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Original Article

Attitude toward death in nursing staffs in hospitals of Rafsanjan (south east Iran)

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ABSTRACT

Background & Aim: Fear of death can cause death anxiety for everyone. In health care professions, death anxiety becomes a routine source of stress and may lead to unwanted consequences. Coping strategies of nurses and different approaches to death can affect the quality of health care services. The aim of this study was to determine attitudes toward death in nursing staff in hospitals of Rafsanjan.

Methods & Materials: This was a cross-sectional study. The population study consisted of 400 (all nursing staff) working in hospitals of Rafsanjan University of Medical Sciences (RUMS) in 2012. The data were collected using demographic and death attitude profile revised questionnaires.

Results: Fear of death was significantly higher in women, younger participants with little work experience, those without experience of intensive care unit working, and those without a history of education about death ($P < 0.0500$). Death escape scores were significantly higher in the age group of 31-35 years. An approach toward death was significantly better in women, those with related training, those older than 46 years, and those with over 20 years of work experience.

Conclusion: RUMS treatment centers had a favorable attitude toward death in five categories. This is probably due to religious beliefs and looking at death as a bridge to the afterlife.

Introduction

Despite major advances in medical science and technology, there is no way to escape death (1). Although everyone is aware of the inevitability of death, they are not aware how and when it may happen (2) for this reason most people fear death and even thinking about it.

The death of very ill patients sometimes may occur in hospitals when nurses are responsible for them. Thus, death is one of the most important topics in the nursing profession (3, 4). Nurses frequently encounter dying in the daily care of patients (5, 6). Fear of death can cause anxiety or stress. Dunn et al. (7) found that regardless of how nurses feel about death, their experience with dying patients, have a positive relationship with better care practice in emergency wards. In health care professions, death anxiety may lead to unsuitable consequences for health professionals (e.g. dissatisfaction, psychological, and psychosomatic problems) and their patients (e.g. not receiving proper care) (1). Gama et al. (8) determined age, experience, and religious beliefs as some determinants of nurses' attitudes toward death.

Attitude toward death is one of the most important factors that influence the behavior of

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health care professionals (9). Also, nurses reactions associated with the death of their patients have a serious impact on others behavior, especially in patients. In many cases, the nurse is the only person who takes care of a dying patient. Nurses' approach toward death can be effective in caring for dying patients and their families. An experienced nurse will use coping strategies before and after the death of a patient to manage the hard situation, and this requires knowledge, attitude and practice (10).

If health care workers feel that death is frightening and ominous, they will not be able to deal gently and effective with the death of patients (11). Unfortunately, facing patient death during clinical practice can be a painful and scary experience for nurses (12). Studies have shown that many nurses do not have a proper interpretation of death and dying, and lack enough preparation to provide care for a dying patient (11). This is more important in nursing staff which encountering patients' death at their first clinical experience (12). Death anxiety in nurses and physicians can affect on care process of patients in particular dying patients (13). The success of nurses in palliative care for dying patients depends on their attitude toward death. Fear of death and anxiety can negatively affect the services to the dying patients and their families.

Most nurses are not educated to care for dying patients. Mallory showed that increasing knowledge of nurses in palliative care can affect on their attitude toward death and can lead to better practice and coping strategies (14). Dunn et al. (7) also found that realistic knowledge learned from professional practice may influence how nurses care for dying patients. Peters et al. (15) showed that nurses are caring for dying patients especially have poor coping strategies with families of dying patients.

Despite the abundant resources about nurses interacting with patients and the quality of end of life care, still little is known about nurse's attitude toward death in some cultures and societies (16). There are also few studies that investigated the nurse's attitude toward death while knowing the attitude of the nurses, help them to cope with their feelings. Furthermore, due to religious and cultural differences between middle east countries with western countries, and lack of information on this issue, attitude toward death among nurses and medical staffs of Muslim countries is of high priority for health system in these countries. So far no study about the attitudes toward death among nursing staff in Rafsanjan Health Centers, Rafsanjan University of Medical Sciences (RUMS) (South East Iran) has been done, therefore aim of this study was to determine the attitude toward death among nursing staffs in hospitals of, RUMS, in 2012.

