Journal of Integrative Nursing and Palliative Care (JINPC)

Cross-Sectional Study

Volume 7 | Issue 1 | Page 1-15

The Relationship between Intensive Care Nurses' Perceptions of a Good Death and End-of-Life Care Attitudes: A Cross-Sectional Study

Michelle Tan[1]*, Kelvin Lim[1], Adrian Goh[2]

[1]Department of Nursing and Supportive Medicine, Faculty of Health Sciences, Nanyang Technological University, Singapore.
[2]Department of Palliative Clinical Care, Faculty of Medicine, Duke-NUS Medical School, Singapore.

Abstract

Intensive care environments are characterized by high levels of technical and emotional complexity, where nursing staff routinely encounter patient mortality. Throughout this process, the quality of care delivered is directly shaped by nurses' viewpoints on what constitutes a good death, as well as their overall attitudes and practical behaviors regarding end-of-life care. Investigating how these components interact is critical for advancing the standards of holistic end-of-life care. A descriptive and correlational research design was used to explore the connections among intensive care nurses' perceptions of a good death, their corresponding end-of-life care attitudes and behaviors, and the underlying factors influencing these variables. The required sample size was computed using a standard statistical formula for a known population size, resulting in the selection of 136 intensive care nurses via random sampling. The research took place in Trabzon, Türkiye, from March to October 2022. Assessment tools included a Nurse Information Form, the Scale of Attitudes and Behaviors of Intensive Care Nurses Toward End-of-Life Care, and the Good Death Scale. Statistical analysis of the data was performed using IBM SPSS Statistics version 23. The analysis demonstrated a moderate, positive, and statistically significant correlation between a nurse's perception of a good death and their end-of-life care attitudes and behaviors ($r = 0.425$; $P < 0.001$). Higher levels of positive perception within the psychosocial-spiritual and clinical subdimensions were associated with more favorable attitudes toward end-of-life care. Conversely, the personal control subdimension displayed no significant correlation. Nurses who interacted more regularly with dying patients and those who experienced physiological or psychological impacts during the process exhibited more positive attitudes. While longer general professional experience was linked to positive shifts in clinical perceptions, specific intensive care tenure yielded no statistically significant variations. No meaningful relationships were detected between sociodemographic traits and the observed outcomes. This investigation demonstrated that intensive care nurses' perception of a good death is immediately reflected in their end-of-life caregiving processes. The evidence indicates that the notion of a "good death" must be evaluated beyond basic clinical boundaries to incorporate ethical, cultural, and emotional frameworks. This underscores the need to implement multi-faceted, experience-centered strategies within nursing curricula and professional development programs.

Keywords: Good death, End-of-life care, Intensive care nurses, Nursing attitudes, Nursing behaviors

Introduction

Progress in healthcare has significantly extended human life expectancy, making the definition of the phrase "end of life" increasingly complex. In the medical literature, a range of definitions characterizes the "end of life" as a timeframe spanning less than 6 months of remaining life, prioritizing the ultimate days, hours, or minutes [1], or

Corresponding author: Michelle Tan
Address: Department of Nursing and Supportive Medicine, Faculty of Health Sciences, Nanyang Technological University, Singapore.
E-mail: ✉ michelle.tan@gmail.com
Received: 02 October 2025; **Accepted:** 09 January 2026; **Published:** 30 June 2026

How to Cite This Article: Tan M, Lim K, Goh A. The Relationship between Intensive Care Nurses' Perceptions of a Good Death and End-of-Life Care Attitudes: A Cross-Sectional Study. J Integr Nurs Palliat Care. 2026;7(1):1-15. https://doi.org/10.51847/1QKNHluxTn

centering on the clinical presentations observed during the concluding days or weeks [2]. Because a universally accepted definition is absent, terms such as "terminal care," "end-of-life care (EoLC)," "palliative care," and "care while actively dying" are often used interchangeably [3]. Mirroring the unique nature of individual lives, definitions of the end of life can differ from person to person. Yet, despite such variability, the end of life remains an inevitable phase that every individual will eventually encounter [4]. For healthcare providers, the capacity to recognize imminent death is vital in clinical settings to ensure the timely initiation and maintenance of respectful and dignified EoLC [5].

Although death is a universal certainty, the personal meaning linked to it is often shaped by age, religious beliefs, cultural backgrounds, core values, and societal traditions. Consequently, the period spent "waiting" for death carries distinct meanings and creates varying requirements for individual patients and their loved ones [6]. The framework of a "good death" emerges as a central element in efforts to satisfy these distinct needs. Establishing a singular, global definition for a good death has proven difficult due to divergent personal outlooks, faith systems, and sociocultural backgrounds [7]. For example, Malinowski [8] highlighted the significance of immediate relatives, and sometimes an entire community, assembling around an individual's bedside as death approaches. At the same time, Middleton [9] characterized a "good death" in Uganda as passing away peacefully and with dignity, free from physical pain or distress, while remaining conscious and capable of clear, though measured, speech. Historically, before the advent of contemporary life-saving medical treatments, individuals with terminal conditions frequently passed away sooner, and these deaths typically occurred within the home environment. However, preventive medicine, public health initiatives, and improved overall living standards have substantially increased human longevity [10]. Alongside these advancements, the trajectory of life-threatening illnesses has lengthened, meaning patients often experience protracted end-of-life periods that demand medical management over extended durations. The requirement to deploy sophisticated, intricate therapeutic interventions arising from hospital-based technological advances has led to end-of-life trajectories increasingly occurring within institutional settings [11]. This shift has necessitated a reevaluation of ethical, clinical, and care-focused methodologies regarding terminal processes, thereby driving the ongoing evolution of the "good death" concept [4].

The expanding global elderly population and the high prevalence of chronic illnesses have steadily intensified the demand for intensive care resources, both throughout active treatment stages and during the final phases of life [12]. Intensive care units (ICUs) represent clinical environments characterized by elevated patient mortality rates [13-16]. As a result, the delivery of EoLC is of paramount importance within ICUs, requiring careful integration of the "good death" concept [17]. As foundational members of critical care teams, nurses perform vital functions in delivering EoLC, given that they maintain a more continuous presence with dying patients than other healthcare practitioners [4]. Undertaking this form of EoLC constitutes one of the most demanding trials in the nursing profession, and the care provided is fundamentally structured by their own insights, perspectives, convictions, and prior experiences concerning mortality [18]. As stated by the American Association of Colleges of Nursing, an essential proficiency for nursing staff tasked with delivering high-quality care to dying individuals involves maintaining a positive outlook toward death and possessing the capacity to support individuals through the dying process [19].

The entitlement to a good death carries equal weight to the right to life itself. From this perspective, individuals are entitled to receive tranquil EoLC within protective settings [20]. Intensive care nurses, who observe the final stages of a patient's journey, provide ongoing clinical management and frequently oversee the dying process, and thus fulfill an indispensable role in this scenario. Pathbreaking investigations have scrutinized nurses' conceptualizations of a good death along with their EoLC attitudes and actions across a variety of cultural and clinical environments. For instance, Menekli *et al*. [6] and Chaiyasit *et al*. [7] illustrated how cultural and environmental factors shape definitions of a good death.

