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Abstract

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This study describes the relationships between perception of workplace, death anxiety, knowledge and attitudes toward care of the dying among palliative care nurses. The study was conducted on a sample of 48 nurses across Northwestern Ontario, Canada. The sample had received a minimum of thirty hours of palliative care education. The questionnaire included a demographic overview, items which rated the nurses' perceptions of their workplaces, Templar's Death Anxiety Scale, the Palliative Care Quiz for Nurses and the Attitude Toward Care of the Dying Scale.

The relationships between perception of workplace, death anxiety, knowledge and attitudes toward care of the dying among palliative care nurses

by

Marilyn Arthur ©

for

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Committee: Dr. Jim Haines
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In partial fulfilment for the requirements for the degree of
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CHAPTER ONE

Introduction

Palliative Care is defined as active, compassionate care of the chronic and terminally ill at a time when the goal is not a cure and is primarily directed towards improving the quality of life. The emphasis of palliative care is on the control of pain and symptoms, and on physical, emotional, spiritual, social and cultural needs. It is multidisciplinary in its approach, encompassing the person, family, caregivers and the community in its scope and extends to include grief and bereavement (NECAH, 1994, p. 24).

In the field of health, palliative care denotes the enabling services given to a group of care recipients, dying persons and their family units, during the transitional period from life to death. Worldwide, a growing movement, called hospice, is being recognized as an emerging specialty field for health care providers. Founded on the principles of supportive care of the dying, it is not a place or program, but a philosophy of care.

According to Bond (1988), "it is always difficult to trace the origins of a change of emphasis in medical and nursing care but it is likely that three influences have contributed to a professional interest in terminal care. Firstly, the rise of the modern hospice movement with its recognition that dying and mourning are normal life events; secondly, the development of sophisticated and successful techniques of palliative care and lastly, the increasing expectations of the populace for a comprehensive and sensitive service for patients, family and care givers at the terminal phase of illness" (p. 1).

Palliative care requires a change in the traditional approach to care of the dying.

Traditional medicine demands a "curative" approach while palliative care focusses on a "comfort" approach. Accompanying this philosophical change are unique questions and concerns for all professional care providers, families and volunteers. When does palliative care begin? Where is it best administered? Who should make the decisions? What are the most appropriate characteristics and attributes of effective care providers?

An understanding of the holistic principles of palliative care is fundamental to the field of practice. Physicians, nurses, volunteers, clergy and members of other related disciplines focus on issues concerning pain and symptom management techniques, effective communication, grief and bereavement counselling and the provision of psychosocial and spiritual care to individuals and families. One critical component of palliative care is the holistic assessment of the individual's needs. The goal of assessment is to gain a deeper awareness of the whole person within the context of his or her own environment. Following assessment, providers then collaborate to develop plans of care which best meet the individual's needs. Programs, services and resources are put into place to support the dying person and the significant people in his or her life.

Palliative care services are interdisciplinary in nature and situated in a variety of community, hospice, and hospital facilities where nurses constitute a major proportion of the service delivery team (Ross, 1996). The interaction between the nurse and the dying patient is thought to influence the quality of life experienced during the last stage of existence. Scanlon (cited in Brockopp,1991) stated that as individuals progress through the last phase of life, nurses are called on to identify psychosocial needs, create a growth-promoting environment, provide education, and give emotional support.

In principle, health care workplaces are founded on mandates, philosophies and policies which intertwine to create each unique workplace culture. In practice, workplaces are dynamic systems founded on human characteristics such as attitudes, values, beliefs and behaviours. Vachon (1978) revealed that the greatest stressor experienced by care providers was the work environment rather than direct work with dying patients. The author concluded that while it is possible that some anxiety about dying patients might be displaced onto system problems, it seems improbable that so many caregivers would blame feelings of stress on organizational climate unless there were some truth to it. Do health care workplaces provide palliative care nurses with psychosocial support, growth-promoting environments, adequate education, and emotional support? This study will focus on the professional registered nurse who is generally the predominant caregiver of the terminally ill person.

The Question

"What is the relationship between perception of workplace, death anxiety, palliative care knowledge and attitudes toward care of the dying among palliative care nurses?"

Summary

The study examines the relationships among perceptions of organizational work culture, death anxiety, knowledge and attitudes of palliative care nurses toward the care of the dying. A palliative care questionnaire was mailed to eighty-three registered nurses across northwestern Ontario.

Expectations

It is anticipated that attitudes toward caring for the dying will depend to a degree on the nurses' perceptions of the organizational culture or climate of the work place. If a workplace is perceived to adhere to the principles of palliative care and to support its nurses in the application of those principles, it is anticipated that positive attitudes toward the care of the dying will prevail.

Second, it is anticipated that older nurses with longer work experience, more education and more death experience will score higher on the knowledge scale, lower on the anxiety scale and rate attitudes toward caring for the dying person more positively.

The Purpose of the Study

The purpose of this study is to describe palliative care nurses in relation to care of the dying by examining the relationships among perceptions of organizational work culture, palliative care knowledge, death anxiety and attitudes toward caring for dying people. Numerous studies have indicated relationships between care of the dying and death anxiety, education, age, experience, attitudes, work settings, comfort levels, stress, and control. Due to the variety of methodologies, results are varied. There is a paucity of research which focusses on these factors in relation to palliative care knowledge and perception of workplace.

To describe the nurses demographically, variables such as age, education, work experience, frequencies of professional and personal death experiences, type of workplace, and community size and location will be documented. Scales will be used to measure nurses' perceptions of their current workplaces, death anxiety levels, palliative care knowledge and attitudes toward caring for dying people. Of particular interest is the relationship between the nurses' perceptions of their workplaces and their attitudes toward care of the dying. By using quantitative data it is possible to describe some of the distinguishing characteristics of a sample of palliative care nurses as well as the relationships between their characteristics and the results of the scales measuring perceptions of their workplace, knowledge, death anxiety and attitudes.

Research Objectives

The following objectives will guide the study of the palliative care nurses:

1. To describe the demographic characteristics of the subjects such as age, work setting, experience and education.
2. To determine respondents' perceptions of organizational work culture and the degree of influence it may have on the nurses' attitudes toward caring for the dying person.
3. To measure basic knowledge related to palliative care principles as delineated in a 20-item palliative care quiz for nursing.
4. To measure the nurses' level of death anxiety by using a 15-item instrument.
5. To explore nurses' attitudes toward care of the dying using a 30-item scale.
6. To describe the relationships between demographic variables and total scores and some item scores on the four scales.
7. To pose themes and issues for further research

Background Information

In 1993, the Ministry of Health of the Ontario government initiated a movement to change its direction in the provision of palliative care. Two factors which appear to have contributed to this change are: an aging population and fiscal pressures. Most deaths occur in the aged population and in hospital settings (Thompson, 1985). Given the growing proportion of older people and the corresponding costs of expensive hospital deaths, the Ministry of Health began to shift its resources into less costly community based programs. Recognizing the need for education and services related to community care for the dying, the Ministry of Health's Long Term Care Division developed a provincial initiative to increase the knowledge and skills of physicians, nurses and members of other health related disciplines in the field of palliative care. In collaboration with Palliative Care Network Northwest, a committee of regional palliative care providers, the Northern Educational Centre for Aging and Health (NECAH) at Lakehead University received the service contract to administer the educational programs in Thunder Bay and across northwestern Ontario. Founded on research done by Sellick, Charles, Dagsvik & Kelley (1996) which identified palliative care providers' perspectives on service and education needs, NECAH's mandate was to administer educational programs to meet the needs of health care providers across the region. Using provincial guidelines and following community consultations, NECAH continues to develop and deliver numerous courses, workshops, lectures, seminars, and conferences to hundreds of health care providers.

In October 1994, the first "Palliative Care Institute" brought together eighty-eight palliative care providers from 16 communities within the Districts of Thunder Bay, Kenora and Rainy River for a thirty-hour course. Physicians, representatives from hospitals, home care agencies, long term care facilities and volunteer groups participated. Nearly seventy workshops, keynote and seminar sessions included such topics as pain and symptom management, grief and bereavement, spiritual issues, communication and team work. Of these delegates, forty-one were registered nurses.

In May 1997, the second Palliative Care Institute was delivered to eighty-two different delegates who represented the same agencies. While all delegates offer palliative care, the actual number of encounters with dying people could range from one to hundreds annually, depending on the work setting. Delegates to the 1997 Institute included physicians, resident physicians, members of the clergy, social workers, licenced practical nurses, occupational therapists, numerous volunteers, a nutritionist and a physiotherapist. Forty-two of the delegates were listed as registered nurses. In total, eighty-three nurses have attended the two Institutes. Since these delegates represent those agencies which provide care to the dying across northwestern Ontario, it is from this comprehensive mailing list that the potential respondents were drawn for this study.

Definition of Terms

Anxiety, according to Folta (cited in Gow & Williams, 1977) is "an expression of diffuse apprehension, the object of which is not clearly understood or recognized, the result being that the quality of danger is to some extent unknown" (p. 192). The sense of danger will be particularly acute when, beyond seeing actual harm in the situation, one believes that this harm cannot be tolerated emotionally if it occurs (Pervin, 1990). The object of anxiety in this study is the dying process and death.

An attitude is defined by Shaw (cited in Gow & Williams, 1977) as an evaluative, affective reaction based upon and reflecting the evaluative concepts and beliefs which have been learned about the characteristics of a social object or class of social objects (p.

192). Anastasi (1976) refers to an attitude as a reaction, either favourable or unfavourable, toward a designated thing.

Continuing Education for nurses is defined as any planned learning experience undertaken by graduates of diploma or baccalaureate nursing programs that contributes to the fulfilment of personal and professional goals and leads to the enhancement of nursing practice, education, administration and research (RNAO, 1988, p.1).

Hospice care is interchangeable with palliative care.

Home Care is a program of the Ministry of Health of Ontario which provides health care to persons in their own homes.

Long Term Care is a program of the Ministry of Health of Ontario for persons who require health care support over a long period of time either in their homes or facilities (i.e. Home for the Aged, Nursing Home, Eldcap and extended care unit in a hospital).

Organizational culture is defined by Robbins (1994), as a system of shared meaning held by members that distinguishes one organization from another. Culture describes how employees perceive those characteristics which the organization values. According to Pervin (1990) a "social culture" produces a set of demands, constraints, and resources that operate contemporaneously in adaptive transactions, though they can be internalized and become part of an individual's personality. Culture is the degree of trust, communication, and supportiveness that exists in the organization (Ford, 1988). In the proposed study, the workplace is the social or organizational culture which will be described according to the perception of each nurse.

Registered Nurse is a graduate of a recognized school of nursing either at a diploma or degree level and eligible to work in the province of Ontario.

CHAPTER TWO

Literature Review

Palliative Care Nursing: Definition and Roles

Nursing is an interpersonal process whereby the professional nurse practitioner assists an individual, family, or community to prevent or cope with the experience of illness and suffering and, if necessary, to find meaning in these experiences (Travelbee, 1975). Whereas palliative medicine focuses on control of symptoms and other distressing aspects of terminal disease, palliative care nursing emphasizes care as the essential element (Williams, 1992).

The quality of nursing care given any ill person is determined by many factors. The nurse's knowledge and ability to apply it, are certainly determinants, but an equally important determinant is the nurse's belief about illness, suffering and death. It takes far more understanding, knowledge and skill to support an individual in time of crisis than to perform any complicated technical treatment (Travelbee, 1975). Nursing, if seen as a process or an experience, stresses the dynamic character inherent in every nursing situation. There is continuous movement, activity or change. To identify and be able to bring about change in a purposeful, enlightened, thoughtful manner is a nursing activity. A nurse is a change agent (Travelbee, 1975).

While some researchers have studied nurses who work with the dying, the results are unclear and difficult to compare. The paucity of research is likely a result of the fairly recent recognition of palliative care as a specialty area. Since the field as a specialty has only emerged since the 1950's, little has been studied specifically in relation to palliative care nurses' characteristics or personal qualities (Brockopp, 1985). To begin to understand this caregiver as a person, a review of the literature will provide an overview of nursing roles.

Palliative care is also referred to as supportive care or continuing care. The supportive care role of the nurse has not been studied extensively. In a 1990 study involving one palliative care nurse, Davies and Oberle explored the supportive role of the nurse. The authors also wanted to address the statement that "no one understands what I do" (p. 87) which is a common statement among hospice nurses. They state that the supportive role comprises six dimensions: valuing the patient, connecting with the person emotionally, empowering the patient to maintain autonomy, "doing for" which refers to a list of tasks, finding meaning in the relationship, and finally preserving one's own integrity. The same study identifies a nurse's job description as having four facets: administrator, educator, consultant and clinician. The supportive role is that set of behaviours aimed at caring for the patient, supporting independent functioning and easing pain and discomfort (p. 87).

