

**Nurses' Attitudes Towards the Care of the Dying**

**by**

**Candance Jo Garossino**

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Department of Nursing  
The University of British Columbia  
Vancouver, Canada

Date April 29/91

## ABSTRACT

Terminally ill patients and their families describe hospital care as nonsupportive to their needs during the final phase of life. Nurses generally are not comfortable with a supportive role when caring for the dying and tend to adhere to a curative role. The purpose of this descriptive, correlational study therefore was to describe the attitudes of general staff nurses working on medical-surgical units in hospitals towards the care of the dying and to ascertain the relationship between these attitudes and the education and experience of the nurses.

An adaptation of the model for role episode, conflict, and ambiguity by Kahn, Wolfe, Quinn, Snoek and Rosenthal (1964) was the applied theoretical framework. The sample consisted of 197 randomly selected registered nurses employed full or part-time on general adult medical-surgical hospital units in British Columbia. The majority of the sample were married, Protestant females, between the ages of 26 and 45 years who were prepared at the diploma level in nursing. The mean length of time worked as a nurse was 8.5 years with a mean of 7.5 years on medical-surgical units.

Attitudes towards the care of the dying were generally ambiguous, neither negative nor positive as measured by scores obtained on the 'Questionnaire for Understanding the Dying Person and His Family'. Additionally, half the respondents did not believe that nurses should be the primary health care professionals equipped to deal with the emotional reactions of the dying yet three-quarters of the sample believed that patients turned to nurses to discuss such emotional issues.

Data revealed that close to two-thirds of the respondents had received structured death and dying content in their basic nursing education yet less

than half furthered their death and dying education since graduation. Overall death education for the sample was low. A small positive correlation ( $r=-0.26$ ) was found between respondents' death education and their attitudes towards the care of the dying; no significant association was found between respondents' level of general nursing education and their attitudes. Although there was variability in the amount of professional and personal death experience, over half of the respondents experienced between one and three terminally ill patient deaths on their medical-surgical units per month. Additionally, the majority of respondents had experienced the death of an immediate family member. Overall death experience was low to moderate. A small, but significant positive correlation ( $r=0.24$ ) was found between overall death experience and attitudes' towards the care of the dying; no significant association was found between general experience and attitude.

Findings suggest that supportive nursing care is not being demonstrated with dying patients and their families. However, the influencing natures of death education and death experience on nurses' attitudes are positive, thereby providing the nursing profession with two possible ways of positively influencing nurses' attitudes to the care of the dying.

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## CHAPTER ONE

### Background to the Problem

In British Columbia, 78.5% of deaths occur in hospital. Many of these deaths are due to chronic life-threatening illnesses such as cancer. The majority of patients with these illnesses are cared for on medical-surgical hospital units. On such units, nurses are the health care professionals who have the most continuous and intimate contact with dying patients and their families. Therefore, as a first step in providing supportive care to the dying it is imperative that medical-surgical nurses develop attitudes about death that are conducive to providing optimal care of the dying. There is however currently little literature addressing the attitude of medical-surgical nurses towards caring for dying patients. The purpose of this study was to examine the attitudes of such a group of nurses.

The care of the terminally ill is a growing concern for the health care system. Advances in medical technology in the 20th century have changed Canadian mortality patterns. The leading cause of death has shifted from acute infectious diseases to chronic diseases such as cancer and heart disease. In addition, these advances have increased the life expectancy of the chronically ill. Current treatment modalities often prolong the lives of individuals with chronic, fatal diseases. Further, such treatment often continues in hospital until close to the time of death (Degner & Gow, 1988a; Holing, 1986; Shedletsky & Fisher, 1986).

Various authors have asserted that the curative philosophy underlying acute caregiving in hospitals is inappropriate during the final stage of a terminal disease (Gotay, 1983; Mount, 1979; Scofield, 1989). In fact, there is evidence that health care professionals are aware of the deficiencies in the hospital based

care given to the dying and their families (Ganz, Breslow, Crane, & Rainey, 1986; Mount, Jones, & Patterson, 1974; Shedletsky & Fisher, 1986). When cure or remission are beyond the scope of current treatment modalities, the philosophy of palliative or supportive care must be assumed. In contrast to curative care, supportive care focuses on symptom management and support of dying patients and their families through the dying trajectory (Mount, 1976). Nurses, having the most direct, continuous, and intimate contact with the terminally ill, have a responsibility to provide appropriate supportive care (Davies & Oberle, 1990; Williams, 1982). Therefore, as the chronically ill enter the final phase of life, the focus of nursing must switch from curative to supportive care (Williams, 1982). Nurses specializing in palliation typically possess this supportive care focus (Davies & Oberle, 1990).

However, the literature suggests that nurses, in general, are not comfortable with the supportive role (Aries, 1974; Kubler-Ross, 1969; Murphy, 1986; Quint, 1966; Williams, 1982). Very little research has been done which examines the comfort of medical-surgical nurses, who care for the majority of dying patients, with the supportive role. The literature suggests that many of these nurses have a curative-oriented focus aimed at restoring the health of patients (Degner & Gow, 1988a; Williams, 1982). This prevalent care focus influences the care of the dying. Ample evidence exists indicating that nurses, in general, inhibit their interactions with dying patients, making hospital deaths isolating and inhumane (Aries, 1974; Kubler-Ross, 1969; Murphy, 1986; Quint, 1966; Reissetter & Thomas, 1986). Stoller (1980) suggests that such behaviors are the result of nurses' attitudes towards the care of the dying. Thus, the attitudes of nurses determine to a large degree the social context in which dying occurs. Until nurses learn to cope with the concept of death, they will continue

to put physical and social distance between themselves and the dying (Hurtig & Stewin, 1990).

Literature addressing the concept of attitude indicates a strong correlation between one's attitude towards something and the behavior exhibited towards that object or symbol (Fishbein, 1967; Kahle, 1984; Wagner, 1969). It stands to reason that nurses with a positive attitude towards the care of the dying will exhibit more effective supportive patient care. Therefore, it is important to understand the attitudes of general medical-surgical nurses towards the care of the dying and to identify factors that might have an influence upon such attitudes.

### Problem Statement

Chronic life-threatening illnesses such as cancer have become the leading cause of death in Canada. People with these fatal diseases are often cared for during the dying trajectory, on general medical-surgical hospital units. The experience of dying on such units has been described in the literature as physically and socially isolating for patients and their families. The literature suggests that the curative focus indigenous to medical-surgical units contributes to this isolating dying experience. Obviously, the curative care focus of medical-surgical units which is appropriate in the care of the acutely ill, is most inappropriate in the care of the terminally-ill. The dying and their families need supportive care. Nurses, by having continuous involvement with the dying, are in the best position of all health care professionals to influence the type of care given to such patients. However, very little is known about the attitudes of nurses in medical-surgical units towards the care of the dying. Further, it is not known whether factors such as education and experience are related to the attitudes of medical-surgical nurses. It is therefore important to

examine the attitudes of these medical-surgical nurses towards the care of the dying and to explore factors, such as education and experience which may be related to nurses' attitudes towards death.

### Purpose

The purpose of this study is to 1) describe the attitudes of general staff nurses working on medical-surgical units in hospitals towards the care of the dying, and 2) ascertain what relationship, if any, exists between education and/or experience and general medical-surgical nurses' attitudes towards the care of the dying.

### Theoretical Framework

The theoretical framework to be utilized in this study is an adaptation of Kahn, Wolfe, Quinn, Snoek and Rosenthal's (1964) theoretical model for role episode, conflict and ambiguity (see Figure 1). This model identifies factors that

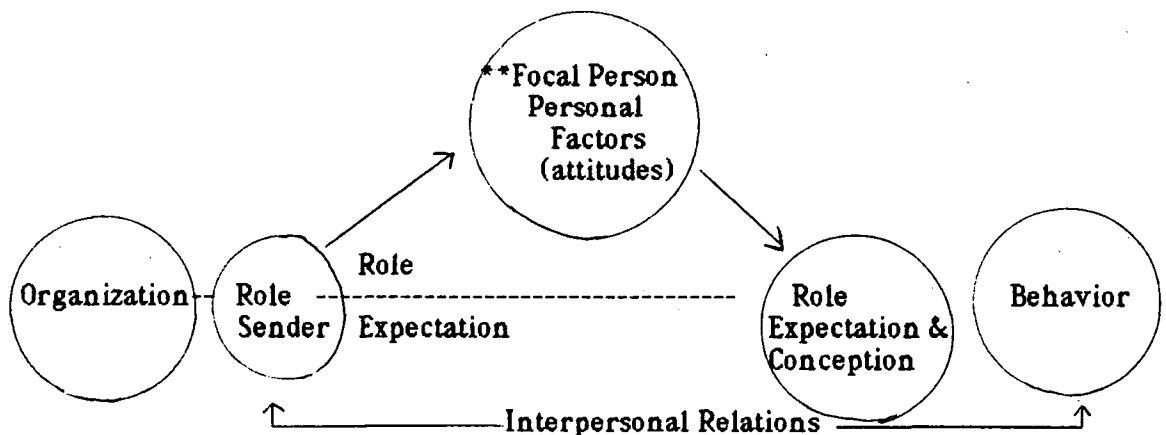


Figure 1. A role model adapted from 'A theoretical model for role conflict and ambiguity'.

From Kahn, R., Wolfe, D., Quinn, R., Snoek, J., & Rosenthal, R. (1964). Adjustment to role conflict and ambiguity in organizations. In B. Biddle, B. & E. Thomas (Eds.), Role Theory: Concepts and Research. New York: John Wiley & Sons.

\*\* Denotes the component to be investigated in this study.

influence behavior and provides a way of identifying and understanding factors involved in the conceptualization of role and subsequent behavior. It presents role behavior, in the context of an organization, as the result of a complex interaction between the person exhibiting the behavior (focal person) and those people (role senders) who exert pressure on the focal person to perform in a certain manner.

The personal factors, such as attitude and anxiety, influence the behavior of the focal person. Role expectation, conception of that role and subsequent behavior are also influenced by the organizational structure and external role expectations coming from the role senders. This process of role identification and subsequent behavior is an ongoing process within the social context of the individuals involved and their interactions. The key components of this model are described in the following sections.

#### Organization

Incorporated in the organization circle are the characteristics of the organization as a whole, including the number of status levels, the method of division of labour, and the descriptions of the relationship of the focal person to the organization. The organizational structure dictates certain formal expectations both to the focal person and to the role sender. The organization formally dictates what a person in an organization is supposed to do. For example, the hospital may have written job descriptions pertaining to the expected behaviors of staff nurses.

#### Role Senders

Role senders are those individuals who exert pressure on the focal group, or on the individual members of that group, to perform in a certain manner. Within a hospital organization there are a number of role senders, such as

patients, nurses, unit managers, physicians and administrative personnel, who may exert pressure on the nurse ( focal person) to perform in a specified way.

### Role, Expectation and Conception

Role has been defined as "what is created when a person puts into effect or action the collection of rights and duties which constitute a status or position" (Schmalenberg & Kramer, 1979, p.204). In other words, a role may be viewed as a collection of functions performed by an individual while she or he is occupying a certain position in society or in an organization (Topham, 1987). Three elements are inherent in the conceptual framework of role. The first element inherent in the conceptual framework is the structurally given demands (role expectations). Role expectations are the demands, both formal and informal, on a person in a particular role (Schmalenberg & Kramer, 1979). These expectations may stem from the people themselves or from external sources. Once expectations are coupled with the personal factors of the focal person, the individual then formulates cognitive expectations of behavior to be performed. The second element, role conception, is the cognitive expectation of behavior or what one thinks the function of a job is. The third element, role behavior, is the overt manifestation of the role conception.

### Focal Person

The focal person is that individual upon whom formal and informal role expectations or demands are placed. Each focal person possesses personal characteristics that influence that person to behave in a certain fashion. These characteristics are composed of attitudes, beliefs, fears, values, habits and sensitivities. In other words, how the focal person views and relates to the world will influence that person's behavior.



### Interpersonal Relations

The interpersonal relations are the patterns of interaction between the senders and the focal person and their orientations towards each other. These patterns of interaction may stem from the formal organizational structure or from the informal interaction between two people which depends upon the presence or absence of an affective bond and/or dependence and the style of communication employed. It is evident from the model that this component will influence the interaction of the players. There are four dimensions to this component: the power of each player in the interaction process, the affective bonds such as trust, friendship, or respect, the dependence on each other in the interaction and the style of communication evident among or between the players.

### Application Of Theoretical Framework

The Theoretical Model for Role Conflict and Ambiguity (Kahn et al., 1964) is appropriate for the study of nurses' attitudes towards the care of the dying and the possible influence of experience and education on those attitudes. The personal factors of the focal person are critical in both the conceptual formulation of his/her role and the subsequent role behavior. The isolation of personal factors within this model allows for their investigation. The focal person in this study is the general medical-surgical nurse. The organization is the hospital in which the nurse is employed and, within that, the general medical-surgical units. The role senders are terminally ill patients and their families, physicians, unit managers, other nurses, and administrative personnel.

In the context of this study, role expectations of the role senders are viewed as expectations of nursing care related to dying patients and their families. Behavior is defined as the professional nursing care given to dying patients.

The specific personal factors to be focused upon are the nurse's attitude to the care of the dying, past experience, and education.

### Research Questions

As will be made evident by a review of the literature there are several gaps in the existing research regarding nurses' attitudes towards the care of the dying have been identified. These include: 1) there is little research regarding the attitudes of general medical-surgical nurses towards the care of the dying; 2) there is little research regarding the education of these nurses; and 3) there is no consensus regarding the relationship between nurses' experience and their attitudes towards the care of the dying. Therefore, this study attempted to answer the following questions.