Methods

This was a cross-sectional survey that population study consisted of 400 (all) nursing staff working in health centers of RUMS in 2012, method of sampling was a census.

Data collection was done during winter 2012. Participation was voluntary and with informed consent. Study objectives and procedure were described to the nursing staff of RUMS at various shifts and when consented they were involved in the study. The data collection tool was a questionnaire that consisted of two parts; the first part was demographic information including age, sex, marital status, income, work experience, experience in dealing with dying patients, and the location of work in 1-year ago, work experience in intensive care unit (ICU) and training experience in caring for dying patients. The second part of questionnaire was death attitude profile revised (DAP-R). The questionnaire which is created by Paul T. P. Wong is a multidimensional measure of death acceptance, death avoidance, and fear of death. It is included 32 questions in five categories that evaluated attitude toward death: Fear of death (implies a negative attitude as death anxiety), avoiding death (implies a negative attitude for example a person avoids thinking or talking about death in order to reduce death anxiety), neutral acceptance (implies that death is considered as an integral part of life), approach Acceptance (belief in a happy afterlife), and escape Acceptance (death is merely relief from pain). The answers was scored based on Likert scale 1 (strongly disagree) to 7 (strongly agree) and average scores of each part were used to assess. Above 5 considered as a positive attitude, 3-5 as neutral, and < 3 were considered as negative.

The convergent-discriminant validity of the original DAP-R was approved by positive correlation of death anxiety scale with fear of death sub-scale. Reliability of original DAP-R was approved by alpha-coefficients range from a low of 0.65 (neutral acceptance) to a high of 0.97 (approach acceptance); stability coefficients range from a low of 0.61 (death avoidance) to a high of 0.95 (approach acceptance). Validation process of DAP-R (Persian version) including questionnaire translation and back translation (by English language expert), content validity, Cronbach's coefficient reliability, and test-retest had been performed previously in Iranian studies (2, 5). Iranmanesh *et al.* (5) had approved the content validity of DAP-R by biostatisticians and clinical nurses from statistical, cultural, and religious points of view. The Cronbach's alpha coefficient for DAP-R varied from a low of 0.63 in fear of death to a high of 0.87 in approach acceptance. The test-retest coefficients of stability for DAP-R varied from a low of 0.67 in fear of death to a high of 0.89 in escape acceptance (5). This shows the acceptable reliability of DAP-R questionnaire in the society where the study has performed.

This study was approved by ethical committee of RUMS.

Nurses at various shifts attended in the study after explaining the study objectives and signing informed consent forms. A study performed in compliance with ethical considerations. All questionnaires were without a name and were encoded. It should be noted that the information remained confidential.

The data analyzed by SPSS software (version 18; SPSS Inc., Chicago, IL, USA). Normality of data was tested by Kolmogorov–Smirnov, and then further analyses were performed by using chi-square test. Results were reported as frequency, mean and standard deviation.

Results

The total sample size was 400, among which 327 nursing staffs participated and completed the study with full consent (response rate 81.75%). The mean age of participants was 31.54 ± 7.19 with a minimum age of 20 years, and maximum age was 53 years. Average work experience of them was 7.77 ± 7.32 with a minimum of 1 and maximum of 29 years. Most were female (73.1%), married (72.2%), with low income (50 millions to 10 million Rials) (68.5%). About 84% of participants were a nurse, and 16% of them were a medical assistant.

Dealing with dying patients in clinical practice was varied due to workplace, 15% were not dealing with death at 1-year, 28.7% were dealing with death 1-2 times a month, 11% were dealing with death 2-5 times a month and 4.3% were dealing with death more than five times a month. Experience of ICU working as a factor in dealing with ill and dying patients were evaluated; 22% had worked in ICU and 56.9% of them had passed training courses about death and care process of dying patients. Subscales of attitude toward death among nursing staffs in RUMS are shown in table 1.

