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ORIGINAL PAPER

Attitudes of Nurses in Turkey Toward Care of Dying Individual and the Associated Religious and Cultural Factors

Ezgi Karadag[1] · Serap Parlar Kilic[2] · Ozlem Ugur[1] · Merve Aliye Akyol[3,4]

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Abstract
The aim of this study was to determine the attitudes of nurses working in two university hospitals located in the west and east of Turkey toward care of dying individual as well as religious and cultural factors that influence their attitudes. The descriptive and comparative study was conducted with a total of 189 nurses who were working in adult inpatient clinics of two university hospitals in western (101 nurses) and eastern (88 nurses) Turkey between July and November 2016. The data were obtained by using the questionnaire and Frommelt Attitudes Toward Care of the Dying Scale. As a result of this study, it was determined that in terms of the status of receiving training the end-of-life care the majority of nurses received this training; however, this rate was higher (51.0%) in nurses working in the eastern hospital ($p = 0.025$). The nurses working in the east (51.6%) were determined to have more problems during caregiving due to their religious and cultural beliefs, the most frequent problem they experienced was "being uncomfortable due to privacy when giving care to patients from opposite gender" (57.1%). The emotions felt mostly by nurses during the care of dying patient were grief (nurses in the east = 48.5%, nurses in the west = 51.5%) and despair (nurses in the east = 40.4%, nurses in the west = 59.6%). Nurses working both in the east (98.27 ± 7.71) and in the west (97.19 ± 8.99) were determined to have positive attitude toward death, and there was no statistically significant difference between both groups in terms of the mean scores of the Attitudes Toward Care of the Dying Scale ($p = 0.373$). In accordance with these results, it is recommended to focus on death issues in end-of-life care during the nursing education and to support nurses with in-service trainings regularly after the graduation.

Keywords Attitude toward death · Care of dying person · Religious and cultural factors · Nursing

Introduction

The death signifying the end of life is a concept that threatens existence, is mandatory, and limits the life as well as being an integral part of the life (Joarder et al. 2014). As a result of medical advances increasing all over the world and the improvements in life conditions,

✉ Ezgi Karadag
ezgikaradag44@gmail.com

Extended author information available on the last page of the article

both the time spent with chronic and fatal diseases increases and the rates of consulting a doctor in case of disease and mortality rates in the hospital have been gradually increasing. With the effect of these factors, frequency of encountering patients with fatal disease and also the duration of giving care to these patients increase in nurses (Arslan et al. 2014). Individuals working in health-related jobs, particularly nurses who spend the most time with the patient, always have to confront with death and dying patient. Care of patients at the end of life and the death event are one of the most difficult aspects of nursing. Nurses need to know physical and psychological needs of such patients, to have developed a healthy attitude toward death, and to accept the death phenomenon in order to provide better care to them (Bilge et al. 2013; Feudtner 2005).

The fact that nurses are able to communicate with dying patient and considering their own emotions and attitudes regarding life, death, and loss to give the support needed by patient certainly is effective in providing physical and psychological care with better quality for the patients (Isik et al. 2009). Healthcare professional working in the units where the death phenomenon is frequently confronted need to understand the emotions established about death at first, to speak his/her emotions with others, and to be aware of biological, psychological, social, and cultural needs of dying patients and their relatives (Aksu and Okçay 2010). Because, qualified individual care can be provided by considering the factors associated with culture, beliefs, habits, and values of the individual as a whole (Duffy 2001). A nurse who could not develop a positive perception of death and accept that this concept is a part of life may display negative emotions and behaviors when he/she faces with death and this is negatively reflected on the care (Besti et al. 2005). It was also reported in previous studies that nurses experienced feelings such as insufficiency in adapting the reality of death, anger, despair, distress, and accusation and parallelly preferred to work in services not offering treatment to dying patients because they were afraid of being insufficient and unsuccessful with care of the patient (Bilge et al. 2013; Çevik and Kav 2013; Menekli and Fadıloğlu 2014).

