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Research Article

The Relationship between Attitudes of Relatives of Terminal Stage Patients towards Death and Principles about Dying with Dignity

Terminal Dönem Hasta Yakınlarının Ölüme ve Saygın Ölüm İlkelerine İlişkin Tutumları Arasındaki İlişki

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Abstract

Aim: The aim of this study is to determine the relationship between the attitudes of the relatives of terminal stage patients towards death and principles about dying with dignity.

Material and Method: This descriptive cross-sectional study was carried out with 308 patient relatives between 20 December 2021 and 21 March 2022. The data were collected using a "Patient Information Form", 'Death Attitude Profile-Revised (DAP-R)' and 'Assessment Scale of Attitudes towards Principles about Dying with Dignity' (ASAPDD). Descriptive statistics, Student t test, One-Way ANOVA test, Kruskal Wallis test, Mann Whitney-U test, Pearson correlation and regression analysis were used to analyze the data.

Results: The mean age of the relatives of the patients participating in the study was 34.88±2.32, 86.0% were female. 38.6% of the relatives of the patients stated that the patient in the intensive care unit was their mother/father, and 44.1% stated that the patient stayed in the intensive care unit for 3-7 days. The mean DAP-R total score was 107.30±25.1 and the ASAPDD total score was 30.62±10.70. A positive and highly significant relationship was found between DAP-R and ASAPDD.

Conclusions: It was determined that as the attitudes of the relatives of the patients towards death became negative, the level of adopting the principles about die with dignity increased. Health professionals should provide death counseling to the relatives of patients in order to increase the quality of life of patients in the terminal period.

Keywords: Intensive care, patient's relative, death, dying with dignity, attitude

Öz

Amaç: Bu çalışmanın amacı, terminal dönem hasta yakınlarının ölüme ve saygın ölüm ilkelerine ilişkin tutumları arasındaki ilişkinin belirlenmesidir.

Materyal ve Metot: Tanımlayıcı ve kesitsel olarak yapılan bu çalışma,20 Aralık 2021- 21 Mart 2022 tarihleri arasında 308 hasta yakını ile tamamlandı. Veriler, Kişisel Bilgi Formu, Ölüme Karşı Tutum Ölçeği (ÖKTÖ) ve Saygın Ölüm İlkelerine İlişkin Tutumları Değerlendirme Ölçeği (SÖİİTDÖ) kullanılarak toplandı. Verilerin analizinde tanımlayıcı istatistikler, Student t testi, One-Way ANOVA testi, Kruskal Wallis testi, Mann Whitney-U testi, Pearson korelasyon ve regresyon analizi kullanıldı.

Bulgular: Araştırmaya katılan hasta yakınlarının yaş ortalaması 34,88±2,32 olup %86,0'ı kadındır. Hasta yakınlarının %38,6'sı yoğun bakımdaki hastasının anne/babası olduğunu ve %44,1'i 3-7 gündür hastasının yoğun bakımda kaldığını belirtmiştir. Hasta yakınlarının ÖKTÖ toplam puan ortalaması 107,30±25,1, SÖİİTDÖ toplam puan ortalaması 30,62±10,70 idi. ÖKTÖ ile SÖİİTDÖ arasında pozitif yönde ve yüksek düzeyde anlamlı bir ilişki saptandı.

Sonuç: Hasta yakınlarının ölüme ilişkin tutumları negatifleştikçe saygın ölüm ilkelerini benimseme düzeylerinin arttığı saptanmıştır. Sağlık profesyonellerinin terminal dönemdeki hastaların yaşam kalitesini arttırmak için hasta yakınlarına ölüm danışmanlığı yapması gerekmektedir.