In contrast, systematic and policy-oriented investigations scrutinized components that facilitate a good death in the Eastern Mediterranean [21], alongside broader discourses on dying well [22, 23]. Research centered specifically on ICUs indicates that nursing staff confronts distinct difficulties when trying to reconcile the ideals of a good death with the pressures of aggressive medical treatments [17, 24]. Supplemental studies have analyzed structural obstacles, ethical dilemmas, and the role of educational preparation in EoLC perspectives and professional conduct [18, 25-28]. Critically, Zarei *et al*. [29] identified a positive association linking a nurse's concept of a good death to their clinical proficiency in administering EoLC. Despite these insights, a majority of current projects use cross-sectional designs that rely on self-reported data, and there remains a distinct scarcity of region-specific ICU data, particularly from northeastern Türkiye. This investigation seeks to fill this literature gap by evaluating perceptions of a good death alongside EoLC attitudes and actions among ICU nurses in this region, offering findings relevant to the local context and useful for clinical operations and training. Correspondingly, the objectives of this research were: (1) to evaluate the current attitudes and behaviors of intensive care nurses regarding EoLC and their interpretations of a good death; (2) to identify the correlations existing between these nurses' EoLC attitudes and behaviors and their viewpoints on a good death; and (3) to examine the sociodemographic variables that influence the participating nurses' EoLC attitudes and behaviors as well as their perceptions of a good death.

Materials and Methods

Study design and setting

This research employed a descriptive and correlational approach. The target population encompassed 204 nurses employed across the adult ICUs of all public healthcare facilities located within a city in northeastern Türkiye. The fieldwork took place across four distinct public hospitals, comprising two training and research institutions and two general public hospitals, spanning a total of 12 adult ICUs (comprising medical, surgical, and mixed care specialties). These medical centers serve patient cohorts from diverse sociodemographic and cultural backgrounds. Over recent periods, an influx of both domestic and international patients visiting the region for healthcare tourism has heightened the frequency with which nursing staff engage with patients holding diverse cultural values. This dynamic is a major factor shaping perspectives on EoLC and a good death. Within this framework, the practical experiences of nurses caring for multicultural populations provided a valuable source of complex, multi-faceted research data. Furthermore, logistical advantages, such as straightforward institutional access and the principal investigator's ability to conduct field observations efficiently, informed the selection of these specific settings.

Sample size and sampling

The required sample size for the project was determined using the standard statistical equation for scenarios with a known population size [30]. Within this algebraic expression, displayed below, n denotes the minimum sample size, N signifies total population size, t represents the confidence coefficient (set at 1.96 to achieve a 95% confidence level), p denotes the probability of the occurrence of a positive event (0.50), q indicates the probability of a negative event (0.50), and d reflects the chosen margin of error (0.05):

$$n = \frac{Nt^2pq}{d^2(N-1)+t^2pq} = \frac{(204)(1.96)^2(0.5)(0.5)}{(0.05)^2(204-1)+(1.96)^2(0.5)(0.5)} \quad (1)$$

Based on this mathematical calculation, a minimum cohort of 134 respondents was required. To account for potential non-participation due to professional leave, medical absences, or explicit declinations, a total of 136 nurses were enrolled. A proportional stratified random sampling technique was used to select participants. Each of the four participating facilities (the two training and research centers and the two general public hospitals) was treated as an independent stratum, with baseline nursing staff size explicitly accounted for at each institution. The specific number of participants drawn from each stratum was determined proportionally to each facility's overall contribution to the total population, ultimately yielding 136 respondents through random selection. This methodology ensured that every medical facility was represented in proportion to its size in the final sample.

Because the project also sought to evaluate the underlying interactions between variables, a post-hoc power analysis was executed via G*Power 3.1 to validate the adequacy of the secured sample size. For a correlational test with a moderate effect size (r = 0.30), α = 0.05, and n = 134, the statistical power was 0.96. For multiple linear regression modeling with six independent predictors, assuming a moderate effect size (f^2 = 0.15), α = 0.05, and n = 134, the statistical power exceeded 0.90. These statistical indicators confirmed that the sample size was fully adequate for robust analysis. Furthermore, by enrolling two additional participants beyond the calculated minimum threshold, potential study attrition was successfully mitigated.

Data collection

In coordination with ICU nurse managers, the investigator reviewed shift schedules to strategically map out data collection timelines. Daily site visits spanning both morning and evening shifts were conducted to capture rotating nursing staff. To accommodate heavy clinical workloads, questionnaires were distributed in individual envelopes during quieter periods, with completion deadlines established collaboratively. These designated return timelines were logged, and the completed surveys were retrieved in sealed envelopes during the researcher's subsequent visits. The field research occurred from March to October 2022.

Instrument

Three separate measurement tools were used to collect data: a Nurse Information Form, the Scale of Attitudes and Behaviors of Intensive Care Nurses Toward End-of-Life Care (EoLCS), and the Good Death Scale (GDS).

Nurse information form

This profiling instrument captured diverse baseline characteristics, including gender, age, educational credentials, marital status, overall nursing tenure, specific adult ICU employment duration, intentionality behind choosing the nursing profession, career satisfaction within critical care, self-assessed literacy regarding EoLC and dignified death, exposure frequency to dying patients, personal psychological/physiological impact from managing terminal

care, and conviction regarding the fulfillment of patient and family wishes during the dying trajectory [6, 17-19, 31].

Scale of attitudes and behaviors of intensive care nurses toward end-of-life care (EoLCS)
Originally developed by Zomorodi *et al*. [31], this metric comprises two discrete subscales: "Attitudes of Intensive Care Nurses Toward End-of-Life Care" (10 items) and "Behaviors of Intensive Care Nurses Toward End-of-Life Care" (6 items). Evaluated using a five-point Likert scale, its baseline design yielded a Cronbach's alpha reliability coefficient of 0.78, with Item 8 of the attitude dimension as the sole reverse-scored item. Cumulative evaluations yield scores from 16 to 80, where higher scores reflect superior clinical attitudes and behavioral patterns regarding EoLC. Yalçınkaya [32] validated the psychometric properties of the Turkish adaptation, noting an alpha internal consistency of 0.70. Panels of experts verified the content validity of this translated variant, establishing Content Validity Ratio (CVR) scores between 0.80 and 1.00, alongside a global Content Validity Index (CVI) of 0.95, confirming strong construct alignment. In the current sample, the alpha value was 0.74.

Good death scale (GDS)
This 17-item instrument, established by Schwartz *et al*. [33], isolates 3 internal dimensions: "Psychosocial-Spiritual" (addressing existential and psychosocial facets of dying: 9 items), "Personal Control" (quantifying cognitive alertness, communication efficacy, and somatic autonomy: 3 items), and "Clinical" (monitoring biomedical and technical features of mortality: 5 items). The framework uses a four-point Likert scale, with no reverse-scored items, and baseline internal consistency alphas ranging from 0.75 to 0.83. Total achievable metrics range from 17 to 68, with higher totals indicating a more positive conceptualization of a dignified death. The Turkish translation and validation, conducted by Aksu and Fadıloğlu [34], yielded a Cronbach's alpha coefficient of 0.92. For the cohort evaluated in this study, the coefficient was 0.84.

Ethical considerations
Before fieldwork initiation, formal ethical clearance was granted by the Avrasya University Institutional Review Board (Protocol Number: 08–2022, Decision Date: 24.02.2022). Following written administrative authorizations from the target clinical facilities, prospective subjects received comprehensive briefings, both oral and written, detailing the study's parameters. Subsequently, written and verbal informed consent was obtained, reinforcing that participation was entirely voluntary and that responses would remain completely anonymous. The entire research trajectory adhered strictly to the principles outlined in the Declaration of Helsinki.

Data analysis
Computational processing was performed using IBM SPSS Statistics 23. Normality assumptions were tested using the Kolmogorov-Smirnov and Shapiro-Wilk tests. Continuous variables exhibiting normal distributions were evaluated using independent-samples t-tests for dichotomous groups, whereas non-normally distributed datasets were analyzed using the Mann-Whitney U test. Variance analysis (one-way ANOVA) was executed to contrast normally distributed data across three or more categories, paired with Duncan's test for post-hoc pairwise comparisons. For multi-group evaluations involving non-normal distributions, the Kruskal-Wallis test was selected, supplemented by Dunn's post-hoc procedure. Bivariate connections between normally distributed scale parameters were calculated utilizing Pearson correlation coefficients, while Spearman's rho was substituted whenever normality criteria were violated. Correlation coefficients were systematically classified using these parameters: ≥ 0.8, very strong; 0.6–0.79, moderately strong; 0.3–0.59, fair; < 0.3, poor; and 0, indicating a total absence of correlation [35]. Quantitative metrics were reported as mean ± standard deviation, and statistical significance was defined as $P < 0.05$.