- 1) What are the attitudes of general staff nurses working on hospital medical-surgical units towards the care of the dying patient?
- 2) What is the relationship between education and general medical-surgical nurses' attitudes towards the care of the dying?
- 3) What is the relationship between experience and general medical-surgical nurses' attitudes towards the care of the dying?

### Definitions of Terms

For the purposes of this study, the following definitions were used.

Attitude: a complex, structured psychological tendency to respond in a consistent way to social objects or situations (Yeaworth, Kapp, & Winget, 1974).

Attitude Towards the Care of the Dying: an individual's psychological tendency (mind-set) to respond in a consistent way to the care of the dying. This variable was operationalized as a score on part 1 of the Winget Questionnaire for

Understanding the Dying Person and his Family (Winget, Yeaworth, & Kapp, 1974) (see Appendix A).

Dying Patients: hospitalized individuals over the age of eighteen who manifest irreversible symptoms of a progressive and fatal condition and who are expected by their nurses to die within six months.

Education: an individual's educational exposure to death and dying during, and subsequent to, their basic nursing program. This education score was measured as the summated score attained on Part 2 of the Subject Information Form (see Appendix B).

Experience: an individual's exposure to death and dying in both a professional and a personal life context. This experience was measured as the summated score attained on Part 3 of the Subject Information Form (see Appendix B).

General Staff Nurses: those individuals who are registered with, and given permission to practice as registered nurses by, the Registered Nurses Association of British Columbia (R.N.A.B.C.). Further, these nurses indicated on the R.N.A.B.C. yearly membership form that they were currently working full or part time in general medical-surgical areas.

Hospital Medical-Surgical Units: inpatient units in urban and rural British Columbia hospitals where primarily active curative treatment is administered to adult patients.

### Assumptions

For the purposes of this study a number of statements are presented that this investigator assumes to be true. The first two assumptions are inherent within the theoretical framework of this study. The third assumption is based upon reason while the remaining statements are based upon knowledge of the sampling technique used.

1. Attitude towards an object or symbol results in the behavioral manifestation of that attitude.
2. Attitude is a complex, multifaceted concept.
3. Respondents will respond to the questionnaire truthfully.
4. The sample will be representative of the target population.
5. The sample is normally distributed.

### Limitations

One limitation of this study was that the results are generalizable only to general medical-surgical nurses working in British Columbia (B.C.) hospitals. The attitudes of nurses towards the care of dying patients employed in other areas of care or other geographical areas may be influenced by factors not controlled for in this study. For example, the health care delivery system in their areas may be different than in B.C., or they may have been exposed to media coverage of issues such as quality of life and euthanasia which may be more or less prevalent in other areas than in B.C..

### Overview of the Thesis Content

This thesis is comprised of five chapters. Chapter One includes the background to the problem, the description of the conceptual framework and the outline of the study's purpose. In Chapter Two, selected literature pertaining to attitude, experience, and education is reviewed. Chapter Three incorporates the research methods including a description of the sampling procedures, the design, the instruments, the data collection, and the statistical procedures. The results of the data analysis and the discussion of the findings constitute the fourth chapter. In the final chapter, a summary of the study, the

conclusions of the study, and the implications for nursing including recommendations for future research, are presented.

## CHAPTER TWO

### LITERATURE REVIEW

Literature was reviewed in three related areas: the attitudes of nurses towards death, the influence of education on attitudes, and the influence of experience on attitudes. The concept of attitude will be described generally followed by a more specific discussion on societal and health care professionals' attitudes to death and dying. Studies emphasizing the effect of education and experience on a nurses' attitude to death and dying will then be addressed.

#### Attitudes of Nurses Towards Death

To facilitate the discussion on societal and health care professionals' attitudes towards death, it is necessary to briefly explore the concept of attitude. A variety of definitions of the concept of attitude are offered in the literature (Fishbein & Raven, 1967; Insko, 1967; Kahle, 1984; Kiesler, Collins & Miller, 1969; Wagner, 1969; Zimbardo, Ebbesen & Maslach, 1977). One element common to all definitions is that attitude is a cognitive affective tendency with some evaluative component attached to it. Wagner (1969) suggests that attitudes are composed of affective, cognitive and behavioral components. The affective component is the individual's evaluation of an object; the cognitive component encompasses the person's knowledge about the object; and, the behavioral component is the predisposition to act in a certain manner toward an object. The following definition of attitude encompasses the aforementioned components of the concept. Attitude is a "complex, structured psychological tendency to respond in a consistent way to social objects or situations" (Yeaworth, Kapp & Winget, 1974).

The underlying assumption is that attitudes do influence behavior and that attitudes reveal something about probable behavior (Insko, 1967; Kahle, 1984). However, the relationship of attitudes to behavior is not clearly known. There is reasonably strong evidence to suggest that the more positive the attitude an individual holds towards an object or symbol, the more likely the person will exhibit positive behavior towards that object or symbol (Fishbein, 1967; Kahle, 1984; Wagner, 1969). Therefore, if one's attitude towards death is positive, it is likely that one's behavior in caring for dying people would be positive as well. However, it is difficult to predict behaviors from attitudes because of the multidimensional nature of the concept (Wagner, 1969). An attitude seldom exists as a separate entity but rather exists as one part of a complex attitudinal system. One's attitude towards death is, therefore, part of a system of attitudes about such issues as quality of life.

In the past, with people dying from epidemics and in wars, people were familiar with the concept of death and could meet it with perhaps more openness and calm -- albeit not with pleasure. With the advent of medical and technological advances there was a shift to alienate death. Anxiety about death began to replace the earlier societal acceptance of the concept (Beckman & Olesen, 1988). Buchanan (1986) stated that society's use of words such as "asleep", "at rest", and "passed away", to denote death implies that the topic of death is to be avoided in conversations. It is likely that the societal view of life is strongly linked to the societal view of death. One of the present fundamental values in Canadian society is that the sanctity of life is to be preserved (Storch, 1983). Life, therefore, is to be treasured and protected at almost any cost while death is to be avoided and ignored. Quint (1966) suggested that attitudes of health professionals to death and dying are the same as, or similar to, those of the larger society. Afterall, a hospital is simply a microcosm of the

surrounding society composed of health professionals who enter the hospital with an array of attitudes and experiences which create biases, fears, and prejudices that influence how they perceive and process information about diseases and patients (Mount, 1976; Scofield, 1989)

To establish the credence of the belief that nurses hold the same attitudes toward death as the larger society, Quint (1966) engaged in an exploratory study designed to "describe the kinds of death which face hospital personnel in their work, and to see how the staff react to, and cope with, the various aspects of death" (p.49). Staff nurses working on a cancer research unit and an intensive care unit were used in the study. Quint concluded that society's distaste for death was also evident in the hospital culture. The avoidance strategies employed by nurses were found to be the same as those used by the middle class lay society for minimizing personal involvement with dying people.

In the hierarchy of the hospital, the nurse has the most direct, continuous, and intimate interaction with the dying and their families. Therefore, the nurse is in an optimal position to provide the supportive care necessary during the dying trajectory. Shneidman (1980) feels that nurses must be available and open to interacting with patients to assist them in reaching a "psychologically comfortable death". However, both theoretical and empirical evidence suggests that health professionals possess a negative attitude towards death and dying and that nurses are not available for open interaction with dying patients and their families (Kubler-Ross, 1969; Glaser & Strauss, 1965; Mount, 1976; Quint, 1966; Scofield, 1989).

Thus far in the discussion it has been established that the multidimensional concept of attitude is linked in some way to behavior. Society's negative attitude towards death has resulted in avoidance of discussions regarding death and dying and the utilization of avoidance



strategies when confronted with dying people and their families. The literature suggests that health care professionals also exhibit the attitude towards death which is prevalent in the larger society. The following empirical literature is reviewed for a more indepth characterization of nurses' attitudes towards death and the care of dying patients.

A number of researchers noted that nurses' attitudes towards death and the care of dying patients were characterized by anxiety (Conboy-Hill, 1986; Glaser & Strauss, 1965; Mandel, 1981; Quint, 1966; Wesney, 1985). This anxiety was thought to be responsible for nurses avoiding the psychological care of patients. The findings of Glaser and Strauss (1965) are in support of this conclusion. These researchers found that many nurses chose to work in areas where there was less chance of contact with dying patients. Further, if confronted with a dying patient, nurses tended to engage in avoidance behavior especially with those patients who were unaware of their impending death, were inclined to ask questions, were unaccepting of death, and/or were in great pain. Nurses' avoidance behaviors identified by Glaser and Strauss, Quint, and Wesney included the use of physical distancing and conversational guarding to avoid discussions about the process of death.

In an attempt to clarify why nurses engage in avoidance behaviors, Mandel (1981) conducted an exploratory study of 40 nurses working with cancer patients in a variety of settings. She identified feelings of anxiety related to anger and guilt towards patients, fear of personal death, and frustration stemming from the lack of a background in dealing with the psychological and emotional needs of patients. These findings are further supported by Conboy-Hill (1986). She compared nurses and an unidentified control group in relation to their anxiety about death. Unfortunately, she did not include a discussion of the sampling methods used, the name or nature of

the questionnaire, or any discussion regarding reliability or validity of the instrument, thus the findings must be regarded with caution. However, both groups were found to have high anxiety towards death with no significant difference in anxiety level. Mandel believed that such feelings of anxiety are responsible for nurses avoiding the psychological care of patients.

The findings of Wesley (1985) clearly support the aforementioned conclusions. Wesley used Mandel's (1981) questionnaire in her descriptive study of nurses' feelings and attitudes about caring for terminally ill patients. Nurses from four hospital areas--paediatric, surgical/orthopaedic, medical, and continuing-care--completed the questionnaire. It is unfortunate that the attitudes and feelings between these groups of nurses were not distinguished. However, one of Wesley's findings was that 89% of these nurses experienced anxiety about discussing psychological concerns with the terminally ill and their families.

In addition to examining nurses' anxiety about death, Conboy-Hill (1986) also examined the social behavior of nurses. In the behavioral observation portion of her study, Conboy-Hill focused on task directed versus social behavior of nurses working with terminally and nonterminally ill patients. Critical differences were found in nurses' interaction with these patients. In contrast to nurses' interaction with nonterminal patients, nurses did not initiate social interaction with the terminally ill. These results support previous research findings that nurses tend to avoid the psychological care of dying patients.

Studies conducted within Canada further support the premise that nurses exhibit anxiety when caring for the dying and that this contributes to the lack of psychological care of these patients and their families. In addition the Canadian researchers found that a significant number of health care professionals are

aware of the unmet needs of the terminally ill. However, there is a lack of self awareness concerning individual insensitivity to these needs.

Mount, Jones, and Patterson (1974) used a questionnaire survey to investigate the attitudes towards death and dying of 638 health care professional staff in a large Canadian teaching hospital. Nurses and physicians had low response rates of 32% and 49% respectively, compared to the 100% response rates of social workers and clergy. The investigators were concerned by the low number of nurse and physician responses and provided the following explanation. Perhaps the discomfort associated with dealing with death resulted in the refusal to answer questions raised by terminal illness. The overall findings of the study revealed that 85% of staff believed that the hospital has an obligation to meet the emotional needs of its patients yet there was widespread feelings that these needs were not being met. Similarly, Shedlesky and Fisher (1986) reported that 97.6% of staff believed in the hospital's obligation and 41% of staff felt this obligation was not being met.

Mount and associates (1974) also reported that staffs' personal fears of death and dying influenced both how candidly they would discuss death with their patients and how well they perceived their patients' feelings. These investigators further suggested that there is a lack of self awareness on the part of health care professionals concerning their own individual insensitivity to the emotional needs of the terminally ill. For example, 83% of nurses believed that they were always aware of the emotional needs of patients. In contrast, only 67% of patients believed that their emotional needs were identified by nurses.

Shedletsky and Fisher (1986), in a partial replication of Mount et al.'s study, assessed and compared the attitudes and behavior of acute care and extended care staff towards terminally ill patients. Eighty percent of the respondents were nurses. Findings were similar to those reported by Mount et

al. (1974): the majority (60%) of acute care staff felt that terminally ill patients should not be treated in acute care areas, and acute care staff were described by their peers as more likely to avoid discussions regarding death with their patients.

Thus far the discussion has focused on the attitudes of staff and nurses to death and dying. Health care professionals, in general, believe that the emotional care of the dying is inadequate in the hospital. Evidence indicates that nurses experience anxiety when caring for the terminally ill. The behavioral manifestation of this anxiety appears to be the physical and/or psychological distancing from such patients. Further, nurses in general, portray a lack of personal awareness of their own such behaviors. A logical question stemming from this synopsis pertains to the effect of staffs' anxiety and avoidance behaviors on the terminally ill and their families.

It is reasonable to expect that the attitudes and behavior patterns of nurses will determine, to a large degree, the social context in which dying occurs (Stoller, 1980). Kubler-Ross (1969) suggested that health professionals' negative attitudes towards death and dying contribute to the dying patient's feelings of isolation and inhumane treatment. In the same context, Glaser & Strauss (1965) believed that the dying patient is often forced to die socially before his or her physical death due to the withdrawal of nurses and the subsequent feelings of isolation experienced by patients. Similarly, the families of the terminally ill experience greater stress when their needs go unmet and this impedes their ability to function effectively (Kristjanson, 1989). The following research pertains to the subjective experience of patients and families during the dying trajectory.

Parkes and Parkes (1984) compared hospice versus hospital care during 1967-9 and 1977-9 as evaluated in semi-structured interviews of spouses of

patients who died in one of the settings. Findings suggested that symptom control improved in both settings over time, but that support and relief for the suffering of families was superior in the hospice setting. For example, 46% of hospital respondents rated their anxiety as very great during the final phase of their spouses life compared to 13% of the hospice respondents. In addition, the hospital was characterized as family-like by 87% of hospice respondents and only 8% of the hospital respondents. Terminally ill patients have also expressed more satisfaction with hospice care than with conventional care (Kane, Berstein, Wales, and Leibowitz, 1984).

