NURSES' PERCEPTION OF DEATH EDUCATION

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ABSTRACT

The primary purpose of this study was to examine nurses', including student nurses', perceptions of death education in southern Alberta as one way of improving future nursing curricula. Five nurse subgroups were included, as follows: college and university students, hospital nurses, community nurses, and nurse educators. A questionnaire was developed and piloted prior to distribution to 450 nurses in six locations, including two urban and four rural sites, in southern Alberta. Completed, useable returns numbered 373 (83%). Descriptive statistics, ANOVA, and t-tests were used to analyze the data from scaled questionnaire items; content analysis was used to interpret written response items. Theoretical and conceptual frameworks were developed and utilized to guide the interpretation of findings.

Generally, nurses perceived that existing death education remains inadequate as preparation for sound clinical nursing practice. Several statistically significant findings related to the provision of professional terminal care were reported among the five nurse subgroups. Nurses identified concerns and deficits within existing nursing death education and offered several specific suggestions for improvement. The improvement of death education for nurses will most likely result in the delivery of safe, effective, quality nursing care practice to the dying person and family.

In loving memory of

LOIS MARGARET GRANT

who, by example, taught me about what really matters in life.

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Prologue

"Death is the ultimate touchstone of human endeavors. It is the ultimate organizer of time. It is the ultimate enemy of self. It is the ultimate leveler of all persons. It is the ultimate uncertainty and the ultimate certainty, the ultimate event, the ultimate negator of passions and plans and power and personal growth" (Kalish, 1985, p. 5).

My interest in death education is related to past experience, both personal and professional. The experience related to the death of my mother 20 years ago led me to believe that there must be a better way to care for terminal patients and families; and that if I were ever in a position to effect change, I would endeavor to do so. While working as a Palliative Care Coordinator, the need for education in the area of death and dying was reinforced. I found that not only did terminal patients and families have tremendous difficulty dealing with death, but that this same difficulty was experienced by health professionals (i.e., nurses) as well. Avoidance of the patient and family by the nurse was a frequently adopted coping strategy. My present position as a nurse educator provides an opportunity to teach student nurses about death and dying; however, in this role I am reminded of the lack of a systematic curriculum regarding death education for nurses.

The need to find answers to several questions regarding terminal care and the need to learn more about the quality of death education provided to nurses served as the foci for my studies. I envisioned a healthy reconciliation with the experience of patient death for all concerned: the patient, family, and caregivers. Professional commitment and personal concern have motivated me to pursue this area as one requiring research.

NURSES' PERCEPTIONS OF DEATH EDUCATION

CHAPTER I

Introduction

Today, in Canada about 70% of our population die within institutions (Lockard, 1989). This means that health professionals are called upon more often to support the dying person and family. A recent trend is that of the terminal patient opting to die in his/her familiar and comfortable home environment, which requires adjustment to yet another situation and another set of circumstances by the patient, family, and caregiver.

Nurses are the members of the health care team who have the most contact with the dying patient and family; they are usually in such situations on a 24-hour basis. Mullins and Merrian (1983) point out that, "Nurses have special relationships with the terminally ill, in contrast with other hospital staff, because nurses and patients usually are together for a time sufficient to establish a relationship" (p. 488). In addition, nurses play a major role in providing humane care and a supportive environment for the patient and his/her family. Rogers and Vachon (1975) state, "nurses by virtue of their personal caring roles and their positions within institutions and in the community at large are uniquely suited to carry more responsibility in providing service to the bereaved" (p. 16). Furthermore, nurses are in a unique position to coordinate effective patient care delivery through utilization of an interdisciplinary approach. Regardless of specialty or setting, nurses are expected to provide safe, sensitive and effective care to the dying patient and family. This expectation places a tremendous amount of responsibility on nurses. Are nurses educationally prepared to take on this responsibility?

Background

A century ago, death was regarded as a normal phenomenon, as a part of family life with family members participating in the care of the dying person and in the funeral

and mourning activities that followed. The 20th century heralded a major shift in patterns of disease and treatment that has influenced the nature of nurses' exposure to the dying process. The use of antibiotics, immunization, and the control of infection through public health measures has shifted mortality patterns. Today, the leading causes of death are chronic diseases such as heart disease and cancer The many effective treatment modalities available lend support to the prevalent societal notion that medical technology will eventually eradicate all disease. As a consequence, aggressive treatment often continues until close to the time of death and death takes place in the hospital rather than at home.

The implications of these shifts are twofold. First, prior to entering nursing, young people are relatively protected from both seeing and talking with the dying. However, as soon as they begin to practice, they are expected to adapt to death as a visible phenomenon and to respond sensitively and effectively when providing care. According to Fochtman (1974), and Hoggatt and Spilka (1978), nurses have described their professional education as being less than adequate in preparing them for such reality. The second implication is that nurses are exposed primarily to the medical model, which is cure-oriented, therefore, they are less likely to encounter effective nursing models related to comfort-oriented care.

Within the hospital environment, patients and families often do not understand modern medical terminology and procedures; thus, death becomes the arena for experts rather than a matter that can be handled by family and friends. The high-tech environment is often sterile, efficient, and professional. Machines, not people, are common features in the death room. In this environment, family members become visitors and children are often excluded.

"Nursing does not exist in a vacuum - it consistently affects and is affected by society" (National League for Nursing, 1989, p. vii). Our death-denying and death-defying society is reflected within our educational institutions. Quint (1967) points

out that "the same taboos have influenced the development of the social institutions in which nurses practice and are taught" (p. 10). Institutions such as hospitals and educational establishments may be viewed as microcosms that mirror society's beliefs, values, and practices. Medical and nursing personnel, patients, teachers, and students merely interpret and live out such beliefs, values, and practices, often oblivious to the ramifications of such action. For example, avoidance of death is a common societal norm that is reflected in the thoughts and behaviours of many health care professionals. Benoliel (1988) maintains that "institutionalized values and the current organization of health care perpetuates a context in which the human and humane side of care giving is left to chance" (p. 41).

Historically, educational practices in society support patriarchal values and beliefs. "The institutions in which we do our teaching are patriarchal institutions, arranged in power-over hierarchies that diminish human experience, despite the educational philosophies of important humanist forefathers" (Chinn, 1989, p. 10). In contrast, traditional values such as caring and compassion are integral to palliative care; hence, a tension exists that cannot be ignored. This disparity is indicative of concerns that will not be addressed at this time; however, it is important to consider the context within which learning occurs.

It is important to consider the predominant theoretical framework that is operative within the hospital where the majority of deaths still occur. Medicine continues to be based on the medical model which emphasizes the cure of disease and/or illness. Belloc and Breslow (1972) offer a medical model definition of health as "a state of being free of signs or symptoms of disease" (cited in Ellis & Nowlis, 1985, p. 80). According to this model, death is viewed as failure, failure to cure and failure to extend and promote life. The major problem with this model as a guiding framework for health care is that it fails to take into account the individual's experience of illness, suffering and dying. The patriarchal underpinnings of the current medical system gear society

toward prolonging life, often at great cost. Governor Lamm of Colorado states, "We can bring people back from medical death so they can be saved only to die again tomorrow" (Watson, 1990, p. 18). It is understandable that if one adheres to the medical model, one would employ every conceivable measure to accomplish goals that promote and prolong life (e.g., the use of heroic measures).

Interestingly, Watson (1988) remarks that:

> There is a greater acknowledgement and public recognition that continued adherence to a medical model for nursing practice and adherence to a traditional natural science model for nursing science is not adequate for addressing the phenomena of human care in nursing and human responses to actual or potential health problems. (p. 18)

Watson (1988) further contests that the medical tradition arises from a "quantitative-rationalistic inquiry model" (p. 20), whereas nursing derives from a "qualitative-phenomenological or naturalistic form of inquiry" (p. 20); both perspectives "derive from disparate assumptions about the nature of reality, the nature of relationships between inquirer and subject/object, and the nature of truth" (p. 20). Adherence to the medical model may, in fact, pose problems for the practitioner of nursing who struggles to provide individualized, holistic terminal care within a system maintained by a reductionistic approach that stresses objectification of the person.

In contrast to the medical model, a philosophy for care, termed palliative care, represents an alternative in terms of care provided to the dying patient and family. One system is concerned with eliminating a curable disease while the other focuses on relieving the symptoms associated with the relentless progression of an incurable illness. In essence, one focuses on cure, the other on care. These two systems of care may often overlap. "Palliative care may be used synonymously with hospice care and represents a philosophy of care for the dying individual for whom treatment aimed at cure and prolongation of life is no longer appropriate. The focus of palliative care is the control of symptoms and the enhancement of quality of life for the individual and his/her family" (Alberta Association of Registered Nurses [AARN] Position Statement on

Palliative Care, 1984, p. 1). In summary, "palliative care is as much an attitude toward care giving as a set of techniques and procedures" (Benoliel, 1988, p. 42).

Rationale

The proposed research relates to the future education of nurses in the area of death education. It is important to the profession of nursing because the mandate of the profession will only be realized through clinical and theoretical change based on nursing research. According to a paper developed by the International Congress of Nursing, "The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge" (cited in Henderson, 1966, p. 15). The Alberta Association of Registered Nurses Nursing Profession Act (1987), stipulates that a registered nurse is entitled to apply professional nursing knowledge for the purpose of "caring for the dying" (p. 5). The nursing mandate supports the need for a research-based body of knowledge related to the care of the dying.

A variety of factors relate to the relevance of this study, specifically: changing demographics, individual preference, the acquired immune deficiency syndrome (AIDS) epidemic, economics, the knowledge explosion, increased technology, reality shock, cultural diversity, and consumer demand.

The changing demographic pattern has implications for the educational needs of nurses in that the Baby Boomer generation will have an impact on the health care system in the twenty-first century with a dramatic increase in the senior segment of the population. Projections based on 1982 population figures for Alberta anticipate that the number of elderly over the age of 65 years will almost double by the year 2006 to over 326,000 individuals. In addition, the percentage of very old seniors (i.e., 85 years and over) is anticipated to have the fastest growth rate (Adult Day Support and Day Hospital

Program: Background and Standards Working Document, 1990). Palliative care requirements will need to be sensitive to this age group.

Even though the majority of patients opt to die in the hospital at the present time, this trend will most likely change in the near future as many individuals indicate a preference for dying in the familiar surroundings of a home environment. This change will invariably place heavy demands on community home care nurses. Gotay, Crockett, and West (1985) maintain that providing care for the dying patient at home is a "distinctive kind of nursing . . . [requiring] specialized educational programs" (p. 9). At present, the emphasis in nursing education supports the preparation of nurses for work in institutional rather than community settings. This notion supports a concern that specialized education will be needed to augment an expanded role of the community home care nurse relative to the resurgence of this trend in nursing practice. It is anticipated that more emphasis will be placed on community health and home care nursing in the future.

The AIDS epidemic brings with it many unresolved concerns. According to a public service announcement, the World Health Organization (1991) predicts that the AIDS virus will infect up to 30 million adults and 10 million children by the end of the century . The population affected by this dreaded disease includes individuals across the entire lifespan. No longer is this disease confined to homosexuals and hemophiliacs; the highest incidence of the disease now occurs among the teenage group. As announced in May, 1991, according to the Centre for Disease Control, the incidence of AIDS among the teenage population has increased 25% during a one year period. Priest (1987) emphasizes that because of the "growing number of young, dying AIDS sufferers, the importance of making high quality palliative care accessible to all in need becomes very real" (p. 14). In addition to the magnitude of the epidemic, many health professionals are educationally unprepared and therefore reluctant to provide care to afflicted

individuals. The impact of the AIDS epidemic remains yet to be fully realized; this, will undoubtedly present a challenge to those engaged in palliative care.

The exorbitant cost of providing institutional care to dying patients will put an increased strain on an already taxed health care system. In 1989, Canadians spent $46 billion on health care as follows: hospitals 40%, other institutions (e.g., nursing homes, homes for the aged) 11%, physician services 16%, drugs 11%, dentists' services 5%, capital expenditures 4%, public health 4%, appliances 2%, and other 7% (Rachlis & Kushner, 1989, p. 28). The cost factor is inextricably linked to the quality of care provided to a population; hence, the economic factor must be addressed.

Closer to home, currently, the cost of an acute care hospital bed in the Lethbridge Regional Hospital is $526.00 per day while that of an auxiliary bed is $137.00 per day (C. Hall, Executive Assistant, personal communication, May 21, 1991). In contrast, the average cost of a palliative care person within the Home Care Program in Lethbridge is $30.00 to $100.00 per day (J. Hunt, Director of Home Care, personal communication, June 6, 1991). The high cost of providing terminal care within the institution supports the need for developing new and creative strategies to bring spending more in line with limited budgets. Palliative care in the future may entail *'doing more with less,'* which means that, educationally, we must entertain such concepts and creatively plan for such occurrence.

The knowledge explosion and increased technology of recent years have served to stimulate many questions. Readily available is the technology to prolong life; as a result, many ethical questions come into play. Nurses live and work in an environment where they are presented with many difficult questions concerning life and death as daily occurrences. We, as nurses, need to prepare ourselves educationally to work with technology in order to provide humane care so that patients are treated as persons and not merely objects of health care.

The dissonance between theory and practice creates a state of "reality shock" for many students (Kramer, 1974). Most current curricula provide minimal classroom preparation and limited clinical experience, yet new graduates are expected to provide quality care when they enter the workforce. Implementation is not easy. Schon (1983) maintains that "we must move from concept to implementation . . . from the high ground of abstract knowledge to the 'messy,' hands-on problem solving that comes when people try to make theory work in practice" (cited in Donley, 1989, p. 1). The disparity between theory and practice must be acknowledged because in the words of Chopoorian (1990), "praxis is our common ground; it unifies our roles and purpose of existence as educators or practitioners" (p. 24). Once the disparity is acknowledged, nurses will then be in a position to offer curricular changes that focus on the kind of quality nursing care that terminal patients and families so deserve.

Southern Alberta (the site for the study) represents a mosaic of diverse cultures. Understanding cultural variation is integral to the effective implementation of palliative care. According to Quint (1967), a lack of understanding of "cultural values concerning death has led to a gap in the education of nurses and in turn, to a gap in the nursing services available to patients who are dying" (p. xiii). Such an understanding can most effectively be accomplished through the purposeful study of the customs and traditions in times of death and bereavement of the various cultures that weave the fabric of our society.

In the 1990s, health care consumers are questioning current health care practice. It is commonplace in health care institutions for the care of the dying to be delegated to the untrained, unskilled, and unprepared (Knight & Field, 1981). The view expressed in the AARN Position Statement on Palliative Care (1984) captures the essence of this concern.

> Current demands from the general public for a more humane approach to the dying arise from dissatisfaction with the nature of the care available. The

> principles underlying high quality terminal care are compassion and personalization of care combined with high level skill and patient care. Holden (1979) states: "The hospice movement far from being a separate and specialized phenomenon supplies a model for getting the whole system back on the track" (p. 985). . . Current knowledge must be translated into improved care for the terminally ill and their families. (p. 2)

The Landmark Study

The landmark study, conducted by nurse J. C. Quint in 1964, was based upon a six-year investigation that gathered data from five schools of nursing in the Bay area of San Francisco. The study showed what happens to student nurses during and after their encounters with death. Further, this study documented the need for a systematic plan for educating nurses about death and dying. As explained by Degner and Gow (1988b):

> Quint maintained that, if nurses are exposed to the care of the dying without accompanying educational preparation and support, they would adopt the behavior of other professionals around them and limit their involvement in death-related situations. In contrast, Quint suggested that if nurses receive systematic death education, they would be less likely to withdraw from care of the dying. (p. 161)

Furthermore, the first year of a nursing student's education is fundamentally important according to Quint (1967), who maintained:

> The lack of well-planned and co-ordinated teaching programmes centered specifically on the nursing care of dying patients contributes to an environment in which many nursing students develop stereotyped and somewhat negative attitudes toward these patients . . . often the practice of withdrawal from dying patients is quite well established by the end of the first year in school. (p. 236)

Purpose

The purpose of this exploratory, descriptive study was to identify, describe, and explore nurses', including student nurses', perceptions of death education in Southern Alberta, whereby the information gleaned may be used to recommend change for nursing curriculum regarding death education. We have, within the nursing profession, a large, readily available, untapped resource in terms of nursing experience/expertise. Nurses possess extensive and varied experience/expertise that may unveil aspects of death

education that have been previously unaddressed. According to Schon (1983), "our knowing is our practice" (cited in Tanner, 1990, p. 3). In the past nurses have not been asked for input, hence, much nursing knowledge and expertise remains unacknowledged. If specific concerns regarding nursing dying patients and families can be identified, nursing curricula may be modified to encompass such topics, which will invariably result in improved patient and family care.

Significance of the Study

The proposed research has both practical and theoretical significance, therefore, the results will be of interest to individuals who teach death education and those who are involved in clinical practice with terminal patients and families.

From a practical perspective, the results of this study may direct future death education programs in hospital, community, and educational settings in southern Alberta. At the very least, this work will serve as a resource to those concerned with death education. There is considerable merit in soliciting input from novice and expert nurse practitioners, because both perspectives are needed to provide a complete understanding of the educational needs of nurses. In addition, there is practical worth in exploring the views of those working in real-world situations, providing nursing care on a daily basis. Because nursing is a practice profession, research grounded in the practitioner's world is of value.

Theoretically, the exploratory approach to the study of understanding nurses' perceptions regarding death and dying has the potential of contributing to future curriculum design in the area of death education. Currently, nursing curriculum experts (e.g., Bevis & Watson, 1989; Henderson, 1990; Symonds, 1990; Tanner, 1990; Watson, 1990) claim that it is important that nurse educators *actively listen* to nursing colleagues as they share the truths embedded in their practices. It remains

plausible that a new theoretical model regarding death education may emerge from such an undertaking.

Research Questions

The following broad question guided the research process in this study.

1. Does present death education in nursing serve as adequate preparation for clinical practice?

Other more specific questions will also be addressed including:

2. What differences exist between student nurses (college and university), hospital nurses, community nurses, and nurse educators regarding perceptions of death education?
3. What specific curriculum components regarding knowledge, attitudes, and skills do nurses consider important, in order to work effectively in this area?
4. What are nurses' greatest concerns regarding the provision of palliative care?

Assumptions, Delimitations, and Limitations

Comments regarding the assumptions, delimitations, and limitations of this study are listed as follows.

Assumptions

A major assumption underlying this study was that nurses (including student nurses) were the best sources of data to describe and, hence, promote comprehension of their perceptions of death education. It was assumed that nurses' views were important and worthy of exploration and that involvement of the nurse practitioner helped to bridge the gap between theory and practice. Further, it was assumed that a nurse researcher facilitated understanding of nurses' concerns within the parameters of the nursing profession.

It was assumed that education regarding death forms an integral part of a person's intellectual and emotional maturation. In addition, it was assumed that death must be considered within a family context utilizing systems theory whereby a change in a part affects the whole (Wright & Leahey, 1984).

Delimitations

The following delimitations were relevant to this study:

1. The study was confined to a sample of nurses' perceptions in Southern Alberta.
2. The study was further delimited by the time period that is specified in the sampling procedure.

Limitations

Several limitations apply to this study. A major limitation in this study pertains to the data, in that very significant information sources, the patient's and family's perceptions, were not included at this time. Another important limitation was that the interview data collected were perceptual data from voluntary participants. In this regard, Salancik (1979) commented, "Our reliance on other people's cooperation selects the knowledge we gather" (p. 641). In addition, these data may change over time.

In this study, the sample consisted of a 95% female population, slightly lower than the total female nursing population in southern Alberta. This sample, however, is not unlike the population to which the results will be generalized.

Organization of the Remaining Thesis

Chapter II provides a review of the literature followed by a description of the methodology in Chapter III. In Chapter IV, an analysis of the findings of the study are reported. A summary and discussion of the research findings are presented in Chapter V.

CHAPTER II

Literature Review

There is a wealth of information in the literature about death education. A comprehensive review of all that has been written would be a complex undertaking, however, several writers have documented major contributions to the field. The work of several authors: Caty, Downe-Wamboidt, and Tamlyn (1982); Degner and Gow (1988a); Dickinson (1986); Feifel (1977); Hurtig (1986); Kubler-Ross (1969); Lyons (1988); Morgan (1990); Morgan and Morgan (1988); Mullins and Merrian (1983); and Quint (1967) have contributed much in terms of theory and research.

Definition--Death Education

The concept of death education is relatively new, dating back to 1956 when Dr. Feifel organized a session on death that was presented at the American Psychological Association Meeting (Morgan, 1990). *Death education* may be defined as "the movement to study the social phenomenon of death and the caring processes for those who are dying" (Seidel, 1981, p. 88). As yet, there is no conclusive evidence as to the effectiveness of death education; in addition, the optimal approach to this area of learning remains to be determined (Hurtig, 1986).

Death Education Offerings

In 1983, research conducted by Caty and Downe-Wamboldt focused on determining the availability of death education by the use of questionnaires that were sent to all Canadian university nursing and medical schools. Forty-five schools (29 from nursing and 16 from medicine) were included in the survey with a 73.3% return rate. All but four nursing programs and two medical schools, which responded to the questionnaires, stated that the topic of death and dying was included in their curricula.

Many respondents suggested that systematic assignment of students to dying patients would be beneficial, but this only occurred in one of the programs. This deficiency means that it is possible for a student nurse to graduate without the experience of caring for a dying patient. Degner (cited in Henderson, 1991), contends that it is unethical to put students in charge of caring for the dying without appropriate preparation and cites the lack of well-prepared faculty as the major obstacle that must be confronted.

According to Morgan (1990), although the death awareness movement has been active for three decades, little impact has been made regarding inclusion of this topic within nursing curricula. A nation-wide study concerning the status of death education was conducted in 1986 (with a telephone verification follow-up completed in 1990), involving contact with nursing schools at 64 universities and colleges across Canada. Morgan's (1990) findings revealed,

> That [the] status of death education has not changed significantly. There is a greater recognition of the need to provide crisis education to students but a lesser emphasis on death and bereavement in the curriculum. Since a curriculum is a statement of priorities, this lack of curricular status to death education is an indication that it is not considered important enough to be included. (p. 5)

The growth of death education in the U.S.A. is similar to that in Canada. A study by Dickinson (1986), which involved the use of questionnaires sent to 396 baccalaureate nursing programs in the U.S.A., revealed that emphasis on death and dying in baccalaureate nursing programs has definitely increased over the last 20 years with 96% of the schools reporting some emphasis on death and dying. Future projections support that a gradual and steady increase in the number of courses can be expected.

Through the pioneering work of Quint (1967, 1969) and Kubler-Ross (1969), nurse educators have recognized the importance of including death education in nursing curricula. The amount and type of instruction often varies significantly, and appears to be an arbitrary decision based on factors such as teacher preference and level

of comfort with the topic. Currently, one mandatory undergraduate palliative care program exists in Canada at the University of Manitoba (Henderson, 1991). Degner, an educator and researcher at that university, is currently in the process of developing a model for palliative care.

Death Education in Southern Alberta

As central to this study, Quint's 1964 landmark study (cited in Quint, 1967) identified the need for systematic death education for nurses; however, in southern Alberta, such practice remains yet to be fully realized. In southern Alberta there are three schools of nursing: Medicine Hat College (MHC) School of Nursing; Lethbridge Community College (LCC) School of Nursing; and the University of Lethbridge (U of L) School of Nursing. Both college programs offer a two or two and one-half year nursing diploma (RN), while the university offers a two year post-basic nursing degree (BN). Within the university system, in order to receive a baccalaureate nursing degree, the student must complete a RN prior to admission to the post-basic program. While classroom instruction regarding death and dying is offered during the first year in both college programs, such an offering is not included as part of the baccalaureate post-basic program; consequently, death education offerings are provided very early in the educational process without follow-up or an opportunity for advanced learning opportunities.

Major curriculum changes are presently in progress as the three institutions have embarked on *The Collaborative Venture,* a joint effort to develop a new curriculum for a four year generic nursing program in southern Alberta. It is anticipated that by the year 2000, a baccalaureate degree in nursing will be required for *Entry to Practice 2000* (EP 2000).

A cursory survey conducted by the researcher in May 1991, revealed the following findings in relation to death education classroom and clinical instruction provided to student nurses.

