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Original scientific paper

Nursing Rituals for Dying and Deceased Patients in Hospitals of the Republic of Croatia: A Qualitative Study

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Abstract

The aim of this research was to examine the end-of-life rituals performed by nurses in hospitals in the Republic of Croatia, considering historical, social, and cultural contexts. A qualitative study was conducted using semi-structured interviews with nine nurses working in three hospitals at the secondary level of healthcare. The study explored their personal and professional practices beyond standardized protocols. The findings revealed diverse rituals, such as opening windows to "release the soul," prayers, and physical care for the deceased. These practices are influenced by cultural traditions, religious beliefs, and personal values, and contribute to nurses' emotional coping with death. The study highlights the importance of understanding cultural and personal dimensions of end-of-life care, suggesting that these practices contribute to holistic nursing and the emotional well-being of healthcare providers. Further research is needed to explore these practices across broader settings.

Introduction

So far, no research in Croatia has systematically addressed the post-mortem rituals performed by nurses, despite the well-known influence of cultural and religious traditions on nursing practice. Most existing studies focus on standardized protocols, while the personal and culturally conditioned aspects of care for dying and deceased patients remain underexplored. To our knowledge, no previous research in Croatia has examined informal post-mortem rituals performed by nurses in hospital settings. This study aims to fill that gap by analyzing practices that go beyond standardized protocols, incorporating the personal beliefs of nurses as well as cultural traditions.

Humans are very likely the only beings aware of their own mortality, and this awareness of mortality is crucial for human existence (1). The inevitability of death is one of the few absolute truths universally understood by humanity. A profound awareness of inevitable death hinders us from engaging in the limited possibilities of our survival (2). However, contemporary perceptions of death view it more as a medical failure than as an expected end of life. Death is often interpreted as a failure to achieve medical goals, leading to denial, repression, and the fear creation resulting in its mystification and distancing from the community (3).

The people farewell approach of the deceased vary influenced by the environment in which individuals were raised. The procedures expressing the respect for life of the deceased when handling the body are referred to as post-mortem procedures or rituals. The structure and execution of these rituals are determined by historical, social, and cultural heritage, as well as religious and spiritual beliefs (4). Different communities have developed rituals providing a grieving process framework for those saying goodbye to the deceased. Within contemporary healthcare systems, traditional rituals related to death and dying are no longer practiced. The reasons for their disappearance include a loss of faith in rituals, unpreparedness for death, and dying outside the family circle (5). Additionally, with the medicalization of death and dying, medical interventions have become more dominant compared to traditional customs and rituals (6).

Healthcare for dying patients intensely affects nurses, often eliciting feelings of compassion, helplessness, and grief. Nurses frequently personally experience the patient's death, which can subsequently impact their relationships with loved ones (7). Over time it has been noted the grief for deceased patients can lead to fatigue and the burnout syndrome emergence (8). Benbenishty et al. conclude that the rituals associated with dying and death performed by nurses are significant for both dying patients and their families, as well as for the nurses themselves (9). Wolf asserts that the actions taken by nurses during moments of confronting a patient's death help them cope with their own emotional states while affirming their respect for the deceased, their family, and the surrounding environment (10). Consequently, these procedures are recognized as important but have not yet been documented or analyzed. It is noteworthy that research on this phenomenon is extremely rare, even globally. This context amplifies the need for a sensitive, compassionate approach, ensuring the emotional and spiritual needs of both the patients and the healthcare providers are respectfully addressed.

In Croatia, nurses manage deceased patients in accordance with standardized procedures established by the Croatian Chamber of Nurses (HKMS) (11). Despite this, some nurses perform certain post-mortem procedures that primarily stem from their own religious and/or spiritual beliefs (9). The perspective of nurses towards patients, along with all normative consequences, differs from that of other healthcare workers due to the unique relationship that nurses establish with both the patient and their loved ones. This results in actions that often deviate from prescribed procedures and are significant for further analysis (12).

The aim of this study is to analyze the post-mortem procedures performed by nurses in several hospitals across the Republic of Croatia, with a focus on the cultural, religious, and personal beliefs that shape these practices. These rituals, deeply influenced by cultural contexts and individual experiences, offer valuable insight into the interplay between tradition and professional nursing practice. By examining these procedures, the study seeks to highlight their significance not only for the quality of healthcare but also for the emotional well-being of nurses. Additionally, this research addresses the broader need to understand the challenges nurses face when caring for dying patients.

