Indian Journal of Science and Technology, Vol 9(20), DOI: 10.17485/ijst/2016/v9i20/94690, May 2016
ISSN (Print) : 0974-6846
ISSN (Online) : 0974-5645

A Study on Perceptions on Death, Actions on Death Preparation, and Death Education among Medical Personnel

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Abstract

Background/Objectives: This study examined perception on death and actions on it, and necessity and importance of death education using medical Personnel (nurses) as survey respondents. It was done to provide information to make medical Personnel have positive perception on death, and to suggest a direction in developing a death education program. **Methods/Statistical Analysis:** During the month of May, 2015, 127 nurses working in the D University Hospital in Daejeon, Chungnam province were selected as survey objects and study was conducted. **Findings:** To the question, "To whom do you notify first that the patient cannot be recovered?", 71 respondents (55.9%) answered that they give notice to protectors, and, among this group of respondents, more respondents answered that death education is neither necessary nor important than those who answered that it is necessary and important. **Improvements:** This research about death perception and death preparation education to develop a death education program will serve as the basis to give information in making medical Personnel have positive perception of death, and to suggest a direction of death education contents.

Keywords: Death Education, Death Preparation, Medical Personnel, Perceptions on Death

1. Introduction

Death cannot be thought of as being separated from life, and, if one knows death well, and accept it, one can escape from the worry and fear of death, and can deal with it properly even if he or she faces it. To accept the problems related with death and solve them well, we should discuss perceptions on death, and education for preparation for death together[1].

When one faces death, the attitude of accepting it is influenced by social and cultural aspects of the time, personal philosophy and value system, life experiences and attitudes. Since nurses in clinical situation face many dying patients while nursing them, they can have negative attitudes on death, and such attitudes can affect their nursing of patients[2,3].

When medical Personnel face or nurse dying patients, they experience anxiety, fear, burden, frustration, and depression, and may be put in mental condition trying to escape from the situation. Negative perception of nurses on death leads them to experience limits as medical Personnel when they confront dying patients, and restrict medical

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services they can provide with. If they cannot find proper measures for dying situations, they fall into vicious cycles where they become increasingly more negative toward death. It is the reason why death preparation education is necessary[3–5].

Researches on death perceptions using nurses as objects are mainly limited to nurses working in special departments such as intensive care unit or hospice ward. But, to nurses working in general wards and nursing home, death is what they frequently experience. Rather, as nurses in hospice ward and nursing home have more opportunities to express their feelings on death and discuss them with others, they have different perceptions on death[3] Many researches up to now have suggested that death perceptions among nurses are different depending on their ages, job experiences, departments, job ranks, and positions. But, there are not sufficient researches on death perceptions, death preparation and death preparation education.

Thus, the examination of how nurses in clinical situation perceive death and how they are ready for death and what education they receive on death can make the basis for the provision of information for education to teach nurses to have positive attitudes on death. Such results can also be used as sources to develop death preparation education.

2. Research Method

2.1 Survey Objects

127 nurses working in the D University Hospital in Daejeon, Chungnam province were selected as survey objects.

2.2 Survey Method

We analyzed the survey data using the R statistical program. To check their general characteristics, we used five variables: age, education level, marriage, living with family members or not, and religion. The number of questions about their perception on death was 4; that about actions for death (preparation) was 3; that about their perception on death education was 4; that about detailed contents on death education was 78. Using the 78 questions on death education contents, two top 10 lists were created for both the necessity and the importance of death education by the rank order of the scores each item got from the respondents when respondents were asked to evaluate the necessity and importance of specific items. General characteristics, perception on death, actions for death (preparation), perception on death education were changed into average scores based on the degrees of necessity and importance, and, when the averages of the former variables were lower than the averages of necessity and importance, they were considered as 'necessary' and 'important', and, when they were higher than the averages of the latter, they were treated as 'not necessary' and 'not important.' For each of the detailed contents on death education, if the average of it is close to 1, it was treated as high.

