

Attitudes of Physicians and Nurses toward End-of-Life Decisions in Türkiye*

Türkiye’de Hekim ve Hemşirelerin Yaşam Sonu Kararları Hakkındaki Tutumları

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ABSTRACT

Aim: Our study aimed to determine the attitudes of physicians and nurses in Türkiye towards end-of-life decisions and to identify the factors influencing these attitudes.

Method: The study is quantitative and cross-sectional. The socio-demographic data form we prepared for the research and the end-of-life decisions scale were used after obtaining the necessary permissions and conducting validity and reliability analyses.

Findings: 870 physicians and nurses participated in the study. Age, gender, marital status, and having children were found to be important and statistically significant ($p \leq 0.05$) socio-demographic variables in terms of perceptions, beliefs, and practices regarding end-of-life decisions. While the variables of education, professional factors, unit of employment, and income level were found to be variables with no statistically significant difference ($p > 0.005$) in terms of perceptions, beliefs, and practices regarding end-of-life decisions. It was determined that 1.6% of the participants had an advanced directive, 83.2% needed additional training on the subject, 46.7% had initiated discussions about end-of-life decisions at least once, 43.7% thought that physicians should initiate discussions about end-of-life decisions, and 41.8% thought that patients should initiate them.

Conclusion: Our research results reveal a serious need for training among healthcare professionals on this subject, the necessity of implementing advance directives, and the importance of Hospital Ethics Committees. It is crucial that relevant institutions identify the needs in this area and act accordingly.

Keywords: Physician, Nurse, End-of-life decisions, Attitude, Türkiye

Öz

Amaç: Araştırmamızda ülkemizdeki hekim ve hemşirelerin yaşam sonu kararları sürecindeki tutumlarını ve bu tutumları etkileyen faktörlerin hangi değişkenler olduğunu saptamayı amaçladık.

Yöntem: Araştırma nicel, kesitsel bir çalışmadır. Araştırma için kendi hazırladığımız sosyo-demografik veri formu ve yaşam sonu kararları ölçeği gerekli izinler alındıktan ve geçerlilik ve güvenilirlik analizleri yapıldıktan sonra kullanılmıştır.

Bulgular: Çalışmaya 870 hekim ve hemşire katılmış olup; yaş, cinsiyet, medeni durum, çocuk sahibi olma değişkenlerinin yaşam sonu kararları konusundaki algı, inanç ve uygulamalar açısından önemli ve istatistiksel olarak anlamlı ($p \leq 0,05$) sosyo-demografik değişkenler olduğu; eğitim, mesleki faktör, çalışılan birim, gelir düzeyi değişkenlerinin ise yaşam sonu kararlarında algı, inanç ve uygulamalar açısından istatistiksel olarak anlamlı farkın olmadığı ($p > 0,005$) değişkenler olduğu saptanmıştır. Katılımcıların %1,6’sının tıbbi vekaletname bıraktığı, %83,2’sinin konu ile ilgili ek eğitimlere ihtiyaç duyduğu, %46,7’sinin yaşam sonu kararları ile ilgili görüşmeleri en az bir kere başlattığı, %43,7’sinin yaşam sonu kararları ile ilgili görüşmeleri hekimlerin, %41,8’inin ise hastaların başlatması gerektiğini düşündüğü saptanmıştır.

Sonuç: Araştırma sonuçlarımız sağlık personelinin konu ile ilgili ciddi bir eğitim ihtiyacını, yetkilendirme bildirimlerinin uygulamaya konulması gerekliliğini ve Hastane Etik Kurullarının önemini ortaya koymaktadır. Alanda konu ile ilgili gereksinimlerin belirlenerek, ilgili kurumların çalışmaları önem arz etmektedir.

Anahtar Kelimeler: Hekim, Hemşire, Yaşam sonu kararları, Tutum, Türkiye

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Introduction

The care of a patients with a terminal illness aims to alleviate the suffering, optimize quality of life until death occurs, and ensure comfort at the time of death. However, achieving these goals is not always easy, and the process may require the patient, their relatives, or physicians to make certain decisions. Physicians, the patient themselves, or the patient's relatives may have to decide on treatment options, such as prolonging the patient's life with the support of medical technology or allowing the natural death. This necessity to make decisions leads to various ethical dilemmas related to death and causes physicians to face these ethical dilemmas.¹⁻² Since the decisions to be made may affect not only the patients but also their family members and society, it is important to protect the rights, dignity and well-being of everyone involved in the ethical decision-making process.³ Furthermore, these decisions allow for more discussion of advance directives such as medical power of attorney and living wills. In this context, it is important to understand what these concepts mean. Advance directives, such as medical powers of attorney and living wills, are ethical and legal documents to be used in medical situations where the patient is unable to make decisions for themselves. The patient can change these decisions whenever they wish. Advance directives are important for all adults. Unexpected end-of-life situations can occur at any age, so all adults can prepare these documents. This way, individuals can receive the medical care they want, avoid unnecessary suffering, and relieve their families, healthcare professionals, and caregivers from the burden of decision-making during times of crisis or grief (facing death) by planning ahead while they are still able. Furthermore, these documents help reduce confusion or disagreement regarding the choices you want made on your behalf. Therefore, our research aims to determine the perceptions, behaviors, and practices of physicians and nurses, who are always part of the end-of-life decision- making process, to reveal the situation in our country. The aim was to determine the practices of physicians and nurses related to the subject, identify differences by determining their perceptions, beliefs, and practices, and identify the sociodemographic variables that influence end-of-life decisions. Furthermore, this study is of great significance from the perspective of medical sociology in that it approaches end-of-life decisions not merely as a clinical or biological process, but as a social act directly shaped by sociodemographic variables such as age, gender, marital status, and parenthood. The study's primary originality lies in its use of concrete data to highlight the conflict of roles and expectations between patients and healthcare professionals within Turkey's healthcare system. While the global literature indicates that patients expect physicians to initiate discussions regarding end-of-life decisions, the fact that physicians and nurses in this study primarily attribute this responsibility to the patient documents a structural disconnect in patient-physician communication. Furthermore, the study highlights the cultural and institutional gaps in the transition from a paternalistic to a patient-centered model by demonstrating how little advance directives and medical power of attorney (tools that protect patient autonomy) are known and utilized in Turkey.

