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Nurses' attitudes towards death in the hospital context: differentiation by care units

Atitudes dos enfermeiros frente à morte no contexto hospitalar: diferenciação por unidades de cuidados

Actitudes de los enfermeros frente a la muerte en el contexto hospitalario: diferenciación por unidades de cuidados

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ABSTRACT

Objective: to identify the occurrence of death in the care units, as well as to analyze the nurses' records and attitudes towards death in the hospital context. **Method:** quantitative, descriptive, cross-sectional study, with the participation of 900 nurses from a hospital in northern Portugal. Using data source triangulation, the collection took place from February to March 2018 through a questionnaire and observation of records made by nurses. For data analysis, descriptive and analytical statistics were used. **Results:** it is the medical units that present the highest number of deaths, with the highest number of occurrences taking place in the night shift. Regarding the nurses' attitudes towards death, with the exception of avoidance, all the others show a similar trend among the professional group, regardless of their area of activity. Nursing records have a higher incidence at the function level rather than focusing on the person's domain. **Conclusion and implications for the practic**e: in addition to the acquisition of knowledge, through participation in training on death and the dying process, the monitoring and support of professionals, may play a fundamental role in preparing nurses to care of people at the end of life.

Keywords: Attitude to Death; Death; Nursing; Nursing Care; Hospitals.

RESUMO

Objetivo: identificar a ocorrência da morte nas unidades de cuidados, bem como analisar os registros e as atitudes dos enfermeiros frente à morte no contexto hospitalar. **Método:** estudo quantitativo, descritivo, transversal, com participação de 900 enfermeiros de um hospital do norte de Portugal. Com recurso à triangulação de fontes de dados, a coleta realizou-se de fevereiro a março de 2018 através de questionário e observação de registros efetuados pelos enfermeiros. Para análise dos dados usou-se estatística descritiva e analítica. **Resultados:** são as unidades de medicina que apresentam maior número de mortes, sendo no turno da noite que se registra um valor mais elevado de ocorrências. Com relação às atitudes dos enfermeiros frente à morte, à exceção do evitamento, todas as outras evidenciam tendência semelhante entre o grupo profissional, independentemente da sua área de atuação. Os registros de enfermagem apresentam maior incidência ao nível da função ao invés de focados no domínio da pessoa. **Conclusão e implicações para a prática:** além da aquisição de conhecimentos através da participação em formações sobre a morte e o processo de morrer, o acompanhamento e apoio dos profissionais, poderão desempenhar um papel fundamental na preparação dos enfermeiros para cuidar das pessoas em fim de vida.

Palavras-chave: Atitude Frente à Morte; Morte; Enfermagem; Cuidados de Enfermagem; Hospitais.

RESUMEN

Objetivo: identificar la ocurrencia de la muerte en unidades de cuidados y analizar registros y actitudes de los enfermeros frente a la muerte en el contexto hospitalario. **Método:** estudio cuantitativo, descriptivo, transversal, con participación de 900 enfermeros de un hospital en el Norte de Portugal. Utilizando la triangulación de fuentes de datos, la recopilación se realizó de febrero a marzo de 2018 a través de cuestionario y observación de registros de enfermeros. Para el análisis, se utilizaron estadísticas descriptivas y analíticas. **Resultados:** las unidades médicas presentan mayor número de muertes, con mayor número de ocurrencias en el turno nocturno. Con respecto a las actitudes de los enfermeros frente a la muerte, con excepción de la evitación, todas las demás muestran una tendencia similar entre el grupo profesional, independientemente de su área de especialización. Los registros de enfermería tienen una mayor incidencia a nivel de función, en lugar de centrarse en el dominio de la persona. **Conclusión e implicaciones para la práctica:** además de la obtención de conocimiento sobre la muerte y el morir, el seguimiento y el apoyo de profesionales puede desempeñar un papel fundamental en la preparación de los enfermeros para cuidar a los enfermos en final de vida.

Palabras clave: Actitud Frente a la Muerte; Muerte; Enfermería; Atención de Enfermería; Hospitales.