Retrospective studies of bereaved spouses revealed similar findings (Godkin, Krant, & Doster, 1983; Vachon, 1977). Godkin and associates reported that families receiving traditional oncological care, as opposed to hospice care, frequently interpreted the final phase of illness as a time of great stress. Alternately, three quarters of the spouses in the hospice setting felt safe, cared for, and supported more often than they had in previous settings. In Vachon's study, eighty-one percent of respondents viewed the final days in hospital as extremely stressful and perceived that, at least in part, their stress was related to the health professionals' modes of care. One complaint expressed by the women was the perceived abandonment by nurses and physicians as death approached. The women bitterly resented the hospital system for this perceived callousness in the care of the dying and the family which contributed to women's stress.

It can be concluded that the psychological care of the terminally ill and their families is sorely lacking in the hospital environment. Reasons for this deficiency include: 1) nurses' attitudes towards death are generally negative; 2) nurses tend to avoid interaction with dying patients; 3) nurses are not comfortable in providing psychological care to dying patients and their families;

and 4) health care professionals lack self awareness pertaining to their own insensitivities in caring for the terminally ill. As a result patients feel a sense of social isolation during the dying trajectory and both patients and their families experience greater anxiety and feel less supported in acute care environments. Obviously, the existing type and quality of care given to the terminally ill and their families in acute care hospitals is of concern and demands further attention.

The nursing profession takes responsibility for the care of the dying since nurses have the most direct and continuous involvement with these people (Davies & Oberle, 1990; Williams, 1982). Clearly there is a need to identify factors which may influence nurses' attitudes towards death in order to help nurses develop comfort in providing psychological care to the dying. Research conducted in this area has primarily focused on two such factors that may influence nurses' attitudes towards death and dying: formal education on death and dying and professional and personal experience with the dying.

#### The Influence of Education on Attitudes towards Death

The potential effect of formal death education upon nurses' attitudes towards death and dying has been the focus of a number of studies. Unfortunately, in many reports of these studies, a discussion of the reliability or validity of the instruments used is not included. However, findings are quite consistent, generally indicating that more academic exposure is related to a more positive attitude towards death and the care of the terminally ill.

Differences between the attitudes of first year and senior nursing students towards death were assessed by Yeaworth, Kapp & Winget (1974). The first year students had not received any formal education on death and dying. The senior students, however, had completed a class on loss and grief, a

class on death and dying, a series of clinical conferences, and an optional individual counselling session to discuss feelings and attitudes about caring for a dying patient. Attitude towards death and dying was measured using a two-part instrument ('Questionnaire for Understanding the Dying Person and His Family') created by an interdisciplinary team. Positive attitudes were assigned low scores reflecting flexibility in interpersonal relations and a desire for open communication around critical issues. Senior nursing students obtained lower scores than first year students, indicating that education positively influences nursing students' attitude towards death and dying.

The same questionnaire was subsequently used by two Canadian nurse researchers (Degner & Gow, 1988b) in a longitudinal quasiexperimental study to evaluate the effectiveness of two educational programs in preparing nurses for care for the dying. The first program was a required course in palliative care that included clinical practice (experimental group); the second was an integrated approach to death education that included classroom and clinical exposure (control group). Death anxiety and attitude toward care of the dying were measured using the Collett-Lester scale and the Winget scale respectively. The test-retest reliability levels of the scales at three sequential testings was good at 0.80, 0.84, 0.83 for the Collett-Lester scale, and 0.74, 0.79, and 0.77 for the Winget scale. Results indicated that the experimental group had greater reductions in death anxiety and felt more prepared to care for the dying than did the control group. Therefore, These results support the conclusions of Yeaworth et. al. (1974).

Two studies involving nursing students used the Hopping Death Attitude Scale with conflicting results. Coolbeth and Sullivan (1984) found that senior students, who had academic exposure to the concept of death through lectures, seminars, and clinical experience, indicated an improvement in attitude toward

the concept of death as a result of this academic exposure. Sophomore students, having no such academic exposure, did not indicate improvement in their attitude toward death. Alternatively, Hopping (1977) used a descriptive comparative design to ascertain whether a change in senior nursing students' attitude toward death and dying was associated with the taking of a four month course focusing on nursing patients with malignant neoplastic diseases. She found that the course was not associated with an improvement in the students' attitude towards death and dying. The results must be interpreted with caution for two reasons. First, the test-retest reliability was marginal at .64 and only fifty percent of the items had discrimination coefficients greater than .30. Second, the course may not have specifically addressed attitudes towards death.

Studies reviewed thus far have focused on the influence of death education programs on student nurses' attitudes to the care of the dying and death anxiety. The general consensus is that death education decreases death anxiety and positively influences students' attitudes to caring for dying patients. The underlying assumption appears to be that the student years are the most crucial in forming attitudes toward death and dying. However, additional research illustrates that educational programs positively influence practicing nurses' attitudes to the care of the dying and reduce death anxiety.

Lester, Getty and Kneisl (1974), explored the attitudes of nursing undergraduate students, graduate students, and faculty toward death and dying in a comparative study at a university school in the United States. The general fear of death and the consistency of attitudes toward death were measured as scores obtained on the previously validated Lester scale. Results indicated that the fear of death and dying tended to decrease as the nurses attained more academic preparation culminating in the faculty indicating the least amount of fear. Although age might provide an alternative explanation for these results,



additional research indicates that death education does indeed influence nurses' attitudes.

Murphy (1986), in a quasiexperimental study, examined the effects of a death awareness workshop on the death anxiety of registered nurses using the Templer Death Anxiety Scale to measure death anxiety of both experimental and control groups. Pre-test results indicated that both groups had similar levels of death anxiety. Post-test results revealed the experimental group had a significant decrease in death anxiety following the conclusion of the workshop. Further, the death anxiety of the nurses in the control group did not significantly change. It appears, then, that the death anxiety of these nurses decreased as a result of workshop participation.

The positive influence of death education on nurses care of the dying was supported by Reisetter and Thomas (1986) who examined the relationship between the quality of care given to terminally ill patients and their families, and selected characteristics of 210 hospital based nurses caring for these patients. Selected nurses characteristics included the amount of educational experience each nurse had obtained through a basic nursing program and postgraduate workshops, inservices, and conferences. Findings indicated a positive relationship between quality of care and the level of educational experience regarding death and dying. Although the correlation coefficient of 0.26 is considered low (Munroe, Visintainer, & Page, 1986) it does indicate that death education programs for practicing nurses are likely to have a positive influence on the care provided to terminally ill patients and their families.

The majority of the aforementioned studies support the statement that increased death education generally results in a more positive attitude towards death accompanied by decreased death anxiety. Further, as nurses become more comfortable with the concept of death there will be an improvement in

their attitudes towards the care of the dying. However, the use of various death attitude and death anxiety measurement techniques illustrates the need for clarification of definitions of such basic concepts as attitude, anxiety, and care.

### The Influence of Experience on Attitudes towards Death

The second major factor thought to influence nurses' attitude toward death is their personal and professional death experience. The discussion in this section will focus on research which addresses the influence of nurses' death experience on their attitudes to the care of the dying. The results of these studies are inconsistent and therefore collectively inconclusive illustrating the need for further research.

Alexander (1990) sought to define what particular features of palliative care are stressful to nurses who work in hospice settings. Through the use of questionnaires and semi-structured interviews, he also examined possible influences on nurses' attitudes towards death. Out of a total of 61 nurses, 90% felt that professional experience with dying patients considerably influenced their attitude to death. Second, the death of someone close to the nurse (personal experience) was an influential factor (61%). Unfortunately, the nature of these influencing factors were not discussed. Other studies however have attempted to identify the nature of influencing variables.

Shusterman and Sechrest (1973) hypothesized that more experienced nurses would express less fear of death of others than those with less experience. Ninety-eight nurses working in one suburban hospital completed the death anxiety questionnaire which consisted of twenty-two items from the Collett-Lester Fear of Death Scale and seventy items constructed by the researcher. Experience was found to correlate negatively ( $r = -.35$ ) with fear of death of others. Professional experience was also found to positively correlate

(0.47) with how much nurses discussed various aspects of death and dying with patients and their families (Reisetter & Thomas, 1986). In other words, as nurses gained more professional experience, they tended to express less fear of someone else dying and engaged more frequently in open communication with dying patients and their families.

In contrast, Stoller (1980) reported that nurses' reports of uneasiness associated with interaction with dying patients increased with years of experience. Stoller suggested that nurses may not acquire effective strategies for handling death-related conversations and that they may accumulate negative experiences when their avoidance strategies prove ineffective. It should be noted that these studies focused on varying aspects of patient care which are not mutually exclusive. Stoller focused on the nurses' reported uneasiness; Shusterman and Sechrest focused on fear of death of others; and Reisetter and Thomas focused on open communication. For example, nurses with more experience may report increased uneasiness with patient interaction while engaging in open communication and experiencing less fear of death.

The relationship between personal death experience and death anxiety among nurses and nursing students was examined by Denton and Wisenbaker (1977) using data obtained from a previous study of 35 nurses and 41 nursing students. An unnamed questionnaire examined three dimensions of personal death experience: 1) the death of a close friend/relative, 2) the experience of witnessing a violent death, and 3) the subjective experience of the respondent. The Templer Anxiety Scale was used to measure death anxiety. Results partially support the hypothesis that death anxiety and death experience are negatively correlated. No relationship was found between the death of a close friend/relative and the nurses' death anxiety. However, death anxiety was negatively correlated with both the experience of witnessing a violent death

and the subjective experience of the respondent ( $r = -0.39$  and  $r = -0.42$  respectively). It has been suggested that if the results were correlated with age, perhaps the nurses' responses, as opposed to the students' responses, would indicate a negative correlation between death anxiety and the death of a significant other (Reisetter & Thomas, 1986). The assumption here is two-fold. First, nurses are assumed to be older, and therefore, are assumed to have experienced more significant other deaths than the younger student cohort.

The death of significant others (personal experience) was also examined for its influence on the quality of care nurses provided for dying patients. Reisetter and Thomas (1986) reported that personal experience correlated weakly (0.15, 0.19, and 0.2) with quality of care. Three measures of quality of care were used: communication about death and dying issues, continuity of care, and family care. In other words, nurses with personal death experience tended to discuss death and dying issues with their patients, maintain continuity of care, and take greater responsibility for meeting the families' needs.

Findings dealing with the relationship between nurses' experience and nurses' attitudes toward death are inconclusive. Definitions of personal and professional experience are varied and therefore it is not clear if length or quality of experience influence nurses' attitude toward death. Clearly, the discrepancies in the literature illustrate the need for further research in this area.

### Summary of Literature Review

The literature reviewed illuminates the complex nature of the concept of attitude. A definition of attitude that incorporated various components of the concept was presented. Although the exact relationship between attitudes and behavior is not known, there is reasonably strong evidence to suggest that a

positive correlation exists between attitudes and behavior. Therefore, it was postulated that a positive attitude towards death would have a positive influence on one's care of the dying.

Society's attitude towards death was shown to be primarily negative as evidenced by people's avoidance of conversations related to death. Both theoretical and empirical literature provided evidence that health care professionals also possessed these predominantly negative attitudes towards death. Since nurses have the most intimate, direct, and continuous contact with dying patients, their attitudes were examined further.

Nurses' attitudes towards death were characterized as anxiety-ridden, contributing to their uneasiness in providing psychological care to dying patients and their families. Further, a lack of nurses' self awareness regarding insensitivities in caring for this group of patients was noted. The influence on patients' and families' well-being was presented. Both patients and families felt socially isolated and unsupported during the dying trajectory. This conclusion is in direct opposition to the philosophy of supportive care proposed by various leaders in the field of palliative care.

Due to the concern that nurses were providing insufficient care to the dying, literature concerning two influencing factors on attitudes was reviewed. First, with regards to education as an influencing factor, the majority of studies indicated that death education had a positive influence on nurses' attitude towards death and decreased death anxiety. It was surmised that, as nurses became more comfortable with the concept of death, an improvement in their attitudes to caring for the dying would become evident. However, it was obvious that authors used different measurement tools and different definitions of death anxiety and death attitudes. This discrepancy in definitions illustrates

the need for further research to clarify definitions and thereby contribute to a more consistent body of research.

The second influencing factor explored consisted of both personal and professional death experience. Relationships between these experience variables and nurses' attitudes towards death and the care of the dying varied. Obviously, the discrepancies in the research findings warrant additional research in this area.

In summary, nurses attitudes towards death appear to be negative, contributing to the insensitive care of the dying and their families. Since the majority of dying people are cared for in acute care hospitals, it is likely that medical-surgical nurses will be most frequently involved in their care. Research addressing the attitudes of this group of nurses to the care of dying patients is sparse. In addition, the need for further research on possible influencing factors on nurses' attitudes has been substantiated. It is to these ends that this study was undertaken.

## CHAPTER THREE

### METHODS

In this chapter a description of the design and the sample are presented. The human rights and ethical considerations, the data collection procedures and instruments, and the data analysis procedures will also be presented.

#### Design

A descriptive correlational design guided this study. This design is appropriate because the investigator expected a relationship between nurses' attitudes towards care of the dying and the education and experience of these nurses. A descriptive correlational design permits an initial description of the variables and provides a method for establishing if there is a relationship between attitudes, education, and experience.

#### Sample

The sample consisted of 200 randomly selected registered nurses employed full or part time on general adult medical-surgical hospital units in British Columbia. Medical-surgical nurses were selected because (a) the majority of dying patients are cared for by these nurses, and (b) the focus of care on medical-surgical units is primarily one of cure. In addition, surveying nurses in general medical-surgical areas of nursing practice controlled for the setting, one component of the organizational structure inherent in the theoretical framework. Participants were obtained in accordance with the following inclusion criteria.