Materials and Methods

The population of the study consists of 144,827 physicians and 152,952 nurses registered with the Ministry of Health and working in the public sector or privately. The numbers are based on data from the Ministry of Health, General Directorate of Health Services, Directorate of Management Services for 2016. It is stated that the data is updated by the ministry every five years. According to the Ministry of Health's 2025 Activity Report, there are currently a total of 164,618 physicians within the Ministry of Health. Of these physicians, 67,020 are specialists, 33,786 are resident physicians, 49,942 are general practitioners, and 13,870 are dentists. Additionally, according to the same report, there are 247,545 nurses and midwives on staff. These numbers were used to calculate the sample size because they represent the most recent data available for the population.

The sample size for the study is estimated to be a minimum of 384 physicians and 384 nurses, calculated with a margin of error of 0.05.⁴ The table and sample calculation used to determine the sample size are provided below (**Table 1**).

Table 1. Sample size calculation table based on a five percent margin of error (d= 0.05)

Population (Number)	± 0.03 sampling error (d)			± 0.05 sampling error (d)			± 0.10 sampling error (d)		
	p=0.5 q=0.5	p=0.8 q= 0.2	p=0.3 q=0.7	p=0.5 q=0.5	p=0.8 q=0.2	p=0.3 q=0.7	p=0.5 q=0.5	p=0.8 q=0.2	p=0.3 q=0.7
100	92	87	90	80	71	77	49	38	45
500	341	289	321	217	165	196	81	55	70
750	441	358	409	254	185	226	85	57	73
1000	516	406	473	278	198	244	88	58	75
2500	748	537	660	333	224	286	93	60	78
5000	880	601	760	357	234	303	94	61	79
10,000	964	639	823	370	240	313	95	61	80
25,000	1023	665	865	378	244	319	96	61	80
50,000	1045	674	881	381	245	321	96	61	81
100,000	1056	678	888	383	245	322	96	61	81
1,000,000	1066	682	896	384	246	323	96	61	81
100,000,000	1067	683	896	384	245	323	96	61	81

The sample size calculation was performed using the formula: $n = Nt^2pq/d^2(N-1) + t^2pq$. N = number of individuals in the population, n = number of individuals to be sampled, p = frequency of occurrence of the event being studied, q = frequency of non-occurrence of the event being studied, t = theoretical value found in the t-table at a specific degree of freedom and determined error level, d = desired ± deviation based on the frequency of occurrence of the event. N=144,827 and 152,952 individuals, p=0.50; q=1-p; t=1.96; d=0.05 were taken, and the sample size was calculated as 384 individuals for each of the two groups.⁴

The survey questions in the study were prepared electronically and sent to the participants' email addresses. Regarding electronic surveys, Survey Monkey, Google Forms, Survey Data, and Survey electronic data collection programs were reviewed and tested on small groups before being used in the research. Survey was chosen for the electronic surveys because it is simple and free to use, allows surveys to be answered on all different brands of mobile phones, tablets, and computers, provides the researcher with the ability to constantly intervene and view the data, prevents data from the same IP address from conflicting, and offers users a wide range of options in terms of different question types. The data for the research was collected between January 15, 2020, and June 15, 2020.

Location and Characteristics of the Research

Since the surveys were to be collected electronically, discussions were held with Medical Chambers to reach physicians throughout Türkiye. Priority was given to the Medical Chambers of Ankara, Istanbul, Izmir, and Diyarbakır, as their membership constituted more than 50% of the total number of members of all Medical Chambers. In case sufficient data could not be collected, the Medical Chambers of Gaziantep, Konya, Antalya, Aydın, Mersin, Van, Şanlıurfa, Trabzon, Hatay, Manisa, Erzurum, Malatya, Sinop, and Sakarya were randomly selected, and the necessary permissions were obtained from these medical associations to distribute the surveys electronically to their members. In order to apply the surveys to nurses, different nursing associations were consulted, and the surveys were sent to their members electronically.

Data Collection Tools of the Study

Within the scope of the research, the Socio-demographic Data Form we created, the End-of-Life Decisions Questionnaire (Physician and Nurse Format) developed by Stoeckle et al. (1998), and the End-of-Life Decisions Scale were applied after conducting Turkish validity and reliability studies. The socio-demographic

data form collected data on participants' gender, age, educational status, the unit they worked in, and their professional experience. The 19 item questionnaire and 20 item scale developed by Stoeckle et al. in 1998 were used to assess physicians' and nurses' perceptions, beliefs, and practices. The scale questions are 5-point Likerttype.⁵

Type of Research

This study is a quantitative, cross-sectional study conducted to determine and evaluate physicians' and nurses' attitudes toward end-of-life decisions in Türkiye and to identify whether there is a difference between nurses and doctors.

Statistical Evaluation

The statistical analyses of the study were performed using the SPSS 20.0 (IBM Inc, IL (Chicago), USA) program. Descriptive measures were presented as mean and standard deviation for ratio-scaled variables and as frequency and percentage for nominal-scaled variables. The scores obtained from the scale used were calculated and compared according to demographic characteristics. The independent sample t-test was used for two independent groups, and One-Way Analysis of Variance was used for multiple categorical characteristics. Tukey HSD pairwise comparison results were preferred for significant results. Chi-square analysis was used for categorical data and Pearson Correlation analysis was used for numerical data to determine the relationships between variables.