INSTITUTION	NUMBER OF HOURS OF CLASSROOM INSTRUCTION	NUMBER OF HOURS OF CLINICAL INSTRUCTION
MHC	6 - 7 hours	unspecified*
LCC	8 - 9 hours	unspecified*
U of L	unspecified*	not offered

* unspecified = may occur but not required by curriculum design

These findings are similar to those documented in the literature, whereby death education is not provided in a systematic manner and is not highly regarded as a topic for inclusion within nursing curricula. As Quint (1967) noted, "This result does not reflect the intent of schools of nursing but rather suggests that the magnitude and nature of the problem has not been sufficiently recognized by those responsible for teaching nurses, or, for that matter, by the public at large" (p. 7).

Themes in the Literature

Three major death education themes seem to appear throughout the literature, including: nurse attitude toward death, nurse experience with death, and educational needs of the nurse. Each factor requires examination because of the dynamic interplay among these variables and the consequent impact on teaching/learning.

Nurse Attitude Toward Death

A major thrust in the literature indicates that nurses' attitudes toward death and dying influence both interaction and communication with terminal patients and families. Some researchers have suggested that the nurses' relationships with dying patients can

have a great influence on how both patients and families cope with death (Fulton & Langton, 1964; Golub & Reznikoff, 1971; Quint, 1967; Sobel, 1969). As stated by Milton (1984), "attitudes of nurses toward dying patients may be considered strong predictors of clinical behavior" (p. 298). Quint (1967) maintained that nurses must be cognizant of the fact that attitudes affect practice, while Kubler-Ross (1969) emphasized that it is imperative that nurses take a look at their attitudes toward death and dying in order to minimize anxiety as they provide care to terminal patients and families.

Gaining awareness of one's attitude toward death remains a difficult but essential task. Nurse educators have recognized the importance of providing opportunities for students to acquire such awareness, especially during the student years when attitude formation takes place (Caty & Tamlyn, 1984; Hurtig, 1986; Quint, 1967; Wise, 1974). The influence of nursing education and experience on attitudes toward death became the focus of a study conducted by Golub and Rezinkoff in 1971. They compared the attitudes toward death and suicide of graduate nurses with those of first year nursing students. The graduate nurses' attitudes were found to differ from those of students and because the difference was present in both younger and older nurses, the researchers suggested that "the influence of nursing experience in forming attitudes toward suicide and death takes place early in the nursing career, most likely during the student years" (p. 507).

In 1974, Yeaworth, Kapp and Winget administered a questionnaire to measure attitudes toward death and dying persons to freshmen and senior baccalaureate nursing students before and after the death education component in a nursing program. Statistically significant findings were found between the two groups; compared to freshmen, senior students' responses revealed greater acceptance of feelings, more open communication and greater flexibility in relating to dying patients and families. Several research studies support similar findings that point to the positive impact of death

education on attitudes (Caty & Tamlyn, 1984; Gow & Degner, 1988a; Miles, 1980; Quint, 1969; Watt, 1977). Other studies found no effect (Martin & Collier, 1975; Swain & Cowles, 1982) or a delayed positive effect (Murray,1974; Laube, 1977).

A basic influence related to the student nurse's attitude toward death and dying is that of the family of origin (Milton, 1984). Family attitudes, usually representative of those in society, are transmitted to the student, who in turn, projects such attitudes during contact with the patient and family. In Milton's study, only 22% of the subjects reported that, as children, death had been discussed openly in their families. Family attitudes toward the discussion of death seemed to influence the number of concerns these subjects expressed in relation to nursing dying patients; more concerns regarding the provision of nursing care were expressed by nurses who did not have opportunities to discuss death openly in their families. If one accepts the information model which postulates that knowledge precedes attitude(s) which precede and predict behavior, then the concern regarding nurse attitude is important in terms of dealing with nurse avoidance of the patient and family.

A two year study of baccalaureate nursing students, conducted by Martin and Collier in 1975, indicated that two factors most often influence a change in attitude, specifically, personal experience with death, and opportunities which facilitate death awareness. However, Lev (1986) asserted that experience alone was not enough to change attitudes, and hence, behaviors of nursing students and graduates. Hurtig (1986) reiterated the importance of including death awareness experiences in educational programs for those learning to care for terminal patients.

Death Anxiety

Popoff, in a nationwide study of 15,000 nurses conducted in 1975, reported an important finding. Two-thirds of the group he questioned, who became anxious and uncomfortable when patients asked about death, had not come to terms with their fears

regarding death. Nurses need to confront personal reactions and feelings toward death before they can be helpful to others (Benoliel, 1970; Popoff, 1975; Price & Burgen, 1977).

Sudnou (1967) indicated that nurses tend to avoid dying patients because they feel less confident dealing with the psychological needs of dying patients than with the technical care needs. Closely related, Quint (1967) found that barriers to verbal communication increased for nurses as the terminal illness of the patient progressed. Often, nurses employ professional defense mechanisms as protective coping measures, such as: creating distance, avoidance, focus on physical tasks, and performance in accordance with routinized schedules. Frequently, this modus operandi takes over very early in one's career, often as a student. Miles (1980) explained that nurses working in high risk areas, for example: intensive care units (ICU), emergency, and coronary care units, were more likely to develop avoidance strategies because of the emphasis on life saving stressed on such units. As well, patients on critical care units often face uncertainty regarding prognosis, and this in turn, may also contribute to nurse anxiety. Lev (1986) documented a very real problem, that of nurse avoidance of the dying alcoholic, psychiatric, and/or AIDS persons. Often nurse anxiety manifests itself in terms of avoidance of the patient and family.

Interestingly, Folta (1965) found that staff nurses showed higher levels of anxiety related to death than did administrative nurses. It seemed apparent that when the threat of death was personalized, the anxiety level rose, whereas, when the death was viewed in the abstract, it was perceived as peaceful and natural.

Mullins and Merrian (1983) conducted a study with 138 subjects in order to determine the effectiveness of workshops that promoted cognitive gains and positive attitudes toward the elderly and the dying conducted with nursing home personnel. The Templer's Death Anxiety Scale was used to determine nurse anxiety regarding death. The results showed higher anxiety scores among those who received education in comparison

to those who did not, the opposite effect to that expected. Interestingly, those who had previous death education also showed greater death anxiety in contrast to those without such exposure. The fact that death anxiety was greater among those who had received education may be interpreted positively. It must be noted that even though death anxiety increased, the nurses' level of information about death also increased.

Nurse Experience With Death

It is generally agreed upon that dealing with death and dying is stressful. On the one hand, Gotay, Crockett & West (1985) reported increased stress levels among nurses who had worked with palliative patients for a short period of time. On the other hand, Pearlman, Stotsky, and Dominick (1969); Stoller (1980), found that cumulative experience in nursing the dying has not been found to be significant, in that uneasiness associated with interactions with dying persons increased with nursing experience.

Pearlman, Stotsky and Dominick (1974) studied 68 nurses using a semistructured interview technique and found that less experienced nursing personnel demonstrated a more open and direct approach in caring for the dying than more experienced colleagues. Similarly, Shusterman and Sechrest (1973) surveyed 188 hospital nurses and found that the more experienced nurses tended to be more satisfied with traditional ways of managing the dying, for example, isolating individuals from other patients and not informing them of their true prognosis.

Popoff (1975) found that nurses were influenced by their age. Older nurses were better able to cope with a patient's death. The age of the patient also had a strong effect. The younger the patient, the more difficulty the nurse had in dealing with feelings about death. In addition, most nurses found it easier to deal with patients who had been told about their terminal condition. Many nurses expressed feelings of depression and helplessness in relation to caring for terminal patients.

The disparity between what is taught in the educational setting and what is practiced on the units adds another dimension to the provision of terminal care (Field & Kitson, 1986). Melia (cited in Field, 1984) speaks of "nursing in the dark," (p. 60) in that the messages given in nursing schools are not supported and reinforced on the units. The structural and hierarchial arrangements of nursing substantially affects both patient care and the nurses' responses to the care of the dying (Field, 1984). Schools of nursing are more likely to transmit a view of care based on "whole person care," (p. 60) whereas, hospital nurses are more likely to emphasize a management, task-oriented approach and therefore likely to view student nurses as "more hands" for "getting the work done" (Melia, 1981, cited in Field, 1984, p. 60). Consequently, students may often become discouraged from trying to implement the nursing ideals espoused in the classroom. Since the student occupies the lowest rung on the hierarchial ladder within the institution, the incongruence between what is taught and what is practiced remains, as the student strives to fit into the system.

Concerns Regarding Nursing Care

An interesting study by Milton (1984) was designed to investigate whether final year baccalaureate nursing students in one faculty of nursing had concerns about nursing dying patients. When concerns were expressed, a major focus centered around how these concerns related to students' personal (i.e., family) experiences with death and/or to critical experiences in learning to nurse dying patients.

A questionnaire was completed by all students in the final year baccalaureate nursing class of one Canadian university. Forty-five of the 46 subjects were female. The questionnaire consisted of categories and indicators selected after a review of the relevant literature and consultation with nursing experts who had varying amounts of experience with dying patients.

in a comparison of responses, concerns related to the provision of emotional support for grieving families predominated (81.9%); followed by provision of emotional support for the patient (76.1%); provision of post-mortem care (75.4%); psychological effects upon self (58.7%); maintenance of self-composure (40.6%); and provision of physical care of the dying patient (39.8%). In contrast, a study by Wheeler (1980) involving community health nurses, who were requested to rate a list of 25 learning experiences related to death, according to level of difficulty, ranked post-mortem care last.

Educational Needs of the Nurse

A 1987 issue of Cancer Nursing reported findings related to a study "Priorities For Cancer Nursing Research" conducted by the Western Consortium for Cancer Nursing Research. Of the fifteen research topics sorted by value for nurses, one of the top two included, "determine ways of helping nurses deal with questions of life and death and their own feelings of grief, loss and frustration" (Henderson, 1991, p. 17). In this regard, Degner (cited in Henderson, 1991) maintained that "every undergraduate program should include a well designed palliative care course" (p. 18) that emphasizes the identified student learning needs.

Benoliel (1988) maintained that physicians and nurses have few educational opportunities to engage in and learn from opportunities related to *teamwork across disciplines*. Rather, medical and nursing students are taught in segregated classes with limited opportunities to engage in discussion about problems that are common in practice. They learn about health care within a system in which competition is emphasized and communication among providers from different disciplines is complicated by differences in gender, age, and social class.

Faulkner and Macleod (1981) identified an urgent need for education regarding *communication skills* for nurses engaged in terminal care. When faced with the death of

a patient, nurses often resort to defense mechanisms to ward off the full impact of the experience; sometimes nurses use a language of avoidance or they may even change the subject in order to lessen the intensity of the experience. Maquire (1985) addressed an important point, that often there is an inability to vocalize emotions and to console the patient because of inadequate communication skills on behalf of the nurse. Maquire spoke of a need for education regarding communication skills through workshops which utilize feedback techniques designed especially for doctors and nurses.

Lyons (1988) conducted a survey whereby 80 nurses were provided with a questionnaire for the purpose of exploring nurses' perceptions of their needs for education concerning dying and grief counselling. Thirty-nine of 40 clinical nurses, and 26 of 40 teaching staff participated. The researcher identified several problems encountered by nurses as they cared for terminal patients: lack of communication between nurses about the needs of dying patients, lack of support for nurse learners when there was a death on the unit, and inadequacies regarding teaching about the care of the dying in both nursing education and clinical settings. The results confirmed that nurses expressed need for support/education in the field of death education, and in particular, bereavement counselling. The strongest response indicated that there should be more opportunities for trained staff to develop skills in grief counselling. Similarly, staff perceived a need for support when a patient dies. Clearly, the need for support and counselling courses for staff members emerged. Seidel (1981) insisted that death education is a continuous process and that it remains the joint responsibility of both the educational institutions and the service agencies to provide such education.

Education has been effective in changing professionals' attitudes toward the dying. The impact of the amount of classroom time on changes in death attitudes was the focus of an experimental study by Rublee and Yarber in 1983. Results of the study suggested that the most rational choice for the length of time to devote to death as a unit of study or

a course, was a minimum of nine class sessions. Shoemaker's 1981 study supported this view; ten sessions were deemed as the necessary amount of time for instruction.

Chapter III

Research Design and Methodology

This chapter presents a description of the methods and procedures employed in accomplishing the purposes of the study. A theoretical model, developed by the researcher, provides a wide-angle perspective for understanding components integral to palliative care nursing practice. A conceptual framework, presented as an untested theory, serves to underpin the central concepts related to the study. The questionnaire that was used to gather the data is described in terms of design and content. Sampling procedures are discussed, ethical considerations are outlined, and the statistical methods for data analysis are described.

THEORETICAL MODEL FOR THE STUDY

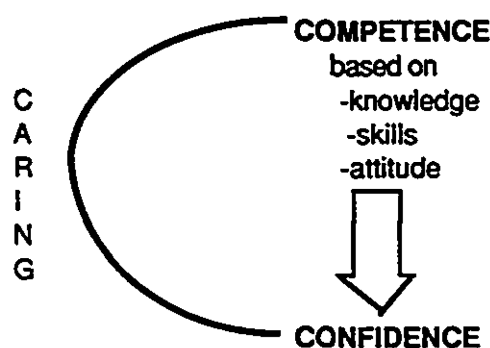


Fig. 1 The C-theory

Theoretical Model for the Study

The *C-theory* (refer to fig. 1), at present an untested theory, was developed by the researcher to serve as the theoretical model for the study. The C-theory is based on a basic premise that nursing is a CARING practice supported by both the COMPETENCE and CONFIDENCE of the nurse. Initially, the nurse must acquire competence within the profession related to knowledge, skill, and attitude (A.A.R.N., 1991). These three

aspects of professional competence are inter-related and interdependent and serve as the foundation for nursing practice. Professional competence is required in order for the nurse to acquire confidence. Both competence and confidence are required for the delivery of a caring practice. This framework provides a meaningful context for the examination of death education because the goal of terminal care is the provision of caring nursing practice.

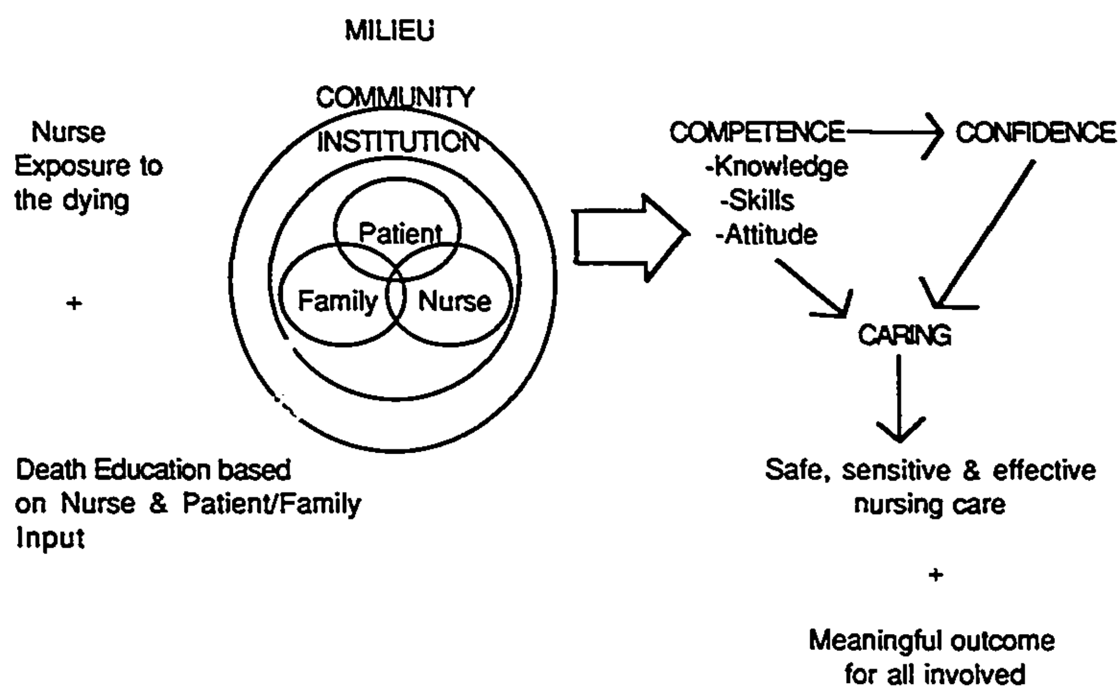


Fig. 2 Application of C-theory

Fig. 2 depicts the application of C-theory. When the nurse within the institution or community is educationally prepared to care for the dying patient and family, professional competency (based on knowledge, skill and attitude) is fostered. Professional competency, in turn, allows the nurse to gain confidence. Both of these qualities, competence and confidence, must be present in order for a caring practice to be delivered to the dying patient and family. A caring practice results in safe, sensitive and

effective nursing care and a meaningful outcome for all involved: the patient, family, and caregiver. This outcome is important not only to the nurse, but to the nursing profession as well. In order for a nurse to remain healthy in the face of repeated exposure to terminal illness, the nurse too, must learn to develop and implement healthy coping mechanisms. In essence, the vitality of the nursing profession depends on such action.

Nurses' Perceptions of Death Education: A Conceptual Framework

A conceptual framework was developed within the research design by the researcher for the purpose of integrating salient information obtained from a review of the literature. Additionally, this framework was utilized to guide the interpretation of the research findings.

This conceptual framework, as shown in Figure 3, comprises four major factors. These factors appear to influence nurses' perceptions of death education, specifically: nurse experience with death; nurse attitude toward death, past educational preparation, and personal nurse variables. Nurses' perceptions, in turn, affect nurses' views regarding death. Nurses' perceptions and views ultimately influence the delivery of terminal care to the dying person and family, the stress level of the nurse, and communication patterns employed by the nurse. For example, communication between the nurse and the dying person may be altered as a result of the nurse's unfinished business related to death and dying.

NURSES' PERCEPTIONS OF DEATH EDUCATION
A CONCEPTUAL FRAMEWORK

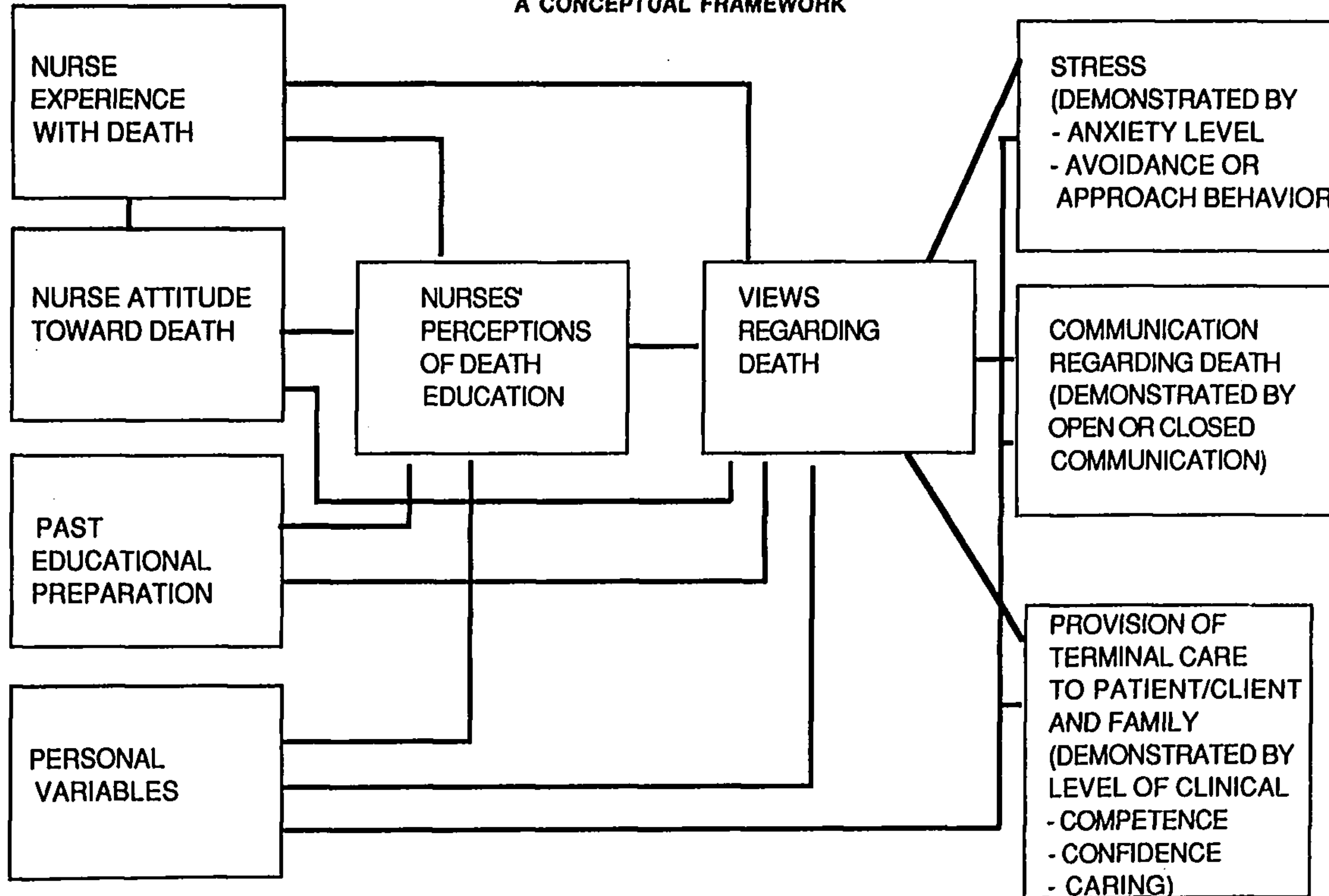


Figure 3 Relationship of variables

Research Design

Method

In this exploratory, descriptive, non-experimental study, data were collected through the use of questionnaires without deliberate manipulation of data or control over the research setting. The research methodology evolved as a result of a desire to survey a large sample population involving nurses from four different settings. According to Polit and Hungler (1991) questionnaires are the data gathering method of choice for studies involving large geographically dispersed samples. In survey research, only associative rather than causal relationships may be implied (Polit & Hungler, 1991).

Measurement

Since an appropriate instrument was unavailable to measure nurses' perceptions regarding death education, a questionnaire (Appendix B) was constructed by the researcher. The tool addresses important educational concerns for nurses involved in terminal care as identified in the literature, as well as issues related to palliative care determined as a result of the researcher's experience. Composed of 55 questions and requiring about 20 minutes for completion, the questionnaire was designed for ease of administration through the use of check mark and Likert scale items. It included information from both the content and process aspects of death education.

The measurement tool was of a self-administered, nine-page questionnaire. A letter to participants explaining the proposed study was appended to each questionnaire (Appendix A). Participants were instructed to leave questions blank if unable to answer, which accounted for a number of missing cases as indicated in the analysis. Respondents were more likely to leave questions if they lacked experience in dealing with a particular aspect of terminal care. This request was made in order to reduce the possibility of *guessing,* thereby increasing the number of accurate responses.

The major variables for consideration in the Views Scale of the questionnaire addressed the following: nurses' views regarding death; information related to nurses' attitudes and experiences with death and death education; and nurses' educational needs regarding death education. The second section of the questionnaire addressed educational needs through utilization of a scale which represents a curriculum model that considers knowledge, skills, and attitudes as the competencies required for nurses beginning to practice in Alberta (Edmonton and Red Deer Nursing Program: Collaborative Model, April, 1991). The third portion of the tool pertained to information related to nurse education and experience. This section included two scales: the first rated the level of difficulty experienced by nurses in relation to the provision of terminal care to specific age-based target populations; the second scale rated the level of anxiety experienced by nurses with regard to the delivery of terminal nursing care responsibilities. The fourth segment of the instrument addressed information reflective of the respondent's background. The fifth and final segment addressed personal written comments and responses.

Development and Validation of the Instrument

Prior to administration of the questionnaire, a pilot study was conducted to help establish clarity, reliability, and validity of the measurement instrument. The pilot study utilized a sample of 21 fourth-year university nursing students. As an additional measure, in order to ensure face and content validity, the questionnaire was assessed by submission to the scrutiny of colleagues and research scholars. The researcher approached a person with expertise in questionnaire development for additional comments and/or suggestions. Consultation with a credible terminal care research consultant was sought.