3. Study Results

3.1 General Characteristics of Respondents

General characteristics of respondents were as follows. Among all the age groups of respondents, the number of those who belong to the group of 25-29 years old was the largest (27.6%), followed by the group of 30-34 (16.5%), the group of 40-44 (16.5%), the group of 35-39 (14.2%), and the group of lower than 24 (14.2%). To the questions asking whether death education is necessary and important, the age group of 50-54 gave the highest scores in the necessity of it, and the age group of 55 or above gave the highest scores on the importance of it. There were differences in responses depending on marital status. The unmarried group gave higher scores than the married group in necessity and importance of detailed contents of death education. Among all the respondents, the largest number of them said they live alone (46.5%). Among those who live alone, there were more respondents who answered that death education is 'unnecessary', but it was not statistically significant. On the other hand, among those who live alone, more respondents answered that it is important. Religion made no significant differences in response patterns. Both the group of respondents who had religion and the group of those who do not answered that death education is 'necessary' and 'important' Table 1.

3.2 Perception of Death as Medical Personnel

Responses to the questions on perception on death are as follows. To the question, "Do you think that, if a patient

Table 1. General characteristics of respondents

Unit: N(%), Mean±S.D

Category	Necessity	Importance	Necessity				Importance			
			Yes	No	Total	p-value	Yes	No	Total	p-value
Age						0.113				0.369
24 or below	1.99±0.33	1.91±0.41	9(15.8)	9(12.9)	18(14.2)		8(13.3)	10(14.9)	18(14.2)	
25-29	2.05±0.31	2.04±0.33	10(17.5)	25(35.7)	35(27.6)		14(23.3)	21(31.3)	35(27.6)	
30-34	2.03±0.39	2.05±0.37	8(14.0)	13(18.6)	21(16.5)		9(15.0)	12(17.9)	21(16.5)	
35-39	1.82±0.42	1.82±0.41	12(21.1)	6(8.6)	18(14.2)		12(20.0)	6(9.0)	18(14.2)	
40-44	1.96±0.30	1.96±0.30	12(21.1)	9(12.9)	21(16.5)		11(18.3)	10(14.9)	21(16.5)	
45-49	1.88±0.25	1.89±0.23	4(7.0)	2(2.9)	6(4.7)		4(6.7)	2(3.0)	6(4.7)	
50-54	2.12±0.12	1.86±0.48	1(1.8)	4(5.7)	5(3.9)		2(3.3)	3(4.5)	5(3.9)	
55 or above	2.11±0.17	2.14±0.14	1(1.8)	2(2.9)	3(2.4)		-	3(4.5)	3(2.4)	
Education						1.000a				0.349a
College	1.98±0.36	1.96±0.38	47(82.5)	58(82.9)	105(82.7)		52(86.7)	53(79.1)	105(82.7)	
Graduate school	2.00±0.22	2.01±0.21	10(17.5)	12(17.1)	22(17.3)		8(13.3)	14(20.9)	22(17.3)	
Marriage						0.368a				0.470a
Not married	2.01±0.34	1.99±0.36	31(54.4)	44(62.9)	75(59.1)		33(55.0)	42(62.7)	75(59.1)	
Married	1.94±0.34	1.93±0.35	26(45.6)	26(37.1)	52(40.9)		27(45.0)	25(37.3)	52(40.9)	
Live with family or not						0.547				0.232
Live alone	1.98±0.34	1.96±0.36	27(47.4)	32(45.7)	59(46.5)		30(50.0)	29(43.3)	59(46.5)	
Live with unmarried offspring	1.95±0.33	1.91±0.35	16(28.1)	15(21.4)	31(24.4)		16(26.7)	15(22.4)	31(24.4)	
Live with parents	2.07±0.37	2.05±0.41	7(12.3)	15(21.4)	22(17.3)		6(10.0)	16(23.9)	22(17.3)	
Others	1.94±0.32	1.98±0.29	7(12.3)	8(11.4)	15(11.8)		8(13.3)	7(10.4)	15(11.8)	
Religion						1.000a				1.000a
No	1.98±0.40	1.97±0.42	30(52.6)	37(52.9)	67(52.8)		32(53.3)	35(52.2)	67(52.8)	
Yes	1.99±0.26	1.97±0.28	27(47.4)	33(47.1)	60(47.2)		28(46.7)	32(47.8)	60(47.2)	
Total			**57(100.0)**	**70(100.0)**	**127(100.0)**		**60(100.0)**	**67(100.0)**	**127(100.0)**	