1. The nurse must be currently registered as a registered nurse with the Registered Nurses Association of British Columbia (R.N.A.B.C.).
2. The nurse must be currently working full or part time in a B.C. hospital on an adult medical-surgical unit.

According to Cohen (1977), a sample of 200 was required for the proposed correlation using a medium effect size of 0.4 with a two tailed t-test, a significance level set at  $p = .05$ , and a power of 0.8. The following reasons are given for choosing an effect size of 0.4: a) the scale chosen to measure attitude has demonstrated adequate reliability and validity; b) the proposed area of research is not new; and, c) the effect will likely be immediately visible. Given that the R.N.A.B.C. registration form does not allow for a separate designation for palliative nurses, some nurses in this area were included in the medical-surgical sample. Therefore, this sample size helped ensure that an adequate number of appropriate respondents was attained following the exclusion of respondents who did not meet the inclusion criteria as identified on the subject information sheet. A sample of this size also helped ensure that a wide variety of views was obtained from the sample and therefore reflected a more representative sample of the population under study.

#### Human Rights and Ethical Considerations

The study was approved by the the University of British Columbia Behavioural Sciences Screening Committee for Research and Other Studies Involving Human Subjects and the R.N.A.B.C.. The letter/consent form clearly stated that participation was voluntary and the completion and return of the questionnaire packet indicated the subjects' consent to participate. Information concerning the name of employers was not requested. In addition, respondents were informed of the general purpose for the study and there were no penalties



if the person did not wish to participate. All respondents in the study remained anonymous and all replies were confidential. Further, all results were analyzed and will be presented as group data.

### Data Collection Procedures

Data were collected through a mail survey. Data collection commenced once the research proposal had received approval from the thesis committee, the external reader, the University of British Columbia Behavioural Sciences Screening Committee for Research and Other Studies Involving Human Subjects, and the R.N.A.B.C..

The R.N.A.B.C. was requested to generate a random list of 400 subjects who met the inclusion criteria. This allowed for a return rate of approximately 50% which is reasonable for a mail survey (Woods & Catanzaro, 1988). Four hundred questionnaire packets were delivered to the R.N.A.B.C.. Each packet was coded by myself and contained 1) the questionnaire packet which included a) the Questionnaire for Understanding the Dying Person and his Family (Appendix A), and b) a Subject Information Form (see Appendix B), 2) a covering letter (see Appendix C) and 3) a self-addressed stamped return envelope and . An address label was affixed to each packet and the packets were then mailed by the R.N.A.B.C. which ensured anonymity of the potential subjects. The R.N.A.B.C. retained a second set of identical address labels with the corresponding code numbers. This investigator kept the list of code numbers and as each questionnaire was returned, the corresponding code number was deleted from the number list. After four weeks time, the investigator gave the code numbers of the nonrespondents to the R.N.A.B.C., who in turn mailed the nonrespondents a reminder letter from this investigator.

### Data Collection Instruments

Instrumentation included one scale and one subject information form. The Questionnaire for Understanding the Dying Person and his Family (QUDPF) was used to measure nurses' attitudes towards the care of the dying. (Winget granted permission for the use of this scale.) The Subject Information Form (SIF) was used to elicit demographic information, educational information, and professional and personal death experience.

Questionnaire for Understanding the Dying Person and his Family (QUDPF) (see Appendix A)

The QUDPF assesses attitudes towards the care of the dying in terms of flexibility in interpersonal relations, desire for open communication about critical issues, and "psychological mindedness" in relation to patients and families of dying patients. The scale consists of 50 items. The authors classify 17 of these items as fillers. The remaining 33 items are scored on a 5 point Likert scale from strongly agree to strongly disagree. Both positively and negatively worded items are used to minimize the halo effect. Positively worded items are scored from 1 (strongly agree) to 5 (strongly disagree); negatively worded items are scored in reverse. The items are summed to yield a total score ranging from 33 to 165. Low scores indicate a positive attitude (reflecting openness and flexibility) whereas high scores reflect a more negative attitude (reflecting rigidity and lack of insight).

Construct validity is evident in this scale. The instrument was shown to discriminate between senior nursing students who had educational and clinical experience in death and dying and freshman nursing students who lacked this exposure. Discriminant validity, therefore, was demonstrated (Yeaworth, Kapp & Winget, 1974). Construct validity was also assessed by comparing the scores obtained on the QUDPF with those scores from the Rotter I-E Scale and the

Defense Mechanisms Inventory (Winget, et. al., 1974). "Those expressing greater affect on the DMI and those who had scores toward the internal control pole on the I-E Scale also had low scores on the death and dying questionnaire" (p.55). Degner and Gow (1988) reported a 0.41 correlation with the Collett-Lester subscale of Dying of Others. In terms of reliability, internal consistency is evidenced by a coefficient alpha of 0.72 (Winget, Yeaworth, Rosalie & Kapp, 1974) and Degner & Gow (1988) reported an alpha coefficient of 0.82. For this study, the Cronbach alpha reliability coefficient for the scale was 0.70.

Although no alteration of the scale was planned, the item to total coefficients did not warrant the removal of any items.

#### Subject Information Form (see Appendix B)

The SIF is composed of three parts: demographic, education, and experience. Part I requests information from respondents regarding their gender, marital status, and age.

Part II requests information related to respondents' basic nursing education and subsequent death education. The first two items ask the respondents their level of formal nursing preparation (diploma or baccalaureate) and whether this included a course specific to death and dying (yes or no). Four items address the subjects' death education since completion of their basic nursing education. For example, "Have you taken a course specific to death and dying since your nursing education?" (yes or no).

A summated score was generated for education yielding a range of scores from zero (0), indicating the least amount of death education, to a score of 7 indicating the greater degree of death education. Each of the items, together with how they were scored is presented in Appendix D.

Part III deals with the respondents' professional and personal death experiences. The first seven items request information regarding professional

experience. For example, "What type of unit are you working on?" (Respondents check the appropriate area, "palliative", "general surgery", "general medicine"). The remaining eight items request more personal information from the respondents. For example, "Has anyone in your immediate family died?" (Respondents answers "yes" or "no" and then check the appropriate relationship--"father", "sister" et cetera). A summated score was generated for death experience. High scores indicate a greater amount of personal and professional death experience than low scores. Each of the items, together with how they were scored, is presented in Appendix D

### Data Analysis

Data were analyzed using frequency and distribution statistics, descriptive statistics, and inferential statistics. Frequency and distribution statistics were used to describe the sample's demographic characteristics, education, and experience. Descriptive statistics were used to address the first research question "What are the attitudes of general medical-surgical nurses towards the care of the dying?". Measures of central tendency and variability were also generated.

The Pearson product moment correlation coefficient was used to address the second and third research questions: "What is the relationship between education and general medical-surgical nurses' attitudes towards the care of the dying?" and, "What is the relationship between experience and general medical-surgical nurses' attitudes towards the care of the dying?". The use of the Pearson correlation coefficient was appropriate for this study because it tests the degree and direction of the association between each of the independent variables and the dependent variable.

Inferential testing was selected because the sample was randomly selected, data were at either interval or ordinal level, and the population was expected to be normally distributed. Although it is often assumed that all data must be at interval level, valid results may also be attained with ordinal data (Munro, Visintainer & Page, 1986). The relationship between the two independent variables and the dependent variable of this study was not known by this investigator, or, if a relationship did exist, in what direction it would be. Therefore, a two tailed level of significance was used and the alpha level was set at 0.05. Data obtained from the questionnaire and the information form were coded and analyzed using the SPSS-X computer program.

## CHAPTER FOUR

### PRESENTATION AND DISCUSSION OF RESULTS

This chapter is divided into three sections. Reported in the first section are the nature and degree of the sample response, the demographic characteristics, the amount and type of death and dying education, and the amount and type of death and dying experience. The findings related to each of the three research questions and the auxillary findings are presented in section two. In section three a discussion of the findings is presented.

#### Sample Characteristics

##### Sample Response

Of the 400 questionnaires mailed, 10 were returned undelivered and 241 were returned completed (60%). One of the returned questionnaires had considerable missing data and was therefore excluded from the analysis. On reviewing the demographic information, a further 44 were excluded because the respondents did not meet the criteria of working full or part-time in an adult medical or surgical area. For example, six were day care nurses, four were pediatric nurses, three were palliative care nurses, two were home care nurses, and two were unemployed or retired nurses. Respondents working in areas such as rehabilitation, oncology, plastic surgery, gynecology, and hemodialysis were included because these areas possess a predominantly medical-surgical focus. Also included were those respondents working in small rural hospitals and those working part-time as medical-surgical float nurses. The final number of usable questionnaires was therefore 197.

### Sample Demographics

The sample is discussed in terms of age, gender, marital status, religion, highest level of education obtained, and general work experience. The majority of respondents were female (96%), married (66.5%), between 26 to 45 years of age (64.8%), and nearly half (44.2%) were Protestant (see Tables I, II, and III). By far the majority (91.4%) of respondents were prepared at the diploma level (see Table IV). The mean length of time worked as a registered nurse was 8.5 years (range 0 to 15 years) yet a bimodal distribution of scores was evident (see Table V). The average length of time worked on a general medical-surgical unit was 7 years (range 0 to 15 years) (see Table VI).

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Table I: Nurses' Marital Status

Marital Status	Frequency	Percent
Married/Partnered	131	66.5
Single	39	19.8
Divorced	18	9.1
Widowed	7	3.6
Did not answer	2	1.0
Total	197	100.0

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### Respondents' Education Regarding Death and Dying

Education regarding death and dying is discussed in terms of whether respondents had death and dying content in their basic nursing education; whether they had attended courses, seminars, workshops, and/or conferences on death and dying as a graduate nurse; and whether they read literature pertaining to death and dying. Data revealed that nearly three-fifths (59.9%) of

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Table II: Nurses' Age Distribution

Age	Frequency	Percent
20-25	24	12.2
26-30	30	15.3
31-35	39	19.9
36-40	31	15.8
41-45	27	13.8
46-50	23	11.7
51-55	13	6.6
56-60	6	3.1
over 60	3	1.5
Did not indicate	1	0.5
Total	197	100.0

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Table III: Nurses' Religious Affiliation

Religion	Frequency	Percent
Protestant	87	44.2
Catholic	51	25.9
Other religions	19	9.6
No religious affiliation	38	19.3
Did not answer	2	1.0
Total	197	100.0

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Table IV: Nurses' Educational Preparation

Education	Frequency	Percent
Diploma	180	91.4
Baccalaureate	13	6.6
Masters	3	1.5
Did not answer	1	0.5
Total	197	100.0

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Table V: Number of Years Worked as a Registered Nurse

Years Worked (mean = 8.5)	Frequency	Percent
0-2	43	21.8
3-5	36	18.3
6-8	17	8.6
9-11	23	11.7
12-14	29	14.7
over 15	48	24.4
Did not indicate	1	0.5
Total	197	100.0

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 Table VI: Number of Years Worked on General Medical-Surgical Units

Years (mean = 7)	Frequency	Percent
0-2	45	22.8
3-5	42	21.3
6-8	21	10.7
9-11	28	14.2
12-14	23	11.7
over 15	37	18.8
Did not indicate	1	0.5
Total	197	100.0

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respondents had received structured content specific to death and dying in their basic nursing education whereas the others (39.6%) had received no such content. Since graduating from their basic nursing program, 44.7% of respondents had attended workshops, seminars, conferences, and/or courses specific to death and dying (see Table VII). Approximately one-half (51.8%) of

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 Table VII: Nurses' Death Education Since Basic Nursing Education

Type of Education	Frequency	Percent
Workshops	34	17.3
Seminars	24	12.2
Conferences	17	8.6
Courses	12	6.1
Did not answer	1	0.5
Total	88	44.7

\*Note: It is possible that a respondent could be represented in more than one category.  
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the sample had not read any literature pertaining to death and dying in the preceeding six month period. However, during the same period, 35.5% of the sample had read one to three articles or books on death and dying, and 12.7% of the respondents had read four or more articles or books.

### Respondents' Professional and Personal Death and Dying Experience

Professional death and dying experience is presented as it relates to respondents' prior work experience in palliative care units and their experience with unit based patient deaths. Personal death and dying experience is discussed in terms of the respondents' talking with others about death and dying, talking with someone who is dying, being with someone at or near the time of their death, attending funerals, conducting condolence calls, and experiencing the death of a family member and/or friend. Findings show that respondents' professional and personal experience with death and dying varied.

Professional death experience. Nearly one-quarter (22%) of respondents had previously worked on a palliative unit. The size of the medical-surgical units where the subjects currently worked ranged from 1 to 60 beds (mean = 29). An average of 2.6 patient deaths occurred every month on these units (range = 0 to 13) (see Table VIII). Three respondents indicated that they did not know the number of patients who had died; three felt that this item was not applicable where they worked; and one respondent did not answer the question. It is reasonable to expect that this item would not apply to medical-surgical float nurses included in the sample because they were not affiliated with one specific unit and therefore could not answer questions pertaining to unit characteristics.

On average, 67% of patients died from or as a result of, a terminal illness, rather than an acute illness. Well over half (60.4%) of the respondents expected all patient deaths whereas a minority of respondents (16.8%) found the deaths relatively or totally unexpected (see Table IX).

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 Table VIII: Patient Deaths per Month on Medical-Surgical Units

Number of Deaths (mean = 2.6)	Frequency	Percent
Zero (0)	32	16.2
1-3	112	56.9
4-6	33	16.8
7-9	9	4.6
10-12	3	1.5
13	1	0.5
Did not know	3	1.5
Not applicable	3	1.5
Did not answer	1	0.5
Total	197	100.0

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 Table IX: Percentage of Deaths Which Were Expected During Final Hospital Admission

Percent Expected	Frequency	Percent
0 (zero) to 25	33	16.8
26 to 50	14	7.1
51 to 75	13	6.6
76 to 100	119	60.4
Did not know	6	3.1
Not applicable	4	2.0
Did not answer	8	4.1
Total	197	100.0

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Personal death experience. Respondents were asked to indicate if they had been with a person at or near the time of death, if they had been asked to discuss death related issues with patients, and if they had discussed their

attitudes toward death with others. A vast majority of respondents (95.9%) had been with a dying person at or near the time of the person's death and a significant percentage (68.5%) of respondents had been asked to talk with a person who was dying about death related issues. In addition, respondents had discussed their attitudes towards death and dying with colleagues (95%), friends (88%), and/or family (84%).

