeleri algılarının; çocuk sahibi olma, eğitim, daha önce bir yakınını kaybetme durumundan, bakım vericilerin ise ölümü düşünme sıklığı ile eğitim düzeyinden etkilendiği bulunmuştur. Sağlık profesyonellerinin Ölüme Karşı Tutum Ölçeği alt boyutlarından olan Kaçış Kabullenme boyutunun Saygın Ölüm İlkelerine İlişkin Tutum arasında pozitif yönlü, orta düzeyli ilişki olduğu tespit edilmiştir ($p<0.05$). Bakım vericilerin Ölüme Karşı Tutum Ölçeği alt boyutlarından Ölüm Korkusu ve Ölümden Kaçınma, Tarafsız Kabullenme ve Yaklaşım Kabullenme ile Kaçış Kabullenme boyutlarının Saygın Ölüm İlkelerine İlişkin Tutum arasında pozitif yönlü, orta düzeyli ilişki olduğu tespit edilmiştir ($p<0.05$).

Sonuç: Ölüm konusunda bakım ve tedavi sağlayıcı sağlık profesyonellerin yanında, hastaların bakımını üstlenen yakınlarına da kapsayan eğitim etkinlikleri önerilir.

Anahtar Kelimeler: ölüme karşı tutum, palyatif bakım, bakım vericiler

Revealing the meaning attached to disease and death by health professionals is a precondition for effective health services. Nurses and doctors who cannot face their own mortality and cannot accept this reality may distance themselves from patients who are dying and their families or may reflect their fear of death onto others (1). Among nurses, 19% experienced emotional attrition while caring for dying patients, while 18% felt helpless/inadequate; additionally, half of participants stated they were negatively and badly affected by caring for dying patients (2). A study determined that nurses did not want to care for patients in their last days of life due to feeling sorrow (3). A study found 73% of nurses and midwives stated they could not easily talk to patients and families about death (4). Nurses had moderate levels of mean points on the attitude toward death scale, while they had low positive attitudes toward caring for patients who were dying (5). The aim of caring for patients who are dying is to ensure the patient's preparation for death with dignity (6,7). For this reason, nurses need to be able to talk about death, be knowledgeable about death, be aware of the mental state of the patient approaching death, and the needs of the dying patient and their family.

When national and international studies are examined, it appears that topics like death anxiety, fear of death, and emotions experienced in the process of dying were dominantly included (8, 9). Studies generally include sample groups of health professionals like doctors and nurses, or students receiving education in nursing, medicine or midwifery schools. However, when the literature related to death and dying with dignity is examined in depth, it appears studies are inadequate to a significant degree in representing the voices, statements and moods of patient relatives caring for the patient. There was no study encountered investigating the correlation between attitudes toward dying with dignity and death of health professionals and patient relatives caring for the patient. From this aspect, our study is original.

Material and Method

This research with descriptive quality was performed with the aim of determining perceptions about death and attitudes toward death with dignity of health professionals and caregivers. The population for the study comprised relatives caring for patients admitted to palliative care clinics in three hospitals located in Türkiye from February-April 2018 and nurses and doctors employed in the palliative care clinics. The research did not use any sample selection but attempted to reach the whole population. The following formula was used to calculate the sample for the research.

$$n = \frac{N.\sigma^2.Z\alpha}{(N-1).d^2}$$

As a result, n was calculated as 65 for patient relatives and 52 for health employees. The research reached 56 health employees and 65 caregivers who agreed to participate in the study.

Data Collection Forms

Data Collection Form for Health Professionals

This form comprised four sections. The first section comprised five questions about information related to sociodemographic characteristics like age, sex, occupation, educational level, experience and unit of employment. The second section included 22 questions about frequency of encountering death, personal death experiences, responses to death and concept of death. The third section comprised the Death Attitude Profile and the fourth section comprised the Attitudes to Principles about Dying with Dignity Scale.