a: by Fisher's Exact Probability Test

Table 2. Perception of death as medical Personnel

Unit: N(%), Mean±S.D

Category	Necessity	Importance	Necessity				Importance			
			Yes	No	Total	p-value	Yes	No	Total	p-value
Notice help? *1						0.069a				0.042*
Yes	2.00±0.34	1.97±0.37	42(73.7)	61(87.1)	103(81.1)		44(73.3)	59(88.1)	103(81.1)	
No	1.93±0.33	1.94±0.33	15(26.3)	9(12.9)	24(18.9)		16(26.7)	8(11.9)	24(18.9)	
Measures sufficient? *2						0.561a				1.000a
Yes	1.97±0.35	1.92±0.41	15(26.3)	22(31.4)	37(29.1)		17(28.3)	20(29.9)	37(29.1)	
No	1.99±0.34	1.99±0.33	42(73.7)	48(68.6)	90(70.9)		43(71.1)	47(70.1)	90(70.9)	
Law knowledge *3						0.467a				1.000a
Know well	1.90±0.31	1.91±0.30	10(17.5)	9(12.9)	19(15.0)		9(15.0)	10(14.9)	19(15.0)	
Does not know well	2.00±0.35	1.98±0.37	47(82.5)	61(87.1)	108(85.0)		51(85.0)	57(85.1)	108(85.0)	
Cause of stress *4						0.255				0.614
Nurse fear *5	2.03±0.34	2.00±0.34	10(17.5)	20(28.6)	30(23.6)		13(21.7)	17(25.4)	30(23.6)	
Negative patients *6	2.04±0.35	2.00±0.41	13(22.8)	19(27.1)	32(25.2)		14(23.3)	18(26.9)	32(25.2)	
Scepticism of nurse *7	1.94±0.34	1.94±0.34	33(57.9)	30(42.9)	63(49.6)		32(53.3)	31(46.3)	63(49.6)	
No stress	1.63	1.63	1(1.8)	-	1(0.8)		1(1.7)	-	1(0.8)	
Others	2.00	2.00	-	1(1.4)	1(0.8)		-	1(1.5)	1(0.8)	
Total			**57(100.0)**	**70(100.0)**	**127(100.0)**		**60(100.0)**	**67(100.0)**	**127(100.0)**	

*p<0.005

a: by Fisher's Exact Probability Test

*1 Notice help?: "Do you think that, if a patient knows that he or she cannot be recovered, it will be helpful for his or her becoming stable, and being treated?"

*2 Measures sufficient?:"Are medical, nursing, and emotional measures the hospital provides with sufficient to patients waiting for death?"

*3 Law knowledge: "How much do you know about the law regarding death of patient?"

*4 Cause of stress: 'the cause of stress from death as medical practitioner

*5 Nurse fear: 'fear and scare about death of the nurse herself'

*6 Negative patient: 'negative or antagonistic response of patients and protectors of patients to the medical team'

*7 Scepticism of nurse: "I felt sceptical whether I, as medical practitioner, did my best to the patient who died"

knows that he or she cannot be recovered, it will be helpful for his or her becoming stable, and being treated?", 103(81.1%) out of 127 respondents said 'yes'. To the question asking respondents whether such a notice to the patient is important, the number of respondents who answered 'no' was larger than that of respondents who did 'yes'. And, it was statistically significant. To the question, "Are medical, nursing, and emotional measures the hospital provides with sufficient to patients waiting for death?" 90 respondents (70.9%) answered, 'no'. To the question, "How much do you know about the law regarding death of patient?" 85% of respondents answered that they did not know much about it. But, it was not statistically significant. When they were asked to choose among multiple choices as 'the cause of stress from death as medical practitioner', the largest proportion of them (49.6%) chose the choice, "I felt sceptical whether I, as medical practitioner, did my best to the patient who died." In particular, it was found that, among those who expressed such scepticism, larger proportion of respondents answered that death education is 'important' and 'necessary' than other groups of respondents. But, it was found that the averages of answering 'important' and 'necessary' per group on the question about the cause of stress from death as medical practitioner are higher than the averages of 'fear and scare about death of the nurse herself' and 'negative or antagonistic response of patients and protectors of patients to the medical team' Table 2.