INTRODUCTION

The meaning of death has been changed over different times and, following social, cultural and historical aspects, in the last decades, the physical space for the moment of death, instead of being the natural habitat of families, is often replaced by the hospitalization spaces in which the sick person is found.[1] Families are no longer the first people to be present in direct contact with sick people, and are the nurses, the professionals who care in their absences, who provide care for people at the end of life.[1]

Death constitutes one of the greatest mysteries and, being a universal phenomenon, is one of the harshest realities that all human beings have to go through and, simultaneously, learn to cope.[2] It is characterized as the end of a cycle that goes on since one is born until one dies, awakening feelings in the human being for which different sciences have sought answers that will make it possible to compensate for the pain of loss and to overcome the overwhelming and irreversible power that has death and dying. However, dying is a process of acceptance, communication, care, which requires skills and training from those who experience it, because although the end is irreversible, we always look for a way to delay it.[3]

From the Nursing professionals, according to their responsibility in providing care and in line with the profession's social mandate, it is expected that they develop skills for the care to be provided at the time of the death of those being cared for, regardless of the stage of the cycle of life in which the patients are, which requires training programs specifically directed to the effect.[2,4] Within the health team, nursing professionals are the ones who spend the most time and are the closest to the sick people, being their attitudes a demonstration of their feelings, their intentions and the way they experience the care they provide in the context of the process of dying and at the time of death.[5,6]

It is also added that there is consensus on the determining role of training in attitudes and in care provided by nursing professionals to people at the end of life.[7,8] And in this context, although in Portugal, the first level of nursing training corresponds to undergraduate courses, in countries where there are nurses, technicians and nursing assistants, of which Brazil is an example, it is important to address this issue within the different levels of training.

With regard to the disciplinary area of Nursing, although there are theorists who base the profession as a science with its own body of knowledge, the care process at the time of death does not appear clearly described. However, there are nursing theorists who refer and guide the provision of care for that moment, through assistance for a quiet death, conceived by Virginia Henderson, to facilitate the transition process that is experienced, conception by Afaf Meleis, as well as to assist, support and enable the person to the moment of death in a culturally significant way, according to the conception of Madeleine Leininger.[9]

With the conviction that nurses must sustain their performance in the framework of the discipline, an attempt was made to approximate these theoretical frameworks and the nurses' experiences in the face of death and the process of dying. Thus, in the context of a broader investigation developed at national level, the results obtained in the hospital under study show that nurses identify with Virginia Henderson's concepts of Nursing and Person, with Dorothea Orem's concept of Health and, with Alfaf Meleis' conception of Environment.[10]

In this sense, it seems to be clear that theoretical references with which nurses most identify, translate their concern to assist the person in meeting all their basic human needs.[9,10] However, in a study carried out in a hospital context, nurses recognize the difficulties in guaranteeing specific follow-up for patients in the process of dying, having also emphasized the importance of specific education and training on this theme.[2] In fact, the main weakness found in nursing professionals, in terms of dealing with death and the process of dying is fundamentally related to their education.[8]

It is known that the themes of death and the process of dying in the context of training have been approached in a superficial and fragmented way.[8] In the perspective of some authors, the best way to optimize the training of health professionals, namely in the area of nursing, passes in a first phase, through assessing their attitudes towards death.[7] The investigation of these attitudes has aroused the interest of several authors, since research already carried out has confirmed that the attitudes of nursing professionals towards death are decisive in the decision-making, behavior and performance of these professionals, as well as the quality of care provided to people who experience death and the process of dying.[7]

Although the maxim of care in the hospital context resides in a paradigm of its provision for the continuity and improvement of people's quality of life, the meaning of death must be studied for the impact it has on the life of those who assist it.[1,11]

Following the aforementioned, the attitudes of nursing professionals towards death are a problem that needs to be studied for the impact it represents, either in the personal or professional context. In this sense, and taking into account the particularities of professional nursing practice in Portugal, within the scope of this study we start from the following question: does the casuistry of death occurrence in the different hospital care units determine the nurses' records and attitudes?