As a result of the pilot study, the instrument was altered to reflect feedback from participants. Specifically, four statements were subsumed into existing statements in

the first scale for a total of 33 items, while six topics were subsumed into existing topics in the second scale for a total of 24 items. Other minor changes were made prior to a final review and submission to two committee members. Upon the completion of these revisions, the data were computer analyzed to determine reliability of the instrument. The reliability coefficient for the 33 item scale reflecting nurse views about death was calculated at .7536. The reliability coefficient for the 24 item nurse competency scale was calculated at .9026. According to Lo Biondo-Wood and Haber (1990), for a tool to be considered reliable, a coefficient of 0.70 or higher is considered an acceptable level of reliability.

Sample Selection

The study sample included voluntary participants consisting of nurses and student nurses from 17 health care institutions and agencies in southern Alberta, which included three educational institutions: Medicine Hat College, Lethbridge Community College, and the University of Lethbridge; six selected hospitals in southern Alberta including two urban sites (i.e., Medicine Hat and Lethbridge), and four rural sites (i.e., Brooks, Taber, Bow Island, and Claresholm), six extended care institutions in the above specified cities; and Community Health and Home Care agencies in both Medicine Hat and Lethbridge. A minimum sample size of 200 nurses was sought in order to obtain sufficient statistical power for the study findings. Students and nurse educators were accessed through the above stated educational institutions and staff nurses were accessed through service institutions.

The following nurse groups became the foci for this study: student nurses (college students who have completed their first year of nursing education, and third year university nursing students); practicing nurses working in the area of palliative care in both active treatment and extended care facilities (e.g., ICU, Medicine, and Long-

Term Care); and nurse educators involved in both the college and university nursing programs in southern Alberta.

Procedure

Prior to administration of the questionnaire, administrative personnel within each institution were contacted in order to provide information about the purpose and plan for the study and to invite their participation. Every attempt was made to work with institutional requests in order to facilitate an understanding of the importance of the study and to help ensure a high return rate. Within each institution, an independent individual was designated to insure that questionnaires were properly completed prior to return. Questionnaires were delivered and, upon completion, collected by the researcher. A plan was in place to send a follow-up letter to participants two weeks following the delivery of the questionnaires, however, this plan was unnecessary due to a high response return. The researcher was contacted three times with requests for more questionnaires to be forwarded to agencies and institutions!

Ethical Considerations

The first step with regard to ethical considerations was to seek permission to conduct the study through the Department of Educational Administration at the University of Lethbridge. Such permission was granted by the Human Subjects Research Committee, Faculty of Education, on November 5, 1991 (Appendix D). The Research Ethics Review Policies and Procedures (January, 1988) were followed throughout the entire study. This procedure entails voluntary consent for participation, concealment of responses, and confidentiality and anonymity of questionnaire responses. An abstract, a letter to the participant, and a questionnaire were sent in advance of questionnaire administration to participating agencies and institutions. Three institutions requested that the questionnaire be submitted to internal institutional ethic review committees.

These requests were accommodated. Additionally, since the chosen research topic may have elicited strong emotional reactions from some participants, a contact number was provided.

Analysis of Data

The data collected via questionnaires served the general purpose of identifying nurses' perceptions of death education as viewed by five subgroups: students both college and university, staff nurses, community nurses, and nurse educators. All statistical analyses were performed using the Statistical Packages for the Social Sciences (SPSS). Descriptive statistics that utilized frequencies, means, medians, and standard deviations were calculated to describe the data. An item analysis was performed for the purpose of determining the reliability of the instrument. One-way analysis of variance (ANOVA) was used to determine significant means among the five identified subgroup samples. Post Hoc multiple comparisons were used to locate significant differences among selected means. Probabilities at or below an alpha level of .05 were considered to be statistically significant.

The responses to the two open-ended questions were tabulated and assessed for emergent themes. Verbatim written representation of the data is included as part of the analysis.

CHAPTER IV

Analysis of Data

In this chapter, findings of the study are presented and reported in four sections. The first section describes the characteristics of the complete sample; this section is further delineated as five sub-groups: college students, university students, hospital nurses, community nurses, and nurse educators. Section two provides data related to the education and experience of subjects. Section three contains the numerical analysis of the Likert items in the first scale of the questionnaire, representing views regarding death. In addition, the results of the other three scales are presented that address nursing competencies, levels of difficulty, and levels of anxiety experienced in relation to the provision of terminal care. Section four addresses the response differences among the five subgroups through various statistical manipulations. The fifth and last section presents the participants' recommendations and comments regarding death education. A summary of major findings concludes each section.

The purpose of this study was to examine nurses' perceptions of death education in southern Alberta. The results offer a substantial information source to those interested in curriculum development in the area of death education for nurses. Findings may also be of interest to individuals who teach death education and those who are involved in clinical practice with terminal patients and families.

All participants were asked to complete the Death Education Questionnaire. Nurses, including students, with palliative care experience or those who had experienced the death education component of a nursing program, were invited to participate in the study. Subjects were from 17 health care institutions/agencies in southern Alberta including: two urban centres--Medicine Hat and Lethbridge; and four rural centers--Brooks, Claresholm, Bow Island, and Taber. Initially, the total number of eligible nurses were estimated at 400, however, due to three unsolicited requests, 450 questionnaires were distributed and picked up by the researcher at the above named

institutions and agencies. A total of 373 questionnaires were completed and returned which represents an 83% return rate. The demographic characteristics of the sample are presented in Table 1.

SECTION I

Characteristics of the Sample

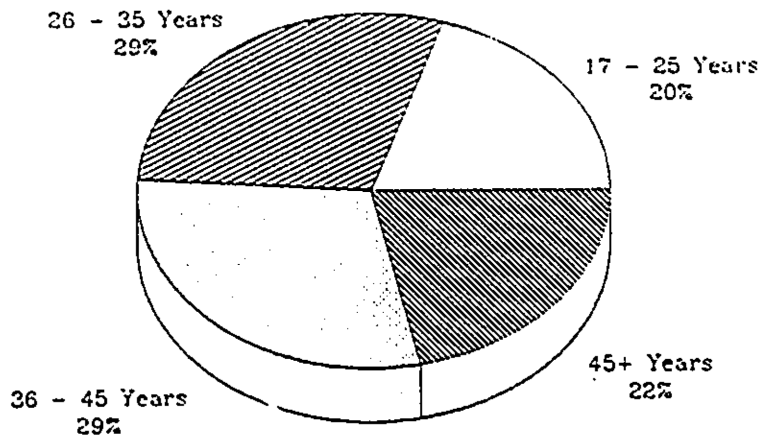
Table 1 (Appendix E) indicates the characteristics of the sample. The great majority of respondents were female (94.6%) in the age range of 26 to 45 years (57.5%), with an average age of 36 years. More than 60% of the sample were married, 26.8% were reported as single (never married), and 6.7% as divorced. Five percent of the sample included those who reported their marital status as widowed, separated or other.

Over one half of the respondents (50.7%) were reported to have fewer than nine years of experience in the nursing profession while more than one quarter (28.4%) possessed greater than 10 years but fewer than 20 years of nursing experience. The highest level of educational preparation obtained by subjects included: students--both diploma and post-basic students (33.5%); registered nurses (33.0%); graduates--both graduate diploma and baccalaureates (23.3%); and, post graduates--both master's and doctoral degrees (4.0%).

A preponderance of nurses sought employment in hospitals (45.6%), including both active treatment and extended care facilities, while students representing 23.9% of the sample, chose either not to work, or to work on a part-time basis. Additionally, nurses were employed by community health agencies (19.8%) and educational institutions (8.8%). Most of these nurses (67.6%) lived in communities with populations greater than 5000; the remainder (32.4%) lived in rural communities with populations of 5000 or less.

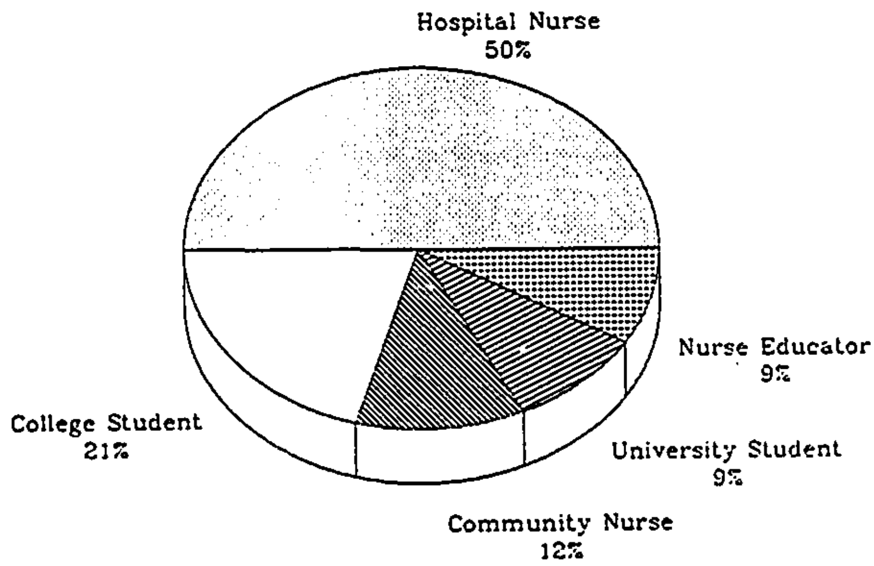
CHARACTERISTICS OF SAMPLE

Age Distribution of Participants

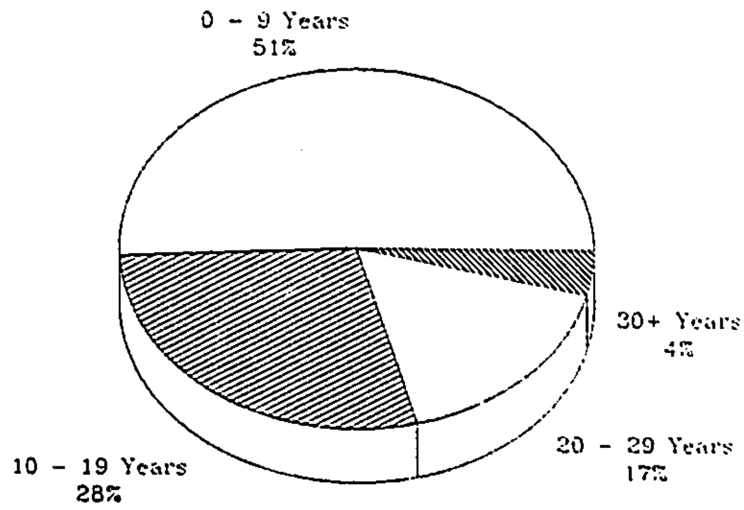


Mean = 36 years

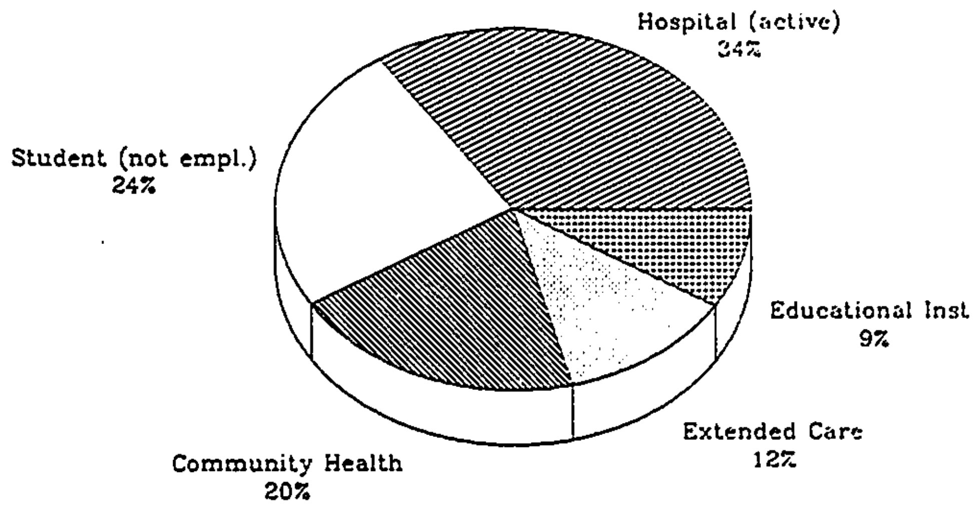
Nurse Subgroups



Years of Nursing Experience



Area of Employment



The majority of respondents claimed to be either Protestant (45.3%) or Roman Catholic (26.5%); 26.1% indicated their religion as one of the following: Buddhist, Church of Jesus Christ of the Latter-Day Saints, Ismaili, Mennonite, or other. The intensity of religious beliefs ranged as follows: very high (18.0%), high (24.4%), moderately high (31.4%), and low (24.9%).

Sample Subgroup #1-College Students

Table 2 (Appendix F) presents information relative to 77 college students' age, gender, education, experience, and religion. Over one half of college students (53.2%) ranged in age from 17 to 25 years; almost one third of college students (29.9%) ranged in age from 26 to 35 years, while 16.9% were 36 years or older. There were proportionately more males (9.1%) in this subgroup than in the total sample (4.6%). Most college students indicated a lack of both previous death education and experience (94.8% and 96.1% respectively). Similar to the sample population, most college students were either Protestant (35.1%) or Roman Catholic (33.8%).

Sample Subgroup #2-University Students

Table 3 (Appendix G) addresses information related to 34 university students' age, gender. education, experience, and religion. University students tended to be older than college students as indicated by 41.2% of students in this subgroup in the 17 to 25 year age range; 38.2% in the 26 to 35 year age range; and 20.6% over the age of 36 years. The proportion of male university students (5.9%) was similar to that of the sample population. All university students held registered nurse (RN) credentials prior to entry to university and indicated that the post-basic program was their highest level of education. Most university students (79.4%) had less than nine years of nursing experience; 14.7% had greater than 10 years but less than 20 years of nursing

experience; and 5.9% had more than 20 years of experience. Different from college students, the greatest percentage of university students were either Roman Catholic (38.2%) or Protestant (29.4%).

Sample Subgroup #3-Hospital Nurses

Table 4 (Appendix H) describes data pertinent to 186 hospital nurses' age, gender, education, experience, and religion. Sixty-two percent of hospital nurses were 36 years of age or older compared with 36 years as the average age in the sample population. Males, among hospital nurses, were represented in the same proportion as in the sample population. Over one half of the hospital nurses (54.3%) indicated that they were registered nurses, while 28.0% had completed baccalaureate degrees or post graduate diplomas in nursing. Thirty-eight percent of hospital nurses claimed to have nine or less years of experience, whereas an almost equal number (35.5%) had 10 to 19 years of experience. Just over one quarter of hospital nurses (26.4%) had 20 or more years of experience. Almost half of this subgroup (46.2%) specified Protestant as their religion, while less than one quarter (22.6%) designated their religion as Roman Catholic.

Sample Subgroup #4-Community Nurses

Table 5 (Appendix I) delineates facts concerning 43 community nurses' age, gender, education, experience, and religion. The term *community nurses* includes both community health and home care nurses. The majority of community nurses (41.9%) were between the ages of 36 and 45 years. Almost one third of the subgroup (32.6%) were 45 years or older while the remainder (25.6%) were between the ages of 26 and 35 years. Interestingly, all community nurses were female. Almost one half (48.8%) were registered nurses (RN) while 37.2% had baccalaureate nursing degrees. The greatest percentage of community nurses (46.5%) had more than 10 but less than 19

years of nursing experience; 30.2% had 20 years or more of experience. The largest percentage of community nurses (60.5%) specified Protestant as their religion, whereas 23.3% indicated Roman Catholic.

Sample Subgroup #5-Nurse Educators

Table 6 (Appendix J) denotes data specific to 33 nurse educators' age, gender, education, experience, and religion. Similar to community nurses, nurse educators tended to be older than nurses in the sample population. The largest percentage of nurse educators (42.4%) were 36 to 45 years of age; 33.3% were 45 years of age or greater. Males were proportionately more highly represented among nurse educators (6.1%) than among the sample population. The level of educational preparation was higher, indicated by 57.6% of educators with baccalaureate nursing degrees, 24.2% with masters' degrees, and 6.1% with doctoral preparation. The majority of nurse educators (36.4%) indicated that they had 10 to 19 years of experience in nursing; 33.3% had 20 to 29 years of experience, 21.2% had nine years or less, and 9.1% had more than 30 years of nursing experience. Again, similar to community nurses, nurse educators (60.6%) specified Protestant as their religion, while 24.2% indicated Roman Catholic.

Summary

An analysis of the demographic data collected from the nurse sample population revealed the following:

1. A more or less equal distribution of nurses occurred among all age groups. Proportionately more diploma nursing students were reported as younger while community nurses and nurse educators were reported as older. College nursing students tended to be younger than university students. These expected findings are representative of the nurse population in Alberta.

2. In general, the ratio of female to male nurses in this study was 19:1 which is slightly higher than the ratio of the general nurse population in Alberta. Interestingly, the ratio of female to male nurses among college students was 10:1. This finding supports a recent trend in nursing which indicates that more males are entering nursing education programs.
3. The majority of nurses (50.7%) were reported to have nine or less years of nursing experience. This group was comprised mostly of college and university students and hospital nurses. Both community nurses and nurse educators possessed higher levels of nursing education and the greatest percentages of these two subgroups (76.7% and 78.8% respectively) claimed to have 10 or more years of nursing experience. This expected finding relates to the notion that nursing education and experience are often linked; nursing is a practice profession in that experience tends to increase with nursing education.
4. Most of the nurses (66.5%) in this study were educationally represented in two groups--students (33.5%), and registered nurses (33.0%).
5. In the sample population, the greatest number of nurses were employed in hospitals (45.6%) with the second greatest number employed by community health agencies (19.8%). This finding supports current medical practice which emphasizes hospital-based treatment and cure rather than community-based prevention and health promotion. Even though an emphasis toward community practice is anticipated, hospital nurses are confronted with death more frequently than are community nurses.

SECTION II

Death Education and Experience

Table 7 examines data related to previous death education and experience. Three-quarters of respondents (75.3%) had experienced previous death education through participation in two to four educational endeavors, for example, a course, reading of literature and/or work experience. Very few nurses (4.6%) had experienced six to seven such experiences. The largest number of nurses (43.2%) dealt with death in the work setting from one to three times per year; 26.3% dealt with death at least once per month; 15.3% reported that they did not deal with death in the work setting; twenty nurses represented as 5.4% of the sample dealt with death more than once per week.

Most nurses have experienced minimal death education preparation. The most frequently reported sources of death education were: seminars (30.0%); workshop/conferences [(1-3 days) 27.1%]; and reading of literature [(at least two articles per month) 18.2%].

A majority of nurses (85.5%) reported that they had experienced the death of someone close to them while the others (14.5%) did not have such experience. In this regard, 70.8% had accepted the death experience as a part of life, 11.0% were in the process of working through the experience while 2.4% were still uneasy with the experience.

Almost 70% of participants rated themselves as calm (a rating of one or two on a five-point scale where 1 is calm, and 5 is anxious) in regard to their feelings about assignment to a terminal patient. Ten percent rated themselves as anxious (a rating of four or five on the same scale). Many nurses (82.0%) had been assigned to the care of a terminal patient as a student; however, 16.6% (62 nurses) had not participated in such an experience.

Nurses were requested to rank three nursing competencies--knowledge, skill, and, attitude--in order of importance as related to the provision of terminal care.

Sixty-five percent of respondents ranked attitude in first place, 22.8% ranked knowledge in first place, while 18.8% ranked skill in first place. This finding supports a need for death education opportunities that promote attitude exploration.

Table 7

Information Related to Nurse Death Education and Experience

Questionnaire Item

1. Previous death education. (Mean=2.902 SD=1.342)

# of Educational Offerings	N	% of Total
1	48	12.9
2	112	30.0
3	101	27.1
4	68	18.2
5	23	6.2
6	10	2.7
7	7	1.9
missing	4	1.0

2. During the past year, how frequently did you encounter death in you work setting? (Mean=2.959) (SD=.998)

Frequency of death encounter	N	% of Total
more than once per week	20	5.4
once per month	98	26.3
1-3 times per year	161	43.2
not at all	57	15.3
other	33	8.8
missing	4	1.0

3. Have you experienced the death of someone close to you? (Mean=1.145 SD=.352)

Death experience	N	% of Total
yes	319	85.5
no	54	14.5

If yes, to what extent have you "come to terms" with the experience?
(Mean=2.842 SD=.490)

Feelings regarding death experience	N	% of Total
still uneasy with experience	9	2.4
in the process of working through the experience	41	11.0
have accepted the experience as part of life	264	70.8
other	8	2.1
missing	51	13.7

4. Rate yourself on the following scale regarding your feelings about being assigned to the care of a terminal person.
(Mean=2.030 SD=1.024)

Feeling scale	N	% of Total
calm 1	138	37.0
2	122	32.7
3	68	18.2
4	33	8.8
anxious 5	5	1.3
missing	7	1.9

5. As a nursing student, I cared for a terminal patient.
(Mean=1.168 SD=.375)

Provision of terminal care	N	% of Total
yes	306	82.0
no	62	16.6
missing	5	1.3

6. Rank the following nursing competencies in order of importance in relation to the provision of nursing care.

Competency	N				% of Total*				Mean*	SD
	First	Second	Third	Missing	First	Second	Third	Missing		
knowledge	85	166	116	6	22.8	44.5	31.1	1.6	2.084	.736
skill	70	118	179	6	18.8	31.6	48.0	1.6	2.297	.769
attitude	244	67	57	5	65.4	18.0	15.3	1.3	1.492	.749

* May not add to 100% due to rounding.

<u>Summary</u>

Analysis of the data related to death education and experience revealed that:

1. The majority of nurses possessed minimal death education preparation. In 1967, J. C. Quint documented the need for a systematic plan for educating nurses about death and dying, however, three decades later, this vision remains yet to be fully realized.
2. A small segment of nurses, 20 nurses (5.4%) in this study, reported that they dealt with death more than once per week. This finding suggests that a formal peer support group may provide an opportunity to debrief following experiences with death, thus, contributing to the well-being of the caregiver. It is essential that the caregiver be mentally and emotionally healthy in order to provide quality care to patients and families, the quality care that they so deserve.
3. Nurses are often professionally confronted with death even though they may not have had an adequate opportunity to personally work through the experience. A portion of nurses indicated feeling anxious in regard to their feelings about assignment to a terminal patient. In such situations, effective education becomes even more important as a possibility for acquiring needed coping skills.
4. A significant number of nurses, 62 nurses (16.6%) in this study, completed nursing programs without assignment to the care of a terminal patient. Degner (cited in Henderson, 1991) contends that it is unrealistic and unethical to expect nurses to provide effective terminal care to patients without prior opportunities for learning.
5. Attitude is deemed to be the most important nursing competency as determined by nurses. This finding implies that education must focus on and allow for opportunities for value clarification and attitude expression.

SECTION III

Numerical Analysis of Likert Items

Views Regarding Death

Table 8 (Appendix K) addresses the responses of 373 nurses to 33 items in the first part of the questionnaire entitled *Views Regarding Death.* For each of the Likert items, respondents indicated the extent to which they agreed or disagreed with the statement. Each statement was followed by a five-point scale on which: 1 is strongly disagree (SD), 2 is disagree (D), 3 is neutral (N), 4 is agree (A), and 5 is strongly agree (SA). The table provides information related to the questionnaire item, frequency, percentage of responses, mean, median, and standard deviation. Analysis focused on the frequency of responses related to the agree, disagree, and neutral categories in addition to a comparison of satisfaction according to age.

A tabulation of the percentage of responses provides insight concerning nurses' views regarding death. For the purpose of this calculation, strongly agree and agree responses were combined into an *agree* category; similarly, strongly disagree and disagree responses were combined into a *disagree* category.

In the agree category, as determined by the researcher, response percentages of 80% or more and means above four were considered worthy of examination. In this case, questionnaire items 5, 6, 7, 9, 18, 20, 23, and 28 had response percentages of 80% or more. The findings related to these items are presented.

