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Original Article

Intensive care nurses' attitudes toward the "dying with dignity" principles and affecting factors

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Abstract

Aim: This research was conducted in order to determine intensive care nurses' attitudes toward the "dying with dignity" principles and factors affecting.

Materials and Methods: This descriptive study was conducted at the Turgut Özal Medical Center of Inonu University from June 2019 to July 2020. Nurses working in intensive care units constituted the population of the research. The research was without sampling choice, and was carried out with 204 nurses who agreed to participate in the research and fit the criteria. The "Personal Information Form" and the "Assessment Scale of Attitudes toward the Principles of Dying with Dignity" were used. Data were analyzed using weight, means, standard deviations, Mann–Whitney U, and Kruskal–Wallis H tests.

Results: It was found that the nurses' "Assessment Scale of Attitudes toward the Principles of Dying with Dignity" score was 45.7±4.25. A negative relationship was found between age and the Assessment Scale of Attitudes toward the Principles of Dying with Dignity score (r:-.181, p<0.05). Moreover, it was found that there was a statistically significant difference (p<0.05) between the Assessment Scale of Attitudes toward the Principles of Dying with Dignity score and variables such as gender, education level, working time in the profession, knowledge about the concept of "dying with dignity," and the desire to work in the intensive care unit.

Conclusion: It was determined that the nurses' attitudes toward the principles of dying with dignity were moderate, and various demographic variables had effects on Principles of Dying with Dignity.

Keywords: Death; dignity; factors; intensive care nurses

INTRODUCTION

Intensive care, also known as critical care, is a multidisciplinary and interprofessional specialty dedicated to the comprehensive management of patients having, or at risk of developing, acute, life-threatening organ dysfunction (1). The number of patients requiring intensive care has gradually increased over time due to advances in science and technology, prolonged lifespan, increases in chronic diseases, and complex health problems (2-4). Intensive care units are special units where life-saving medical treatment is applied in order to provide the highest level of care to patients with life-threatening conditions, as well as being advanced in terms of technological equipment and using multidisciplinary teams (5,6).

Despite the fact that there are complex and advanced treatment and maintenance practices in intensive care units, death is frequently encountered in these units because they involve caring for critically ill and injured patients (7,8). However, the use of life support systems and scientific advances in intensive care units has changed the way death occurs at the present time, allowing the life and death process to be prolonged (9). Nurses, as healthcare providers, play a key role in caring for dying individuals and their families (10). The care that nurses provide to terminally ill or dying patients may be affected by their attitudes toward death (11).

Nurses can provide a respectful death environment for patients by giving quality end-of-life care in intensive care units (12). Human dignity has become an important aspect of health and social care (13). Pullman and Leung defined dignity as a human right that applies equally to all, regardless of circumstances, and that can neither be taken nor lost (14,15). The aim of dying with dignity is to prevent unnecessary stress, to reduce pain and suffering, to avoid exposure to traumatic treatment interventions, and to make the person feel valued. It also aims to allow them to be with their loved ones in the last moments of life and to have the opportunity to say goodbye to them. In this way, the goal is that the person's death is more respectful, dignified, painless, and peaceful (16,17). Guo and Jason have listed the themes of dying with dignity

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as follows: human rights, autonomy and independence, relieved symptom distress, respect, being human and being the self, meaningful relationships, dignified treatment and care, existential satisfaction, privacy, and a calm environment (18).

In order to provide a respectable death process for intensive care patients, it is very important that nurses adopt dying with dignity principles and provide care along with these principles, as well as being aware of the biological, psychological, social, cultural, and spiritual needs of dying patients and their relatives (19,20).

Research regarding the dying with dignity concepts is newly emerging in Turkey. Although there have been studies investigating the concepts of death, euthanasia, end-of-life care, and death anxiety in professionals, there are very few studies on attitudes toward the principles of dying with dignity. This research was conducted in order to determine the attitudes of intensive care nurses with regard to the principles of dying with dignity and factors affecting it.

MATERIALS and METHODS

Research type: This research is descriptive.

Place and time of the research: This research was conducted at the Turgut Ozal Medical Center of Inonu University from June 2019 to July 2020.

Population and sampling: The population of the research included intensive care nurses working at Turgut Özal Medical Center. The research was aimed to reach the entire population (350), hasn't been used for the sample selection. Nurses, who were on leave during the research (40), did not want to participate (33), and filled in the forms incompletely (7) were excluded from the sample. The scope of the research included 204 nurses who worked in an intensive care unit for at least three months and who volunteered to participate in the research. 58.2% of the population was reached.