Aim

In a country where cultural norms and traditions play a significant role, the findings aim to illuminate how these factors influence nursing practices and contribute to holistic, patient-centered care.

Methods

The study employed a qualitative, phenomenological approach, based on semi-structured interviews that enabled the collection of capture rich, detailed narratives from participants. The advantage of this methodological approach is the ability to gain detailed insights into the participants' subjective experiences and individual perceptions regarding the research topic. The open structure of this type of interview allows researchers to uncover specific aspects of the phenomenon being examined, which are often overlooked in studies that utilize rigid research strategies, such as closed-ended questions with pre-defined answers (13). To reflect on the rituals performed by nurses after patients' deaths, it was deemed that semi-structured interviews would provide more comprehensive data on this emotionally sensitive and intimate experience.

The research was conducted by two investigators, both male nurses with personal experience in performing end-of-life rituals, which motivated them to explore this sensitive topic. They do not have formal research experience in this specific area but were driven by their professional practice to document these rituals.

The study involved nine participants, all nurses, eight were female and one male. Prior to the commencement of the study, ethical approval was requested from the Ethics Committees of seven hospitals in which the participating nurses were employed. Out of the seven requests submitted, four Ethics Committees granted approval for the research to be conducted: the General Hospital Karlovac, the "Dr. Tomislav Bardek" General Hospital in Koprivnica, "Merkur" Clinical Hospital in Zagreb, and the "Dr. Ivo Pedišić" General Hospital in Sisak. Following the approval from the Ethics Committees, participants who expressed a desire to participate signed a consent form.

Participants were purposefully selected through personal acquaintances and recommendations to ensure involvement of individuals with relevant experience. Participation in the study was voluntary and without monetary compensation. The consent form included the option of recording conversations using a dictaphone or taking manual notes. All participants chose the option of taking manual notes. No audio or video recordings were made during the interviews. Demographic data were collected, including age, years of nursing experience, gender, and education level, but this information was not explicitly analyzed in the results section. For clarity, labels S1 to S9 will be used for research participants when presenting results. No pilot study was conducted prior to data collection.

The interviews were conducted in a private setting, with only the researcher and the participant present, ensuring confidentiality and minimizing external influence on responses. Four participants were previously known to the investigators before the study, whereas others were not. Participants were fully informed about the study's objectives, ethical considerations, and data collection methods before providing their consent. Each interview was conducted once, with no follow-up or repeated interviews. Their prior knowledge and interest in the subject may have influenced the interviews; however, efforts were made to maintain objectivity and ensure a balanced data collection process.

The study is grounded in the theoretical framework of cultural and ritualistic practices in healthcare, specifically focusing on the intersection between personal beliefs, professional responsibilities, and cultural traditions in end-of-life care. The research questions are well integrated into this theoretical framework, as they explore how personal, religious, and cultural factors shape nursing rituals for dying patients. By situating the study within this broader context, it contributes to the understanding of non-standardized nursing practices and their implications for healthcare.

The first question in the interview was: "*Can you describe the procedure with a deceased patient?*" This question aimed to determine which post-mortem procedures the research participants performed.

The purpose of the additional questions was to gain a deeper and more comprehensive insight into the phenomenon being studied. Additional questions included: "*What feelings prompt you to perform this ritual at the moment of the patient's death, and what feelings does performing it evoke in you?*"; "*What do you believe you accomplish by performing this ritual?*"; *"Have you seen anyone from your family and/or broader environment perform these rituals?*"; "*Did you learn (adopt) any rituals/procedures from other colleagues during your education or work?*"; *"Are your colleagues and/or the deceased patient's family members aware that you perform these procedures?*"; "*Do you remember when you first performed this ritual and what prompted you to do so?*"; and "*Have you ever discussed with the patient before their death that you would perform this ritual? If not, do you consider it ethical to act in this way without their consent?*"

The data collected from interviews was analyzed using thematic analysis, a technique that enables the identification of key themes, patterns, and participant responses to the questions posed. The analytical process was documented using relevant references to ensure the reliability of the analysis (14). During the analysis, the interview transcripts were carefully reviewed to identify the main themes and patterns in participants' responses. Subsequently, segments of text related to similar themes were coded. This methodical approach allows researchers to uncover significant insights and provides a comprehensive understanding of the phenomenon being studied. Thematic analysis is particularly effective in qualitative research for distilling meaningful patterns from complex datasets, thereby facilitating a nuanced interpretation of participants' experiences and perspectives. Data analysis was conducted manually without the use of qualitative data analysis software.