Table 3. Actions to death (preparation)

Unit: N(%), Mean±S.D

Category	Necessity	Importance	Necessity				Importance			
			Yes	No	Total	p-value	Yes	No	Total	p-value
First notice *1						0.262				0.654
to patient	1.54±0.40	1.55±0.49	2(3.5)	-	2(1.6)		1(1.7)	1(1.5)	2(1.6)	
to protector	2.01±0.04	1.99±0.04	28(49.1)	43(61.4)	71(55.9)		30(50.0)	41(61.2)	71(55.9)	
to patient and protector	2.05±0.15	1.94±0.16	5(8.8)	6(8.6)	11(8.7)		6(10.0)	5(7.5)	11(8.7)	
depend on situation	1.93±0.05	1.94±0.05	22(38.6)	21(30.0)	43(33.9)		23(38.3)	20(29.9)	43(33.9)	
Nurse stress *2						0.819a				0.363a
Yes	1.99±0.33	1.97±0.35	46(80.7)	58(82.9)	104(81.9)		47(78.3)	57(85.1)	104(81.9)	
No	1.97±0.39	1.94±0.40	11(19.3)	12(17.1)	23(18.1)		13(21.7)	10(14.9)	23(18.1)	
Hospice experience *3						0.573a				1.000a
Yes	1.99±0.28	2.00±0.27	22(36.5)	29(42.4)	51(40.2)		22(36.7)	29(43.3)	51(40.2)	
No	1.97±0.39	1.94±0.41	35(63.5)	41(57.6)	76(59.8)		38(63.3)	38(56.7)	76(59.8)	
Total			**57(100.0)**	**70(100.0)**	**127(100.0)**		**60(100.0)**	**67(100.0)**	**127(100.0)**	

a: by Fisher's Exact Probability Test

*1 First notice: "To whom do you notify first that the patient cannot be recovered?"

*2 Nurse stress: "Do you feel stress when patients die?"

*3 Hospice experience: "Do you have any experience as working at the hospice ward for patients in terminal illnesses?"

Table 4. Perception on death education

Unit: N(%), Mean±S.D

Category	Necessity	Importance	Necessity				Importance			
			Yes	No	Total	p-value	Yes	No	Total	p-value
Edu experience *1						0.148a				0.679a
Yes	2.01±0.24	2.01±0.24	10(17.5)	21(30.0)	31(24.4)		13(21.7)	18(26.9)	31(24.4)	
No	1.98±0.37	1.96±0.39	47(82.5)	49(70.0)	96(75.6)		47(78.3)	49(73.1)	96(75.6)	
Will get edu. *2						0.259a				0.367a
Yes	1.99±0.32	1.97±0.35	47(82.5)	53(75.6)	100(78.7)		49(81.7)	51(76.1)	100(78.7)	
No	1.96±0.44	1.96±0.42	10(17.5)	17(13.4)	27(21.3)		11(18.3)	16(23.9)	27(21.3)	
Proper time *3						0.725				0.747
Elemen. school or before	1.94±0.30	2.03±0.26	1(1.8)	2(2.9)	3(2.4)		1(1.7)	2(3.0)	3(2.4)	
Middle, high school	1.93±0.31	1.93±0.32	26(45.6)	27(39.1)	53(42.1)		27(45.0)	26(39.4)	53(42.1)	
College or above	2.02±0.36	1.99±0.39	30(52.6)	40(58.0)	70(55.5)		32(53.3)	38(57.6)	70(55.5)	
Proper institution *4						0.913				0.975
Educational Insti.	1.98±0.33	1.97±0.36	33(57.9)	38(54.3)	71(55.9)		33(55.0)	38(56.7)	71(55.9)	
Religious Insti.	2.02±0.32	1.99±0.32	5(8.8)	6(8.6)	11(8.7)		6(10.0)	5(7.5)	11(8.7)	
social welfare Insti.	1.96±0.40	1.90±0.43	8(14.0)	13(18.6)	21(16.5)		9(15.0)	12(17.9)	21(16.5)	
Medical Insti.	1.99±0.33	2.00±0.32	9(15.8)	9(12.9)	18(14.2)		9(15.0)	9(13.4)	18(14.2)	
Others	2.03±0.37	2.01±0.30	2(3.5)	4(5.7)	6(4.7)		3(5.0)	3(4.5)	6(4.7)	
Total			**57(100.0)**	**70(100.0)**	**127(100.0)**		**60(100.0)**	**67(100.0)**	**127(100.0)**	