Data collection

Researchers conducted the data collection at the intensive care units. The nurses working in the intensive care units were given the necessary explanations about the purpose of the research, and they volunteered to participate in it. Written or verbal consent was obtained from the nurses. Forms were distributed to the nurses to be filled in within a specific time period (10–15 minutes). While collecting the data, the researcher explained to the nurses to fill in all the answers independently and individually so that the nurses' responses would not affect each other. The completed forms were collected by the researchers. A sufficient number of forms were left at the clinic for the nurses who were on guard duty, and these completed forms were collected at the next clinic visit.

Data collection tools

Two separate forms were used in order to collect the data for the research. The first one was the Personal Information Form regarding the nurses, which was prepared by the researchers in line with the literature (6, 7, 19), whereas the second one was the Assessment Scale of Attitudes toward the Principles of Dying with Dignity (ASAPDD).

Personal Information Form

There were eight questions regarding the nurses' socio-demographic variables, such as age, gender, marital status, education level, and features related to working in intensive care.

Assessment Scale of Attitudes toward the Principles of Dying with Dignity (ASAPDD)

"The Assessment Scale of Attitudes toward the Principles of Dying with Dignity" is a verified and reliable scale that was made by Duyan on the basis of the published 12 Reputable Death Principles, which were identified by The Future of Health and Care of Older People and the Debate of the Age Health and Care Study Group (21). The scale consists of single factor, 12 items, and a five-point Likert-type scale. Scale items are answered by selecting one of the following options: "strongly disagree = 1, disagree = 2, neither agree nor disagree = 3, agree = 4, and strongly agree = 5." The total score that can be obtained from the scale varies between 12 and 60. In Duyan's research, the Cronbach's alpha value of the scale was identified as .89 (22). The Cronbach's alpha value of the scale was calculated as .90 in this study.

Data analysis

Data were analyzed through SPSS 23 (Statistical Package for Social Science) software. The suitability of the data to normal distribution was analyzed using Kolmogorov–Smirnov and Shapiro–Wilk tests. Non-parametric tests were used for variables that did not fit the normal distribution. The Cronbach's alpha reliability coefficient was used to determine the internal consistency of the ASAPDD. In order to show the distribution of the socio-demographic characteristics of the nurses, the number, percentage, mean, and standard deviation were used. Independent-samples t-tests, Mann–Whitney U, and Kruskal–Wallis H tests were used.

Ethical issues of the research

Ethical approval for the research was obtained from the Scientific Research and Publication Ethics board of Inonu University (2019/306). In addition, permission was received from Turgut Özal Medical Center. Nurses were informed about the study, and written or oral consent was obtained from those who agreed to participate. The principle of "respect for human dignity" has been fulfilled by informing the participants about the purpose, plan, and usage of the obtained data, and the principle of "respect for autonomy" has been fulfilled by recruiting those who wished volunteered to participate in the research.

Limitations of the research

The collection of research data from a single center constituted the limitation of the research in terms of the generalizability of the results. In order not to be impressed by the answers given by the nurses, the researcher was

present with the nurses while the data were collected. Not being able to be with the nurses on guard duty is another limitation of the study.

RESULTS

The average age of the nurses participating in the study was 34.2±5.2 years old. It was found that 55.4% of the nurses were female, 58.8% were married, 74% had a bachelor's degree or higher education level, 43.6% had worked in the profession for 5–10 years, and 34.3% worked in internal intensive care units. In addition, it was identified that 57.8% of the nurses participating in the study wanted to work in another service rather than intensive care units, 74.5% did not have information about the concept of "dying with dignity," and 65.7% felt "helpless" during a patient's death (Table 1).

Table 1. The socio-demographic features of nurses who participated in the research

Socio-demographic features X±SD	Number	Percentage %
Age	**34.2±5.2**	
Gender		
Female	113	55.4
Male	91	44.6
Marital status		
Married	120	58.8
Single	84	41.2
Education level		
Vocational high school	20	9.8
Associate degree	33	16.2
Bachelor's degree and over	151	74.0
Working time in the profession		
0-5 years	50	24.5
5-10 years	89	43.6
11-17 years	38	18.6
18+ years	27	13.3
Working unit		
Internal intensive care units	70	34.3
Surgical intensive care units	67	32.8
Pediatrics intensive care units	46	22.6
Reanimation intensive care unit	21	10.3
Do you want to work in the intensive care unit?		
Yes, I want	86	42.2
No, I want to work at another service	118	57.8
Do you have information about the concept of "respectable death"?		
Yes	52	25.5
No	152	74.5
The feeling while facing patient's death		
Guiltiness	51	25.0
Unsuccess	107	52.5
Anger	89	43.6
Anxiety	30	14.7
Helpless	134	65.7
Grief / sadness	84	41.2
Fear	29	14.2