Anahtar Kelimeler: Yoğun bakım, hasta yakını, ölüm, saygın ölüm, tutum

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INTRODUCTION

Intensive care units are special areas in hospitals equipped with complex devices, separate from other clinics with their general appearance and atmosphere. The mortality rates of the patients hospitalized in these units are quite high due to their severe illnesses, long-term dependence on invasive procedures and mechanical devices (1). However, with the rapid technological developments and the advancement of diagnosis and treatment techniques, it has become possible to treat deadliest diseases today. With the developing treatment methods, the life expectancy of people has also increased. While technological developments have extended the life expectancy, they have also led to an increase in the number of chronic diseases and patients who need care in the terminal period (2,3).

The terminal period is defined as the last period before death, in which vital functions are expected to end within a certain period, during which holistic care is given to the patient to maintain the quality of life. The term terminal patient mean patient who is in the last days of their life and who is about to die (4). Death is an inevitable life process for every individual. People are aware of death, but they are not aware of how and when it will happen. Although people develop a positive attitude towards death, their attitudes and behaviors towards death are affected by factors such as sociodemographic characteristics, cultural structure and belief systems (5). As attitudes developed against death lose their balance and harmony, the level of anxiety of individuals increases and their adaptation to the environment may become difficult (1).

The diagnosis of terminal illness is a crisis for the patient and their relatives, which is woven with complex emotional reactions. The death process of a patient is a difficult period accompanied by physical and mental distress (6,7). Being with the patient at the time of death and giving care to the dying patient are the most difficult experiences for the family members of the patients as well as the healthcare providers. Undoubtedly, facing the reality of death can be traumatic for healthcare professionals, patients, and their relatives (1,6). The role of the patient's relatives during end-of-life care is too important to overlook.

Reasons such as the inability of patients' relatives to consider death as a part of life, their fear of the death process, their lack of awareness about death, and the lack of knowledge about how to request and provide services when a person is on their deathbed can lead to a worsening of the patients' quality of life and the grieving process (8-11).Individuals who are nearing death want to be prepared for death, to say goodbye to their relatives, to spend time with their relatives, to reconsider their lives, to protect their personal dignity and to die with dignity (12). It is among the important responsibilities of both health professionals and patient relatives that patients can achieve a dignified death, which is a basic human right. For this reason, relatives of patients need to better understand death, accept it and prepare for it with a mature attitude. Relatives of patients should have information about death and be able to talk in order to realize the needs of the patient whose death is approaching. In short, they need to have a positive attitude towards death (8,10,13).

Although there are studies in the literature about health professionals and students in which principles about die with dignity and attitudes towards death are evaluated (1,5,7,14-20), no study has been found on the attitudes of patients' relatives towards "death and principles about dying with dignity. With this study, determining the attitudes of patient relatives towards death and principles about dying with dignity will provide information on increasing the quality of end-of-life care. In addition, in line with the results of the research, it will be able to contribute to the strengthening of the variables that increase the level of adopting principles about dying with dignity", and to the organization of death education programs for the relatives of the patients to provide a respectable death process.

Aim

The aim "of this study is to determine the relationship between the attitudes of the relatives of terminal patients towards death and the principles about dying with" dignity.

Research Questions

1. Do "the sociodemographic characteristics of the relatives of terminal patients affect their level of attitude towards death and principles about dying with dignity?
2. What are the attitude levels of the relatives of terminal patients towards death and the principles about dying with dignity?
3. Is there a relationship between the attitude levels of relatives of terminal patients towards death and principles about dying with" dignity?

MATERIAL AND METHOD

Design and Study Population

This research "was designed as a descriptive and cross-sectional study. The population of the study was consisted of the relatives of the patients who were treated in the intensive care units of Inonu University, Turgut Ozal Medical Center (Internal Medicine, Neurology, General, Anesthesiology, and Reanimation) between 20.12.2021 - 21.03.2022. In the study, the universe was studied (356 relatives of the patients). Sample selection was not made. 308 of these relatives who met the inclusion criteria were included in the study. 48 relatives of patients did not accept to participate in the study, so they were excluded from the study". Study participation rate was 86.5%. The inclusion criteria of the study comprised the following:

- being a relative of a patient who had been on advanced cardiac life support for at least three days at the time of the study and was considered to be in the terminal phase,

- being older than 18 years of age,
- being consanguineous with the patient,
- being able to communicate with the intensive care staff,
- being able to meet the patient's needs one-to-one,
- having no psychiatric disorder
- agreeing to participate in the research.