Many of nurses cannot know how to behave in case of the realty of death (İnci and Öz 2012). This is because the death concept and responses to death vary from culture to culture and religion, social value judgments, beliefs, habits, and traditions play important role in this issue (Olgun 2014). While the death is very easily discussed and talked in some cultures despite the fact that it is inevitable for human, it is not talked about death in some cultures. Death experience and the meaning given to death, and cultural and religious practices related to death are different for all people. Death might be deemed as failure in communities that make future plans for continuously developing the health and value health, and make an effort to be younger. It was found in studies conducted in Korea that Korean nurses considered not extending life time as a failure based on developed modern medicine and science and did not want to accept the death (Jo et al. 2009). If someone dies at home in some cultures, family members either abandon the house or clean the house with a ritual; on the other hand, in another culture it is not deemed suitable to talk about even the name of died person. It is important for some religions to oil the dying person or to organize religious ritual (Eues 2007; Jo et al. 2009). Different beliefs and religions have brought various approaches to death. According to Judaism, death is the heaviest one of punishments and is perceived as a horrible fact. According to Christianity, human consists of soul and the body and only the body dies. The life is not ended with the death and takes a more beautiful and more different form. In Muslim societies, like Turkey, death is considered as elevation of human soul to the presence of Allah by taking it from the body (Erdoğdu and Özkan 2007).

It was determined in the literature that death-related thoughts and emotions of health-care personnel confronting death based on their own experiences considerably affected their value and belief systems associated with death (Eues 2007; Jo et al. 2009; Neimeyer et al. 2004). In this sense, nurses may develop different attitudes toward death in parallel with cultural characteristics of the society they live in and may reflect this positively or negatively to their care. There are numerous factors such as gender, socioeconomic status, race, ethnical and cultural characteristics affecting attitudes and behaviors of nurses toward death. In the study conducted by Lange et al. (2008) with 355 oncology nurses working in an extensive cancer center, nurses with more experiences were found to have more positive perspective toward death compared to nurses with less experiences. Abu Hasheesh et al. (2013) determined in their study that nurses displayed positive attitude toward death.

It is an important deficiency that the number of studies examining attitudes of nurses regarding death and the associated religious and cultural factors in Turkey is limited and regional differences are not investigated in studies. In addition, if nurses are aware of their own attitudes and cultural perspectives regarding the care of dying patients, they can plan and practice the death-related care of the patients considering their cultural values when they recognize their own cultural barriers. In this study planned with these materials, it was aimed to determine the attitudes of nurses working in two university hospitals located in the west and east of Turkey toward care of dying person and religious and cultural factors that affected their attitudes.

Methods

Design and Sample

This study was conducted in descriptive and comparative design and with nurses working in two university hospitals located in the west and east of Turkey. Two of the seven geographical regions in Turkey are Aegean region and Eastern Anatolia Region. While Aegean region is located in the west of Turkey, Eastern Anatolia Region is located in the east of Turkey. The study was carried out at university hospitals in İzmir (in Aegean region) which is located in western Turkey is one of the provinces receiving immigrants intensively and has high population density in Turkey and in Elazig (in Eastern Anatolia Region) located in eastern Turkey. The sample of the study consisted of a total of 189 nurses who worked in adult inpatient clinics of two university hospitals located in west (101 nurses) and east (88 nurses) of Turkey between July and November 2016 and were voluntary to participate in the study.

Data Collection

The data of the study were collected using a questionnaire prepared by researchers utilizing from the literature (Arslan et al. 2014; Bilge et al. 2013; Jo et al. 2009; Lange et al. 2008) and Frommelt Attitudes Toward Care of the Dying Scale. The nurses were briefly informed about the study and questionnaires before the study, and the study was started by using face-to-face interview method after receiving their verbal consents. It took approximately 8–10 min to complete the questionnaire.