Benoliel (1976) states that the patient who receives supportive care has three areas of need. Supportive caregivers should provide the dying person with: continuity of contact with one person, opportunities to know what is happening and participation in decisions affecting how one will live and die and confidence and trust in those providing care.

Finally, Dobratz (1990) categorized roles of a specialist in palliative care nursing, particularly in the home setting:

- intensive caring or the management of physical, psychological, social and spiritual problems of dying persons and their families;
- collaborative sharing or coordinating the extended and expanded components of hospice service;
- continuous giving or balancing the nurse's own self care needs to the complexities of repeated death encounters and;
- continuous knowing or the acquisition of the extensive knowledge required (p.117).

The roles of the nurse who provides palliative care are numerous as well as formidable.

Organizational Work Culture

Organizational culture is defined by Robbins (1994), as "a system of shared meaning held by members that distinguishes one organization from another" (p. 245). Culture describes how employees perceive those characteristics which the organization values. Culture is not concerned solely with location, but also with its physical features, important but unwritten rules and routines and significant aspects of its context.

Robbins (1994) argues that it is the "shared meaning" aspect of culture that makes it such a potent device for guiding and shaping behaviour. He states that in strong workplaces, core values are intensely held and widely shared. Such unanimity of purpose builds cohesiveness, loyalty and organizational commitment. Culture has a boundary defining role, it conveys a sense of identity for members, it facilitates commitment to something larger and it enhances social system stability. Further, Robbins states that when the employee fits into the culture of the organization and expectations and reality concur, the employee is likely to approach work more positively.

Based on Robbins' (1994) work on the organizational culture of work settings, there are ten characteristics of environments perceived by employees in varying degrees. These ten characteristics are:

1. Individual initiative: the degree of responsibility, freedom, and independence the individuals have;
2. Risk tolerance: the degree to which employees are encouraged to be aggressive, innovative, and risk seeking;
3. Direction: the degree to which the organization creates clear objectives and performance expectations;
4. Integration: the degree to which units within the organization are encouraged to operate in a coordinated manner;
5. Management support: the degree to which managers provide clear communication, assistance, and support to their subordinates;
6. Control: the number of rules and regulations, and the amount of direct supervision that is used to oversee and control employee behaviour;
7. Identity: the degree to which members identify with the organization as a whole rather than with their particular work group or field of professional experience;
8. Reward system: the degree to which reward allocations (such as: salary increases, promotions) are based on employee performance criteria in contrast to seniority, favouritism and so on;

9. Conflict tolerance: the degree to which employees are encouraged to air conflicts and criticisms openly; and
10. Communication patterns: the degree to which organizational communications are restricted to the formal hierarchy of authority (p. 245).

Robbins' workplace characteristics could be applied to various palliative care work settings. If, for example, a nurse who is accustomed to the death occurrences in an intensive care unit participates in a death in a home for the aged, the expectation of the need to cure might clash with the reality of the need to comfort. Adherence to the principles of palliative care may be completely different in each setting. It may be that the nurse does not seem to fit into the work culture or the work culture does not appear to support the nurse. If a nurse feels strongly supported by management and peers, Robbins might expect the nurse to have more favourable attitudes toward work, in this case caring for dying people.

Nurses' Work Settings. Christopher & MacLeod (1993) believe that palliative care needs to take place in a wide range of settings. Work settings or workplaces can range from hospitals, hospice units or group homes, to private homes in the community and long term care facilities such as homes for the aged or nursing homes. Thompson (1985) investigated the relationships between nurses' death anxiety and attitudes toward the dying with respect to types of work settings, years of experience and frequency of contacts with dying people in one hospital. Findings indicated that the type of work setting related more closely to nurses' attitudes than years of experience or frequency of contact with dying people. Specialists, or those whose caseloads consist mainly of dying people, were more at ease caring for patients than were curative-setting nurses. Specialists appeared more comfortable with such things as counselling and supporting. Specialized palliative care nurses approach their work with greater ease than non-specialists, enter a more personal relationship with the patient, share their feelings with the patient, and feel rewarded by their work (Thompson, 1985). Thompson argues that the emotional climate and work activities in a specialized unit such as acute care, hospice, or chronic care, encourage a particular point of view toward working with the dying. Each site is characterized by a different task structure, mortality rate, philosophy, management style and climate. It may be that nurses in hospice settings do not expect cures and are therefore more comfortable with a comforting role. It may be that nurses in long term care settings expect lingering deaths and are more anxious in critical care situations.

A number of studies have considered the special needs of hospice nursing staff. Hospice in this case usually means a free standing home or unit in a hospital totally devoted to caring for dying people in the last stages of life. Vachon (1987) found that hospice staff experience higher levels of stress, exhaustion, somatic complaints, anxiety, depression, anger and other symptoms of emotional distress than do caregivers working with other types of patients. Nursing staff providing care to residents in long term care settings have not been well investigated according to Rutman (1992).

There has also been little research done on nurses who provide palliative care in the community. Ross & McDonald's report on community based nurses in 1996 states that nurses caring for older persons at home experienced isolation and reported an increase need for emotional support and education. Dobratz (1990) provided a comprehensive review of the issues around hospice care in the home and states the importance of a supportive workplace which encourages open communication.

Each work setting has its own unique culture with written and unwritten goals and expectations. Curative or therapeutic treatment settings have different expectations than palliative care settings. Thompson (1985) notes that one cannot assume all nurses will, simply with experience, be equally able to cope with dying patients. Thompson suggested that philosophical reorientation is necessary to escape role strain. Nurses might experience less discomfort if managers aided new staff in the development of a philosophical approach to caring by clarifying the differences between curative and palliative nursing. Newlin & Wellisch (1978) recommended that oncology nurses in hospitals should be ensured emotional support upon hiring. They recommended both formal and informal opportunities for discussion and sharing of experiences.

Gow & Williams (1977) measured the difference in attitudes of nurses who worked in three other settings; community, hospital and chronic facilities. They found that the type of agency had minimal effect on nurses' attitudes toward the dying. Vickio and Cavanaugh (1985) used Templer's Death Anxiety Scale to assess the anxiety level of a small number of nurses in a nursing home and found that death anxiety was directly related to ageist attitudes.

A question remains as to how palliative care nurses come to be in particular work settings. Did they initially choose to work with dying people in a particular workplace or did they inadvertently slip into the career? Vachon (1978) asked what would motivate a person to seek such work. Is it by accident, convenience, part of one's caseload, a desire to do the "in thing", to affiliate with a charismatic leader, intellectual appeal, a calling or the desire for control and mastery over illness, pain and death? How people choose to become palliative care nurses and why they remain in palliative care nursing does not appear to be addressed in the literature. Whether or not the type of work site has any bearing on the attitudes of the staff therein remains to be investigated. Reisetter & Thomas (1986) call for further study of the nurses' characteristics as well as the setting in which care is given.

Death Anxiety

Perhaps no subject in nursing arouses such an emotional response as care of terminally ill patients. Many nurses, because of fears and anxieties avoid and isolate dying patients. Personal anxieties about death, lack of preparation regarding the care of dying patients and their families, and a professional orientation that emphasizes cure and future health, contribute to the nurse's uneasiness with terminally ill patients (Reisetter & Thomas, 1986). Poppoff (1975) found that nurses who had not worked through their own fear of death were much more likely to report feeling anxious or uncomfortable when patients spoke of impending death.

Anxiety around death is a difficult concept to measure since scales such as Templer's Death Anxiety Scale (1971) refer to anxiety around one's own death as opposed to the death of others. There is no definitive scale which measures the relationship between anxiety about one's own death and how one responds to the death of others, particularly within a health care setting. This study will investigate death anxiety level and attitudes toward dying patients to determine if there is a relationship evident.

Another difficulty in relating death anxiety to care of the dying is that nurses' characteristics have not been studied consistently throughout the research. For example, age may be construed as years of work experience. The number of years worked may not mean in palliative care specifically. Types of death experiences vary widely from traumatic to lingering. The ages of the dying patients may lead to different results. Since results have been inconclusive, Denton & Wisenbaker (1977) call for more in-depth research about nurses' anxiety levels in relation to characteristics such as age, years of experience and types of death experience.

While Templer's Death Scale is the most widely used death attitude scale, it is questionable as to whether a total score can be interpreted as a straightforward measure of death anxiety (Durlak, 1982). For purposes of this study, a total score will be used.

Nurses' Experiences with the Dying. Can a human being be repeatedly exposed to illness, suffering and death without being changed as a result of these encounters? How does working with the dying affect palliative care nurses? What kinds of problems or stressors do palliative care nurses encounter? How do they cope with the death of patients who have become a part of their lives? How does the culture of the work place influence the nurse?

Commonly cited responses of some health care providers are withdrawal or detachment from the dying person, denial of one's feelings, levity and joking, selecting favourites such as old people over young people and feelings of anger and depression (Travelbee, 1975). Some nurses believe pain management is the most important concern and that just "being" or offering emotional support is the most stressful and difficult aspect of work (Hockley, 1989). The perils of emotional induction into a family may leave the nurse suffering the losses and being blamed for retreating from the patient at the end of the shift. The nurse experiences "life on an emotional roller coaster", struggling with issues such as identification with the dying and guilt for having failed the dying person (Newlin & Wellisch (1978). As a result, the nurse may develop "battle fatigue" and its danger signs such as depression, conflict dreams, obsessive thinking, repetitive accidents and absenteeism (Vachon, 1987).

Hare and Pratt's study of nurses' comfort level found that nurses with high to moderate exposure to the dying were significantly more comfortable than nurses with low exposure (1989). Other research by Brockopp, King & Hamilton (1991) and Frommelt (1991) examined the relationship between the amount of experience nurses had with dying patients, the nurses' attitudes and the quality of care they provided. The authors found that palliative care nurses had more positive attitudes about dying than other nurses. Reitsetter & Thomas (1986) found nurses with greater clinical experience as well as personal experience with death were found to be more sensitive psychologically to the needs of the dying patient. Less experienced nurses demonstrated a more open and direct approach to caring for the dying but they tended to be more satisfied with isolating the dying and not informing them of prognoses (Degner and Gow, 1988). Thompson (1985) also found that experience had some relationship with nurses' attitudes. The longer they were in the profession, the more they favoured allowing a patient to die after reasonable care.

By describing the respondents' years of nursing experience, years providing palliative care, the number of patients served directly or indirectly, the number of deaths attended and the number of personal deaths experienced, this study may shed light on the relationship between experience and anxiety levels, knowledge and attitudes toward the dying patient.

Palliative Care Knowledge

There is both a special knowledge (the science), and a compassionate caring (the art) required to meet the physical, emotional and spiritual needs of people requiring palliative care (Roe, 1992). Dobratz (1990) states that the practice of hospice nursing demands a level of clinical competency, an assurance of high standards of care, an assimilation into formal education and a clinical practice that is built on a firm theoretical foundation. In their in-depth interviews with one palliative care nurse, Davies and Oberle (1990) related the vast knowledge, skills and personal coping strategies essential to provide care to cancer patients. The authors argued that experience rooted in systematic study and in actual clinical practice is the crucial element in the development of clinical knowledge.

Dobratz (1990) identifies the following topics and related theories which the palliative care nurse needs to know

- family and social systems;
- hospice and community systems;
- coping and adaptation;
- grief and loss;
- death and dying;

- management and decision making;
- counseling and interaction;
- ethical, spiritual and human values;
- psychological and physiological functions and responses of terminal illness;
- teaching and learning; and
- humanistic caring.

This list of topics is in addition to those covered in basic nursing education. Ross and McDonald (1996) identify the need for a standardized mechanism to evaluate the level of knowledge disseminated in academic and clinical programmes of an educational nature.

Nurses' Education. The relationship between levels of education and attitudes toward death and dying has been the focus of several studies. Dependent upon the definition of attitude and the instrument used, there appears to be a positive relationship between educational level and attitude (Reisetter & Thomas,1986). Degner and Gow (1988) argue that evaluation research has focussed on exposure to dying and few if any studies have been designed to examine the relationship between education and nursing behaviours in caring for the dying. To determine the need for death education with a clinical practice approach, Degner and Gow (1988) studied death anxiety and attitudes toward death with 330 nursing students. The study reinforced the classic work by Quint (1967), whose theoretical model maintained that if nurses were exposed to care of the dying without accompanying educational support, they would adopt the behaviour of other professionals around them and limit their involvement in death related situations.

This behaviour is referred to as the non-approach style or avoidance.

Reisetter and Thomas (1986) found that education had a positive relationship to attitudes. Lev (1986) evaluated a hospice nursing course and demonstrated that experience alone was not enough to change attitudes and behaviours of nursing students and graduates, and that education resulted in behaviour change. Maintaining a social distance by avoiding the dying, alcoholic, psychiatric or AIDS patient was a very real problem. The experimental group who received education demonstrated significantly less fear of death and dying and significantly fewer avoidance behaviours (Lev, 1986).