Even though nurses (86.4%) lacked definite views about death, they (85.2%) were able to accept others with different views. A majority of participants (86.8%) indicated that more death education is needed in schools of nursing, in fact, there was a strong preference among nurses (84.2%) for a specific course requirement related to death and dying with a component designated to student assignment to a terminal patient (93%), and opportunities to gain more knowledge and skill regarding communication (92.2%). Nurse respondents (89.8%) thought it was appropriate for the nurse to show

grief in response to a death in the work setting. Most nurses (94.1%) emphasized the *caring* aspect of their practices.

As determined by the researcher, in the disagree category, a response percentage of 40% or more was examined in terms of the main ideas expressed. Questionnaire items 10, 14, 17, 22, 27, 31, 32, and 33 had response percentages of 40% or more as well as means below three. More than one half of nurses (53.1%) expressed that they did not possess a high level of expertise in the area of terminal care; 43.9% of nurses lacked a sound knowledge base regarding ethnic and cultural beliefs and values regarding death. A majority of nurses (64.6%) reported that the amount of time allocated to the teaching of death and dying in their basic nursing programs was inadequate; a similar finding related to the quality of preparation, in that 57.6% of nurses thought that their educational preparation regarding death and dying was inadequate to serve as a sound foundation for clinical practice. More than three-quarters of the nurse participants (78%) concluded that opportunities to participate in death awareness exercises in basic nursing programs were inadequate. In spite of such findings, 58.5% of nurses maintained that their thoughts about death have not remained private. Forty-six percent of nurses expressed that there is inadequate support available to nurses following a death in the work setting. Of interest, 40.5% of nurse respondents acknowledged a lack of opportunity to communicate with other disciplines regarding planned terminal care.

Although not represented by a table, analysis included a comparison of satisfaction as related to age. A *t-test* was utilized to statistically analyze the difference between the means related to age and satisfaction. Forty-nine respondents expressed dissatisfaction related to the provision of terminal care; 227 participants indicated satisfaction. Results of the t-test revealed that satisfaction (mean = 36.07) and dissatisfaction (mean = 36.20) were equally distributed across the age range. In other words, the ages of those who experienced satisfaction in relation to the terminal care that they were able to provide, were similar to the ages of those who experienced

dissatisfaction; both were similar to the mean age for the sample population (36.16 years). This finding suggests that age does not appear to be a determinant of nurse satisfaction related to terminal care.

Nursing Competencies

Table 9 provides information related to nurses' perceived importance of three areas of nursing competencies--knowledge, skill, and, attitude. For each item in the *Nursing Competencies Scale*, respondents indicated the extent to which they considered a topic as important. Each topic was followed by a four-point scale on which: 1 is unimportant, 2 is somewhat important, 3 is important, and 4 is very important. The table provides data related to the area of nursing competency, topic, frequency, percentage of responses, mean, and standard deviation.

In order of priority, the following five topics were deemed important by the sample population, as determined by means:

	Topic	Mean
1.	pain control and symptom management;	(3.92)
2.	grief counselling, communication and psychological support;	(3.70)
3.	terminal care;	(3.69)
4.	bereavement and coping with loss; and	(3.68)
5.	support for the caregiver.	(3.65)

Topics considered to be of least importance, according to the total survey sample, as determined by means included:

	Topic	Mean
1.	models of palliative care;	(2.97)
2.	anomalies (e.g., near death experiences);	(3.07)
3.	burials, funerals, rituals;	(3.11)
4.	euthanasia; and	(3.13)
5.	non-medical treatment modalities (e.g., relaxation).	(3.35)

Table 9

Nurses' Perceived Importance of Three Areas of Nursing Competencies (Knowledge, Skill, and Attitude)

Area of Nursing Competency	Topic	Frequency		% of Responses					
		N	Missing	Unimportant	Somewhat Important	Important	Very Important	Mean	SD
Knowledge									
34.	Models of palliative care	359	14	2.1	21.4	51.0	23.6	2.978	.747
35.	Stages of death and dying	370	3	.3	6.7	41.6	50.7	3.438	.631
36.	Community resources	372	1	.3	2.7	38.1	58.7	3.556	.564
37.	Religious, spiritual and cultural beliefs	372	1	0	5.4	36.2	58.2	3.530	.598
38.	Burials, funerals, rituals	371	2	1.1	20.4	44.2	38.8	3.113	.759
39.	Ethical/legal issues	371	2	0	5.1	37.0	57.4	3.526	.594
40.	Euthanasia	366	7	3.5	18.8	37.0	38.9	3.134	.845
41.	Living wills	371	2	0	10.2	42.1	47.2	3.372	.663
42.	Pain control and symptom management	371	2	0	0	7.5	92.0	3.925	.265
43.	Oncology nursing	367	6	.5	4.3	32.2	61.4	3.569	.605
44.	Death across the lifespan (e.g., children, adolescents, adults, older adults)	365	8	0	4.0	33.5	60.3	3.575	.572
45.	Death due to AIDS	372	1	.3	6.7	41.6	51.2	3.441	.631
46.	Sudden death	372	1	0	7.5	36.2	56.0	3.487	.634
47.	Family dynamics	371	2	0	3.8	33.0	62.7	3.593	.564
Skill									
48.	Grief counselling, communication and psychological support	372	1	0	1.6	26.3	71.8	3.704	.491
49.	Team building across the disciplines	368	5	0	4.0	46.9	47.7	3.443	.574
50.	Support for the caregiver	372	1	0	2.1	30.6	67.0	3.651	.521
51.	Physical care	370	3	0	2.1	33.2	63.8	3.622	.528

Table 9 (cont'd)

Nurses' Perceived Importance of Three Areas of Nursing Competencies (Knowledge, Skill, and Attitude)

		Frequency		% of Responses					
Area of Nursing Competency	Topic	N	Missing	Unimportant	Somewhat Important	Important	Very Important	Mean	SD
Skill (cont'd)									
52.	Non-medical treatment modalities (e.g., relaxation)	370	3	.5	7.2	48.3	43.2	3.351	.638
53.	Terminal care	369	4	0	.5	29.5	68.9	3.691	.474
Attitude									
54.	Death awareness	369	4	0	1.9	39.4	57.6	3.564	.534
55.	Death anxiety	367	6	0	2.1	39.1	57.1	3.559	.539
56.	Bereavement and coping with loss	368	5	0	.8	29.2	68.6	3.688	.481
57.	Anomalies (e.g., near death experiences)	348	25	1.1	18.5	46.1	27.6	3.075	.732

Note: May not add to 100% due to rounding.
Mean based on a 4-point scale where 1 = unimportant, 4 = very important.

Levels of Difficulty

In table 10, the levels of difficulty experienced by nurses in relationship to the provision of terminal care to individuals in nine age groups are examined. For each age grouping, the respondents indicated the extent of difficulty related to the provision of terminal nursing care. Each age group was followed by a four-point scale on which: 1 is extreme difficulty, 2 is moderate difficulty, 3 is very little difficulty, and 4 is no difficulty. The table provides information related to the age group, frequency, percentage of responses, mean, and standard deviation.

In order of priority, as indicated by means, difficulty was experienced by nurses related to the provision of terminal care to individuals in the following age groups: preschooler (mean = 1.18); elementary school age child (mean = 1.19); adolescent [13-19 years (mean = 1.29)]; infant (mean = 1.30); young adult [20 - 44 years (mean = 1.63)]; stillbirth (mean = 1.96); middle age adult [45 - 65 years (mean = 2.32)]; miscarriage (mean = 2.57); and older adult [65+ years (mean = 2.93)].

Levels of Anxiety

Table 11 addresses data related to levels of anxiety experienced by nurses in response to various aspects of terminal care. Each component of care was followed by a four-point scale where: 1 is extreme anxiety, 2 is moderate anxiety, 3 is very little anxiety, and 4 is no anxiety. This table provides findings related to the questionnaire item, frequency, percentage of responses, mean, and standard deviation.

Table 10

Levels of Difficulty Experienced by Nurses in Relation to Age Groups

Age Group	Frequency		% of Responses				Mean	SD
	N	Missing	Extreme Difficulty	Moderate Difficulty	Very Little Difficulty	No Difficulty		
Older Adult (65 + years)	370	3	.5	25.2	53.4	20.1	2.938	.690
Middle age adult (45 - 65 years)	369	4	6.4	59.0	28.4	5.1	2.325	.674
Young adult (20 - 44 years)	361	12	44.0	45.8	5.1	1.9	1.637	.674
Adolescent (13 - 19 years)	356	17	70.5	22.5	1.9	.5	1.292	.530
Elementary school age child	354	19	79.1	13.9	1.3	.5	1.192	.467
Preschooler	355	18	80.4	12.6	.13	.8	1.186	.480
Infant	354	19	71.3	19.0	3.5	1.1	1.308	.596
Stillbirth	354	19	33.0	36.7	20.4	4.8	1.969	.876
Miscarriage	357	16	7.8	37.0	38.9	12.1	2.577	.813

Note: May not add to 100% due to rounding.
Mean based on a 4-point scale where 1 = extreme difficulty, 4 = no difficulty.

Table 11

Levels of Anxiety Experienced by Nurses in Relation to the Provision of Terminal Care

Questionnaire Item	Frequency		% of Responses				Mean	SD
	N	Missing	Extreme Anxiety	Moderate Anxiety	Very Little Anxiety	No Anxiety		
Provision of emotional support for the family	368	5	7.0	52.8	33.0	5.9	2.383	.706
Provision of post-mortem care	358	15	8.0	26.0	37.8	24.1	2.813	.908
Maintenance of self-composure	369	4	3.2	33.5	52.5	9.7	2.694	.688
Provision of emotional support for the dying person	370	3	8.3	41.8	40.2	8.8	2.500	.773
Psychological effects upon self	367	6	4.0	42.6	46.4	5.4	2.540	.664
Provision of physical care for the dying person	369	4	1.1	18.8	47.2	31.9	3.111	.738

Note: May not add to 100% due to rounding.
Mean based on a 4-point scale where 1 = extreme anxiety, 4 = no anxiety.

Components of terminal care that produced the most nurse anxiety are ranked, in priority, according to means, as follows:

	Topic	Mean
1.	provision of emotional support for the family;	(2.38)
2.	provision of emotional support for the dying person;	(2.50)
3.	psychological effects upon self;	(2.54)
4.	maintenance of self-composure;	(2.69)
5.	provision of post-mortem care; and	(2.81)
6.	provision of physical care for the dying person.	(3.11)

Summary

An analysis of the four scales in the questionnaire (views regarding death, nursing competencies, and levels of difficulty and anxiety) revealed the following:

1. The majority of nurses (86.8%) maintained that more death education is needed in schools of nursing, furthermore, 84% supported that a specific course regarding death and dying should be a requirement for all nurses. A number of respondents (57.6%) expressed that their educational preparation regarding death and dying was considered insufficient to serve as a basis for sound clinical practice. Both the lack of time and the lack of quality instruction were cited as barriers to effective death education. A resurgence of interest in the topic during the past decade has not corresponded with more effective death education for nurses. Morgan (1990) concluded that the "status of death education has not changed" (p. 5). In view of this finding, more emphasis on death education in future nursing curricula development is warranted. These findings support Quint's 1964 landmark study (cited in Quint, 1967) that documents the need for a systematic plan for educating nurses about death and dying.

2. Nurses offered support for several curricular components that would strengthen existing death education, such as:

   A. a specific course requirement;

   B. student assignment to a terminal patient;

   C. increased opportunities for participation in death awareness exercises in basic nursing programs;

   D. increased opportunities to gain more knowledge and skill regarding communication with terminal patients and families;

   E. instruction related to ethnic and cultural beliefs and values regarding death;

   F. development of a multidisciplinary approach to terminal care; and

   G. creation of a supportive network for those involved with terminal care.

3. Five topics related to curriculum development, stated as nursing competencies, were deemed as important. These included: pain control and symptom management, grief counselling, communication and psychological support, terminal care, bereavement and coping with loss, and support for the caregiver. These selected topics compliment the essence of terminal care--patient comfort, quality of life, meaningful communication, the healthy resolution of loss, and caregiver well-being.

   The topics considered to be of lesser importance included: models of palliative care; anomalies (e.g., near death experiences); burials, funerals, and rituals; euthanasia; and non-medical treatment modalities. Of particular interest, euthanasia is a topic of present national and global interest, however, in this study, nurses considered it to be of lesser importance. Nurses live and work in environments where questions concerning life and death are everyday occurrences; the topic of euthanasia has tremendous implications for nursing practice. Further consideration will be given to this topic later on in this work. As a result of this finding, it may be worthwhile to explore the topic of euthanasia in future research.

4. Certain patient age groups posed difficulty for nurses providing terminal care. In general, the younger the patient, the more difficulty experienced by the nurse. This finding concurs with that of Popoff (1975).
5. The provision of terminal care often produced nurse anxiety. Nurse anxiety was most often invoked by the provision of emotional support to both the family and dying person. The least amount of nurse anxiety occurred in response to the performance of terminal care skills, for example, the provision of physical care to the dying person. These findings are congruent with those of Milton (1984) even though baccalaureate nursing students served as subjects for that study.
6. The provision of emotional support is based on one's ability to effectively communicate. Faulkner and Macleod (1981) identified an urgent need for education regarding communication skills for nurses engaged in terminal care. Ten years later, this need is still present as evidenced by 92.2% of the sample population who stressed the importance of opportunities for the improvement of communication skills.

SECTION IV

Differences Between Subgroup Samples

This section addresses the differences between subgroup samples through the use of *one-way analysis of variance* (ANOVA). Four scales in the questionnaire are analyzed in this regard, as follows: nurses' perceptions regarding death and death education; nurses' perceived importance of nursing competencies; levels of difficulty experienced by nurses in relation to age groups; and levels of anxiety experienced by nurses in relation to the provision of terminal care. The latter portion of this section provides findings relevant to religion, and its impact on care. Specifically, the intensity of the participants' religious beliefs are analyzed through the use of t-tests.

Nurses' Perceptions Regarding Death and Death Education: One-way Analysis of Variance

Table 12 (Appendix L) documents findings relevant to nurses' perceptions regarding death and death education through statistical analysis utilizing one-way analysis of variance. ANOVA is a parametric procedure used to test the significance of differences between means (Polit & Hungler, 1991). The table provides data related to the questionnaire item, frequency, mean, and standard deviation.

Statistically significant findings were noted between several subgroup samples in relation to several items in the *Views Scale* of the questionnaire as follows:

1. Questionnaire item #3 - Both hospital and community nurses acknowledged that it was easier to discuss death with colleagues than was indicated by college students. This expected finding lends support to the notion that education and experience provide a basis for comfort with the topic of death.
2. Questionnaire item #4 - Nurse educators were less inclined to view death as "a beginning" than were college students and hospital nurses. Possibly, in relation to a combination of education and experience, nurse educators were able to pose more questions, and consequently were reluctant to agree upon a definitive statement.
3. Questionnaire item #5 - Hospital nurses were more definite in support of student assignment to a terminal patient than were college students. Hospital nurses may have been more inclined to understand the realities of terminal care and the difficulties inherent in such practice based on experience and, therefore, were able to express support for this position.
4. Questionnaire item #6 - Most nurses indicated that they did not have any definite views about death as yet, however, this perception was more pronounced among hospital nurses and nurse educators than among college students. In an attempt to explain this phenomenon, it may be that the more education and experience one acquires, the less certain one becomes about accepting any definite view.

5. Questionnaire item #7 - Nurse educators maintained that their terminal nursing care emphasized a caring focus to a greater extent than did college students. Nurse educators may be more cognizant of and, therefore, able to apply current nursing theory which maintains that caring, in fact, is the essence of nursing practice.
6. Questionnaire item #10 - Community nurses, on the one hand, more than any other subgroup, maintained that the amount of time allocated to death and dying in basic nursing programs was inadequate. College students, on the other hand, more than any other subgroup, expressed a neutral opinion regarding the amount of time allocated to death and dying in basic nursing programs. It appears that some improvement with regard to time allocation may be evident even though the survey conducted by the researcher in May, 1991 does not reflect this position. Another explanation is that community palliative care remains a relatively new focus in nursing practice, a focus for which insufficient time has been given in nursing curricula.
7. Questionnaire item #11 - University students, to a greater extent than college students, expressed that in the work setting, it is appropriate to become involved with dying persons. University students involved in programs with particular emphasis on communication and psychosocial aspects of caring, may be more emphatic about applying these concepts. Another possibility is that university students may be more confident than college students in their abilities to form therapeutic and helping relationships with patients and families.
8. Questionnaire item #13 - Hospital nurses indicated that they had "come to terms" with eventual mortality to a greater extent than did university students. It is necessary to come to terms with one's own mortality in order to allow another person to do the same. It remains possible that hospital nurses have adapted by confronting their own deaths in order to survive and thrive in the hospital environment. University students, involved in the educational process, may be in a

position of questioning and working through this issue and, therefore, less supportive of this statement.

9. Questionnaire item #14 - Both hospital and community nurses, as compared to college students, were less inclined to agree that the quality of death and dying educational preparation received in basic nursing programs served as a sound basis for clinical practice. This important statement addresses a major research question--Does present death education in nursing serve as adequate preparation for clinical practice? Due to the fact that hospital and community nurses possess more education and experience than college students, the views of the former would seem more credible. To add strength to the position of hospital and community nurses regarding the quality of death education, both groups may be considered as front-line health care professionals, in strategic positions, with views that integrate theory and practice. This finding supports the need to consider the quality of death education programs in terms of congruence between theory and practice.
10. Questionnaire item #15 - College students tended to think about death more often than did hospital nurses. This expected finding supports the notion that the development of one's values and beliefs is a cognitive process. Hospital nurses generally have had more opportunity to develop values and beliefs with respect to death, consequently, they became less engaged in this activity than did college students.
11. Questionnaire item #16 - Both hospital nurses and nurse educators reported feeling more comfortable than did college students in reference to communication with bereaved relatives. A plausible explanation is that a combination of education and experience helps one to become more comfortable with the process of communication.
12. Questionnaire item #17 - Nurse educators, more than any other subgroup, contended that when a death occurs in the work setting, there is inadequate support

available to the nurse. College students and community and hospital nurses were less likely to support this proposition. It may be that nurse educators, because they are not continuously immersed in the work setting, view the situation from a different perspective. It is important to note that all subgroups offered support to this position.

13. Questionnaire item #18 - Although all subgroups supported the statement that more death education is needed in schools of nursing, university students were more insistent on this position than were college students. Again, this finding may be related to greater exposure by university students to theory, research, and practice.
14. Questionnaire item #20 - All nurses expressed preference for opportunities to gain more knowledge regarding communication with terminal patients and families, however, college students indicated a stronger preference than did hospital nurses. It may be that college students perceived potential in this area due to a lack of education and experience while hospital nurses perceived this aspect of care as more fully developed through clinical practice.
15. Questionnaire item #24 - Several statistically significant findings were noted in relation to this item. Hospital nurses offered more support than did university students and nurse educators in terms of the availability of support from the nurse to the patient and family, when a death occurs in the work setting. Hospital nurses may perceive the situation more favorably in order to validate their practices, realizing the many demands of nursing care. In contrast, university students and nurse educators may view nurse support from a perspective which emphasizes assessment of patient and family needs. College students' perceptions differed significantly from those of university students. It appears that the university students' perceptions may be more closely aligned with those of nurse educators; similarly, college students' perceptions may be more congruent with those of

hospital nurses. A difference in focus between diploma and baccalaureate nursing education may account for these differences.

16. Questionnaire item #26 - College students offered the least amount of support for the statement that views about death affect practice. Hospital and community nurses were more supportive of this statement. The correlation between one's views and one's practice is substantiated by this finding, in that nurses with more in depth knowledge and experience are able to link these concepts.
17. Questionnaire item #31 - Hospital and community nurses and nurse educators possessed higher levels of expertise in the area of terminal care than did college students. This expected finding may bear a relationship to the amount of education and experience of the nurse.
18. Questionnaire item #32 - College students offered more agreement than did nurse educators in reference to the adequacy of opportunities for participation in 'death awareness' exercises in basic nursing education programs. This finding may be positively interpreted, in that more opportunities to engage in death awareness exercises may currently be offered as part of basic nursing education programs. Also, nurse educators may be more aware of the importance of death awareness exercises in attitude formation. In this study, attitude was deemed to be the most important nursing competency.

Nurses' Perceived Importance of Nursing Competencies: One-way Analysis of Variance

Table 13 (Appendix M) reveals findings concerning nurses' perceived importance of nursing competencies through statistical analyses utilizing one-way analysis of variance. Respondents were requested to indicate the extent to which they considered each of 24 identified topics as important. The table provides information related to the questionnaire item, frequency, mean, and standard deviation.

As determined by a comparison of means, statistically significant findings were noted in the competencies scale of the questionnaire, between five subgroup samples, related to three areas of nursing competencies (knowledge, skill, and attitude), as follows:

1. Questionnaire item #7 - Hospital nurses were more inclined than both university students and nurse educators to perceive euthanasia as a topic of lesser importance for nursing curricula. In fact, euthanasia was deemed to be a topic of lesser importance to the entire sample population. This is an unexpected finding in that one would expect hospital nurses to be more frequently involved with issues concerning euthanasia in the workplace, and thus more supportive of the educational relevance and importance of this topic. It may be that both university students and nurse educators were more current with biomedical issues and, therefore, viewed euthanasia as an important topic. Another possibility is that hospital nurses may have felt restricted by the operationalization of the medical model within the hospital setting. This finding suggests further study.
2. Questionnaire item #11 - University students considered the study of death across the lifespan to be of more importance than did hospital nurses. This finding may reflect the lifespan approach to teaching/learning emphasized in baccalaureate nursing education. In this regard university students may have been keenly aware of, and consequently emphasized, the unique needs of dying persons in particular developmental age groups, for example, children, adolescents, and older adults.
3. Questionnaire item #14 - Nurse educators identified the importance of family dynamics as a possible topic for study to a greater extent than did hospital nurses. Again, this finding may have represented curricular focus in baccalaureate nursing education.
4. Questionnaire item #18 - College student maintained the importance of learning about physical care to a greater degree than did hospital nurses. As expected, college

students' perceptions were more congruent with nurse educators' perceptions than with perceptions of any other subgroup. The increased emphasis on physical care may be attributed to the students' focus on learning new skills.

5. Questionnaire item #19 - College and university students and nurse educators indicated the importance of learning about non-medical treatment modalities to a greater extent than did hospital nurses. It may be that hospital nurses question the practical application of non-medical treatment modalities. Possibly hospital nurses felt constrained by medical treatment regimens utilized within the hospital setting. Students and educators may have accessed the literature to a greater degree and may have been eager to learn more about these concepts as related to patient care.

Levels of Difficulty Experienced by Nurses in Relationship to Age Groups: One-way Analysis of Variance

Table 14 contains information related to the *Level of Difficulty Scale* in the questionnaire represented by four levels of difficulty experienced by nurses in relationship to the provision of care to palliative persons in designated age groups. Data, in the table, are provided respective of the questionnaire item, frequency, mean, and standard deviation.

In the table, statistically significant findings between subgroups are indicated by letters following the mean (e.g., a, b, c, or d). Subgroups identified by the same letter are statistically significant. Certain subgroups may be identified by more than one letter; in such a case, consider each letter on an individual basis and search for the corresponding letter from among other subgroups. For example, subgroups identified by an "a" are statistically significant.

This scale in the questionnaire contains statistically significant findings, determined by a comparison of means, among all six questionnaire items, as follows:

Table 14

Levels of Difficulty Experienced by Nurses
According to Patient Age Groups
One-way Analysis of Variance

1. Age: Older Adult (65 + years)

	N	Mean	SD
College Student	75	2.8800	.6568
University Student	34	2.8235	.8338
Hospital Nurse	186	2.9946	.6698
Community Nurse	43	2.9535	.6885
Nurse Educator	32	2.8438	.7233
Total	370	2.9378	.6898

2. Age: Middle Age Adult (45 - 65 years)

	N	Mean	SD
College Student	74	2.2703	.6884
University Student	34	2.2059	.6410
Hospital Nurse	185	2.3297	.6294
Community Nurse	43	2.4186	.7938
Nurse Educator	33	2.4242	.7513
Total	369	2.3252	.6736

3. Age: Young Adult (20 - 44 years)

	N	Mean	SD
College Student	74	1.5000 a	.6248
University Student	34	1.5294	.6147
Hospital Nurse	180	1.6444	.6220
Community Nurse	41	1.7317	.7424
Nurse Educator	32	1.9063 a	.9284
Total	361	1.6371	.6738

4. Age: Adolescent (13-19 years)

	N	Mean	SD
College Student	74	1.2297	.5114
University Student	32	1.1875	.3966
Hospital Nurse	178	1.2865	.4894
Community Nurse	40	1.3500	.5796
Nurse Educator	32	1.5000	.7620
Total	356	1.2921	.5297

Mean based on a 4-point scale where 1 = extreme difficulty, 4 = no difficulty.
a, b, c, and d denotes groups significant at the .05 level.