a: by Fisher's Exact Probability Test
*1 Edu experience: "Do you have any experience of receiving death-related education?"
*2 Will get edu. : "Will you participate in death education if it is available?"
*3 Proper time: "When do you think is proper time to receive such an education?"
*4 Proper institution: "Which institution do you think is the proper institution to provide such an education?"

3.3 Actions to Death (Preparation)

The responses on the actions to death (preparation) were as follows. To the question, "To whom do you notify first that the patient cannot be recovered?" 71 respondents (55.9%) said that they notify it to the protector of the patient. 43 (33.9%) answered that it depends on the situation. Among those who answered that they notify it to the protector of patient, there were more respondents who answered that death education is neither important nor necessary than whose who answered that it is important and necessary. On the other hand, among those who answered that it depends on the situation, there were more respondents who answered that death education is important and necessary than those who answered the question negatively. To the question about whether the respondents feel stress when patients die, 104 respondents (81.9%) said 'yes'. But, in their average scores on the question on necessity and importance of death education, those who answered that they felt stress to the previous question were not different from those who answered that they did not. To the question whether they have any experience as working at the hospice ward for patients in terminal illnesses, 76 respondents (59.8%) said they did not have such experiences Table 3.

3.4 Perception on Death Education

96 respondents (75.6%) said they did not have any experience of receiving death-related education. The averages of importance and necessity of death education were higher among those who had experience of receiving death-related education than those among those who did not have such experiences. To the question whether they would participate in death education if it is available, 100 respondents (78.7%) said that they would participate in such an education. To the question, "When do you think is proper time to receive such an education?", 70 respondents (55.5%) responded that during collage days or above, followed by during middle and high school days (42.1%), and elementary school days or before that time (2.4%). To the question asking proper institutions to provide such an education, 79 respondents (55.9%) said

Table 5. Top 10 list on necessity of death education

Unit: N(%), Mean±S.D

Classification	Category	Necessity
Rights of dying patient *1	Notice of death *2	1.48±0.57
Rights of dying patient	Self-determination of dying patient	1.48±0.57
Rights of dying patient	Expected death *3	1.53±0.59
Well-dying	Decent death *4	1.57±0.62
Effect of death	Suicide and education to prevent it	1.58±0.63
Family communication	Consensus-building with family	1.59±0.54
Medical team communication	Consensus and empathy	1.61±0.57
Medical team communication	Response to anger	1.62±0.60
Medical team communication	Controlling emotion of doctor	1.62±0.60
Medical team communication	Understanding emotion of others	1.62±0.57

*1 Rights of dying patient: 'The right to know and the right of self-determination of dying patients'
*2 Notice of death: "It is necessary to explain to family members of the patient what death they want to face, and make them to prepare for it,"
*3 Expected death: "it is necessary to make patient to meet expected death, than to face unexpected death"
*4 Decent death: 'decent death respected as human being, death with family members, and altruistic death'

that educational institutions are proper ones, followed by social welfare institutions (18.6%), medical centers (14.2%), religious institutions (8.7%), and others (4.7%) Table 4.

