

The Impact of Geography and Occupation on the Perspective of the Good Death Among the Healthcare Professionals: A Cross-sectional Study

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Abstract

Objective: The aim of this study was to investigate the perspective of good death and related factors among healthcare professionals (HCPs), as well as to compare the perspective of good death regarding to live region and occupation.

Materials and Methods: This cross-sectional study was performed one hundred ninety-five HCPs. The good death scale (GDS) was used to assess the perspective of HCPs on the concept of good death.

Results: A total of 195 HCPs were included in this study. One hundred twenty-four (63.6%) participants were women. Ninety-eight (50.3%) and 95 (48.7%) of the participants were registered nurses and were living in the east, respectively. Seventy-five (38.5%) of the participants had 11 years or more of professional experience, and 132 (67.7%) of them grew up in the region where they worked. The mean score of all participants in GDS was 57.5 ± 6.3 , and the mean scores of the sub-dimensions were 30.9 ± 3.8 for the "psychosocial and spiritual sub-dimension", 10 ± 1.9 for the "personal control sub-dimension" and 16.6 ± 2.4 for the "clinical sub-dimension". In multiple linear regression, living in the east, being a nurse, being a woman, and taking education on "good death" were positively related to the GDS score of the HCPs.

Conclusion: Given the growing importance of "good death," it is increasingly important to clarify the definitions and constantly raise awareness by providing appropriate education. In this study, the small number of participants and the inhomogeneous distribution of the sample by age, gender, occupation, and region could lead to potential biases and concerns about generalizability. It is recommended to conduct research using a scale to assess nurses' and doctors' perceptions of death in a more homogeneous and larger group.

Keywords: Advance directive, geriatric nursing, geriatric palliative care, geriatric psychology, good death, psychological gerontology, social gerontology

Introduction

As known, the place of death has changed over the years, and most deaths from all causes occur in the hospital. This suggests that in the last moments before death, people are more likely to be accompanied by healthcare professionals (HCPs) than

by their families. Therefore, HCPs are increasingly focusing on providing patient-centered care that respects individuals' values, preferences, and dignity, especially at the end of life and, the concept of a good death is becoming more significant in the daily practice of HCPs.

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The definition of a "good death" is indeed subjective and can vary depending on various factors, such as political, individual, social, cultural, and religious perspectives (1). Common fundamental features of "good death" in modern medicine are pain relief, preserving dignity, family support, respect for patients' autonomy at the end of life and chance to "settling personal matters". Furthermore, it should reflect the needs of the community, especially those of the dying individual and their relatives (2). Advance directives (ADs) play a significant role in facilitating good death by allowing individuals to express their preferences and provide guidance to their HCPs. However, the good death can be difficult to adapt these definitions conceptually to life in practice, especially in countries without ADs.

Previous studies have shown that western society values individualism, independence, and autonomy of the individual, while eastern society generally values collectivism, interdependence, and autonomy, which is mainly centered on the family. Turkey, located at the crossroads of Europe and Asia, has a rich structure that is a synthesis of eastern and western cultures. In addition to the differences in regional perspectives on good death, there may be differences in the professional perspectives of HCPs (3). For example, although there is agreement among HCPs with painless death, dying in sleep and not being a burden to the relatives of the patients are seen as more important to nurses (4). We must create a one-size-fits-all approach that meets all of these expectations. Therefore, for a society that has not yet established ADs, studies on attitudes toward and perspectives on the concept of good death are needed first. Good death studies in Turkey are generally conducted with nurses, patients, and family members. The differences between eastern and western cultures were not investigated in these studies. The purpose of this study was to investigate factors affecting the perspectives of HCPs on the concept of good death, especially in terms of region and profession. This study can provide valuable insights into the cultural, ethical, and professional factors that shape end-of-life care practices.

Materials and Methods

Setting and Participants

G*Power 3.1 software was used for sample size estimation. The sample size was calculated as 184 participants, 92 participants at the western tertiary hospital, 92 participants at the eastern tertiary hospital, with an effect size of 0.5, a margin of error of 0.05, and a power of 0.95 to represent the universe (5).