Results and Discussion

Because all 136 distributed questionnaires were fully completed, the entire sample was included in the data analysis. The participants had a mean age of 33.63 ± 3.23 years, with a predominance of females (83.8%). Regarding demographic backgrounds, the majority of respondents were married (65.4%) and held a bachelor's degree (61.8%). In terms of clinical practice, the largest proportion of the sample possessed 10–20 years of professional nursing experience (37.5%) alongside 1–5 years of specific intensive care practice (33.8%). Most individuals (72.1%) indicated they entered the nursing profession voluntarily and expressed satisfaction with their current placement in the intensive care unit (ICU) (85.3%). Furthermore, 46.3% of the respondents noted witnessing a patient death once a week, 57.4% experienced physiological and psychological impacts when providing care to dying patients, and 57% maintained that the preferences of patients and their families ought to be honored during the dying process. A substantial majority of the cohort reported prior knowledge regarding end-of-life care (EoLC) (80.9%) and the concept of a good death (68.4%), noting that this information was

primarily acquired through institutional in-service training programs (EoLC: 44.5%, Good Death: 47.9%) **(Table 1).**

Table 1. Descriptive characteristics of the nurses (n = 136). From: Intensive care nurses' perceptions of good death and end-of-life care attitudes and behaviors: a descriptive and correlational quantitative study.

Characteristic	%	N
Age group (years)		
20–30	39.0	53
30–40	29.4	40
40–50	31.6	43
Mean age ± SD		**33.63 ± 3.23**
Sex		
Female participants	83.8	114
Male participants	16.2	22
Marital status		
Married	65.4	89
Unmarried/Single	34.6	47
Educational attainment		
High school diploma	5.9	8
Associate degree	22.1	30
Bachelor's degree	61.8	84
Master's degree or higher	10.2	14
Voluntary choice of profession		
Yes	72.1	98
No	27.9	38
Satisfaction with working in intensive care		
Yes	85.3	116
No	14.7	20
Knowledge of end-of-life care (EoLC)		
Yes	80.9	110
No	19.1	26
Source of EoLC knowledge (among those answering yes)		
Undergraduate studies	41.8	46
Graduate studies	2.7	3
In-service education/training	44.5	49
Internet resources	6.4	7
Other sources	4.5	5
Knowledge of the good death concept		
Yes	68.4	93
No	31.6	43
Source of knowledge regarding good death (among those answering yes)		
Undergraduate studies	32.3	30
Graduate studies	4.3	4
In-service education/training	48.4	45
Internet resources	6.5	6
Other sources	8.6	8
Frequency of caring for patients in the dying process		
Once per month	18.4	25
Once per week	46.3	63
Twice per week	9.6	13
Three to four times per week	25.7	35
Physiological and psychological impact of caring for dying patients		
Yes	57.4	78
No	42.6	58
Belief that the patient and family's wishes should be respected during the dying process		
Yes	57.0	77
No/Sometimes	43.0	58
Overall professional experience		
Less than 1 year	5.1	7

1–5 years	21.3	29
5–10 years	22.8	31
10–20 years	37.5	51
20 years or more	13.2	18
Experience in intensive care settings		
Less than 1 year	7.4	10
1–5 years	33.8	46
5–10 years	25.7	35
10 years or more	33.1	45

EoLC End-of-Life Care

The mean scores for the attitude and behavior subdimensions of the End-of-Life Care Scale (EoLCS) were 35.28 ± 5.04 and 19.04 ± 4.81, respectively, yielding an overall mean score of 54.32 ± 7.99. These values signify that the surveyed nurses demonstrated constructive attitudes and behavioral patterns regarding EoLC. For the Good Death Scale (GDS), the overall mean score was 54.20 ± 7.24; the corresponding subscale scores were 29.09 ± 4.39 for the psychosocial and spiritual aspects of death, 9.02 ± 2.37 for personal control, and 16.09 ± 2.38 for the clinical and biomedical elements of death. These findings demonstrate that the participating nursing staff held favorable perceptions regarding the concept of a good death **(Table 2).**

Table 2. Descriptive statistics of the scales and subdimensions (n = 136). From: Intensive care nurses' perceptions of good death and end-of-life care attitudes and behaviors: a descriptive and correlational quantitative study.

Measure/Component	Mean score ± Standard deviation
End-of-Life Care Competency Scale (EoLCS)	54.32 ± 7.99
Attitude Dimension	35.28 ± 5.04
Behavioral Dimension	19.04 ± 4.81
Good Death Scale (GDS)	54.20 ± 7.24
Psychosocial and Spiritual Domain	29.09 ± 4.39
Personal Control Domain	9.02 ± 2.37
Clinical Domain	16.09 ± 2.38

Abbreviations: EoLCS = End-of-Life Care Scale, GDS = Good Death Scale, and SD = Standard deviation.

As illustrated in **Table 3**, a statistically significant, moderate positive correlation was identified between the overall GDS score and the overall EoLCS score (r = 0.425; P < 0.001). Correspondingly, statistically significant, moderate positive correlations emerged when pairing the total GDS score with the distinct attitude (r = 0.398; P < 0.001) and behavior (r = 0.305; P < 0.001) subdimensions of the EoLCS. This indicates that practitioners possessing enhanced perceptions of a good death likewise displayed more favorable attitudes and behaviors when administering EoLC. Furthermore, the total EoLCS score exhibited moderately significant positive correlations with both the psychosocial-spiritual subdimension (r = 0.463; P < 0.001) and the clinical subdimension (r = 0.313; P < 0.001) of the GDS. Nurses who viewed the psychosocial, spiritual, and clinical components of a good death more favorably reported more positive clinical behaviors and more positive views of EoLC. Conversely, no statistically meaningful association was observed between the personal control component of a good death and EoLC outcomes.

Table 3. Pearson correlations between scales and subdimensions (n = 136). From: Intensive care nurses' perceptions of good death and end-of-life care attitudes and behaviors: a descriptive and correlational quantitative study.

Scale/Subdimension	GDS	
	P	**r**
EoLCS	< 0.001	0.425
Attitudes	< 0.001	0.398
Behaviors	< 0.001	0.305
GDS	**EoLCS**	
Psychosocial-Spiritual	< 0.001	0.463
Personal control	0.224	0.105
Clinical	< 0.001	0.313

Abbreviations: EoLCS = End-of-life care scale, and GDS = Good death scale.

Inferential statistical analyses outlined in **Table 4** indicated that participants' sociodemographic backgrounds did not significantly influence their overall perceptions of a good death or their behavioral and attitudinal responses toward EoLC (P > 0.05).

Table 4. Correlational statistics for participants' sociodemographic characteristics and total scale scores and subdimensions (n = 136). From: Intensive care nurses' perceptions of good death and end-of-life care attitudes and behaviors: a descriptive and correlational quantitative study.