Data Collection Form for Caregiving Relatives

This form comprised four sections. The first section comprised 5 questions about information like age, sex, occupation, educational level and marital status. The second section included 11 questions about closeness to the patient in palliative care, previous experience of caring for another patient in palliative care, personal experience of death, death concept and responses to death. The third section comprised the Death Attitude Profile and the fourth section comprised the Attitudes to Principles about Dying with Dignity Scale.

Death Attitude Profile (DAP)

The DAP was included in the Turkish literature with a study about validity-reliability for Turkish society by Işık (10). The scale comprises the subscales of neutral acceptance and approach acceptance, escape acceptance, and fear of death and death avoidance. Each subscale has 7-point Likert rating, with response points of 1 for definitely disagree and 7 for definitely agree. The maximum points on the scale are 182, with minimum points of 26. As the points obtained from the scale increase, negative attitudes toward death develop; as points reduce, positive attitudes toward death develop. The Cronbach alpha value for the whole scale was 0,81. In our study, the reliability coefficient for the scale was determined as 0,8.

Attitudes to Principles About Dying with Dignity Scale (APDDS)

The APDDS was developed by Duyan based on the 12 principles about 'dying with dignity' defined by the Debate of the Age Health and Care Study Group for the Future of Health and Care of Older People. Validity and reliability studies were completed. The APDDS comprises 12 items. Each item has a 5-point Likert rating with 1 point for completely disagree and 5 points for completely agree. High points obtained on the scale indicate high levels of adopting the principles of death with dignity, while low points show low levels of adopting the principles of death with dignity. The scale was determined to be reliable with Cronbach alpha coefficient calculated as 0.89 (9). In our study, the Cronbach alpha coefficient was calculated as 0.8.

Analysis of Data

For statistical analyses, the Statistical Package for the Social Sciences version 21.0 (SPSS) was used. When analyzing study data, descriptive statistical methods were used (frequency, percentage, mean, standard deviation). For comparison of quantitative data, if two groups contained parameters with normal distribution, comparisons used the independent samples t test. Comparisons of quantitative data in more than two groups used the one-way ANOVA test for parameters with normal distribution. To identify correlations between scales, correlation analysis was applied. Results were assessed in the %95 confidence interval at $p<0.05$ significance level.

Ethical Aspect of the Research

Before beginning the research, ethics committee permission was obtained (date: 29/01/2018 Number: 02/32). Institutional permission was obtained from the hospitals (date: 07/02/2018 Number: 69668506-799; date: 07/02/2018 Number: 0710212018; date: 02/02/2018 Number: 61660846). During the implementation of the research, patient relatives who were caregivers and health employees provided consent.

Results

The mean DAP points were 4,3±1,2 for health professionals and 4,4±0,7 for caregivers. There were no statistically significant differences found between the DAP total points and subscale points for health professionals and caregivers, with the groups similar to each other. However, when examined generally, it was identified that neutral acceptance of death and approach acceptance levels were higher (Table 1).

Table 1: DAP mean points for health professionals and caregivers

Subscales	Health professionals	Caregivers	Statistical analysis*	
	$\bar{x}$± SS		t	p
Fear of death and death avoidance	3,5±1,3	3,7±1,8	2,1	0,1
Neutral acceptance and approach acceptance	5,3 ± ,9	4,8±1,4	1,8	0,2
Escape acceptance	4,0±1,2	4,3±1,5	1,6	0,3
Total scale points	4,3±1,2	4,4 ±,7	2,2	0,1

**Independent t test*

The APDSS total points for health professionals were 3,9±1,0 while for caregivers they were 3,4±1,4 there was no difference in statistical terms between the groups and they had similar features. Highest points for the principles of death with dignity in both groups were for the '*necessary to be able to access care services not just in hospital but in different environments*' and '*necessary to have the desired spiritual or emotional support.*' The principle with lowest points in both groups was *'necessary to know when death will come and to be able to understand what to expect.*' (Table 2).