Compliance With Ethical Rules

The research questions were sent electronically to physicians and nurses registered with the Turkish Medical Associations and Nurses' Associations. At the beginning of the questionnaire, there is a section where participants are informed about the research and give their consent. Electronic questionnaires completed by individuals who voluntarily agreed to participate in the research after being informed about it were included in the research. The research was conducted in accordance with the principles of the Declaration of Helsinki. Before starting the study, ethical approval was obtained from the Burdur Mehmet Akif Ersoy University Non-Interventional Clinical Research Ethics Committee (approved on February 2, 2019; approval number: GO2019/01)

Results

A total of 870 volunteers participated in the study, and the sociodemographic characteristics of the participants are presented in **Table 2**.

Table 2. Socio-demographic information of End-of-Life Decisions Questionnaire

Socio-demographic Information	Variables	Physician (Number- Percentage)	Nurse (Number- Percentage)	Level of Understanding P
Age	0-24	2a (0.4%)	24b (5.7%)	<0.001*
	25-29	20a (4.4%)	84b (20.0%)	
	30-34	56a (12.4%)	104b (24.8%)	
	35-39	48a (10.7%)	84b (20.0)	
	40-44	66 (14.7%)	76 (18.1%)	
	45-49	70a (15.6%)	28b (6.7%)	
	50-54	72a (16.0%)	16b (3.8%)	

	55-59	48a (10.7%)	4b (1.0%)	
	60-64	48a (10.7%)	0b (0.0%)	
	65	20a (4.4%)	0b (0.0%)	
Gender	Female	236a (52.4%)	400b (95.2%)	<0.001*
	Male	214a (47.6%)	20b (4.8%)	
Marital Status	Married	366a (81.3%)	260b (61.9%)	
	Widowed	4 (0.9%)	4 (1.0%)	<0.001*
	Divorced	26 (5.8%)	20 (4.8%)	
	Single	54a (12.0%)	136b (32.4%)	
Having Children	Yes	370a (82.2%)	212b (50.5%)	<0.001*
	No	80a (17.8%)	208b (49.5%)	
Educational Degree	Bachelor	0a (0.0%)	192b (45.8%)	
	Master	76a (16.9%)	172b (40.9%)	<0.001*
	Specialization	374a (83.1%)	0b (0.0%)	
	Doctorate	0a (0.0%)	56b (13.3%)	
Field of Study	Basic Medicine	8a (1.8%)	0b (0.0%)	<0.001*
	Internal Medicine	240a (53.3%)	332b (79.0%)	
	Surgical Medicine	202a (44.9%)	88b (21.0%)	
Income	Income is less than expenses	56a (12.4%)	124b (29.5%)	<0.001*
	Revenue equals expenses	218 (48.4%)	228 (54.3%)	
	Revenue Exceeds Expenses	176a (39.1%)	68b (16.2%)	

*: Indicates the level of statistical significance between groups using different sub-expressions (a and b).

The section of the End-of-Life Decisions Questionnaire administered to participants following the socio-demographic information consists of questions about end-of-life decisions. The findings in this section are presented in **Tables 3-4-5-6**.

Table 3. Findings from the end-of-life decisions questionnaire I

End-of-Life Decisions Questionnaire	Yes Total	Yes Physician	Yes Nurse	Level of Understanding
Questions	Number - Percentage	Number - Percentage	Number - Percentage	p
Have you received any post-graduation training related to ethics?	392 (45.1%)	140a (%31.1)	252b (60.0%)	0.001
Have you ever participated in any course, seminar, or workshop that included the topic of 'Patient Self-Determination'?	230 (26.4%)	102a (22.7%)	128b (30.5%)	0.009
Have you ever participated in a course, seminar, or workshop on values, ethics, or moral development?	354 (40.7%)	134a (29.8%)	220b (52.4%)	0.001
Have you ever had a family member or close friend who experienced a life-threatening situation or had a terminal illness?	706 (81.1%)	358 (79.6%)	348 (82.9%)	0.213

Did this life-threatening experience or experience with a life-threatening illness change your beliefs, values, or behaviors regarding life and death?	466 (53.6%)	198a (44.0%)	268b (63.8%)	0.001
Has your personal experience with a life-threatening event or terminal illness changed the way you approach discussions about end-of-life treatment and care with patients and their families?	448 (51.5%)	196a (43.6%)	252b (60.0%)	0.001*
Have you ever discussed your end-of-life treatment and care preferences with your family?	346 (39.8%)	142a (31.6%)	204b (48.6%)	0.001*
Have you ever considered preparing an "advanced directive" in which you designate a person who can make medical decisions on your behalf in the event you lose your decision-making capacity?	288 (33.1%)	120a (26.7%)	168b (40.0%)	0.001*
Have you filled out/prepared an advanced directive for yourself?	20 (2.3%)	12 (2.7%)	8 (1.9%)	0.454
Do you know your family members' end-of-life treatment and care preferences?	292 (33.6%)	124a (27.6%)	168b (40.0%)	0.001
Has anyone in your family completed/prepared an advanced directive designating a person who can make medical decisions on their behalf should they lose decision-making capacity in the future?	4 (0.5%)	0a (0.0%)	4b (1.0%)	0.038*
Have you completed/prepared a living will for yourself?	32 (3.7%)	12 (2.7%)	20 (4.8%)	0.101
Would you consider leaving a living will for yourself?	620 (71.3%)	284a (63.1%)	336b (80.0%)	0.001
Has anyone in your family filled out/prepared a living will?	26 (3.0%)	10 (2.2%)	16 (3.8%)	0.169

*: Indicates the level of statistical significance between groups using different sub-expressions (a and b).