	Clinical	Personal control	Psychosocial-Spiritual	GDS overall score	Behaviors	Attitudes	EoLCS overall score
	Mean ± SD	Mean ± SD	Mean ± SD	Mean ± SD	Mean ± SD	Mean ± SD	Mean ± SD
Age, years							
20–30	16.25 ± 2.59	8.96 ± 2.52	29.21 ± 4.9	54.42 ± 8.67	18.96 ± 5.01	35.13 ± 5.07	54.09 ± 8.01
30–40	15.98 ± 2.25	8.68 ± 2.04	28.95 ± 3.8	53.6 ± 5.31	18.48 ± 4.5	35.48 ± 4.66	53.95 ± 7.45
40–50	16 ± 2.28	9.42 ± 2.45	29.07 ± 4.34	54.49 ± 6.98	19.65 ± 4.88	35.28 ± 5.44	54.93 ± 8.57
Test St.	$\chi^2 = 1.076$	$\chi^2 = 3.002$	$\chi^2 = 0.454$	F = 0.273	F = 0.626	F = 0.052	F = 0.187
P	0.584	0.223	0.797	0.762	0.536	0.949	0.829
Gender							
Female	16.2 ± 2.2	9.02 ± 2.3	29.14 ± 4.34	54.36 ± 7.03	18.75 ± 4.79	35.56 ± 5.03	54.32 ± 8.04
Male	15.5 ± 3.14	9.05 ± 2.73	28.82 ± 4.75	53.36 ± 8.36	20.5 ± 4.78	33.82 ± 4.95	54.32 ± 7.91
Test St.	U = 1111.5	U = 1226	U = 1197.5	U = 1192.5	t=−1.566	t = 1.492	t=−0.001
P	0.395	0.865	0.738	0.716	0.120	0.138	0.999
Marital status							
Married	15.92 ± 2.19	8.9 ± 2.36	28.72 ± 4.17	53.54 ± 6.73	19.09 ± 4.72	35.38 ± 4.91	54.47 ± 7.78
Single	16.4 ± 2.7	9.26 ± 2.4	29.79 ± 4.76	55.45 ± 8.04	18.94 ± 5.03	35.09 ± 5.32	54.02 ± 8.45
Test St.	U = 1823.5	U = 1990	U = 1740.5	U = 1773.5	0.177	t = 0.326	t = 0.321
P	0.216	0.634	0.107	0.145	0.860	0.745	0.756
High school	Education level	8.25 ± 3.85	26.38 ± 7.35	49.63 ± 13.77	19.13 ± 5.22	33.5 ± 5.76	52.63 ± 4.44
Associate's degree	15 ± 4.72	9.83 ± 2.38	29.43 ± 4.55	55.9 ± 6.98	20.03 ± 5.24	35.93 ± 5.72	55.97 ± 9.53
Bachelor's degree	16.63 ± 2.44	8.9 ± 2.09	29.19 ± 3.76	54.04 ± 5.88	18.67 ± 4.38	35.36 ± 4.75	54.02 ± 7.42
Master's degree and above	15.94 ± 2.06	8.43 ± 2.71	29.29 ± 5.48	54.14 ± 9.65	19.07 ± 6.23	34.43 ± 5.02	53.5 ± 9.43
Test St.	16.43 ± 2.21	$\chi^2 = 4.986$	$\chi^2 = 1.003$	F = 0.837	F = 0.59	$\chi^2 = 1.682$	$\chi^2 = 0.626$
P	$\chi^2 = 1.509$	0.173	0.800	0.488	0.622	0.641	0.890
	0.680						

Abbreviations: EoLCS = End-of-life care scale, GDS = Good death scale, SD = Standard deviation, F = one-way analysis of variance, t = independent samples t-test, $\chi 2$ = Kruskal-Wallis test, U = Mann-Whitney U test

According to the data compiled in **Table 5,** the regularity with which nurses encountered dying patients significantly affected their attitudes toward EoLC, with higher exposure frequencies corresponding to more favorable attitudes (P = 0.006). This encounter frequency also modified how nurses perceived the clinical domain of a good death; individuals with higher exposure rates demonstrated more positive outlooks regarding the clinical and biomedical features of a good death (P = 0.004). Variations were also observed in overall EoLC scores and associated behavioral expressions based on the physiological and psychological toll experienced while caring for patients at the end of life (P = 0.046 and P = 0.004, respectively). Specifically, nurses who acknowledged being physically and emotionally affected by this care regimen displayed highly constructive behaviors and outlooks toward EoLC.

Additionally, total scores on the EoLCS varied significantly depending on whether participants believed that patients' and families' preferences should be fulfilled during the dying phase; those who advocated fulfilling these wishes showed more positive orientations toward EoLC (P = 0.012). Analysis of the personal control subdimension revealed significant variation associated with professional longevity (P = 0.027). Nurses with over 20 years of clinical experience demonstrated more favorable evaluations of mental attention, communication capacity, and physical function management during a good death than colleagues with only 1–5 years of tenure.

Finally, nurses who entered the profession by personal choice exhibited elevated total EoLCS scores, more favorable attitudes and behaviors, and enhanced perceptions of a good death across its psychosocial-spiritual, personal control, and clinical subdimensions; however, these trends did not satisfy the criteria for statistical significance (P > 0.05). Similarly, no statistically significant shifts were observed in EoLCS or GDS metrics when participants were evaluated by their level of ICU job satisfaction, prior knowledge of these concepts, or the extent of their specialized intensive care experience (P > 0.05).

Table 5. Correlational statistics for participants' descriptive characteristics and total scale scores and subdimensions (n = 136). From: Intensive care nurses' perceptions of good death and end-of-life care attitudes and behaviors: a descriptive and correlational quantitative study

	Clinical	Personal control	Psychosocial-spiritual	GDS overall score	Behaviors	Attitudes	EoLCS overall score
	Mean ± SD	Mean ± SD	Mean ± SD	Mean ± SD	Mean ± SD	Mean ± SD	Mean ± SD
Choose the profession willingly							
Yes	16.14 ± 2.41	9.22 ± 2.42	29.18 ± 4.53	54.42 ± 7.41	19.09 ± 4.95	35.46 ± 5.16	54.55 ± 8.36
No	15.95 ± 2.34	8.5 ± 2.17	29.05 ± 4.07	53.63 ± 6.84	18.89 ± 4.51	34.82 ± 4.75	53.71 ± 7.01
P	U = 1806.5 0.786	U = 1514 0.083	U = 1837.5 0.905	U = 1746.5 0.575	t = 0.214 0.831	t = 0.667 0.506	U = 1806.50 0.788
Satisfied working in intensive care							
Yes	16.05 ± 2.36	9.1 ± 2.41	29.08 ± 4.44	54.23 ± 7.21	18.8 ± 4.58	35.22 ± 5.14	54.03 ± 7.92
No	16.3 ± 2.54	8.55 ± 2.11	29.15 ± 4.25	54 ± 7.57	20.4 ± 5.94	35.6 ± 4.49	56 ± 8.4
P	U = 1118.5 0.797	U = 924.5 0.138	U = 1137.5 0.890	U = 1080 0.623	t = -1.377 0.171	t = -0.307 0.759	U = 1005.0 0.340
Possesses knowledge about EoLC							
Yes	16.15 ± 2.29	9.12 ± 2.28	29.37 ± 4.28	54.64 ± 7.15	19.34 ± 4.37	35.62 ± 4.98	54.95 ± 7.26
No	15.85 ± 2.78	8.62 ± 2.71	27.88 ± 4.74	52.35 ± 7.45	17.77 ± 6.29	33.85 ± 5.13	51.62 ± 10.25
P	U = 1417 0.942	U = 1299 0.457	U = 1175 0.157	U = 1187.5 0.179	t = 1.204 0.238	t = 1.622 0.107	U = 1147.0 0.117
Possesses knowledge about the concept of good death							
Yes	16.27 ± 2.28	9.18 ± 2.45	29.13 ± 4.44	54.58 ± 7.39	19 (10-30)	35.61 ± 4.97	54.73 ± 7.19
No	15.7 ± 2.58	8.67 ± 2.16	29 ± 4.34	53.37 ± 6.91	19 (8-30)	34.56 ± 5.17	53.42 ± 9.51
P	U = 1754 0.246	U = 1706 0.159	U = 1913.5 0.686	U = 1774.5 0.292	t = 0.290 0.773	t = 1.136 0.258	U = 1815 0.387
Frequency of encountering a patient in the process of dying							
Once a month	15.04 ± 2.54	9.12 ± 2.54	27.44 ± 5.49	51.6 ± 9.5	18.36 ± 5.15	32.76 ± 4.72 [a]	51.12 ± 9.05
Once a week	15.92 ± 2.16	8.59 ± 2.35	29.68 ± 3.46	54.19 ± 6.39	19.46 ± 4.63	36.63 ± 4.5 [b]	56.1 ± 7.89
Other (twice a week)	16.77 ± 3.52	9.62 ± 2.6	29.54 ± 5.84	55.92 ± 10.04	20.62 ± 5.42	33.77 ± 5.72 [ab]	54.38 ± 7.47