Based on the guiding question, this study aimed to identify the occurrence of death in the care units, as well as to analyze the nurses' records and attitudes towards death in the hospital context.

METHOD

This is a quantitative, descriptive and cross-sectional study supported by the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) tool, using triangulation of data sources:[12] the number of deaths per hospital care unit; nursing records and nurses' attitudes towards death. At the hospital in the north of Portugal where the study was carried out, of a universe of 1,239 nurses, a sample of 900 nurses was obtained, with a 95% reliability, with a margin of error of 1.71. Inclusion criteria were defined as: being at the time of data collection and developing

their work in adult hospital care units: surgery (Surgical Clinic in Brazil), medicine (Medical Clinic in Brazil) or intensive care medicine (Intensive Care in Brazil). Since in Portugal, the first level of training in nursing corresponds to the degree (undergraduate courses in Brazil), in this study only nurses participated. As for the professional category currently in force in Portugal, these professionals can practice the profession as general care nurses, specialist nurses and nurse managers.

The total number of deaths in the selected areas in 2017 was 2,566. The nursing records of deceased patients, in the same period, were 36,281.

Data related to the casuistry of deaths and nursing records were obtained from the information systems in use, SClinico® and Bsimple®, and their analysis was supported by the Classificação Internacional para a Prática de Enfermagem – CIPE® (International Classification for Nursing Practice, in free translation) Beta 2 version.[13] Data collection on nurses' attitudes towards death was obtained using a questionnaire composed of two parts: the first, with the sociodemographic and professional characterization of the participants; and the second, with the Escala de Avaliação do Perfil de Atitudes acerca da Morte – EAPAM (Attitude Profile Assessment Scale about Death, in free translation).[14]

The EAPAM, already validated for the Portuguese context, consists of 32 items and five dimensions: fear (7 items), avoidance (5 items), neutrality/neutral acceptance (5 items), acceptance as approximation (10 items) and acceptance as escape (5 items).[14] The answer to each item is given on a Likert scale from 1 (strongly disagree) to 7 points (completely agree). The total score of the Scale can vary between 32, if all answers correspond to option 1, and 224 if in all answers 7 points are obtained. It was found that the EAPAM in the study sample had an alpha cronbach of 0.869, which certifies the instrument's internal consistency.

Nurses' participation was voluntary, upon presentation of the study objectives and prior invitation. The questionnaires were delivered to all nurses in the care units under study, eligible according to the criteria, and subsequently collected and analyzed in the first quarter of 2018.

For data analysis, descriptive and analytical statistics were used. Regarding the quantitative variables, the average, mode and standard deviation were listed, with a 95% confidence interval. The normality distribution of the variables was assessed using the Kruskal-Wallis Test and the Mannn-Whitney U Test. The qualitative variables of interest were the nurses' attitudes towards death in daily hospital work, which, in addition to being expressed in absolute frequencies, were tested using the chi-square test, considering a significance level of 5% ($p<0.05$). Statistical Package for the Social Sciences (SPSS) version 22.0[15] was used for statistical analysis

It should be added that the confidentiality and anonymity of the participating nurses was guaranteed and the study was carried out after a favorable opinion from the Ethics Committee (Opinion 102/2017), approved by the Board of Directors of the hospital under study, on March 30, 2017.

RESULTS

In line with the objectives defined in this study, we begin to describe the results by the occurrence of death in hospital care units. Thus, from the analysis to the death records, there were differences in the three areas, with the highest number of deaths occurring in medicine (49.61%), followed by intensive care (36.24%) and, finally, surgery (14.15%). As for the analysis of deaths per shift, it was found that the shift with the highest number of occurrences is the night shift (40.76%), followed by the morning shift (30.28%) and, finally, the afternoon shift (28.96%) (Table 1).

In view of the differences in the distribution of occurrences of deaths in the three areas, when analyzing the nursing records in light of the person and function domains, according to the ICNP® Beta 2 Version,[13] it was found that there are differences in the distribution of the records, because the frequencies of these are substantially different for the three areas (Table 2).