Studies related to education are difficult to compare since academic preparation or the highest level of formal education achieved and continuing professional education are different, and not consistently compared in the research. Without consistent evaluations of student achievement, it is not possible to measure how much a student actually learns in a continuing professional education program. Generalizability is difficult since attitudes are defined differently, samples are drawn from nursing students or licenced practical nurses and not necessarily professional nurses who are currently practicing. However, based on Frommelt's study of attitudes toward care of the dying in 1991 there is evidence that there are significant increases in self-reported attitudes of nurses, including hospice nurses following palliative care education.

Currently in Canada there is neither a national standardized evaluation of knowledge or certification in the field of palliative care. Ross and McDonald (1996) developed the Palliative Care Quiz for Nurses as a first step in establishing a baseline of knowledge related to palliative care. The relationship among education, knowledge and attitudes needs to be understood in greater depth.

Nurses' Attitudes Toward Care of the Dying

Lev (1986) refers to attitudes as a pattern of views reflecting cumulative prior perceptions and experiences which includes cognitive, affective and behavioural components. The cognitive component adopts the premise of a human's need for balance, symmetry or reduced dissonance. In striving to achieve consistency attitudes may undergo change. The second aspect of attitudes is the affective component. Positive or negative tendencies toward the object may result in seeking versus avoiding and liking versus disliking. Positive affective tendencies may account for those nurses who feel comfortable around dying persons. Negative affective tendencies may account for those nurses who feel disengaged from dying patients and emotionally withdraw. Finally, the behavioural component, is the action taken by the individual, either seeking palliative care work or avoiding the context altogether.

Fishbein and Ajzen (1972) state that the relationship between attitudes and action is difficult to determine using self-report scales unless two prerequisites are met. The attitude being measured must be appropriate and the criterion must be methodogically acceptable. Investigating behavioural intentions of subjects is recommended as a behaviour criterion. Frommelt's Attitude Toward Caring for the Dying Scale (1991) meets these criteria as a tool in the measurement of nurses' attitudes.

Caring for an individual with a terminal illness requires great skill and understanding on the part of nurses. Davies and Oberle (1990) state that the characteristics of the nurse as a person are critical in the establishment of trust. Although a systematic investigation of the variables that are important in providing effective care for the dying has not been conducted, the variables of death anxiety and attitudes toward death and dying have been identified within the clinical literature as being significant (Brockopp, 1991). Nurses who are anxious in relation to death and have negative attitudes toward death are described as retreating from dying patients and therefore unable to provide effective care (Brockopp, 1991). This result relates feelings of anxiety directly to negative attitudes and withdrawal behaviours. Thompson (1985) reviewed studies related to nurses' attitudes toward death and dying and found that many nurses developed defensive strategies to manage their feelings of uncertainty, helplessness and frustration. The "ideal" positive attitudes to care of the dying are defined as flexibility in interpersonal relations, desire for open communication about critical issues, and psychological mindedness in relation to patients and families of dying patients (Ward & Lindeman,1978). How nurses feel about caring for persons with a terminal illness will depend, to a large extent, on the nurses' feelings and ideas about death and dying, their religious convictions, and their philosophies of death and life. Nurses' beliefs and feelings about palliative care are more likely to represent their personal experiences and value system (Vachon, 1978). Davis and Aroskar (1983) state that values are significant as they influence perceptions, guide our actions, and have consequences. Values are basic to a given way of life and serve to give direction to life. A value system can have an important impact on one's perception of stress and ability to cope. According to Vachon (1978), for some, a value system is a philosophy of life that does not necessarily involve religious values, while for others, their value systems are fairly heavily influenced by religion.

There are ways in which values may consciously or unconsciously undergird one's professional practice. Vachon (1978) lists four commonly held values described by professional caregivers who work with the dying: (a) Caregivers are beyond the normal human emotions of depression, anger, frustration, and despair and are always patient and understanding, (b) caregivers should be able to relate equally well to all patients and families, (c) caregivers are capable of separating the stressors of their personal and professional lives, and (d) caregivers are completely up to date with the most recent technological advances.

Organizations are driven by certain values which may or may not coincide with the personal value system of the nurse. It may be that an organization expects nurses in its employ to adhere to the values mentioned by Vachon (1978).

It is apparent that values, beliefs, knowledge and attitudes are interrelated and interdependent. Anastasi (1976) states that the measurement of attitudes is both difficult and controversial. Whether expressed opinions can be regarded as indicators of "real" attitudes has frequently been questioned.

Nurses' Ages and Attitudes. Poppoff's (1975) survey of nurses' attitudes toward death and dying found that the age of nurses had little effect on their response to issues surrounding death and dying. Interestingly, older nurses' abilities to cope with death did not necessarily increase with experience. However, Gow (1977) found death anxiety decreases in older, more experienced nurses. When studying age in relation to type of care administered, the younger nurse tended to focus more on psychosocial needs of the dying person and older nurses focussed more on physical needs. Once again, this may reflect the type of educational training the nurses received. It seems that coping ability, death anxiety and areas of focus are quite different variables.

Interestingly, Vachon's work (1975) reinforced Poppoff's study which indicated that for all age groups, the major stressors for nurses were related to work environment, not dying patients. Younger nurses indicated stressors most often related to their colleagues and team communication problems. Middle and older age groups described communication problems with patients from different ethnic backgrounds and value systems. The single greatest stressor in the older nurses was identification with patients and families. Identifying with patients means empathizing to the degree of transference. It may be a surprise that in Poppoff's study increased age and experience did not result in less feeling toward the patient. This rather dispels the ageist myth of the "hardened, older nurse."

In 1987, Vachon's study noted that all age groups reported the major psychological manifestations of stress were depression, grief and guilt. Coping strategies, which were similar for all ages, were cited as developing a sense of competence and maintaining control or pleasure in the work situation. Older nurses coped by developing the idea of team philosophy and mutual support. The trend indicated that the number of stressors decreased and the coping strategies increased with age. Age and years of experience are more useful if we know the types and frequencies of deaths as well as the setting in which care is given.

The literature review indicates that positive work environments relate to positive employee attitudes. Evidence is clear that older nurses with more experience and education do not report high death anxiety. They are likely to have more cumulative knowledge about palliative care and maintain more positive attitudes toward care of the dying. Nurses with high death anxiety may perceive workplaces less positively and in turn may have negative attitudes toward caring for dying people. An overview of the literature provides a rationale for the importance of investigating relationships between the perception of workplaces, death anxiety, knowledge and attitudes among palliative care nurses.

CHAPTER THREE

Design of the Study

Participants

While forty-eight respondents volunteered to answer questions related to their perception of workplaces, death anxiety level, knowledge and attitudes, an additional twenty delegates chose not to participate in the study. Eighty-three Registered Nurses from 15 communities in northwestern Ontario were mailed a package containing a letter of invitation to participate in the study (Appendix A), a consent form (Appendix B) and The Palliative Care Questionnaire (Appendix C). All of the eighty-three potential respondents had attended a thirty-hour educational program called the Palliative Care Institute in Thunder Bay, either in October 1994 or May 1997. Every three years health care administrators are asked to select one representative from their agency to attend the palliative care course. The criteria for this selection are based on a number of things such as; interest in the field, job description, skill level, availability, and willingness to become part of a regional network of palliative care providers. Delegates represented long term care agencies, home support agencies, home care agencies, community based agencies and hospitals.

The criteria for participation in this study were that they be a Registered Nurse licenced to practice in Ontario, currently employed either full or part time, and have cared for at least one terminally ill person within the past two years. Respondents must have attended either the Palliative Care Institute in 1994 or 1997. Due to an extensive restructuring of the health care sector since 1994, the expected response rate was between

40 and 50 nurses. It was also determined that not all 83 potential respondents were necessarily registered nurses. Some registered practical nurses (RPN's) identify themselves on registration forms as professionals who work in *nursing*. This information would only be determined once the delegate received the package of information and read the criteria for participation.

Selection of the original delegates to the Institutes may demonstrate bias since administrators or managers were asked to choose employees who would best fit criteria as described by the Northern Educational Centre for Aging and Health, the administrator of the palliative care courses. Delegates were expected to become resource persons within their agencies and communities. Selection of the delegate could have been random or motivated by such things as favouritism, reward, a need to improve the delegate's skills, or staffing availability.

The questionnaire was somewhat personal in nature and could have been thought of as too intrusive or revealing. The researcher received two calls from potential respondents who expressed concern that they would not feel comfortable about rating their workplaces and therefore could not participate.

Instruments

The study employed a self-administered questionnaire called The Palliative Care Questionnaire which incorporated demographic data with three scales and a quiz (Appendix C). The questionnaire consisted of 92 questions and took approximately 45 minutes to complete. The study examined the relationships between demographic variables and perceptions of workplaces, knowledge, death anxiety and attitude toward care of the dying.

The Questionnaire (Appendix C). The questionnaire was presented in 5 parts:

Part A: Demographic Overview

Part B: Perception of Workplace Scale

Part C: Templer's Death Anxiety Scale

Part D: Palliative Care Quiz for Nurses (PCQN)

Part E: Frommelt's Attitudes Toward Care of the Dying Scale.

Part A: Demographic Overview

Using closed ended questions or tick boxes, the variables assessed in items 1 to 17 were: age, years of nursing experience, years of palliative nursing experience, agency type, job title, length of time at current agency and employment status, either full or part time. Items also included the community size, the catchment of the agency and the distance to the nearest hospital. Respondents were asked to identify the total number of palliative patients served over their nursing careers, the number of patient deaths they had been directly involved with and the number of times they had attended a death. Part A also asked respondents to indicate the age groups for most of the deceased and the numbers of family or friend's deaths they had experienced. The respondents were asked for the highest level of education achieved and for a list of continuing palliative care education courses attended.

Part B: Perception of Workplace Scale

To identify the nurses' perception of the organizational culture of their current workplaces a ten-item scale was developed by the researcher based on the model developed by Robbins (1994). Robbins listed ten characteristics of environments perceived by employees in varying degrees: individual initiative, risk tolerance, direction, integration, management support, control, identity, reward system, conflict tolerance, and communication patterns. To develop a scale, each of the ten characteristics were transformed into a statement. Using a Likert scale, respondents were asked to rate each statement which followed the stem: "The agency or setting in which I presently work...".

Part C: Templer's Death Anxiety Scale (TDAS)

Anxiety was operationalized by employing the widely used Templer's Death Anxiety Scale (Templer, 1971), a 15-item true or false instrument designed to measure the respondents' anxiety about death. According to Fischer (1994) "the overall score is what is considered meaningful" (p. 656). A major advantage of the TDAS is that it has been studied and used extensively with a variety of population samples including males and females, adolescents and adults, psychiatric patients and a number of occupational groups. Respondents total in the several thousands. Means of "normal" respondents vary from 4.5 to 7.0 with scores being higher for females and psychiatric patients. For a cross sectional sample of middle class people, the means reported were 7.5 for youth, 7.25 for young adults, 6.85 for middle-aged, and 5.74 for elderly respondents (Fischer, 1994). The Kuder-Richardson measure of internal consistency is .76 with a three-week retest correlation of .83. Evidence for concurrent validity is a correlation of .74 with the Fear of Death Scale, another commonly used scale (Fischer, 1994).

Part D: Palliative Care Quiz for Nurses (PCQN)

The Palliative Care Quiz for Nurses (Ross, McDonald & McGuinness, 1996) consists of statements related to basic palliative care knowledge and asks respondents to reply true, false or don't know. According to the authors, the instrument measures basic knowledge of palliative care issues which are congruent with the content of the Canadian Palliative Care Curriculum prepared by McDonald (cited in Ross, McDonald & McGuinness (1996). The distribution according to conceptual category of content is as follows: (a) philosophy and principles (n=4); (b) management of pain and other symptoms (n=13); and (c) psychosocial aspects of care (n=3). The authors state the quiz is also useful for identifying informational needs and misconceptions and for stimulating discussions during which erroneous information can be corrected.

When tested on 200 students who were non-nurses, 155 registered nurses and 41 registered practical nurses, the Kuder-Richardson formula 20 for internal consistency was 0.78. The test-retest assessment for consistency between time one and time two resulted in a correlation coefficient of 0.56. There were also no statistically significant differences in scores at first writing when compared with scores at second writing and items to total correlations were positive. Respondents varied in their responses according to the level of education and experience with registered nurses scoring higher than students and registered practical nurses (Ross, McDonald & McGuinness, 1996).