The majority of respondents (86.8%) had experienced the death of one or more immediate family members (see Table X), yet the death of a friend was less common (see Table XI). Eighty-six percent of respondents indicated that

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Table X: Family Death Experience

Deceased Family Member	Mean Age of Sample at time of Death	Percent
Grandparent	20.7	66.6
Father	29.3	36.5
Mother	32.5	19.8
Sister	23.3	5.6
Brother	38.1	4.6
Spouse/Partner	47.5	2.5
Child	43.0	3.0

\*Note: It is possible that a respondent could be represented in more than one category.  
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they usually attended the funerals of relatives, friends, and close colleagues and 69% reported that they had made condolence visits to the families of the deceased person.

Of the 197 in the sample, 46.2% had not made a will for themselves whereas 52.3% had. Three subjects did not answer the question. Slightly over

half (55.8%) of the subjects believed in life after death, 33% were undecided, 9.6% had no such belief, and 0.5% did not answer the question.

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Table XI: Friend Death Experience

Cause of Friend's Death	Frequency	Percent
Accident	71	36.7
Old Age	59	29.9
Chronic Illness	55	27.9
Acute Illness	52	26.4
Suicide	24	12.2

\*Note: It is possible that a respondent could be represented in more than one category.  
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### Findings Related to Research Questions

Results pertaining to the first question reveal the respondents' attitudes toward the care of the dying. Results pertaining to the second question describe the nature and direction of the relationship between death education and attitudes towards the care of the dying. The third set of results describes the nature and direction of the relationship between death experience and attitudes towards the care of the dying.

#### Research Question 1: Attitudes Towards the Care of the Dying

Data regarding respondents' attitudes toward the care of the dying are presented using the summated score for 33 items of the 'Questionnaire for Understanding the Dying Person and His Family' (see Table XII). Lower scores indicate a more positive attitude whereas high scores reflect a more negative attitude. Scores reveal a normal distribution with a mean of 70.1, a range of

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Table XII: Attitude Towards the Care of the Dying

Score	Frequency	Percent
33-42	0	0.0
43-52	5	3.0
53-62	30	15.2
63-72	96	48.8
73-82	51	25.9
83-92	16	8.1
93-102	1	0.5
103-165	0	0.0
Total	197	100.0

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43 to 95, and a standard deviation of 8.6. In order to retain respondents who did not answer one or two items, the missing items were replaced with the median for that item since it is unlikely that the median would skew the results (Tabachnick & Fidell, 1983).

Research Question 2. Relationship of Death Education to Attitudes Towards the Care of the Dying

Summated education scores are presented in Table XIII. These education scores comprise scores on the following items: whether respondents had death and dying content in their basic nursing education; whether they had attended courses, seminars, workshops, and/or conferences on death and dying as a graduate nurse; and whether they read literature pertaining to death and dying. The greater the exposure to death and dying education the higher the summated score (range- 0 to 7). Scores ranged from zero to six with a mean of 1.7 (S.D. -1.1).

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Table XIII: Death and Dying Education

Score	Frequency	Percent
none	28	14.2
1	67	34.0
2	61	31.0
3	28	14.2
4	10	15.1
5	0	0.0
6	2	1.0
7	0	0.0
Did not answer	1	0.5
Total	197	100.0

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Using Pearson product moment correlation, the degree and nature of the relationship between subjects' death education correlated negatively ( $r = -0.26$ ,  $p = 0.00$ ) with attitudes towards the care of the dying. The more death and dying education that nurses had, the more positive their attitude towards the care of the dying.

Research Question 3. Relationship of Death Experience to Attitudes Towards the Care of the Dying

Summated scores for death experience incorporate item scores pertaining to both personal and professional death experience. These items relate to respondents' prior work experience in palliative care units, their experience with unit based patient deaths, their talking with others about death and dying, their talking with someone who is dying, their being with someone at or near the time of their death, their attending funerals and conducting condolence calls, and their experience with the death of a family member and/or friend. Higher scores indicate greater amounts of death experience. Results reveal a relatively



normal distribution with a range from 4 to 26 (mean = 12.2, S.D. = 3.9) (see Table XIV).

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Table XIV: Personal and Professional Death Experience

Score Ranges	Frequency	Percent
0 to 3	0	0.0
4 to 7	21	10.7
8 to 11	62	31.5
12 to 15	69	35.0
16 to 19	23	11.7
20 to 23	6	3.0
24 to 27	3	1.5
Did not answer	13	6.6
Total	197	100.0

Note. The minimum score obtainable is zero. The maximum score is subject determined.

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Pearson product moment correlations indicated that death experience was related to attitudes towards the care of the dying ( $r = 0.24$ ,  $p = 0.001$ ). Although this correlation is small it does suggest that subjects with more death experience had more favorable attitudes towards the care of the dying than did those with less death experience.

#### Auxillary Findings

In reviewing the foregoing findings, a number of additional areas of exploration were deemed worthwhile. First, results indicated that respondents' attitudes towards the care of the dying were more positive for those with increased death experience. This raised a further question about the difference

in attitude among those with low, medium, and high levels of death experience. Therefore, the sample was divided into three groups based upon their level of death experience. Those respondents with scores of less than or equal to ten ( $n = 69$ ) were considered to have a small amount of death experience; those with scores ranging from 11 to 17 ( $n = 99$ ) were considered to have a moderate amount of death experience; and those with scores above 18 ( $n = 16$ ) were considered to have a substantial amount of death experience. Using analysis of variance (ANOVA) there was a significant difference ( $F = 42, p = 0.02$ ) in attitude based on level of death experience. Post hoc analysis using the Scheffe test (appropriate for different size groups) showed a significant difference in attitudes towards the care of the dying between the groups with lowest (mean = 71.1) and highest (mean = 64.7) levels of death experience. There were no differences in attitude between the middle group and the other two groups. Therefore, a considerable amount of death experience is related to positive attitudes toward the care of the dying.

Second, other areas explored related to differences in attitudes based on the respondents' general nursing experience, their level of general nursing education, and their age. Although ANOVA revealed a significant difference in respondents' attitudes toward the care of the dying based on the number of years they worked as a registered nurse ( $F = 2.9, p = 0.01$ ), no differences were found in the post hoc analysis between the groups. The additional analysis using ANOVA indicated that neither levels of general nursing education ( $F = 1.3, p = 0.58$ ) nor age ( $F = 1.8, p = 0.08$ ) were related to attitude towards the care of the dying.

Third, responses to individual items on the QUDPF revealed interesting data. Nearly three quarters (73.1%) of respondents felt that nurses and doctors do not communicate easily with each other on issues relating to the needs of the

dying patient. A seemingly contradictory finding was that 77.7% of nurses felt at ease talking with physicians about dying patients. Half the respondents (46.7%) believed that medical personnel tended to decrease the number of visits to the terminally ill and the same percentage of respondents agreed that terminally ill patients are "skipped" on teaching rounds. Further, half the respondents (51.3%) did not believe that nurses should be the primary professionals prepared to deal with the emotional reactions of dying patients even though 72.1% believed that patients turn to both nurses and doctors to discuss their feelings about dying.

### Discussion of Results

Findings will be discussed under the following four headings: sample characteristics, attitudes towards the care of the dying, relationship of death education to attitudes towards the care of the dying, and relationship of death experience to attitudes towards the care of the dying. A summary will conclude this chapter.

#### Sample Characteristics

The sample in this study is representative of the target population (see Table XV). At the time of this study, the size of the target population of practicing registered nurses living in British Columbia, employed in nursing on a full or part time basis in acute care hospitals in medical or surgical areas, and working at the general staff level was 5,635 people. The random sample of 400 nurses who were mailed a questionnaire represented 7.1% of the target population (C. Kermacks, Director of Regulatory Services at R.N.A.B.C., personal communication, November 6, 1990). The response rate of 60% (N = 241) was reasonably good and within the expected range for mail surveys (Woods & Catanzaro, 1988). Respondents therefore represented 4% of the target

population. The sample is similar to the population of British Columbia registered nurses in age, gender, marital status and education characteristics (Statistics Canada, 1989) (see Table XV).

Table XV: Comparison of Sample and Population Characteristics

Characteristics	Sample	Population
Age range	20 to over 60 years	20 to over 55 years
Age majority	26 to 45 years (64.4%)	26 to 45 years (60.7%)
Gender:		
Female	(97.0%)	(97.7%)
Male	(3.0%)	(2.3%)
Marital Status:		
Married	(66.5%)	(67.7%)
Single	(19.8%)	(21.0%)
Nursing Education:		
Diploma	(91.4%)	(84.6%)
Baccalaureate	(6.6%)	(14.2%)
Masters or higher	(1.5%)	(1.2%)

#### Attitudes Towards the Care of the Dying

Similarities and differences in attitudes towards the care of the dying were found between this investigator's findings and those of other researchers who used the same measurement tool. The mean, and the distribution of scores, for this sample were similar to Canadian (Degner and Gow, 1988) and American (Yeaworth, Kapp and Winget, 1974) senior university nursing students who had completed death education programs; this sample differed from students who did not have exposure to such programs. The difference between this sample and the students without the death education was not surprising because those students' attitudes would likely reflect those of the greater society since they,

compared to registered nurses, would have less exposure to death and dying literature and less experience in the area.

However, the fact that the nurses' scores were similar to senior nursing students' scores was somewhat puzzling. If death education and experience affect changes in attitudes, then as nurses' gain more death experience and death education, their scores should reflect more positive attitudes than senior nursing students' scores. A possible explanation for why this conclusion was not substantiated is that the attitudes acquired by nurses early in their professional experience, perhaps as early as their basic nursing education, remain relatively stable throughout their career (Golub & Reznikoff, 1971). Alternatively, perhaps further death education and experience do continue to influence nurses' attitudes but are offset by factors such as nurses' workload and employer expectations.

Neither Degner and Gow (1988) nor Yeaworth, Kapp and Winget (1974) describe the attitudes of their samples towards the care of the dying. When using a scale, such as the QUDPF, it is crucial that the scores be interpreted and examined. The following is an interpretation and examination of the QUDPF scores for this study.

Attitudes towards the care of the dying can be viewed on a continuum with positive attitudes and negative attitudes on opposite ends (see Figure 2). At the extreme left are positive attitudes which reflect a flexibility in interpersonal relations, a desire for open communication around critical issues, and a psychological mindedness in relation to dying patients and their families. At the extreme right are negative attitudes which reflect a rigidity in interpersonal relations, a focus on physical needs during terminal illness, and a lack of insight into psychological factors influencing self and others (Yeaworth, Kapp & Winget, 1974).

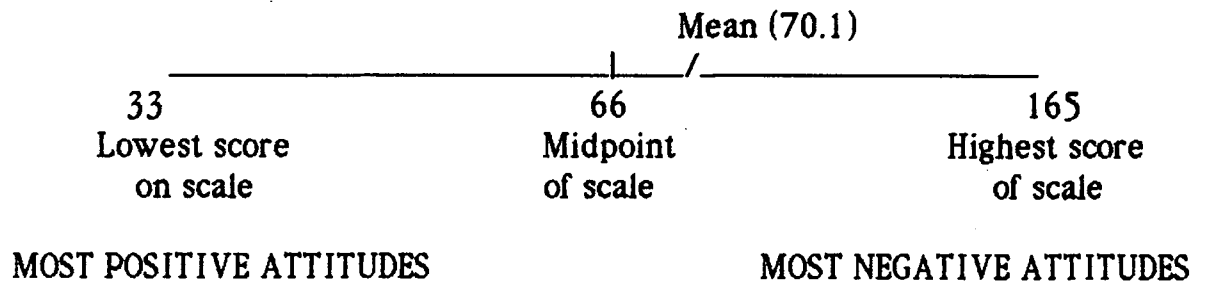


Figure 2. Continuum of the response range on the QUDPF.

This study, which used the QUDPF scale to measure attitudes towards the care of the dying, revealed a normal distribution of attitude scores and a relatively small standard deviation. Scores ranged from 43 to 95 on the scale where the possible range was 33 to 165. The mean response (70.1) of general medical and surgical nurses lay just to the right of the central point (66) on the QUDPF continuum (see Figure 2). Therefore, nurses' attitudes cannot be classified as strongly positive or negative. The mean score in fact reflects a relatively neutral attitude. The prevalence of such an attitude is disturbing for several reasons.

First, nurses with neutral attitudes may fail to identify the supportive, psychological care needs of the dying. The theoretical framework for this study links people's attitude towards an object to the conceptualization of their role and the subsequent behavior exhibited towards that object (Kahn, Wolfe, Quinn, Snoek & Rosenthal, 1964). It follows then, that in order for individuals to act positively or negatively towards a particular object, they must first possess the respective attitude towards that object and believe it is their role to act in a certain manner towards the object in question. If people have a neutral attitude towards an object, it is likely that little attention or investigation will ensue surrounding that object. It is therefore probable, yet a frightening

prospect, that nurses with nonspecific attitudes towards the care of the dying will fail to identify that palliative patients require care which differs from the care required by non-palliative patients.

Mount, Jones, and Patterson (1974) suggest that nurses, in general, may lack insight into the psychological care of the dying. Perhaps nurses with neutral attitudes are unaware of the depth or degree of psychological care required in supportive care and are therefore unlikely to intervene therapeutically in the psychological care of these patients. The lack of insight into the psychological care of the dying may account for the respondents' general reluctance to discuss death with dying patients and their families.