Data Collection Forms

Questionnaire

Questionnaire consists of three parts including open-ended and close-ended questions. The first part containing demographic characteristics of nurses involves totally eight questions including age, gender, educational level, place of birth, marital status, clinic, the duration of working in the institution, the type of work, and residence place. There are five questions in the second part of the questionnaire to determine attitudes of nurses toward death and giving care to dying person and the associated religious and cultural factors. The third part includes 13 questions identifying knowledge and training status of nurses regarding the end-of-life care and the death.

Frommelt Attitude Toward Care of the Dying Scale/FATCOD

FATCOD is a 30-item scale created by Katherine H. Murray Frommelt in 1988. The scale consists of items in equal number including positive/favorable and negative/unfavorable attitudes. The scale is likert type and is scored as 1—I absolutely agree and 5—I absolutely disagree. In scoring the scale, total score is obtained by adding items including negative attitudes that are reversed together with positive answers. While total score to be obtained from the instrument ranges between 30 and 150, high scores indicate more positive attitude. Frommelt Attitude Toward Care of the Dying Scale/FATCOD is commonly used in America, Japan, and Iran. Validity–reliability study of the scale was conducted by Çelik and Kav (2013) in Turkey, and Cronbach's alpha coefficient was found to be 0.73.

Data Analysis

Statistical evaluation of the data obtained as a result of the study was carried out by using the SPSS (Statistical Package for Social Sciences) package program, and $p < 0.05$ was accepted as statistically significant. Numbers, percentage, two-way analysis of variance, Pearson's Chi-square test, Fisher's exact test and correlation analysis were used to analyze the data.

Ethical Approval

In order to carry out the study, written permission was taken from Scientific Ethics Committee of Dokuz Eylül University Hospital (ethics committee number 2016/21-28) and chief physician of hospitals in which the study was conducted.

Results

Sociodemographic Characteristics of Nurses

When demographic characteristics of the nurses constituting the sample of the study were evaluated in terms of regions, average age of nurses working in the hospital in the east was 30.54 ± 7.68, 81.8% were female, 61.4% were married, 67.0% had bachelor's degree, 48.9% were working in internal medicine units, 65.9% were working for 5 years or a shorter time, 48.9% were working in shifts, and 87.5% stated they were residing in the city.

Average age of nurses working in the hospital in the west was 34.94 ± 7.57, 95.0% were female, 67.3% were married, 80.2% had bachelor's degree, 55.4% were working in internal medicine units, 57.4% were working for 5 years and a shorter time, 78.2% were working in shifts, and 87.2% stated they were residing in the city. It was determined that there was a significant difference between nurses working in the hospitals in the east and the west in terms of gender, age, the school of graduation, manner of working and period of working, and this difference was resulted from nurses working in the west who had greater ratio of female gender, bachelor's degree, rate of working in shift, older age and longer period of working (Table 1).

Religious and Cultural Factors Affecting Nurses' Attitudes Toward Death

It was determined that no other language except for Turkish was spoken in families of a majority of nurses constituting the sample of the study. 61.6% of nurses who indicated that no other language was spoken in their families but Turkish were nurses working in the west ($p = 0.035$). Among the nurses who stated another language was also spoken in their families except for Turkish, families of nurses working in the west were observed to speak mostly Arabic and English, whereas Kurdish and Arabic were mostly spoken in families of nurses working in the east (Table 2).

While 57.7% of nurses working in the east stated that cultural belief and religious belief of the person positively affected the attitude toward the death and giving care to dying patient, 70.0% of nurses working in the west stated that they did not affect. A minority of nurses were determined to have problems due to cultural beliefs and religious beliefs. It established the fact that the state of nurses to have problem while giving care due to their own cultural and religious beliefs was higher in nurses working in the east (51.6%), they had most problems because of "being uncomfortable while giving care to patients from the opposite gender due to privacy" (57.1%) (Table 2).