Fear of death was significantly higher in women, nurses, younger participants with little work experience, those without experience of ICU working, and those without a history of education about death ($P < 0.0500$).

There was no significant difference between different levels of family income and marital status in regard with fear of death (Table 2).

Avoiding death was significantly higher in nurses, those with high income, age group 41-45 years, and those with over 20 years of work experience ($P < 0.0500$).

Table 1. Sub scales of attitude toward death among nursing staffs in RUMS

Attitude toward death	Frequency [N (%)]		
	Negative	Neutral	Positive
Fear of death	51 (15.6)	200 (61.2)	76 (23.2)
Avoiding death	148 (45.3)	148 (45.3)	31 (9.5)
Approach acceptance	4 (1.2)	138 (42.2)	185 (56.6)
Escape acceptance	93 (28.4)	181 (55.4)	53 (16.2)
Neural acceptance	11 (3.4)	158 (48.3)	158 (48.3)

Table 2. Comparing fear of death in the study population in regard with demographic variables

Variable	Fear of death			chi-square	df	P value†
	Negative [N (%)]	Neutral [N (%)]	Positive [N (%)]			
Gender						
Female	31 (13)	145 (60.7)	63 (26.4)	7.676	2	0.0220
Male	20 (22.7)	55 (62.5)	13 (14.8)			
Occupation						
Nurse	38 (13.7)	170 (61.4)	69 (24.9)	6.278	2	0.0430
Other health workers	13 (26)	30 (60)	7 (14)			
Economic status						
Poor	30 (13.4)	140 (62.5)	54 (24.1)	6.327	4	0.1760
Moderate	17 (18.7)	56 (61.5)	18 (19.8)			
Good	4 (33.3)	4 (33.3)	4 (33.3)			
Marital status						
Single	18 (20.5)	56 (63.6)	14 (15.9)	6.764	4	0.1420
Married	33 (14)	141 (59.7)	62 (26.3)			
Divorced	0 (0)	3 (100)	0 (0)			
ICU experience						
Yes	17 (23.6)	36 (50)	19 (26.4)	6.077	2	0.0480
No	34 (13.3)	164 (64.3)	57 (22.4)			
Training courses						
Yes	27 (14.5)	97 (52.2)	62 (33.3)	24.952	2	0.0010
No	24 (17)	103 (73)	14 (9.9)			
Age						
< 25	13 (15.9)	48 (58.5)	21 (25.6)	29.118	10	0.0010
26-30	10 (11.8)	54 (63.5)	21 (24.7)			
31-35	6 (9.4)	47 (73.4)	11 (17.2)			
36-40	7 (12.7)	30 (54.5)	18 (32.7)			
41-45	8 (27.6)	16 (55.2)	5 (17.2)			
> 46	7 (58.3)	5 (41.7)	0 (0)			
Work experience						
< 5	21 (11.8)	110 (61.8)	47 (26.4)	16.935	8	0.0310
6-10	10 (16.4)	37 (60.7)	14 (23)			
11-15	2 (7.7)	17 (65.4)	7 (26.9)			
16-20	9 (23.7)	22 (57.9)	7 (18.4)			
> 20	9 (37.5)	14 (58.3)	1 (4.2)			

†Using chi-square test. ICU: Intensive care unit

Avoiding death was higher in women, but this difference was not statistically significant. The differences in death avoiding were not significant in regard with a history of education about death, experience of ICU working and marital status (Table 3).

Acceptance of death (approach acceptance) was more in women, other healthcare workers, those older than 46 years, and those with 11-15 years of work experience, but the difference was not statistically significant. Family income, marital status, the experience of ICU working and history of education about death was not also significantly different (Table 4).