This cross-sectional study was performed with 100 HCPs at Ege University Hospital (western group) and 95 HCPs at University of Health Sciences Turkey, Gazi Yaşargil Training and Research Hospital (eastern group) between November 2022 and December 2022. The HCPs included in the study were divided into groups

according to region (west or east) and occupation [internal medicine physician (MD) or registered nurse (RN) working in internal medicine ward]. Ethical approval for the study was granted by Ege University Clinical Research Ethics Committee (approval number: E-99166796-050.06.04-978843, date: 08.11.2022).

Study Measurements

The questionnaire form was developed following the literature review of "good death" issue. The online questionnaire was entered into Google Forms through Google Drive to share with participants and collect data. Data from HCPs participating in this study were collected online. At the beginning of the online survey, a section was created in which the participants declared that they were willing to participate, as well as providing informed consent and information about the study. Demographic data, attendance to courses or modules of death education, definition of death, and good death were asked, and a good death scale was administered. The characteristics of HCPs affecting the view on good death were assessed through sociodemographic characteristics (age, sex, occupation, region), individual experience (definition of death and good death, getting education on "good death" and "end of life", having family member with cancer, previously giving care to family member with terminally ill), and professional experience (working time in internal medicine clinic, talking about "death") (6).

The good death scale (GDS) was used to assess the perspective of HCPs on the concept of good death (7,8). This scale was developed by Schwartz et al. (7) in 2003 to measure perceptions of good death among HCPs. The validity and reliability of the Turkish version of the good death scale was adapted, and the general Cronbach's alpha coefficient was found to be 0.92. The scale comprises 17 questions and three sub-dimensions. The first sub-dimension consists of 9 questions describing the psychosocial and spiritual aspects of death (4th, 6th, 7th, 8th, 9th, 10th, 11th, 12th, 13th questions) and is named the psychosocial-spiritual sub-dimension. The second sub-dimension consists of 3 questions that define mental attention, communication ability, and control of physical functions (15th, 16th, 17th questions) and is named personal control sub-dimension. The third sub-dimension consists of 5 questions describing the clinical or biomedical aspects of death (1st, 2nd, 3rd, 5th, 14th questions) and is named the clinical sub-dimension. Each item in the scale was evaluated using a four-point Likert scale (not necessary: 1 point, desirable: 2 points, important: 3 points, essential: 4 points). There are no reverse-scored items. The total scale score varies between 17-68 points.

Statistics

All statistical analyses were performed using SPSS Statistics 25.0. A p-value of <0.05 was considered statistically significant.

Data normality was obtained using skewness and kurtosis (acceptable values felt between -3 and +3). The chi-squared (χ^2) test and Fisher's exact test were used to compare categorical variables, while the independent sample t-test and Mann-Whitney U test were used to compare continuous variables. Baseline characteristics of the study population are presented as means \pm standard deviations for normally distributed continuous variables or medians and minimum-maximum values for skewed continuous data. The multivariate analysis included parameters that were significant in univariate analysis. Multiple linear regression, the "backward" method, was used to define descriptive variables on the good death scale. $P < 0.05$ was identified as significant in this study. Numbers and percentages are used for categorical variables.

Results

Characteristics of the Participants

One hundred ninety-seven individuals answered the online questionnaire. Two of them were excluded due to their refusal to participate in the study. The mean age of all participants was 32.8 ± 6.6 years (63.6% female, 63.1% married, 50.3% RN). A total of 49% (n=95) were participants in the east. Seventy-five (38.5%) of the participants had 11 years or more of professional experience, and 132 (67.7%) of the participants grew up in the region where they worked. The mean score of all participants in GDS was 57.5 ± 6.3 , and the mean scores of the sub-dimensions were 30.9 ± 3.8 for the "psychosocial and spiritual sub-dimension", 10 ± 1.9 for the "personal control sub-dimension" and 16.6 ± 2.4 for the "clinical sub-dimension". The mean scores of the GDS, the psychosocial-spiritual sub-dimension and the clinical sub-dimension were higher in RNs than in internal medicine MDs ($p=0.008$, $p=0.05$ and $p=0.006$ respectively), while the mean score for the personal control sub-dimension was higher in the east than in the west ($p=0.04$). As a further analysis, the scores given by west and east, by nurses and physicians to the 17 questions of the scale were analyzed separately on a question-by-question basis and are presented in Table 1. When the mean scores for GDS items were examined, "that it be peaceful" (3.87 ± 0.4 vs 3.8 ± 0.4 for west and east, 3.8 ± 0.4 vs 3.9 ± 0.3 for MDs and RNs) and "that the person's