Part E: Attitudes Toward Care of the Dying Scale (FATCOD)

A 30-item Likert scale called Attitudes Toward Care of the Dying (Frommelt, 1988) was administered to respondents. The instrument was designed to assure that the items addressed nurses' attitudes toward terminally ill persons and their family members. Two thirds of the items relate directly to attitudes toward the patient and one-third relate to attitudes toward the family members (Frommelt, 1991).

Frommelt (1991) claims the scale has adequate content validity. Pretest reliability was computed using a small sample of nurses and is satisfactory for research purposes (r=.90).

Method

Pilot Study Procedures

The questionnaire was piloted with four persons in Thunder Bay during the fall of 1997. A pilot questionnaire was sent to the Director of Nursing or Manager in each of four work settings: a hospital, a home care agency, a home support agency and a long term care agency. The sample was drawn from a similar population to the study. The pilot was used to refine the questionnaire and identify potential problems, ambiguities and omissions. Pilot agency respondents were asked to review wording in the instructions, questions and explanations and comment on the style and format of the questionnaire. Typographical revisions were made to the cover letter before distribution of the survey.

Distribution

Since the Northern Education Centre for Aging and Health at Lakehead University, Thunder Bay, administers palliative care education across Northwestern Ontario, registration lists were accessed from the NECAH office. The researcher identified eighty-three delegates who had attended the 30 hour Palliative Care Institutes in 1994 or 1997 who stated they were either *nurses* or *worked in nursing.* Letters were sent to all 83 delegates requesting their involvement in the study. Each potential respondent received a package containing an explanatory cover letter (Appendix A), the appropriate consent form (Appendix B) and The Palliative Care Questionnaire (Appendix C). The respondents were asked to participate in the study if they were eligible, sign the consent form and return it with the completed questionnaire to the researcher in the stamped, addressed envelope provided. The questionnaire took approximately 45 minutes to complete. The first mail out resulted in 38 responses. A second mail out a month later resulted in an additional 10 responses for a total of 48. Since a total of 68 nurses were actually eligible to participate and 48 responded, the response rate was 70.5%. This response rate is considered acceptable for a mail survey (Borg, Gall & Gall, 1981).

Ethical Considerations

All measures were taken to ensure confidentiality and anonymity was guaranteed. Respondents' identities are not noted in any written material. All respondents received a letter explaining the research and returned a signed consent with the completed questionnaire.

Expectations

The following relationships were anticipated:

1. Nurses having more positive perceptions of the workplace will also exhibit more positive attitudes toward care of the dying. (Scores of the nurse's Perceptions of Workplace (Part B) will relate positively to scores on Frommelt's Attitude Toward Caring of the Dying scale (Part E).)
2. Nurses who are older, with longer experience and further education will demonstrate a lower level of death anxiety. (Age, years of nursing experience, palliative care experience and education, specifically palliative care education,

will relate negatively with scores on Templer's Death Anxiety Scale (Part C).)

3. Nurses who are older, with longer experience and further education will demonstrate greater knowledge related to palliative care. (Age, years of nursing experience, palliative care experience and education, specifically palliative care education, will relate positively with scores on the Palliative Care Quiz for Nurses (Part D).)

4. Nurses who are older, with longer experience and further education will exhibit more positive attitudes toward caring for the dying. (Age, years of nursing experience, palliative care experience and education, specifically palliative care education, will relate positively to scores on Frommelt's Attitude Toward Care of the Dying scale (Part E).)

4. Nurses who demonstrate greater death anxiety will feel less positively toward workplaces and will demonstrate less positive attitudes toward working with dying people. (Scores on Templer's Death Anxiety Scale (Part C) will relate negatively to scores on Perceptions of Workplace (Part B) and Frommelt's Attitude Toward Caring of the Dying scale (Part E).)

6. Nurses with greater knowledge about palliative care will demonstrate more positive attitudes toward care of the dying. (Scores on the Palliative Care Quiz for Nurses (Part D) will relate positively to scores on Frommelt's Attitude Toward Caring of the Dying Scale (Part E).)

CHAPTER FOUR

Results

Demographic characteristics of the sample are summarized using descriptive statistics. Two-tailed correlations were computed between demographic characteristics and perceptions of workplaces, death anxiety, knowledge and attitudes toward care of the dying as measured by scores on the four instruments.

Demographic Characteristics

The Sample. Between September and November of 1997, 83 former delegates to the Palliative Care Institutes in 1994 and 1997 were mailed the palliative care questionnaire along with a cover letter and a consent form. Of the 83 persons on the mailing list, 15 did not meet the criteria for participation. Ten of the ineligible delegates were registered practical nurses who had been listed in the registration under "nursing" profession. Five other respondents could not be located. Of the remaining 68 eligible subjects, 20 did not reply and gave no explanation. In total, 48 registered nurses responded to the survey for a response rate of 70.5% (see Table 1).

Table 1

The Sample Selection	n
Mailed questionnaires	83
Ineligible participants	10
Could not be located	5
Number of eligible respondents	68
Did not reply	20
Number of participants in study	N=48

Age. The 48 subjects were all female and ranged in age from 24 years to 65 years with a mean of 45.7 years (SD= 9.56).

Workplace Settings. The subjects represented five categories of workplaces (see Table 2). The "other" category represented 22.9% of the respondents. These 11 nurses worked in day centres, clinics and supportive housing, which are also community based settings.

Table 2

Types of Workplace Settings (N=48)

Workplace	n	%
hospital	11	22.9
hospice	2	4.2
community nursing	13	27.1
long term care facility	11	22.9
other	11	22.9

Job Titles. When asked for job titles, 46% of the subjects referred to themselves as *nurses*, 10% replied *nurse manager*, 13% replied case manager and the remaining 31% chose the "other" category. The "other" category included job titles such as "clinician, coordinator, director, assistant director, program assistant, supervisor, nurse/educator or nurse/social worker".

Length of Employment at Current Workplace. The length of employment at the nurses' currènt workplaces ranged from half a year to 25 years with a mean length of 9.45 years (SD=6.67).

Job Status. Almost two thirds of the nurses (62.5%) reported that they worked full time in their current jobs and the remainder (37.5%) were classified as regular, part time employees.

Populations of Communities. Just over half of the nurses worked in a community with a population of over 50,000 (54.2%) and the remaining 45.8% worked in communities with less than 50,000 people (see Table 3). Only one nurse worked in a community with less than 1,000 people. Fifteen communities across Northwestern Ontario were represented in the survey.

Table 3

Populations of Communities

Community size	n	%
<1,000	1	2.1
1,000-5,000	9	18.8
5,000-10.000	9	18.8
10,000-50,000	3	6.3
>50,000 .	26	54.2

Agency Catchment Area. The largest percentage of nurses (44.7%) responded that their agencies provided care to persons with a radius greater than 100 km while 39.6% fell into the 20-100 km range and 14.6% offered care to people within a 20 km radius.

Proximity to Hospital. Most of the respondents (81.2 %) stated that the closest hospital to their community was within 20 km while 18.8% would have to travel between 20 and 100 km to the nearest hospital.

Years of Nursing Experience. The average number of years worked as a nurse was 23.0 with a range from 4 years to 43 years (SD=9.5). Two thirds (n=32, 66.7%) of the nurses had practised nursing more than 23 years (see Table 4).

Years Providing Palliative Care. When asked for the number of years worked in the field of palliative care the responses ranged form zero years (n=3) to 31 years (see Table 4). The average number of years providing palliative care was 11.9 (SD=8.8). The three respondents who claimed not to have provided palliative care indicated they did not practise palliative care exclusively. They did however, state a number when asked how many dying patients they had served. These three respondents were therefore included in the study. One subject did not respond to the question but did report having served a number of dying patients. Thirty-seven or 77.1% of the respondents had provided care for palliative patients for more than the average number of years (M=11.9).

Table 4

Years of Nursing Experience and Palliative Care Experience

Number of years	n	M	SD
Nursing	48	23.04	9.51
Palliative care nursing	48	11.92	8.79

Palliative Patients Served. Table 5 describes the results when nurses were asked for the number of palliative patients for whom they had provided care over their nursing careers. The responses ranged from 10 to 1500 with a mean of 153.8 (n=41, SD=277.5). Two nurses reported they had cared for 1000 and 1500 people respectfully. Of these two nurses, one had 33 years of nursing experience, 17 of which were in a cancer centre. The other nurse had 40 years of nursing experience with 12 of those years in a home for the aged. When these 2 nurses were removed from the calculation, the responses ranged from 10 to 500 patients (n=39, M=97.6, SD=106.3). Seven nurses (14.6%) did not respond to this question. Some of these seven nurses commented that there were "too many to count" or "had no idea".

The nurses were also asked to state the number of palliative patients with whom they had been directly involved (see Table 5). Direct involvement means the provision of direct or "hands-on"care. The response ranged from zero to 500 with a mean of 84.16

(n=43, SD=131.9). Five respondents (10.4%) either did not respond or replied in writing they "had no idea"or there were "too many to count".

Table 5

Number of Palliative Patients Served

Number of patients	n	M	SD
Palliative patients served over career	39*	97.6*	106.3*
Palliative patients cared for directly	43	84.16	131.86

Note. calculations with 2 extreme respondents removed

Number of Deaths Attended. When asked how many deaths the nurses had attended, 44 nurses responded. The responses ranged from zero to 100 with a mean of 22.68. (SD= 30.0) Six respondents (12.5%) had never been present at a death while four (8.3%) had attended over 100 deaths.

Age Intervals of Deceased Patients. Nurses were asked for the approximate ages of their deceased patients or the age of the group of patients most commonly seen.(see Table 6). The age interval which was identified most often was from 66 to 75 years (50%). Most of the deceased (85.5%) were over 65 years of age (N=48).

Table 6

Age Intervals of Deceased Patients

Age Intervals	n	%
under 30 years	1	2.1
30-55	2	4.2
56-65	4	8.3
66-75	24	50.0
76-85	15	31.3
over 85 years	2	4.2

Number of Personal Deaths Experienced. When asked for the number of non-patients who have died, such as family or friends considered close to the respondent, responses ranged from zero to 20 with a mean of 8.1 (n=46, SD=4.4). Nearly half (45.5%) of the respondents had experienced more than 10 deaths within their circle of family or friends. The largest numbers of personal deaths fell between 5 and 10 (67.4%).

Highest Education. The highest level of education received ranged from 29.2% who had received college diplomas to 39.6% with university degrees (see Table 7). An additional 25% of the respondents were college graduates who had taken some university courses. Two nurses had graduate degrees.

Table 7

Highest Education Achieved (N= 48)

Category	n	%
College diploma	14	29.2
College and some university	12	25.0
University degree	19	39.6
University and some college	1	2.1
Graduate degree	2	4.2

Continuing Professional Education. Table 8 indicates the total number of hours of continuing education in palliative care received by the nurses. The number of hours of continuing professional education ranged from 30 hours to 140 hours with a mean of 56.8 hours (SD=29.9). While 29.2% (n=14) received the minimum 30 hours at the Palliative Care Institutes in 1994 or 1997, 70.9% (n=34) of the respondents participated in additional palliative care educational programs such as seminars, workshops, conferences and courses.

Table 8

Hours of Continuing Professional Palliative Care Education

Hours	n	%
30	14	29.2
31-100	27	56.3
>100	7	14.6

Perception of Workplace Scale is a 10-item Likert scale which asked respondents to rate statements about perceptions of their workplaces. With a maximum score of 50 indicating the most positive perception, responses ranged from 21 to 50 with a mean of 37.6 (SD=6.5).

It was expected that the scores on the perception of workplace scale would correlate positively with scores on the attitude scale. Two positive correlations were identified. The scores on the perception of workplace scale correlated positively with the number of hours of palliative care education (N=48, r=.39, p<.01) as well as the attitude scale (N=48, r=.33, p<.02). Of the 11 nurses who worked in long term care facilities, 63.6% rated their agencies below the mean score for the sample (M=37.6, N=48)

Item Scores. An overview of the items of the Perception of Workplace Scale revealed that Item 21, which states: "The agency in which I presently work encourages integration and coordination among staff and other departments", yielded the ***highest*** ratings (M=4.54, SD=.62). Item 19 yielded the *lowest* rating (M=3.25, SD=.89) and states: "The agency in which I presently work encourages innovative ideas and some amount of risk taking" (see Table 9).

Table 9

Means of Item Scores on Perception of Workplace Scale (N=48)

Reported Agency Characteristic	M	SD
Allows for individual initiative such as responsibility, freedom and independence	3.71	.80
Encourages innovative ideas and some amount of risk taking	3.25	.89
Sets clear objectives and performance expectations	3.98	.91
Encourages integration (working with others) and coordination among staff and other departments	4.54	.62
Supports and assists employees when necessary	4.00	.79
Provides effective employee supervision with appropriate rules and regulations	3.87	.89
Makes me feel good about identifying with the organization as a whole rather that with only my professional designation	3.96	.99
Makes me feel rewarded for my efforts	3.44	.90
Allows an opportunity to air conflicts and criticisms openly and without reprisal	3.44	.80
Allows open, less formal communication with all levels of the organization	3.6	.92

Note. 5= Always, 4= Often, 3= Sometimes, 2= Seldom, 1= Never

Templer's Death Anxiety Scale is a 15-item true or false scale which rates one's anxiety toward death. The lower scores indicate lower levels of anxiety. The responses ranged from 0 to 12 with a mean score of 6.58 (SD=2.5). Of the 11 nurses who worked in long term care facilities, 81.8% scored over the mean for the sample.