Most escape acceptance was in the age group of 31-35 years and, there was a significant difference between age groups in regard with this variable ($P < 0.0500$). Escape acceptance was more in women, but the difference from men was not statistically significant. Differences in escape acceptance were not significant between subgroups of the job, training courses, work experience in ICU, family income, and marital status (Table 5).

Neutral acceptance in women, other health workers, those who had been training, those older than 46 years, and those with over 20 years of work experience was better, and this difference was statistically significant ($P < 0.0500$). There was no significant difference between different levels of economic status, marital status, and work experience in ICU in regard to approach toward death (Table 6).

Table 3. Comparison of avoiding death in the study population in regard to demographic variables

Variable	Avoiding death			chi-square	df	P value†
	Negative [N (%)]	Neutral [N (%)]	Positive [N (%)]			
Gender						
Female	111 (4.46)	103 (43.1)	25 (10.5)	7.676	2	0.3510
Male	37 (42)	45 (51.1)	6 (6.8)			
Occupation						
Nurse	132 (47.7)	115 (41.5)	30 (10.8)	6.278	2	0.0030
Other health workers	16 (32)	33 (66%)	1 (2)			
Economic status						
Poor	94 (42)	112 (50)	18 (8)	6.327	4	0.0070
Moderate	50 (54.9)	32 (35.2)	9 (9.9)			
Good	4 (33.3)	4 (33.3)	4 (33.3)			
Marital status						
Single	40 (45.5)	41 (46.6)	7 (8)	6.764	4	0.9000
Married	106 (44.9)	106 (44.9)	24 (10.2)			
Divorced	2 (66.7)	1 (33.3)	0 (0)			
ICU experience						
Yes	31 (43.1)	36 (50)	5 (6.9)	6.077	2	0.5530
No	117 (45.9)	112 (43.9)	26 (10.2)			
Training courses						
Yes	80 (43)	90 (48.4)	16 (8.6)	24.952	2	0.4140
No	68 (48.2)	58 (41.1)	15 (10.6)			
Age						
< 25	36 (43.9)	39 (47.6)	7 (8.5)	29.118	10	0.0270
26-30	38 (44.7)	36 (42.4)	11 (12.9)			
31-35	40 (62.5)	17 (26.6)	7 (10.9)			
36-40	22 (40)	30 (54.5)	3 (5.5)			
41-45	7 (24.1)	19 (65.5)	3 (10.3)			
> 46	5 (41.7)	7 (58.3)	0 (0)			
Work experience						
< 5	81 (45.5)	75 (42.1)	22 (12.4)	17.854	8	0.0220
6-10	35 (57.4)	21 (34.4)	5 (8.2)			
11-15	7 (26.9)	18 (69.2)	1 (3.8)			
16-20	15 (39.5)	23 (60.5)	0 (0)			
> 20	10 (41.7)	11 (45.8)	3 (12.5)			

†Using chi-square test. ICU: Intensive care unit

Table 4. Comparison of approach acceptance in the study population on the basis of demographic variables