In this context, we used the chi-square test to test the homogeneity of the proportions of the records, that is, to test whether the distribution of the records is the same for all areas, adopting a significance level of 5%. The chi-square test statistic was 1,802.4, with a *p*-value <0.001, so, confirming the previous finding, it is concluded that there are significant differences between the distribution of records in the three areas.

In order to detail this analysis, the pairs of areas were also compared, that is, the surgical area was compared with the medical area, the surgical area with the intensive area and the medical area with the intensive area. For this purpose, the homogeneity of proportions test was used again. The values of the statistics of the chi-square test and corresponding p-values for the three comparisons indicated above are presented below.

In relation to the surgical area versus the medical area, the test statistic was 43.1, with a p-value <0.001, so the proportion of records in the function domain is higher in the surgical area than

Table 1. Occurrence of death by care units and shift, Porto, 2018.

Units	Shift 8am – 3pm (n)	Shift 3pm – 10pm (n)	Shift 10pm – 8am (n)	Total n(%)
Medical Area	391	316	566	1273 (49.61)
Surgical Area	110	105	148	363 (14.15)
Intensive Area	276	322	332	930 (36.24)
Total	777	743	1,046	2,566

Table 2. Records by care units under study, Porto, 2018.

	Surgical Area		Medical Area		Intensive Area		Total	
	n	%	n	%	n	%	n	%
Function	2,662	52.8	9,017	47.6	8,826	71.8	20,505	56.5
Person	2,378	47.2	9,924	52.4	3,474	28.2	15,776	43.5
Total	5,040	100.0	18,941	100.0	12,300	100.0	36,281	100.0

in the medical area, occurring the reverse with the proportion of records in the person's domain.

With regard to the surgical area *versus* the intensive area, the test statistic was 572.7, with a *p*-value <0.001, verifying that the proportion of records in the function domain is lower in the surgical area than in the intensive area, occurring the reverse with the proportion of records in the person's domain.

With regard to the medical area *versus* the intensive area, the test statistic was 1,774.1, with a *p*-value <0.001. In summary, the proportion of records in the function domain is lower in the medical area than in the intensive area, occurring the reverse with the proportion of records in the person's domain.

From the analysis, it was found that the area of intensive care is the one with the highest proportion of records in the function domain, followed by the surgical area and the medical area. Naturally, the reverse is true with registrations in the person's domain.

Regarding the characterization of nurses who answered the questionnaire, 36.62% performed functions in medicine, 34.24% in intensive care and 29.14% in surgery. Were part of the study 689 women (76.6%), of which 28.4% were from medicine, 25.1% from intensive care and 23.1% from surgery. On the other hand, of the 211 male participants (23.4%), 8.8% were from intensive care, 7.4% from surgery and 7.2% from medicine. In view of marital status, 507 nurses (56.3%) were married or living in a stable union and 509 participants (56.6%) had children. Regarding the link they maintained with the hospital, 468 nurses (52.0%) were the holders of an individual work contract without a term, this being the type of contract that most nurses had in different areas: intensive care 19.6%, medicine 17.3% and surgery 15.1%.

As for the professional category, which in Portugal has three levels: general care nurse, specialist nurse and manager nurse, 638 participants (71.0%) were recognized as general care nurses, with 24.8% working in medicine, 23.6% in surgery and 22.6% in intensive care. With regard to postgraduate training, 231 nurses had a specialty. The areas that stood out the most were rehabilitation nursing with 102 nurses (44.16%) and medical-surgical nursing with 69 nurses (29.87%), which correspond to two of the areas of specialization recognized by the Order of Nurses of Portugal. In intensive care, the percentage of specialist nurses in medical-surgical nursing was 20.78%, in medicine 5.63% and in surgery 3.46%. The percentage of specialist nurses in rehabilitation nursing in intensive care was 16.88%, in medicine 15.59% and in surgery 11.69%.

As for the experience of the death process of someone who was significant for the participants, 637 nurses (70.8%) had not experienced this process in the last year. Regarding religious beliefs, 689 nurses (76.6%) are practitioners or believers in a religion, and the Catholic religion was mentioned by 633 nurses (70.3%).

