Original article

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Attitudes of physicians in a tertiary care children's hospital in the face of death

Federico Prado[a], Carlos A. Vázquez[a], Florencia B. Afflitto[a], Antonella Marangelli[a], Agustina B. Antola[a], Guadalupe Salazar Miller[a]

ABSTRACT

Introduction. For physicians, death involves an intricate analysis that determines their attitude towards the patient.

Objectives. 1) To describe the attitudes towards death among medical staff working at a children's hospital. 2) To explore factors associated with such attitudes.

Population and methods. Cross-sectional, survey study. The physicians working at a tertiary care children's hospital completed the *Questionnaire of attitudes towards death* (QAD). Sociodemographic variables, professional category, work setting, having witnessed the death of patients, self-perception of a positive attitude towards death, and attitude towards death according to the QAD were studied.

Results. Between June 1st, 2021 and June 1st, 2022, 362 participants were included; mean age: 39.88 years (± 11.56), health care experience: 14.06 years (± 11.97). A positive attitude was observed in 35 (9.67%). A statistical significance was observed for a greater probability of a positive attitude among those who were ≥ 40 years old (p = 0.02, 95% CI: 1.1–3.9), had health care experience for ≥ 14 years (p = 0.042, 95% CI: 1–4.1), had a religious belief (p = 0.003, 95% CI: 1.4–10.5), actively practiced their religion (p < 0.001, 95% CI: 1.6–6.9), and had a positive self-perception in the face of death (p = 0.002, 95% CI: 1.7–30.8).

Conclusions. A positive attitude towards death was observed in 9.67% of surveyed participants. Associated factors were age ≥ 40 years, health care experience for ≥ 14 years, religious belief, active religious practice, and self-perception of a positive attitude towards death.

Keywords: *attitude towards death; attitude of health care staff; pediatrics; children's hospitals; end-of-life care.*

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[a] *Hospital General de Niños Pedro de Elizalde, City of Buenos Aires, Argentina.*

Correspondence to *Federico Prado: drpradofederico@gmail.com*

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INTRODUCTION

Death is a biopsychosocial process, not a momentary phenomenon.[1–3] Death awareness is a human characteristic, and attitudes, beliefs, feelings, and behaviors are psychosocial phenomena, culturally learned and reinforced during life.[1,2]

Attitudes towards death have varied over time across different societies and cultures. In addition, the attitude that each person adopts will depend on their personal history, losses, religious or agnostic beliefs, philosophical conceptions, and ability to face the reality of life or the reality or potential of death. These variables have a direct impact on the approach to accompanying others who face death and the final attitude towards the death of others.[1,3,4]

For physicians, death involves an intricate analysis that determines their attitude towards the patient, especially their behavior in relation to diagnosis, treatment, and the physician-patient relationship.[1,2] Although society assumes that health care providers are the ones best trained by, for, and against death, this is not always the case.

Society expects children to live longer than adults. However, they also suffer from chronic or acute conditions that lead to a terminal stage.[1] It is important that the health care providers caring for these families are aware of the variety of emotional reactions generated by the death of a child and are capable of coping with them and responding positively, thus avoiding a negative attitude towards death.[5]

The bibliography describes differences among physicians in how they deal with death and concludes that death from acute or critical conditions is dealt with more effectively than death from chronic diseases.[6]

A positive attitude towards death achieves a rational behavior, contemplates death in a realistic manner, and allows a better, comprehensive patient care.[1–7]

We did not find any studies describing the attitude towards death among physicians in Argentine children's hospitals. Knowing the attitude of physicians towards death in our hospital may help to improve the training and accompaniment of health care providers and families.[1,3,4,7,8]

The objectives of this study were to describe the attitudes of the medical staff of a tertiary care children's hospital in the face of death and explore whether there are associated factors.

POPULATION AND METHODS

Cross-sectional study with a self-administered survey. The sample was selected by convenience. All active medical staff members of Hospital General de Niños Pedro de Elizalde (HGNPE) were invited to participate between June 2021 and June 2022.

Each respondent completed the survey in an online form (*Supplementary material and Table 1*). We contacted active physicians and sent the survey link by e-mail or instant messaging application. We repeated this process monthly during the study period, limited to a single survey per participant. The first survey item corresponded to the participant's agreement to participate.