spiritual needs be met" (3.7 ± 0.5 vs 3.8 ± 0.4 for west and east, 3.7 ± 0.5 vs 3.8 ± 0.4 for MDs and RNs) were found to be the items with the highest mean scores in both region and occupation. However, "that it be painless or largely pain-free" was more important item on "good death" for MDs, while "that loved ones be present" was more important item on "good death" for RNs. Sub-dimensions and items of GDS regarding occupations and regions are presented in Supplementary Material.

The statistics related to scale scores and their results are presented in Table 2. Backward multiple regression analysis showed that region, occupation, gender, and education on "good death" were associated factors of good death scale ($R^2 = 0.114$, $F = 6.128$, $p < 0.001$; Table 3). Living in the east, being a nurse, being a woman, and taking education on "good death" were positively related to the HCPs' score on the good death scale.

Discussion

The perception of good death can be influenced by education, faith, the environment in which we have grown up, and personal experiences. Using the good death scale, we investigated the impact of geography and occupation on HCPs' views of good death. The good death scale score was higher for RNs than for MDs, but there was no statistical difference between the west and the east. Backward multiple regression analysis revealed that living in the east, being a nurse, being a woman, and taking education on "good death" were positively associated with good death scores of HCPs.

Most studies have investigated MDs' attitudes toward euthanasia, physician-assisted dying, or knowledge about brain death. Unfortunately, there are only a few studies on the attitude toward death of MDs. RNs have a more positive attitude toward death than MDs in our study. Studies have shown that nurses have adopted the phenomenon of death as a natural process of human life (9). Nurses may also have a higher perception of good death, as palliative care and end-of-life care are core components of the nursing curriculum in Turkey. However, these issues play a comparatively minor role in medical education. Medical education in Turkey is more focused on disease diagnosis and treatment.

Table 1. The statistics of answers given by the healthcare professionals to the scale questions

QN, questions	West mean \pm SD	East mean \pm SD	p	MD mean \pm SD	RN mean \pm SD	p
Q3. That it be sudden and unexpected	3.2 ± 0.8	3.4 ± 0.8	0.139	3.13 ± 0.8	3.4 ± 0.8	0.027
Q5. That it occur naturally, without technical equipment	3.1 ± 0.9	3.2 ± 0.7	0.221	3 ± 0.9	3.3 ± 0.7	0.003
Q7. That loved ones be present	3.6 ± 0.8	3.7 ± 0.5	0.24	3.5 ± 0.7	3.8 ± 0.6	0.001
Q8. That the person's spiritual needs be met	3.7 ± 0.5	3.8 ± 0.4	0.03	3.7 ± 0.5	3.8 ± 0.4	0.226
Q17. That the ability to communicate be present until death	3.2 ± 0.7	3.5 ± 0.7	0.021	3.3 ± 0.8	3.4 ± 0.7	0.354

QN: Question number on the good death scale, X: Means, SD: Standard deviation, MD: Internal medicine physician, RN: Registered nurse

Table 2. Statistics of the healthcare professionals on good death scale and sub-dimension of psychosocial-spiritual, personal control, and clinical