Finally, when asked about their participation in training on death, loss or mourning, 855 nurses (95.0%) reported not having attended any type of training.

From the results of the EAPAM,[14] the distribution between each component and in the different areas of activity was analyzed (Table 3).

In the medical area, the variation of the component fear was from 7 to 49 points, with an average of 27.56 points, with a standard deviation of 8.763, the mode being 29. The acceptance / approximation component ranged from 10 to 68, with an average of 36.48 points and a standard deviation of 11.996, being the mode of 40 points. It is added that this was the component that obtained the greatest dispersion around the average. Acceptance / neutrality ranged from 14 to 35 points, with a standard deviation of 3.892, which indicated less dispersion when compared to the other components and a mode of 26 points. Acceptance / escape ranged from 5 to 34, with an average of 15.47, a standard deviation of 6.244 and mode of 19. Finally, avoidance ranged from 5 to 35, with an average of 17.06, a standard deviation 7,346, and mode of 10.

In the surgical area, the component fear ranged from 8 to 47 points, with an average of 28.75 points, with a standard deviation of 8.442 and mode of 31. The acceptance / approximation component ranged from 10 to 70, with an average of 36.67 points and a standard deviation of 11.779, the mode being 40 points. It should be added that, as happened in the medical field, acceptance / approximation was the component that had the greatest dispersion around the average. The acceptance / neutrality component varied from 14 to 35 points, with a standard deviation of 3.943, with the mode of 26. This was the component that showed the least dispersion. The acceptance / escape component ranged from 5 to 35, with an average of 16.24, a standard deviation of 6.565 and mode of 20. Finally, avoidance ranged from 5 to 34, with an average of 18.54 and a standard deviation of 7.135, with the mode of 10.

In the area of intensive medicine, fear ranged from 8 to 48 points, with an average of 27.89, with a standard deviation of 8.355 and mode of 28. Acceptance / approximation ranged from 10 to 69 points, with an average of 39.00 points and a standard deviation of 11.790, the mode being 40 points. It should be added

Table 3. Attitudes of nurses towards death by area of activity, Porto, 2018.

			Fear	Acceptance / Approximation	Acceptance / Neutrality	Acceptance / Escape	Avoidance
Medicine	n	Valid	311	311	311	311	311
		Missing	0	0	0	0	0
	Average		27.56	36.48	27.44	15.47	17.06
	Mode		29	40	26	19	10
	Standard Deviation		8.763	11.996	3.892	6.244	7.346
	Minimum		7	10	14	5	5
	Maximum		49	68	35	34	35
	Sum		8,572	11,346	8,534	4,811	5,306
Surgery	n	Valid	275	275	275	275	275
		Missing	0	0	0	0	0
	Average		28.75	36.67	27.14	16.24	18.54
	Mode		31	40	26	20	10
	Standard Deviation		8.442	11.779	3.943	6.565	7.135
	Minimum		8	10	14	5	5
	Maximum		47	70	35	35	34
	Sum		7,906	10,084	7,463	4,466	5,099
Intensive Medicine	n	Valid	314	314	313	314	314
		Missing	0	0	1	0	0
	Average		27.89	36.47	27.19	15.26	17.15
	Mode		28	40	28	20	10
	Standard Deviation		8.355	11.790	4.099	5.960	7.144
	Minimum		8	10	9	5	5
	Maximum		48	69	35	35	34
	Sum		8,759	11,451	8,509	4,791	5,386

that, as in the other areas of activity, this component was the one that had the greatest dispersion around the average. Acceptance / neutrality ranged from 9 to 35 points, with a standard deviation of 4.099, which showed less dispersion when compared to the other components, with the mode of 28. Acceptance / escape varied from 5 to 35, an average of 15.00, with a standard deviation of 5.960 and mode of 20. Finally, avoidance varied from 5 to 34 points, with an average of 17.15 and a standard deviation of 7.144, with the mode of 10.

In view of the results described for each area and for each component of the attitude towards death, it was asked whether these differences were significant using the Kruskal-Wallis test for independent samples, adopting a significance level of 0.05 (Table 4).