Three positive correlations with the anxiety scale were identified; age (r=.29, p<.04); years practising as a nurse (r=.31, p<.05) and the number of palliative patients served (r=.39, p<.01). These results were the inverse of the expectations.

Scores on the anxiety scale were expected to relate negatively to scores on the perception of workplace scale (r=-.026, p:NS) and the attitude scale (r=-.126, p:NS). No relationships were identified.

Item Scores. Table 10 describes the percentages of responses for each item of Templer's Death Anxiety Scale. The highest anxiety rating was found on Item 41 "The sight of a dead body horrifies me", with 100% responding true. The lowest anxiety rating was found on Item 37, "The subject of life after death troubles me greatly", with 4.2% responding true.

Table 10

Agreement/Disagreement with Templer's Death Anxiety Scale Items

Statement	% True	% False
I am very much afraid to die.[a]	18.8	80.9
The thought of death seldom enters my mind.	25.0	75.0
It doesn't make me nervous when people talk about death.	85.4	14.6
I dread to think about having an operation.[a]	43.8	54.2
I am not at all afraid to die.	25.0	72.9
I am not particularly afraid of getting cancer.	39.6	58.3
The thought of death never bothers me.	8.3	87.5
I am often distressed by the way time flies so very rapidly.[a]	54.2	45.8
I fear dying a painful death.[a]	62.5	37.5
The subject of life after death troubles me greatly.[a]	4.2	93.8
I am really scared of having a heart attack.[a]	18.8	79.2
I often think about how short life really is.[a]	75.0	25.0
I shudder when I hear people talking about World War III.[a]	27.1	70.8
The sight of a dead body is horrifying to me.[a]	100.0	0.0
I feel that the future holds nothing for me to fear.	29.2	62.5

Note. [a] agreement with these items indicates higher anxiety. Agreement with other items indicates lower anxiety.

The Palliative Care Quiz for Nursing is a 20 item true or false scale which rates one's basic knowledge of palliative care. The scores ranged from 6 to 20 (30% to 100%) with a mean score of 14.58 or 72.9% (SD=2.6).

It was expected that scores on the knowledge quiz would correlate positively with the scores on the attitude scale (r=.17, p:NS), age (r=-.16, p:NS), number of years of nursing experience (r=-.00, p:NS), and education (r=.16, p:NS). There were no significant relationships identified. Of the 11 long term care nurses, 63.6% scored above the mean for the sample (n=48, M=14.58).

Item Scores. Table 11 reports the percentages of correct and incorrect responses for the knowledge quiz. The item most often answered *incorrectly* (n=40) was item 54, "The philosophy of palliative care is compatible with that of aggressive treatment." The correct answer is true and 83.3% responded false.

The items most often answered *correctly* (n=46) were items 49 and 50. "Drug addiction is a major problem when morphine is used on a long-term basis for the management of pain." The correct answer is false and 95.8% responded correctly. Item 50 states "Individuals who are taking opioids should also follow a bowel regime." The correct answer is true and 95.8% answered correctly. When ranked, the four most often incorrectly answered questions were related to the use of drugs for pain and symptom management.

Table 11

Percentages of Correct and Incorrect Answers to the Palliative Care Quiz for Nurses (N=48)

Statement	% Correct	% Incorrect
Palliative care is appropriate only in situations where there is evidence of a downhill trajectory or deterioration	91.7	8.3
Morphine is the standard used to compare the analgesic effect of other opioids	64.6	31.3
The extent of the disease determines the method of pain treatment	70.8	29.2
Adjuvant therapies are important in managing pain	91.7	6.3
It is crucial for family members to remain at the bedside until death occurs	66.7	31.3
During the last days of life, the drowsiness associated with electrolyte imbalance may decrease the need for sedation	56.3	43.8
Drug addiction is a major problem when morphine is used on a long-term basis for the management of pain	95.8	4.2
Individuals who are taking opioids should also follow a bowel regime	95.8	4.2
The provision of palliative care requires emotional detachment	93.8	6.3
During the terminal stages of an illness, drugs that can cause respiratory depression are appropriate for the treatment of severe dyspnoea	54.2	43.8
Men generally reconcile their grief more quickly than women	68.8	29.2
The philosophy of palliative care is compatible with that of aggressive treatment.	14.6	83.3
The use of placebos is appropriate in the treatment of some types of pain	79.2	18.8
In high doses, codeine causes more nausea and vomiting than morphine	39.6	56.3
Suffering and physical pain are synonymous	81.3	16.7
Demerol is not an effective analgesic in the control of chronic pain	87.5	12.5

Table 11 (continued)

The accumulation of losses renders burnout inevitable for those who seek work in palliative care	70.8	27.1
Manifestations of chronic pain are different from those of acute pain	87.5	12.5
The loss of a distant or contentious relationship is easier to resolve than the loss of one that is close or intimate	60.4	39.6
The pain threshold is lowered by anxiety or fatigue	68.8	31.3

Note. 5= Always, 4= Often, 3= Sometimes, 2= Seldom, 1= Never

Frommelt's Attitudes Toward Care of the Dying is a 30-item Likert scale with a maximum total score of 150. The higher scores reflect more positive attitudes toward caring for dying patients. The responses ranged from 112 to 150 with a mean score of 133.62 (SD=9.8).

It was expected that there would be positive relationships between the scores on the attitude scale and age, years of nursing experience, palliative care experience, education and the perception of workplace. As previously mentioned, significance was determined between scores on the attitude scale and scores on the perception of workplace scale (r=.33, p<.02). Another significant relationship was identified between the scores on the attitude scale and the hours of palliative care education (r=.40, p<.01).

Item Scores. Table 12 reports the percentage of the items answered positively or negatively on the attitude scale. All nurses responded they would be comfortable talking with a dying person and they would want to be assigned to a dying person. Fifty per cent of the responses strongly agreed that the dying person should be the decision maker in charge. Sixty per cent strongly agreed that dying persons should be given honest answers about their conditions. More than half of the nurses felt that to some degree family members who stay close to a dying person often interfere with a professional's job.

Table 12

Percentage of Responses to Items in Frommelt's Attitudes Toward Care of the Dying Scale (N=48)

Statement	%SD	%D	%U	%A	%SA
Giving nursing care to the dying person is a worthwhile learning experience.[a]	-	-	-	25.0	75.0
Death is not the worst thing that can happen to a person.[a]	2.1	2.1	8.3	47.9	39.6
I would be uncomfortable talking about impending death with the dying person.	41.7	54.2	4.2	-	-
Nursing care for the patient's family should continue throughout the period of grief and bereavement.[a]	-	-	8.3	33.3	58.3
I would not want to be assigned to care for a dying person.	62.5	37.5	-	-	-
The nurse should not be the one to talk about death with the dying person.	56.3	37.5	4.2	2.1	-
The length of time required to give nursing care to a dying person would frustrate me.	52.1	43.8	4.2	-	-
I would be upset when the dying person I was caring for gave up hope of getting better.	35.4	60.4	2.1	2.1	-
It is difficult to form a close relationship with the family of a dying person.	52.1	43.8	-	4.2	-
There are times when death is welcomed by the dying person.[a]	-	-	2.1	39.6	58.3
When a patient asks, "Nurse, am I dying?", I think it is best to change the subject to something cheerful.	62.5	37.5	-	-	-
The family should be involved in the physical care of the dying person.[a]	2.1	6.3	4.2	56.3	29.2
I would hope the person I'm caring for dies when I am not present.	37.5	54.2	6.3	2.1	-
I am afraid to become friends with a dying person.	45.8	52.1	2.1	-	-
I would feel like running away when the person actually died.	58.3	37.5	4.2	-	-

Table 12 (continued)

Families need emotional support to accept the behaviour changes of the dying person.[a]	-	2.1	-	33.3	64.6
As a patient nears death, the nurse should withdraw from his/her involvement with the patient.	64.6	33.3	2.1	-	-
Families should be concerned about helping their dying member make the best of his/her remaining life.[a]	-	6.3	8.3	54.2	31.3
The dying person should not be allowed to make decisions about his/her physical care.	75.0	18.8	-	2.1	-
Families should maintain as normal an environment as possible for their dying member.[a]	-	-	8.3	54.2	37.5
It is beneficial for the dying person to verbalize his/her feelings.[a]	-	-	10.4	43.8	45.8
Nursing care should extend to the family of the dying person.[a]	-	-	2.1	35.4	62.5
Nurses should permit dying persons to have flexible visiting schedules.[a]	-	-	-	20.8	77.1
The dying person and his/her family should be the in-charge decision makers.[a]	-	4.2	6.3	39.6	50.0
Addiction to pain relieving medication should not be a nursing concern when dealing with a dying person.	-	2.1	4.2	18.8	75.0
I would be uncomfortable if I entered the room of a terminally ill person and found him/her crying.	45.8	39.6	8.3	6.3	-
Dying persons should be given honest answers about their condition.[a]	-	-	4.2	35.4	60.4
Educating families about death and dying is not a nursing responsibility.[a]	47.9	52.1	-	-	-
Family members who stay close to a dying person often interfere with a professional's job with the patient.	47.9	45.8	4.2	2.1	-
It is possible for nurses to help patients prepare for death.[a]	-	-	-	45.8	54.2

Note. SD=Strongly Disagree, D=Disagree, U=Uncertain, A=Agree, SA= Strongly Agree

[a] agreement with these items indicates positive attitudes. Agreement with the other items indicates negative attitudes.

Relationships Between Variables

This section will describe the relationships between demographics and the total scores on the four instruments: Perception of Workplace Scale, Templer's Death Anxiety Scale, Palliative Care Quiz for Nurses and Frommelt's Attitudes Toward Care of the Dying Scale.

Palliative care experience includes the following variables: years of palliative care nursing, the number of palliative patients served, the number of palliative patients cared for directly, the number of deaths attended and the number of personal deaths experienced. Education includes the variables, the highest education received and the number of hours of continuing education in palliative care.

Age. Positive correlations were noted between age and years of nursing practice (N=48, r=.94, p<.01), the number of years practising palliative care nursing (N=48, r=.36, p<.01), and the number of hours of palliative care education (N=48, r=.33, p<.02).

It was expected that there would be a negative correlation between age and the score on the anxiety quiz, in fact, the reverse was evident (N=48, r=.29, p<.04). When a Chi-Square was performed on 3 age categories; less than 40 years, 41 to 50 years and over 50 years, the oldest nurses obtained a higher mean on the anxiety scale (M=8.0, n=15) when compared to either the middle aged group (M=5.95, n=23) or the younger group (M= 5.90, n= 10), χ^2(2, N=48) = 7.46, p<.05. It was expected that there would be positive correlations between age and scores on the knowledge quiz (N=48, r=-.12, p:NS) and age and scores on the attitude scale (N=48, r=.02, p:NS). These expectations were not confirmed.

There were no significant relationships found when correlations were computed between age and the number of palliative care patients (n=41, r=.24, p:NS), the number of patients cared for directly (n=43, r=.02, p:NS), the number of deaths attended (n=44, r=.13, p:NS), or the scores on the workplace scale (N=48,r=.16,p:NS). When a Chi-Square was calculated using the three age groups and agency type a significant relationship was found, χ^2(4, N=48) = 10.05, p<.05). The largest percentage of middle aged nurses, 41-50 year olds, worked in community settings (n=15, 62.5%).

Type of Agency. A significant relationship was found between agency type and the number of personal deaths experienced, χ^2(4, N=48) = 10.28, p<.05. Of the 13 nurses who worked in hospitals, 61.5% had experienced fewer personal deaths than the mean for the sample (M= 8.8, n=46). Of the 11 nurses from long term care settings, 63.6% experienced more than 8 personal deaths. No other significant relationships were identified between the type of agency and other variables.

Years of Nursing Experience. It was expected that there would be a negative relationship between years of nursing experience and scores on the anxiety scale. However, obtained results contradicted this expectation (N=48, r=.31, p<.03). It was expected there would be a positive relationship between years of nursing and scores on the knowledge quiz (N=48, r=-.09, p:NS) and years of nursing and the attitude scale (N=48, r=.04, p:NS). No statistically significant relationships were found.