	Good death scale X±SD	Psychosocial-spiritual X±SD	Personal control X±SD	Clinical X±SD
Gender, n (%)				
Female, 124 (63.6)	58.4±5.5	31.3±3.4	10.1±1.8	17±2.2
Male, 71 (36.4)	56±7.2	30±4.2	10±2.2	16±2.5
p	0.017	0.026	0.769	0.04
Marital status, n (%)				
Married, 123 (63.1)	57.7±5.7	30.9±3.7	10.1±2	16.8±2.2
Single, 72 (36.9)	57.1±7.2	30.8±4	10.1±1.9	16.3±2.5
p	0.495	0.836	0.710	0.195
Professional experience, n (%)				
10 years and less, 120 (61.5)	57.2±7	30.7±4	10.1±2	16.4±2.6
11 years and more, 75 (38.5)	58±5	31.1±3.4	10±2	16.9±2
p	0.351	0.394	0.652	0.148
Growing up in the region where he/she work, n (%)				
Yes, 132 (67.7)	57.8±5.9	31.1±3.5	10.1±1.9	16.7±2.3
No, 63 (32.3)	56.7±6.9	30.4±4.2	9.9±2	16.5±2.4
p	0.238	0.246	0.4	0.554
Region, n (%)				
West, 100 (51.3)	57.1±6.5	30.8±4	9.8±2	16.5±2.4
East, 95 (48.7)	57.9±6.1	30.9±3.7	10.3±2	16.7±2.4
p	0.324	0.817	0.04	0.564
Occupation, n (%)				
MD, 97 (49.7)	56.3±6.7	30.3±4	9.8±2	16.1±2.4
RN, 98 (50.3)	58.7±5.6	31.4±3.5	10.2±2	17.1±2.3
p	0.008	0.05	0.148	0.006
Education on "good death", n (%)				
Yes, 12 (6.2)	62.3±6.7	33±3	10.4±2.7	18.8±1.7
No, 183 (93.8)	57.2±6.1	30.7±3.9	10±1.9	16.5±2.3
p	0.006	0.041	0.469	0.001
Presence of comorbidities, n (%)				
Yes, 38 (19.5)	58.4±5.4	31.6±3.3	9.7±1.7	17.1±2
No, 157 (80.5)	57.3±6.5	30.7±3.9	10.1±2	16.5±2.4
p	0.304	0.156	0.224	0.145
Having family member with cancer, n (%)				
Yes, 134 (68.7)	57.5±5.9	30.9±3.6	10±1.9	16.6±2.3
No, 61 (31.3)	57.4±7.1	30.7±4.1	10.1±1.9	16.6±2.5
p	0.956	0.777	0.607	0.9
Previously giving care to family member with terminally ill, n (%)				
Yes, 75 (38.5)	57.4±5.8	30.8±3.8	10±2	16.5±2.4
No, 120 (61.5)	57.5±6.6	30.9±3.8	10.1±1.9	16.7±2.3
p	0.863	0.872	0.652	0.737
Talking about "death", n (%)				
Yes, 149 (76.4)	57.7±6.4	31±3.9	10.1±1.9	16.7±2.4
No, 46 (23.6)	56.7±5.8	30.5±3.5	9.9±2	16.3±2.1
p	0.331	0.444	0.715	0.289

Less than 0.05 and significant p-values are indicated in bold
 SD: Standard deviations, X: Means, MD: Internal medicine physician, RN: Registered nurse

Table 3. Factors influencing good death scale scores in the healthcare professionals

Variables	Good death scale total	
	β (95% CI)	p*
Region (west)	0.158 (0.202, 3.738)	0.029
Occupation (MD)	0.144 (-0.00, 3.607)	0.051
Gender (female)	-0.165 (-4.060, -0.214)	0.03
Education on "good death" (no)	0.232 (2.440, 0.606)	0.001
R ² =0.114, Adj. R ² =0.096, F =6.128, p=0.000		
*Backward multiple regression analysis CI: Confidence interval, MD: Internal medicine physician, Adj. R ² : Adjusted R ² , β: Standardized estimates		

Nurses have more contact with end-of-life patients than other HCPs (10). Thus, most research on attitudes toward death has focused on nurses. The good death scores assessed by GDS range from 52 to 60 in RNs working in different clinics. Our results revealed that nurses' attitudes toward death were similar to those reported in other studies (6,11,12). It is known that nurses play a significant role in understanding AD and end-of-life care (13,14). Attitudes toward death were positively correlated with attitudes toward AD (15). Turkey is a country where written AD is not legal. Nevertheless, previous studies have shown that Turkish nurses' attitudes toward death were positively. This gives us the advantage of planning a good death even if we do not have an AD procedure.