Knowledge and Thoughts of Nurses on Regarding the End-of-Life Care

In terms of receiving training about the end-of-life care, the majority of nurses were detected to receive this training but the rate of those received training was significantly higher in nurses working in hospital in the east (51.0%) compared to those in the west (49.0%) ($p = 0.025$). In addition, only the minority of nurses who received this training considered that the training was sufficient and the rate of those considered the training on the end-of-life care was higher in nurses working in hospital in the west (60.0%) compared to those in the east (40.0%). In both groups, this training was determined to be received mostly during professional education. Majority of the group thinking that religious beliefs and cultural values of dying patient and her/his family are critical in nursing care were nurses working in the west at the rate of 53.5% (Table 3).

Attitudes and Feelings of Nurses on Regarding the Death and the End-of-Life Care

Great majority of sample group (nurses in the east = 42.9%, nurses in the west = 57.1%) were determined to face with the death phenomenon in the clinic. While the feelings most frequently experienced by nurses working in hospital in the east when they faced with the death phenomenon were "I cried and was very sad" (56.9%) and "I did not feel anything"

Table 1 Nurses' sociodemographic characteristics

	University hospital in the east (n = 88)		University hospital in the west (n = 101)		p*
	n	%	n	%	
Gender					
Female	72	81.8	96	95.0	0.004
Male	16	18.2	5	5.0	
Marital status					
Married	54	61.4	68	67.3	0.393
Single	34	38.6	33	32.7	
Age groups					
29 years and under	43	48.9	24	23.8	< 0.001
30–39 years	31	35.2	49	48.5	
40 years and above	14	15.9	28	27.7	
Graduated from					
Vocational school of health	13	14.8	2	2.0	< 0.001
Associate degree	13	14.8	6	5.9	
Bachelor's degree	59	67.0	81	80.2	
Master's degree	3	3.4	12	11.9	
Clinics					
Department of Internal Medicine	43	48.9	56	55.4	0.534
Department of surgery	23	26.1	–	–	
intensive care unit	22	25.0	29	28.7	
Oncology unit	–	–	16	15.8	
Working years					
5 years and under	58	65.9	58	57.4	0.339
6–12 years	23	26.1	27	26.7	
13–19 years	5	5.7	9	8.9	
20 years and above	2	2.3	7	6.9	
Working period					
Shift	43	48.9	79	78.2	< 0.001
Only day time	42	47.7	21	20.8	
Only at night	3	3.4	1	1.0	
Living place					
Village	4	4.5	6	5.9	0.216
Country	7	8.0	16	15.8	
City	77	87.5	79	78.2	
Mean age ($\bar{X} \pm$ SD)	30.54 ± 7.68		34.94 ± 7.57		< 0.001
Mean working years ($\bar{X} \pm$ SD)	8.57 ± 6.52		11.69 ± 8.06		0.004

*Chi-square test

Table 2 Religious and cultural factors affecting nurses' attitudes toward death

	University hospital (east) (n = 88) n (%)	University hospital (west) (n = 101) n (%)	Total sample (n = 189) n (%)	p*
Presence of another language spoken in the family other than Turkish				
Yes	32 (74.4)	11 (25.6)	43 (100.0)	0.035
No	56 (38.4)	90 (61.6)	146 (100.0)	
The language spoken in the family except for Turkish (n = 43)				
Arabic	–	3 (100.0)	3 (100.0)	–
Bulgarian	–	1 (100.0)	1 (100.0)	
Lazuri	–	1 (100.0)	1 (100.0)	
Kurdish	25 (92.6)	2 (7.4)	27 (100.0)	
Zaza language	5 (83.3)	1 (16.7)	6 (100.0)	
English	1 (25.0)	3 (75.0)	4 (100.0)	
French	1 (100.0)	–	1 (100.0)	
The state of cultural belief and/or religious belief to influence the death and the attitude toward giving care to dying patient				
It affects positively	64 (57.7)	47 (42.3)	111 (100.0)	0.210
It affects negatively	3 (37.5)	5 (62.5)	8 (100.0)	
Does not affect	21 (30.0)	49 (70.0)	70 (100.0)	
Having problem with the care because of cultural belief and/or religious belief				
Yes	16 (51.6)	15 (48.4)	31 (100.0)	0.537
No	72 (45.6)	86 (54.4)	158 (100.0)	
Problem encountered in the care because of cultural belief and/or religious belief (n = 31)				
Being uncomfortable due to privacy while giving care to patients in the opposite gender	8 (57.1)	6 (42.9)	14 (100.0)	–
Not being able to give sufficient physical care to patients in the opposite gender	2 (50.0)	2 (50.0)	4 (100.0)	
Having difficulty in meeting patients and their relatives who can't speak Turkish	5 (50.0)	5 (50.0)	10 (100.0)	
Having difficulty in explaining or understanding while giving care due to difference in religious belief	1 (33.3)	2 (66.7)	3 (100.0)	