Ethics

This qualitative research was conducted in accordance with the Croatian Chamber of Nurses Ethical Code, the provisions of the General Data Protection Regulation (GDPR), and the Implementation of the General Data Protection Regulation Act.

Results

The results are presented through the responses of the research participants, labeled from S1 to S9. The participants consisted of eight female and one male nurse.

Through thematic analysis of the responses to the questions posed, three main areas are identified and described in the results: ritual procedures at the physical level and care for the deceased, faith and spirituality, and personal relationships and emotional involvement towards the dying.

Ritual procedures at the physical level and care for the deceased

Nurses practice the same procedures with dying patients, albeit with minor differences among workplaces, and these align with the guidelines set by the Croatian Chamber of Nurses (HKMS) (11). Participants in the study explain the nursing and technical procedures they perform at the time of a patient's death: (S8) "When the patient dies and we take care of them, we remove everything from them, record the ECG twice: immediately after death and 30 minutes later, tie the jaw, remove the teeth, place an identification tag (a tag that is tied around the ankle or thumb of the deceased), list and pack the belongings. (...) They stay in the department for two hours before being taken away from us." Another participant notes: (S7) "They stay with us for three hours after death, not two as is the practice elsewhere." Patients remain in the department for at least two hours after death, until early signs of death appear, after which they are transported to the morgue.

Six participants open a window when a patient dies, while one participant opens the window a few moments before death. They describe this practice for reasons such as: (S3) "to let the soul go," (S1) "so that the soul can freely 'leave,' to exit the space," (S4) "to let them into the heavenly realms," (S5) "I open the window, you know, if there is a soul, let it go outside," and (S2) "I always open the window because my grandmother taught me that's how the soul exits." Participants also mention that sometimes they do not open windows due to external temperatures: (S6) "I don't know why, but a long time ago, a col-

league told me that when someone is suffering, you should open the window. Except when it's cold. Then I don't do it," while conversely (S7) states, "if it's cold outside, we open the window; if it's summer, we don't because of the air conditioning."

Most nurses opened windows based on personal beliefs, but some observed this ritual from colleagues in the workplace: (S2) "...an older technician who was on shift with me told me when he saw me: 'I'm glad you opened the window. If you hadn't, I would have opened it myself.'" Another participant noted: (S4) "At the beginning, as soon as I joined the team where this was the rule of practice."

Although opening windows and prayer are the most common procedures performed by nurses, some participants add their own rituals and/or practices conducted in the department: (S1) "We put a few milliliters of water in the mouth before securing the sheet so that they 'won't go thirsty' to the other world," or (S6) "I usually verbally thank them when death occurs: 'that's it, you've turned off, you're going peacefully,' and I open the window."

Some rituals are related to light, candles, or silence: (S6) "I have never left a deceased person in the dark. I make sure the light is on. I try to treat the deceased as if they were someone close to me." (S7) "I learned this pattern from my colleagues. We always remain silent when a person passes away." And (S4) "A few times, family members have asked us to light a candle, and we have done so. As a wish."

Other rituals obtained from the interviews were directed towards individuals or were pre-arranged to honor the patients' wishes: (S5) "I had a case where a guy told me that his mom didn't come to the hospital and asked me to hug him. I did that. Other nurses were also asked to hug him. It was as if the parents were ashamed of the diagnosis. When he died, I told his mother that he just wanted to be hugged." (S7) "...I know that one patient told one of my colleagues before her death that she wanted to be made up and have a box of cigarettes and lipstick placed in her coffin. The colleague she told wasn't on shift when she died, but knowing the patient's wish, it was honored." Or: (S7) "With the patient, I communicated about death and his wishes through conversation. If the person wanted to see someone, we engaged a social worker. If they wanted something to eat, we made an effort to bring it. I remember when we brought orange juice to one woman. Not all of my actions are religious; some are simply human." (S2) "I think it's important to tell patients what we are doing or what we will do, and I believe it's right to respect their wishes if they have any."