Table 14 (cont'd)

Levels of Difficulty Experienced by Nurses According to Patient Age Groups One-way Analysis of Variance

5. Age: Elementary School Age Child

	N	Mean	SD
College Student	74	1.1486 b	.4588
University Student	32	1.0313 a	.1768
Hospital Nurse	176	1.1761 c	.4109
Community Nurse	40	1.2500	.4935
Nurse Educator	32	1.4688 a,b,c	.7613
Total	354	1.1921	.4669

6. Age: Preschooler

	N	Mean	SD
College Student	74	1.1622 c	.4973
University Student	32	1.0313 a	.1768
Hospital Nurse	177	1.1582 b	.4235
Community Nurse	40	1.2500	.4935
Nurse Educator	32	1.4688 a,b,c	.7613
Total	355	1.1859	.4805

7. Age: Infant

	N	Mean	SD
College Student	74	1.2568	.5982
University Student	32	1.1563 a	.3689
Hospital Nurse	176	1.2557 b	.5210
Community Nurse	40	1.5250	.6789
Nurse Educator	32	1.5938 a,b	.8747
Total	354	1.3079	.5961

8. Age: Stillbirth

	N	Mean	SD
College Student	74	1.8649 b	.9264
University Student	31	1.7097 a	.7829
Hospital Nurse	177	1.9322	.8434
Community Nurse	40	2.3500 a,b	.8336
Nurse Educator	32	2.1875	.9311
Total	354	1.9689	.8756

Mean based on a 4-point scale where 1 = extreme difficulty, 4 = no difficulty.
a, b, c, and d denotes groups significant at the .05 level.

Table 14 (cont'd)

Levels of Difficulty Experienced by Nurses
According to Patient Age Groups
One-way Analysis of Variance

9. Age: Miscarriage

	N	Mean	SD
College Student	74	2.3919 d	.8410
University Student	32	2.1250 a,b,c	.9419
Hospital Nurse	178	2.6236 a	.7583
Community Nurse	41	2.7561 b	.6993
Nurse Educator	32	2.9688 c,d	.7822
Total	357	2.5770	.8127

1. Questionnaire item #3 - College students experienced a greater level of difficulty than did nurse educators in the provision of terminal care to young adults (20 - 44 years). The ages of college students may be similar to those in the young adult group; the similarity of age may have invoked some level of difficulty with regard to the provision of terminal care. Also, nurse educators have had more opportunities than students to engage in additional education and experience which may have served to provide context and meaning for dealing with death-related situations.
2. Questionnaire item #5 - College and university students and hospital nurses experienced a greater level of difficulty than did nurse educators regarding the provision of terminal care to elementary school age children. University students experienced a slightly greater level of difficulty than did college students. The education and experience of members of the various nurse subgroups may have accounted for the apparent differences. As university students tended to be older, the increased level of difficulty noted among university students may have been attributed to identification related to circumstantial similarity.
3. Questionnaire item #6 - A similar finding was noted in that college and university students and hospital nurses experienced a greater level of difficulty than did nurse

Mean based on a 4-point scale where 1 = extreme difficulty, 4 = no difficulty.
a, b, c, and d denotes groups significant at the .05 level.

educators in response to caring for terminal preschoolers. Again, university students experienced slightly greater levels of difficulty than did college students. Education and experience may have been key variables related to this finding.

4. Questionnaire item #7 - University students and hospital nurses experienced greater difficulty than did nurse educators in terms of dealing with infant deaths. This phenomenon remains congruent with previously cited findings.
5. Questionnaire item #8 - College and university students reported greater levels of difficulty than did nurse educators in relationship to caring for women who had experienced stillbirth deliveries. A consistent theme persisted; nurse educators experienced less difficulty than other subgroups in the provision of terminal care to persons in specific age groups.
6. Questionnaire item #9 - College and university students expressed more difficulty than hospital and community nurses and nurse educators in relationship to the level of difficulty experienced during the provision of terminal care to those who had experienced miscarriages. Nurse educators experienced the least amount of difficulty in this respect. College and university students were most likely more similar with respect to age than were nurse educators to those who had experienced miscarriages.

Findings of this study concur with those cited by Popoff (1975), in that nurses experienced greater levels of difficulty in response to the care of young terminal persons. The results revealed increased levels of difficulty in caring for terminal persons in the following age groups, rated according to priority, as follows: preschooler; elementary school child; adolescent; infant; young adult; stillbirth; middle age adult; miscarriage; and older adult. Interestingly, respondents found it less difficult to provide terminal care to infants than to other persons younger than twenty years of age.

Levels of Anxiety Experienced by Nurses in Relation to the Provision of Terminal Care: One-way Analysis of Variance

Table 15 provides findings related to a four-point *Anxiety Scale* relevant to six aspects of terminal care, which were gleaned from the literature. In the table, data are provided pertaining to the questionnaire item, frequency, mean, and standard deviation.

Statistically significant findings are presented respective of all six components of terminal care, listed in the scale, as follows:

1. Questionnaire item #1 - Hospital nurses were less anxious than college students regarding the provision of emotional support to bereaved families. Nurse educators also reported less anxiety than college and university students and community nurses in this regard. Possibly hospital nurses and nurse educators have had more contact than other subgroups with grieving families, and hence more opportunities to acquire skills that increase competency levels, and consequently decrease anxiety levels.
2. Questionnaire item #2 - College students expressed a greater level of anxiety than did hospital nurses or nurse educators in response to the provision of post-mortem care. This expected finding may be due to the skill level of the nurse based on experience.
3. Questionnaire item #3 - Again similar findings were noted. College students became more anxious than hospital nurses or nurse educators regarding the maintenance of self-composure during the provision of terminal care. It is important to consider that student anxiety may be induced by a lack of awareness of a multitude of variables. Effective death education would provide learning opportunities that would heighten self-awareness which, in turn, would be reflected by decreased levels of anxiety.

Table 15

Levels of Anxiety Experienced by Nurses in Relation to the Provision of Terminal Care

One-way Analysis of Variance

1. Provision of emotional support for the family

	N	Mean	SD
College Student	75	2.0933 a,b	.6813
University Student	33	2.1515 c	.6671
Hospital Nurse	184	2.4891 a	.6934
Community Nurse	43	2.2791 d	.5488
Nurse Educator	33	2.8182 b,c,d	.7269
Total	368	2.3832	.7061

2. Provision of post-mortem care

	N	Mean	SD
College Student	74	2.3378 a,b	.8645
University Student	33	2.5758	.9692
Hospital Nurse	178	3.0169 a	.8402
Community Nurse	41	2.8049	.8432
Nurse Educator	32	3.0313 b	.9667
Total	358	2.8128	.9082

3. Maintenance of self-composure

	N	Mean	SD
College Student	75	2.4133 a,b	.7550
University Student	33	2.6970	.7282
Hospital Nurse	185	2.7514 a	.6280
Community Nurse	43	2.7209	.6664
Nurse Educator	33	2.9697 b	.6840
Total	369	2.6938	.6884

4. Provision of emotional support for the dying person

	N	Mean	SD
College Student	76	2.2895 a	.8766
University Student	33	2.4242 c	.7084
Hospital Nurse	185	2.5351 d	.7446
Community Nurse	43	2.4186 b	.6261
Nurse Educator	33	2.9697 a,b,c,d	.7282
Total	370	2.5000	.7730

Mean based on a 4-point scale where 1 = extreme anxiety, 4 = no anxiety.
a, b, c, and d denotes groups statistically significant at the .05 level.

Table 15 (cont'd)

Levels of Anxiety Experienced by Nurses in Relation to the Provision of Terminal Care

One-way Analysis of Variance

5. Psychological effects upon self

	N	Mean	SD
College Student	76	2.1711 a,b,c	.6406
University Student	33	2.3333 d	.5951
Hospital Nurse	183	2.6612 b	.6419
Community Nurse	43	2.6512 a	.6504
Nurse Educator	32	2.7813 c,d	.5527
Total	367	2.5395	.6636

6. Provision of physical care for the dying person

	N	Mean	SD
College Student	76	2.9211 a	.8448
University Student	33	2.9697	.7699
Hospital Nurse	184	3.2228 a	.6688
Community Nurse	43	2.9767	.7712
Nurse Educator	33	3.2424	.6629
Total	369	3.1111	.7380

4. Questionnaire item #4- Nurse educators generally experienced less anxiety than all other subgroups in response to the provision of emotional support for the dying person. In this instance, the increased educational preparation of nurse educators may have contributed to this finding.

5. Questionnaire item #5 - Several statistically significant findings were noted regarding the level of anxiety induced as a result of the psychological effects upon oneself in relation to the provision of terminal care. College students experienced more anxiety than did hospital and community nurses and nurse educators; university students experienced more anxiety than nurse educators. Nurses with higher levels of education and experience tended to experience lower levels of death-related anxiety. This finding is opposite to that of Mullins and Marrian (1983),

Mean based on a 4-point scale where 1 = extreme anxiety, 4 = no anxiety.
a, b, c, and d denotes groups statistically significant at the .05 level.

who found that those who had experienced previous death education showed greater levels of anxiety in contrast to those without such exposure.

6. Questionnaire item #6 - College students experienced more anxiety than did hospital nurses in response to the provision of physical care to the dying person. This is most likely due to the limited experience of the student.

Summary

1. Generally, perceptions of students differed significantly from those of other subgroups (hospital and community nurses and nurse educators). Furthermore, in some instances, the perceptions of college students significantly differed from those of university students. It appears that a combination of education and experience may have accounted for some of the difference noted between subgroups. For example, nurses with more education and experience were more able to accept that one's views affect one's practice.
2. It seems apparent that the more education one possesses, the more questions one is able to generate, and the less certain one becomes in claiming any definite view. Possibly, further education may even cause one to raise a whole new set of questions. For example, nurses with more education possessed less definite views about death.
3. Different foci noted between diploma and baccalaureate nursing education may have accounted for some of the differences between subgroups, especially the student subgroups. For example, diploma programs currently focus on producing institutional health care professionals whereas baccalaureate programs educate generalist health care professionals capable of functioning in both institutional and alternative health care settings. Differences between diploma and baccalaureate nursing curricula may have altered nurses' perceptions of death education.

4. Hospital nurses differed from other subgroups in that they perceived the following five topics, related to nursing competencies, to be of lesser importance: euthanasia; death across the lifespan; family dynamics; physical care; and non-medical treatment modalities. This is an interesting finding in and of itself. To further understand this phenomena, it must be noted that hospital nurses comprised 45.5% of the total sample and a majority of this group possessed a RN as the highest educational credential. It is reasonable to expect that variation related to educational preparation may have accounted for some of the noted differences between subgroups.
5. In general, nurses perceived a greater level of difficulty in response to providing terminal care to young persons; the younger the person, the greater the level of perceived difficulty. Nurse educators consistently experienced less difficulty than other subgroups respective of the provision of terminal care to persons in specific age groups.
6. Nurses with higher levels of education and experience tended to experience lower levels of death-related anxiety.

Participants' Religious Beliefs

In reference to the provision of terminal care, the religious aspect of the caregiver merits consideration. Results of this study suggest that the intensity of one's religious beliefs rather than one's particular religious denomination, influence perceptions regarding death and death education. Respondents with high and low intensities of religious beliefs were analyzed through the use of t-tests.

Table 16 provides information related to a sample of participants with high intensities of religious beliefs (N = 87) and participants with low intensities of religious beliefs (N = 33). The areas of employment for respondents with high intensities of religious beliefs were represented, as follows: Hospital nurses (35.8%);

community nurses (24.1%); nurse educators (13.8%); students (12.6%); extended care nurses (11.5%); and other (1.1%). Those with low intensities of religious beliefs were allocated in the following nurse groups: hospital nurses (48.5%), students (27.3%), community nurses (18.2%), and extended care nurses (6.1%).

A t-test of responses by persons with high intensities of religious beliefs and persons with low intensities of religious beliefs revealed statistically significant differences on several items. Pertinent data is provided in Table 17 (Appendix N). Persons with high intensities of religious beliefs were more likely than persons with low intensities of religious beliefs to:

Table 16

Employment Status Related to Participants' Religious Beliefs

Employment Status	Frequency (Total=87)	% of Responses High Intensity of Religious Beliefs	Frequency (Total=33)	% of Responses Low Intensity of Religious Beliefs
Student (not employed)	11	12.6	9	27.3
Hospital (active treatment)	32	36.8	16	48.5
Extended care facility	10	11.5	2	6.1
Community health agency	21	24.1	6	18.2
Educational institution	12	13.8	0	0
Other		1.1		

1. be older (mean 40.89 vs mean 33.27, $p<.001$),
2. possess more years of nursing experience (mean 14.20 vs mean 9.30, $p<.05$),
3. have experienced less previous death education (mean 2.98 vs mean 3.66, $p<.05$),
4. indicate that more death education is needed in schools of nursing (mean 4.58 vs mean 3.60, $p<.001$),
5. comment less favorably regarding the quality of death and dying educational preparation (mean 1.65 vs mean 3.78, $p<.001$),

6. offer less support concerning the adequacy of the time allocation to death and dying in basic nursing programs (mean 1.33 vs mean 3.66, $p<.001$),
7. experience less satisfaction in relation to the provision of terminal care (mean 3.56 vs mean 3.96, $p<.05$),
8. perceive that their clinical skills are less strong with regard to symptom management and pain control (mean 3.34 vs mean 3.78, $p<.05$),
9. disagree that adequate support is available to the nurse when a death occurs in the work setting (mean 2.36 vs mean 2.93, $p<.05$),
10. indicate the importance of knowledge concerning community resources (mean 3.75 vs mean 3.54, $p<.05$),
11. view death as "a beginning" (mean 4.16 vs mean 2.49, $p<.001$),
12. possess sound knowledge regarding religious beliefs and values regarding death (mean 4.24 vs mean 2.58, $p<.001$),
13. have "come to terms" with mortality (mean 4.21 vs mean 3.21, $p<.001$), and
14. turn to religion as a source of comfort and meaning when dealing with death (mean 4.75 vs mean 2.56, $p<.001$).

Summary

The intensity of one's religious beliefs rather than one's particular religious denomination influences perceptions regarding death and death education. This finding suggests that nurse educators need to be cognizant of the learner's values and beliefs within the context of teaching and learning.

SECTION V

Participant Input

The questionnaire contained two open-ended statements which addressed recommendations for future death education for nurses, in addition to other comments

and suggestions. A number of participants responded with lengthy, descriptive comments; a few even wrote personal letters, two of which were very moving. These written responses illuminated and enriched the insights gained from the study, and allowed an opportunity for personal expression on behalf of the subjects. Such data complimented information gleaned through the descriptive and statistical analysis. In response to both questions, findings are analyzed according to emergent themes.

The conceptual framework specific to nurses' perceptions of death education, presented in Chapter III, provides the structure and terminology utilized in this analysis. Three variables appear to underpin the essence of the participants' written responses, as follows: nurse experience with death, nurse attitude toward death, and educational preparation regarding death.

Nurse Experience with Death

Central to the provision of palliative care, nurse experience with death plays a crucial role. The following participant comments exemplify these beliefs:

- It's about time more emphasis was placed on this subject as not everyone is comfortable with death and dying. I relate this to learned behavior and what was presented in the family unit on death/dying. This subject is very relevant to practice, especially with the aging population and the increased prevalence of chronic disease.

- All too often, nurses are called upon to care for the dying, provide support to family and friends, and interface with the community services available. However, the opportunity for nurses to "debrief" is limited, if not totally nonexistent. We carry the burden often and never seem to be free to "unload" it except at coffee, lunch, or at home with family - all of which are not appropriate places.

- I found that when I experienced my first death I was scared. I held the man's hand and he died so peacefully, yet I found myself tearful and felt bad that I was being so emotional when I didn't know the man.

- I think to become more comfortable with nursing the dying, we must be willing to expose ourselves to situations of caring for the dying and we must be willing to be vulnerable in those situations and feel the emotions.

Nurse Attitude Toward Death

Nurses consistently acknowledged and documented the need for educational experiences that endeavor to develop and promote attitude formation, for example, value clarification and attitude awareness experiences. This finding concurs with aforementioned results, in that attitude was deemed to be the most important nursing competency related to palliative care. Additionally, the literature is resplendent with studies that focus on nurse attitude toward death. The following comments allude to this notion:

- we need to remove the belief or sense that death represents failure of either medical treatment or cure.
- There is still a stigma attached to those who become "over-involved" with their patients or who show emotion openly after a death. Consequently, many nurses cover up with gallows [sic] humor or apparent off-handedness. This is a pity, but it won't change until those in authority let it be known that it is quite acceptable to truly care and that it won't reflect negatively on your evaluation.
- Not everyone has this talent, so a nurse who is afraid of her own mortality and death can't possibly help the patient to a peaceful death.
- Develop those tools which support the learner in identifying attitude development and a sense of caring . . . she [the nurse] needs to develop confidence and abilities in dealing with clients.
- More than providing nursing students with specific knowledge about dying and death, I would like to see nurses assisting and empowering other nurses to develop attitudes and skills related to caring.

Educational Preparation

Nurses overwhelmingly offered support for more and better death education for nurses. Some view a caring model as a prototype for nursing curriculum; others are definite about the components required to improve present death education curriculum. Examples of responses related to educational preparation are as follows:

- I feel that we must try to move farther and farther away from the traditional medical model where "no cure" often equates with "no care." Nursing needs to take a leadership role in the provision of palliative/terminal care, and the best place to start preparing nurses for such a role is in basic education programs.

- We must stop training nurses and start educating them . . . the concept of caring should be a basis on which the entire curriculum is based.

- More exposure to all facets of caring for the terminally ill will increase the confidence of the caregiver.

- The whole family and support system needs to be treated as a grieving unit.

- Closer contact is needed with the support groups in the community.

- A must for nursing education . . . It is as part of nursing that cannot be avoided.

- This is an extremely delicate issue but it is extremely important for nurses to be able to cope effectively rather than burn out.

Several nurse participants offered specific comments related to nurses' educational needs. The well-being of the nurse in addition to that of the dying patient and family was stressed.

- There should be a full course on this subject. For too long it was low priority in nursing education.

- A death education course should be mandatory, not an elective, but it should not be in the first six months, since there is enough to cope with as a student.

- Palliative care is a speciality with unique requirements and training needs. I think that post graduate training should be required to best meet the needs of this client group.

- Might be good to have a couple of four week long programs (1 x weekly) on an ongoing basis every year.

- Develop team work assignments.

- I feel there should be inservices or counsellors for nurses because we too must deal with death and dying and must sort out our own feelings before we can assist anyone else.

Nurse respondents also expressed concern regarding the educational preparation of other health care professionals. Closely related, other nurses questioned the educational preparation of those responsible for teaching professionals. Benoliel (1988) maintained that physicians and nurses have few educational opportunities to engage in and learn from opportunities related to teamwork across the disciplines. Additionally, several researchers document the need for well prepared teachers in this

area (Benoliel, 1988; Caty, Downe-Wamboldt, & Tamlyn, 1982; Degner, & Gow, 1988a; & Kubler-Ross, 1969).

- Give doctors the same education in death and dying.

- It has been my experience that very few instructors have had enough experience themselves to handle all these issues in exemplary fashion.

- I feel that it is essential not only to offer the nursing students exposure in dealing with dying patients of all ages, but to also have a course that provides for death education specifically. Because death is a developmental stage (albeit the final stage), it is essential for the nurse to be able to provide competent care while at the same time be able to recognize within herself the meaning of death and dying. I wonder, though, how qualified anyone would be to teach it.

The suggestion of several other topics related to death education further substantiates the importance of curriculum development. Nurses indicated interest in the following topics:

- communication with families
- psychological care for the patient and family
- the power of "touch"
- ethical issues
- professional networking
- support for the caregiver
- conflict resolution for the caregiver
- "inner healing"
- universal concepts for humankind
- living with HIV

Summary

Nurses among the total sample population agreed that improved death education for nurses is required. Improved death education will need to consider at least four variables, as follows: nurse experience with death; nurse attitude toward death; past educational preparation; and personal variables related to the nurse.

CHAPTER V

Summary and Discussion

This chapter provides an overview of the investigation and procedures used. The major research findings are presented and discussed in relationship to the literature and research questions. Recommendations for nursing education and further research are outlined.

Overview of the Problem Investigated and Procedures Used

The central purpose of this study was to examine nurses' perceptions of death education in southern Alberta as one way to influence and improve nursing curricula. A questionnaire was developed, piloted, and distributed to nurses representing health care agencies and institutions in this geographical area.

Major Research Findings

The major research findings include the following:

1. Nurses, including student nurses, held distinct and identifiable perceptions regarding death and death education.
2. Generally, nurses perceived that existing death education remains inadequate in terms of the quality of education provided and the amount of time allocated to the subject. More than half of the respondents (57.6%) considered existing preparation inadequate as a basis for sound clinical practice.
3. The majority of nurses (86.8%) maintained that more death education is needed in schools of nursing; furthermore, 84% offered support for the inclusion of a required course, specific to death and dying, as an integral component of basic nursing education.
4. Nurses overwhelmingly agreed (93.8%) that assignment to a terminal patient must be part of basic nursing education.

5. Nurses offered support for the improvement of existing death education for nurses by the inclusion of several curricular components, as follows: a specific course requirement; student assignment to a terminal patient; increased opportunities for participation in death awareness exercises in basic nursing programs; increased opportunities to gain more knowledge and skill regarding communication with terminal patients and families; education related to ethnic and cultural beliefs and values regarding death; development of a multidisciplinary approach to terminal care; and the creation of a supportive network for those involved with terminal care.
6. Attitude was deemed to be the most important nursing competency related to death education.
7. The five educational topics considered to be of greatest importance, stated as nursing competencies, included: pain control and symptom management; grief counselling, communication and psychological support; terminal care; bereavement and coping with loss; and support for the caregiver. Models of palliative care; anomalies (e.g., near death experiences); burials, funerals, and rituals; euthanasia; and non-medical treatment modalities were considered to be topics of lesser importance.
8. Certain patient age groups posed greater difficulty for nurses regarding the delivery of terminal care; in general, the younger the person, the more difficulty experienced by the nurse.
9. The provision of terminal care often produced nurse anxiety. Nurse anxiety was most often invoked by the provision of emotional support to both the dying person and family; the least amount of nurse anxiety occurred in response to the provision of physical care to the dying person. Nursing skills that required interpersonal communication and collaboration seemed to increase nurse anxiety.
10. Generally, perceptions of students differed significantly from those of other subgroups (hospital and community nurses and nurse educators). In particular,

college and university students experienced greater levels of difficulty than did other subgroups with reference to the provision of terminal care to young persons. Similarly, college students experienced greater levels of anxiety than did other subgroups in response to the provision of terminal care. Nurses with higher levels of education and experience tended to experience less difficulty with respect to the provision of terminal care and lower levels of death-related anxiety.

11. Hospital nurses differed from other subgroups in that they perceived the following five topics, related to nursing competencies, to be of lesser importance: euthanasia, death across the lifespan, family dynamics, physical care, and non-medical treatment modalities. In this regard, one must consider the possibility that perceptions may be reflected in practice.

    Differences regarding nurses' education and experience, dissimilarity between the educational foci of diploma and baccalaureate programs, and differences among practice milieus, may have accounted for the statistically significant differences noted between several subgroups. Consequently, understanding the context within which learning occurs becomes crucial.
12. The intensity of one's religious beliefs, rather than one's particular religious denomination, influenced perceptions regarding death and death education.
13. Educators who endeavor to improve death education will need to consider at least four factors, as follows: nurse experience with death, nurse attitude toward death, past educational preparation, and personal variables related to the nurse.