A second reason why neutral attitudes towards the dying are disturbing is that nurses may fail to internalize the components of supportive care within their professional role. It has been established that the supportive care of patients and families through the dying trajectory is primarily a nursing responsibility (Davies & Oberle, 1990; Williams, 1982). However, while three-quarters (72.1%) of the sample believed that patients turned to nurses discuss their feelings about death, well over half (61.9%) of the nurses in the sample were unsure or did not believe that nurses should be the primary health care professionals to intervene therapeutically in the psychological management of the dying. This lack of professional responsibility is distressing and may account, in part, for the neutral attitudes the sample holds towards the dying. Nurses, believing that the psychological care of the dying is not their responsibility, may guard against providing such care and develop neutral attitudes towards this group of patients. Further, nurses in this sample indicated that it was fairly frequent practice for the medical team to decrease their visits with these same patients. If the physicians are exhibiting avoidance behaviors and the nurses do not believe it is their role to address the emotional

needs of the dying, then it is likely that the terminally ill are indeed dying in emotional isolation as suggested by Stoller (1980).

Third, the combination of neutral attitudes towards the care of the dying and corresponding beliefs that the psychological care of patients is not a nursing responsibility, may result in nurses exhibiting *laissez-faire*, non-interfering behaviors when caring for the dying. Research addressing the care of the dying has identified such behaviors in nurses. For example, nurses tend to avoid interaction with dying patients and tend to negate the psychological care of the dying (Conboy-Hill, 1986; Glaser & Strauss, 1965; Mount, Jones, & Patterson, 1974; Quint, 1966; Shedlesky & Fisher, 1986; Wesney, 1985). Subjective experiences of dying patients and their families expose the effects (feelings of isolation, helplessness, fear, and bitterness) of this failure to identify and attend to the special needs of the dying (Godkin, Krant & Doster, 1983; Kane, Bernstein, Wales & Leibowitz, 1984; Parkes & Parkes, 1984; Vachon, 1977). It is therefore suggested that nurses are maintaining the status quo in the care they provide to the dying by attending to the physical needs of the patients while ignoring the psychological needs.

In summary, attitudes of general medical-surgical nurses towards the care of the dying are remarkably homogeneous and neither strongly positive nor negative, but rather neutral in nature. This investigator believes this neutral attitude results in the nurses' inability to discriminate the supportive needs of the terminally ill from the curative needs of the non terminally ill. Because of this inability to distinguish the needs of terminally ill patients, nurses have failed to internalize the components of supportive care within their professional role. The resulting *laissez-faire* nursing care given to the dying is inappropriate and, in fact, detrimental to the well-being of these patients and families. However, results regarding the positive influence of death education



on medical-surgical nurses' attitudes towards the care of the dying are more promising.

#### Relationship of Death Education to Nurses' Attitudes

Nurses had little exposure to death education during and subsequent to their basic nursing program. This finding may be due to the fact that the primary focus of nursing is not death and dying; therefore the need for further education in that area is not perceived as necessary. However, approximately one-half of the nurses had read material pertaining to death and dying in the preceeding six month period. Considering that these nurses were working in a curative, treatment-oriented setting, the fact that they read these articles illustrates some interest in the care of the dying.

Almost two-thirds of the sample had structured death and dying content in their basic nursing education; none had a specific course on death and dying. Although the amount, type, and quality of this content was not assessed, most respondents indicated that the content centered around the stages of death proposed by Kubler-Ross. It is likely that the nurses responded affirmatively to the question of death education content in their basic program regardless of the amount or quality of that death education. Therefore, nurses with less exposure to death and dying content were not differentiated from those who had more exposure. The finding that one-third of the sample had no death content in their basic program is disturbing. Perhaps the integration of such content was done to the point that the topic of death was emmeshed in other content and therefore students did not identify the content as death and dying per se. Further, prior to Kubler-Ross's work (1964), most nursing programs focused on the post mortem care of patients rather than the care of the patient prior to death. If specific content on the care of the dying was taught, the recall of such material may have been hindered by time for the 26% of the sample who

graduated before 1970 and even more so for the 9% who graduated before 1960.

Since graduation, only one-third of the nurses had exposure to semi-structured education programs regarding death and dying through attendance at courses, seminars, workshops, or conferences. Attendance at workshops and seminars was the most frequently cited by the 63 nurses who did attend educational programs. Perhaps this is a function of time and money since seminars and workshops, as opposed to conferences and courses, are often part of, and paid for by, hospital inservice programs.

It is alarming, although not totally unexpected, that the majority of nurses in this study had little overall death and dying education. The respondents' lack of death education partly accounts for their neutral attitudes. Nurses with considerable death education tended to have more positive attitudes towards the dying. Alternatively, nurses with little death education tended to have more negative attitudes. Reisetter & Thomas (1986), using a similar method to quantify death education, found similar results: approximately 80% of their sample had relatively low amounts of death education and only 6% had considerable education on death and dying. Other descriptive studies have shown a positive relationship between death education and the attitude of nurses towards the dying (Coolbeth & Sullivan, 1984; Lester, Getty & Kneisl, 1974; Reisetter & Thomas, 1986; Yeaworth, Kapp & Winget, 1974). Experimental studies have illustrated that death education does indeed enhance nurses' attitudes towards death and the care of the dying (Degner & Gow, 1988b; Hurtig & Stewin, 1990; Laube, 1977; Miles, 1980; Murphy, 1986). Further, attitudinal theorists suggest that attitudes can be altered, as well as positively influenced, by providing more knowledge about the object or person which is the focus of the attitude (Wagner, 1969). Therefore, educating nurses

about the needs of palliative patients and the components of supportive care will likely positively influence their attitudes towards the care of these patients.

Relationships between level of formal nursing education and attitudes towards the dying patient indicated that diploma, baccalaureate, and masters prepared nurses had similar attitudes towards the care of the dying. Similar findings were reported by Reisetter and Thomas (1986). This lack of distinction may, in part, be explained by the extremely uneven group sizes. There were few nurses in the sample who were masters prepared (3) and baccalaureate prepared (13) compared to the 180 diploma prepared nurses. Results do suggest, however, that attitudes towards the care of the dying are more sensitive to death related education as opposed to general nursing education.

The theoretical framework for this study implies a positive relationship between death education and attitudes towards death. By virtue of the interactive nature of this model, personal factors, such as educational experience and personal attitude, interact and influence each other. Education influences attitudes and, conversely, attitudes influence education. Therefore, a sample, such as this one, that exhibits low levels of death education would be unlikely to demonstrate positive attitudes towards the dying.

In summary, medical-surgical nurses, in general, have little death education. The positive association found between attitude toward the care of the dying and amount of death education was neither unexpected nor unexplainable. Findings concurred with previous research in this area and can be explained from a theoretical perspective. Level of general nursing education was not associated with attitudes towards the dying. Since death education and attitudes towards the dying are positively related, the lack of death education most likely reinforces the neutral attitudes these nurses possess towards the

care of the dying. Therefore, death education opportunities must be made available to nurses so that the attitudes towards the dying will improve.

### Relationship of Death Experience to Nurses' Attitudes

Generally, the nurses had little experience with death, although the majority of the sample indicated personal and professional death experiences. Professional death experiences. Few nurses had palliative care experience per se, yet the majority experienced one or more deaths on their unit per month. A substantial number of those patients who died were considered to have a terminal illness and their deaths were generally expected. These findings concur with the statement that a significant number of the terminally ill are being cared for in acute care hospitals up until the time of their death (Degner & Gow, 1988a; Holing, 1986; Shedletsky & Fisher, 1986). In addition, the overwhelming majority (87%) of the sample had been with a dying person at or near the time of their death and a considerable number (69%) had been asked to talk with a dying person about death-related issues.

Personal death experience. In addition to professional death experience, the majority of respondents also had personal death experiences. This finding concurs with similar reports from other samples (Laube, 1977; Reisetter & Thomas, 1986; Yeaworth, Kapp & Winget, 1974, ). The majority (87.2%) of this sample had experienced the death of at least one family member and frequently attended funerals of loved ones. Even with this extensive personal experience, the majority (96%) of the nurses did not have particularly positive attitudes towards the dying. This finding does not support previous research which reported that nurses with personal death experiences tend to discuss death and dying issues with their patients, maintain continuity of care, and take greater responsibility for meeting the families' needs (Reisetter & Thomas, 1986). Personal experience may be an influencing factor on nurses' attitudes;

perhaps it must be combined with professional experience in order to significantly influence nurses' attitudes.

Overall death experience. No association was found between years of nursing experience and nurses' attitudes towards the dying. However, a positive correlation between nurses' death experience and their attitudes towards the care of the dying was demonstrated. Generally, the more experience with death, the more positive the attitudes towards the dying. Similar relationships have been reported by Denton & Weisenbaker (1977), Reisetter & Thomas (1986), and Shusterman & Sechrest (1973). As stated earlier, nurses in the current study had neutral attitudes towards the care of the dying. Moreover, most (77.2%) of the nurses had either low or medium levels of general death experience. Because experience and attitudes are positively correlated, it is not surprising that the attitudes of this sample towards the care of the dying were found to be neutral. Further, it is assumed that attitudes influence behaviors. Therefore, nurses with little death experience and neutral attitudes will likely provide inadequate care to the dying.

Experience is the basis of knowledge since people must be aware of or exposed to something, before they can begin to learn about that something (Meleis, 1985). It stands to reason then that the more experience people have with an object, the more specialized knowledge they develop concerning that object. Perhaps this reasoning accounts for the findings that nurses' general work experience and general nursing education did not significantly correlate with their attitudes towards the dying. Therefore, to increase nurses' knowledge concerning the dying, it may be that educational and work experiences must be specific to death and dying.

In summary, the majority of nurses in this sample had professional and personal death experience yet the overall general death experience for these

nurses was low to medium. A positive correlation between nurses' death experience and their attitudes towards the care of the dying was demonstrated, illustrating that nurses' attitudes towards the care of the dying are generally more positive with increased amounts of death experience.

### Summary of Results and Discussion

A survey pertaining to experience with, and attitudes towards, the care of the dying was mailed to 400 medical-surgical nurses and yielded a 60% response rate ( $n = 197$ ). Respondents were, for the most part, married, Protestant, females between the ages of 26 and 45 years. The majority of respondents were prepared at the diploma level and had worked in the nursing profession for an average of 8.5 years.

Nearly two-thirds of the nurses had received structured content specific to death and dying in their basic nursing education. However, less than half of the respondents had additional death-related education since graduating from their nursing program. The majority of respondents had worked with the terminally ill and had personal death experiences, such as the death of a family member.

The first research question concerning nurses' attitudes towards the care of the dying was addressed using respondents' scores on the QUDPF; high scores reflected negative attitudes and low scores indicated positive attitudes. The scores obtained revealed a normal distribution with a mean of 70.1 (midpoint - 66), a range of 43 to 95 (possible range = 33 to 165). Respondents' attitudes towards the care of the dying, therefore, were characterized as neutral. The second and third research questions examined the association between attitudes towards the care of the dying and death education and death experience respectively.

An overall death education score was calculated for each person based on their responses to specific death education related items on the Subject Information Form. The higher a respondent's score, the greater the amount of death education. The sample's death education scores indicated a positively skewed distribution with a mean of 1.7 (midpoint = 3), a range of zero to 6 (possible range = 0 to 7), and a standard deviation of 1.1. Levels of death education related negatively with attitudes towards the care of the dying ( $r = -0.26$ ).

The summated score for death experience included item scores pertaining to both personal and professional death experience. Higher scores indicated a greater amount of death experience than lower scores. The death experience scores were relatively normally distributed with a range of 4 to 26 (possible range = 0 to 26), a mean of 12.2 (midpoint = 13), and a standard deviation of 3.9. A negative correlation ( $r = -0.24$ ) between nurses' attitudes and their overall death experience was determined by a Pearson product moment correlation.

Auxillary findings illuminated a number of the aforementioned findings. Results indicated that nurses' attitudes were more positive with increased death experience. Respondents were then divided into groups of low, medium, and high death experience and ANOVA revealed there was a significant difference in attitude based on level of death experience. A subsequent Scheffe test showed respondents with considerable death experience as possessing more positive attitude than those with low levels of death experience. No significant difference in nurses attitudes towards the dying based on general nursing experience was found. A tendency, however, towards more positive attitudes with more general nursing experience was noted. Additional results did not reveal significant differences in nurses' attitudes based on either level of

nursing education or age. Results pertaining to individual items on the QUDPF were disturbing. Almost three quarters of the sample felt that patients frequently wish to discuss death and dying issues with nurses and physicians. Half the respondents, however, did not believe it was their responsibility to discuss such issues with patients. Further, the sample indicated that medical staff tended to avoid dying patients. It appears quite evident, then, that the two professional groups most frequently consulted on emotional issues by the dying are unwilling to discuss such issues with these patients.

Findings related to the sample characteristics, the attitudes towards the care of the dying, the relationship of death education to attitudes towards the care of the dying, and the relationship of death experience to attitudes towards the care of the dying were discussed in section three of this chapter. The sample was shown to be representative of the target population on the basis of age, gender, marital status, and education. Study results therefore are generalizable to the target population of practicing registered nurses living in British Columbia, employed in nursing on a full or part time basis in acute care hospitals in medical or surgical areas, and working at the general staff level.

Findings related to the nurses' attitudes towards the care of the dying were distressing. Nurses' attitudes towards the dying were generally neutral in nature with a slight tendency towards more negative attitudes. These neutral attitudes, in conjunction with the lack of professional responsibility in providing psychological care to the dying, implies that nurses are failing to distinguish the needs of the dying from the needs of other patients. It was argued that this lack of distinction results in nurses providing inadequate psychological care to the dying and their families. Ultimately, the dying and their families are emotionally isolated from the very people responsible for the provision of supportive care.