Table 2: APDDS mean points for health professionals and caregivers				
APDDS	**Groups**		***Statistics**	
	Health professionals	**Caregivers**	**t**	**p**
	$\bar{x}$ and SS	**$\bar{x}$ and SS**		
It is necessary to know when death will come and to understand what can be expected.	2.9±1.1	2.7±1.3	1.1	0.1
It is necessary to maintain control of the process or progression.	3.2±1.0	3.0±1.2	1.2	0.1
It is necessary to be able to preserve dignity and privacy.	4.3±0.7	3.7±1.3	1.3	0.2
It is necessary to be able to control pain and other symptoms.	4.2±0.7	3.5±1.3	1.4	0.3
It is necessary to be able to choose or control where death will occur (at home or elsewhere).	3.4±1.5	3.0±1.4	1.1	0.0
It is necessary to be able to obtain any and all information and expertise that will be needed	3.9±1.1	3.4±1.3	1.1	0.1
It is necessary to have the desired spiritual or emotional support.	4.4±0.7	4.0±1.3	1.3	0.2
It is necessary to be able to access care services not just in hospital but in other environments.	4.6±0.4	4.1±1.3	1.6	0.3
It is necessary to be able to determine who will be there at the last moment and the people who will share that moment.	4.2±1.0	3.7±1.3	1.3	0.2
It is necessary to be able to issue advance directives about wishes that should be fulfilled.	4.1±1.0	3.7±1.2	1.2	0.1
It is necessary to have time to say goodbye and to be able to control timing.	4.0±1.1	3.5±1.3	1.2	0.1
It is necessary to be able to go when the time comes and not have life prolonged pointlessly.	3.5±1.4	3.1±1.5	1.3	0.2
Total Points	3.9±1.0	3.4±1.4	1.1	0.1
* Independent t test				

It was identified that the DAP subscale of fear of death and death avoidance differed according to educational status of caregivers ($p<0.05$). Caregivers who were university graduates had higher levels of fear of death and death avoidance ($\bar{x}$=4,5) compared to caregivers who were secondary education graduates ($\bar{x}$=3,0). The escape acceptance subscale was determined to be different in terms of frequency of thoughts about death ($p<0.05$). Caregivers who reported thinking about their own death very frequently had higher escape acceptance levels ($\bar{x}$=4,9) than caregivers stating they thought about their own death occasionally ($\bar{x}$=3,8) (Table 3).

Table 3: Comparison of mean DAP and APDDS points of caregivers according to some characteristics

Characteristics	**Scales**				
	DAP				**APDDS**
	Fear of death	**Neutral acceptance**	**Escape acceptance**	**General attitude toward death**	
	$\bar{x}$ and SD	$\bar{x}$ and SD	$\bar{x}$ and SD	$\bar{x}$ and SD	$\bar{x}$ and SD
Educational status					
Primary education Secondary education University *Statistic	3.8±1.6 3.0±1.2 4.5±2.3 **p=0.018** F=6.7	4.7±1.7 4.8±1.4 4.9±1.0 p=0.869 F=0.1	4.1±1.6 4.3±1.5 4.4±1.5 p=0.775 F=0.9	4.5±0.6 4.5±.8 4.3±0.8 p=0.760 F=0.9	3.3±1.0 3.2±0.9 3.8±0.5 p=0.071 F=2.8
Thoughts about own death					
Very frequent Occasionally Very rare * Statistic	3.4±1.3 4.0±2.3 3.6±1.5 p=0.5 F=0.6	5.3±0.9 4.6±1.6 4.6±1.5 p=0.1 F=1.6	4.9±1.2 3.8±1.6 4.2±1.5 **p=0.041** F=3.3	4.4±0.8 4.7±0.6 4.0±0.8 **p=0.052** F=3.1	3.5±0.6 3.3±1.0 3.6±0.9 p=0.599 F=0.5
** One-way ANOVA test*					

The APDDS points of health professionals receiving special education apart from basic professional education about palliative care were identified to be at higher levels compared to health professionals who did not receive education ($p<0.05$). The points for the DAP subdimension of fear of death and death avoidance were higher for health professionals without children compared to health professionals with children. The neutral acceptance and escape acceptance levels of health professionals who had not previously lost a relative were higher, which negatively affected attitudes towards death ($p<0.05$) (Table 4).