Death Education as Preparation for Clinical Practice

This segment discusses the findings and literature related to the following research question:

Does present death education serve as adequate preparation for clinical practice?

The major research question in this study sought to determine if existing death education provided a sound basis for clinical practice. Several items in the Views Scale of the questionnaire related to this fundamental concept, specifically questions 10, 12, 14, 16, 20, 24, 27, 31, and 32. Findings pertaining to these questions are discussed as they relate to this concern.

Understanding the inherent complexities of clinical practice is indeed a challenge. Results of this study suggest that existing death education does not adequately prepare nurses for clinical practice. This finding, in part, relates to the continuing low status accorded to death education within current nursing curricula. As expressed by Quint (1967), "This result does not reflect the intent of schools of nursing but rather suggests that the magnitude and nature of the problem has not been sufficiently recognized by those responsible for teaching nurses, or, for that matter, by the public at large" (p. 7). Several other factors support this claim, as follows: inadequate time allotment within nursing curricula; lack of quality education; identifiable knowledge deficits; stated need for improved communication; and the lack of nurse support within the work environment.

The amount of time designated to a topic often provides an indicator of the importance of the subject matter; the quality of instruction usually correlates with the learning outcomes. Questionnaire items 10 and 14 addressed these two aspects of death education. The majority of respondents (64.6%) indicated that the amount of time allocated to death and dying in basic nursing programs was inadequate. This finding supports the notion that this subject matter is not considered important by those in decision making positions; hence, the topic is given low priority within nursing curricula. This sentiment concurs with that of Morgan (1990) who maintained that "this lack of curricular status to death education is an indication that it is not considered important enough to be included" (p. 5). A substantial number of nurses (57.6%) indicated that the quality of death and dying educational preparation provided in basic

nursing programs did not provide a sound basis for clinical practice. This outcome may be correlated with the disparity between theory and practice which is somewhat apparent in the broader context of nursing education. Often students lack the opportunity to apply new theory. Another plausible explanation relates to the educational preparation of nurse educators. Since nurse educators have also been educated and consequently influenced by the present system, they may be unaware of the problem, or unwilling to risk changing the system in order to facilitate this aspect of nursing education. The lack of well-prepared nursing faculty may also be implicated. Degner (cited in Henderson, 1991) maintained that the lack of well-prepared nursing faculty contributed to the status quo image of terminal care nursing. The lack of well prepared faculty has often been cited as a major obstacle that must be overcome in order for nursing to advance as a profession.

The precursor of clinical expertise is a well-developed theory base. Questionnaire items 12, 27, and 31 related to the participants' knowledge base. Although nurses responded to specific questions regarding content, it must be remembered that knowledge is not synonymous with subject matter. Rather, knowledge is personal and contextual, created and shaped by individuals (Nelms, 1991). Of those surveyed, 20.4% possessed expertise in the area of terminal care while 53.1% lacked such expertise. Closely related to expertise, 27.6% of nurses lacked a sound knowledge base regarding religious beliefs and values regarding death, while 49.3% expressed knowledge deficits related to ethnic and cultural beliefs and values regarding death. These data imply that clinical practice may be impeded due to identifiable knowledge deficits.

The ability of the nurse to effectively communicate with colleagues, health care professionals, professionals from other disciplines, and the patient and family underpins the quality of terminal care nursing practice. Questionnaire items 16, 20, and 33 reflected this aspect of quality terminal care. A majority of respondents

(92.9%) indicated a preference for opportunities to acquire more knowledge regarding communication with terminal patients and families. In response to a death in the work setting, 27.3% of nurses experienced discomfort related to communication with bereaved relatives. More than one third of the sample population (40.5%) expressed that opportunities for dialogue with members of other disciplines were lacking. These findings support the need for increased emphasis on communication enhancement among disciplines. That, in turn, would promote clinical effectiveness.

The creation of a supportive environment for the patient and family remains one of the primary goals of successful terminal care. Questionnaire item 24 revealed ambivalent results. On the one hand, more than one third of respondents (34.6%) considered that inadequate support was offered by the nurse to the patient and family following the death of a loved one. On the other hand, 36.5% indicated that support was available to the patient and family while 25.7% of nurses provided neutral responses. These findings may be related to a variety of factors. It is well documented in the literature that nurses tend to avoid dying patients because they feel less confident dealing with the psychological needs of dying patients than with the technical care needs (Quint, 1967; Sudnou, 1967). Lev (1986) contended that nurses also tend to avoid the dying alcoholic, psychiatric, or AIDS person. Another reasonable explanation for the lack of support offered by the nurse to the terminal patient and family relates to the perceived amount of support, or lack of support, experienced by the nurse. As indicated by questionnaire respondents, 46.1% maintained that when a death occurred in the work setting, the availability of support to the nurse was inadequate. Similar results were found in Lyon's (1988) study, in that staff perceived a need for support when a patient dies. Factors such as nurse avoidance of the patient and family and perceived inadequacy of nurse support, no doubt, affect the communication process between the nurse and the patient and family and, hence, the quality of clinical practice. This finding supports the

need to create supportive networks for nurses within the workplace. Such networks might also include members from other health-related disciplines.

In response to these claims, nurse educators need to assume responsibility for becoming informed about issues related to death education, and to pursue responsible action aimed at the improvement of existing death education that will ultimately result in safe, sensitive, and effective care to the patient and family and a meaningful outcome for all involved. With increased awareness, nurses can collectively direct effort toward exploring how certain situations might be mitigated, and other situations enhanced, to provide and promote effective death education for nurses.

Even though several concerns were identified, nurses offered support for the improvement of existing death education by the inclusion of several curricular components, such as: a specific course requirement; student assignment to a terminal patient; increased opportunities for participation in death awareness exercises in basic nursing programs; increased opportunities to gain more knowledge and skill regarding communication with terminal patients and families; education related to ethnic and cultural beliefs and values regarding death; development of a multidisciplinary approach to terminal care; and the creation of a supportive network for those involved with terminal care.

Differences Regarding Perceptions of Subgroup Samples

This segment discusses the findings and literature related to the following research question:

What differences exist between student nurses, hospital nurses, community nurses, and nurse educators regarding perceptions of death education?

An important research question focused on determining differences between subgroup samples (college and university students, hospital and community nurses, and

nurse educators) and the meaning and implications of these differences. The literature is devoid of studies with this particular emphasis. Nevertheless, the views expressed by nurses who work in alternate health care settings, for example, extended care institutions and communities, are important and merit consideration related to educational planning.

The following four scales in the questionnaire were analyzed through the use of one-way analysis of variance: nurses' perceptions regarding death and death education, nurses' perceived importance of nursing competencies, levels of difficulty experienced by nurses in relation to age groups, and levels of anxiety experienced by nurses in relation to the provision of terminal care. The differences between perceptions of college and university students, hospital nurses, community nurses, and nurse educators are described in the following four sections.

College and university students.

Most of the student sample indicated that they lacked previous death education and experience (94.8% and 96.1% respectively). This lack of education and experience may have accounted for some of the statistically significant differences found between college students and all other subgroups.

The perceptions of students consistently differed from those of other subgroups. For example, college students were less inclined than other subgroups to perceive that views toward death affect practice with terminal patients and families. An important viewpoint expressed in the literature indicated that nurses' attitudes/views toward death influenced both interaction and communication with terminal patients and families (Fulton & Langton, 1964; Quint, 1967; Golub & Rezinkoff, 1971; Sobel, 1969). Furthermore, Milton (1984) stated that "attitudes of nurses toward dying patients may be considered strong predictors of clinical behavior" (p. 298). As noted among other subgroups, nurses with more education and experience were more likely to perceive that

views toward death affect practice. This finding suggests that as nurses become more educated and experienced, they gain self-awareness and develop insights that may be positively reflected in clinical practice.

College students reported higher anxiety levels than all other subgroups related to the provision of terminal care. College students also experienced greater levels of difficulty than other subgroups in terms of discussing death with colleagues, and more discomfort regarding communication with bereaved relatives. As expected, college students possessed lower levels of expertise in the area of terminal care than did other nurses in the study. In contrast, higher mean scores were attributed to those with higher levels of education and experience. These findings support the need for increased of death education for nurses.

Of particular interest, the perceptions of college students significantly differed from those of university students regarding emotional involvement with dying persons. University students indicated to a greater degree than college students that in the work setting, it is appropriate to become emotionally involved with dying persons. On the one hand, it may be that university students felt more confident than college students and, therefore, more comfortable in terms of emotional involvement with dying persons. On the other hand, the modelling effect may have influenced college students' perceptions. The perceptions of college students were more closely aligned with those of hospital nurses than with any other subgroup. Quint (cited in Degner & Gow, 1988b) maintained that "without accompanying educational preparation and support, they [nurses] would adopt the behaviors of other professionals around them and limit their involvement in death-related situations" (p. 161). In reference to this finding, it is critical that novice nurses receive well-planned death education within a supportive environment early in their careers, within the first six months, if possible. Quint (1967) maintained similar views as she noted that "often the practice of withdrawal from dying patients is quite well established by the end of the first year in school" (p. 236).

Although all subgroups supported a need for more death education in schools of nursing, university students were more committed to this position than were college students. Education and experience most likely contributed to this finding.

Differences between college and university students' perceptions may also be attributed to distinctive foci specific to educational programs. Currently, diploma programs focus on the preparation of nurses capable of functioning within institutional settings whereas baccalaureate programs prepare nurses to practice in institutional and community-based settings. In this regard, dissimilarity between educational foci of nursing programs may have contributed to the differences between these two groups. University students, exposed to complex health care issues and a broadened scope of practice, no doubt, interpret issues/concerns related to terminal care from a different vantage point.

Hospital nurses.

Hospital nurses differed from other subgroups in that they perceived the following five topics, related to nursing competencies, to be of lesser importance: euthanasia; death across the lifespan; family dynamics; physical care ; and non-medical treatment modalities. The mean scores related to four-out-of-five of the above mentioned topics were lower for hospital nurses than for all other subgroup samples.

Caution must be exercised with the interpretation of these data. One would expect hospital nurses to signify these topics as very important in relationship to practical and clinical significance. A plausible explanation for these findings may be related to perceived constraints experienced by hospital nurses who work within a system operationalized by the cure-oriented medical model.

The finding related to hospital nurses perceived importance of the topic 'euthanasia' requires further exploration and clarification. Hospital nurses live and work in environments where difficult questions concerning life and death occur on a

daily basis. Euthanasia remains a topic of much debate in both national and global spheres. Rather than conjecture at this time, research is required to further examine the topic as related to nurses' educational needs.

Community nursing.

Community nurses, more than all other subgroups, maintained that the amount of time allocated to death and dying in basic nursing programs was inadequate. A community-focussed, futuristic trend within the health care system gives credence to this finding. As more dying persons opt to die within their familiar home environments, nurses will be required to assist with meeting individual and family needs in community settings. Traditionally, nurses have not been educated for this role, nor has time been provided on the job for nurses to acquire the necessary attitudes, knowledge, and skills.

In addition, community nurses, more than all other subgroups, indicated that the quality of death and dying educational preparation was inadequate to serve as a basis for sound clinical practice. It may be that community nurses have unique educational needs that remain unidentified and, therefore, unaddressed. Further investigation is necessary.

Community nurses were eager to participate in this research as demonstrated by several unsolicited requests for questionnaires from community health staff and requests to participate in this research project.

Nurse educators.

As compared to other subgroups, nurse educators were more definite in their claim that views about death affected practice with terminal patients and families. Terminal care experts such as Quint (1967) and Kubler-Ross (1969) maintained that nurses must be cognizant of the fact that attitudes/views affect practice.

Nurse educators, more than all other subgroups, indicated that when a death occurred in the work setting, adequate support available from the nurse to the patient and family was lacking. Closely linked, this subgroup also perceived that when a death occurred in the work setting, adequate support available to the nurse was lacking. These findings are congruent in that the nurse must perceive self-support in order to be able to provide support to others. This finding alludes to the importance of nurse support groups/networks within the workplace.

In general, nurse educators experienced less difficulty and anxiety than other subgroups related to the provision of terminal care. This finding supports the contention that education and experience positively influence the perceived level of difficulty and anxiety related to terminal patient care. Contrary to the findings of this study, Pearlman, Stotsky, and Dominick (1969), and Stoller (1980) found that uneasiness associated with interactions with dying persons increased with nursing experience.

Apparent differences noted between subgroup samples suggest that nurses who possess more education and experience related to death hold unique perceptions. These nurses who understand that views affect practice, possess greater levels of knowledge and skill, and display more confidence and competence regarding terminal care practice. Additionally, educated and experienced nurses tend to perceive lower levels of difficulty and anxiety related to the provision of terminal care. Several statistically significant findings between subgroup samples imply that each nurse subgroup may possess different learning needs.

Required Nursing Competencies

This segment discusses the findings and literature related to the following research question:

What specific curriculum components regarding knowledge, attitudes, and skills do nurses consider important, in order to work effectively in this area?

In order of priority, the following five topics were deemed as important by the sample population, as determined by means on a four-point scale: pain control and symptom management; grief counselling, communication and psychological support; terminal care; bereavement and coping with loss, and support for the caregiver. Models of palliative care; anomalies (e.g., near death experiences); burials, funerals, and rituals; euthanasia; and non-medical treatment modalities were considered to be topics of lesser importance. Although euthanasia was identified as a topic of lesser importance by the study sample, further investigation regarding euthanasia in Canada may be warranted given the changing attitudes to euthanasia in Europe.

Findings similar to those of this study have been identified by nurses working in clinical and educational settings (Fulton & Langton, 1964; Golub & Reznikoff, 1971; Gow & Degner, 1988(a); Milton, 1984; Quint, 1967; Sobel, 1969; Caty & Tamlyn, 1984; and Watt, 1977). Knowledge and skill related to pain control and symptom management form the keystone of terminal care practice; caring based on effective communication determines successful resolve.

<u>Concerns Regarding Palliative Care</u>

This segment discusses the findings and literature related to the following research question.

What are nurses' greatest concerns regarding the provision of palliative care?

Nurses' concerns regarding the provision of terminal care were examined in terms of the level of perceived difficulty experienced in relationship to the age of the dying person. The level of perceived anxiety experienced by the nurse related to the

provision of certain aspects of terminal care was also examined. Milton's 1984 study served as the framework for the development of the latter component.

Certain patient age groups posed greater difficulty for nurses regarding the delivery of terminal care; in general, the younger the dying person, the greater the level of difficulty experienced by the nurse. Popoff (1975) produced similar results. Such findings suggest that educators consider the utilization of a developmental approach to teaching/learning (e.g., death across the lifespan--children, adolescents, adults, older adults).

The provision of terminal care often appears to produce nurse anxiety. Components of terminal care that produced the most nurse anxiety were ranked according to priority, as follows: provision of emotional support for the family; provision of emotional support for the dying person; psychological effects upon self; maintenance of self-composure; provision of post-mortem care; and provision of physical care for the dying person. Results were similar to those documented by Milton (1984). Interestingly, nurse educators experienced less anxiety related to all aspects of terminal care suggesting that both education and experience may be implicated. Clearly, education that promotes and enhances communication and collaboration skills merits consideration.

Recommendations for Nursing Education

Several recommendations for nursing education emerged from the findings and conclusions of this study. These recommendations are presented below.

1. Nurses should take immediate action by becoming informed about the issues and concerns surrounding death education. As informed health care professionals, nurses should collectively offer support for the inclusion of increased quality death education within nursing program curricula and nursing inservice education.

2. Nurse educators and curriculum development specialists should take responsibility for ensuring that nurses' views/perceptions are integrated and clearly represented within nursing curricula.
3. Health care and educational institutions should offer additional support to nurse educators for advanced, specialized palliative care preparation.
4. Palliative care educators should accurately assess the unique educational needs of nurses working in alternate health care settings (e.g., communities). Death education programs sensitive to identified learner needs should be planned, implemented, and evaluated.
5. Those responsible for the professional development of nurses should assume leadership roles in the initiation of multidisciplinary support groups/networks within work settings.
6. Nurse scholars should continue to develop, test, and apply theory to the practice of palliative care nursing. Additionally, nurses should assume leadership roles regarding the dissemination of this information at the provincial, national, and international levels.
7. Nurses should continue to work collaboratively with colleagues and members of other disciplines to improve the quality of death education.
8. Nursing programs and associations should continue to positively influence public policy regarding care for the terminally ill.

Recommendations for Further Research

The results of this study suggest several possibilities for further investigation.

1. Further investigation is required to assess the perceptions of dying persons and their families about what constitutes effective care.

2. Findings of this study are based upon a sample of nurses from southern Alberta. It is recommended that the study be replicated using samples from other regions of the province or other geographic areas.
3. The data were collected by means of a questionnaire designed specifically for this study. However, further investigation utilizing different instruments would assist in determining if the perceptions identified in this study are valid and reliable when compared to outcomes of other studies using different approaches.
4. Rather than utilizing a wide-angle approach, investigation is required regarding specific aspects of terminal care (e.g., euthanasia).
5. Further study is required to determine the perceptions of other health care professionals. It is recommended that this research instrument be modified for that purpose.
6. A phenomenological study related to palliative care nurses' lived experiences would add another dimension to understanding the education needs of nurses.
7. Research is required to evaluate C-theory, as developed by this researcher.

Conclusion

Nurses identified concerns and deficits within existing nursing death education curricula and offered several specific suggestions for improvement. A major focus of the study sought to determine if differences existed regarding perceptions of death education between subgroup samples. Results of the study revealed several statistically significant findings that may be attributed to differences in nurses' education and experience, basic education programs, and practice milieus. In order to accommodate these differences, educators who endeavor to improve death education will need to consider at least four factors: nurse experience with death, nurse attitude toward death, past educational preparation, and personal variables related to the nurse. The

improvement of death education for nurses will most likely result in the delivery of quality professional nursing care practice to the dying person and family.

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APPENDICES

APPENDIX A

LETTER OF INTRODUCTION

The University of Lethbridge

4401 University Drive
Lethbridge, Alberta, Canada
T1K 3M4
403-329-2699
FAX: 403-329-2668

THE SCHOOL OF NURSING

December 2, 1991

Dear Nurse Colleague,

I am a graduate student in the Master of Education program at the University of Lethbridge with a strong interest in palliative care. I am conducting a research study on nurses' perceptions of death education and would like to request your participation.

The purpose of this study is to identify, describe, and explore nurses' (including student nurses) perceptions of death education in Southern Alberta. The information gleaned may be used to recommend curriculum change for death education in nursing. I believe that this study has significance, not only for nurse educators, but for all nurses involved in health care delivery. Regardless of setting or clinical specialization, nurses are expected to provide safe, sensitive and effective care to the dying patient and family.

Participation in this study is completely voluntary. I realize that nurses are extemely busy people with many and varied responsibilities. I would very much appreciate your participation in this study by completion of the attached questionnaire, which will require approximately fifteen minutes of your valuable time. Please note that all information will be handled in a confidential and professional manner. When responses are released, they will be reported in summary form only. Furthermore, names, locations, and any other identifing information will not be included in any discussion of the results.

The results of this study will become part of a Master Of Education Thesis. Following completion of the study, results will be available upon request.

I very much appreciate your prompt assistance in response to this study. For further information, please feel free to contact me at the University of Lethbridge: 329-2724; residence 381-0589; Dr. Frank Sovka, Professor of Education, Chairman of the Thesis Committee, University of Lethbridge at 329-2457; or Dr. Jane O'Dea, Chairman of the Ethics Review Committee, University of Lethbridge at 329-2458.

Thank you for your interest in nursing research.

Yours truly,

Ruth Kalischuk, R.N., B.N.
M. Ed. Candidate
150 Algonquin Rd.
Lethbridge, AB
T1k 5Y7

RK/wh

Encls.

APPENDIX B

DEATH EDUCATION QUESTIONNAIRE

DEATH EDUCATION QUESTIONNAIRE
NURSES' PERCEPTION OF DEATH EDUCATION

VIEWS REGARDING DEATH

DIRECTIONS: Listed below are statements concerned with views regarding death. Each item is followed by five numbers indicating a scale on which: 1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, and 5 = strongly agree. Please circle the number that best indicates the extent to which you agree or disagree with each item.

NOTE: If you are unable to answer a a question, please leave the question blank.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. Death is not a frightening subject.	1	2	3	4	5
2. Death was discussed openly in my family of origin.	1	2	3	4	5
3. Death is an easy topic to discuss with colleagues.	1	2	3	4	5
4. To me, death signifies "a beginning."	1	2	3	4	5
5. Assignment to a terminal patient should be part of basic nursing education.	1	2	3	4	5
6. As yet, I do not have any definite views about death.	1	2	3	4	5
7. In practice, my terminal nursing care emphasizes the CARING aspect.	1	2	3	4	5
8. I possess strong clinical skills regarding symptom management and pain control.	1	2	3	4	5
9. When a person dies in the work setting, it is appropriate for the nurse to show grief.	1	2	3	4	5
10. The amount of time allocated to death and dying in my basic nursing program was adequate.	1	2	3	4	5
11. In the work setting, it is appropriate to become emotionally involved with a dying person.	1	2	3	4	5

		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
12.	I possess a sound knowledge base regarding religious beliefs and values regarding death.	1	2	3	4	5
13.	I have "come to terms" with my own mortality.	1	2	3	4	5
14.	The <u>quality</u> of death and dying educational preparation that I received in my basic nursing program serves as a sound basis for clinical practice.	1	2	3	4	5
15.	I try not to think about death.	1	2	3	4	5
16.	When a death occurs in the work setting, I feel comfortable communicating with bereaved relatives.	1	2	3	4	5
17.	When a death occurs in the work setting, there is adequate support available to the nurse.	1	2	3	4	5
18.	More death education is needed in schools of nursing.	1	2	3	4	5
19.	I turn to my religion as a source of comfort and meaning when dealing with death.	1	2	3	4	5
20.	I would like to have the opportunity to gain more knowledge regarding communication with terminal patients and families.	1	2	3	4	5
21.	The institution in which I work supports a terminal CARING practice standard.	1	2	3	4	5
22.	My thoughts about death remain private.	1	2	3	4	5
23.	A specific course regarding death and dying should be a requirement for all nurses.	1	2	3	4	5

	Item	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
24.	When a death occurs in the work setting, there is adequate support from the nurse available to the patient and the family.	1	2	3	4	5
25.	I experience satisfaction in relation to the terminal care that I am able to provide.	1	2	3	4	5
26.	My views about death affect my practice with terminal patients and families.	1	2	3	4	5
27.	I possess a sound knowledge base regarding ethnic and cultural beliefs and values regarding death.	1	2	3	4	5
28.	I readily accept others with views about death that differ from my views.	1	2	3	4	5
29.	Death education should be offered as an elective course.	1	2	3	4	5
30.	Death is an easy topic to discuss with friends.	1	2	3	4	5
31.	I possess a high level of expertise in the area of terminal care.	1	2	3	4	5
32.	In my basic nursing education program, there was adequate opportunity to participate in "death awareness' exercises.	1	2	3	4	5
33.	At work, I have ample opportunity to communicate with other disciplines (e.g., physician, recreational therapist) regarding planned terminal care.	1	2	3	4	5

DIRECTIONS: Listed below are three areas of nursing competencies: knowledge, skill and attitude. Each topic is followed by four numbers indicating a scale on which: 1 = Unimportant, 2 = Somewhat Important, 3 = Important, and 4 = Very Important. Please CIRCLE the number that best indicates the extent to which you consider each topic as important.