Instruments

The data were obtained with thePersonal Information Form, the Death Attitude Profile-Revised (DAP-R) Scale, and the Assessment Scale of Attitudes towards Principles about Dying with Dignity (ASAPDD).

Personal Information Form: In the form developed in the light of the literature (5,11,13,15,16,21,22), there were 14 questions questioning the descriptive characteristics of the patients (age, gender occupation, education level, marital status, patient's length of stay in the intensive care unit, closeness with the patient, previous care for another patient in the intensive care unit, frequency of meeting with the patient, frequency of thinking about own death, previous loss of a loved one, sharing thoughts on death, receiving education about death, reaction to death).

Death Attitude Profile-Revised (DAP-R): The scale was developed by Wong et al. in 1994 (23). The Turkish validity and reliability study was conducted by Işık et al. in 2009 (24). The scale consists of 26 items and has three subscales: "Neutral Acceptance and Approach Acceptance", "Escape Acceptance" and "Fear of Death and Death Avoidance". "Neutral Acceptance and Approach Acceptance" subscale contains items of 4,6,8,12,13,14,15,19,21,22,23,25. "Escape Acceptance" contains 5,9,11,20,24th items, and "Fear of Death and Death Avoidance" contains the items of 1,2,3,7,10,16,17,18,26. The Cronbach's Alpha coefficient of the scale is 0.81 in the total scale, 0.82, 0.72 and 0.70 in the subscales, respectively. The expressions of the scale, which is in seven-point Likert type, are between "Strongly Agree" (1 point) and "Strongly Disagree" (7 points). It is evaluated that as the score obtained from the scale increases, negative attitude towards death develops, and as the score decreases, the attitude towards death develops in a positive direction. The Cronbach's alpha value of the scale was 0.81 (24), and this study was 0.84.

Assessment Scale of Attitudes towards Principles about Dying with Dignity (ASAPDD): The scale, which was developed by Duyan (25) in 2014 and includes 12 principles regarding dying with dignity, is in the five-point Likert type. The lowest score is 12 points and the highest 60 points are taken from the scale. A high score on the scale is an indication of high acceptance of the principles of dying with dignity. The Cronbach's Alpha value of the scale was 0.89 (25), and this study was 0.93.

Data Collection

Forms were completed in the rest room by face-to-face interview on the days and hours available to the relatives of the patients who agreed to participate in the study between 20 December 2021 and 21 March 2022. Relatives of the patients were informed about the study and voluntary consent forms were signed. Filling out the forms took approximately 8-10 minutes.

Data Analysis

In the study, the data were analyzed with the Statistical Package for Social Science (SPSS) 24.0 package program. (SPSS) Data distribution was evaluated using the Kolmogorov-Smirnov test. Cronbach's alpha coefficient was calculated for reliability. In independent groups, t test, analysis of variance (ANOVA), Kruskal Wallis test, Mann Whitney-U test, Pearson correlation and regression analysis were used. In the study, the p value was accepted as below 0.05.

Ethical Approval

The Ethical Committee approval (2021-43/18) was obtained to conduct the study. The relatives of the patient have written consent was obtained. Permission to use the above measurement instruments in the study was received from their developers. This study was conducted in accordance with the Good Clinical Practices of the Declaration of Helsinki.

RESULTS

It was determined that 49.3% of the participants were in the 26-32 age groups and average age of all participants was 34.88±2.32 (Table 1). 86.0% of the relatives of the patients were women, 59.4% were single, 70.5% were secondary school graduates, and 63.3% were high school graduates. 38.6% of the patients' relatives were the mother/father of the patient they cared for, while 61.7% of them had previously taken care of patients in the intensive care unit. 65.9% of the patients' relatives saw their patients for 10 minutes or less a day. It was determined that 44.1% of the participants' patients were treated in the ICU for 3-7 days (Table 1).