Nurses' attitudes towards the care of the dying were positively related to death education. Generally, medical-surgical nurses had a low level of death education, partly accounting for their neutral attitudes. Exposure to death education was shown to be lower once the nurses graduated from their basic nursing programs. It was suggested that medical-surgical nurses, whose main focus is not death and dying, do not perceive the need for further education in this area. However, the fact that these same nurses are frequently caring for dying patients and are neglecting the psychological care of these patients demonstrates a need for further death education.

Nurses' attitudes towards the care of the dying were also positively related to death experience. Although the majority of respondents had professional and personal death experience, their overall death experience was moderate at best. Perhaps the amount of death experience is less influential on nurses' attitudes than the nature of that experience, or, moderate amounts of death experience are not sufficient to develop more positive attitudes and therefore the attitudes remain neutral.

In summary, the sample in this study was representative of the target population. The majority of respondents possessed neutral attitudes towards the care of the dying. Since attitudes are related to behaviors, it is unlikely that nurses with these neutral attitudes are providing excellent psychological care to this group of patients.

## CHAPTER FIVE

### SUMMARY, CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

This study was designed to describe the attitudes of general staff nurses working on medical-surgical units in hospitals towards the care of the dying. Additionally, relationships between education and/or experience and general medical-surgical nurses' attitudes towards the care of the dying were explored. An overview of the study is presented in this chapter, followed by conclusions, implications for nursing theory, practice, and education, and recommendations for further research.

#### Summary

The summary section includes a synopsis of the background to the study, the guiding theoretical framework, the literature reviewed, and concludes with a summary of the actual study. This study was based upon the premise that a large percentage of people with chronic life-threatening illnesses, such as cancer, die in acute care settings where the focus of care is primarily curative. However, this curative philosophy is inappropriate for the care of these people during the final stage life. Supportive care, focusing on symptom management and support of dying patients and their families, is generally considered the more appropriate care philosophy. Nurses have a professional responsibility to provide such care. However, the literature reviewed illustrates that nurses, in general, are not comfortable with the supportive role and tend to adhere to the curative role when caring for the dying. It was proposed that this curative nursing care philosophy, prevalent on medical-surgical units, contributes to the isolating and inhumane hospital care reported by the dying and their families.

Therefore it was deemed important to examine the attitudes of general medical-surgical nurses to the care of the dying and to explore the influencing nature of experience and education upon these attitudes.

An adaptation of the model for role episode, conflict, and ambiguity (Kahn, Wolfe, Quinn, Snoek and Rosenthal, 1964) was the theoretical framework chosen for this study. This theoretical model identified personal factors as critical to both the conceptualization of one's role and the subsequent role behavior. Personal factors included the nurse's attitude towards the care of the dying, past experience caring for the dying, and education pertaining to death and dying. The role behavior was defined as the nursing care given to dying patients and their families.

Following a review of the literature, attitude was defined as the complex, structured psychological tendency to respond in a consistent way to social objects or situations (Yeaworth, Kapp, & Winget, 1974). Further, evidence indicated that a positive correlation likely exists between attitudes and behavior (Insko, 1967; Kahle, 1984). Therefore, nurses with a positive attitude towards death are likely to provide care to the dying which reflects this positive attitude. However, literature was consistent in describing nurses' attitudes towards death and the care of the dying as negative. These negative attitudes are thought to contribute to the inadequate care of the dying and their families (Conboy-Hill, 1986; Glaser & Strauss, 1965; Kubler-Ross, 1969; Mandel, 1981; Mount, 1976; Mount, Jones, & Patterson, 1974; Quint, 1966; Scofield, 1989; Shedletsky & Fisher, 1986; Shneidman, 1980; Stoller, 1980; Wesney, 1985). Thus, patients and their families felt unsupported and isolated during the dying trajectory (Godkin, Krant, & Doster, 1983; Parkes & Parkes, 1984; Vachon, 1977). Additional literature provided evidence that education positively influences nurses attitudes towards the care of the dying (Coolbeth & Sullivan, 1984;

Degner & Gow, 1988b; Murphy, 1986; Reisetter & Thomas, 1986, 1986; Yeaworth, Kapp, & Winget, 1974). However, literature was inconclusive regarding the influencing nature of experience on nurses' attitudes (Alexander, 1990; Denton & Wisenbaker, 1977; Reisetter & Thomas, 1986; Shusterman & Sechrest, 1973; Stoller, 1980). The discrepancies in definitions of attitude in previous research, the inconclusive results, and the lack of literature concerning medical-surgical nurses' attitudes warranted further research. Therefore, this study was designed to describe general medical-surgical nurses' attitudes towards the care of the dying and to ascertain the degree and nature of the relationships of education and experience upon such attitudes.

This descriptive correlational study was conducted using randomly selected registered nurses employed full or part-time on general adult medical-surgical hospital units in British Columbia. With the help of the R.N.A.B.C., 400 questionnaire packets and subsequent reminder letters were mailed while maintaining complete anonymity of the potential and actual respondents. The final sample was comprised of 197 nurses who met the inclusion criteria. Each of the respondents completed the 'Questionnaire for Understanding the Dying Person and His Family' (QUDPF) and the Subject Information Form (SIF). Data were analyzed using frequency, distribution, descriptive, and inferential statistics.

The random sampling process ensured that the sample was representative of the target population. The majority of the sample were married, protestant females, between the ages of 26 and 45 years, who were prepared at the diploma level in nursing. The mean length of time worked as a nurse was 8.5 years with a mean of 7.5 years on medical-surgical units.

Results indicated that attitudes towards the care of the dying were generally ambiguous, neither negative nor positive, best described as neutral.

The scores on the QUDPF illustrated a normal distribution with a mean of 70.1 (scale midpoint = 66), a range of 43 to 95 (scale range 33 to 165), and a standard deviation of 8.6. Similar distributions of attitude scores were found by Degner and Gow (1988b) and Yeaworth, Kapp, and Winget (1974). A particularly disturbing finding was that half the respondents did not believe that nurses should be the primary health care professionals equipped to deal with the emotional reactions of the dying; yet, three-quarters of the sample believed that patients turned to nurses to discuss such emotional issues.

Data revealed that close to two-thirds of the respondents had received structured death and dying content in their basic nursing education; yet, less than half furthered their death and dying education since graduation. A low overall death education of the sample was reflected in the scores which generated a mean of 1.7 (scale midpoint = 3.5), a range of 0 (zero) to 6 (scale range = 0 to 7), and a standard deviation of 1.1. A small positive association was determined between respondents' death education and their attitudes towards the care of the dying; no significant association was found between respondents' level of general nursing education and their attitudes. Therefore, education specific to death and dying, as opposed to general education, did influence nurses' attitudes towards the care of the dying. Previous research findings pertaining to the influencing nature of education on attitudes concur with the results of this study (Coolbeth & Sullivan, 1984; Degner & Gow, 1988b; Murphy, 1986; Reissetter & Thomas, 1986; Yeaworth, Kapp, & Winget, 1974).

Although there was variability in the amount of professional and personal death experience, over half of the respondents experienced between one and three terminally ill patient deaths on their medical-surgical units per month. Additionally, the majority of respondents had experienced the death of an immediate family member. Overall death experience scores revealed a mean

of 12.2 (scale midpoint = 13), a range of 4 to 26 (scale range = 0 to 26), and a standard deviation of 3.9. Results indicated a low to moderate level of death experience for this sample. A small, but significant positive association was found between overall death experience and attitudes towards the care of the dying; no significant association was determined between general experience and attitude. Therefore, as with education, the experience of the respondents needed to be specific to the care of the dying for an association between experience and attitudes to be determined. Previous research in the area of death and dying has shown similar results (Denton & Wisenbaker, 1977; Reisetter & Thomas, 1986; Shusterman & Sechrest, 1973).

The theoretical framework, which indicated a positive association between attitudes and behavior, guided the interpretation of the study results. It was reasoned that respondents' ambiguous attitudes towards the dying would hinder their ability to distinguish the needs of the terminally ill. Further, this investigator proposed that the lack of professional responsibility related to the psychological care of the dying adversely affects the care given to this group of patients. Therefore, the major findings, that the majority of respondents' attitudes to the dying were neutral and that half of the respondents' did not believe it was their responsibility to provide psychological care to the dying, strongly suggest that supportive nursing care is not being demonstrated with such patients and their families. However, the influencing natures of death education and death experience on nurses' attitudes are positive, thereby providing the nursing profession with two avenues by which to influence positively nurses' attitudes to the care of the dying.

### Conclusions

The results of this study should be interpreted with some caution since the sample size of 197 represents only 4% of the population. Further, there may be some bias among those nurses who chose to respond to the questionnaire. Perhaps the responders, as opposed to the nonresponders, were more interested in caring for dying patients or were more frustrated about the care given to the dying. However, the random sampling technique used helped ensure the attainment of a wide variety of views. Therefore, the sample is likely representative of full or part-time registered nurses employed on adult general medical-surgical units in British Columbia. On the basis of this investigator's findings, the following conclusions regarding medical-surgical nurses in British Columbia are made. Almost all medical-surgical nurses experience 1 to 3 patient deaths on their units per month and the majority of these deaths are expected. Most nurses have been with a dying person at or near the time of death and have been asked to talk with the dying person. Although considerable variation exists, most nurses have experienced the death of a family member or friend. Further, the majority of nurses have received structured death and dying education in their basic nursing program. Although a significant number of nurses continue to partake in death educational programs or read articles pertaining to death and dying, there are an equal number of nurses who have not explored any of these educational opportunities since their graduation.

Although many factors contribute to the formulation of attitudes to death and dying, experience and education play a significant role. Greater professional and personal death experience is related to more positive attitudes towards the care of the dying. Although the relationship is not strong, there is a also a relationship between increased death education and attitudes towards the

care of the dying. Therefore, it is likely that nurses with greater death experience and education possess more positive attitudes towards caring for the dying than nurses with less death experience and education.

Generally, medical-surgical nurses in British Columbia have neither predominantly positive nor negative attitudes towards the care of the dying. Rather, such nurses possess an ambiguous or neutral attitude towards caring for terminally ill patients and their families. Since attitudes influence behavior, the nursing care of patients and families throughout the dying trajectory is likely inadequate on medical-surgical units in British Columbia. The most disturbing conclusion from this study is that half the medical-surgical nurses in this province are either unsure or do not believe that it is their responsibility to look after the psychological needs of dying patients.

#### Implications for Nursing Theory, Practice, and Education

This study provided support for Kahn, Wolfe, Quinn, Snoek and Rosenthal's (1964) theory for role episode, conflict, and ambiguity in the following three ways. The interactive nature of the personal factors of attitude, experience, and education was substantiated. Further, this study supported these authors' supposition that a variety of factors influence attitudes. The unexpected finding concerning nurses' role conception provided support for the theoretical link between attitudes and role conception.

Implications for nursing practice and education are clear from the conclusions of this study. First, palliative care services should be supported and expanded in hospitals. It is crucial to form palliative care services if particular hospitals do not have such services in existence. Second, nurses must become aware of their attitudes towards the dying and the possible behavioral manifestation of those attitudes. Third, nurses must become aware of the



provincial professional practice standards (Registered Nurses Association of British Columbia, 1987) and the national code of ethics (Canadian Nurses Association, 1991); both provide guidelines which help ensure appropriate and adequate care for the dying. Nurses must then identify, and strive to diminish, incongruencies between the attitudes they hold and the professional practice standards and the professional code of ethics. Nurses, once aware of their attitudes to the dying, will need support and assistance to understand and enact the concept of supportive care. Educative and experiential learning will assist nurses in formulating attitudes conducive to providing appropriate care to the dying.

The following suggested educational strategies to improve nurses' attitudes to the dying address the cognitive, affective and/or behavioral dimensions of attitude. Hospital orientation programs need to address nursings' responsibilities in the care of terminally ill patients and their families. Seminars and workshops regarding supportive care should be offered to nurses throughout the year. Articles addressing nurses' attitudes to the dying, behavioral manifestations of such attitudes, and components of supportive care should be published in readily accessible nursing journals such as the R.N.A.B.C. News. Further, the palliative care clinical nurse specialist or resource nurse, should frequent medical-surgical units in the hospital and be active in quality assurance programs. By being visible to staff, available for consultation, and acting as a role model, the clinical specialist or resource person can educate nurses in the care of the dying, assist nurses in clarifying their role responsibilities, and assist nurses in developing appropriate intervention strategies when caring for the dying. As stated earlier, if no palliative team exists, one should to be formed. Until such time as a palliative team is operational, nurse managers, instructors, and administrators, in consultation

with a palliative care specialist, must support and educate nurses in the care of the dying.

Student nurses also need assistance and support in the development of attitudes conducive to supportive care of the dying. Nursing schools have a primary responsibility to ensure that graduates meet the professional standards set forth by the R.N.A.B.C. (Registered Nursing Association of British Columbia, 1987). The results of this study suggest that nursing schools may need to revamp existing programs to include additional structured content specific to the care of the dying and family nursing. Further, nurse educators need to consider emphasizing to students, the professional responsibility of providing supportive care to all patients while decreasing the emphasis on curative care. Experiential learning can be enhanced by rotating students through palliative care units or assigning the students terminally ill patients. It is vital that students be given support and guidance during these experiences with the dying. It is also essential that any experiential learning take place at the same time or, preferably, following structured content on death, family nursing and role responsibility.

### Recommendations for Research

Because attitude is a multidimensional concept, it is important to differentiate the affective, cognitive, and behavioral dimensions within a scale measuring attitude. Therefore, a factor analysis of the QUDPF should be done to determine if these dimensions can be identified within subscales. If the affective, cognitive, and behavioral components of attitude towards the care of the dying are identified within subscales, then the specific dimensions can be measured and studied. Alternatively, if the attitude dimensions can not be identified, research exploring the dimensions of attitudes towards the care of

the dying is warranted. Additionally, nursing care of dying patients needs to be explored from the perspectives of terminally ill patients, patient families, and nurses.