AREA OF NURSING COMPETENCY	TOPIC	Unimportant	Somewhat Important	Important	Very Important
34. Knowledge	Models of palliative care	1	2	3	4
	Stages of death and dying	1	2	3	4
	Community Resources	1	2	3	4
	Religious, spiritual and cultural beliefs	1	2	3	4
	Burials, funerals, rituals	1	2	3	4
	Ethical / legal issues	1	2	3	4
	Euthanasia	1	2	3	4
	Living wills	1	2	3	4
	Pain control and symptom management	1	2	3	4
	Oncology nursing	1	2	3	4
	Death across the lifespan (e.g., children, adolescents, adults, older adults)	1	2	3	4
	Death due to AIDS	1	2	3	4
	Sudden death	1	2	3	4
	Family dynamics	1	2	3	4
35. Skill	Grief counselling, communication and psychological support	1	2	3	4
	Team building across the disciplines	1	2	3	4
	Support for the caregiver	1	2	3	4
	Physical care	1	2	3	4
	Non-medical treatment modalities (e.g., relaxation)	1	2	3	4
	Terminal care	1	2	3	4
36. Attitude	Death awareness	1	2	3	4
	Death anxiety	1	2	3	4
	Bereavement and coping with loss	1	2	3	4
	Anomalies (e.g., near death experiences)	1	2	3	4
Other	(please specify)	1	2	3	4

INFORMATION RELATED TO EDUCATION AND EXPERIENCE

DIRECTIONS: Please check the appropriate answer.

37. Previous death education includes: (check all that apply)

- course (30 hours or more) 1. ______
- seminar (1-8 hours) 2. ______
- workshop / conference (1-3 days) 3. ______
- reading of literature (at least 2 articles per month) 4. ______
- education provided in nursing school 5. ______
- work experience 6. ______
- teaching death education 7. ______
- other (please specify) 8. ______________

38. During the past year, how frequently did you encounter death in your work situation? (check one)

- more than once per week 1. ______
- once per month 2. ______
- 1 - 3 times per year 3. ______
- not at all 4. ______
- other (please explain) 5. ______________

39. Have you experienced the death of someone close to you? (check one)

yes 1. _____ no 2. _____

If yes, to what extent have you "come to terms" with the experience?

- still uneasy with the experience 1. ______
- in the process of working through the experience 2. ______
- have accepted the experience as part of life 3. ______
- other (please specify) 4. ______________

40. Rate yourself on the following scale regarding your feeling about being assigned to the care of a terminal person.

Calm 1. ____ 2. ____ 3. ____ 4. ____ 5. ____ Anxious

41. As a nursing student, I cared for a terminal patient.

yes 1. _____ no 2. _____

42. RANK the following nursing competencies in order of importance in relation to the provision of nursing care (e.g., 1 = most important, 2 = second most important, 3 = least important)

- Knowledge a. ______
- Skill b. ______
- Attitude c. ______

43. For a number of reasons, nurses express difficulty in terms of dealing with terminal persons in certain age groups. RATE the following age groups in relation to level of difficulty experienced.

	Extreme Difficulty	Moderate Difficulty	Very Little Difficulty	No Difficulty
Older adult (65 + years)	1	2	3	4
Middle age adult (45-65 years)	1	2	3	4
Young adult (20-44 years)	1	2	3	4
Adolescent (13-19 years)	1	2	3	4
Elementary school age child	1	2	3	4
Preschooler	1	2	3	4
Infant	1	2	3	4
Stillbirth	1	2	3	4
Miscarriage	1	2	3	4

44. Nurses often express anxiety related to providing nursing care to dying persons. RATE the following aspects of care regarding the level of anxiety that you experience.

	Extreme Anxiety	Moderate Anxiety	Very Little Anxiety	No Anxiety
Provision of emotional support for the family	1	2	3	4
Provision of post-mortum care	1	2	3	4
Maintenance of self-composure	1	2	3	4
Provision of emotional support for the dying person	1	2	3	4
Psychological effects upon self	1	2	3	4
Provision of physical care for the dying person	1	2	3	4

BACKGROUND INFORMATION

45. Indicate your level of education: (check one)

student, diploma program	1. ______
student, post-basic program	2. ______
R.N.	3. ______
post graduate diploma in nursing	4. ______
post basic baccalaureate (B.N.)	5. ______
master's degree	6. ______
doctorate	7. ______
other (please specify)	8. ______________________

46. Number of years experience in nursing [full-time equivalent]: __________

47. Area of current employment: (check one)

student (not employed)	1. ______
hospital (active treatment)	2. ______
extended care facility	3. ______
community health care agency	4. ______
educational institution	5. ______
other (please specify)	6. ______________________

48. Size of community of residence: (check one)

under 250	1. ______
250 - 999	2. ______
1000 - 2499	3. ______
2500 - 4999	4. ______
over 5000	5. ______

49. Religion: (check one)

Buddhist	1. ______
Church of Jesus Christ of the Latter-Day Saints	2. ______
Hindu	3. ______
Ismaili (Muslim)	4. ______
Jewish	5. ______
Mennonite	6. ______
Protestant	7. ______
Roman Catholic	8. ______
Sikh	9. ______
Other (please specify)	10. ______________________

50. Intensity of religious beliefs: (check one)

very high	1. ______
high	2. ______
moderately high	3. ______
low	4. ______

51. Gender: (check one)

female	1. ______
male	2. ______

52. Current marital status: (check one)

single (never married)	1. ______
married	2. ______
widowed	3. ______
divorced	4. ______
separated	5. ______
other	6. ______

53. Age on July 1, 1991: __________

ADDITIONAL RESPONSES

54. What recommendation(s)/suggestions would you give to educators planning death education for nurses?

55. Comments and suggestions:

THANK YOU

If you have any comments or suggestions, please feel free to contact:

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Dr. Lillian Douglass - Medicine Hat College
Dr. Nancy Grigg - University of Lethbridge
Dr. Edna McHutchion - University of Calgary

October 4, 1991

APPENDIX C

GLOSSARY OF TERMS

Glossary of Terms

Terms which are central to this study are defined as follows:

1. Caring - "Addresses what matters to the patient/client through the critical application and evaluation of relevant knowledge, attitudes and skills" (A.A.R.N. Nursing Practice Standards, 1991).
2. Competency - "Refers to the ability to demonstrate the requisite knowledge, skills and attitudes of nurses beginning to practice" (A.A.R.N. Nursing Practice Standards, 1991).
3. Curriculum - "Those transactions and interactions that take place between students and teachers and among students with the intent that learning take place" (Bevis, 1989, p. 72).
4. Death education - "The movement to study the social phenomenon of death and the caring processes for those who are dying" (Seidel, 1981, p. 88).
5. Nursing - "The practice of professional nursing as a Registered Nurse means the performance for compensation of any act, the goal of which is TO ASSIST the individual and family, and /or "significant other," regardless of the practice, to achieve their potential for health. Such practice involves a process which is a systematic, goal-dected, individualized approach to CARE" (AARN Position Paper on Nursing, 1976, p. 5).
6. Nursing practice - " A synthesis of the interaction among the concepts of person, health, environment and nursing" (A.A.R.N. Nursing Practice Standards, 1991).
7. Palliative care - "Palliative care may be used synonymously with hospice care and represents a philosophy of care for the dying individual for whom treatment aimed at cure and prolongation of life is no longer appropriate. The focus of palliative care is the control of symptoms and the enhancement of quality of life

for the dying individual and his/her family" (Alberta Association of Registered Nurses Position Statement on Palliative Care, 1984, p. 1).

8. Perception - "The understanding of the world that you construct from data obtained through your senses" (Shaver, 1981, p. 83).

APPENDIX D

HUMAN SUBJECTS RESEARCH COMMITTEE FORM

FACULTY OF EDUCATION
HUMAN SUBJECT RESEARCH CHECKLIST

Title of Study: Nurses Perceptions of Death Education

Principal Investigator: Ruth Kalischuk

Instructor (if student): DR. Frank Scurka

	Check if Acceptable
1. The proposal contains a clear statement of the nature, intent and duration of the research.	✓
2. The proposal includes adequate information about instrumentation and/or testing procedures to be used.	✓
3. Participants have been apprised of their rights to inquire about the research.	✓
4. If necessary, participants can direct inquiries to a resource person outside the research group. include name of chair person of H.S.R.C.	✓
5. Provision has been made for obtaining the informed consent of all participants, or their parents or guardians. (Unless otherwise stated, this should be in writing).	✓
6. There will be no coercion, constraints or undue inducement.	✓
7. All participants and/or their parents or guardians have been informed of their right to withdraw without prejudice at any time.	✓
8. Provision has been made to inform participants of the degree of confidentiality that will be maintained in the study.	✓
9. In cases where participants have essential information withheld and/or are intentionally mislead as part of the research procedure the proposal clearly explains the reasons for this.	☐
10. The research being proposed is not potentially threatening or harmful to any participant.	☐

Committee Decision: ✓ Approve Date: Nov. 5 1991

___ Resubmit Date: ______________

Signature of Chairperson: [signature]

APPENDIX E

TABLE 1 CHARACTERISTICS OF THE SAMPLE

Table 1

Characteristics of the Sample

	Total (N=373)	% of Total
AGE:		
17 - 61		100
17 - 25	74	19.8
26 - 35	106	28.4
36 - 45	108	29.1
46 +	80	21.4
missing	5	1.3
mean age = 36.16 years		
GENDER:		
female	353	94.6
male	17	4.6
missing	3	.8
MARITAL STATUS:		
single (never married)	100	26.8
married	226	60.6
widowed	3	.8
divorced	25	6.7
separated	11	2.9
other	4	1.1
missing	4	1.1
YEARS OF EXPERIENCE IN NURSING: (full-time equivalent)		
0 - 9 years	189	50.7
10 - 19 years	106	28.4
20 - 29 years	63	16.9
30 + years	15	4.0
LEVEL OF EDUCATION:		
student, diploma program	79	21.2
student, post-basic program	46	12.3
R.N.	123	33.0
post graduate diploma in nursing	13	3.5
post basic baccalaureate (B.N.)	74	19.8
master's degree	13	3.5
doctorate	2	.5
other	22	5.9
missing	1	.3

Table 1 (cont'd)

Characteristics of the Sample

	Total (N=373)	% of Total
AREA OF EMPLOYMENT:		
student (not employed)	89	23.9
hospital (active treatment)	126	33.8
extended care facility	44	11.8
community health care agency	74	19.8
education institution	33	8.8
other	6	1.6
missing	1	.3
SIZE OF COMMUNITY RESIDENCE:		
under 250	23	6.2
250 - 999	16	4.3
1000 - 2499	26	7.0
2500 - 4999	49	13.1
over 5000	232	67.6
missing	7	1.8
RELIGION:		
Buddhist	5	1.3
Church of Jesus Christ of the Latter-Day Saints	15	4.0
Ismaili (Muslim)	1	.3
Mennonite	9	2.4
Protestant	169	45.3
Roman Catholic	99	26.5
other	67	18.1
missing	8	2.1
INTENSITY OF RELIGIOUS BELIEFS:		
very high	67	18.0
high	91	24.4
moderately high	117	31.4
low	93	24.9
missing	5	1.3

APPENDIX F

TABLE 2 SAMPLE SUBGROUP #1–COLLEGE STUDENTS ACCORDING TO AGE, GENDER, EDUCATION, EXPERIENCE, AND RELIGION

Table 2

Sample Subgroup #1
College Students According to Age, Gender, Education, Experience, and Religion

	Total (N=77)	% of Total
AGE:		
17 - 25	41	53.2
26 - 35	23	29.9
36 - 45	11	14.3
45 +	2	2.6
GENDER:		
Female	70	90.9
Male	7	9.1
EDUCATION:		
student, diploma program	73	94.8
student, post-basic program	3	3.9
other	1	1.3
EXPERIENCE: (full-time equivalent)		
0 - 9 years	74	96.1
10 - 19 years	3	3.9
RELIGION:		
Church of Jesus Christ of the Latter-Day Saints	6	7.8
Protestant	27	35.1
Roman Catholic	26	33.8
other	16	20.8
missing	2	2.6

APPENDIX G

TABLE 3 SAMPLE SUBGROUP #2--UNIVERSITY STUDENTS ACCORDING TO AGE, GENDER, EDUCATION, EXPERIENCE, AND RELIGION

Table 3

Sample Subgroup #2
University Students According to Age, Gender, Education, Experience, and Religion

	Total (N=34)	% of Total
AGE:		
17 - 25	14	41.2
26 - 35	13	38.2
36 - 45	7	20.6
GENDER:		
female	32	94.1
male	2	5.9
EDUCATION:		
student, post-basic program	34	100.0
EXPERIENCE:		
0 - 9 years	27	79.4
10 - 19 years	5	14.7
20 - 29 years	2	5.9
RELIGION:		
Buddhist	1	2.9
Church of Jesus Christ of the Latter-Day Saints	1	2.9
Protestant	10	29.4
Roman Catholic	13	38.2
other	8	23.5
missing	1	2.9

APPENDIX H

TABLE 4 SAMPLE SUBGROUP #3--HOSPITAL NURSES ACCORDING TO AGE, GENDER, EDUCATION, EXPERIENCE, AND RELIGION

Table 4

Sample Subgroup #3
Hospital Nurses According to Age, Gender, Education, Experience, and Religion

	Total (N=186)	% of Total
AGE:		
17 - 25	19	10.2
26 - 35	51	27.4
36 - 45	58	31.2
45 +	58	31.2
GENDER:		
female	178	95.7
male	6	3.2
missing	2	1.1
EDUCATION:		
student, diploma program	5	2.7
student, post-basic program	9	4.8
R.N.	101	54.3
post graduate diploma in nursing	13	7.0
post basic baccalaureate (BN)	39	21.0
master's degree	5	2.7
other	14	7.5
EXPERIENCE: (full-time equivalent)		
0 - 9 years	71	38.2
10 - 19 years	66	35.5
20 - 29 years	37	19.9
30 + years	12	6.5
RELIGION:		
Buddhist	4	2.2
Church of Jesus Christ of the Latter-Day Saints	8	4.3
Ismaili (Muslim)	1	.5
Mennonite	5	2.7
Protestant	86	46.2
Roman Catholic	42	22.6
other	38	20.4
missing	2	1.1

APPENDIX I

TABLE 5 SAMPLE SUBGROUP #4--COMMUNITY NURSES ACCORDING TO AGE, GENDER, EDUCATION, EXPERIENCE, AND RELIGION

Table 5

Sample Subgroup #4
Community Nurses According to Age, Gender, Education, Experience, and Religion

	Total (N=43)	% of Total
AGE:		
26 - 35	11	25.6
36 - 45	18	41.9
45 +	14	32.6
GENDER:		
female	43	100.0
EDUCATION:		
student, post-basic program	2	4.7
R.N.	21	48.8
post basic baccalaureate (BN)	16	37.2
other	4	9.3
EXPERIENCE: (full-time equivalent)		
0 - 9 years	10	23.3
10 - 19 years	20	46.5
20 - 29 years	13	30.2
RELIGION:		
Mennonite	2	4.7
Protestant	26	60.5
Roman Catholic	10	23.3
other	4	9.3
missing	1	2.3

APPENDIX J

TABLE 6 SAMPLE SUBGROUP #5–NURSE EDUCATORS ACCORDING TO AGE, GENDER, EDUCATION, EXPERIENCE, AND RELIGION

Table 6

Sample Subgroup #5
Nurse Educators According to Age, Gender, Education, Experience, and Religion

	Total (N=33)	% of Total
AGE:		
26 - 35	8	24.2
36 - 45	14	42.4
45 +	11	33.3
GENDER:		
female	30	90.9
male	2	6.1
missing	1	3.0
EDUCATION:		
post basic baccalaureate (BN)	19	57.6
master's degree	8	24.2
doctorate	2	6.1
other	3	9.1
missing	1	3.0
EXPERIENCE: (full-time equivalent)		
0 - 9 years	7	21.2
10 - 19 years	12	36.4
20 - 29 years	11	33.3
30 + years	3	9.1
RELIGION:		
Mennonite	2	6.1
Protestant	20	60.6
Roman Catholic	8	24.2
other	1	3.0
missing	2	6.1

APPENDIX K

TABLE 8 NURSES' PERCEPTIONS REGARDING DEATH AND DEATH EDUCATION

Table 8

Nurses' Perceptions Regarding Death and Death Education

Questionnaire Item	Frequency		% of Responses					Mean	Median	SD
	N	Missing	1=SD	2=D	3=N	4=A	5=SA			
1. Death is not a frightening subject.	269	4	14.7	34.6	11.5	29.0	9.1	2.170	3.000	1.258
2. Death was discussed openly in my family of origin.	373	0	9.7	28.2	19.0	33.2	9.9	3.056	3.000	1.182
3. Death is an easy topic to discuss with colleagues	371	2	.5	21.2	14.7	48.5	14.5	3.555	4.000	.999
4. To me, death signifies a "beginning."	365	8	5.1	22.3	29.8	27.1	13.7	3.225	3.000	1.106
5. Assignment to a terminal patient should be part of basic nursing education.	372	1	.3	2.1	3.5	37.8	56.0	4.476	5.000	.694
6. As yet, I do not have any definite views about death.	373	0	.3	.59	7.5	44.8	41.6	3.124	2.000	.841
7. In practice, my terminal nursing care emphasizes the CARING aspect.	363	10	.5	.3	2.4	44.5	49.6	4.463	5.000	.618
8. I possess strong clinical skills regarding symptom management and pain control.	362	11	2.1	13.1	22.0	49.1	10.7	3.547	4.000	9.35

Table 8 (cont'd)

Nurses' Perceptions Regarding Death and Death Education

Questionnaire Item	Frequency		% of Responses					Mean	Median	SD
	N	Missing	1=SD	2=D	3=N	4=A	5=SA			
9. When a person dies in the work setting, it is appropriate for the nurse to show grief.	361	2	.5	1.9	7.2	56.6	33.2	4.208	4.000	.699
10. The amount of time allocated to death and dying in my basic nursing program was adequate.	368	5	26.3	38.3	11.5	19.8	2.7	2.334	2.000	1.151
11. In the work setting, it is appropriate to become emotionally involved with a dying person.	366	7	1.3	12.6	26.5	48.5	9.1	1.475	4.000	.881
12. I possess a sound knowledge base regarding religious beliefs and values regarding death.	369	4	1.9	25.7	22.3	36.2	12.9	3.328	3.000	1.057
13. I have "come to terms" with my own mortality.	368	5	1.6	15.6	21.4	43.4	15.5	3.554	4.000	1.000
14. The quality of death and dying educational preparation that I received in my basic nursing program serves as a sound basis for clinical practice.	369	4	17.4	40.2	18.0	20.1	3.2	2.509	2.000	1.099
15. I try <u>not</u> to think about death.	370	3	.8	15.0	21.7	49.1	12.6	2.581	2.000	.923

Table 8 (cont'd)

Nurses' Perceptions Regarding Death and Death Education

Questionnaire Item	Frequency		% of Responses					Mean	Median	SD
	N	Missing	1=SD	2=D	3=N	4=A	5=SA			
16. When death occurs in the work setting, I feel comfortable communicating with bereaved relatives.	366	7	1.9	25.5	19.0	39.7	12.1	3.352	4.000	1.054
17. When a death occurs in the work setting, there is adequate support available to the nurse.	360	13	11.0	35.1	24.1	24.1	2.1	2.703	3.000	1.036
18. More death education is needed in schools of nursing.	363	10	.5	3.5	7.0	51.9	34.9	4.198	4.000	.765
19. I turn to my religion as a source of comfort and meaning when dealing with death.	368	5	3.8	9.7	21.7	36.5	27.1	3.745	4.000	1.080
20. I would like to have the opportunity to gain more knowledge regarding communication with terminal patients and families.	371	2	.3	2.1	4.8	55.5	36.7	4.270	4.000	.676
21. The institution in which I work supports a terminal CARING practice standard.	338	35	.8	6.4	22.0	43.4	18.0	3.787	4.000	.873
22. My thoughts about death remain private.	370	3	7.8	50.7	20.4	18.5	1.9	2.557	2.000	.945

Table 8 (cont'd)

Nurses' Perceptions Regarding Death and Death Education

Questionnaire Item	Frequency		% of Responses					Mean	Median	SD
	N	Missing	1=SD	2=D	3=N	4=A	5=SA			
23. A specific course regarding death and dying should be a requirement for all nurses.	369	4	.5	3.5	10.7	44.5	39.7	4.206	4.000	.812
24. When a death occurs in the work setting, there is adequate support from the nurse available to the patient and the family.	361	12	2.1	3.24	25.7	33.8	2.7	3.025	3.000	.941
25. I experience satisfaction in relation to the terminal care that I am able to provide.	351	22	.8	12.3	19.3	51.7	9.9	3.613	4.000	.874
26. My views about death affect my practice with terminal patients and families.	366	7	4.0	16.1	11.8	49.9	16.4	3.596	4.000	1.073
27. I possess a sound knowledge base regarding ethnic and cultural beliefs and values regarding death.	371	2	4.8	44.5	23.3	23.1	3.8	2.763	3.000	.985
28. I readily accept others with views about death that differ from my views.	372	1	.3	4.0	10.2	66.2	19.0	4.000	4.000	.693

Table 8 (cont'd)

Nurses' Perceptions Regarding Death and Death Education

Questionnaire Item	Frequency		% of Responses					Mean	Median	SD
	N	Missing	1=SD	2=D	3=N	4=A	5=SA			
29. Death education should be offered as an elective course.	365	8	11.0	30.0	13.1	33.5	10.2	3.019	3.000	1.232
30. Death is an easy topic to discuss with friends.	372	1	4.6	33.0	22.8	35.9	3.5	3.008	3.000	1.008
31. I possess a high level of expertise in the area of terminal care.	370	3	13.4	39.7	25.7	18.8	1.6	2.551	2.000	.998
32. In my basic nursing education program, there was adequate opportunity to participate in "death awareness" exercises.	367	6	23.3	54.7	10.5	8.8	1.1	2.082	2.000	.893
33. At work, I have ample opportunity to communicate with other disciplines (e.g., physician, recreational therapist) regarding planned terminal care.	354	19	9.1	31.4	23.3	27.1	4.0	2.847	3.000	1.072

Note: May not add to 100% due to rounding.
Mean based on a 5-point scale where 1 = strongly disagree, 5 = strongly agree.

APPENDIX L

TABLE 12 NURSES' PERCEPTIONS REGARDING DEATH AND DEATH EDUCATION--ONE WAY ANALYSIS OF VARIANCE

Table 12

Nurses' Perceptions Regarding Death and Death Education
One-way Analysis of Variance

Questionnaire Item

1. Death is not a frightening subject.

	N	Mean	SD
College Student	77	2.3377	1.2419
University Student	34	2.2647	1.4420
Hospital Nurse	184	2.1522	1.2186
Community Nurse	43	1.7907	1.2451
Nurse Educator	31	2.2903	1.2960
Total	369	2.1707	1.2578

2. Death was discussed openly in my family of origin.

	N	Mean	SD
College Student	77	3.1299	1.1280
University Student	34	3.2353	1.2075
Hospital Nurse	186	3.0000	1.2125
Community Nurse	43	2.9070	1.1300
Nurse Educator	33	3.2121	1.1926
Total	373	3.0563	1.1821

3. Death is an easy topic to discuss with colleagues.

	N	Mean	SD
College Student	77	3.2208 a,b	1.0082
University Student	34	3.5294	1.0513
Hospital Nurse	184	3.6250 a	1.0003
Community Nurse	43	3.8605 b	.8614
Nurse Educator	33	3.5758	.9364
Total	371	3.5553	.9995

4. To me, death signifies "a beginning."

	N	Mean	SD
College Student	75	3.3867 b	1.0513
University Student	33	3.1818	1.2613
Hospital Nurse	184	3.2935 a	1.1018
Community Nurse	42	3.1190	.9160
Nurse Educator	31	2.6129 a,b	1.1741
Total	365	3.2247	1.1064

Mean based on a 5-point scale where 1 = strongly disagree, 5 = strongly agree.
a, b, c, and d denotes groups statistically significant at the .05 level.