Table 4: Comparison of mean DAP and APDDS points of health professionals according to some characteristics

Characteristics	Scales				
	DAP				APDDS
	Fear of death	Neutral acceptance	Escape acceptance	General attitude toward death	
	x̄ and SS	x̄ and SS	x̄and SS	x̄ and SS	x̄ and SS
Man	2.7±1.4	4.7±1.5	4.0±1.8	4.2±0.7	3.0±0.9
Woman	3.6±1.3	3.4±1.2	4.3±1.4	4.5±0.7	3.5±0.9
*Statistic	**p=0.05** t= 0.7	p=0.828 t=0.1	p=0.648 t=1.7	p=0.270 t=0.2	p=0.125 t=0.2
Has children					
Yes	3.2±1.3	4.79±1.5	4.1±1.5	4.5±0.7	3.5±0.9
No	4.0±1.3	5.0±1.3	4.5±1.2	4.4±0.7	3.1±0.9
*Statistic	p=**0.046** t=0.0	p=0.537 t=0.3	p=0.466 t=0.6	p=0.773 t=0.0	p=0.129 t=0.0
Received education about palliative care					
Yes	3.5± 1.6	5.2± 1.1	4.6± 1.6	4.1 ±0.8	3.9±0.5
No	3.5±1.3	4.7± 1.5	4.1 ±1.4	4.5±0 .7	3.2±0.9
*Statistic	p=0.996 t=0.342	p=0.278 t=0.1	p=0.350 t=0.0	p=0.114 t=0.2	p=**0.026** t=3.4
Previous loss of someone close					
Yes	3.5±3.1	5.0±3.7	4.4±3.0	4.4±4.4	3.4±3.2
No	1.2±2.2	1.3±1.8	1.3±2.1	0.7±0.6	0.8±1.3
*Statistic	p=0.461 t=12.51	**p=0.034** t=1.3	**p=0.023** t=2.8	p=0.994 t=0.7	p=0.626 t=3.8
**Independent t test*					

Correlation analysis between attitudes about death and attitudes about death with dignity principles of caregivers identified positive and moderate correlations between the Death Attitudes Profile subdimensions of fear of death and death avoidance, neutral acceptance and approach acceptance and escape acceptance with the APDDS ($p<0.05$) (Figure 1).