In an analysis of the three types of acceptance, it was found that in the acceptance component as an approximation, the distribution was similar between the areas with the value of p=0.861; in neutral acceptance or neutrality, the distribution was also similar in the three areas of activity, with a value of p=0.562; finally, in the acceptance as an escape, the similarity between the areas of operation is maintained with the value of p=0.131. With regard to the fear component, the range of distribution by areas was also similar with a value of p=0.200. However, in the avoidance component, the distribution is not similar between the three areas of operation (p=0.016), with greater dispersion in the area of surgery.

For the global understanding of attitudes, we analyzed the result of the scale in its entirety using the Kruskal-Wallis test for independent samples and also adopting a significance level of 0.05. It was concluded that the distribution is the same between the components and the areas of operation (p=0.080).

Figure 1 summarizes all the study findings.

From the data analysis of the three sources, it was found that the number of nurses for each area of activity was similar, as well as their attitudes towards death. Regarding the occurrence of death, the incidence is higher in the medical field. Regarding

Table 4. Analysis of the significance of the components of attitudes towards death by areas of activity, Porto, 2018.

Components by areas of expertise	*p*-value	Decission
Fear	0.200	There is no significant difference
Acceptance / Approximation	0.861	There is no significant difference
Acceptance / Neutrality	0.562	There is no significant difference
Acceptance / Escape	0.131	There is no significant difference
Avoidance	0.016	There is a significant difference