*Statistical analysis between university hospital in the east and university hospital in the west

(44.4%); the feelings mostly experienced by nurses working in hospital in the west were "I thought that his/her pains ended and he/she was freed" (66.7%) and "I was afraid" (62.5%) when they faced with the death phenomenon (Table 4).

Most of nurses were found to provide care to dying patient in the clinic. The rate of nurses working in the west (56.3%) was considerably higher than nurses working in the east (43.7%) in terms of giving care to dying patient (p = 0.007). The feelings most frequently experienced by nurses working in both hospitals during care of dying patient were observed to be; "grief and sadness" (nurses in the east = 48.5%, nurses in the

Table 3 Knowledge and thoughts of nurses on regarding the end-of-life care

	University hospital (east) (n = 88) n (%)	University hospital (west) (n = 101) n (%)	Total sample (n = 189) n (%)	p*
Receiving training about the end-of-life care				
Yes	74 (51.0)	71 (49.0)	145 (100.0)	0.025
No	14 (31.8)	30 (68.2)	44 (100.0)	
Status of considering the training sufficient (n = 145)				
Yes	14 (40.0)	21 (60.0)	35 (100.0)	0.070
No	60 (54.5)	50 (45.5)	110 (100.0)	
*Resources where information about the end-of-life care was obtained***				
During professional education (Nursing school of graduation)	68 (50.7)	66 (59.3)	134 (100.0)	–
From in-service training	24 (50.0)	24 (50.0)	48 (100.0)	
From books and journals	18 (54.5)	15 (45.5)	33 (100.0)	
From congress/symposiums/ seminars	10 (43.5)	13 (56.5)	23 (100.0)	
Media (TV, radio, newspapers)	14 (73.7)	5 (26.3)	19 (100.0)	
Internet	16 (69.6)	7 (30.4)	23 (100.0)	
Importance of religious beliefs and cultural values of dying patient and his/her family in nursing care				
Important	85 (46.4)	98 (53.5)	183 (100.0)	0.864
Not important	3 (50.0)	3 (50.0)	6 (100.0)	

*Statistical analysis between university hospital in the east and university hospital in the west

**Nurses reported more than one answer

west = 51.5%) and "despair" (nurses in the east = 40.4%, nurses in the west = 59.6%). Most of nurses (nurses in the east = 47.8%, nurses in the west = 52.2%) were determined to state that they were not be able to comfortably speak with dying patient about death and "I consider death as a fact of nature and try to relax" (nurses in the east = 43.6%, nurses in the west = 56.4%) as the method of coping they mostly used after confronting death (Table 4).

Mean Scores of Nurses for Frommelt Attitude Toward Care of the Dying Scale

It was determined in the study that both nurses in the east and nurses in the west had high mean scores of attitude scale and had a positive attitude toward death (nurses in the east = 98.27 ± 7.71; nurses in the west = 97.19 ± 8.99). As nurses in the east and nurses in the west were compared in terms of mean scores from Attitude Toward Care of the Dying Scale, it was observed that there was no significant difference between two groups (p = 0.373) (Table 5).