Other (3-4 times a week)	16.89 ± 1.83	9.51 ± 2.13	29.03 ± 4.32	55.43 ± 5.17	18.17 ± 4.62	35.2 ± 5.26 [ab]	53.37 ± 6.93
P	$\chi^2 = 13.579$	$\chi^2 = 5.318$	$\chi^2 = 3.164$	F = 1.246	F = 1.176	F = 4.287	F = 2.632
	0.004	0.150	0.367	0.306	0.321	**0.006**	0.053
Affected physiologically and psychologically by caring for dying patients							
Yes	16.06 ± 2.19	9.33 ± 2.23	29.12 ± 4.22	54.51 ± 6.69	20.06 ± 4.64	35.4 ± 5.54	55.46 ± 8.25
No	16.12 ± 2.64	8.6 ± 2.5	29.05 ± 4.65	53.78 ± 7.96	17.66 ± 4.73	35.12 ± 4.31	52.78 ± 7.41
P	U = 2126.5	U = 1909	U = 2207.5	t = 0.586	t = 2.970	U = 2219.5	U = 1809.5
	0.547	0.111	0.810	0.559	**0.004**	0.851	**0.046**
The wishes of the patient and family should be fulfilled during the dying process							
Yes	16.14 ± 2.08	9.12 ± 2.33	29.42 ± 4.22	54.68 ± 7.2	19.74 ± 4.63	35.86 ± 5.62	55.6 ± 8.42
No or sometimes	16.05 ± 2.75	8.93 ± 2.44	28.59 ± 4.62	53.57 ± 7.37	18.1 ± 4.97	34.48 ± 4.11	52.59 ± 7.16
P	U = 2200	U = 2160	U = 2014.5	t = 0.875	t = 1.970	t = 1.641	U = 1667.5
	0.882	0.739	0.330	0.383	0.051	0.103	**0.012**
Professional experience							
Less than 1 year	15.71 ± 4.07	9.14 ± 2.34 [ab]	28.57 ± 6.21	53.43 ± 9.32	19.86 ± 4.1	37.29 ± 3.95	57.14 ± 7.93
1-5 years	15.9 ± 2.51	8.17 ± 2.59 [b]	28.21 ± 4.95	52.28 ± 8.75	18.86 ± 4.8	33.86 ± 5.71	52.72 ± 8.31
5-10 years	16.65 ± 2.3	9.48 ± 2.22 [ab]	30.16 ± 3.92	56.29 ± 6.75	18.48 ± 5.57	36.13 ± 4.76	54.61 ± 8.62
10-20 years	15.78 ± 2.03	8.8 ± 2.28 [ab]	29.16 ± 3.94	53.75 ± 6.22	19.31 ± 4.63	34.94 ± 5.05	54.25 ± 7.65
20 years or more	16.44 ± 2.48	10.17 ± 2.09 [a]	28.67 ± 4.78	55.28 ± 7	19.17 ± 4.59	36.28 ± 4.42	55.44 ± 7.61
P	$\chi^2 = 4.176$	$\chi^2 = 10.941$	$\chi^2 = 2.004$	F = 1.342	$\chi^2 = 1.246$	$\chi^2 = 5.328$	$\chi^2 = 2.667$
	0.383	**0.027**	0.735	0.258	0.870	0.255	0.615
Intensive care experience							
Less than 1 year	16.1 ± 3.51	8.8 ± 2.2	28.4 ± 5.17	53.3 ± 8.01	19.1 ± 4.28	36.7 ± 4.35	55.8 ± 6.86
1-5 years	16.3 ± 2.48	8.83 ± 2.51	28.83 ± 4.82	53.96 ± 8.01	19.33 ± 5.38	35 ± 5.54	54.33 ± 8.78
5-10 years	16.09 ± 2.34	8.97 ± 2.48	29.89 ± 3.82	54.94 ± 7.01	19.09 ± 5	35.77 ± 5.45	54.86 ± 8.74
10 years or more	15.87 ± 2.06	9.31 ± 2.21	28.89 ± 4.24	54.07 ± 6.58	18.69 ± 4.26	34.87 ± 4.34	53.56 ± 6.85
P	$\chi^2 = 1.762$	$\chi^2 = 1.351$	$\chi^2 = 1.041$	F = 0.193	F = 0.133	$\chi^2 = 0.889$	F = 0.300
	0.623	0.717	0.791	0.901	0.940	0.828	0.825

There is no difference between groups marked with the same superscripted letter.
Abbreviations: EoLCS = End-of-life care scale, GDS = Good death scale, SD = Standard deviation, F = one-way analysis of variance; t = independent samples t-test, $\chi 2$ = Kruskal-Wallis test, and U = Mann-Whitney U test.

Intensive care nurses routinely engage with the end-of-life process, and their knowledge, attitudes, actions, and perspectives regarding mortality significantly influence how it is managed. The objective of this research was to evaluate intensive care nurses' attitudes and behaviors regarding end-of-life care (EoLC), analyze their perceptions of a good death, examine relationships among these variables, and identify factors influencing these attitudes and perceptions. The subsequent discussion frames these results in terms of the need to enhance EoLC quality, operationalize the concept of a good death, and empower intensive care nurses in this clinical domain.

In this investigation, intensive care nurses demonstrated generally favorable attitudes and behaviors toward EoLC. Nonetheless, given that the maximum achievable score on the evaluation scale is 80, the participants' absolute EoLCS scores were not notably elevated. This aligns with another recent study involving intensive care nurses in Türkiye, which similarly reported that mean EoLCS scores were not high [25]. Furthermore, prior research has indicated that intensive care nurses frequently feel ill-equipped to manage EoLC within intensive care unit (ICU) environments and characterize their understanding of EoLC as substandard [26, 36, 37].

Eugene *et al*. [38] asserted that high-quality EoLC within ICUs is intimately linked to the knowledge, competencies, and attitudes that ICU nurses possess when caring for patients at the end of life. Parallel investigations in this field have corroborated that the quality of care delivered is directly influenced by nurses' attitudes toward EoLC [39, 40].

The perspectives of ICU nurses regarding EoLC are shaped by a range of cultural, individual, religious, and organizational factors [41]. Consequently, the personal and cultural paradigms nurses hold regarding the value of death, dying, and life-prolonging interventions can significantly dictate their viewpoints and attitudes toward a good death and EoLC [27, 42-44]. Acknowledging this variation is essential, as differing cultural beliefs and attitudes toward dying can lead to divergent perceptions among intensive care nurses, patients, and families. In the current study, ICU nurses expressed positive views of a good death, and their GDS score (68 points) approached a high level. In a comparable study conducted in Türkiye, the average GDS score among palliative care nurses was similar to that observed here [6]. Similarly, a Turkish study evaluating nurses' attitudes toward caring for dying patients alongside associated religious and cultural variables established that a majority of nurses maintained positive perspectives on death [45]. In communities dominated by traditional Muslim belief frameworks, death is conceptualized as the transition of the human soul from the physical body to God, and a fatalistic orientation toward death is prevalent. This dimension of Turkish societal culture likely shapes how nurses perceive death.