Variable	Approach acceptance			P value†
	Negative [N (%)]	Neutral [N (%)]	Positive [N (%)]	
Gender				
Female	0 (0)	99 (41.4)	140 (58.6)	NS‡
Male	4 (4.5)	39 (44.3)	45 (51.1)	
Occupation				
Nurse	4 (1.4)	118 (42.6)	155 (56)	NS
Health workers	0 (0)	20 (40)	30 (60)	
Economic status				
Poor	4 (1.8)	99 (44.2)	121 (54)	NS
Moderate	0 (0)	34 (37.4)	57 (62.6)	
Good	0 (0)	5 (41.7)	7 (58.3)	
Marital status				
Single	0 (0)	31 (35.2)	57 (64.8)	NS
Married	4 (1.7)	105 (44.5)	127 (53.8)	
Divorced	0 (0)	2 (66.7)	1 (33.3)	
ICU experience				
Yes	0(0%)	33(45.8%)	39(54.2%)	NS
No	4 (1.6)	105 (41.2)	146 (57.3)	
Training courses				
Yes	0 (0)	79 (42.5)	107 (57.5)	NS
No	4 (2.8)	59 (41.8)	78 (55.3)	
Age				
< 25	0 (0)	44 (53.7)	38 (46.3)	NS
26-30	0 (0)	36 (42.4)	49 (57.6)	
31-35	2 (3.1)	21 (32.8)	41 (64.1)	
36-40	2 (3.6)	20 (36.4)	33 (60)	
41-45	0 (0)	14 (48.3)	15 (51.7)	
> 46	0 (0)	3 (25)	9 (75)	
Work experience				
< 5	0 (0)	79 (44.4)	99 (55.6)	NS
6-10	4 (6.6)	26 (42.6)	31 (50.8)	
11-15	0 (0)	6 (23.1)	20 (76.9)	
16-20	0 (0)	18 (47.4)	20 (52.6)	
> 20	0 (0)	9 (37.5)	15 (62.5)	

†Using chi-square test. ‡NS: Not significant, ICU: Intensive care unit

Table 5. Comparison of escape acceptance in the study population on the basis of the demographic variables

Variable	Escape acceptance			P value†	df	chi-square
	Negative [N (%)]	Neutral [N (%)]	Positive [N (%)]			
Gender						
Female	65 (27.2)	135 (56.5)	39 (16.3)	0.7060	2	0.696
Male	28 (31.8)	46 (52.3)	14 (15.9)			
Occupation						
Nurse	81 (29.2)	155 (56)	41 (14.8)	0.2540	2	2.740
Other health workers	12 (24)	26 (52)	12 (24)			
Economic status						
Poor	69 (30.8)	120 (53.6)	35 (15.6)			
Moderate	20 (22)	54 (59.3)	17 (18.7)	0.5350	4	3.136
Good	4 (33.3)	7 (58.3)	1 (8.3)			
Marital status						
Single	29 (33)	40 (45.5)	19 (21.6)			
Married	64 (27.1)	138 (58.5)	34 (14.4)	-	-	-
Divorced	0 (0)	3 (100)	0 (0)			
ICU experience						
Yes	22 (30.6)	40 (55.6)	10 (13.9)	0.7980	2	0.452
No	71 (27.8)	141 (55.3)	43 (16.9)			
Training courses						
Yes	51 (27.4)	104 (55.9)	31 (16.7)	0.8870	2	0.239
No	42 (29.8)	77 (54.6)	22 (15.6)			
Age						
< 25	19 (23.2)	54 (65.9)	9 (11)			
26-30	30 (35.3)	45 (52.9)	10 (11.8)			
31-35	13 (20.3)	34 (53.1)	17 (26.6)	0.0350	10	19.464
36-40	17 (30.9)	28 (50.9)	10 (18.2)			
41-45	13 (44.8)	11 (37.9)	5 (17.2)			
> 46	1 (8.3)	9 (75)	2 (16.7)			
Work experience						
< 5	50 (28.1)	103 (57.9)	25 (14)			
6-10	18 (29.5)	30 (49.2)	13 (21.3)			
11-15	10 (38.5)	14 (53.8)	2 (7.7)	0.6140	8	6.295
16-20	8 (21.1)	21 (55.3)	9 (23.7)			
> 20	7 (29.2)	13 (54.2)	4 (16.7)			

†Using chi-square test. ICU: Intensive care unit

Table 6. Comparison of neutral acceptance in the study population on the basis of demographic variables