Recorded data included sex, age, years of health care experience, professional category within the health care system, work setting, unit within the HGNPE, religious beliefs, end-of-life care, number of patient deaths witnessed, and self-perception of a positive attitude towards death (*Supplementary material*). We invited participants to complete the *Questionnaire of attitudes towards death* (QAD), an instrument with a Cuban version validated in Spanish language that measures the attitude of health care providers in the face of death. It includes 33 items with 2 potential answers (agree or disagree) and each item scores 1 or 5 points, as applicable (*Table 1*); the minimum score is 33 and the maximum score is 165. A score of 141 points or higher indicates a positive attitude towards death. The QAD includes 6 domains: "acceptance" (view of death as a natural reality), "avoidance" (difficulty in coping with thoughts of death), "passage" (belief in death as a transition to another state), "professional perspective" (feelings from caring for patients in such situation), "exit" (belief in death as a way out or solution to life), and "fear" (anxiety and worry about death or being a relative of a dying person). Each domain scores a maximum of 25 points; except professional perspective, with a maximum of 40.[1,3,4,9]

The sample size was estimated at a total of 571 physicians, as per the human resources department, considering that 20% would have a positive attitude towards death, with a 5% accuracy, a 95% confidence interval (CI), and a 2-points design effect for convenience sampling, and adding 5% for incomplete surveys, the estimation was at least 361 participants.

Descriptive analysis

Quantitative variables are described as mean and standard deviation (SD) or as median and

Table 1. Questionnaire of attitudes towards death

No.	Item	Agree (points)	Disagree points)
Acceptance			
2	Acceptance of death helps me to have more responsibility in life.	5	1
7	My life has more meaning because I accept the fact of my own death.	5	1
16	I have thought of my death as an inevitable situation.	5	1
23	Recognizing death as an inevitable situation helps my personal growth.	5	1
27	I feel freer by accepting my death.	5	1
Avoidance			
1	Thinking about death is a waste of time.	1	5
8	I consider it morbid to deliberately think about my inevitable death.	1	5
17	I'd rather not think about death really.	1	5
22	I have not thought of death as a real possibility until now.	5	1
32	People should only think about death once they are old.	1	5
Passage			
4	I think that there is a better place after life.	5	1
10	I think I will live after my death.	5	1
18	I see death as a passage to eternity.	5	1
25	I look forward with pleasure to life after death.	5	1
29	I will find happiness after death.	5	1
Professional perspective			
6	I feel that the death of my patient is a professional failure.	1	5
11	I would not want to witness the end of life of a patient in my specialty.	1	5
12	I can't help but think of my family in the face of a patient who is going to die.	1	5
19	When I take care of a terminally ill patient, I start thinking about my own death.	1	5
20	I get emotional when facing the family of a dying patient.	5	1
26	The greatest significance of my job is to save a patient's life.	1	5
30	Frequent contact with death has made me see it as something natural.	5	1
33	I feel more comfortable if the request to assist a dying person comes from their family members.	5	1
Exit			
5	Death may be the way out of the burden of life.	1	5
14	I think there is nothing left to see in this world.	1	5
15	I'd rather die than have a poor quality of life.	5	1
21	I've considered that life is not worth living.	1	5
31	There are times when death may be a relief.	5	1
Fear			
3	The possibility of my own death makes me feel anxious.	1	5
9	I feel upset when I think about the brevity of life.	1	5
13	I'm scared of dying young.	1	5
24	I find it difficult to face death.	1	5
28	I feel dread at the possibility of developing a disease that will lead to my death.	1	5

interquartile range, depending on their adjustment or not to normality (Kolmogorov test). Qualitative variables are described as percentage and the corresponding 95% CI. The association between the variables and the attitude towards death was assessed using the χ^2 test or the t test, as applicable, with an estimation of the odds ratio (OR) and the corresponding 95% CI. The statistical analysis was done using the SPSS® version 20.0 software. The accepted level of significance was < 0.05.

This study was approved by the Research Ethics Committee of HGNPE.