Table 4. Findings from the end-of-life decisions questionnaire II

Questions	Variables	Physician (Number-Percentage)	Nurse (Number-Percentage)	Total (Number-Percentage)	Level of Understanding (p)
Have you given a medical power of attorney for yourself?	Yes	2 (0.4%)	12 (2.9%)	14 (1.6%)	0.011
Would you consider preparing a 'medical power of attorney' for yourself?	Yes	296 (65.8%)	240 (57.1%)	536 (61.6%)	0.09
If you were to grant medical power of attorney, who would you consider appointing as your representative?	A family member	382 (84.9%)	356 (84.8%)	738 (84.8%)	0.03
	Close Friend	42 (9.3%)	52 (12.4%)	94 (10.8%)	
	Lawyer	6 (1.3%)	0 (0.0%)	6 (0.7%)	
	Doctor	20 (4.4%)	12 (2.9%)	32 (3.7%)	
Has anyone in your family given or prepared a 'medical power of attorney'?	Yes	0 (0.0%)	16 (3.8%)	16 (2.0%)	0.001*

*: Indicates the statistical significance level between variables.

Table 5. Findings from the end-of-life decisions questionnaire III

Questions	Variables	Physician (Number-Percentage)	Nurse (Number-Percentage)	Total (Number-Percentage)	Meaning Level (p)
There is no ethical difference between withholding treatment and withdrawing treatment	I agree	116 (25.8%)	96 (22.8%)	216 (24.9%)	0.001
	I disagree	240 (53.3%)	280 (66.7%)	520 (59.8%)	
	Not sure	94 (20.9%)	40 (9.5%)	134 (15.3%)	
Have you ever initiated a discussion with patients or their families about end-of-life care decisions?	Yes	218 (48.4%)	188 (44.8%)	406 (46.7%)	0.277
	No	232 (51.6%)	232 (55.2%)	464 (53.3%)	
If your answer is 'Yes', how many times have you initiated such discussions	<10	326 (72.4%)	376b (%89.5)	702 (80.7%)	0.001*
	10-49	58 (12.9%)	28b (6.7%)	86 (9.9%)	
	50-99	26 (5.8%)	0b (0.0%)	26 (3.0%)	
	>100	32 (7.1%)	12b (2.9%)	44 (5.1%)	
	All Patients	8 (1.8%)	4 (1.0%)	12 (1.4%)	
How comfortable do you feel when initiating discussions with	Very	44 (9.8%)	12 (2.9%)	56 (6.4%)	0.001
	Some	154 (34.2%)	192 (45.7%)	346 (39.8%)	
	None	252 (56.0%)	216 (51.4%)	468 (53.8%)	

your patients about end-of-life decisions?					
Do you think that additional training on end-of-life decisions will improve your ability to communicate with patients and their families on this subject?	Yes	364 (80.9%)	360 (85.7%)	724 (83.2%)	0.001
	No	22 (4.9%)	16 (3.8%)	38 (4.4%)	
	Not sure	64 (14.2%)	44 (10.5%)	108 (12.4%)	
If your answer is 'Yes', when do you think this training should be provided?	Undergraduate	36 (8.0%)	76 (18.1%)	112 (12.9%)	0.001
	Graduate	46 (10.2%)	16 (3.8%)	62 (7.1%)	
	Continuing	80 (17.8%)	80 (19.0%)	180 (18.4%)	
	Professional Education				
	All Processes	288 (64.0%)	248 (59.0%)	536 (61.6%)	

*: Indicates the statistical significance level between variables.

Table 6. Findings related to the end-of-life decisions questionnaire IV

Who do you think should initiate discussions about end-of-life decisions?	1.	2.	3.	4.	5.	6.
1. Family (p≤0.001*)	30 (6.7%)	126 (28.0%)	186 (41.3%)	58 (12.9%)	50 (11.1%)	0 (0.0%)
Physician	12 (2.9%)	108 (25.7%)	92 (21.9%)	140 (33.3%)	44 (10.5%)	24 (5.7%)
Nurse	42 (4.8%)	234 (26.9%)	278 (32.0%)	198 (22.8%)	94 (10.8%)	24 (2.8%)
Total	4 (0.9%)	32 (7.1%)	68 (15.1%)	208 (46.2%)	100 (22.2%)	38 (8.4%)
2. Nurse (p≤0.001*)	24 (5.7%)	116 (27.6%)	116 (27.6%)	116 (27.6%)	28 (6.7%)	20 (4.8%)
Physician	28 (4.2%)	148 (17.0%)	184 (21.1%)	324 (37.2%)	128 (14.7%)	58 (6.7%)
Nurse	8 (1.8%)	20 (4.4%)	20 (4.4%)	80 (17.8%)	286 (63.6%)	4 (0.9%)
Religious official	16 (3.8%)	16 (3.8%)	28 (6.7%)	88 (21.0%)	244 (58.1%)	0 (0.0%)
(p=0.077)	24 (2.8%)	36 (4.1%)	48 (5.5%)	60 (6.9%)	168 (19.3%)	530 (60.9%)
Physician	192 (42.7%)	108 (24.0%)	38 (8.4%)	48 (10.7%)	38 (8.4%)	26 (5.8%)
4. Patient (p≤0.006*)	172 (41.0%)	56 (13.3%)	48 (11.4%)	52 (12.4%)	68 (16.2%)	24 (5.7%)
Physician	364 (41.8%)	164 (18.9%)	86 (9.9%)	100 (11.5%)	106 (12.2%)	50 (5.7%)
Nurse	208 (46.2%)	124 (27.6%)	92 (20.4%)	4 (0.59%)	6 (1.3%)	16 (3.6%)
Physician	172 (41.0%)	88 (21.0%)	80 (19.0%)	60 (14.3%)	16 (3.8%)	4 (1.0%)
5. Physician (p≤0.001*)	380 (43.7%)	212 (24.4%)	172 (19.8%)	64 (7.4%)	22 (2.5%)	20 (2.3%)
Physician	8 (1.8%)	40 (8.9%)	46 (10.2%)	100 (22.2%)	176 (39.1%)	80 (17.8%)
Social worker	24 (5.7%)	36 (8.6%)	56 (13.3%)	24 (5.7%)	176 (41.9%)	104 (24.8%)
(p=0.790)	32 (3.7%)	76 (8.7%)	102 (11.7%)	124 (14.3%)	352 (40.5%)	184 (21.1%)