There was a positive relationship between years of nursing and years practising palliative care (N=48, r=.35, p<.01). There was a positive relationship between years of nursing and the number of hours of continuing palliative care education (N=48, r=.37, p<.01). No other statistically significant correlations were found. No significant relationships were found between years of experience and agency type, χ^2 (2, N=48) = 1.33, p:NS or highest education received, χ^2 (3, N=48) = 5.30, p:NS.

Years Practising Palliative Care Nursing. It was expected there would be an inverse relationship between the number of years providing palliative care and scores on the anxiety scale (N=48, r=.25, p:NS) and a positive relationship between years practising palliative care and scores on the knowledge scale (N=48, r=-.01, p:NS) and the attitude scale (r=.04, p:NS). These expectations were not confirmed.

The Number of Palliative Patients Served. There is a significant relationship between the total number of dying patients and the number of patients cared for directly (N=40, r=.49, p<.01). When a Chi-Square was computed using three groups of patients, less than 100,100 to 499 and 500 or more patients, no relationship with agency type, χ^2 (4, N=48) = 2.79, p:NS nor highest education received χ^2 (6, N=48) = 8.45, p:NS was found.

It was expected that nurses with more palliative care patients would score lower on the anxiety scale, however, there was a positive correlation between the number of palliative patients and the total score on the anxiety scale (n=41, r=.39, p<.01). It was further expected that nurses who had cared for more palliative patients would also score higher on the knowledge quiz (n=41, r=.14, p:NS) and the attitude scale (n=41, r=.15, p:NS). No statistically significant relationships were found.

Number of Palliative Patients Cared for Directly. It was expected that there would be a negative relationship between the number of patients cared for directly and the scores on the anxiety scale (n=43, r=-.02, p:NS) and a positive relationship between the number of patients and the knowledge quiz (n=43, r=.23, p:NS) and the attitude scale (n=43, r=.28, p:NS). No significant relationships were found.

There was a significant correlation between the number of patients cared for directly and the number of patient deaths attended (n=41, r=.60, p<.01). The nurses with the highest number of palliative patients also had achieved the highest number of hours of palliative care education (n=43, r=.41, p<.01).

Number of Deaths Attended. It was expected that there would be an inverse relationship between the number of deaths attended and the scores on the anxiety scale (n=44, r=.07, p:NS) and a positive relationship between the number of deaths attended and scores on the knowledge quiz (n=44, r=.14, p:NS) and the attitude scale (n=44, r=.24, p:NS). No statistically significant relationships were found.

The number of deaths attended correlated positively with the number of personal deaths experienced (n=44, r= .51, p<.01) and with the number of palliative patients cared for directly (n=41, r=.60, p<.01). Also, the number of deaths attended correlated positively with the number of hours of palliative care education achieved (n=44, r=.30, p<.05).

Number of Personal Deaths Experienced. It was expected that there would be a negative relationship between the number of personal deaths experienced and scores on the anxiety scale ($\underline{N}$=48, r=.06, p:NS). The finding was not statistically significant. It was expected that there would be a positive relationship between the number of personal deaths experienced and scores on the knowledge quiz ($\underline{N}$=48, r=-.37, p:NS) as well as the attitude scale ($\underline{N}$=48, r=.17, p:NS). No significant relationships were found. The Chi-Square failed to indicate a significant relationship between the number of personal deaths and the highest education received, χ^2 (6, N=48) = 5.72.

Hours of Continuing Palliative Care Education. It was expected that there would be a negative relationship between continuing palliative care education and the scores on the anxiety scale ($\underline{N}$=48, r=-.002, p:NS). It was also expected that there would be a positive relationship between hours of education and the scores on the knowledge quiz ($\underline{N}$=48, r=.16, p:NS). There was a significant relationship between hours of education and the scores of the attitude toward care of the dying scale ($\underline{N}$=48, r=.40, p<.01).

Summary of Findings

Nurses who perceived their workplaces positively reported having received more hours of continuing professional education. These nurses also indicated more positive attitudes toward caring for the dying.

Older nurses, those over 50 years of age, and nurses with more years of nursing experience and greater numbers of palliative patients served, reported higher death anxiety. Older nurses, with more nursing experience, had also received more hours of palliative care education.

Nurses with the most hours of palliative care education represented those with the largest number of palliative patients and the most patient deaths attended.

The greater the number of hours of palliative care education nurses received, the more positive were their attitudes toward caring for the dying.

CHAPTER FIVE

Discussion and Conclusions

Perception of Workplace and Attitudes Toward Care of the Dying

It was anticipated that there would be a significant positive relationship between scores on the Perception of Workplace Scale and scores on Frommelt's Attitude Toward Care of the Dying Scale. Nurses who perceived their workplaces more positively did score significantly more positively on the attitude scale. Robbins' (1994) states that strong cultures have a greater impact on employee behaviour. "A strong culture demonstrates high agreement among members about what the organization stands for and such unanimity of purpose builds cohesiveness, loyalty, and organizational commitment" (p. 228-254). Most of the nurses perceived their workplaces favourably with only one person rating a workplace with less than fifty per cent.

This result may have to do with optimistic personality types. In other words, these nurses may hold positive attitudes toward many aspects of life. These respondents were selected to be delegates at palliative care educational programs therefore may be highly regarded agency members who demonstrated positive attitudes initially. They may also have volunteered to become a delegate which means they may not be representative of the population at large. The sample may indicate bias considering that two of the twenty nurses who did not respond to the questionnaire indicated they were uncomfortable rating their workplaces. This may indicate that nurses who responded were more likely to perceive their workplaces more positively.

However, the results would appear to indicate that there may be merit to Robbins'

(1994) view that supportive, encouraging workplaces do foster positive attitudes toward work itself. Positive workplace cultures allow opportunities for nurses to demonstrate initiative and innovation while feeling a sense of control. Appropriate management support and guidance, an understanding of agency objectives, and open communication are other characteristics which create a positive workplace culture. Further research is required to determine perceptions of workplaces using statements specifically related to the organization's adherence to the principles of palliative care. Furthermore, research should focus on the relationships between perceptions of workplace, attitudes and corresponding nursing behaviours toward dying patients.

Perception of Workplace and Continuing Palliative Care Education

Another interesting finding was that nurses who had received more hours of palliative care education viewed their workplaces more positively. It may be that nurses who have supportive workplaces are allowed the opportunity to attend educational programs more readily. Palliative care education provides knowledge that increases a nurse's ability to assess a patient's needs, plan and implement care plans and evaluate outcomes. Skills such as communication and knowledge of pain and symptom management are also gained through education. Increased knowledge and skills may lead to improved self-esteem and a feeling of success, hence a positive view of the workplace. The relationship between perceptions of workplaces and education needs more in-depth research with a larger and more varied sample.

Death Anxiety and Age

Although it was expected that nurses who were older would report lower death anxiety on Templer's Death Anxiety Scale, the opposite was reported. Several researchers state there is no relationship between age and anxiety levels (Degner & Gow, 1988; Gow & Williams, 1977; Thompson, 1986). "Older nurses view their work as rewarding and cope with anxiety by engaging the patient as a whole person, and also report not viewing their work as distressing" (Thompson, 1986, p. 238). However, in this study, older nurses, over 50 years of age, scored higher on the anxiety scale. This finding is consistent with the findings of Poppoff (1975) who stated nurses' abilities to cope did not necessarily increase with age.

Difficulty lies in the comparisons of research findings since instruments used to measure anxiety vary. Measuring the ability to cope with anxiety implies that there is anxiety initially. Additional research could focus on the relationship between death anxiety and how nurses cope with their anxiety.

Vachon (1984) found the single greatest stressor of older nurses was identification with patients and families. It may be that older nurses identify with the prospect of death as they themselves get closer to the end of life. These older nurses may have witnessed "difficult" deaths and feel anxious about the prospects for themselves. It may be that older nurses, particularly those who work in long term care settings with the elderly, and nurses who work in intensive acute care settings, have a closer day-to-day relationship with death and fewer opportunities to escape the realities. Death anxiety may be a reflection of cumulative life experiences. Interviews with individual nurses who report high death anxiety may reveal that difficult death experiences early in their careers, prior to adequate pain and symptom management techniques, might have contributed to their anxiety. Those nurses who have not worked through their own fear of death were more likely to report feeling anxious according to Popoff (1975). Since "working through" one's own fear of death seems to be a powerful tool to reduce anxiety, further research is required to clarify exactly what is meant by "working through".

Interviews may reveal that education has had an impact on their feelings today. Further research which looks at nurses of different ages, work settings, and personal characteristics is needed to determine if there is a consistent relationship between death anxiety and age.

Death Anxiety and Years of Experience

Another unexpected finding was the relationship between nursing experience and scores on the anxiety scale. Nurses who had worked longer in the field experienced significantly higher anxiety levels. This finding reinforces studies which stated that nurses' abilities to cope with death did not necessarily increase with experience, in fact, experience actually added to death anxiety (Popoff, 1975; Thompson, 1985). Because age and years of nursing experience are directly related, this finding could be directly related to age as previously mentioned. Older nurses may become more vulnerable to the effects of death of clients if they have worked with them for several years and if they are closer in age to their clients. On the other hand, there may be a possibility that the longer one works in the field, the more anxious about death one becomes, regardless of age. Further research could focus on the relationships between anxiety, the length of time nurses spend with individual dying patients and how the meaning of the experience impacts the nurse.

Death Anxiety and Number of Palliative Patients

A third unexpected significant finding was that nurses who had served more palliative patients over their careers also scored higher on the death anxiety scale. Since age, experience and the number of palliative patients served over a nurse's career are interrelated, it is difficult to separate one from the other. It may well be that the more dying people one encounters, the more discomfort one feels. Possibly one's anxiety would depend on the type of deaths one has witnessed. The cumulative effect of experiencing lingering, painful deaths, deaths of young people, traumatic deaths, and unexpected deaths may take an emotional toll on care providers. Life on an emotional rollercoaster, according to Newlin and Wellisch (1978), can lead to the battle fatigue described by Vachon (1987). Another area for further research is the study of death anxiety in relation to the types of deaths experienced. To explore the impact of various types of deaths on care providers, a qualitative study which sampled nurses from various sites would be one feasible approach.

It is difficult to draw conclusions from the results of Templer's Death Anxiety Scale since anxiety is a multidimensional construct. The scale does not measure actual behaviours or even potential behaviours. In addition, some of the statements are somewhat ambiguous. For example, "I often think about how short life really is" is intended to be answered false, indicating low anxiety. It is unclear why thinking about our lives as short is indicative of death anxiety. Another statement expecting a false response, indicating low anxiety, is "The thought of death seldom enters my mind". It is unrealistic to think that palliative care nurses could answer false to this statement since the focus of their work revolves around death.

Age and Continuing Palliative Care Education

The significant finding that older nurses achieved more hours of continuing palliative care education may be attributed to numerous factors. Since formal, palliative care education for care providers only began in 1993 in Ontario, older nurses would not necessarily have had more opportunities to take courses over a longer period of time. It is possible they were identified by managers as having a need for professional upgrading, or they themselves identified this need. Perhaps their knowledge, enthusiasm and experience gave them the status within their organizations to be selected to become resource persons. It must be recalled that the criteria for selection of delegates to attend Palliative Care Institutes is that the delegates should be a well respected, responsible persons with a willingness to learn and teach others. Finally, older nurses who are more often managers, were likely more available to attend continuing professional education. Further research could focus on the relationship between age and continuing professional education.

Death Anxiety and Attitudes Toward Care of the Dying

It was expected that the nurses having higher death anxiety tend to have less positive attitudes toward care of the dying. However, no significant relationship was found between death anxiety and attitude scale scores. The absence of a significant relationship is puzzling and discussion in the absence of further data is speculative.

Since the anxiety scale content focuses on one's own death and the attitude scale concentrates on caring for another, their relationship may be a matter of speculation. It may be that a curvilinear relationship exists between the two variables. Individuals with very low death anxiety may experience lower levels of arousal or motivation to care for patients nearing death. However, nurses experiencing high anxiety may tend to find it exacerbated in some situations involving dying patients and perhaps become less involved in these circumstances.

Further research with appropriate samples is needed to examine possible relationships between high and low death anxiety, attitudes toward care of the dying and actual nursing behaviours.

Knowledge Quiz and Age, Years of Experience and Education

It was anticipated that age, years of nursing experience, palliative care experience and education, specifically palliative care education, would relate significantly to scores on the Palliative Care Quiz for Nurses. None of the anticipated positive relationships were found. Since all the respondents had received at least thirty hours of palliative care education prior to taking the knowledge quiz, the scores within the group were not expected to be great. However, considering the educational level of the nurses, it is surprising to find that five nurses or 10% of the sample scored 50% or less on the knowledge quiz.