Further, research needs to be done to assess the influence of other factors that may contribute to attitudes towards the care of the dying such as organizational, interpersonal, interprofessional, and intraprofessional factors. Additionally, experimental studies are indicated to assess the effect of educational or experiential learning on the attitudes of nurses towards the dying. Observational and descriptive studies should also be conducted to assess the possible relationship between nurses' attitudes and the actual care they provide to the dying. A final recommendation for research is that a replication of this study should be conducted with palliative care nurses in British Columbia to assess their attitudes to the care of the dying and to compare such results with this investigator's findings.

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**Appendix A: Questionnaire for Understanding the Dying Person and His Family**

Questionnaire for Understanding the Dying Person and His Family

Part 1: Using the following code, please circle the response that best matches your actual current attitude for each of the following statements.

CODE: SA = Strongly agree  
A = Agree  
U = Uncertain  
D = Disagree  
SD = Strongly disagree

- |             |   |
|-------------|---|
| SA A U D SD | 1. Regardless of his/her age, disabilities, and personal preference, a person should be kept alive as long as possible.                               |
| SA A U D SD | 2. Dying patients should be told they are dying.  |
| SA A U D SD | 3. Medical personnel find it more satisfying to work with patients who are expected to improve rather than with patients that are likely to die.      |
| SA A U D SD | 4. The dying patient is best served by a matter-of-fact focus on medical issues.  |
| SA A U D SD | 5. Discussion among doctors, nurses, and other health workers about the care of the dying may reveal differences in attitudes toward death and dying. |
| SA A U D SD | 6. It is important in the treatment of the dying patient to discuss his/her feelings with him/her.  |
| SA A U D SD | 7. Doctors, nurses, family and friends, if they prefer, can keep knowledge about his/her status from the dying patient.                               |
| SA A U D SD | 8. Fear of death is natural in all of us.   |

- SA A U D SD      9. Feelings of depression in the dying patient are unusual.
- SA A U D SD      10. The patient is better off not knowing his/her diagnosis even when it carries an implication of imminent death.
- SA A U D SD      11. If a patient talks about his/her fear of death, his/her doctors and nurses should reassure him/her that he/she has little to worry about.
- SA A U D SD      12. Nurses and doctors usually communicate easily with each other on issues relating to the needs of the dying patient.
- SA A U D SD      13. Those who support the principle of "death with dignity" endorse active as well as passive euthanasia.
- SA A U D SD      14. No matter what my personal beliefs, in my role as a medical professional I would fight to keep the patient alive.
- SA A U D SD      15. The dying patient who talks about his/her future plans for work, family, trips, etc., does not realize the seriousness of his/her condition.
- SA A U D SD      16. Individual freedom of choice ultimately should mean freedom of choice to live or die within the context of responsibility for self and others.
- SA A U D SD      17. Even if they don't ask, relatives should be told when death is imminent in the ill patient.
- SA A U D SD      18. Dealing with a dying patient makes one aware of his/her own feelings regarding death.

- SA A U D SD 19. Family members who stay close to a dying patient often interfere with the professional's job with the patient.
- SA A U D SD 20. Death means annihilation of the physical, social, and psychological self.
- SA A U D SD 21. Dying in Canada is handled more humanely than it is in most other parts of the world.
- SA A U D SD 22. If given a choice, I prefer to avoid contact with dying people.
- SA A U D SD 23. It is natural for medical personnel to grieve for their patients who die.
- SA A U D SD 24. I rarely think of dying.
- SA A U D SD 25. The dying patient is physically ugly.
- SA A U D SD 26. It is possible for medical personnel to help patients prepare for death.
- SA A U D SD 27. Medical personnel tend to cut down on their visits to the dying patient if there is little that can be done for him medically.
- SA A U D SD 28. Patients are better off dying in a hospital than at home.
- SA A U D SD 29. Suicide is wrong.
- SA A U D SD 30. When thinking of dying, I fear the idea of disability and pain more than death itself.

- SA A U D SD 31. Dying patients feel less comfortable if they have frequent visitors during their final days.
- SA A U D SD 32. Nurses should be the primary professionals equipped to deal with the reaction of a dying patient.
- SA A U D SD 33. Some patients should be allowed to die without making heroic efforts to prolong their lives.
- SA A U D SD 34. Relatives who know the prognosis of the terminally ill patient make patient management more difficult.
- SA A U D SD 35. The terminally ill patient frequently turns to his/her doctors and nurse to discuss his/her feelings about dying.
- SA A U D SD 36. Our imagination about dying is harder to handle than the reality.
- SA A U D SD 37. The more intelligent a person is, the less he/she fears death.
- SA A U D SD 38. The dying patient mourns his/her own coming death.
- SA A U D SD 39. Dying is a painful process.
- SA A U D SD 40. Training medical personnel on attitudes toward dying is inappropriate because helping people to live is their goal.
- SA A U D SD 41. The dying patient should be separated from other patients during the final period.

- SA A U D SD 42. Many patients prefer to be told when their death is near.
- SA A U D SD 43. The term "pass away" is preferable to the term "die".
- SA A U D SD 44. It is all right for people to whisper to one another in the presence of a dying person.
- SA A U D SD 45. Doctors and nurses should be detached emotionally if they are to work in the best interests of the dying patient.
- SA A U D SD 46. Sometimes patients give up on themselves because the medical personnel have given up on them.
- SA A U D SD 47. It is a common tendency to "skip over" dying persons on teaching rounds.
- SA A U D SD 48. I usually feel at ease talking with physicians about dying patients for whom they are responsible.
- SA A U D SD 49. The physician ordinarily discusses frankly with the family the implications of a diagnosis of a usually fatal disease.
- SA A U D SD 50. Suicide may be justified in the terminally ill.

Appendix B: Subject Information Form



### Subject Information Form

The following questions seek information regarding your nursing experience and your personal experience related to death and dying. Please remember that your responses are anonymous and confidential.

Please check or fill in the appropriate space that applies to you.

#### Part 1: Demographic Information

1. Gender:        male \_\_\_\_  
                     female \_\_\_\_
  
2. Marital status: single \_\_\_\_  
                         married/partnered \_\_\_\_  
                         divorced \_\_\_\_  
                         widowed \_\_\_\_
  
3. Religion:        Protestant \_\_\_\_  
                         Catholic \_\_\_\_  
                         Jewish \_\_\_\_  
                         Other (please specify) \_\_\_\_  
                         None \_\_\_\_
  
4. Age:                20 to 25 \_\_\_\_                                46 to 50 \_\_\_\_  
                         26 to 30 \_\_\_\_                                51 to 55 \_\_\_\_  
                         31 to 35 \_\_\_\_                                56 to 60 \_\_\_\_  
                         36 to 40 \_\_\_\_                                60 and over \_\_\_\_  
                         41 to 45 \_\_\_\_

#### Part 2: Education Information

1. What is the highest level of nursing education you have?  
      Diploma \_\_\_\_  
      Baccalaureate \_\_\_\_  
      Masters \_\_\_\_

2. What year did you graduate from your basic nursing education program?

\_\_\_\_\_

3. Did your basic nursing education include any structured content specific to death and dying? No \_\_\_\_\_

Yes \_\_\_\_\_

If yes, please describe briefly.

\_\_\_\_\_

\_\_\_\_\_

4. Since completing your basic nursing education have you attended courses/seminars/conferences related to death and dying?

No \_\_\_\_\_

Yes \_\_\_\_\_

If yes, please indicate which of the following you have attended.

courses \_\_\_\_\_ workshops \_\_\_\_\_

seminars \_\_\_\_\_ conferences \_\_\_\_\_

5. How many articles/books pertaining to death and dying have you read in the past 6 months?

0 \_\_\_\_\_

1 to 3 \_\_\_\_\_

4 or more \_\_\_\_\_

6. Have you used a consultant in your care of the dying within the past six months? (For example, a Clinical Nurse Specialist, a Psychologist, a Social Worker, or a Chaplain)

No \_\_\_\_\_

Yes \_\_\_\_\_

If yes, please explain why the person was consulted and in what way their expertise was used.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Part 3. Experience

1. How many years have you worked as a Registered Nurse?

0 to 2 \_\_\_\_\_

9 to 11 \_\_\_\_\_

3 to 5 \_\_\_\_\_

12 to 15 \_\_\_\_\_

6 to 8 \_\_\_\_\_

15 or more \_\_\_\_\_

2. On what type of unit are you presently working?

General Surgery \_\_\_\_

General Medicine \_\_\_\_

Palliative Care \_\_\_\_

Other (please specify) \_\_\_\_\_

3. How many years have you worked in general medical-surgical nursing including the unit where you now work?

0 to 2 \_\_\_\_

9 to 11 \_\_\_\_

3 to 5 \_\_\_\_

12 to 14 \_\_\_\_

6 to 8 \_\_\_\_

15 or more \_\_\_\_

4. Have you ever worked on a palliative care unit?

\_\_\_\_NO

\_\_\_\_YES

5. How many active beds are on your unit? \_\_\_\_\_

6. In your estimation how many patients die on your unit per month? \_\_\_\_\_

7. How many of these patients would you classify as terminally ill? \_\_\_\_\_

8. How many of these patients' deaths did you expect during their hospitalization. \_\_\_\_\_

9. Have you ever discussed attitudes toward death and dying with your:

	NO	YES
friends?	_____	_____
family?	_____	_____
colleagues?	_____	_____

10. Have you ever been asked to talk with a person who is dying?

\_\_\_\_NO

\_\_\_\_YES

11. Do you usually go to funerals of relatives, friends, and close colleagues?

\_\_\_\_NO

\_\_\_\_YES

12. Do you usually pay condolence calls on the families of deceased relatives, friends, and close colleagues?

\_\_\_NO  
\_\_\_YES

13. Have you ever been with a dying person at or near the time of her or his death?

\_\_\_NO  
\_\_\_YES

14. Has anyone in your immediate family died?

\_\_\_NO  
\_\_\_YES

Relationship:		Your age then:
Father	___	___
Mother	___	___
Sister	___	___
Brother	___	___
Grandparent	___	___
Close relative	___	___

15. Have any of your close friends died as a result of:

	YES	NO
Suicide?	___	___
Accident?	___	___
Acute illness?	___	___
Chronic illness?	___	___
Old age?	___	___

16. Have you made a will?

\_\_\_NO  
\_\_\_YES

17. Do you believe in life after death?

\_\_\_NO  
\_\_\_YES  
\_\_\_undecided

Appendix C: Information-Consent Letter

Information-Consent Letter

Dear Participant,

My name is Candy Garossino and I am requesting your assistance for my thesis research. My research focuses on attitudes of nurses towards death and dying. Hopefully, the results will assist us, as nurses, in the care of dying patients and their families.

Using the R.N.A.B.C. computer, R.N.A.B.C. staff generated a random list of names, affixed the address labels and mailed the questionnaire packets. The R.N.A.B.C. was reimbursed for the services. You are assured of complete confidentiality and anonymity. You will notice a number on the right hand corner of the questionnaires. This number is to be used to assist me in keeping my records in order and is not associated with your name in any way. Your participation in this study is totally voluntary and the return of the completed packet will be considered as your consent to participate.

Completing the questionnaires will take approximately 45 minutes of your time and I would appreciate your response within 10 days.

Thank you for your interest in my research and for your participation. If you have any questions or comments please do not hesitate to contact me

Candy Garossino BScN  
M.S.N. student  
U.B.C. School of Nursing

This research is being conducted under the supervision of:  
Sally Thorne R.N., M.S.N., Ph.D. Candidate  
Associate Professor,  
U.B.C. School of Nursing

Elizabeth Davies R.N., PhD.  
Associate Professor,  
U.B.C. School of Nursing

**Appendix D: Scoring Index for Subject Information Sheet**

## Scoring Index for Subject Information Sheet

### Part 1: Demographic

descriptive

### Part 2: Education

- |  |             |
|--|-------------|
| 1. Nursing education                                     | descriptive |
| 2. Year of graduation                                    | descriptive |
| 3. Structured content on death and dying                 |             |
| NO   | (0)         |
| YES  | (1)         |
| 4. Attendance at: courses/seminars/workshops/conferences |             |
| NO   | (0) each    |
| YES  | (1) each    |
| 5. Articles/books read                                   |             |
| Zero   | (0)         |
| 1 to 3   | (1)         |
| 4 or >   | (2)         |
| 6. Use of consultant                                     | descriptive |

### Part 3: Experience

- |   |             |
|---|-------------|
| 1. Years of experience as R.N   | descriptive |
| 2. Unit presently worked. This question allowed for the removal of respondents not meeting the inclusion criteria |             |
| 3. Years of experience in general medical-surgical area   | descriptive |
| 4. Past palliative care experience  |             |
| NO  | (0)         |
| YES   | (1)         |
| 5. Active beds  | descriptive |



## 6. Number of deaths per month

0	(0)
1	(1)
2	(2)
3	(3)
4	(4)
5	(5)
6	(6)
7	(7)
8	(8)
9	(9)
10	(10)
11	(11)
12	(12)
13	(13)

7. Number of #6 that were terminally ill descriptive

8. Number of deaths expected descriptive

## 9. Discussions regarding death with: family/friends/colleagues

NO	(0) each
YES	(1) each

## 10. Talking with dying person

NO	(0)
YES	(1)

## 11. Funeral attendance

NO	(0)
YES	(1)

## 12. Condolence calls

NO	(0)
YES	(1)

## 13. Present at time of death

NO	(0)
YES	(1)

## 14. Family deaths

NO	(0) each
YES	(1) each

15. Close friends deaths

NO

(0) each

YES

(1) each

16. Will

descriptive

17. Life after death

descriptive