3.5. Top 10 list on importance &necessity of death education

The top 10 items in terms of rank orders of the average scores of importance and necessity respondents gave are as follows. Respondents gave the highest scores in terms of importance and necessity for the following two theses: "It is necessary to explain to family members of the patient what death they want to face, and make them to prepare for it," and 'patient's right of self-determination."' It is necessary to make patient to meet expected death than to face unexpected death" received the third highest scores. So, we can notice that the three items related with the right to know and the rights of self-determination of dying patients are considered by respondents as the most necessary items. The fact that the thesis of 'decent death respected as human being, death with family members, and altruistic death' was ranked highly lead us to assume that medical Personnel also are aware of the necessity of well-dying. And, the fact that the four items related with medical team communication are included in the top ten list shows the necessity of such communication. In the rank order of the average scores of importance, the three items related with the right to know and the right of self-determination of dying patients were the highest 3 items. Compared with the scores in necessity, we can find that items of education contents related with hospice and alleviation treatment are ranked highly. In the necessity and importance, medical Personnel are found that they consider the right to know and the right of self-determination of dying patients are necessary and important, that they think communication between the medical team and patient or protector is necessary, and that they think hospice alleviation treatment is important Tables 5 and 6.

4. Discussion

This study examined perception on death and actions on it, and necessity and importance of death education using medical Personnel (nurses) as survey respondents. It was done to provide information to make medical Personnel have positive perception on death, and to suggest a direction in developing a death education program.

Table 6. Top 10 list on importance of death education

Unit: N(%), Mean±S.D

Classification	Category	Importance
Rights of dying patient	Notice of death	1.44±0.53
Rights of dying patient	Self-determination of dying patient	1.47±0.56
Rights of dying patient	Expected death	1.47±0.55
Well-dying	Decent death	1.57±0.64
Hospice alleviation treatment	Symptoms of dying person and measures to them	1.57±0.54
Effect of death	Suicide and education to prevent it	1.58±0.65
Hospice alleviation treatment	Non-medication	1.60±0.55
Hospice alleviation treatment	Medication	1.61±0.59
Medical team communication	Understanding emotion of others	1.62±0.55
Effect of death	Effect on remaining family members	1.62±0.58

There were some differences in response patterns depending on general characteristics of respondents. In terms of age, those respondents who were 50-54 years old gave the highest scores on the necessity of death education, and those of 55 or above gave the highest scores on the importance of death education. The findings are similar to the previous researches that those who are 60 years old or above gave the highest scores on the necessity of death education[1], and, among nursing home nurses, those who were 50 years old or above gave high scores on negative and positive meanings of death[2]. The findings show that when people pass from the middle age to the old age, they become more concerned about well-dying than about death itself. The group of nurses who live with their parents gave higher scores in necessity and importance of death education than other groups did. Even though the group of nurses who live alone gave the highest scores on death education, it was not statistically significant. Recently, the tradition of taking care of the elderly within the family is weakened, and is disappearing. And, when a person gets near dying time, the person is moved from his or her house to hospital or nursing home[3]. Considering the finding that the group of nurses who live with their parents gave higher scores in necessity and importance of death education, it is necessary to do research on whether death education improves positive attitudes on death, and what effect such education has on caring the elderly at home.

Those respondents who answered 'no' to the question, "Do you think that awareness of patient that he or she cannot be cured is helpful to make the patient stable and to get treatment?" gave higher scores to the importance of death education than those who answered 'yes' to the question. It was statistically significant. That is, they think that it is better to make the patient stable and to give treatment if the patient does not know that he or she will not be cured. However, a recent study on cancer patients and their protectors[4] found that, although patients want to know their conditions, their protectors are reluctant to tell them exactly. Another study using nursing home care-givers as survey respondents showed that the majority of patients (69.9%) want to know true conditions of themselves[1]. Thus, it seems that, although patients want to know their conditions, their protectors and medical Personnel do not want to tell patients that they are unrecoverable.