Table 12 (cont'd)

Nurses' Perceptions Regarding Death and Death Education
One-way Analysis of Variance

Questionnaire Item

5. Assignment to a terminal patient should be part of basic nursing education.

	N	Mean	SD
College Student	76	4.2237 a	.7042
University Student	34	4.5882	.4996
Hospital Nurse	186	4.5591 a	.6732
Community Nurse	43	4.5116	.6680
Nurse Educator	33	4.4242	.8671
Total	372	4.4758	.6942

6. As yet, I do not have any definite views about death.

	N	Mean	SD
College Student	77	2.9221 a,b	.9426
University Student	34	3.0000	.9535
Hospital Nurse	186	3.3333 b	.7401
Community Nurse	43	3.2093	.8326
Nurse Educator	33	3.4545 a	.8326
Total	373	3.2145	.8406

7. In practice, my terminal nursing care emphasizes the CARING aspect.

	N	Mean	SD
College Student	76	4.2895 a	.6494
University Student	33	4.4848	.8337
Hospital Nurse	180	4.5222	.5437
Community Nurse	41	4.3415	.6561
Nurse Educator	33	4.6667 a	.5401
Total	363	4.4628	.6180

8. I possess strong clinical skills regarding symptom management and pain control.

	N	Mean	SD
College Student	74	3.4189	.8760
University Student	32	3.7813	.9750
Hospital Nurse	181	3.6022	.9350
Community Nurse	43	3.3721	.9765
Nurse Educator	32	3.5313	.9499
Total	363	3.5470	.9352

Mean based on a 5-point scale where 1 = strongly disagree, 5 = strongly agree.
a, b, c, and d denotes groups statistically significant at the .05 level.

Table 12 (cont'd)

Nurses' Perceptions Regarding Death and Death Education
One-way Analysis of Variance

Questionnaire Item

9. When a person dies in the work setting, it is appropriate for the nurse to show grief.

	N	Mean	SD
College Student	77	4.1039	.5755
University Student	34	4.4706	.5633
Hospital Nurse	184	4.1630	.7931
Community Nurse	43	4.2326	.5706
Nurse Educator	33	4.3939	.6093
Total	371	4.2075	.6995

10. The amount of time allocated to death and dying in my basic nursing program was adequate.

	N	Mean	SD
College Student	75	2.5867 a	1.1161
University Student	34	2.4412	1.1855
Hospital Nurse	184	2.3098	1.1436
Community Nurse	42	1.9524 a	1.1033
Nurse Educator	33	2.2727	1.2060
Total	368	2.3342	1.1506

11. In the work setting, it is appropriate to become emotionally involved with a dying person.

	N	Mean	SD
College Student	74	3.3243 a	.7783
University Student	34	3.8824 a	.8444
Hospital Nurse	183	3.4426	.9113
Community Nurse	42	3.7143	.8348
Nurse Educator	33	3.8182	.8461
Total	366	3.5246	.8810

12. I possess a sound knowledge base regarding religious beliefs and values regarding death.

	N	Mean	SD
College Student	77	3.2208	1.0714
University Student	34	3.2647	1.1628
Hospital Nurse	184	3.3533	1.0865
Community Nurse	43	3.4651	.8549
Nurse Educator	31	3.3226	1.0128
Total	369	3.3279	1.0572

Mean based on a 5-point scale where 1 = strongly disagree, 5 = strongly agree.
a, b, c, and d denotes groups statistically significant at the .05 level.

Table 12 (cont'd)

Nurses' Perceptions Regarding Death and Death Education
One-way Analysis of Variance

Questionnaire Item

13. I have "come to terms" with my own mortality.

	N	Mean	SD
College Student	77	3.4026	.9902
University Student	33	3.1212 a	1.1926
Hospital Nurse	184	3.6739 a	.9363
Community Nurse	42	3.5714	.8595
Nurse Educator	32	3.6563	1.2078
Total	368	3.5543	.9999

14. The quality of death and dying educational preparation that I received in my basic nursing program serves as a sound basis for clinical practice.

	N	Mean	SD
College Student	77	2.9481 a,b	1.0374
University Student	34	2.3824	.9539
Hospital Nurse	184	2.4185 b	1.1327
Community Nurse	42	2.2143 a	.9762
Nurse Educator	32	2.5000	1.1072
Total	369	2.5095	1.0987

15. I try not to think about death.

	N	Mean	SD
College Student	77	2.2987 a	.9742
University Student	34	2.6765	.9445
Hospital Nurse	185	2.7135 a	.8717
Community Nurse	43	2.5349	.8266
Nurse Educator	31	2.4516	1.0595
Total	370	2.5811	.9226

16. When a death occurs in the work setting, I feel comfortable communicating with bereaved relatives.

	N	Mean	SD
College Student	72	2.9306 a,b	1.0658
University Student	34	3.0294	1.0867
Hospital Nurse	185	3.5081 a	.9952
Community Nurse	43	3.4651	.9599
Nurse Educator	32	3.5938 b	1.1601
Total	366	3.3525	1.0541

Mean based on a 5-point scale where 1 = strongly disagree, 5 = strongly agree.
a, b, c, and d denotes groups statistically significant at the .05 level.

Table 12 (cont'd)

Nurses' Perceptions Regarding Death and Death Education
One-way Analysis of Variance

Questionnaire
Item

17. When a death occurs in the work setting, there is adequate support available to the nurse.

	N	Mean	SD
College Student	69	2.9710 c	.9070
University Student	34	2.5294	1.0513
Hospital Nurse	183	2.7213 a	1.0503
Community Nurse	42	2.8095 b	.9687
Nurse Educator	32	2.0625 a,b,c	1.0453
Total	360	2.7028	1.0358

18. More death education is needed in schools of nursing.

	N	Mean	SD
College Student	75	4.0400 a	.6666
University Student	34	4.5000 a	.5641
Hospital Nurse	181	4.1602	.8312
Community Nurse	41	4.4390	.5937
Nurse Educator	32	4.1563	.8466
Total	363	4.1983	.7648

19. I turn to my religion as a source of comfort and meaning when dealing with death.

	N	Mean	SD
College Student	77	3.6104	1.0533
University Student	32	3.9375	1.0453
Hospital Nurse	184	3.7609	1.0951
Community Nurse	43	3.8372	.9742
Nurse Educator	32	3.6563	1.2342
Total	368	3.7446	1.0799

20. I would like to have the opportunity to gain more knowledge regarding communication with terminal patients and families.

	N	Mean	SD
College Student	77	4.4286 a	.5239
University Student	34	4.4706	.5633
Hospital Nurse	185	4.1676 a	.7365
Community Nurse	43	4.3256	.6444
Nurse Educator	32	4.1875	.6927
Total	371	4.2695	.6759

Mean based on a 5-point scale where 1 = strongly disagree, 5 = strongly agree.
a, b, c, and d denotes groups statistically significant at the .05 level.

Table 12 (cont'd)

Nurses' Perceptions Regarding Death and Death Education
One-way Analysis of Variance

Questionnaire
Item

21. The institution in which I work supports a terminal CARING practice standard.

	N	Mean	SD
College Student	68	3.6618	.6826
University Student	29	3.5517	1.0885
Hospital Nurse	177	3.8362	.8668
Community Nurse	38	4.0789	1.0235
Nurse Educator	26	3.6154	.7524
Total	338	3.7870	.8727

22. My thoughts about death remain private.

	N	Mean	SD
College Student	76	2.6842	.9827
University Student	34	2.4706	.8956
Hospital Nurse	185	2.4649	.9208
Community Nurse	43	2.6512	.8697
Nurse Educator	32	2.7500	1.1072
Total	370	2.5568	.9447

23. A specific course regarding death and dying should be a requirement for all nurses.

	N	Mean	SD
College Student	76	4.1316	.7544
University Student	34	4.3235	.6840
Hospital Nurse	184	4.1685	.8090
Community Nurse	43	4.5116	.6680
Nurse Educator	32	4.0625	1.1341
Total	369	4.2060	.8115

24. When a death occurs in the work setting, there is adequate support from the nurse available to the patient and family.

	N	Mean	SD
College Student	71	3.1831 c,d	.8334
University Student	34	2.5294 b,d	.7876
Hospital Nurse	183	3.1475 a,b	.9694
Community Nurse	41	3.0244	.9080
Nurse Educator	32	2.5000 a,c	.8799
Total	361	3.0249	.9410

Mean based on a 5-point scale where 1 = strongly disagree, 5 = strongly agree.
a, b, c, and d denotes groups statistically significant at the .05 level.

Table 12 (cont'd)

Nurses' Perceptions Regarding Death and Death Education
One-way Analysis of Variance

Questionnaire
Item

25. I experience satisfaction in relation to the terminal care that I am able to provide.

	N	Mean	SD
College Student	71	3.6056	.8698
University Student	32	3.5313	.9499
Hospital Nurse	179	3.6648	.8476
Community Nurse	40	3.4500	.9323
Nurse Educator	29	3.6207	.9209
Total	351	3.6125	.8739

26. My views about death affect my practice with terminal patients and families.

	N	Mean	SD
College Student	76	3.1316 a,b,c	1.2148
University Student	33	3.6061	1.0880
Hospital Nurse	184	3.6739 a	.9985
Community Nurse	43	3.6977 b	.8873
Nurse Educator	30	4.1333 c	1.0080
Total	366	3.5956	1.0729

27. I possess a sound knowledge base regarding ethnic and cultural beliefs and values regarding death.

	N	Mean	SD
College Student	76	2.7368	1.0375
University Student	33	2.7879	1.2439
Hospital Nurse	186	2.7419	.9687
Community Nurse	43	2.8372	.8710
Nurse Educator	33	2.8182	.8461
Total	371	2.7628	.9852

28. I readily accept others with views about death that differ from my views.

	N	Mean	SD
College Student	77	4.1169	.7429
University Student	34	4.1471	.5004
Hospital Nurse	186	3.9301	.7282
Community Nurse	42	3.9286	.5584
Nurse Educator	33	4.0606	.6586
Total	372	4.0000	.6927

Mean based on a 5-point scale where 1 = strongly disagree, 5 = strongly agree.
a, b, c, and d denotes groups statistically significant at the .05 level.

Table 12 (cont'd)

Nurses' Perceptions Regarding Death and Death Education
One-way Analysis of Variance

Questionnaire Item

29. Death education should be offered as an elective course.

	N	Mean	SD
College Student	76	3.0658	1.2147
University Student	33	3.3636	1.3879
Hospital Nurse	182	3.0165	1.2325
Community Nurse	42	2.5476	1.0639
Nurse Educator	32	3.1875	1.2032
Total	365	3.0192	1.2324

30. Death is an easy topic to discuss with friends.

	N	Mean	SD
College Student	77	2.8312	1.0311
University Student	34	3.2941	.9384
Hospital Nurse	185	3.0541	.9985
Community Nurse	43	2.9767	.9877
Nurse Educator	33	2.9091	1.0713
Total	372	3.0081	1.0080

31. I possess a high level of expertise in the area of terminal care.

	N	Mean	SD
College Student	77	1.9870 a,b,c	.8810
University Student	34	2.4412	.9274
Hospital Nurse	184	2.7717 c	.9363
Community Nurse	43	2.6744 b	1.0850
Nurse Educator	32	2.5938 a	1.0734
Total	370	2.5514	.9980

32. In my basic nursing education program, there was adequate opportunity to participate in 'death awareness' exercises.

	N	Mean	SD
College Student	77	2.3377 a	.9544
University Student	34	1.9706	.5766
Hospital Nurse	183	2.0765	.9462
Community Nurse	42	1.9524	.7636
Nurse Educator	31	1.7742 a	.7169
Total	367	2.0817	.8925

Mean based on a 5-point scale where 1 = strongly disagree, 5 = strongly agree.
a, b, c, and d denotes groups statistically significant at the .05 level.

Table 12 (cont'd)

Nurses' Perceptions Regarding Death and Death Education
One-way Analysis of Variance

Questionnaire Item

33. At work, I have ample opportunity to communicate with other disciplines (e.g., physician, recreational therapist) regarding planned terminal care.

	N	Mean	SD
College Stuaent	73	2.7397	.9432
University Student	32	2.4375	.9817
Hospital Nurse	181	2.9669	1.1050
Community Nurse	40	3.0750	1.0715
Nurse Educator	28	2.5000	1.1055
Total	354	2.8475	1.0721

Mean based on a 5-point scale where 1 = strongly disagree, 5 = strongly agree.
a, b, c, and d denotes groups statistically significant at the .05 level.

APPENDIX M

TABLE 13 NURSES' PERCEIVED IMPORTANCE OF NURSING COMPETENCIES--ONE WAY ANALYSIS

Table 13

Nurses' Perceived Importance of Nursing Competencies
One-way Analysis of Variance

1. Models of palliative care

	N	Mean	SD
College Student	77	3.1039	.6606
University Student	34	3.1471	.7020
Hospital Nurse	176	2.9261	.7561
Community Nurse	39	2.8462	.8441
Nurse Educator	33	2.9394	.7882
Total	359	2.9777	.7471

2. Stages of death and dying

	N	Mean	SD
College Student	77	3.4416	.5255
University Student	34	3.5294	.5066
Hospital Nurse	183	3.4208	.6898
Community Nurse	43	3.4419	.6629
Nurse Educator	33	3.4242	.6629
Total	370	3.4378	.6313

3. Community resources

	N	Mean	SD
College Student	77	3.5325	.5521
University Student	34	3.7353	.4478
Hospital Nurse	185	3.5027	.5909
Community Nurse	43	3.6279	.5783
Nurse Educator	33	3.6364	.4885
Total	372	3.5565	.5635

4. Religious, spiritual, and cultural beliefs

	N	Mean	SD
College Student	77	3.4416	.6385
University Student	34	3.5882	.4996
Hospital Nurse	185	3.5514	.5978
Community Nurse	43	3.5349	.5916
Nurse Educator	33	3.5455	.6170
Total	372	3.5296	.5980

Mean based on a 4-point scale where 1 = unimportant , 4 = very important.
a, b, c, and d denotes groups statistically significant at the .05 level.

Table 13 (cont'd)

Nurses' Perceived Importance of Nursing Competencies One-way Analysis of Variance

5. Burials, funerals, and rituals

	N	Mean	SD
College Student	77	3.1299	.7136
University Student	34	3.2059	.8449
Hospital Nurse	185	3.0757	.7835
Community Nurse	42	3.1667	.6955
Nurse Educator	33	3.1212	.7398
Total	371	3.1132	.7592

6. Ethical/legal issues

	N	Mean	SD
College Student	77	3.4675	.5755
University Student	34	3.7353	.4478
Hospital Nurse	184	3.4946	.6005
Community Nurse	43	3.4884	.7028
Nurse Educator	33	3.6667	.5401
Total	371	3.5256	.5939

7. Euthanasia

	N	Mean	SD
College Student	76	3.2105	.8216
University Student	32	3.5625 b	.5644
Hospital Nurse	182	2.9835 a,b	.8949
Community Nurse	43	3.0233	.7712
Nurse Educator	33	3.5152 a	.6671
Total	366	3.1339	.8447

8. Living wills

	N	Mean	SD
College Student	77	3.3766	.6890
University Student	34	3.5294	.5633
Hospital Nurse	184	3.3261	.6547
Community Nurse	43	3.2558	.7268
Nurse Educator	33	3.6061	.6093
Total	371	3.3720	.6631

Mean based on a 4-point scale where 1 = unimportant , 4 = very important.
a, b, c, and d denotes groups statistically significant at the .05 level.

Table 13 (cont'd)

Nurses' Perceived Importance of Nursing Competencies
One-way Analysis of Variance

9. Pain control and symptom management

	N	Mean	SD
College Student	76	3.8947	.3089
University Student	34	3.9412	.2388
Hospital Nurse	185	3.9243	.2652
Community Nurse	43	3.9767	.1525
Nurse Educator	33	3.9091	.2919
Total	371	3.9245	.2645

10. Oncology nursing

	N	Mean	SD
College Student	72	3.5972	.5972
University Student	34	3.7353	.4478
Hospital Nurse	185	3.5622	.5968
Community Nurse	43	3.5814	.4992
Nurse Educator	33	3.3636	.8594
Total	367	3.5695	.6050

11. Death across the lifespan (e.g., children, adolescents, adults, older adults)

	N	Mean	SD
College Student	77	3.6234	.5140
University Student	34	3.8235 a	.3870
Hospital Nurse	180	3.5000 a	.6118
Community Nurse	42	3.5714	.5903
Nurse Educator	32	3.6250	.5536
Total	365	3.5753	.5722

12. Death due to AIDS

	N	Mean	SD
College Student	77	3.4675	.6195
University Student	34	3.6471	.5971
Hospital Nurse	185	3.4108	.6289
Community Nurse	43	3.4419	.6656
Nurse Educator	33	3.3333	.6455
Total	372	3.4409	.6310

Mean based on a 4-point scale where 1 = unimportant , 4 = very important.
a, b, c, and d denotes groups statistically significant at the .05 level.

Table 13 (cont'd)

Nurses' Perceived Importance of Nursing Competencies
One-way Analysis of Variance

13. Sudden death

	N	Mean	SD
College Student	77	3.5844	.5701
University Student	34	3.6176	.6038
Hospital Nurse	185	3.4811	.6263
Community Nurse	43	3.3256	.7471
Nurse Educator	33	3.3636	.6528
Total	372	3.4866	.6336

14. Family dynamics

	N	Mean	SD
College Student	77	3.5455	.5512
University Student	34	3.7353	.4478
Hospital Nurse	184	3.5163 a	.6094
Community Nurse	43	3.7209	.5036
Nurse Educator	33	3.8182 a	.3917
Total	371	3.5930	.5636

15. Grief counselling, communication, and psychological support

	N	Mean	SD
College Student	77	3.7403	.4702
University Student	34	3.7941	.4104
Hospital Nurse	185	3.6486	.5324
Community Nurse	43	3.7209	.4539
Nurse Educator	33	3.8182	.3917
Total	372	3.7043	.4911

16. Team building across the disciplines

	N	Mean	SD
College Student	77	3.3636	.5828
University Student	34	3.6176	.4933
Hospital Nurse	182	3.4011	.5933
Community Nurse	43	3.4884	.5508
Nurse Educator	32	3.6250	.4919
Total	368	3.4429	.5737

Mean based on a 4-point scale where 1 = unimportant , 4 = very important.
a, b, c, and d denotes groups statistically significant at the .05 level.

Table 13 (cont'd)

Nurses' Perceived Importance of Nursing Competencies
One-way Analysis of Variance

17. Support for the caregiver

	N	Mean	SD
College Student	77	3.6234	.5390
University Student	34	3.6471	.4851
Hospital Nurse	185	3.6108	.5516
Community Nurse	43	3.7209	.4539
Nurse Educator	33	3.8485	.3641
Total	372	3.6505	.5207

18. Physical care

	N	Mean	SD
College Student	77	3.7662 a	.4260
University Student	34	3.6176	.5513
Hospital Nurse	184	3.5652 a	.5592
Community Nurse	43	3.5349	.5047
Nurse Educator	32	3.7188	.5227
Total	370	3.6216	.5284

19. Non-medical treatment modalities (e.g., relaxation)

	N	Mean	SD
College Student	77	3.5065 a	.5531
University Student	34	3.5294 b	.5066
Hospital Nurse	184	3.1793 a,b,c	.6819
Community Nurse	42	3.3571	.5768
Nurse Educator	33	3.7576 c	.4352
Total	370	3.3514	.6383

20. Terminal care

	N	Mean	SD
College Student	76	3.7632	.4280
University Student	34	3.7059	.4625
Hospital Nurse	185	3.6541	.4992
Community Nurse	42	3.6190	.4915
Nurse Educator	32	3.8125	.3966
Total	369	3.6911	.4743

Mean based on a 4-point scale where 1 = unimportant , 4 = very important.
a, b, c, and d denotes groups statistically significant at the .05 level.

Table 13 (cont'd)

Nurses' Perceived Importance of Nursing Competencies One-way Analysis of Variance

21. Death awareness

	N	Mean	SD
College Student	77	3.6104	.4909
University Student	34	3.6765	.4749
Hospital Nurse	185	3.5027	.5626
Community Nurse	42	3.6190	.5389
Nurse Educator	31	3.6129	.4951
Total	369	3.5637	.5335

22. Death anxiety

	N	Mean	SD
College Student	76	3.5921	.4947
University Student	34	3.6765	.5349
Hospital Nurse	183	3.5027	.5633
Community Nurse	42	3.5714	.5474
Nurse Educator	32	3.6563	.4826
Total	367	3.5586	.5394

23. Bereavement and coping with loss

	N	Mean	SD
College Student	77	3.7532	.4339
University Student	34	3.7647	.4306
Hospital Nurse	182	3.6264	.5074
Community Nurse	43	3.6977	.5134
Nurse Educator	32	3.7813	.4200
Total	368	3.6875	.4814

24. Anomalies (e.g, near death experiences)

	N	Mean	SD
College Student	74	3.0270	.7017
University Student	33	3.2727	.7613
Hospital Nurse	173	3.0231	.7389
Community Nurse	37	3.1351	.7134
Nurse Educator	31	3.1935	.7492
Total	348	3.0747	.7322

Mean based on a 4-point scale where 1 = unimportant , 4 = very important.
a, b, c, and d denotes groups statistically significant at the .05 level.

APPENDIX N

TABLE 17 PARTICIPANTS' RELIGIOUS BELIEFS--T-TESTS

Table 17

Participants' Religious Beliefs T-tests

1. Questionnaire item: To me, death signifies "a beginning."

Group	Frequency	Mean	SD
High intensity religious beliefs (HIRB)	65	4.1692	.911
Low intensity religious beliefs (LIRB)	89	2.4944	.967

2 - Tailed probability=.001

2. Questionnaire item: I possess a sound knowledge base regarding religious beliefs and values regarding death.

Group	Frequency	Mean	SD
(HIRB)	65	4.2462	.791
(LIRB)	92	2.5870	.841

2 - Tailed probability=.001

3. Questionnaire item: I have "come to terms" with my own mortality.

Group	Frequency	Mean	SD
(HIRB)	66	4.2121	.869
(LIRB)	92	3.1274	1.046

2 - Tailed probability=.001

4. Questionnaire item: I turn to my religion as a source of comfort and meaning when dealing with death.

Group	Frequency	Mean	SD
(HIRB)	66	4.7576	.432
(LIRB)	90	2.5667	1.050

2 - Tailed probability=.001

5. Questionnaire item: Age

Group	Frequency	Mean	SD
(HIRB)	87	40.8966	9.773
(LIRB)	33	33.2727	10.872

2 - Tailed probability=.001
Mean based on continuous scale.

6. Questionnaire item: Years of nursing experience

Group	Frequency	Mean	SD
(HIRB)	87	14.2069	9.179
(LIRB)	33	9.3030	10.406

2 - Tailed probability=.021
Mean based on continuous scale.

7. Questionnaire item: Previous death education

Group	Frequency	Mean	SD
(HIRB)	86	2.9884	1.553
(LIRB)	33	3.6667	1.514

2 - Tailed probability=.034
Mean based on 7-point checklist.

8. Questionnaire item: More death education is needed in schools of nursing.

Group	Frequency	Mean	SD
(HIRB)	87	4.5862	.708
(LIRB)	33	3.6061	1.029

2 - Tailed probability=.001

9. Questionnaire item: The _quality_ of death and dying educational preparation that I received in my basic nursing program serves as a sound basis for clinical practice.

Group	Frequency	Mean	SD
(HIRB)	86	1.6512	.851
(LIRB)	33	3.7879	1.053

2 - Tailed probability=.001

10. Questionnaire item: The amount of _time_ allocated to death and dying in my basic nursing program was adequate.

Group	Frequency	Mean	SD
(HIRB)	87	1.3333	.623
(LIRB)	33	3.6667	1.051

2 - Tailed probability=.001

11. Questionnaire item: I experience satisfaction in relation to the terminal care that I am able to provide.

Group	Frequency	Mean	SD
(HIRB)	81	3.5679	1.024
(LIRB)	31	3.9677	.706

2 - Tailed probability=.021

12. Questionnaire item: I possess strong clinical skills regarding symptom management and pain control.

Group	Frequency	Mean	SD
(HIRB)	87	3.3448	1.129
(LIRB)	32	3.7813	.906

2 - Tailed probability=.033

13. Questionnaire item: When a death occurs in the work setting, there is adequate support available to the nurse.

Group	Frequency	Mean	SD
(HIRB)	85	2.3647	1.153
(LIRB)	31	2.9355	1.181

2 - Tailed probability=.024

14. Questionnaire item: Importance of topic--community resources

Group	Frequency	Mean	SD
(HIRB)	86	3.7558	.530
(LIRB)	33	3.5455	.506

2 - Tailed probability=.049
Mean based on a 4-point scale.

Mean based on a 5-point scale, unless otherwise indicated.