As a result of the study, it was also revealed that the correlation between religious and cultural characteristics of nurses in both hospitals, their knowledge and attitudes toward the end-of-life care and mean scores of nurses from attitude scale was not statistically significant ($p > 0.05$).

Table 4 Attitudes and feelings of nurses on regarding the death and the end-of-life care

	University hospital (east) (n = 88) n (%)	University hospital (west) (n = 101) n (%)	Total sample (n = 189) n (%)	p*
Status of facing death in the clinic				
Yes	73 (42.9)	97 (57.1)	170 (100.0)	0.824
No	15 (78.9)	4 (21.1)	19 (100.0)	
Emotions felt/experienced when facing death (n = 170)**				
I did not feel anything	4 (44.4)	5 (55.6)	9 (100.0)	–
I was scared	3 (37.5)	5 (62.5)	8 (100.0)	
I cried and was very sad	37 (56.9)	28 (43.1)	65 (100.0)	
I reacted normally, I considered it as a fact of nature	23 (41.8)	32 (58.2)	55 (100.0)	
I thought that his/her pains ended and he/she was freed	17 (33.3)	34 (66.7)	51 (100.0)	
Losing a first degree relative				
Yes	27 (32.1)	57 (67.9)	84 (100.0)	0.099
No	61 (58.1)	44 (41.9)	105 (100.0)	
Giving care to a dying patient				
Yes	76 (43.7)	98 (56.3)	174 (100.0)	0.007
No	12 (80.0)	3 (20.0)	15 (100.0)	
Being eager about giving care to dying patient				
Yes	67 (51.5)	63 (48.5)	130 (100.0)	0.052
No	21 (35.6)	38 (64.4)	59 (100.0)	
Emotions felt when giving care to dying patient (n = 174)**				
Guilt	1 (14.3)	6 (85.7)	7 (100.0)	–
Failure	4 (33.3)	8 (66.7)	12 (100.0)	
Anger	2 (33.3)	4 (66.7)	6 (100.0)	
Anxiety	8 (42.1)	11 (57.9)	19 (100.0)	
Despair	23 (40.4)	34 (59.6)	57 (100.0)	
Grief/sadness	50 (48.5)	53 (51.5)	103 (100.0)	
Fear	2 (18.2)	9 (81.8)	11 (100.0)	
State of easily speaking about death with dying patient				
Yes	11 (39.3)	17 (60.7)	28 (100.0)	0.403
No	77 (47.8)	84 (52.2)	161 (100.0)	
*The methods of coping used after facing with death***				
I cry	18 (58.1)	13 (41.9)	31 (100.0)	–
I prey	43 (76.2)	21 (32.8)	64 (100.0)	
I talk to my friends about this issue	15 (33.3)	30 (66.7)	45 (100.0)	
I talk to my family about this issue	14 (56.0)	11 (44.0)	25 (100.0)	
I consider death is a natural thing and I try to relax	48 (43.6)	62 (56.4)	110 (100.0)	
I do nothing	6 (40.0)	9 (60.0)	15 (100.0)	

*Statistical analysis between university hospital in the east and university hospital in the west

**Nurses reported more than one answer

Table 5 Mean scores of nurses for Frommelt Attitude Toward Care of the Dying Scale

Scores	University hospital (east) Mean ± SD	University hospital (west) Mean ± SD	Significance p value
Attitude scale	97.19 ± 8.99	98.27 ± 7.71	$t = -0.892$ 0.373

Discussion

According to results of literature review, the present study is considered as the first one to determine attitudes of nurses working in two different regions of Turkey toward giving care to dying person and the associated religious and cultural factors. Death is one of the most important events that people have to cope with in their lives and a universal phenomenon shared by all of the living organisms (Işık et al. 2009). Death experience, the meaning attributed to death and cultural and religious practices toward death are different for all individuals. In this challenging process, approach and positive attitude of the nurse to these individuals are extremely critical (Eues 2007).