Faith and spirituality

Of the nine participants, six are Roman Catholics who regularly practice their faith, one is a Roman Catholic who practices as needed (S2), one is an atheist (S5), and one participant did not specify their beliefs. The participants mention prayer or blessing the deceased by making the sign of the cross on their foreheads or crossing themselves and/or the deceased: (S1) "I always pray for the soul of the deceased, and I make the sign of the cross on their forehead, but only if I know that the person I am preparing was a Roman Catholic." (S7) "...when they die, if I happen to be there at that moment, I pray." (S8) "I always make the sign of the cross over patients, more often at the time of death, and sometimes even when we prepare them for the morgue." (S9) "...I felt the need to make the sign of the cross over their forehead in the moments before death." (S7) "I introduced crossing the deceased and praying if I know they were Catholics."

Religious beliefs and/or spirituality of nurses play a role in the rituals they perform: (S9) "Since there has been documentation of wishes, we record religious affiliations. So, we knew what someone wanted, and if someone needed to receive a representative of their faith at the end of life, I made an effort to do so. Based on that, I formed an attitude. If they expressed a need for a spiritual advisor, I felt assured that my cross wouldn't be intrusive. Even if they didn't confirm it, I made the sign of the cross—probably for my own sake." (S8) "When I cross them, I feel a sense of relief. It's like I'm giving them permission to peacefully go in the direction they need to go." (S7) "When I pray silently, I feel that people die more peacefully." Or (S2) "I'm not religiously oriented, but I believe that the soul must depart because of the beliefs instilled in me by my grandmother and out of respect for death, life, and life after death." (S2) "When a patient dies, I don't pray because I'm not sure what their faith was."

One nurse mentions that she learned the rituals of prayer from an older colleague: (S9) "Soon after I started working... I had a good teacher—an older nurse who didn't give me instructions per se, but she talked about herself and also felt the need to cross

a person or place a picture in their hand, and that somehow encouraged me to do something because I felt the need."

Personal relationship and emotional involvement with the dying

The most common feelings that nurses verbalize after a patient's death are tranquility, peace, and relief. (S9) "Personally, it was a relief for me because I believe this is not the end. There is a continuation somewhere beyond. I felt calm within myself." (S1) "For me personally, these rituals bring peace and satisfaction that after everything I did for that person in their final moments of life, I did everything in my power to give them a final blessing." (S6) "I actually feel the need and relief that I did this. I never thought about it. I don't know for whom I do it. Maybe I do it for myself." (S5) "I feel that they left in peace, and that's it. I am more satisfied. That's the last thing I could do. There are no words to describe it. The feeling, maybe the soul has left the body. It calms me. I did everything. We do so much until death. We fulfill wishes. Everything from a drink of alcohol to pizza, and then death happens at 11:00 PM. The act of dying is silent. I have one memory. A young woman was dying from breast cancer. She had one wish. She wanted her friends to bring pizza and beer. She said we should all treat ourselves, including her. And then she died the next day, maybe even that night."

Participants focused on their own emotions or the religious aspect of life after death when asked what they believe they achieve by performing certain rituals. Only one nurse, in her response to this question, directed her thoughts towards the patient's life: (S9) "I believe that in this way I respect human life until the end and that I pay my final respects to the body of the deceased. I have always thought that a person remains worthy even after death. One should behave toward them as a human being even after they have passed away. This is done not only as a professional but also with additional emotions. I can't feel for everyone, but I do empathize."

Participants also spoke about how rituals help them personally to cope with death. This is evident in their responses: (S4) "I don't know if I achieved anything. I think it makes me happy. I gave everything for him. Completely." (S8) "I think I do this mostly to make it easier for myself." (S5) "I am satisfied. It brings me personal fulfillment. I was with them until the end. I would love to sing – 'I've gone, I won't return...' I know the patients well; we had a patient who was a tamburitza player, and I thought I'd love to sing to you just as you sang to me. It comes to me to do that, even if just internally." (When asked if she ever sang, the participant replied no, but that she has the desire.) (S9) "After each death, there's a sense of unrest. It's not fear; it's more sorrow. Discontent. Did we do everything we could? But this way has freed me from that discomfort. It has eased those emotions." (S9) "... of course, it's a reflection – when you see someone else dying, you start to fear your own death. I was aware that this is my job. But you can't forget that this is someone's a mother, father... and I might be in a position to lose someone dear to me, and I would want someone to send them off like that too. That has helped me."