RESULTS

A total of 362 physicians (63.39% of all) completed the survey. *Table 2* describes their sociodemographic characteristics. The total participants included 128 residents of clinical pediatrics (35.36%) and 234 non-residents

Table 2. Sociodemographic characteristics of the study population (n = 362)

Variables	Answers	n	%
Sex	Female	281	77.62
Professional category within the health care system	Residents of clinical pediatrics	128	35.36
	Pediatricians	91	25.14
	Pediatric subspecialists	143	39.50
Work setting at HGNPE	General outpatient office	161	44.48
	Hospitalization ward	90	24.86
	Intensive care unit (pediatric, neonatal, o cardiovascular)	35	9.67
	Day hospital	11	3.04
	Outpatient emergency service	42	11.60
	Operating room	10	2.76
	Other	13	3.59
Religious belief	Yes	206	56.91
	No	131	36.19
	Does not answer	25	6.91
Actively practicing a religion	Yes	115	31.77
	No	238	65.75
	Does not answer	9	2.49
Practiced religion	Catholicism	131	36.19
	Judaism	10	2.76
	Evangelism	3	0.83
	Buddhism	2	0.55
	Not practiced	216	58.22
Having witnessed the death of a patient	Yes	286	79.01
Number of patient deaths witnessed	0	73	20.17
	1 to 5	179	49.45
	6 to 10	47	12.98
	11 to 15	20	5.52
	More than 15	43	11.88
Providing end-of-life care	Yes	309	85.36
Self-perception of a positive attitude towards the death of a patient	Yes	260	71.82

HGNPE: Hospital General de Niños Pedro de Elizalde.

(64.64%), i.e., pediatricians without a subspecialty (n = 91, 25.14%) or pediatric subspecialists (n = 143, 39.50%). A feeling of professional failure in the face of the death of a patient was mentioned by 10.5%. Also, 28.8% said that facing death made them think of their own death and 54.14%, that it made them think of the death of a relative. Only 35 (9.67%) obtained a score equivalent to a positive attitude towards death.

Table 3 describes a univariate analysis of the primary variables and the professional category within the health care system. It is worth noting that the average QAD score obtained by residents of pediatrics was similar to that of the overall population, with a lower SD (118.76 ± 16.28 points).

Table 4 describes the analysis of the primary variables and the work setting at HGNPE. A statistically significant difference was observed between the average overall score in the QAD when analyzed by work setting (p = 0.016). The highest average score was obtained by physicians working in the intensive care unit (ICU), whereas the lowest score was observed in those working in the Day Hospital. ICU physicians obtained a higher score in the professional perspective domain (p = 0.002) and accounted for the highest number of physicians with a positive self-perception towards death (p = 0.045). No statistical significance was observed in terms of a positive attitude towards death as measured by the QAD among the different work settings.

Table 5 describes the statistical analysis of the primary variables and a positive attitude towards

Table 3. Analysis by professional category within the health care system (n = 362)

	Age (years)	Years of experience working in health care	QAD domains						Overall questionnaire score		Having witnessed the death of a patient	Providing end-of-life care	Self-perception of a positive attitude towards the death of a patient	Attitude towards death
			Ac	Av	P	PP	E	F			Yes	Yes	Yes	POSITIVE
TOTAL STUDY POPULATION (n = 362)														
MEAN	40.21	14.06	18.47	17.54	8.37	28.18	21.30	13.34	118.76	**n**	286	309	260	35
SD	11.56	11.97	6.75	4.15	8.62	7.23	3.62	8.06	16.28	**%**	79.01	85.36	71.82	9.67
RESIDENTS OF CLINICAL PEDIATRICS (n = 128, 35.36%)														
MEAN	30.03	3.94	18.28	17.66	6.95	29.73	20.98	12.93	118.22	**n**	76	108	88	10
SD	2.26	1.58	6.44	4.25	7.43	7.08	3.82	8.10	15.84	**%**	59.38	84.38	68.75	7.81
PEDIATRICIANS AND PEDIATRIC SUBSPECIALISTS (n = 234, 64.64%)														
MEAN	45.45	19.59	18.57	17.48	9.15	27.33	21.47	13.57	119.05	**n**	210	201	172	25
SD	10.95	11.55	6.92	4.10	9.13	7.18	3.51	8.05	16.55	**%**	89.74	85.9	73.5	10.68
p	< 0.001	< 0.001	0.569	0.376	0.657	0.626	0.338	0.716	1.40	**OR***	5.98	1.12	1.26	1.41
										95% CI	3.4–10.3	0.61–2.06	0.78–2.02	0.65–3.04
										p	< 0.001	0.695	0.336	0.376