In our study, "that loved ones be present" was more important component of "good death" in RNs than in MDs. Likewise, Yun et al. (16) found that "that loved ones be present" has been recognized as the most important fundamental element of a good death by patients and their families but not by MDs. On the other hand, "not being a burden to the others" had the importance on definition of good death for both RNs, MDs, and patients in the studies, as well as in our study (4,16). In addition, "that it be painless" was considered the most important component of a good death for MDs. The reason is that the MDs' views on a good death were more biomedical than those of RNs. Individual health beliefs and perspectives on good death care are important components in developing strategies to improve AD. This means that HCPs should be aware of the cultures and beliefs of patients in their care (17). HCPs are ambivalent about the dignity of dying, as they try to define what it means to good death (18).

Uzunkaya Oztoprak and Terzioglu (6) showed that talking to patients about death did not influence views about a good death and attitudes toward the principles of dying with dignity, but had a positive impact on attitudes toward care for dying patients. Our study also found that talking about death did not affect attitudes toward death. Nurses are frequently required to accompany and care for dying patients (19). Most symptoms experienced by patients at the end of life are often reported to nurses or assessed by hospital nurses. Therefore, nurses typically spend more time with patients in the hospital than MDs during

the latter days of patients (6). In our study, RNs had a higher score for good death than MDs. Nurses' attitudes toward death may be more positive than those of MDs, as nurses often care for dying patients. The concept of "good death" may be secondary, as the primary goal of physicians is to prolong patient life. However, a recent study indicated that MDs should play a leadership role in ensuring a good death for patients at the end of life (20). Another reason may be that MDs focus entirely on treatment, whereas nurses focus on care and healing. Acceptance of death also influences HCPs' attitudes toward death (21). Sofia et al. (22) found that RNs were more "afraid of death" but more likely to accept death than MDs.

The attitude toward death is influenced by subjective well-being, age, gender, working in intensive care units, losing relatives with cancer, death experience, personal and professional characteristics (6,9,11,23,24). However, we found that only female gender had a positive effect on GDS scores. Similar to our study, recent studies have shown that female gender has a positive effect on attitudes toward death (6,25).

The effect of education on attitudes toward death has been demonstrated to be important. Ceyhan et al. (11) reported that intensive care education status and receiving information about death at the end of life had no effect on good death scores. In contrast to "end of life" education, "good death" education had a positive effect on GDS scores. Even though the number of individuals with education on "good death" was small in our study, the impact of such education was still noticeable. Therefore, it is important to include issues of good death in nursing education programs as well as in-service training programs.

In Turkey, AD planning includes only organ and tissue donation by law. Do-not-resuscitate orders are strictly prohibited. Patients in inpatient wards have the right to refuse treatment only which will not cause fatal organ damage. This means that HCPs have to decide what is best for the patient, even at the end of life. Stigma against suicide in HCPs decreased with increasing positive attitudes toward death (26). Therefore, the perception of good death is of particular importance in developing countries that do not have written AD.

Study Limitations

One of the limitations of this study is that it was conducted with a small number of participants. Sample distribution by age, gender, occupation, and region was not homogeneously. The quality and content of the received education on "good death" were unknown. In addition, the perspective of good death can be influenced by many factors, depending on personality, culture, and the individual. Therefore, the low R-squared value in the linear regression indicates that this study should be repeated with larger and more homogeneous groups, with the addition of more factors that may influence the perspective of good death.