It was determined that most of the nurses included in the study spoke Turkish, *cultural belief and/or religious belief* positively affected attitude toward death and they did not have problem. It is important for nurses to know that culture and religious beliefs of all of the patients and the families they give care are not the same as theirs, to learn what normal responses of patient and relatives against death are, how they consider death and about their death rituals, and to have approach in this direction. It is required that nurses do not force their own religious or cultural beliefs down patients and their relatives' throat.

In this study, it was determined that most of the nurses working in hospitals in both west and east received training on the end-of-life care, but most of them found their training insufficient and received this training during their occupational education. In a previous study, doctors and nurses considered that the training which they received about the end-of-life care was insufficient, and in other studies nurses were determined to receive training on the end-of-life care during their undergraduate education; however, they did not find this training sufficient (Çevik and Kav 2013; Menekli and Fadıloğlu 2014; Yılmaz and Vermişli 2015). Giving care to dying patients requires nurses to be knowledgeable and skillful in several fields and to appropriately cope with stress. The fact that nurses are trained regarding the death and care of dying patient and acquire insight about their own behaviors underlies in the basis of providing qualified care to patients and their families. Therefore, the meanings attributed to disease and the death by nurses need to be revealed. Nurses who cannot face with their own mortality and accept this reality move away from dying patient and the family or may reflect their own fear of death to them (Abu Hasheesh et al. 2013; İnci and Öz 2012). It is stated in the literature that planned trainings applied to nurses improve attitudes of nurses toward death positively and cause to decrease the death anxiety they experienced (Abu Hasheed et al. 2013; Işık et al. 2009). Professional competences of nurses can be increased by giving trainings about death process. Thus, awareness of nurses may be raised in terms of describing emotional and physical needs of terminally ill patients and their families (Yılmaz and Vermişli 2015).

Despite the fact that most of nurses in the present study considered that the training they received on the end-of-life care was insufficient, majority of nurses working at hospitals

both in the west and in the east stated that they considered it was important to provide care as sensitive to religious beliefs and culture of the patients and their families while giving care to patient. In the end-of-life care, religion, cultural beliefs, and traditions are very important. Nurse should protect religious practices and cultural values of the patients and their family as well as their own religious practices and beliefs. It is important for nurses to recognize that not all of the patients and their families they give care have the same culture and religious belief as they have, in terms of decreasing cultural stereotyping factors, preventing difficulties of communication, and preventing treatment-induced damages. Planning of patient care should also be sensitive to their rituals about death, autonomies, and demands (Chin 2015; Fleming 2003; Neimeyer et al. 2004).

In the present study, while most of nurses were found to confront death in the clinic, to give care dying patient, and to experience emotions such as grief, despair, anxiety when giving care to dying patient; a great majority of them were determined to accept death as a natural process, to cry, and to be very sad when they faced with death. In similar studies, most of nurses confronted death in the clinic, considered death as a natural event, were sad against death, and felt themselves desperate (Çevik and Kav 2013). In study by Karahisar (2006), nurses were found to feel desperate when giving care to dying patient and define the death process as a very tiring event with a scary end. Menekli and Fadıloğlu (2014) determined in their study that a large majority of nurses confronted death in the clinic and felt sadness–fear. It is stated in the literature that nurses also experience several emotions and responses experienced by patients while they were giving care to dying patient (Çevik and Kav 2013; Eues 2007; Özdemir and Senol Çelik 2010). It was also indicated that nurses were afraid of being insufficient and unsuccessful in care of dying patients, they experienced feelings of anger and grief in case that patient did not respond to treatment properly, disease progressed, and patient could not be prevented from suffering, and *they could not talk to patients about death* (Çevik and Kav 2013; Eues 2007; Özdemir and Senol Çelik 2010). In the present study, most of nurses were determined not to talk to their patients about death. The results are in line with the literature. In societies where Muslim and traditional structure is dominant, like Turkey, it is not regarded as good to talk and discuss about death. This result might be the reflection of traditional Turkish social structure on nurses.