*: Indicates the statistical significance level between the physician and nurse groups.

In the end-of-life decisions scale used to learn participants' opinions regarding end-of-life decisions, the scale scores were generally below average. The items with the highest average scores and the most participation were, respectively healthcare professionals provide patients and their families with sufficient information about end-of-life treatment and care preferences (3.43 ± 1.07), I feel comfortable using the words "die" or "death" when discussing end-of-life treatment and care decisions with my patients or their families (3.13 ± 1.11), and Terminal patients have sufficient resources to cope with pain (3.13 ± 0.98). In addition, the items with the lowest participation rates were End-of-life treatment and care discussions accelerate physician-patient agreement on treatment preferences (1.95 ± 0.70), I believe that patients and their relatives are better able to evaluate end-of-life decisions in a calm and non-coercive environment (1.95 ± 0.86), and Even if they are not in the terminal phase, all patients have the right to make decisions regarding end-of-life treatment and care (life support), even if this decision could lead to death (1.99 ± 0.98). Physicians showed a high level of agreement with the statements that healthcare professionals provide patients with sufficient information about end-of-life treatment and care, that terminal patients have sufficient resources to cope with pain, and that end-of-life treatments are recorded in the patient follow-up form.

Although there was no significant difference between physicians and nurses, nurses showed a high level of agreement with the statements that the word "death" is used comfortably when discussing end-of-life treatment, that healthcare professionals have sufficient information about end-of-life treatment, and that patients end-of-life treatment information is recorded in the patient form. Physicians did not agree with the view that terminal patients receive adequate support for pain control. Nurses did not agree that end-of-life care discussions improve patient-physician harmony (**Table 7**).

Table 7. End-of-life decisions scale results, mean scores

End-of-Life Decisions Scale Questions	$\bar{X}$ $\pm$ SS	$\bar{X}$ $\pm$ SS	$\bar{X}$ $\pm$ SS
	Physician	Nurse	Total
I believe that my work experience has enabled me to discuss end-of-life treatment and care decisions with patients and their families.	2.33 $\pm$ 1.09	2.34 $\pm$ 1.02	2.34 $\pm$ 1.06
I believe that my education has prepared me to discuss end-of-life treatment and care decisions with patients and their families.	2.81 $\pm$ 1.16	2.70 $\pm$ 1.10	2.76 $\pm$ 1.14
When discussing end-of-life treatment and care decisions with my patients or their families, I am comfortable using the words "die" or "death."	2.95 $\pm$ 1.12	3.32 $\pm$ 1.06	3.13 $\pm$ 1.11
Healthcare professionals provide patients and their families with sufficient information regarding end-of-life treatment and care preferences.	3.53 $\pm$ 0.96	3.31 $\pm$ 1.15	3.43 $\pm$ 1.07
The patient's wishes and details regarding end-of-life treatment and care discussions are recorded in the patient follow-up form.	3.01 $\pm$ 1.21	3.18 $\pm$ 1.27	3.09 $\pm$ 1.25
End-of-life treatment and care discussions accelerate physician-patient agreement on treatment preferences.	2.03 $\pm$ 0.69	1.86 $\pm$ 0.69	1.95 $\pm$ 0.70
Terminal-stage patients receive adequate support for pain control.	1.95 $\pm$ 0.90	2.19 $\pm$ 1.15	2.07 $\pm$ 1.04
Details of discussions regarding end-of-life treatment and care, as well as patient preferences, are recorded in the patient follow-up form.	2.89 $\pm$ 1.12	3.08 $\pm$ 1.31	2.99 $\pm$ 1.22
Patients understand the information provided about end-of-life treatment and care.	2.93 $\pm$ 0.89	2.87 $\pm$ 0.93	2.91 $\pm$ 0.91
I frequently discuss pain management for my terminal patients with other nurses or physicians.	2.19 $\pm$ 0.95	1.95 $\pm$ 0.82	2.08 $\pm$ 0.90
Even if they are not in the terminal phase, all patients have the right to make decisions regarding end-of-life treatment and care (life support), even if this decision could lead to their death.	2.00 $\pm$ 0.93	1.97 $\pm$ 1.02	1.99 $\pm$ 0.98
Patients and their families are provided with consistent information about end-of-life treatment and care decisions and the consequences of these decisions.	2.46 $\pm$ 0.95	2.72 $\pm$ 1.16	2.59 $\pm$ 1.07
I frequently discuss pain management with my end-of-life patients.	2.23 $\pm$ 0.95	1.99 $\pm$ 0.81	2.11 $\pm$ 0.90
Terminal-stage patients have sufficient resources to cope with pain.	3.17 $\pm$ 0.93	3.08 $\pm$ 1.02	3.13 $\pm$ 0.98
Patients and their families are also often offered 'futile/useless' treatment options that prolong the treatment process.	2.58 $\pm$ 0.96	2.58 $\pm$ 0.95	2.58 $\pm$ 0.96
Patients and families are given sufficient time to make end-of-life treatment and care decisions.	2.70 $\pm$ 0.95	2.66 $\pm$ 0.95	2.69 $\pm$ 0.96
I wait for the patient or family to initiate end-of-life care discussions.	2.39 $\pm$ 0.82	2.39 $\pm$ 0.97	2.39 $\pm$ 0.90
I frequently collaborate with other healthcare professionals to facilitate end-of-life decisions.	2.27 $\pm$ 0.89	2.19 $\pm$ 0.92	2.23 $\pm$ 0.91