It was found that individuals, who were male, married, and had a child scored higher on the DAP-R's "Fear of Death" and "Death Avoidance" subscales, and the difference between the groups was statistically significant ($p< 0.05$). Individuals who were the offspring of the patients in ICU scored higher on the DAP-R's "Neutral Acceptance and Approach Acceptance" subscale, and the difference between the groups was statistically significant ($p<0.05$). Individuals aged 40-46 years, male, who had previously taken care of patients in the intensive care unit, who visited their patients between 11-20 minutes daily, and whose patients were treated in the intensive care unit for more than 12 days, obtained higher scores from DAP-R's "Escape Acceptance" subscale compared to other groups.

Accordingly, the difference between the groups was found to be statistically significant (p<0.05). It was found that the individuals who were female, married, were the parents of the patient receiving treatment in the intensive care unit and were previously took care of patients in the intensive care unit scored higher in the DAP-R total score than the other groups, and the difference between the groups was statistically significant (p<0.05) (Table 1).

Table 1. Comparison of the participants' mean total scores according to the information about sociodemographic (n=308)

Variables	n	%	DAP-R	ASAPDD
Age				
26-32	152	49.3	105.78±2.10	30.73±1.94
33-39	99	32.2	107.67±2.06	30.56±1.81
40-46	57	18.5	109.04±2.19	30.00±1.90
p[a]			0.087	0.053
Gender				
Female	265	86.0	107.50±2.02	32.84±1.89
Male	43	14.0	107.27±2.42	29.78±2.05
p[c]			0.094	0.004
Income Level				
Low	25	8.1	108.96±2.71	31.55±2.56
Middle	217	70.5	107.86±2.11	30.80±1.89
High	66	21.4	107.43±1.83	29.40±1.64
P[d]			0.051	0.241
Marital status				
Single	183	59.4	107.90±2.16	28.82±1.94
Married	125	40.6	106.50±0.70	32.00±1.41
p[b]			0.980	0.016
Education Level				
Primary-Secondary School	84	27.3	108.90±2.16	30.80±1.93
High School	195		107.87±2.14	30.86±1.96
University	29	63.3	107.55±2.70	30.03±1.20
p[d]	9.4		0.934	0.780
Relationship with the patient in the intensive care unit				
Mother/Father	119	38.6	107.97±2.09	30.81±1.89
Offspring	20	6.5	106.87±2.19	33.79±1.87
Spouse	94	30.5	108.80±2.36	29.05±2.21
Sibling	75	24.4	107.82±1.91	28.38±1.42
p[d]			0.933	0.009
Previous caring for another patient in the ICU				
Yes	190	61.7	107.74±2.55	29.14±2.49
No	118	38.3	108.82±2.10	31.70±1.84
p[d]			0.073	0.001
Frequency of meeting with the patient (daily)				
10 min and less	203	65.9	108.50±2.55	30.06±2.14
11 min-20 min.	105	34.1	107.79±2.06	30.78±1.90
p[b]			0.802	0.350
Duration of stay of the patient in the ICU				
3-7 days	136	44.1	107.58±2.26	30.35±2.78
7-11 days	100	32.5	106.81±2.11	30.74±1.85
12 days and longer	72	23.4	107.55±2.88	30.00±2.30
p[d]			0.130	0.804

Note: [a] Variance analysis (ANOVA), [b] Independent samples t-test, [c] Kruskal Wallis Test, [d] Mann Whitney U Test, *p<0.05, **p<0.001; DAP-R: Death Attitude Profile-Revised, ASAPDD: Assessment Scale of Attitudes towards Principles about Dying with Dignity; ICU: Intensive Care Unit

It was determined that 52.3% of the participants had lost a loved one before, 51.6% thought about their own death from time to time, 87.3% did not share their thoughts about death, 73.4% did not receive education about death, and 47.7% showed a fear reaction in the face of death.It was found that individuals who think about their own death very often and react with fear in the face of death have a high score in the "Fear of Death and Death Avoidance" subscale of DAP-R, and the difference between the groups is statistically significant (p<0.05) (Table 2).