Conclusion

It may not be possible to achieve a single definition of good death, mostly because it depends on the complex interaction between the needs of the limitations of the healthcare system and the dying patients (18). A positive attitude toward death improves the quality of death. Given the growing importance of "good death," it is increasingly important to clarify the definitions and constantly raise awareness by providing appropriate education. It is recommended to conduct research using a scale to assess nurses' and doctors' perceptions of death in a more homogeneous and larger group.

Ethics

Ethics Committee Approval: Ethical approval for the study was granted by Ege University Clinical Research Ethics Committee (approval number: E-99166796-050.06.04-978843, date: 08.11.2022).

Informed Consent: All patients were informed about the study protocols in details and their informed written consents were provided.

Authorship Contributions

Surgical and Medical Practices: F.Ö.K.K., S.Ç., H.E.A., S.Ö., E.S., S.Ş., Y.Y., Concept: F.Ö.K.K., S.Ş., Y.Y., Design: F.Ö.K.K., S.Ş., Y.Y., Data Collection or Processing: F.Ö.K.K., S.Ç., H.E.A., S.Ö., E.S., Analysis or Interpretation: F.Ö.K.K., Y.Y., Literature Search: F.Ö.K.K., Y.Y., Writing: F.Ö.K.K., Y.Y.

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Supplementary Material. Sub-dimensions of "good death scale"						
	West n=100	East n=95	p	MD n=97	RN n=98	p
The psychosocial-spiritual sub-dimension	30.8±3.9	30.9±3.7	0.817	30.3±4	31.4±3.5	0.05
4. That family and doctors follow the person's wishes	3.6±0.6	3.6±0.6	0.201	3.5±0.6	3.7±0.5	0.113
6. That it be peaceful	3.9±0.4	3.8±0.4	0.36	3.8±0.4	3.9±0.3	0.126
7. That loved ones be present	3.6±0.8	3.7±0.5	0.24	3.5±0.7	3.8±0.6	0.001
8. That the person's spiritual needs be met	3.7±0.5	3.8 ±0.4	0.03	3.7±0.5	3.8±0.4	0.226
9. That the person is able to accept death	3.5±0.7	3.5±0.8	0.586	3.4±0.7	3.5±0.7	0.394
10. That the person had a chance to complete important tasks	3.4±0.7	3.3±0.8	0.228	3.4±0.8	3.4±0.8	0.672
11. That the person had an opportunity to say "good-bye"	3.6±0.8	3.5±0.7	0.831	3.6±0.7	3.6±0.8	0.966
12. That the person was able to remain at home	2.7±0.9	2.8±1	0.375	2.7±1	2.8±0.9	0.190
13. That the person lived until a key event	2.9±0.9	2.8±1	0.618	2.8±1	2.9±0.9	0.290
The personal control sub-dimension	9.8±1.9	10.3±1.9	0.04	9.8±2	10.2±2	0.148
15. That there be mental alertness until the end	3.3±0.7	3.4±0.8	0.311	3.3±0.7	3.4±0.8	0.408
16. That there be control of bodily functions until death	3.2±0.8	3.5±0.7	0.051	3.2±0.7	3.5±0.8	0.051
17. That the ability to communicate be present until death	3.2±0.7	3.5±0.7	0.021	3.3±0.8	3.4±0.7	0.354
The clinical sub-dimension	16.5±2.4	16.7±2.4	0.564	16.1±2.4	17.1±2.3	0.006
1. That it be painless or largely pain-free	3.8±0.5	3.7±0.6	0.129	3.73±0.5	3.74±0.6	0.864
2. That the dying period be short	3.5±0.6	3.6±0.7	0.567	3.49±0.6	3.59±0.7	0.3
3. That it be sudden and unexpected	3.2±0.8	3.4±0.8	0.139	3.13±0.8	3.4±0.8	0.027
5. That it occur naturally, without technical equipment	3.1±0.9	3.2±0.7	0.221	3±0.9	3.3±0.7	0.003
14. That death occurs during sleep	2.9±0.9	2.9±1.1	0.851	2.8±1	3±1	0.133

MD: Internal medicine physician, RN: Registered nurse