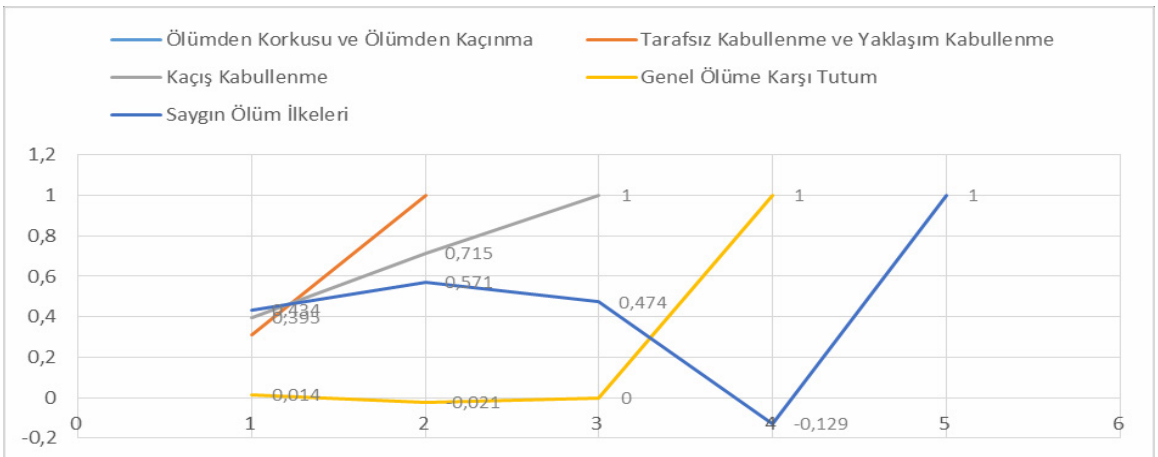

Figure 1: Correlation of DAP and APDDS for caregivers

Positive and moderate levels of correlation were identified between the DAP subdimension of escape acceptance with the APDDS ($p<0.05$). The APDDS levels of caregivers were identified to be positively and highly correlated with the general DAP levels of health professionals ($p<0.05$) (Figure 2).