I believe that patients and their families are better able to evaluate end-of-life decisions in a calm and non-coercive environment.	1.99±0.81	1.90±0.90	1.95±0.86
Patients and families are regularly involved in current discussions about end-of-life decisions.	2.85±0.95	2.97±1.09	2.91±1.02

Discussion

With death, the desires we pursued throughout our lives, the dreams we built, our plans for the future in short, the story of our lives come to an end with this infinite silence. The thoughts, feelings, experiences, and activities of a dying person in the final months, days, and moments of their life, where and how they died, what their wishes were during this final period of their life, and how they went through this process can sometimes be more important than the causes of death. This does not mean that the environment in which the person dies is unimportant or that the cause of death, which varies according to the degree of suffering it causes, is unimportant; however, what may be most meaningful for the individual and the family and friends left behind, especially for patients whose death is expected, is that this process is completed comfortably, with as little suffering as possible, and with the wishes expressed by the patient while they are still able to make decisions being fulfilled.

By the nature of their work, physicians and nurses are an important part of the decision-making process regarding human life. Although they are sometimes the implementers of the decisions made, their knowledge, experience, and expertise are frequently sought during the decision-making stage.

The main purpose of planning end-of-life treatment and care decisions in advance is to ensure that the patient, their family, and the physician discuss and consider the best treatment options, are prepared for certain medical situations, and make the best possible medical decisions. Therefore, healthcare professionals, whose medical knowledge and experience are trusted, emerge as important actors in end-of-life treatment and care decisions. Therefore, this study aims to determine the attitudes of physicians and nurses in Türkiye towards end- of-life decisions and compare them with research results from different countries. While reviewing the literature on the subject, the study aims to discuss the research results with the most data.

When reviewing the literature on end-of-life decisions, it is noticeable that the most discussed and researched topic is education related to end-of-life decisions and advance directives. A study by You et al. (2014) found strong evidence that physicians lack communication training and skills, have negative attitudes toward death in the intensive care unit, focus on clinical parameters, and do not trust their patients' own decisions regarding their actual condition.⁶ In a study by Wittenberg et al. (2018) addressing death and the grieving process in oncology patients and their families, it was emphasized that nurses' education and communication regarding end-of-life decisions and care were inadequate, and therefore there was a need for training, support, experience, and role models to help them develop their communication skills.⁷ In a qualitative study conducted by Zheng et al. (2015) to examine the care experiences of oncology nurses with terminally ill patients, it was found that nurses were willing to communicate with patients about quality end-of-life decisions and provide end-of-life care but were challenged by a lack of knowledge and experience.⁸

Hendricks-Ferguson et al. (2015) conducted a study with 14 nurses who had less than one year of work experience in pediatric oncology and concluded that nurses did not have sufficient knowledge about the dying process.⁹ In their research on nurses' perceptions of death. In a study conducted by Yılmazlı and Vermişli (2015) to determine the attitudes of nurses working in intensive care regarding death and caring for dying patients, it was determined that 63.3% of nurses had received training on death, but the majority (56.7%) did not find this training sufficient.¹⁰ According to a study conducted by Attia et al. (2013) to identify the barriers and supportive factors in intensive care nurses providing end-of-life care to patients in the

terminal phase and discussing end-of-life decisions, lack of knowledge, experience, and training about end-of-life processes, poor design of intensive care units, heavy workload of nurses, and the family's inability to accept the patient's poor prognosis were identified as barriers to end-of-life care and end-of-life decisions.¹¹

In a study conducted by Friedenberg et al. (2012) to identify barriers to providing quality end-of-life care in intensive care units and discussing end-of-life decisions with patients, it was found that the two main barriers nurses encounter in this area are lack of training in end-of-life care during their education and after entering the workforce, and communication difficulties.¹² Balboni et al. (2013) conducted a study involving 339 nurses and physicians to identify factors contributing to the provision of spiritual care by nurses and physicians caring for patients in the terminal phase. It was found that the vast majority of nurses (88%) and physicians (86%) believed they did not receive adequate training on end-of-life decisions and processes.¹³

According to a study conducted by Ho et al. (2010) examining the opinions and attitudes of Spanish nephrology nurses regarding end-of-life decisions for patients in the terminal phase, 88.9% of participants perceived end-of-life care as an emotionally challenging task, 95.3% reported that addressing death-related issues requires special skills and training, and 92.6% stated that regular in-service training is necessary to ensure correct decisions are made and proper communication is maintained during the end-of-life decision-making process.¹⁴

Espinosa et al. (2010) studied the decision-making processes and caregiving experiences of intensive care nurses in the end-of-life period. They concluded that training nurses in staff support and communication would improve care for dying patients and their families, as well as shortening the time taken to make decisions related to the process.¹⁵ In our study, when the participants' status of receiving training on end-of-life decisions was examined, it was found that 45.1% of the participants had received training on ethical issues after graduation, 26.4% had participated in training on the patient's own decision-making, and 40.7% had participated in training covering values, ethics, or moral development. Furthermore, 83.2% of participants believed that additional training on end-of-life decisions would improve their ability to communicate with patients and their families on this subject. Of those who held this view, 61.6% stated that such training should be provided throughout the entire professional education process. In this respect, our research results reveal the lack of and need for training on this subject and are consistent with the literature in the field.