Obtained data shows that those who received training on death had higher scores from the "Neutral Acceptance and Approach Acceptance" subscale of DAP-R, and the difference between the groups was statistically significant (p<0.05). Those who lost a loved one before and those who had a fearful reaction to death scored higher on the DAP-R total score compared to the other groups, and the difference between the groups was statistically significant (p<0.05). It was found that those who lost a loved one before, those who think about their own death very often, those who share their thoughts about death, and those who receive education about death have higher ASAPDD total scores than the other groups, and the difference between the groups is statistically significant (p<0.05) (Table 2).

In the study, it was determined that the total mean score of individuals from DAP-R was 107.30±25.1. "Neutral Acceptance and Approach Acceptance" subscale mean score of DAP-R is 54.59±12.15, "Escape Acceptance" subscale mean score is 17.20±5.83, "Fear of Death and Death Avoidance" subscale mean score is 46.19±10.16. Individuals' total mean score obtained from ASAPDD was found to be 30.62±10.70 (Table 3).

Table 2. Comparison of the participants' mean total scores according to the information about Death (n=308)

Variables	n	%	DAP-R	ASAPDD
Previous Loss of a Loved One				
Yes	162	52.6	109.90±2.15	33.80±1.92
No	146	47.4	106.50±2.12	28.0±4.24
p[b]			0.005	0.001
Frequency of thinking about own death				
Very often	75	24.4	107.59±2.02	34.20±1.89
Occasionally	159	51.6	106.60±2.31	28.84±1.96
Rarely	74	24.0	107.46±2.90	27.70±1.08
p[a]			0.881	0.001
Sharing thoughts about death				
Yes	39	12.7	107.63±2.00	32.66±1.80
No	269	87.3	107.96±2.22	29.88±1.99
p[c]			0.046	0.001
Education about Death				
Yes	82	26.6	106.59±2.19	33.44±1.78
No	226	73.4	107.95±2.05	27.98±1.96
p[a]			0.224	0.001*
Reaction to Death				
Fear	147	47.7	110.15±2.24	30.02±2.01
Anxiety	120	39.0	105.18±1.77	30.20±1.45
Guilt	41	13.3	107.98±2.13	30.96±2.11
p[d]			0.003*	0.604

Note: [a]Variance analysis (ANOVA), [b]Independent samples t-test, [c] Kruskal Wallis Test, [d]Mann Whitney U Test, *p<0.001; DAP-R: Death Attitude Profile-Revised, ASAPDD: Assessment Scale of Attitudes towards Principles about Dying with Dignity

Table 3. The mean scores of the participants from DAP-R and ASAPDD (n=308)

Scale Subscales	Mean ± SD	Min-Max
Neutral Acceptance and Approach Acceptance	54.59 ± 12.15	24-83
Escape Acceptance	17.20 ± 5.83	4-32
Fear of Death and Death Avoidance	46.19 ± 10.16	29-60
DAP-R Total	107.30 ± 25.1	30-178
ASAPDD Total	30.62±10.70	12-50

Note: Min: Minimum, Max: Maximum, SD: Standard deviation, DAP-R: Death Attitude Profile-Revised, ASAPDD: Assessment Scale of Attitudes towards Principles about Dying with Dignity

In Table 4, in the correlation analysis of the relationship between the attitudes towards death and attitudes towards principles about die with dignity of the relatives of the patients, it was determined that there is a positive and high-level relationship between the DAP-R subscales of "Fear of Death and Death Avoidance", "Neutral Acceptance and Approach Acceptance", "Escape Acceptance", and Assessment Scale of Attitudes towards Principles about Die with Dignity (p<0.05).