Ac: acceptance.
Av: avoidance.
P: passage.
PP: professional perspective.
E: exit.
F: fear.
SD: standard deviation.
**OR: odds ratio for each variable in relation to a higher QAD score.*

death as measured by the QAD. A statistically significant difference was observed between physicians aged 40 years or older and younger physicians (p = 0.02, OR: 2.08, 95% CI: 1.1–3.9) and between physicians with a health care experience of 14 years or more and those with less experience (p = 0.042, OR: 2.04, 95% CI: 1–4.1). A statistically significant difference was noted between physicians who had a religious belief (p = 0.003, OR: 3.96, 95% CI: 1.4–10.5) or those who actively practiced a religion (p < 0.001, OR: 3.36, 95% CI: 1.6–6.9) compared to those who did not. Catholicism is the prevailing religion in our population and no statistical significance was observed in relation to it (p = 0.633). A statistically significant difference was observed between physicians who had a self-perception of a positive attitude towards the death of a patient and those who had a negative self-perception (p = 0.002, OR: 7.26, 95% CI: 1.7–30.8).

In addition, 14.91% (n = 54) of respondents made suggestions to improve health care providers' attitudes towards death. These were grouped into 1) training during graduate education (n = 12, 22.22%), 2) training during pediatric residency program (n = 24, 44.44%), 3) multidisciplinary meetings to share experiences (n = 19, 35.18%), and 4) strengthening of the physician-patient relationship (n = 6, 11.11%).

DISCUSSION

We assessed the attitudes towards death of 362 physicians working at a tertiary care children's hospital and explored associated factors.

The QAD was used in studies conducted in Cuba (survey of 50 family physicians)[3] and in Mexico (31 palliative care providers; 29% were physicians).[4] In those studies, 70% and 80.7% of participants, respectively, were younger than 40 years; whereas, in our study, 47.5% were younger than 40 years.[3,4] We observed a greater probability of a positive attitude towards death among health care providers older than 40 years or who had more than 14 years of health care experience; this is consistent with other studies, in which these were the variables with a stronger influence on the attitude towards death, with a positive unidirectional correlation.[3,4]

Sánchez-Sánchez, in a population with a similar age, health care experience, and pediatric care, found that 15.79% (n = 6) of participants had a positive attitude, a percentage that was higher to that found in our study. They also obtained better results when data were analyzed by professional category, among residents (15.39%) and non-residents (17.7%), compared to 7.81%

Table 4. Analysis by working setting at Hospital General de Niños Pedro de Elizalde (n = 362)

	Age (years) w	Years of experience orking in health care	QAD domains						Overall questionnaire score of a patient		Having witnessed the death attitude towards the death of a patient	Providing end-of-life care	Self-perception of a positive	Attitude towards death
			Ac	Av	P	PP	E	F			Yes	Yes	Yes	POSITIVE
TOTAL STUDY POPULATION (n = 362)														
MEAN	40.21	14.06	18.47	17.54	8.37	28.18	21.30	13.34	118.76	**n**	286	309	260	35
SD	11.56	11.97	6.75	4.15	8.62	7.23	3.62	8.06	16.28	**%**	79.01	85.36	71.82	9.67
OUTPATIENT OFFICE (n = 161, 44.48%)														
MEAN	40.22	14.32	18.23	17.11	8.39	27.27	20.81	12.61	116.53	**n**	127	135	109	13
SD	11.51	12.01	6.86	4.28	8.51	6.98	3.87	7.91	16.19	**%**	78.88	83.85	67.7	8.07
HOSPITALIZATION WARD (n = 90, 24.86%)														
MEAN	35.33	9.57	18.22	18.22	8.56	29.11	21.28	13.06	119.76	**n**	60	74	67	13
SD	10.78	11.08	7.04	3.70	8.22	7.29	3.48	7.74	16.56	**%**	66.67	88.22	74.44	14.44
PEDIATRIC, NEONATAL, O CARDIOVASCULAR INTENSIVE CARE UNIT (n = 35, 9.67%)														
MEAN	41.26	15.17	21.29	18.14	7.14	32.57	22.43	16.86	127.74	**n**	33	34	32	4
SD	11.68	12.28	4.59	3.85	8.34	4.91	3.06	7.87	9.93	**%**	94.29	97.14	91.43	11.43
DAY HOSPITAL (n = 11, 3.04%)														
MEAN	41.61	15.27	17.73	18.18	5.45	28.18	21.82	12.27	115.91	**n**	11	10	8	0
SD	12.31	12.67	6.84	4.05	8.79	7.51	3.37	9.32	17.99	**%**	100	90.91	72.73	0
OUTPATIENT EMERGENCY SERVICE (n = 42, 11.60%)														
MEAN	43.50	17.26	17.62	16.90	10.00	26.90	21.55	12.98	117.76	**n**	34	38	28	3
SD	10.07	10.65	6.83	3.82	9.63	6.98	3.40	8.70	17.56	**%**	80.95	90.48	66.67	7.14
OPERATING ROOM (n = 10, 2.76%)														
MEAN	44.93	19.00	20.50	18.50	7.50	29.00	22.00	16.50	124.20	**n**	9	9	8	1
SD	9.94	10.27	6.43	2.42	11.12	9.07	3.50	8.83	16.63	**%**	90	90	80	10
OTHER (n = 13, 3.59%)														
MEAN	49.76	23.62	17.31	17.31	8.08	24.62	22.69	14.62	116.69	**n**	12	9	8	1
SD	11.07	11.63	7.25	7.25	8.79	9.46	3.30	7.49	16.93	**%**	92.31	69.23	61.54	7.69
p	**< 0.001**	**< 0.001**	**0.203**	**0.664**	**0.523**	**0.002**	**0.173**	**0.106**	**0.016**	***p***	**0.003**	**0.196**	**0.045**	**0.765**