While some nurses described providing dignified care for the deceased, others focused on efficiency, noting the presence of other patients awaiting assistance. One participant stated: (S9) "Once I prepared the body for pathology, I no longer wanted to see that person. When I finished preparing, wrapped the body, and placed a barrier, I knew I had to go work with those who were waiting for my help. I didn't feel the need to see that person anymore."

Nurses are divided in their views regarding the appropriateness of rituals after a patient's death. One participant stated: (S1) "Given the workplace I am in, sudden deaths often occur, leaving little time for such things. If it's an expected death and palliative patients, they often spend their last phase of life not in contact and unable to discuss their wishes and needs after death. I believe it is ethically correct because my actions do nothing harmful to the patient or their integrity. And I believe many would willingly agree if they had the opportunity to express that wish." She added, "I think that by this act, I pay respect to the person after their death, and I believe that through my prayer and blessing, I opened a path for their soul to Heaven." Another nurse expressed uncertainty about the correctness of her actions: (S2) "I'm not sure if it's right and whether I achieved something for that person; however, if it is right and true, I don't want to know that I intentionally missed something by not opening the window. I don't want the soul to remain where it died." (S3) added, "...I think that by this act, their soul won't stay in the institution." (S8) commented, "I think I gave them absolution from sin and

a chance to cross over. It's as if I were the one who allowed them to leave this world."

Two participants secretly practice rituals during the dying process or after a patient's death. The others perform rituals in front of colleagues but not in front of the family: (S1, S2, and S3 respond almost identically) "The colleagues I work with know that I practice these rituals; some we even do together, but the family members of the deceased are unaware because I am not in contact with them due to the workplace I am in."

Participants commented on their rituals and the situation in the department: (S4) "I tell everyone. I even tell the interns that we will open the window. Sometimes they laugh a little, but they do it." (S5) "I think everyone knows. Some know. Although mostly I don't do anything else than what I've described. Some kiss the forehead, light a candle, or something similar. But I don't know about that, nor do I do it. Even those who do it don't talk about it. They keep silent." (S9) "With some colleagues, I've had the opportunity to talk about it, especially if I knew we shared the same worldview. That was a relief for them too. If I wasn't sure if the family wanted that, I didn't mention it to them. But I did talk to the family about the dying process when there was an opportunity. I always chose my words carefully, considering their well-being, so I didn't burden them with even what the patient said, especially anything negative. I often mentioned that the patient spoke positively about them at the end."

All participants confirmed that rituals were not discussed during their education. Two individuals had never seen colleagues practicing any rituals at work, while the others learned certain rituals from colleagues (doctors or nurses) in the department. One participant noted: (S9) "They would say that each of you will find some answer in such situations that you cannot cope with, after which you can continue to do your job. I saw that some of my colleagues had that need. They would cross themselves and say: 'God, it has come to an end.' In fact, quite a few people do that." Another participant added: (S7) "I learned the pattern from my colleagues."

Discussion

It is necessary to consider nurses' reactions to patient death in the context of their individual backgrounds, subjective experiences of dignity, and cultural traditions that they inherit and transform through education. To explore this context, a qualitative study was conducted involving nurses from several Croatian hospitals, aiming to gain detailed insights into their personal experiences with post-mortem rituals. This refers to specific post-mortem procedures that are not formally regulated by standardized protocols for the deceased, which some of them practice at the moment of a patient's passing.

Procedures regarding the deceased in the Republic of Croatia are prescribed by the regulatory body (HKMS, SOP 2.21) and relate to the process of preparing the dead body for transport to the morgue, waiting for the prescribed time until clear signs of death appear, the transport itself, documentation and, if required, an autopsy. In addition to the existence of formal mandatory rules regarding the treatment of deceased patients in hospitals, it has been established that there are also informal ritual practices that some healthcare professionals perform. Despite these regulations, informal practices are influenced by cultural and social factors, allowing for individual interpretations (15).