The knowledge quiz is an effective instrument for many reasons. Item ranking the responses to the quiz will provide educators with information regarding palliative care educational needs of nurses. Two items scores found in this study matched Ross' study (1996) in that the same two items were the most frequently answered incorrectly. For example, it was unclear to most nurses that the philosophy of palliative care is compatible with that of aggressive treatment. The term "aggressive" may be misleading to some who think of palliation only in terms of passive, comfort care. Also, nurses were most often deficient in their knowledge of pain and symptom management, specifically in relation to opioid use. This information is very useful for educators when designing curriculum for continuing professional education programs, and for agency managers when designing staff orientation programs within workplaces.

The knowledge quiz has research potential for the longitudinal tracking of students' progress. Students who begin the three-year cycle of education could be pretested, tested annually and tested upon completion of the program. The quiz also has the potential to be modified for use by any professional caregivers who work with dying people, as well as families, friends and volunteers. Given that palliative care service and education are interdisciplinary in nature, it is essential to develop multidisciplinary approaches to service and education. By replacing medical items with psychosocial items it may be possible to identify areas paraprofessionals or lay persons could use for discussion or clarification. Curriculum could also be designed to meet the specific needs of these target groups. It would be beneficial to include a section which asks respondents to identify and rate educational topics that they feel are most urgent. It is also essential to identify the level of learning required; basic, intermediate or advanced.

Future research should include pre-test and post-test knowledge testing for all delegates who attend the Palliative Care Institutes. Results could be beneficial in identifying learning gaps and planning the curriculum for follow-up sessions. Research should also attempt to compare the scores of sample groups who have received palliative care education with those who have not.

Attitudes Toward Care of the Dying and Age, Experience and Education

Nurses who had received more hours of palliative care education demonstrated significantly more positive attitudes toward caring for the dying. This is consistent with the findings of several researchers who report that attitudes showed improvement following continuing education courses (Degner & Gow, 1988; Frommelt, 1991; Lev, 1986; Reisetter & Thomas, 1986). Although this study did not measure attitude change, there is a relationship between attitude and education. It may be that respondents who indicate positive attitudes toward the dying patient do so because they feel they "should" report positively. It is possible that the nurses who willingly participate in education also start out with positive attitudes toward their patients and their families. The measurement of attitudes is difficult since self reporting does not necessarily translate into actual behaviour. Further research is needed to measure the attitudes of students prior to palliative care education and again following the program. Research should attempt to determine if there are consistent relationships between continuing education, attitudes and actual nursing behaviours.

Practice, Research and Education

The findings in this study have relevance for practice, research and education.

Practice.

The results of this study could serve to heighten the awareness of administrators of health care agencies with regards to the importance of the relationship between positive workplace cultures and attitudes toward caring for people who are dying. It is recommended that the Perception of Workplace Scale be developed as an instrument to aid in the assessment of palliative care work environments specifically. Potentially, the scale could be used to identify needs and gaps as well as strengths within an organization. Results could lead to the development of employee support programs, the identification of meaningful forms of recognition, and the improvement of communication. For example, employees may feel that emotional support is needed from peers following the death of a patient. Employees could be offered the opportunity to design and participate in various forms of bereavement such as individual, peer or group counselling. Dealing with death is a personal journey and employees should be permitted to grieve in their own way.

Recognizing that working with dying people can be anxiety producing for some nurses implies that organizations should be prepared to identify the most appropriate way of dealing with that anxiety. It may well be that those who score high on death anxiety scales perform satisfactorily in a palliative care environment. It may also be that those who score low do not perform any more satisfactorily. It may be that a balance is required in all the components of attitudes; cognitive, affective and behavioural, in order to be an effective palliative care nurse. Finding that balance is the key to establishing some harmony between personal and professional endeavours.

Unfortunately, only when one's anxiety level becomes outwardly inappropriate would managers or peers identify a problem. For example, withdrawal or avoidance behaviour could be indicative of an inappropriate anxiety level possibly resulting in alienation and burnout. In practice, once a problem is identified, it would be advisable for managers to offer alternative forms of support. An informal approach could include promoting interaction with peers or managers, offering literature, suggesting time off or a move to another unit. Formally, individual or group counselling might be appropriate.

Research.

Numerous recommendations have been made for further research. Although this study did not find a significant relationship between high death anxiety and negative attitudes toward dying people, it is important to be aware that self-reported attitudes may not always be accurate or consistent with actual behaviours. It is recommended that a future study focus on behaviours of nurses who provide palliative care. Research could be modeled using the three components of attitudes; cognitive, affective and behavioural (Lev, 1986). Data could be collected using surveys, personal interviews, observation and key informants. Every attempt should be made to include the most important key informant, the dying person.

Moreover, to better understand the characteristics of nurses who provide palliative care, James (1993) suggests that a study of their personal experiences will reveal a deeper awareness of the meaning of caring for dying people. To better understand that meaning, it is recommended that personal interviews or small focus groups be conducted with a sample of the respondents to gather more information. This approach could provide an opportunity to hear nurses describe their experiences, perceptions, feelings and stressors in much greater detail and depth. It is expected that themes around personal characteristics of palliative care nurses would emerge, possibly around issues such as self-esteem, control, mastery, support and spirituality. Hearing directly from nurses who work with dying people would prove to be an interesting and rewarding follow-up to this study.

Education.

Educationally, the Perception of Workplace has the potential for use in management training seminars as well as staff education. Robbins' (1994) ten characteristics for an effective workplace lend themselves very well to much broader areas of discussion. For example, newly employed nurses would have an opportunity to develop the "shared meaning" of a workplace. Educational sessions which focus on the workplace could clarify an agency's core values, goals, and expectations. This researcher strongly concurs with Thompson (1985) who stated that to best fit into a palliative care workplace it is recommended that nurses receive "philosophical reorientation".

With respect to formally assisting nurses who are experiencing high levels of anxiety, continuing professional education could be an alternative. Education that includes self-awareness exercises coupled with an opportunity to express anxieties could be beneficial to some nurses who are expected to work with palliative patients and their families. Perhaps the most important messages to impart to nurses are that death anxiety is not uncommon and that an awareness of one's own anxiety level together with strategies to moderate it fosters positive caring behaviour when dealing with dying patients.

It was also important to study the knowledge base of respondents for many reasons. The results of the basic knowledge quiz could be useful to palliative care educators and agency managers as a guide to planning orientation and continuing education programs. Item scores indicate gaps in learning which could be either addressed promptly on site or built into future educational programs.

Since this study also related continuing professional education to positive attitudes toward the dying, it is recommended that the content of continuing professional education be specifically related to the principles of palliative care, pain and symptom management, and attitude development. In particular, nurses need greater information related to medication use and symptoms related to palliation.

Given that most people die beyond the age of 65 years, it is recommended that gerontology and geriatric care become cornerstones in the curriculum of palliative care education. The current focus on palliative care education, and its effort to promote positive attitudes and increase skills and knowledge among health care practitioners, is essential. As the field of palliative care gradually moves toward a national, standardized core of knowledge, the relationship between education and attitudes needs to be understood in greater depth. Whether or not education can modify behaviours as well as attitudes toward caring for the dying person is a significantly important area for future research.

This study focussed on the characteristics of nurses who provide palliative care. Perceptions of their workplaces, palliative care knowledge, anxiety about death and attitudes toward caring for the dying were examined. It is evident that more extensive research is needed to be able to understand the essence of palliative care nursing. While education is a fundamental component of palliative care, a combination of substantive research and strong educational programming will surely aid in the provision of care for dying persons.

References

Anastasi, A. (1976). Psychological testing. New York: Macmillan.

Bond, M. (1988). Safer death. New York: Plenum Press.

Borg, W., Gall, J., & Gall, M. (1993). Applying Educational Research: A Practical Guide. New York & London: Longman Publishing Group.

Brockopp, D., King, D., & Hamilton, J. (1991). The dying patient: A comparative study of nurse caregiver characteristics. Death Studies, 15, 245-258.

Craig, J., & Cavanaugh, J. (1985). Relationships among death anxiety, attitudes toward aging, and experiences with death in nursing home employees. Journal of Gerontology, 40(3), 347-349.

Davies, B., & Oberle, K. (1990). Dimensions of the supportive role of the nurse in palliative care. Oncology Nursing Forum, 17(1), 87-94.

Davis, A. J., & Aroskar, M. A. (1983). Ethical dilemmas and nursing practice. Norwalk, CT: Appleton-Century-Crofts..

Degner, L. F., & Gow, C. M. (1988). Preparing nurses for care of the dying: A longitudinal study. Cancer Nursing,11(3), 160-169.

Denton, J. S., & Wisenbaker, V. B. (1977). Death experience and death anxiety among nurses and nursing students. Nursing Research, 26, 61-64.

Dobratz, M. C. (1990). Hospice nursing: present perspectives and future directives. Cancer Nursing, 13(2), 116-122.

Durlak, J. A. (1982). Using the Templer scale to assess "death anxiety": A cautionary note. Psychological Reports, 50, 1257-1258.

Elliot, G. R., & Eisdorfer, C. (Eds.). (1982). Stress and human health: Analysis and implications of research. New York: Springer.

Fishbein, M., & Ajzen, I. (1972). Attitudes and opinions. Annual Review of Psychology, 23, 488-544.

Fischer, J., & Corcoran, K. (1994). Measures for clinical practice: A sourcebook. New York: Simon & Schuster Inc.

Ford, R. L. (1988). Work, organization and power. Massachusetts: Simon & Schuster.

Frommelt, K. (1988). Frommelt attitude toward care of the dying scale. Unpublished master's thesis, University of Dubuque, Dubuque, IA.

Frommelt, K. (1991, Sept/Oct). The effects of death education on nurses' attitudes toward caring for terminally ill persons and their families. The American Journal of Hospice & Palliative Care, 37-43.

Gagne, R. (1977). The conditions of learning. New York: Holt, Rinehart and Winston.

Golub, S., & Rezinkoff, M. (1971, November-December). Attitudes toward death: A comparison of nursing students and graduate nurses. Nursing Research, 20(6), 503-508.

Gow, C. M., & Williams, J. I. (1977). Nurses' attitudes toward death and dying: A causal interpretation. Social Science Medicine, 11, 191-198.

Hare, J., & Pratt, C. (1989). Nurses' fear of death and comfort level with dying patients. Death Studies, 13, 349-369.

James, C. R., & MacLeod, R. D. (1993). The problematic nature of education in palliative care. Journal of Palliative Care, 9(4), 5-10.

Lev, E. (1986). Teaching humane care for dying patients. Nursing Outlook, 34(5), 41-243.

Mandel, H. (1981, June). Nurses' feelings about working with the dying. American Journal of Nursing, 1194-1196.

McCorkle, R. (1978). Hospices-A British reality and an American dream: Current perspectives in oncologic nursing. St. Louis, MO: Mosby.

Nebauer, M., Prior, D., Berggren, I., Haberecht, J., Ku, M., Mitchell, A., & Davies, E. (1996). Nurses' perceptions of palliative care nursing. International Journal of Palliative Nursing, 2(1), 26-34.

Newlin, N.J., & Wellisch, D.K. (1978, December). The oncology nurse: Life of an emotional roller coaster. Cancer Nursing, 447-449.

Northern Educational Centre for Aging and Health (1994). Palliative care: Taking the challenge together. Thunder Bay: Lakehead University.

Pearlin, L. I., & Schooler, C. (1978). The structure of coping. Journal of Health and Social Behaviour, 19, 2-21.

Pervin, L. A. (1990). Handbook of Personality: Theory and Research. New York: The Guilford Press.

Poppoff, D. (1975). About death and dying. Part 2. Nursing, 5(8), 16-22.

Poppoff, D. (1975) What are your feelings about death and dying? Nursing, 5(9), 53-62.

Quint, J. Q. (1967). The nurse and the dying patient. New York: Macmillan.

Registered Nurses' Association of Ontario. (1980, February). Position Paper on Continuing Education for Registered Nurses.

Reisetter, K. H., & Thomas, B. (1986). Nursing care of the dying: its relationship to selected nurse characteristics. International Journal of Nursing Studies,23(1), 39-50.

Robbins, S. P. (1994). Essentials of organizational behavior. New Jersey: Prentice Hall.

Roe, D. J. (1992). Palliative Care 2000-Home Care. Journal of Palliative Care, 8(1), 28-32.

Ross, M. M., & McDonald, B. (1996). Determining the educational and support needs of community-based nurses regarding palliative care and aging. Hamilton, Ontario: McMaster University.

Ross, M. M., McDonald, B., & McGuinness, J. (1996). The palliative care quiz for nursing (PCQN): The development of an instrument to measure nurses' knowledge of palliative care. Journal of Advanced Nursing 23, 126-137

Rutman, D., & Parke B. (1989). Palliative care needs of residents, families and staff in long term care facilities. Journal of Palliative Care, 8(2), 23-29.