In the present study, the attitudes and behaviors of intensive care nurses toward EoLC were influenced by their perceptions of a good death. Specifically, enhanced perceptions of a good death corresponded with more positive attitudes and behaviors toward EoLC. Indeed, existing literature [46, 47] indicates that when nurses hold positive views of a good death, they demonstrate more effective communication, superior pain management, and more patient-centered care practices. Correspondingly, Lim and Kim [28] underscored that death perceptions play a defining role in nurses' ethical decision-making frameworks, suggesting that cultivating positive perceptions can heighten ethical sensitivity during EoLC. Based on these insights, pedagogical and institutional interventions designed to elevate nurses' perceptions of a good death can be expected to substantially improve the overall quality of EoLC. Future interventional research in this domain is required to substantiate this assumption.

As the ICU nurses in this study demonstrated increased positive perceptions regarding the psychosocial and spiritual dimensions of death, their behaviors and attitudes toward EoLC concurrently improved. The psychosocial-spiritual realm of death encompasses the totality of an individual's emotional, social, interpersonal, and spiritual or moral experiences when confronting mortality. These facets are vital for both patients and healthcare clinicians, particularly within the EoLC framework. Puchalski *et al*. [48] highlighted that death transcends physical expiration to encompass a profound psychosocial and spiritual experience. These observations also comport with studies indicating that nurses who struggle to accept death as a natural component of existence, or who maintain negative views on mortality, may experience detrimental emotions and behaviors while delivering patient care [45], and that such negative emotions can compromise a nurse's capacity to execute their professional duties efficiently [49]. Within this framework, adverse perceptions of death can undermine both the self-efficacy of nurses and the standard of care extended to patients and their families [45, 49]. Consequently, addressing the psychosocial and spiritual elements of death during EoLC is essential to comprehensively support dying patients and their relatives.

The capacity of a dying patient to sustain relationships with family members and peers, engage in decision-making, and retain a sense of autonomy constitutes a core component of a good death [21]. However, the findings of this study revealed that intensive care nurses' perceptions of mental attentiveness, communication capacity, and physical functional control within the paradigm of a good death did not alter their clinical attitudes or behaviors toward dying patients. This implies that nurses prioritize the humanistic, ethical, and emotional elements of EoLC, internalizing the ideal of a "good death" through these specific lenses. The existing literature similarly indicates that nurses' definitions of a good death primarily emphasize attributes such as freedom from pain, dying peacefully, companionship, and religious or spiritual support. In contrast, physical functionality and cognitive awareness are emphasized less [6, 22, 23]. The current study's finding that positive perceptions of the

clinical and biomedical elements of death favorably influence attitudes and behaviors toward EoLC reinforces these earlier investigations. Particularly within ICU environments, where many patients are unresponsive, intubated, or unable to communicate, the relevance of cognitive and physical functions may become secondary from the nursing perspective. Under these conditions, nurses may place greater value on humanistic care components—such as compassion, respect, and holistic support—over physiological variables beyond their control. Ultimately, viewing a good death as a multidimensional phenomenon underscores the importance of the nurse's role as a patient advocate in ICU environments.

This study demonstrated that the attitudes, behaviors, and perceptions of a good death among intensive care nurses were independent of demographic variables, including age, gender, marital status, and education level. Multiple studies in the literature have likewise concluded that demographic attributes do not dictate the EoLC convictions of nursing staff [23, 42, 43]. Conversely, alternative research exploring perceptions of a good death among intensive care nurses has reported that factors such as age [29, 50], gender, marital status [24], and educational background [29] are associated with these perceptions. Concurrently, several of these studies failed to confirm significant correlations between gender [29, 47], marital status [29], or education level [47] and perceptions of a good death. These conflicting findings imply that the impact of demographic characteristics varies across different clinical, cultural, and personal settings, underscoring the need for further research in this field.

A research project by Zarei *et al*. [29] demonstrated that end-of-life care (EoLC) competence among intensive care staff improved alongside a more refined understanding of a good death. Parallel to those observations, the current investigation revealed that intensive care nurses with a higher frequency of exposure to dying patients displayed more constructive attitudes toward EoLC and demonstrated elevated awareness concerning physical comfort, symptom management, and biological death mechanisms within their conceptual frame of a good death. These observations align with Benner's non-linear professional advancement paradigm, which posits that knowledge and practical experience evolve in tandem. Benner explains that this trajectory unfolds as clinicians develop intuitive decision-making capabilities through accumulated hands-on experience [51]. The present inquiry revealed that intensive care professionals with greater career longevity placed greater emphasis on preserving cognitive awareness, communication capacity, and physical functioning in dying patients. Conversely, analyzing intensive care unit (ICU) tenure in isolation yielded no statistically meaningful influence on either EoLC approaches or good death interpretations. This implies that such outlooks and viewpoints should be assessed collectively alongside other determinants, such as overall professional experience, the regularity of encountering active dying, and the frequency of providing direct bedside care. As noted by Benner [51], nursing practices are guided by a "practical wisdom" that is cultivated through clinical patterns established over time, an attribute inextricably linked to a nurse's unique experiential learning path. Furthermore, these results indicate that recognizing the components of a good death and translating them into clinical habits is crucial for nurses to deliver high-quality EoLC. Within this framework, experiential exercises that enable nursing students and practitioners to encounter and navigate the dying trajectory during care delivery should be embedded in both undergraduate and postgraduate nursing curricula, and corresponding professional development programs should be systematically implemented in clinical settings.

Utami *et al*. [26] documented that caring for dying individuals presents substantial emotional and psychological difficulties for nursing staff, while Stokes *et al*. [37] indicated that a strong correlation exists between a nurse's personal emotional state and the thoroughness and quality of care they provide to patients. In this study, ICU nurses who experienced physiological and psychological impacts while caring for dying patients demonstrated more constructive behaviors toward EoLC. These observations align with Benner's assertion that nursing professionals are capable of making more informed clinical choices by drawing on the intuitive understanding and emotional sensitivity that mature through experience [51]. Moreover, ICU nurses who supported honoring patients' and relatives' preferences throughout the dying trajectory exhibited more favorable attitudes and actions toward EoLC. Consistent with these outcomes, subjects in an earlier study affirmed that support systems must be extended to the families of patients nearing death [36]. Prior investigations have similarly reported that nurses' emotional investment and dedication to providing meaningful support culminate in more comprehensive, compassionate, and positive behaviors during EoLC [26, 29, 37]. Consequently, a nurse's responsiveness to patient autonomy and familial values enhances the standard of EoLC, establishing it as a foundational element of ethical and professional nursing practice.

While knowledge of EoLC and the concept of a good death is vital [38], such understanding does not automatically translate into clinical attitudes and behaviors. The translation of theoretical knowledge into clinical practice is governed by additional elements, including personal awareness, ethical principles, practical experience, and emotional maturity [48]. In the current investigation, baseline knowledge of ICU nurses regarding EoLC and a good death did not directly or meaningfully affect how they perceived these principles. Multiple studies have previously reported that a nurse's educational level regarding this topic does not effectively determine the implementation of EoLC [18, 29, 38, 47, 50], suggesting that information alone, without practical experience and ongoing mentorship, fails to elicit behavioral changes [18]. Conversely, alternative literature indicates that educational initiatives intended to elevate EoLC awareness yield favorable outcomes regarding nurses' knowledge

baselines and clinical actions [25, 43]. These divergent outcomes across studies may stem from various influences, including variations in information sources or research designs, individual interpretations of data, and distinct pathways for translating information into clinical practice. Nevertheless, evidence suggests that ICU nursing staff are eager to engage in continuing education initiatives to enhance their mastery of EoLC [17, 42]. Given that most ICU nurses in these investigations possessed fundamental knowledge of EoLC, it is crucial to maintain continuous educational streams on a good death and to expand research in this domain.