Another frequently discussed topic in research on end-of-life decisions is whether the individuals participating in these studies have taken any initiative regarding the subject. In this context, participants are usually asked to provide information on the following: Which documents they have prepared or are considering preparing, such as living wills and advance directives. Whether anyone in their family or among their close friends has prepared such documents. Their level of knowledge about these documents. Where they obtained their information. Accordingly, in a study conducted by Rao et al. (2014) in the United States with patients in different hospitals regarding end-of-life decisions and power of attorney, it was found that 26.3% of 7,946 participants had a power of attorney.¹⁶

Yadav et al.'s 2017 study systematically reviewed studies published between 2011 and 2016 to determine the proportion of US adults who had a living will, an advance directive, or both. Of the 795,909 individuals in the 150 studies analyzed, 29.3% had a living will and 36.7% had completed a power of attorney.¹⁷

Heyland and colleagues interviewed 516 older patients and 366 family members at 12 different centers in Canada. They found that 76.3% of the elderly had thought about end-of-life care decisions before being admitted to the hospital, but only 11.9% had implemented this by leaving a living will. They found that 30.3% of these decisions were discussed with family physicians, while 55.3% were discussed with someone else.

However, it was observed that only 30.2% of medical records contained the patient's wishes regarding end-of-life decisions or documents about the decisions made by the family regarding the patient.¹⁸

In a study conducted by Gamble and colleagues with 75 older adults in North Carolina, it was found that although 64% of the elderly knew what a living will was and the government had a program for it, none of them had completed a living will, and only two (3%) had discussed their end-of-life treatment and care preferences with their doctors. In another study conducted in the UK with 76 older adults, 82% of participants were found to be unfamiliar with terms such as living will or advance directives; of the 13 individuals who said they had heard of a living will, only 4 were able to define it correctly.¹⁹ In a study by Say Şahin and colleagues (2024), it was found that elderly individuals wanted to leave an advance directives if they were diagnosed with a terminal illness.²⁰

In their study investigating whether advance directives help in decision-making regarding end-of-life decisions, Peicius et al. found that only 16.7% of healthcare professionals were knowledgeable about advance directives, while others had limited knowledge on the subject. They also found that the level of knowledge was statistically significant in terms of gender and department, and that physicians were more familiar with the concept than nurses and pharmacists.²¹ In our study, when asked, "Have you ever participated in any course, seminar, or workshop that included the topic of 'Patient Self-Determination'? Are you knowledgeable about this topic?" It was found that 22% of physicians and 30% of nurses answered 'Yes' to this question, and that the level of knowledge was statistically significant in terms of the units studied (basic, internal, and surgical) ($p=0.005$) (Table 3).

When we examine the results of the study conducted by Stoeckle et al. (1998), we find that 88% of the participants had experienced a life-threatening event or experience, and 68.4% of those who had such an experience reported that their preferences and decisions regarding end-of-life care had changed after this experience. 77,5 % of participants reported that they considered discussing their end-of-life preferences with their families or friends. 75% of participants knew their families' preferences and wishes. However, only 25.8% of participants stated that they had completed a document regarding "advance directives" for end-of-life decisions. It was found that only 35% of the participants' families had such a statement, and participants stated that professional experience was an important factor in discussing end-of-life preferences with patients and their families.⁵ Overall, the research results show that even if people are knowledgeable about end-of-life decisions and living wills and consider preparing a living will, very few actually do so. Looking at our research results, in our study, 81.1% of participants had previously experienced a terminal illness or life-threatening situation, 56% of those who had this experience reported a change in their beliefs and values regarding life and death, 38.9% discussed their end-of-life treatment and care preferences with their family or a close friend, 33.1% considered preparing an advance directive but only 2.3% actually prepared one, 1.6% left a medical power of attorney, 61.6% considered leaving a medical power of attorney, 33.6% knew the wishes of their family members regarding end-of-life treatment and care, only 0.5% of family members had a power of attorney, 3.7% of participants had a living will, and 71.3% of participants without a living will considered leaving one (Table 4 and Table 5). At this point, it can be assumed that participants did not prepare a power of attorney because they thought it would not be legally valid even if they did. In this respect, our research results are consistent with the literature.

Looking at the research conducted by Şahin and Büken (2020) with 448 older adults in Türkiye, after explaining what a living will is to the elderly, it was found that 79% of older adults would consider leaving a living will. Although these concepts are new in our country and we do not see these practices in real life, the results of the study mentioned above show that the situation is not much different in other countries.²²

In end-of-life decision-making and advance directives we often see participants being asked questions such as Who would you want to make decisions on your behalf? or Who would you consider authorizing? Looking at the literature in particular, it is possible to mention the existence of many studies conducted with older adults regarding end-of-life decisions. It can be said that the main reason for this is that the elderly are considered to be individuals who are closer to the end of their lives. However, a review of the literature reveals that research has tended to focus more on questions for physicians and nurses regarding medical and technical issues such as resuscitation orders, mechanical ventilation, and futile treatments, with less research on who they would want to authorize in terms of advance directives or who they think should initiate discussions about end-of-life decisions. Therefore, in our study, we also questioned physicians and nurses about their thoughts on who should initiate discussions regarding end-of-life decisions. Accordingly, when we looked at our results, we found that 42.7% of physicians and 41% of nurses responded that the patient should initiate the discussions (Table 6). In the study by O'Sullivan and colleagues, 72.3% of participants believed that discussions regarding advance directives should be initiated by family physicians.²³