X: Ortalama, SD: Std. Deviation

The nurses' highest scores in principle of the "Principles about die with dignity" were for the following statements: "I want to be afforded dignity and privacy," "I want to have access to hospice care in any location, not only in hospital," "I want to have access to any spiritual or emotional support required," "I want to have control over pain relief and other symptom control," and "I want to have time to say goodbye, and control over other aspects of timing." In contrast, the lowest score was found for "I want to know when death is coming, and to understand what can be expected." In addition, it was found that the ASAPDD score for the nurses was 45.7±4.25. According to the mean score obtained from the scale, it was observed that intensive care nurses had high levels of adoption of principles about die with dignity. (Table 2).

Table 2. The mean scores of the nurses' Principles of Good Death

"Principles of Good Death"	Min- Max	X±SD
3. To be afforded dignity and privacy	1.0-5.0	4.47±0.78
8. To have access to hospice care in any location, not only in hospital	1.0-5.0	4.33±0.87
7. To have access to any spiritual or emotional support required	1.0-5.0	4.29±0.92
4. To have control over pain relief and other symptom control	1.0-5.0	4.28±1.04
11. To have time to say goodbye, and control over other aspects of timing	2.0-5.0	4.27±0.71
9. To have control over who is present and who shares the end	2.0-5.0	4.17±0.79
2. To be able to retain control of what happens	2.0-5.0	4.13±0.83
10. To be able to issue advance directives which ensure wishes are respected	2.0-5.0	4.12±0.80
5. To have choice and control over where death occurs (at home or elsewhere)	1.0-5.0	4.12±0.78
6. To have access to information and expertise of whatever kind is necessary	1.0-5.0	4.05±0.75
12. To be able to leave when it is time to go, and not to have life prolonged pointlessly	1.0-5.0	3.89±1.13
1. To know when death is coming, and to understand what can be expected	1.0-5.0	3.75±1.30
Total scale	33.0-54.0	**45.7±4.25**

X: Mean, SD: Std. Deviation

It was found that there was a weak negative correlation between age and ASAPDD scores, and the difference between them was statistically significant (r:-.181, p<0.05). The difference between gender, marital status, and the mean score of the ASAPDD was not statistically significant (p>0.05), but female and married nurses had higher levels of adoption of principles about die with dignity. The difference between the level of education, the duration of work in the profession, and the mean score of the ASAPDD was statistically significant (p<0.05). It was determined that those nurses who had a bachelor's degree or higher education level (49.9±4.7) and 18 or more years of professional experience (50.5±4.2) had higher levels of adoption of principles about die with dignity. It was found that the difference between the working unit and the mean of the ASAPDD score was not statistically significant (p>0.05); however, the nurses working in the internal intensive care units had the highest ASAPDD scores. The difference between the variables of desire to work in intensive care, having knowledge about "dying with dignity," and the mean score of the ASAPDD was statistically significant (p<0.05). It was found that nurses who desired to work in intensive care units adopted more principles about die with dignity (Table 3).

Table 3. Comparison of the Nurses' Socio-demographic Characteristics and Assessment Scale of Attitudes toward the Principles of Dying with Dignity (ASAPDD)

Socio-demographic Characteristics	N	M±SD	Test and p value
Age		r: -181	
		p=0.014	
Gender			
Female	113	48.9±4.5	t=.946
Male	91	48.3±4.0	p=0.355
Marital status			
Married	116	116	t=-.725
Single	88	88	p=0.470
Education level			
Vocational high school	20	46.1±4.1	
Associate degree	33	47.7±3.9	KW=11.468
Bachelor's degree and over	151	49.9±4.7	**p=0.030***
Working time in the profession			
0-5 years	50	46.8±3.8	
5-10 years	89	45.7±4.1	KW:14.617
11-17 years	38	49.9±5.4	**p=0.002***
18+ years	27	50.5±4.2	
Working department			
Internal intensive care units	67	47.1±3.5	
Surgical intensive care units	70	45.9±4.7	KW:1.641
Pediatrics intensive care units	46	46.9±4.4	p=0.650
Reanimation intensive care unit	21	46.5±4.2	
Do you want to work in the intensive care unit?			
Yes, I want	86	47.3±4.0	MWU:3128.5
No, I want to work at another service	118	44.2±4.4	**p=0.010***
Do you have information about the concept of "respectable death"?			
Yes	52	50.1±4.2	MWU:4983.0
No	152	46.3±3.9	**p=0.000**