In this analysis, intensive care nurses who entered the profession voluntarily and those who reported career satisfaction within the intensive care setting did not show statistically significant differences in their EoLC attitudes or good death perspectives. This implies that professional preferences and workplace satisfaction alone are insufficient indicators for predicting clinical behaviors during EoLC or perceptions of a good death. This outcome may be indirectly linked to systemic infrastructural challenges stemming from nursing shortages and excessive workloads, documented across multiple nations, including Türkiye [17, 18]. The research by Korsah and Schmollgruber is particularly relevant here; they observed that while intensive care nurses were dedicated to assisting both patients and families during EoLC, they encountered multi-faceted obstacles, including familial attitudes, sparse educational preparation for EoLC, physician-controlled decision-making frameworks, and the physical constraints of the ICU environment [52]. These conclusions demonstrate that the caliber of EoLC is determined not only by personal attributes but also by institutional, environmental, and systemic factors.

The outcomes of this research must be interpreted in light of certain limitations. First, because the study employed a descriptive and correlational framework, definitive causal links among the variables could not be established. Second, gathering data from intensive care staff via self-reported questionnaires introduces a potential social desirability bias, as respondents may answer in ways that conform to perceived social expectations. Third, because the participant pool was drawn from specific healthcare facilities, the gathered data cannot be universally generalized to the entire population of intensive care nurses. This methodology was selected, however, due to its feasibility within clinical environments where data collection can be logistically challenging. Lastly, the instruments used to gauge perceptions of EoLC and a good death lacked qualitative metrics, thereby limiting the ability to capture nuanced experiences and viewpoints. Subsequent research should utilize mixed-methods designs to collect more comprehensive data.

Conclusion

This investigation confirmed a meaningful and positive correlation between intensive care nurses' perceptions of a good death and their clinical attitudes and behaviors regarding EoLC processes. Specifically, nurses who encountered the dying process more frequently and were more physiologically or emotionally affected by those experiences demonstrated more empathetic, comprehensive, and attentive approaches to EoLC. The data also indicated that nurses' positive viewpoints regarding the psychosocial, spiritual, and clinical facets of mortality are reflected in their care delivery; conversely, the capacity of certain abstract domains, such as personal autonomy, to guide these outlooks is more constrained. Professional longevity, humanistic bonds with patients, and clinical experiences surrounding active dying emerge as primary factors dictating how nurses conceptualize a good death and how that conceptualization translates into practice. In this context, it is critical to weave not only technical knowledge but also experiential dialogue and emotional preparation for EoLC into foundational nursing education and institutional training modules.

Intensive care units represent technologically sophisticated, life-prolonging environments where patients are frequently unresponsive, which can impede their ability to communicate preferences regarding their death. This environment creates a risk that individual autonomy and personal values may be overlooked. However, a good death extends beyond basic pain alleviation and symptom control; the dignity, self-determination, and socio-emotional requirements of the individual must be preserved to the greatest extent possible. Throughout this process, nurses bear the obligation to act as patient advocates and fulfill comprehensive roles, including preventing unnecessary medical interventions, maintaining transparent and considerate communication with families, and identifying cultural and emotional expectations. Consequently, achieving a good death within ICU environments relies not only on the technological expertise and clinical skills of the nurse but also on their ethical sensitivity, communication efficacy, and holistic approach to patient care.

In summary, this study has illustrated that the definition of a good death cannot be confined solely to biomedical parameters; it must be approached through a multidimensional lens that acknowledges its ethical, cultural, and emotional facets. Within this framework, it is crucial to organize EoLC practices around a holistic methodology that respects the multi-faceted responsibilities of nursing professionals.

Acknowledgments: We gratefully acknowledge the voluntary participation of intensive care nurses, whose insights and experiences significantly contributed to the value of this research.

Conflict of interest: None

Financial support: None

Ethics statement: Ethics approval was obtained from the Ethics Committee of Avrasya University before beginning the study (Protocol Number: 08-2022, Decision Date: 24.02.2022). Written informed consent was obtained from all participants. The research process was conducted in line with the Declaration of Helsinki.

References

1. Crang C, Muncey T. Quality of life in palliative care: being at ease in the here and now. Int J Palliat Nurs. 2008;14(2):90-7.
2. National Consensus Project for Quality Palliative Care. Clinical Practice Guidelines for Quality Palliative Care. 4th ed. Richmond (VA): National Coalition for Hospice and Palliative Care; 2018.
3. Hui D, Nooruddin Z, Didwaniya N, Kim SH, Dev R, De La Cruz M, et al. Concepts and definitions for "actively dying," "end of life," "terminally ill," "terminal care," and "transition of care": a systematic review. J Pain Symptom Manage. 2014;47(1):77-89.
4. Huffman JL, Waheed A, Harmer B. End of life. In: StatPearls. Treasure Island (FL): StatPearls Publishing; 2019.
5. Choo PY, Tan-Ho G, Dutta O, Tan-Ho V, Patinadan PV, Ho AHY, et al. Reciprocal dynamics of dignity in end-of-life care: a multiperspective systematic review of qualitative and mixed methods research. Am J Hosp Palliat Care. 2020;37(5):385-98. doi:10.1177/1049909119878860
6. Menekli T, Dolu S, Coşkun Ö, Torun M. Opinions of palliative care patients, relatives and nurses on good death. J Nursology. 2021;24(1):84-94. doi:10.17049/ataunihem.775855
7. Chaiyasit Y, Thong-On R, Chanbunlawat K, Soonthornchaiya R. Thai nurses' perceptions of a good death: an integrative review. Bangkok Med J. 2020;16(1):102-8. doi:10.31524/bkkmedj.2020.13.003
8. Malinowski B. Magic, science and religion. Özkal S, translator. 2nd ed. Istanbul: Kabalcı Yayınevi; 2000. p. 44.
9. Middleton J. Lugbara death. In: Bloch M, Parry J, editors. Death and the regeneration of life. 6th ed. Cambridge: Cambridge University Press; 1999. p. 142.
10. Knaul FM, Farmer PE, Krakauer EL, De Lima L, Bhadelia A, Jiang Kwete X, et al. Alleviating the access abyss in palliative care and pain relief—an imperative of universal health coverage: the Lancet Commission report. Lancet. 2018;391(10128):1391-454. doi:10.1016/S0140-6736(17)32513-8
11. Krakauer EL. Palliative care and the right to health: international human rights standards and the National Palliative Care Policy Scorecard. J Pain Symptom Manage. 2018;55(2 Suppl):S72-83. doi:10.1016/j.jpainsymman.2017.03.015
12. World Health Organization. Noncommunicable diseases [Internet]. Geneva: World Health Organization; 2024.
13. Capuzzo M, Volta C, Tassinati T, Moreno R, Valentin A, Guidet B, et al. Hospital mortality of adults admitted to intensive care units in hospitals with and without intermediate care units: a multicentre European cohort study. Crit Care. 2014;18(5):551. doi:10.1186/s13054-014-0551-8
14. Nazer L, Lopez-Olivo MA, Cuenca JA, Awad W, Brown AR, Abusara A, et al. All-cause mortality in cancer patients treated for sepsis in intensive care units: a systematic review and meta-analysis. Support Care Cancer. 2022;30(12):10099-109. doi:10.1007/s00520-022-07392-w
15. Zimmerman JE, Kramer AA, Knaus WA. Changes in hospital mortality for United States intensive care unit admissions from 1988 to 2012. Crit Care. 2013;17(2):R81. doi:10.1186/cc12695
16. Siddiqui S. Mortality profile across our intensive care units: a 5-year database report from a Singapore restructured hospital. Indian J Crit Care Med. 2015;19(12):726-7. doi:10.4103/0972-5229.171401
17. Xu DD, Luo D, Chen J, Zeng JL, Cheng XL, Li J, et al. Nurses' perceptions of barriers and supportive behaviors in end-of-life care in the intensive care unit: a cross-sectional study. BMC Palliat Care. 2022;21(1):130.
18. Alshammari F, Sim J, Lapkin S, Stephens M. Registered nurses' knowledge, attitudes and beliefs about end-of-life care in non-specialist palliative care settings: a mixed studies review. Nurse Educ Pract. 2022;59:103294. doi:10.1016/j.nepr.2022.103294
19. Schlairet C. End of life nursing care: statewide survey of nurse's education needs and effects of education. J Prof Nurs. 2009;25(3):170-7. doi:10.1016/j.profnurs.2008.10.005
20. Peisah C, Sampson EL, Rabheru K, Wand A, Lapid M. The human rights of older people with mental health conditions and psychosocial disability to a good death and dying well. Am J Geriatr Psychiatry. 2021;29(10):1041-6. doi:10.1016/j.jagp.2021.05.015
21. Fereidouni A, Rassouli M, Kianian T, Elahikhah M, Souri H, Azizi S, et al. Factors related to good death in the Eastern Mediterranean Region: a systematic review. East Mediterr Health J. 2022;28(8):601-9. doi:10.26719/emhj.22.069