Sellick, S. M., Charles, K., Dagsvik, J., & Kelley, M. L. (1996). Palliative care providers' perspectives on service and education needs. Journal of Palliative Care, 12(2), 34-38.

Templer, D. (1971). Death anxiety scale means, standard deviations, and embedding. Psychological Reports, 29, 173-174.

Thompson, E. (1985). Palliative and curative care nurses' attitudes toward dying and death in the hospital setting. Omega,16, 233-243.

Travelbee, J. (1975). Interpersonal aspects of nursing. Philadelphia: F.A. Davis Company.

Vachon, M.L. (1987). Occupational stress in the care of the critically ill, the dying and the bereaved. New York: Hemisphere Publishing Corporation.

Vachon, M. L. (1978). Motivation and stress experienced by staff working with the terminally ill. Death Education, 2, 113-122.

Vickio, C., & Cavanaugh, J. (1985). Relationships among death anxiety, attitudes toward aging, and experience with death in nursing home employees. Journal of Gerontology, 40(3), 347-349.

Ward, M. J., & Lindeman, C. A. (1978). Instruments for measuring nursing practice and other health care variables Vol.1. Washington, DC: US Government Printing Office.

Wilkinson, H. J., & Wilkinson, J. W. (1986-87). Evaluation of a hospice volunteer training program. Omega,17(3), 263-276.

Yeaworth, R., Kapp, F. T., & Winget, C. (1974). Attitudes of nursing students toward the dying patient. Nursing Research, 23(1), 20-24.

Appendices

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Appendix A

An Invitation to Registered Nurses to Participate in Palliative Care Research

In order to complete the requirements of a Master of Education, Administration, with a Gerontology Specialty at Lakehead University, I will be conducting a study of palliative care nurses across northwestern Ontario over the next few months. The research will examine:

The relationships between organizational work culture, death anxiety, knowledge and attitudes of palliative care nurses toward caring for dying people.

In an endeavor to provide terminally ill people the highest quality of care it is extremely important to understand those who most often provide palliative care, Registered Nurses.

The purpose of this research project is to study the relationship between nurses' perceptions of the culture of their work environments and their attitudes toward caring for terminally ill people. Questions include, but are not limited to the following: age, work experience, education, experiences with death. Scales which address work culture, death anxiety, attitudes and knowledge will be administered. The information gained will offer insight into the relationships between work culture, death anxiety, knowledge and attitudes of nurses across northwestern Ontario toward the dying person.

The Palliative Care Questionnaire will take approximately 45 minutes to complete. There are no risks involved in this research and with the exception of the knowledge quiz, no "correct" answers. Questionnaires will be coded to enable follow up contact with four or five participants for purposes of face-to-face interviews. All information will be kept strictly confidential on file at Lakehead University in the office of my supervisor, Dr. Alan Bowd, for seven (7) years. However, the general results of this research will be made available to you at your request upon completion.

Participants must be Registered Nurses, currently employed either full or part time, who have cared for <u>at least one</u> terminally ill person.

If you are willing to participate in this research project, please sign the enclosed consent form and mail it with the completed questionnaire in the enclosed addressed and stamped envelope as soon as possible. If you have any questions, please call me at (807) 343-2115 anytime. Leave your name and phone number and I will contact you as soon as possible.
I look forward to your participation and thank you for your cooperation.

Sincerely,

Marilyn Arthur

NECAH

Appendix B

Consent Form

Title of Research: The relationships between perception of workplace, death anxiety, knowledge and attitudes toward care of the dying among palliative care nurses.

Marilyn Arthur is the researcher completing a Master's degree in Education, (Administration) with a Specialization in Gerontology, at Lakehead University.
Phone:(807)345-0417 Fax :(807)345-8345

I,____________________________, consent to take part in a study which will examine my perceptions of my work culture, my level of death anxiety, my knowledge, and my attitudes toward caring for terminally ill people.

I understand that the study will involve the completion of a questionnaire and a selected number of follow-up, face-to-face interviews will be requested with four or five of the participants.

I understand that any information collected about me during this study will be kept strictly confidential on file at Lakehead University in the office of the supervisor, Dr. Alan Bowd, and for seven (7) years. I will receive a summary of the research upon request, following the completion of the research.

I understand that as a volunteer I may withdraw from the study at any time, even after signing this form.

Signature of Participant______________________________ Date________________

Appendix C
Palliative Care Questionnaire

Part A

The first part of the questionnaire requests background information. If you are a registered nurse who provides palliative care, please complete the following (✓):

1. Please indicate your age in years ____________

2. Total number of years as a practising nurse ______________

3. Total number of years as a practising palliative care nurse____________

4. Type of agency in which you currently work

☐ hospital
☐ community nursing
☐ long term care facility
☐ hospice unit or hospice home
☐ other (please specify)________________________

5. Job title

☐ nurse
☐ nurse manager
☐ case manager
☐ other_______________________

6. Length of time at this agency (in years)_____________

7. Employment status

☐ full time
☐ regular part time
☐ occasional part time
☐ other____________________________

8. Size of community

☐ less than 1000
☐ 1000-5000
☐ 5000-10,000
☐ 10,000-50,000
☐ over 50,000

9. Catchment area of your agency (one way)

☐ under 20 km
☐ 20-100 km
☐ over 100 km

10. Distance to nearest hospital for most people in your community

☐ under 20 km
☐ 20-100 km
☐ over 100 km

11. Approximate number of patients to whom you have provided palliative care ___________

12. Approximate number of patient deaths you have been directly involved with ___________

13. Approximate number of times death of a patient occurred in your presence ___________

14. Number of persons close to you who have died in the past (family, friends) ___________

15. Most deaths on your caseload occurred in following age groups:

☐ under 30 years
☐ 30-55
☐ 56-65
☐ 66-75
☐ 76-85
☐ over 85 years

16. Highest level of education you have achieved

☐ college diploma
☐ some college courses

☐ university degree
☐ some university courses
☐ graduate degree

17. Continuing education course(s) achieved, specifically dealing with palliative care such as:

☐ Palliative Care Institute 1994
☐ Northern Lights: Advanced Palliative Care 1995
☐ Kindred Spirits: The Palliative Care Family 1996
☐ Palliative Care: Psychogeriatric Issues 1995/96
☐ Palliative Care Institute 1997
☐ Ontario Palliative Care Association Conference
☐ Canadian Palliative Care Conference
☐ Other: please list including year ______________________________

____

Part B

Complete the following statements by checking the appropriate box. (✓)
The agency or setting in which I presently work ...

18. Allows for individual initiative such as responsibility, freedom and independence

not at all ☐ seldom ☐ sometimes☐ often☐ always

19. Encourages innovative ideas and some amount of risk taking

not at all ☐ seldom ☐ sometimes☐ often☐ always

20. Sets clear objectives and performance expectations

not at all ☐ seldom ☐ sometimes☐ often☐ always

21. Encourages integration (working with others) and coordination among staff and other departments

not at all ☐ seldom ☐ sometimes☐ often☐ always

22. Supports and assists employees when necessary

not at all ☐ seldom ☐ sometimes☐ often☐ always

23. Provides effective employee supervision with appropriate rules and regulations

not at all ☐ seldom ☐ sometimes☐ often☐ always

24. Makes me feel good about identifying with the organization as a whole rather than with only my professional designation

not at all ☐ seldom ☐ sometimes☐ often☐ always

25. Makes me feel rewarded for my efforts

not at all ☐ seldom ☐ sometimes☐ often☐ always

26. Allows an opportunity to air conflicts and criticisms openly and without reprisal

not at all ☐ seldom ☐ sometimes☐ often☐ always

27. Allows open, less formal communication with all levels of the organization

not at all ☐ seldom ☐ sometimes☐ often☐ always

Part C

Please circle True or False.

28. I am very much afraid to die. 28. T F

29. The thought of death seldom enters my mind. 29. T F

30. It doesn't make me nervous when people talk about death 30. T F

31. I dread to think about having an operation. 31. T F

32. I am not at all afraid to die. 32. T F

33. I am not particularly afraid of getting cancer. 33. T F

34. The thought of death never bothers me. 34. T F

35. I am often distressed by the way time flies so very rapidly. 35. T F

36. I fear dying a painful death. 36. T F

37. The subject of life after death troubles me greatly. 37. T F

38. I am really scared of having a heart attack. 38. T F

39. I often think about how short life really is 39. T F

40. I shudder when I hear people talking about World War III. 40. T F

41. The sight of a dead body is horrifying to me. 41. T F

42. I feel that the future holds nothing for me to fear. 42. T F

Part D

Please circle True, False or DK (Don't Know)

43. Palliative care is appropriate only in situations where there is evidence of a downhill trajectory or deterioration 43. T F DK

44. Morphine is the standard used to compare the analgesic effect of other opioids 44. T F DK

45. The extent of the disease determines the method of pain treatment. 45. T F DK

46. Adjuvant therapies are important in managing pain 46. T F DK

47. It is crucial for family members to remain at the bedside until death occurs 47. T F DK

48. During the last days of life, the drowsiness associated with electrolyte imbalance may decrease the need for sedation 48. T F DK

49. Drug addiction is a major problem when morphine is used on a long-term basis for the management of pain 49. T F DK

50. Individuals who are taking opioids should also follow a bowel regime 50. T F DK

51. The provision of palliative care requires emotional detachment 51. T F DK

52. During the terminal stages of an illness, drugs that can cause respiratory depression are appropriate for the treatment of severe dyspnoea 52. T F DK

53. Men generally reconcile their grief more quickly than women 53. T F DK

54. The philosophy of palliative care is compatible with that of aggressive treatment 54. T F DK

55. The use of placebos is appropriate in the treatment of some types of pain 55. T F DK

56. In high doses, codeine causes more nausea and vomiting than morphine 56. T F DK

57. Suffering and physical pain are synonymous 57. T F DK

58. Demerol is not an effective analgesic in the control of chronic pain 58. T F DK

59. The accumulation of losses renders burnout inevitable for those who seek work in palliative care 59. T F DK

60. Manifestations of chronic pain are different from those of acute pain 60. T F DK

61. The loss of a distant or contentious relationship is easier to resolve than the loss of one that is close or intimate 61. T F DK

62. The pain threshold is lowered by anxiety or fatigue 62. T F DK

Part E

Please circle one:

SD=Strongly Disagree D=Disagree U=Uncertain A=Agree SA= Strongly Agree

63. Giving nursing care to the dying person is a worthwhile learning experience.

SD D U A SA

64. Death is not the worst thing that can happen to a person.

SD D U A SA

65. I would be uncomfortable talking about impending death with the dying person.

SD D U A SA

66. Nursing care for the patient's family should continue throughout the period of grief and bereavement.

SD D U A SA

67. I would not want to be assigned to care for a dying person.

SD D U A SA

68. The nurse should not be the one to talk about death with the dying person.

SD D U A SA

69. The length of time required to give nursing care to a dying person would frustrate me.

SD D U A SA

70. I would be upset when the dying person I was caring for gave up hope of getting better.

SD D U A SA

71. It is difficult to form a close relationship with the family of a dying person.

SD D U A SA

72. There are times when death is welcomed by the dying person.

SD D U A SA

73. When a patient asks, "Nurse am I dying?", I think it is best to change the subject to something cheerful.

SD D U A SA

74. The family should be involved in the physical care of the dying person.

SD D U A SA

75. I would hope the person I'm caring for dies when I am not present.

SD D U A SA

76. I am afraid to become friends with a dying person.

SD D U A SA

77. I would feel like running away when the person actually died.

SD D U A SA

78. Families need emotional support to accept the behaviour changes of the dying person.

SD D U A SA

79. As a patient nears death, the nurse should withdraw from his/her involvement with the patient.

SD D U A SA

80. Families should be concerned about helping their dying member make the best of his/her remaining life.

SD D U A SA

81. The dying person should not be allowed to make decisions about his/her physical care.

SD D U A SA

82. Families should maintain as normal an environment as possible for their dying member.

SD D U A SA

83. It is beneficial for the dying person to verbalize his/her feelings.

SD D U A SA

84. Nursing care should extend to the family of the dying person.

SD D U A SA

85. Nurses should permit dying persons to have flexible visiting schedules.

SD D U A SA

86. The dying person and his/her family should be the in-charge decision makers.

SD D U A SA

87. Addiction to pain relieving medication should not be a nursing concern when dealing with a dying person.

SD D U A SA

88. I would be uncomfortable if I entered the room of a terminally ill person and found him/her crying.

SD D U A SA

89. Dying persons should be given honest answers about their condition.

SD D U A SA

90. Educating families about death and dying is not a nursing responsibility.

SD D U A SA

91. Family members who stay close to a dying person often interfere with a professionals' job with the pati

SD D U A SA

92. It is possible for nurses to help patients prepare for death.

SD D U A SA

Thank you for participating in this research study!