As a result of simple linear regression analysis, a significant correlation was found between DAP-R total and subscales and ASAPDD (R=.740, R2=.548, p<.01). Of the selected independent variables, DAP-R total (β:2.175, p=.000), DAP-R Neutral Acceptance and Approach Acceptance (β: 1.505, p=.000), DAP-R Escape Acceptance (β: 0.872, p=.000) and DAP-R Fear of Death and Death Avoidance (β:0.397, p=.000) were found to predict ASAPDD statistically significantly and positively. Accordingly, selected independent variables affect ASAPDD at a rate of 54.8% (Table 5).

Table 4. Relationship between the mean DAP-R and ASAPDD (n=308)

DAP-R	ASAPDD	
	r	p*
DAP-R Total	0.655	0.040
Fear of Death and Death Avoidance Subscale	0.783	0.030
Neutral Acceptance and Approach Acceptance Subscale	0.709	0.021
Escape Acceptance Subscale	0.661	0.039

Note: Pearson correlation, *p<0.05; DAP-R: Death Attitude Profile-Revised, ASAPDD: Assessment Scale of Attitudes towards Principles about Dying with Dignity

Table 5. Simple linear regression analysis between DAP-R ve ASAPDD (n=308)

Variable	B	Std. Error	Beta	t	p
Constant)	114.610	.0408		11.058	.001*
DAP-R Total	1.472	0.521	2.175	6.735	.001*
Fear of Death and Death Avoidance	0.630	0.200	0.397	3.742	.030**
Neutral Acceptance and Approach Acceptance	1.227	0.486	1.505	5.011	.001*
Escape Acceptance	0.934	0.353	0.872	4.899	.038*

Note: * p< 0.01 **p<0 .05 β: Beta; DAP-R: Death Attitude Profile-Revised, ASAPDD: Assessment Scale of Attitudes towards Principles about Dying with Dignity

DISCUSSION

Even though death seems distant to healthy people, for a patient who has passed the terminal stage, it becomes much closer. Death which every living thing will inevitably experience is a complex, incomprehensible and real situation in human life. While the people whose death is approaching experience some emotions in the last stage of his life, at the same time, the emotional state of many people such as their family, environment and health professionals is affected, causing them to develop attitudes and behaviors towards death, and prevents patients from living a dignified death (1,7,19).

In "this study, it was determined that the mean DAP-R score of the relatives of the patients was 107.30±25.1 and they had a negative attitude towards death. In Neutral Acceptance and Approach Acceptance Subscale, patient relatives' attitudes are more negative, while in Fear of Death and Death Avoidance" Subscale, there is moderate acceptance. When the literature is examined, similar results have been reported in the general average and subscales of attitude towards death (1,13,14,26). Death is an abstract concept that extends to whole life. Although death seems like a natural part of life for people, it is also a difficult/undesirable end. It is observed that the relatives of patients who care for terminal patients have a negative attitude towards death due to the fear of losing a relative.

Dignity is a subjective concept and the importance of dignity in the care of the near-death patient cannot be denied. People deserve to receive dignified and respected care at the end of their life. For this reason, it is essential that the relatives of the patients, together with the health personnel, demand and maintain the care that is suitable for the needs of the patient and that will protect their honor and dignity (1). In this study, the average ASAPDD score of the relatives of the patients was 30.62±10.70, which is moderate. When the literature is examined, it has been determined that the ASAPDD averages are high in studies conducted with health personnel and students studying in the field of health (1,3,12,15,22,27). Due to the difference between the results of the study, it can be thought that health professionals have adopted the principles of a respectable death and learned about this issue during their education, since they constantly encounter death in intensive care settings. It is thought that the difference in the attitudes of the relatives of the patients is due to the fear of losing their loved one and their lack of awareness about how to treat the patient during the death process.