Variable	Neutral acceptance			P value†	df	chi-square
	Negative [N (%)]	Neutral [N (%)]	Positive [N (%)]			
Gender						
Female	3 (1.3)	118 (49.4)	118 (49.4)	0.0020	2	12.148
Male	8 (9.1)	40 (45.5)	40 (45.5)			
Occupation						
Nurse	11 (4)	140 (50.5)	126 (45.5)	0.0330	2	6.843
Other health workers	0 (0)	18 (36)	32 (64)			
Economic status						
Poor	9 (4)	100 (44.6)	115 (51.3)			
Moderate	2 (2.2)	51 (56)	38 (41.8)	0.3550	4	4.399
Good	0 (0)	7 (58.3)	5 (41.7)			
Marital status						
Single	4 (4.5)	46 (52.3)	38 (43.2)			
Married	7 (3)	112 (47.5)	117 (49.6)	-	-	-
Divorced	0 (0)	0 (0)	3 (100)			
ICU experience						
Yes	0 (0)	36 (50)	36 (50)	0.2000	2	3.124
No	11 (4.3)	122 (47.8)	122 (47.8)			
Training courses						
Yes	7 (3.8)	74 (39.8)	105 (56.5)	0.0020	2	12.611
No	4 (2.8)	84 (59.6)	53 (37.6)			
Age						
< 25	1 (1.2)	48 (58.5)	33 (40.2)			
26-30	4 (4.7)	48 (56.5)	33 (38.8)			
31-35	3 (4.7)	26 (40.6)	35 (54.7)	0.0270	10	20.273
36-40	3 (5.5)	19 (34.5)	33 (60)			
41-45	0 (0)	15 (51.7)	14 (48.3)			
> 46	0 (0)	2 (16.7)	10 (83.3)			
Work experience						
< 5	3 (1.7)	99 (55.6)	76 (42.7)			
6-10	7 (11.5)	20 (32.8)	34 (55.7)			
11-15	1 (3.8)	16 (61.5)	9 (34.6)	< 0.0010	8	29.709
16-20	0 (0)	16 (42.1)	22 (57.9)			
> 20	0 (0)	7 (29.2)	17 (70.8)			

†Using chi-square test. ICU: Intensive care unit

Discussion

In our study, fear of death was modest in majority of those surveyed. There was a significant negative relationship between fear of death with ICU work experience, formal training in the field of death, age and general work experience. Furthermore, fear of death was more in female participants and nurses (compared to medical assistants). The results of Hegedus and colleagues study showed fear of death is reducing among medical assistants with academic training. Also, age, gender, and experience were effective on fear of death. The most important factor in improving attitudes toward death was the increased awareness on the care of dying patients (17). This is consistent with our results.

In study of Zargham-Boroujeni and colleagues (18), they have seen significant difference between the attitude toward death before and after training and it is recommended that this part of education should be considered more serious in Iran. This is aligned with our results; we have seen a great fear of death among nurses and medical assistances, and this factor may cause anxiety to care for dying patients in nurses and medical assistances. Death anxiety can negatively affect the quality of care delivered to dying patients and their families (19). Providing appropriate training and retraining courses to reduce the fear of death, may improve attitudes toward death and makes health care provider staffs to look at death as part of life and do their best to help the patients and their caregivers. Education, and clinical practice and spiritual beliefs can positively affect attitude towards death and hence quality of care delivered (19).

Our study shows that with increasing age and experience, avoiding death are less among medical assistances probably due to better recognition, increase awareness and reduce staff anxiety.

Rooda and colleagues (20) study evaluated the attitudes toward death based on dealing with dying patients. The results of this study showed that the main factor affecting care of the dying patient was attitudes toward death. Lange and colleagues showed a significant association between age, clinical experience and history of dealing with dying patients with attitudes toward death. With increasing these three factors attitudes toward death were more positive and attitude to treatment services to dying patients was also improved (21). Gama et al. (8) in a descriptive study on 360 nurses from different wards tried to identify factors influencing nurses' attitudes toward death. They found that nurses with more ICU work experience had higher escape acceptance ($P < 0.0001$). Also, age was positively correlated with escape acceptance ($P < 0.0001$). Religious acceptance was higher in female nurses ($P < 0.0001$). Nurses from internal medicine, oncology, and hematology wards had significantly higher fear attitudes ($P < 0.0100$), avoidance of death attitudes ($P < 0.0001$), and escape acceptance attitudes ($P < 0.0002$) than palliative care nurses.