Ac: acceptance.
Av: avoidance.
P: passage.
PP: professional perspective.
E: exit.
F: fear.
SD: standard deviation.

and 10.68%, respectively, in our study; however, this value was not statistically significant in either study. Although the population shared similar characteristics, its composition was the reverse of that in our study: 68.4% (n = 26) were residents and 37.6%, non-residents (n = 12).[1]

Sánchez-Sánchez and Ascensio-Huertas conducted studies in hospitals where most patients had chronic, incapacitating, or critical diseases, so a positive attitude is essential to provide high-quality care; even so, those authors reported that end-of-life care was not a priority for the Mexican health care system.[1,4] Hernández-Cabrera stated that the ability to offer relief with verbal and non-verbal communication has reduced in current Cuban medical practice, which has interfered in the detection of patients' actual health problem, which may not be death itself, but the process prior to it, pain, or what it may cause in other people.[3] The appreciation of death across different societies and cultures is a variable that may influence the results.[1,3,4] We infer that our results are due to the type of training received and current culture, where the idea of death as an enemy is involuntarily reinforced and, therefore, physicians must fight it and preserve life.[1,3,7,10] Our study was conducted at a single children's hospital, where most of the physicians are Argentine and Latin American, thus maintaining cultural biases.

Coping with the process of death is a difficulty among health care providers, particularly physicians.[1,3,4,6,10] The main causes described

Table 5. Attitude towards death as measured by the *Questionnaire of attitudes towards death* (n = 362)

	Total study population		Attitude towards death as per the QAD				OR* 95% CI
	n = 362	%	POSITIVE (n = 35)	%	NEGATIVE (n = 327)	%	*p*
SEX							
FEMALE	281	77.62	25	71.43	256	78.29	**OR 1.44 95% CI 0.6–3.1 *p* 0.354**
AGE							
> 40 YEARS	149	41.16	20	57.14	129	39.45	**OR 2.08 95% CI 1.1–3.9 *p* 0.020**
YEARS OF EXPERIENCE WORKING IN HEALTH CARE							
> 14 YEARS	139	38.40	19	54.29	120	36.70	**OR 2.04 95% CI 1–4.1 *p* 0.042**
PROFESSIONAL CATEGORY WITHIN THE HEALTH CARE SYSTEM							
NON-RESIDENTS	234	64.64	25	71.43	209	63.91	**OR 0.708 95% CI 0.3–1.5 *p* 0.376**
WORK SETTING AT HGNPE							
INTENSIVE CARE	35	9.67	4	11.43	31	9.48	**OR 1.23 95% CI 0.4–3.7 *p* 0.711**
RELIGIOUS BELIEF							
Yes	206	56.91	28	84.85	178	58.55	**OR 3.96 95% CI 1.4–10.5 *p* 0.003**
ACTIVELY PRACTICING A RELIGION							
Yes	115	32.58	20	58.82	95	29.78	**OR 3.36 95% CI 1.6–6.9 *p* < 0.001**
HAVING WITNESSED THE DEATH OF A PATIENT							
Yes	286	79.01	26	74.29	260	79.51	**OR 0.74 95% CI 0.3–1.6 *p* 0.470**
PROVIDING END-OF-LIFE CARE							
Yes	309	85.36	31	88.57	278	85.02	**OR 1.36 95% CI 0.4–4.0 *p* 0.571**
SELF-PERCEPTION OF A POSITIVE ATTITUDE TOWARDS THE DEATH OF A PATIENT							
Yes	260	71.82	33	94.29	227	69.42	**OR 7.26 95% CI 1.7–30.8 *p* 0.002**