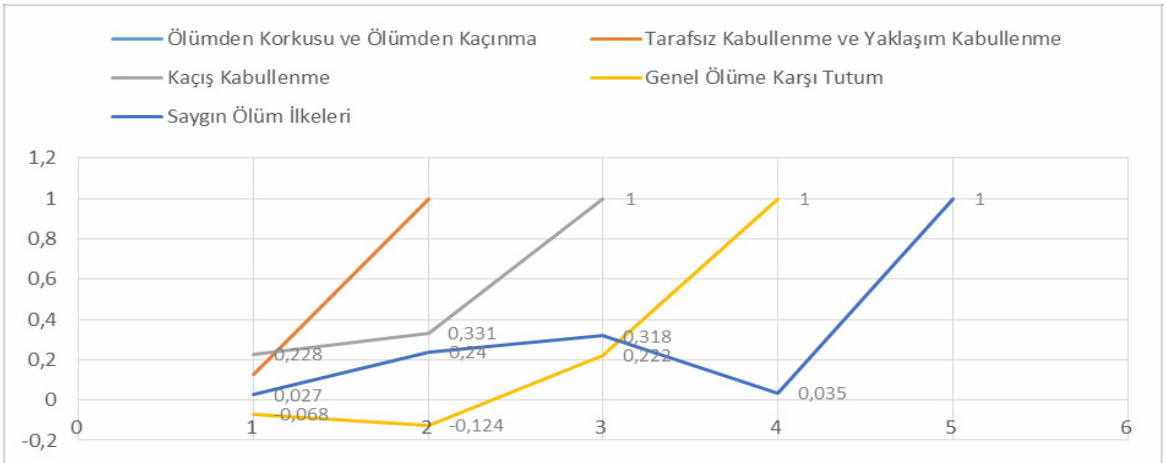

Figure 2: Correlation graph of DAP and APDDS for health professionals

Discussion

The attitudes toward death of health professionals were determined to be at moderate levels. When points obtained from subdimensions of the scale are investigated, there was a more positive approach to fear of death and death avoidance, while there was a more negative attitudes to the neutral acceptance and approach acceptance dimension. According to these results, health professionals were identified to have more negative attitudes to believing there is life after death and death being an unavoidable part of life. There were higher beliefs that avoiding talking or thinking about death would reduce the fear and anxiety caused by death (Table 1). Caregivers were identified to have moderate levels of attitudes toward death. When points obtained from the subscales are investigated, there was very little difference between the points, while caregivers who were patient relatives were identified to have more positive attitudes to the fear of death and death avoidance subscale and more negative attitudes to the neutral acceptance and escape acceptance subscale (Table 1). There may be two reasons for the mean points received from the DAP and its subscales by these two groups living in the same society being similar; the first is interactions between the perceptions of caregivers and health professionals and the second is that members of the same society have similar perceptions about death, a cultural element. In both situations, the attitudes of health professionals affect caregiving relatives and the attitudes of caregiving relatives affect the health professionals. This result shows that increasing the attitudes toward death of health professionals in a positive way will positively increase the attitudes toward death of caregiving patient relatives. It is important that health professionals are aware of this interaction. In the literature, the study by Çevik investigated the attitudes toward death and caring for dying patients among nurses and identified the points were 3,5 for the escape acceptance subdimension and 5,5 for the neutral acceptance subdimension (3). The study by Önsöz found the mean total DAP points for intensive care nurses were 4,18±0,71 with points for the DAP subdimensions of 4,77±0,89 for the neutral acceptance and approach acceptance, 3,29±1,36 for escape acceptance, and 3,87±1,18 for the fear of death and death avoidance (11). Çelik in a study of intensive care nurses found mean total DAP points were 4,14±1,02 neutral acceptance and approach acceptance mean points were 4,70±1,31 escape acceptance mean points were 3,65±1,20 and fear of death and death avoidance mean points were 3,68±1,27 (12). A study by Maria et al. found the points for escape acceptance were 2,6 while points for neutral acceptance were 5,6 in their study performed with the aim of determining the attitudes toward death of Greek nurses (13). In studies it was identified that there were more negative attitudes for the neutral acceptance and approach acceptance subscale and more positive attitudes for the escape

acceptance subscale. These research results are compatible with our study; however, in other research assessing attitudes toward death, higher points were received for fear of death and death avoidance subscale, in other words more negative attitudes were encountered (5,14). The different results obtained in the literature lead to consideration that perception of death is shaped by many parameters including socioeconomic, cultural and spiritual factors.

No assessment could be performed as no study determining the attitudes toward death of caregiving relatives and relatives accompanying patients in palliative care clinics or other clinics was available in the literature. Those accompanying patients in palliative care especially and oncology wards experience more emotional distress than relatives accompanying patients in other clinics. Considering that relatives are expecting news about patients struggling between life and death in intensive care, we can say it is necessary to focus not just on health professionals in studies but also on patient relatives.

APDDS mean total points were 3,9±1,0 for health professionals and 3,4±1,4 for caregivers (Table 2). The points in these two groups had similar qualities. Health professionals and relatives caring for patients had higher agreement with the statements *"it is necessary to be able to access care services not just in hospital but in other environments"* and *"it is necessary to have the desired spiritual or emotional support"* compared to the other statements. It was identified that the two principles with highest agreement by health professionals and caregivers were the same. Health professionals and relatives caring for patients had lowest agreement levels with the statements *"it is necessary to know when death will come and to understand what can be expected"* and *"it is necessary to maintain control of the process or progression"* compared to the other principles. Among the notable results of this study are that both groups received similar points from the DAP and APDDS scales and both groups agreed most and least with the same principles among the death with dignity principles.

Dağ performed a study about attitudes to death with dignity principles of doctors and nurses with participation of 590 subjects (15). Doctors and nurses agreed at high rates with the death with dignity principles of being able to preserve dignity and privacy, to control pain and other symptoms, to have the desired spiritual or emotional support, to access care services not just in hospital but in other environments, to determine who will be present and who to share their final moments with, and to fulfilling previously stated wishes. The findings of this research are parallel to our study. Health professionals think that dying patients should receive care not just in hospital but also in different environments like at home, etc.

In our study, health professionals had moderate levels of agreement with the APDDS item about 'it is necessary to know when death will come and to understand what can be expected' (Table 2). A study determined that most nurses did not agree that patients should be asked about their choice of location for death (3); however, another study determined that it was important for a quality end to life and death with dignity that patients be able to choose where death will occur and have their choice respected (16). A study by Thomas determined that patients' fear of loss of dignity affected their choice of death location (17). A study determined that a poor death was qualified by patient autonomy and dignity not being respected, wishes not being fulfilled, and ineffective treatments and invasive interventions with connection to life support units to extend life meaninglessly (18). İdentified that health professionals were still uncertain about delaying life while ignoring quality of life in a study with participation of 816 nurses (19). In our study, the agreement rates with the item 'it is necessary to know when death will come and to understand what can be expected', emphasizing the importance of quality of life instead of meaninglessly extended life, were at moderate levels, which is a marker that health professionals are still uncertain about this topic.