In this study, there were "*preying*" in hospital in the east, "*considering the death as a natural process*" in hospital in the west as coping method used by nurses after confronting death. When whole group was examined, it is seen that coping method mostly used by both groups after death was thinking of death as a natural process and relaxing with this thought. Likewise, in the study by Çevik and Kav (2013), 43.4% of nurses confronting the death phenomenon were determined to consider death as a natural process, to prey or to talk to their friends in order to cope with. The word "prayer" is used in several places of Quran the holly book of Islam, and individuals were reported to more easily cope with stress, depression, and hopelessness by preying (Ağılkaya 2010).

As is in every religion, beliefs influence not only health behaviors and life style from birth to death but also care in Muslim Turkish community as well. Both religion and cultural beliefs have impacts on individuals in terms of health aspects ranging from nutrition to their decisions about disorders and death (Tasçi 2012). In the present study, most of nurses were determined to have no problem while giving nursing care of dying patient and his/her family due to religious and cultural beliefs. However, nurses having problem were identified to have difficulties mostly due to "religious privacy while giving care to patient from the opposite sex (for example, patients do not allow healthcare personnel from the opposite gender for their care)" or due to use of other language except for

Turkish. It was also emphasized in the literature that nurses may have conflicts with patients they care due to language barriers and privacy resulting from different gender, and this situation may be a reflection of society's cultural structure (Ayaz and Bilgili 2009; Chin 2015; Parlar Kilic et al. 2014). It is considerably important to speak the same language in communication during diagnosis, treatment, and care processes of disorders. Communication problems that will develop depending on deficiencies in use of common language affect and change approach of treatment and care. While even those who speak the same language have problems in perceiving, more problems may be experienced in process evaluation in those speaking different native languages (Ayaz and Bilgili 2009; Tasçi 2012). The data were compatible with the literature.

In the present study, the score that nurses working in hospitals both in the east and in the west received from attitude scale regarding care of dying patient indicated "positive attitude" and significant difference was not found between them. This shows us that the death is a universal phenomenon and attitude toward death may be similar wherever or in which region it is. Even though there is no study with regional comparison, attitude toward death was found to be positive in other studies conducted with nurses (Abu Hasheesh et al. 2013; Çevik and Kav 2013; Lange et al. 2008).

Limitations

The results of the present study cannot be generalized because the sample determined attitudes of nurses working only at two university hospitals in Turkey regarding giving care to dying patient and the associated religious and cultural factors. Therefore, these results cannot be generalized to nurses working in other geographical regions.

Conclusion and Recommendations

As a result of this study, nurses working in two different regions of Turkey were seen to display positive attitude toward death. *Cultural belief and religious belief* positively affected attitude of majority of nurses toward death and hence they did not have problem. Nurses were determined to experience feelings such as grief, despair, and anxiety while giving care to dying patient, not to talk to patients about death, and find the training they received insufficient. In accordance with these results, it is recommended to focus on topics of education regarding the end-of-life care in nursing curriculum and to support the end-of-life care practices with regular in-service trainings after graduation. Availability of psychological consultancy and guidance services that is easily reached by healthcare professionals, patients and their relatives would facilitate coping with death.

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Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

Informed Consent Informed consents were obtained from all nurses in line with the Declaration of Helsinki.

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Affiliations

Ezgi Karadag[1] · Serap Parlar Kilic[2] · Ozlem Ugur[1] · Merve Aliye Akyol[3,4]

Serap Parlar Kilic
serap.parlar27@gmail.com

Ozlem Ugur
ozlem.ugur@deu.edu.tr

Merve Aliye Akyol
merve.akyol@deu.edu.tr

[1] Department of Oncology Nursing, Faculty of Nursing, Dokuz Eylul University, Izmir, Turkey

[2] Health Science Faculty, Firat University, Elazig, Turkey

[3] Department of Internal Medicine Nursing, Faculty of Nursing, Dokuz Eylul University, Izmir, Turkey

[4] Department of Internal Medicine Nursing, Institute of Health Sciences, Dokuz University, Izmir, Turkey