N: Number, X: Mean, SD: Std. Deviation, t: Independent-Samples T-Test, MWU: Mann-Whitney U, KW: Kruskal-Wallis H Test

DISCUSSION

The results of our research of evaluating the attitudes of nurses working in intensive care units toward principles about die with dignity are discussed with the related literature. It was determined that the nurses scored 45.7±4.25 points from the ASAPDD, and the levels of adopting respectable death principles were high. In the study carried out by Celik, it was determined that the intensive care nurses scored 43.9±11.0 points from the ASAPDD (23). In one of the studies conducted in Turkey, it was seen that the nurses and physicians working in intensive care units had high levels of adoption of dignified death principles and scored 50.60±6.6 points on the ASAPDD (24); in another study, the nurses scored 49.8±7.2 points (25). Mean scores of both have been seen to be close to each other. Physicians and nurses

play an important role in providing humane and dignified healthcare services that the patient will need in the last days of life (24). The high level of adoption of dying with dignity principles in this study plays an important role in improving the quality of the end-of-life care given. It is thought that with nurses' increased awareness dying with dignity, communication with dying patients and families will also improve.

In our study, it was determined that the nurses adopted the principle of "I want to be afforded dignity and privacy" the most frequently. In the research conducted by Demir et al., and Dag and Badir it was found that the health workers mostly adopted the principle of "to be afforded dignity and privacy" (3,19). The research conducted by Duyan et al. found that social workers ranked the principle of "to be afforded dignity and privacy" as third among the most widely adopted principles (26). In the results of other research conducted in the literature, it was determined that the protection of dignity in death is important for the deceased patients, their families, and healthcare providers (27,28). In addition, the protection of privacy in Turkey is legally guaranteed. According to a provision in the 21st item of the "Patient Rights Regulation," "It is essential to respect the patient's privacy. The patient may also explicitly request the protection of his/her privacy. Any medical intervention performed should respect the patient's privacy" (29). Ensuring the confidentiality of patient data is a requirement of respect for the patient's right to privacy (30).

The nurses also adopted the following principles: "I want to have access to hospice care in any location, not only in hospital" "to have access to any spiritual or emotional support required", "to have control over pain relief and other symptom control", "to have time to say goodbye, and control over other aspects of timing", and to have control over who is present and who shares the end." In Dag and Badir's research, it was found that physicians and nurses agreed on the following principles: "to have control over pain relief and other symptom control", "to have access to any spiritual or emotional support required", "to have access to hospice care in any location, not only in hospital", and to have control over who is present and who shares the end" (19). Moreover, Demir et al., found that "I want to have access to any spiritual or emotional support required", "to have control over who is present and who shares the end", "to have access to hospice care in any location, not only in hospital" and "to have control over pain relief and other symptom control" were the principles that nurses adopted (3). Kose et al., evaluated the nurses' "thoughts and attitudes towards death," and determined that 77.9% of the nurses visited their deceased patients and 89.9% wanted to be taken to the patients' relatives. The same research asked nurses, "What do you think is important when you die?" to which 56.2% of the nurses answered that relatives should be there (31). Even though the order of the principles adopted by nurses varies, it is generally seen that families, social support, and symptoms management are always important.

According to our research results, a significant negative correlation was found between age and the "Assessment Scale of Attitudes toward the Principles of Dying with Dignity" score. It has been determined that the level of adopting respectable death principles decreases with an increase in age. Dag and Badir determined in their study that the ASAPDD scale score decreased as the age increased (19). In another study conducted in Turkey, there was a significant difference between the age groups and adopting the respectable death principles; it was found that the 33–38 age group of nurses had higher levels of adopting the principles of a good death than the nurses who were 39 and older (32). Lange and his colleagues found that there was a significant difference between the age groups of nurses and their attitudes toward the care for dying patients. They found that those over 50 years old were more positive in their attitudes toward death (33). However, the research by Hasgul regarding home care students found no significant difference between age and adopting respectable death principles (34). In this study, it is thought that the negative correlation between age and adopting principles about die with dignity may increase due to the knowledge of new graduates and post-life care.