Another item with low APDDS points compared to other items was 'it is necessary to be able to choose or control where death will occur (at home or elsewhere)' (Table 2). The reason for this item being agreed with less often may be that how and in what way death occurs is more important than where death occurs. However, hospitals may be considered better sites for death due to life-limiting diseases. Reasons affecting a better and happier form of death include the disease of the individual and pain linked to disease, as much as care. Both in research about life satisfaction in Türkiye and in most national or international statistics, there is a lack of adequate information about 'place of death'. Most people with a life-limiting disease are emphasized to die in regional or local hospitals close to where they reside (20,21).

In our research, no significant difference was determined for the total DAP and subscales according to the sex of health professionals (Table 4). A study determined mean

points for the death acceptance subscale were significantly higher for women when they analyzed the DAP with the sex factor (7). A study of students who will be health professionals determined that sex did not affect DAP total points and mean points for the subscales. These studies are consistent with our study (3).

The mean points for the DAP and subscales were higher for health professionals who had received education apart from basic education about palliative care compared to those without this education; however the difference was not significant (Tablo 4). Nurses who received education about patient care in the terminal period appeared to have significantly increased mean points for fear of death and neutral approach acceptance points after training (23). Similarly, nursing students receiving education about caring for dying patients were determined to display more positive attitudes (24).

In our research, health professionals who had previously lost a relative were determined to have higher points for neutral acceptance, approach acceptance and escape acceptance subscale points ($p<0.05$) (Table 4). A study of nursing students determined that students who had encountered death in their close surroundings had significantly higher points for the escape acceptance subscale of the DAP (25). The study is similar to our study.

Correlation analysis between the attitudes toward death and attitudes about dying with dignity principles of caregivers identified positive and moderate levels of correlation between the DAP subscales of fear of death and death avoidance, neutral acceptance and approach acceptance and escape acceptance with the APDDS (Figure 1). For health professionals, there was positive and moderate level of correlation between the DAP subdimension of escape acceptance with the APDDS ($p<0.05$) (Figure 2). According to our study, as the escape acceptance (belief in the physical and psychological salvation of life through death) subscale of the DAP increases, the levels of agreement with death with dignity principles increase. As the attitudes related to the escape acceptance subscale, explained as belief in the physical and psychological salvation of life through death, increase, the adoption levels for the death with dignity principles increase. As understood from these findings, perceptions related to death affect perceptions of death with dignity. Acceptance of death by health professionals will ensure their adoption of the death with dignity principles. For this reason, it is important that health professionals be aware of their own perceptions about death in terms of the rights of patients when caring for those with mortal diseases. Positive perceptions of death by health professionals will ensure more comfortable and positive approaches toward patients. There is no study with this finding in the literature. This result is very important in terms of impacting the approach of health professionals to dying patients.

Conclusion

With this research it was determined that the death perceptions and perceptions about the dying with dignity principles of health professionals and caregivers affect each other and are similar, some individual features affect perceptions about death and dying with dignity and the perceptions related to death with dignity in both groups were affected by perceptions of death. The results of this study are considered to guide planning for activities and organizations that will strengthen health professionals caring for dying patients in providing more effective service and the more effective participation of caregivers in this process.

Declarations

Declarations of Interest

The authors declare no conflict of interest.

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Conflict of Interest

The author declared that there is no conflict of interest

Ethical Approval

The study was approved by Ankara University Non-Interventional Clinical Research Ethics Committee (date 29/01/2018 and number 02/32).

Availability of data and material

Available.

Authors' contributions

All authors have made substantial contributions to this article being submitted for publications. All authors critically reviewed the manuscript and approved the final form.

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