We observed more similarities than differences among the experiences of nurses. The conducted research found the most common post-mortem procedures participants performed included opening a window after death (or in one case, just before death). Additionally, opening a window serves a practical hygienic purpose by allowing fresh air into the room. Also, there is a medical purpose for the dying patient to receive fresh air. Several participants mentioned praying for the deceased's soul and performing the sign of the cross on their forehead. Furthermore, a post-mortem ritual of lighting a candle ("so that the dead body is not in darkness") or placing a few milliliters of water in the mouth ("so they do not leave thirsty for the other world") was established. In addition to these rituals, one participant noted that before death, if possible, she fulfills the dying patient's wishes in terms of food and drink and also respects regulations if the deceased was Muslim (in terms of

ritual washing). The post-mortem rituals performed by nurses in Croatia reflect local cultural and religious identities. For example, opening a window after death may be connected to folk beliefs about releasing the soul, while placing water in the mouth of the deceased may have roots in local customs.

In sporadic studies from Europe and the Middle East, post-mortem rituals such as touching the chest of the deceased, reciting prayers or reading specific texts, lighting candles as symbols of eternal life, and positioning the body with hands folded over the chest have been noted (9). In a study conducted in an Israeli intensive care unit, the entire staff refrained from consuming food or water from the moment of a patient's death until the body was taken to the morgue (9).

In a study conducted in Sweden and the United States where some nurses open a window when a patient dies, even though they are not sure why they do it (16). The authors explain that participating in and adapting to this ritual act seems natural, even if the meaning behind it is somewhat unclear (17). Research by Benbenishty et al. shows that by performing rituals, nurses establish order in their interactions and shared experiences (9). Their study indicates that rituals were rarely visible to others but were motivated by the personal and learned values of the nurse performing them, as well as by the practice of traditional care for the dying.

In addition to generational transfer of experience, participants indicated that their internal motivation for performing post-mortem rituals is to facilitate the "departure of the soul." One participant mentioned that she releases the deceased into "heavenly realms." In doing so, participants expressed that they generally felt better themselves; they reported increased self-confidence, reduced fear of death, contemplation of life's continuity, a sense of calm and relief, and a feeling of respect for the individual until the end.

The concept of the "journey" and "survival" of the soul is particularly noteworthy. Although it is not necessarily tied to a religious interpretation, considering that seven participants identified as believers, it can be concluded that this is motivated by religious teachings and motives. Additionally, a participant who identifies as an atheist stated that she releases the soul, "if it exists," to depart. The idea of releasing the soul supports the experience of a sense of immortality associated with the dualistic understanding of body and soul. In this context, the soul can be thought of as the principle of animating the body itself, yet independent of it, as accepted in the hylomorphic Christian interpretation. When discussing the immortality of the human soul, we refer to real and personal immortality, which differs from metaphorical or pantheistic immortality (18). Participants in the study do not feel that unfavorable procedures are the reason for this; they do not doubt its correctness. However, while some contemplate that it is an act that does not deprive a person if not performed, one participant argues that the act is very important and that she would personally want someone to do it for her.

It is worth noting that participants indicate they generally do not discuss the procedures they perform on deceased patients with the family members of the deceased. Although most participants engaged in post-mortem rituals, some expressed uncertainty about their significance or preferred not to discuss them openly. However, these practices are either talked about among colleagues or there is an awareness that some colleagues engage in them. Despite the fact that these acts are not prescribed by standardized procedures or ethical codes, they fit into traditional behaviors. These variations suggest a spectrum of beliefs and practices among nurses, which warrants further investigation. Additionally, the authors conclude that the rituals described do not conflict with professional practices and ethical principles.

The challenges of providing care for dying patients are significant, as the outcome is already known. Research by Wilson and Kirshbaum indicates that nurses are motivated to perform tasks that preserve the dignity of patients during death or dying, even though they sometimes find it difficult to cope with the situation themselves (19). The study revealed that the death of patients affects nurses and that they expressed the need for more education on coping with loss. Although all participants reported that they had not had the opportunity to learn about post-mortem rituals during their formal education, it was found that knowledge and experiences were primarily transmitted generationally from older colleagues. Most participants indicated that they were guided by senior colleagues at the beginning of their careers. In one case, it was noted that opening a window was a common practice among all staff in the department,

while in another instance, a nurse learned this practice from her grandmother, who was confirmed and encouraged by a colleague to perform it, especially in cases where someone is "struggling" during the dying process. Additionally, regarding the need for education on the topic of death and dying patients, nurses in the study by Makowicz et al. believe that the highest level of ethical behavior towards the dying should focus on ensuring dignified conditions for a peaceful death, and this perspective increases with the level of education of the respondents (20). These findings highlight the necessity for further research to explore how these practices impact both nurses and overall healthcare delivery.