This study found that the difference between gender and the ASAPDD point average was not statistically significant, but that female nurses' average ASAPDD scores were higher than those of male nurses. In the research by Gurdogan et al., it was found that the difference between gender and the ASAPDD score was statistically significant and that women had higher levels of adopting principles about die with dignity (25). In another study conducted with students who intended to become health professionals, it was determined that women are considered to be neutral toward death and men have higher death anxiety (35). In Uzunkaya's thesis, it was stated that female nurses' perceptions of good death were better than those of male nurses. This may be the reason women have taken on a caring role since ancient times and have become more sensitive (32).

It was determined that the difference between the variables of education level and knowledge of the concept of dignified death regarding the average ASAPDD score was statistically significant, and that those with a bachelor's degree or higher education levels had the highest levels of acceptance of principles about die with dignity. Similar to our study, Demir et al., determined that there was a significant difference between the level of education and the ASAPDD score: it was determined that the nurses who had undergraduate and graduate education degrees had the highest levels of adoption of principles about die with dignity (3). In the research carried out by Dag and Badir, there was no significant difference between the education levels of the nurses and the mean score of the ASAPDD; however, the difference between the education levels of the doctors and the mean score of the ASAPDD was found to be statistically significant. It was determined that specialist doctors adopt of principles about die with dignity more frequently (19). In the research conducted

by Gurdogan et al., no significant difference was found between the education levels of nurses and principles about die with dignity. However, those who had a higher education degree had higher levels of adopting principles (25). Focusing on topics such as end-of-life care training for nurses during undergraduate education, approaches to patients, and practices in the terminal period may have created this difference. It was stated that 62.3% of the nurses who participated in Uzunkaya's thesis study received training on taking care of dying patients. Approximately one third of them received training during undergraduate or in-service education, and 50.5% did not find this training sufficient (32). Other research results in the literature indicate that nurses' education about death and end-of-life care is inadequate (36, 37). However, it is stated in the literature that education about death can be useful for changing the negative attitudes toward caring for the terminal and gaining the knowledge, psychosocial skills, and cultural sensitivity necessary for the formation of positive attitudes (6). In the current study, it was determined that the number of nurses who had knowledge of the concept of respectable death was small (25.5%), but this group's level of knowledge of respectable death was significantly higher. It is anticipated that education about death, the approach to terminal patients, and dying with dignity will improve nurses' perceptions of care.

It was determined that the difference between the duration of working in the profession and the mean score of the ASAPDD was statistically significant ($p<0.05$) and that the nurses working for 18 years or more had the highest levels of adopting the respectable death principles. Gurdogan and his colleagues identified a positively significant correlation between the length of time working in the field and the ASAPDD score as well (25). In different studies from the literature, it has been determined that there is a significant difference between working time and attitudes toward death and terminal patients (33, 38). These results are in line with our research findings. It is thought that many care experiences professionals have can be effective at increasing improving perceptions about respectable death. There was no significant correlation between working in the intensive care unit and the ASAPDD ($p>0.05$), but nurses working in internal intensive care units were more likely to adopt the principles about die with dignity. In the study by Dag and Badir, no significant difference was found between the working unit of the nurses and the ASAPDD score. However, it was determined that the physicians working in the internal diseases units adopted the principles of dying with dignity more (19). A different study found that intensive care workers in surgical units had lower levels of adopting principles of dying with dignity than participants working in general intensive care ($p<0.01$) (24). It was determined that the nurses who wanted to work in intensive care units were more likely to adopt principles about die with dignity and that the difference between the groups was significant ($p<0.05$). Similarly, Kose et al. found that those who liked working at their current unit adopted principles about die with dignity and that the difference between the groups was significant (24). Furthermore, there was no significant difference between the nurses' willingness to continue working in oncology and the mean score of the ASAPDD ($p>0.05$) in Uzunkaya's thesis (32). It is believed that working voluntarily in clinics where complex treatment and care practices, such as intensive care, are carried out, doing work with love increases the level of adoption of the principles.

CONCLUSION

According to the results of the current research, it was found that intensive care nurses had a high level of adoption of dignified death principles, and variables such as age, gender, education level, working time in the profession, knowledge of the concept of respectable death, and willingness to work in intensive care affected the level of adoption of these principles. Studies comparing the various demographics of nurses and the respectable death principles are rare in the literature. In this context, it is recommended to conduct descriptive or experimental research on wider sample groups. For the improvement of maintenance, it is recommended that principles of dying with dignity are adopted by institutions and organizations providing healthcare, that care services are organized in line with those principles for patients who are in their last days of life, and that physicians and nurses who are trained and experienced in end-of-life care are assigned in units that provide end-of-life care.

Conflict of interest: The authors declare that they have no competing interest.

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