Lange et al. (21), Jo and Lee (22) in a study showed a relationship between attitudes toward death with depression and life satisfaction. The main predictor of attitudes toward death, was life satisfaction, and expressed the need for a plan to improve life and promote a positive attitude towards death we did not assessed depression and life satisfaction in our study. Afrasyabi and colleagues showed that 52.5% of samples are well aware of the physical and psychological care of dying patients, also 60.8% have a positive attitude (23). In our study 49.4% of female and 45.5% male participants had a positive attitude toward death.

In the category of escape from death, responses indicated that most of participants escape from death; and this was significantly related with age. In the subtype of approach to death, the most responses indicate moderate and good approach to death. There was a significant difference between sub-groups of gender, occupation, educational courses in the field of death, age and work experience in regard to neutral acceptance.

Bagherian and colleagues (2) conducted a study that showed most respondents were noted to death as a natural part of life and a way to achieve life after death. Most nurses' were willing to care for dying patients and emotional support for their families, but they did not like to talk about death with patients or their families. Personal views of nurses as their personal experiences influence their attitudes toward death

and caring for dying patients, respectively.

More than 50% of participants in almost all sub-groups showed a positive approach acceptance and differences between sub-groups were not statistically significant. This shows a homogeny in participants in regard to approach acceptance. This item is designed based on religious and spiritual beliefs. Hence, this is probably due to religious and good belief of nursing staff in RUMS to Islam and accepting death as part of the stages of life and a bridge for prosperity and happiness of human being. Good and reasonable acceptance of death can calm the patient and his/her relatives in end-stage of disease. Zargham-Boroujeniand colleagues (18) findings showed that the most important idea that will help nurses to deal better with the phenomenon of death is their beliefs in life after death. Understanding death as the fate of all living beings can also bring peace to mankind. Such an approach is not only relaxing but also helps the nurse to relax her/his dying patients and their families. These investigators believe the nursing profession has increased this idealism and spiritualism, so that their doubts about the afterlife are lower. In fact, image drawn from death in this study is raised from the spiritual point of view.

Conclusion

The majority of those surveyed, fear of death were modest. And there was a significant negative relationship between fear of death with ICU work experience, formal training in the field of death, age and general work experience. Furthermore, fear of death was more in female participants and nurses (compared to medical assistants). Positive fear of death is seen among medical assistants with academic training. Our study shows that with increasing age and experience, avoiding death are less among health care workers probably due to better recognition, increase awareness and reduce staff anxiety.

Death acceptance was favorable and homogeny in most participants.

In all this study showed that nursing staffs in RUMS treatment centers had a positive attitude toward death in five categories. This is probably due to religious beliefs and look at death as a bridge to the afterlife. Appropriate training courses for nursing staffs, use of the experienced personnel for shifts which more death may occur is recommended.

Based on results of our study and other studies, we suggest using more experienced and older staffs in RUMS's treatment centers that more dying patients are receiving health care. Increasing training courses in the field of death and care of dying patients is suggested specially for nurses who are dealing with dying patients. Repeated evaluation of health care providers attitudes toward death is suggested to improve its. Also, training and retraining courses for younger and low experienced staffs is suggested to improve attitudes toward death.

Future trials is suggested to evaluate the impact of spirituality or religious attitudes toward death and its impact on improving service delivery and reducing the anxiety of staffs, patients and their companions. Also cohort studies could be designed to survey young and inexperienced nurses dealing with dying patients and follow them during years to observe the health outcomes for nurses, patients and their families.

Although it has been validated in the society where the study has performed, but using DAP-R which has designed in USA is still a limitation.

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Conflict of interest

The authors declare no conflict of interest.

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