In this study, it was "determined that as the attitudes of

the relatives of the patients became negative, the level of adopting principles about dying with dignity increased. As can be understood from this result, the perception of death affects the perception of respectable death. In a study conducted by Çelik (2019) with intensive care nurses, it was determined that as nurses' attitudes towards death become negative, their level of adopting principles about dying with dignity increases (1). In the study conducted by Köse et al. (2019) with physicians and nurses, it was determined that there was no relationship between the attitude towards death and the level of adopting principles" about dying with dignity (12). In the study conducted by Bilgiç (2021), it was determined that the increase in nursing students' perceptions of death positively affected their adoption of principles about dying with dignity (28). In the sub-dimensions of DAP-R, there are expressions such as accepting death objectively and as an approach, escaping from death, fear of death and avoiding death. The negative increase in these attitudes, that is, more fear or avoidance of death, may have caused the relatives of the patients to adopt the principles of respectable death more. Because death is a situation that not only the patients cared for by their relatives, but also all humanity and living things, including themselves. Being aware of this may have a positive effect on the dignity of the individual regarding death. Death, which is a negative thing that the relatives of the patients avoid for themselves, may have caused them to behave more sensitively and respect the family member they care for.

In our study, no correlation was found between the DAP-R scores of the patient's relatives and their sociodemographic characteristics. A significant difference was found between the ASAPDD mean scores of women, married people, those whose children were hospitalized in the intensive care unit, and those who did not care for another patient in the intensive care unit before. In the literature, it has been stated that the ASAPDD scores of women and those who are married are high (3,6,29). Although gender does not directly affect the perception of death, it can affect the approach to respectable death. It is thought that women, married people and people with children develop more values such as care, empathy and compassion, and in this context, they can behave more sensitively towards respectable death.

When death is encountered, with the effect of remembering the losses experienced, feelings such as sadness, fear, and thinking of being saved may occur, while behaviors such as freezing, and crying may occur. In our study, it was determined that the DAP-R scores of those who experienced fear of death were high, and that both the DAP-R and ASAPDD scores of the relatives of the patients who lost a loved one before were high. Ay and Gençtürk (2013) in their qualitative study with midwifery students stated that most students faced death by losing a family member before they were even midwifery students, they were afraid of death, but they had to face death in a dignified manner at home (30). Death experience and fears in individual life can affect people's perceptions of death and their approaches to respectable death. It is thought that the relatives of the patients who have experienced death perceive that death is real and inevitable and they can display a more accepting approach towards death.

In our study, it was determined that the relatives of the patients who think about their own death very often, share their thoughts about death and receive education about death have a higher level of adopting the principles of respectable death. When the literature is examined, it can be seen that physicians and nurses who receive palliative care training, have high palliative care competence, and nursing students who receive training on the care of the dying patient during their education can talk about death and dying more easily, share their thoughts comfortably, adopt the principles of respect death more easily, and improve the quality of care (3,6,15,31). In the study of Chen et al. (2020), they stated that death education facilitates acceptance, increases competency about death, and it is possible to talk about death comfortably (8).Jung et al. (2021) stated that family members of hospice patients make great demands for information about death symptoms before death counseling training, and they need support to ensure a comfortable death after death counseling. In addition, it was determined that the relatives of the patients wanted support to protect their human dignity and sense of well-being until the last moment of their lives (32). The results support our study, and it is thought that when the relatives of the patients receive education about death, they believe that by talking or thinking about death, it will reduce the fear and anxiety of death, thus they accept a dignified death comfortably and the quality-of-care increases.

CONCLUSION

It has been observed that the relatives of the patients who have to care for patients close to death have negative attitudes towards death, and they also adopt the respectable care that should be given to terminal patients. The ability of patient relatives to provide effective and quality care to their terminal patients can be achieved by gaining awareness of their individual feelings and thoughts against death. It is very important that patients who are close to death receive respectable care. In this direction, arrangements are needed to provide adequate social support, as well as to plan a comprehensive and qualified death education by determining the needs of patients' relatives in order to turn their attitudes towards death into a positive one.

Limitations

This study consists of relatives of patients who were treated in the intensive care units of a Medical Faculty in Turkey and accepted to participate in the study and cannot be generalized.

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