22. Borgstrom E. What is a good death? A critical discourse policy analysis. BMJ Support Palliat Care. 2024;14(Suppl 3):e2546-53. doi:10.1136/bmjspcare-2019-002173
23. Zaman M, Andoniou E, Wind K, Gibson J, Upshur R, Rojas G, et al. A good death: non-negotiable personal conditions for clinicians, healthcare administrators and support staff. BMJ Support Palliat Care. 2023;13(4):434-7. doi:10.1136/bmjspcare-2020-002878
24. Aksoy B, Kasikçi E. The concept of a good death from the perspectives of nurses caring for patients diagnosed with COVID-19 in intensive care unit. Omega (Westport). 2023. doi:10.1177/00302228231156945
25. Demir F, Polat Dunya C, Özkan İ. The effect of end-of-life care awareness education on the knowledge, attitudes and behaviours of intensive care nurses: a randomized controlled trial. Nurs Crit Care. 2025;30(2):e13192. doi:10.1111/nicc.13192
26. Utami RS, Pujianto A, Setyawan D, Naviati E, Rochana N. Critical care nurses' experiences of end-of-life care: a qualitative study. Nurse Media J Nurs. 2020;10(3):260-74. doi:10.14710/nmjn.v10i3.31302
27. Mian R, Rejnö Å. The meaning of culture in nursing at the end of life: an interview study with nurses in specialized palliative care. BMC Palliat Care. 2024;23(1):166. doi:10.1186/s12904-024-01493-5
28. Lim A, Kim S. Nurses' ethical decision-making during end of life care in South Korea: a cross-sectional descriptive survey. BMC Med Ethics. 2021;22:1-9. doi:10.1186/s12910-021-00665-9
29. Zarei F, Mahlagha D, Shahrbabaki PM. The relationship between perception of good death with clinical competence of end-of-life care in critical care nurses. Omega (Westport). 2022:1-17. doi:10.1177/00302228221134721
30. Cochran WG. Sampling techniques. 3rd ed. New York: Wiley; 1977.
31. Zomorodi M, Lynn M. Instrument development measuring critical care nurses' attitudes and behaviours with end-of-life care. Nurs Res. 2010;59(4):234-40. doi:10.1097/NNR.0b013e3181dd25ef
32. Yalçınkaya SO. The adaptation of the scale of the attitudes and behaviors of ICU nurses intended for end of life care to the Turkish culture: the validity and reliability study [master's thesis]. Bolu (Turkey): Abant İzzet Baysal University Institute of Health Sciences; 2016.
33. Schwartz CE, Mazor K, Rogers J, Ma Y, Reed G. Validation of a new measure of concept of a good death. J Palliat Med. 2003;6(4):575-84. doi:10.1089/109662103768253687
34. Aksu T, Fadılıoğlu Ç. Validity and reliability of good death scale. J Ege Univ Nurs Fac. 2013;29(1):1-15.
35. Chan YH. Biostatistics 104: correlational analysis. Singapore Med J. 2003;44(12):614-9.
36. Kisorio LC, Langley GC. Intensive care nurses' experiences of end-of-life care. Intensive Crit Care Nurs. 2016;33:30-8.
37. Stokes H, Vanderspank-Wright B, Bourbonnais FF, Wright DK. Meaningful experiences and end-of-life care in the intensive care unit: a qualitative study. Intensive Crit Care Nurs. 2019;53:1-7. doi:10.1016/j.iccn.2019.03.010
38. Eugene H, Choi S, Yun KY, Kim SH, Sanghee K, Yun HY. A scoping review of end-of-life care education programs for critical care nurses. Korean J Med Ethics. 2023;26(3):185-207. doi:10.35301/ksme.2023.26.3.185
39. Wilson O, Avalos G, Dowling M. Knowledge of palliative care and attitudes towards nursing the dying patient. Br J Nurs. 2016;25(11):600-5. doi:10.12968/bjon.2016.25.11.600
40. Kurnia TA, Trisyani Y, Prawesti A. Factors associated with nurses' self-efficacy in applying palliative care in intensive care unit. J Ners. 2019;13(2):219-26. doi:10.20473/jn.v13i2.9986
41. Tripathy S, Routray PK, Mishra JC. Intensive care nurses' attitude on palliative and end of life care. Indian J Crit Care Med. 2017;21(10):655-9. doi:10.4103/ijccm.IJCCM_240_16
42. Alshammari F, Sim J, McErlean G, Lapkin S. Registered nurses' beliefs about end-of-life care: a mixed method study. Nurs Open. 2023;10(12):7796-810. doi:10.1002/nop2.2027
43. Fernández-Gutiérrez MC, Benavente-Fernández I, Jiménez-Luque N, et al. Nurses' perception of caring and attitudes toward caring for dying patients: exploring the relationship using a descriptive cross-sectional design. Healthcare (Basel). 2024;12(13):1331. doi:10.3390/healthcare12131331
44. Zhang J, Tao H, Mao J, Qi X, Zhou H. Correlation between nurses' attitudes towards death and their subjective well-being. Ann Palliat Med. 2021;10(12):12159-70. doi:10.21037/apm-21-2943
45. Karadag E, Parlar Kilic S, Ugur O, Akyol MA. Attitudes of nurses in Turkey toward care of dying individual and the associated religious and cultural factors. J Relig Health. 2019;58:303-16. doi:10.1007/s10943-018-0657-4
46. Kim HJ, Kwon SH. Impact of interprofessional communication and person-centered care on perceived quality of death in intensive care units by nurses: a cross-sectional study. Korean J Adult Nurs. 2025;37(2):153-64. doi:10.7475/kjan.2025.0210
47. Lee H, Choi SH. Factors associated with quality of dying and death in Korean intensive care units: perceptions of nurses. Healthcare (Basel). 2021;9(1):40. doi:10.3390/healthcare9010040

48. Puchalski CM, Ferrell B, Virani R, Otis-Green S, Baird P, Bull J, et al. Improving the quality of spiritual care as a dimension of palliative care: the report of the consensus conference. J Palliat Med. 2009;12(10):885-904. doi:10.1089/jpm.2009.0142
49. McKenzie EL, Brown PM. Nursing students' death anxiety and fear towards dementia patients. Australas J Ageing. 2017;36:e32-5. doi:10.1111/ajag.12414
50. Ceyhan Ö, Özen B, Zincir H, Şimşek N, Başaran M. How intensive care nurses perceive good death. Death Stud. 2018;42(10):667-72. doi:10.1080/07481187.2018.1430084
51. Benner P. From novice to expert: excellence and power in clinical nursing practice. Menlo Park (CA): Addison-Wesley; 1983. p. 13-34.
52. Korsah EK, Schmollgruber S. Barriers and facilitators to end-of-life care in the adult intensive care unit: a scoping review. Int J Afr Nurs Sci. 2023;19:100636. doi:10.1016/j.ijans.2023.100636