Though nurses are in the situation where they are the closest to dying patients to nurse them, most of nurses suffer the feeling of burden, fear, frustration, depression, and stress in their conditions where they should take care of dying patients. We can think of their stress related with the fact that they are not very clear about perception of death[5].

To the question, "To whom do you notify first that the patient cannot be recovered?", 71 respondents (55.9%) answered that they give notice to protectors, and, among this group of respondents, more respondents answered that death education is neither necessary nor important than those who answered that it is necessary and important. On the other hand, among respondents who answered that 'it depends on the situation', more respondents answered that such education is necessary and important than those who answered that it is neither necessary nor important. To the question, "Do you feel stress when patients die?", overwhelming majority of respondents (81.9%) answered 'yes', which is similar to other researches[5–7] revealing that medical Personnel, when they face or nurse dying patients, suffer stress and anxiety, and tend to avoid the situation feeling burden, fear and sorrow.

75.5% of respondents answered that they had not received death-related education, and it was found that those who had ever received such an education felt more that death education is both necessary and important than those who did not receive such an education. Compared with other researches that those who received death preparation education had more positive attitudes than those who did not receive such an education[8], and the former group felt less anxiety than the latter group[9,10], and, furthermore, death preparation education could generate attitude changes to have decent death[11], this research showing that those who had ever received such an education felt more that death education is both necessary and important than those who did not receive such an education proves that such an education produces positive results.

In the top 10 list of the items which won the higher scores of necessity and importance from the respondents than other items, "Do you think that, if a patient knows that he or she cannot be recovered, it will be helpful for his or her becoming stable, and being treated?" and 'the right of self-determination of dying patient' won the first and second highest scores of necessity and importance from respondents. The item which got the third highest score was "it is necessary to make patient to meet expected death than to face unexpected death." The findings prove

that the right to know and the right of self-determination of patients are considered as very important and necessary by respondents. Among the items included in the top 10 list of necessity, four items related with the medical team communication were included. Among the items included in the top 10 list of importance, 3 items related with hospice alleviation treatment were included, proving that there are some differences in respondents' opinions on necessity and importance of various items. The fact that item related with well-dying, 'decent death respected as human being, death with family members, and altruistic death' was ranked the 4th in both necessity and importance list shows that respondents consider good death, or 'how to dye well' as necessary and important.

There is a research showing that the efforts of patient's protector not to give burden to other people by dying of the patient can lead to depression of the protector. Thus, it is a serious problem[12]. Therefore, reflecting changing views of people over time, there have been national level researches to show importance and direction of well-dying. One study[13] suggests 9 strategies related with beautiful closing of life, and, it was found that sharing of care-giving, education of medical Personnel on dying patient management, and founding of alleviation medical facilities were ranked high among those strategies.

With the development of medical technology, human life span has been expanded, which increased the chronic diseases. And, the management of dying and death is transferred from patients and their family members to medical facilities and medical Personnel[14]. However, negative perception on death among medical Personnel prevents them from giving proper care to patients and their protectors[15]. Therefore, it is necessary for medical Personnel to establish their views and philosophy on death through the understanding of death. As death education, as a method of establishing such views and philosophies, is effective in overcoming death anxiety, and improving death acceptance, life satisfaction, and selfintegration[16,17], it is necessary to induce and internalize change of perception and value. It seems desirable that contents of death education are decided by testing necessity and importance to each object, and unique program should be given to each object based on the test.

5. Conclusion

This research about death perception and death preparation education to develop a death education program will serve as the basis to give information in making medical Personnel have positive perception of death, and to suggest a direction of death education contents. Recently in Korea, with the increase of old population and improvement of general life quality, to meet desirable death beyond living well has emerged as an important value. Thus, like the case of Germany and Japan, it is necessary to include death preparation education in curriculum. And, like the case of Canada and America, it is necessary for the state to feel the necessity to develop policies for well-dying.

6. Acknowledgement

This study was conducted in an accordance with the National Research Foundation of Korea (NRF) 2014S1A5B6035107.

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