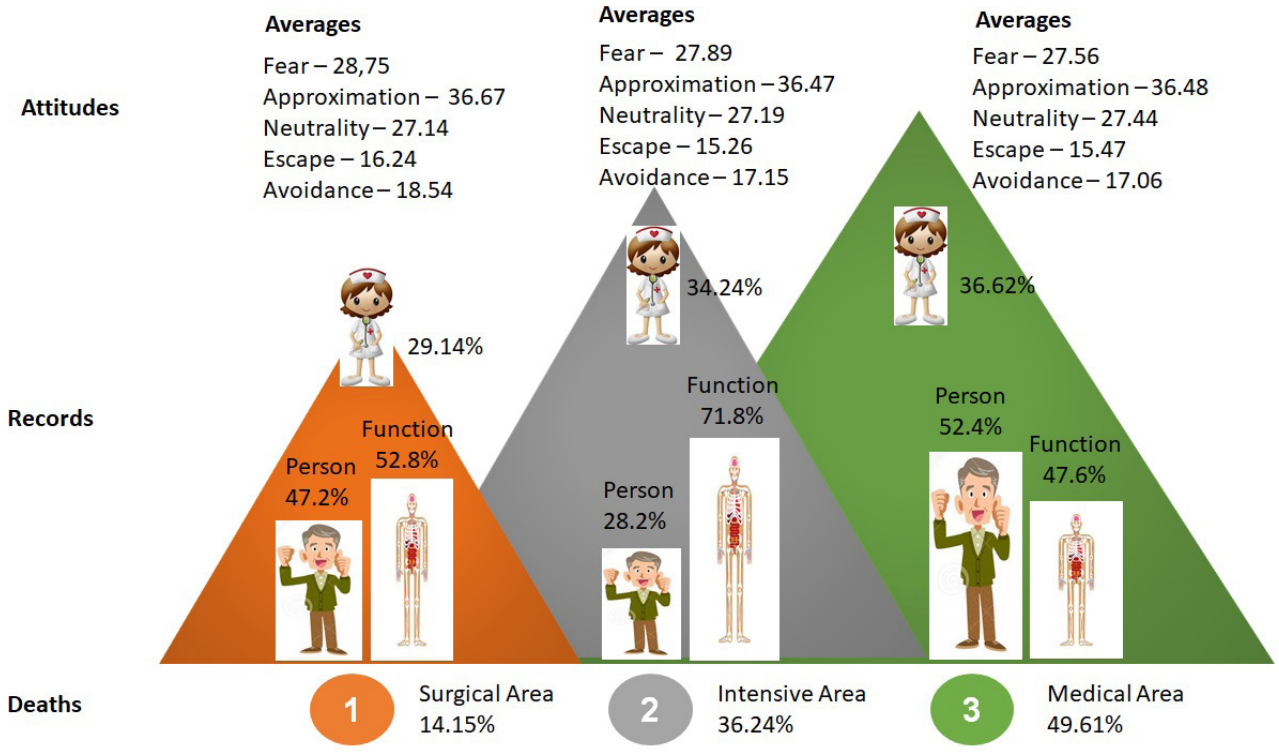

Figure 1. Total analysis of the study findings.
Source: Prepared by the authors.

the records made by nurses, it was found that in the surgical area and in the intensive area they were predominantly in the function domain; on the other hand, in the medical field, records in the domain of the person prevailed. Such findings indicate trends for the design of training, as well as for the monitoring of nursing professionals.

DISCUSSION

The finitude of life is inherent to the human being. It is a stage that is known to happen, but it is not known how or when, or under what circumstances. The context in which one dies is uncertain, but it is often marked by hospital buildings. Usually, people leave their home environment to seek professional help in order to continue to live, but it is not always possible to maintain life, therefore going through a process of dying.[1]

Currently, there is a consensus that the improvement of living conditions and technical and scientific advances in the health field have determined an increase in average life expectancy, often accompanied by an increasing number of people with chronic pathology. It is also added that the impact of population aging is directly observed by the average age of people who resort to emergency services in hospitals, and that, consequently, are hospitalized, namely in the medical services.[16] From the analysis of the data obtained in this study, the medical units are the ones that register most deaths, followed by the intensive care units.

From the target areas of the study, medicine is characterized by the differentiated care it offers based on the knowledge built by the different specialties, and the people to whom the most nursing care is provided are often in the process of aging or progressive disease.[16] Intensive care units are characterized by the complexity of the care provided there, where the condition

of the sick person is often from severe to critical, which requires continuous and intensive surveillance, or complex treatments or even technological support to maintain vital functions.[17] The area of surgery is seen as transitory, dedicating itself in a targeted way to surgical treatment, in situations where an improvement in health conditions is sought in the face of a pathological process, and hence the lowest percentage of deaths.

Thus, it is congruent to say that the area of medicine has a higher number of registered deaths, taking into account the population to whom professionals provide care for, followed by intensive care units, due to the complexity and severity of disease processes.

From the results it was found that the night shift is the one with the highest percentage of death events. In a study carried out in Portugal by the Escola Nacional de Saúde Pública (National School of Public Health, in free translation), which, in this case, is the only similar study in which the data can be compared to, it is described that in 2009 more people died during the night shift.[18] The aforementioned leads to a reflection: it is during the night shift that the service is quieter, that the hospitalized people rest and essentially focus on comfort care; it is also the shift in which nurses, in smaller numbers than in other shifts, are more alone in the direct care and, therefore, closer to the experience of the moment of death, something that elucidates the need for the preparation and training of these nurses for the dying process.

Regarding nursing records, although in the area of medicine, the greatest incidence is in the domain of the person, in the remaining areas, the records are mostly in the domain of function. We are thus oriented towards the carrying out of records with an impact on the technical procedures performed throughout the dying process, instead of focusing on the person and the experience he/she has before the finitude of life. This fact was also confirmed in a study carried out previously, in which it was found that the nursing documentation mainly focused on the domain of function.[19] This means that greater appreciation of the transition experienced by people involved in death and in the process of dying is required.[19]

Given the current reality and the increasingly frequent presence in the hospital context, death as a natural process of the life cycle requires to be studied for its consequences in the lives of the professionals who care for and experience it. The nurses' attitude towards death not only characterizes their care process, but also their processes of relationship, communication, experiencing the moment, but also their beliefs and values.[5,8]

We know from practice that nurses, as providers of direct care, can be determinants both for life and for the process of dying. Thus, analyzing their attitudes towards death leads us to reflect on the care provided at that time. From the characterization of the 900 participants, we know that they are predominantly general care nurses, mostly female, with an indefinite link to the hospital under study, and mainly exercising their activity in the medical units. According to the data obtained, nurses' attitudes towards death are identical between the different areas of activity. Effectively, from the application of the scale, the three forms of acceptance, neutral acceptance or neutrality (death understood as an integral part of life), acceptance as approximation (death understood as a passage associated with religious beliefs) and acceptance as escape (death as the end of pain or suffering) do not vary among nurses in different areas.