HGNPE: Hospital General de Niños Pedro de Elizalde.
OR: odds ratio for each of the variables with a QAD score equivalent to a positive attitude (> 141 points)*
QAD: Questionnaire of attitudes towards death.

include 1) training deficiencies (66.66% of physicians suggested further training);[1,2,4,6,7,10] 2) a feeling of professional failure (10.5% agreed with item 6 of the QAD);[1,2,4,6] and 3) facing death as a source of distress and a negative attitude towards their own death (28.8% of respondents thought of their own death and 54.14%, of the death of a relative).[1,2,4]

Having witnessed the death of a patient on some occasion reflected a greater probability of having a positive attitude, when analyzed between residents and non-residents. We expected that ICU providers would have better results, since they are most exposed to critically ill patients

and deaths; we observed higher mean scores in the QAD. Hospitalists and ICU physicians showed the greatest positive attitude towards death as measured by the QAD (14.44% and 11.43%, respectively), although the value was not statistically significant. This aspect was not studied by other authors.

The only domain with statistical significance was professional perspective. Physicians who have more frequent contact with critical patients, advanced diseases, or death, such as those working at the ICU, hospitalization wards, and the operating room, stand out. This was also mentioned by other authors.[4,6]

Six (1.66%) physicians from the Department of Palliative Care participated and 2 of them had a positive attitude towards death. It has been reported that physicians with this specialty are more likely to have a positive attitude towards death.[2,5,6] We assume that this depends on the solid philosophical and medical training they have in terms of terminal patient care and death, which they understand as a natural process.[2–4]

We observed that staff members with a religious belief or who actively practice their religion are more likely to have a positive attitude towards death. The sample size did not allow us to establish differences among religions. Other authors did not analyze such variables.

In our study population, 71.82% (n = 260) believed they had a positive attitude towards death. This significantly increases the probability of having such positive attitude, since 94.29% (n = 33) of those who perceived themselves as having a positive attitude obtained a satisfactory score on the QAD (p = 0.002, OR: 7.26, 95% CI: 1.7–30.8). We believe that the broad difference between physicians who obtained a positive score on the QAD (9.67%) and those who perceive themselves as having a positive attitude (71.82%) may be due to the demanding cut-off point proposed by the QAD or to the fact that each health care provider may have a different concept of the definition of a positive attitude towards death.

Given the weakness of this study with a non-probability sampling, we applied a design effect in order to require a sufficiently demanding sample size to achieve a greater representativeness.

We conducted a quantitative study, classifying the attitude towards death as positive or negative. This is a limited approach to a topic that may be experienced in different ways. Supplementary studies with a qualitative approach would be valuable in exploring this topic.[1,3,4]

Reinforcing the concept of death as a natural, biological, psychosocial, and cultural process, which is part of life and not a failure of medical knowledge or practice, will make us more empathetic towards patients and improve the accompaniment of both patients and their families, thus achieving a better attitude towards death.[1,2]

It is very important to work as part of multidisciplinary teams, with health care providers who are fully trained by, for, and against death, seeing it as a biological and human reality that we will all experience.[2,4–6]

CONCLUSIONS

A positive attitude towards death was observed in 9.67% (n = 35) of physicians working at Hospital General de Niños Pedro de Elizalde.

Physicians with any of the following characteristics are more likely to have a positive attitude towards death:

- Age 40 years or older.
- Health care experience of 14 years or more.
- Having a religious belief or actively practicing a religion.
- Self-perception of having a positive attitude towards death.

Staff members working in pediatric, neonatal, or cardiovascular intensive care had a better attitude towards death. ■

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Supplementary material available at: https://www.sap.org.ar/docs/publicaciones/archivosarg/2023/2909_AO_Prado_Anexo.pdf

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