In the studies conducted by Şahin and Büken (2020) with older adults, participants believed that they could appoint a family member (58.9%) as their medical proxy, secondly their physician (38.6%), and finally a close friend (2.5%) as their guardian, but they considered the physician's opinion and approval to be important when making medical decisions. Gamgle et al. (1991) found in their study with older adults that when they were unable to make decisions for themselves, 93% wanted their family or spouse to be the medical decision-maker on their behalf, but they also wanted these decisions to be shaped with the healthcare personnel caring for them.¹⁹ Schiff et al.'s (2000) study found that 75% of elderly individuals in the UK would choose relatives and spouses, 5% would choose friends, and 20% would choose doctors as medical decision-makers on their behalf.²⁴ A study conducted by the Kaiser Family Foundation (2015) with 1,202 adults revealed that individuals feel most comfortable and willing to discuss end-of-life care with their spouses or partners (83%), but healthcare professionals were identified as the most appropriate individuals to make medical decisions. It was found that discussions about end-of-life care were shared with doctors and other healthcare providers at a rate of 57%, with close friends at 51%, and with a religious or spiritual advisor at 50%, and it was suggested that 64% of these discussions should be initiated by physicians.²⁵ According to the results of a study conducted by Stoeckle et al. (1998) with healthcare professionals, participants placed the patient themselves at the top of the list of who should initiate discussions about end-of-life decisions and believed that the patient should initiate these discussions.⁵

In a study by Miccinesi et al. (2005), doctors stated that nurses played a role in 2,412 (78.3%) of the 3,086 end-of-life decisions made. In 66 cases (2.1%), nurses were thought to have initiated the discussion regarding end-of-life decisions, while in 328 cases the primary physician was mentioned, and in 2,438 cases (79.3%) intensive care unit physicians were mentioned. In 105 cases (3.4%), a consulting physician, in 119 cases (3.9%) the family, and in 19 cases (0.6%) the patient was identified as the initiator of the discussion.²⁶ Our study did not include a question about who initiated the discussion, but the question of who should initiate it was examined in detail.

As a result, when our research results are compared with the literature, an interesting difference emerges. Although our study did not investigate patients' thoughts on end-of-life decisions, our research results and other studies indicate that physicians and nurses believe patients should initiate discussions about end-of-life decisions (Table 7). However, according to the literature, patients mostly believe that physicians should initiate these discussions and that they are best positioned to make the most appropriate medical treatment decisions.

Conclusion

During the end-of-life process, nurses providing care and physicians making medical decisions are the primary sources of support and information for patients and their families. Therefore, the attitudes and thoughts of physicians and nurses, who are an important part of this process, regarding end-of-life decisions are important both in planning care and in managing this process in the most appropriate way with the patient's relatives.

Both the results of our research and the relevant literature reveal that healthcare professionals have a serious need for training in the end-of-life decision-making process. It is essential that healthcare professionals receive training on end-of-life decisions and palliative care, as well as training on the dying process, during their undergraduate, graduate, and specialist training. Furthermore, it is important that this training be provided as part of in-service training in the units where they work, that it be repeated, and that it be sustainable. Palliative care units and intensive care units are the units where end-of-life decisions are most frequently discussed. The existence of guidelines for healthcare professionals working in these units regarding the palliative care process and end-of-life decisions can facilitate the management of the process.

Our research results show that although advance directives are considered important, the number of physicians and nurses who put this idea into practice and fill out authorization notices is quite low. While this situation may be due to reasons such as not knowing what an advance directive is or thinking that one is too young for it, the existence of many barriers related to advance directives can negatively affect the end-of-life decision-making process. Therefore, classifying the 'barriers related to advance directives in the end-of-life decision-making process' is important in terms of understanding the difficulties we will encounter in this process. The prevailing view in modern medical practice is that the patient should be the primary decision-maker. Therefore, in consultation with clinical ethics experts and scientists from other disciplines conducting research on the subject, consideration should be given to making regulations to overcome the obstacles to the advance directives, creating applicable and guiding templates, and developing guidelines for end-of-life care training and communication between patients and healthcare professionals regarding end-of-life decisions.

Limitations of the Study

One limitation of the research is that the forms were distributed only to participants who were members of the Medical Chambers and Nurses Associations; forms could not be delivered to physicians and nurses who were not members.

Türkiye's sociodemographic structure, the distribution of healthcare personnel, and end-of-life decisions have become more complex due to the impact of extraordinary circumstances such as the 2020 pandemic and the major earthquake in February 2023. The heavy workload, psychosocial stress, and uncertainty experienced by healthcare workers during the COVID-19 pandemic may have directly influenced their attitudes and practices regarding end-of-life decisions. Additionally, the major earthquake disaster that struck Türkiye in 2023 claimed the lives of thousands of people. During this process, healthcare personnel served with great dedication both in the field and within healthcare institutions, and this tragic experience has heightened the importance of awareness and practices regarding end-of-life care. In this context, it is of great importance to reassess healthcare workers' views and practices regarding end-of-life decisions within the framework of these crisis experiences, and for new academic studies in this field to elucidate the effects of emergencies on healthcare services and ethical approaches.

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Ethical Approval

This study was approved by Burdur Mehmet Akif Ersoy University Non-Interventional Clinical Research Ethics Committee (Date: 02.02.2019, approval number: GO2019/01) This study is based on a doctoral dissertation registered with the National Thesis Center under thesis number 721493.

Author Contributions

Deniz Say Şahin: Idea/concept, design, data collection, analyses and interpretation, literature review, writing-review.

Nüket Örnek Büken: Control/Supervision, literature review, writing-review., critical review.

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