Limitations of the study and guidelines for future research

This study faced limitations due to the lack of available comparative studies that would allow for a more thorough comparison of results, thereby restricting the ability to draw general conclusions on post-mortem rituals. However, in contrast to international studies, post-mortem procedures in Croatia are characterized by specific local and religious traditions. Additionally, the limited number of participants in the study may affect the generalizability of the results. While the data collected provided rich insights, it remains unclear whether theoretical saturation was fully achieved.

Another important limitation concerns the researcher's lack of formal experience in conducting qualitative interviews, which may have influenced the depth and consistency of data collection. Moreover, a personal relationship existed between the researcher and some of the participants. This could suggest the possibility of a shared value system between the researcher and participants, thereby reducing the level of neutrality expected in qualitative research.

Future research should focus on expanding the participant pool and incorporating comparative studies from different cultural contexts to enhance understanding of post-mortem rituals. Also, all the hospitals in Croatia should be included. Furthermore, the reasons why some participants perform rituals in secrecy or choose not to involve families in these practices were not explored in detail. Investigating these motivations in future studies could provide valuable insights into personal, professional, or cultural factors influencing such behavior. Addressing these limitations will help to create a more comprehensive framework for understanding the role of post-mortem rituals in healthcare settings.

Despite the noted limitations, this study lays an important foundation for further research into the role of cultural traditions in end-of-life care and the professional responsibilities of nurses within this sensitive area of practice.

Implications for clinical practice

Within the healthcare team, there should be an awareness of the various post-mortem rituals that nurses practice, as well as support and understanding for these practices. Encouraging the exchange of experiences can lead to a better understanding of these rituals. Hospital teams engaged in quality improvement may consider providing additional education for nurses on coping with patient death, thereby enhancing both the quality of care and the emotional well-being of healthcare workers. Further research is needed to better understand the impact of these practices on the emotional and psychological state of nurses and to ensure support in their implementation. Incorporating end-of-life care training into formal nursing education programs would equip future nurses with the necessary skills and emotional preparedness to handle these sensitive situations with professionalism and compassion. However, it is important to acknowledge that the recognition and promotion of such rituals may carry ethical risks, particularly for individuals who identify as atheists or agnostics, whether they are healthcare workers or patients. Ensuring that the implementation of these practices is inclusive and respectful of diverse beliefs is essential to maintaining an ethical and culturally sensitive approach. Recognizing and valuing these rituals can contribute to the quality of healthcare and the preservation of the cultural heritage of a given area.

Conclusion

The conducted research, which included nine participants, found that all engagement in post-mortem ritual behaviors extends beyond the prescribed standardized procedures for handling deceased bodies. These practices are primarily shaped by personal experiences of human dignity after death, as well as by inherited cultural traditions and the theoretical and practical components of nursing education.

It was found that nurses most commonly open windows, recite prayers, or make the sign of the cross over the forehead, along with other sporadically mentioned rituals. These behaviors are primarily learned from older colleagues and are often justified as a means to facilitate the soul's departure, in addition to providing a sense of peace, well-being, and satisfaction from the act. However, given the profound impact of these practices on both nurses and patient families, formalized education and training should be considered to ensure ethical and culturally sensitive approaches in end-of-life care.

The findings indicate the post-mortem procedures among participants are influenced by local and religious customs, although further research is needed to draw definitive conclusions. The experience of performing these rituals helps nurses coping more easily with individual deaths and fosters a sense of fulfillment in their duties towards the deceased. These practices are largely passed down through generations but are often overlooked in formal nursing education.

Further research in this area is essential to gain a deeper understanding of the ritual practices performed by nurses after a patient's death, as well as their impact on the nursing profession and healthcare. The professional community should raise awareness about these various ritual practices to provide support and understanding to those who engage in them.

Author contributions

Conceptualization and methodology (ID, DAA, JS); Data curation and formal analysis (ID, DAA, JS); Investigation and project administration (ID, DAA); Writing – original draft and review & editing (ID, DAA). All authors have approved the final manuscript.

Conflict of interest

The authors declare no conflict of interest.

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