Following the findings, we can therefore say that nurses exhibit an attitude of neutrality in understanding death as an event that is part of life.[20,21] In addition, the fact that nurses are mostly practitioners of a religion explains the approaching attitude associated with the continuity of a happy life, meeting harmony and a life full of peace.[1] On the other hand, an attitude of escape, justified by the age that the participants have and the pain experienced in the context of the processes of the disease, being, therefore, the death interpreted as the end of pain and suffering.[7,17]

With regard to fear (feeling associated with fear of dying), nurses also reveal it in an identical way. Talking about death has always scared the human being, hence this subject often being dealt with silence. From the perspective of some authors, although this attitude is a form of defense of the ego against suffering, it will make it difficult to understand the moment of death.[22] Not talking about death is a way to avoid feeling fear.[23,24]

Finally, avoidance (avoiding dialogue about death as a way to reduce a state of anxiety), is experienced differently, being more manifested by nurses in the surgical area. This difference can be explained by the fact that in this area the experience of the death process is less, by the lower number of deaths that occur, and by the profile of patients who are usually hospitalized. On the other hand, nurses in medicine and intensive care units, due to the greater number of deaths, experience greater contact with the process and hence the avoidance is not so evident.

It is also important to highlight the analysis of the characterization of the participants in this study, who mostly had not attended any training on death, loss or mourning. This fact elucidates the need to invest in the training of professionals, so that, before the end of life, they can guarantee an assistance closer to the sick person and family, investing in communication, in the partnership of care, in the management of suffering, the loss and the grieving process.[5,8,25]

Therefore, we must prepare professionals to deal with death and the process of dying in different areas of activity, and to make them capable to direct their intervention to each context, each need, each experience described, so that the final phase of the life cycle is experienced in a dignified way.[8,24]

Although academic training is not the only aspect that influences the performance of nursing professionals, several authors have highlighted their indisputable contribution.[7,8] Among the various suggestions for improvement, changes in curricular plans stand out, the inclusion of disciplines where discussing death and the dying process, as well as the adoption of strategies aimed at developing skills to provide adequate nursing care in the face of terminal situations.[2,8] Along with academic training, it becomes increasingly relevant the inclusion of this theme in the scope of permanent education.[2]

CONCLUSIONS AND IMPLICATIONS FOR PRACTICE

Increasingly, nursing care directed to the specificity of the moment experienced by people at the end of life is required, as being a process that must be lived with dignity, with quality and with full satisfaction of needs, while avoiding feelings of discomfort, anxiety and/or escape from nurses in the face of death and the process of dying.

Although it is assumed as a limitation, the fact that this investigation was only carried out in a hospital institution, which prevents the generalization of the results, from the analysis carried out it is understood that, in the scope of teaching, it becomes relevant to plan training on death and the process of dying for all areas of expertise. In healthcare practice, the daily monitoring of nursing professionals, whether due to the incidence of deaths or the records they make and the attitudes they manifest, requires differentiated care from nurse managers, which, simultaneously, may indicate the need for another type of preparation by these managers as well.

In research, replicating this study in other hospitals would be important in order to validate the findings. What is certain is that, regardless of the number of institutions participating in this type of investigation, once nurses' attitudes towards death are known, responses are required that are adjusted to the needs of these professionals, in order to guarantee their well-being and improve quality of the care they give to people who experience death and the process of dying.

AUTHOR'S CONTRIBUTIONS

Study design. Acquisition, data analysis and interpretation of results. Writing and critical review of the manuscript. Approval of the final version of the article. Responsibility for all aspects of the content and the integrity of the published article. Maria Filomena Passos Teixeira Cardoso.

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