Online Exclusive Article

What Do Nurses Want to Learn From Death Education? A Survey of Their Needs

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Purpose/Objectives: To identify what nurses want to know most about death education and to obtain baseline data to improve nurses' training and education.

Design: A cross-sectional survey.

Setting: Seven hospitals in Shanghai, China.

Sample: 617 RNs.

Methods: A cross-sectional survey using a self-report questionnaire was administered to a purposive sample of RNs. The data were analyzed with SAS® statistical software, version 9.1.3.

Main Research Variables: Nurses' content needs in death education and the characteristics associated with those needs.

Findings: Eight dimensions of needs were extracted by factor analysis from the results. The dimension of managing issues associated with death and dying had the highest score ($\bar{X}$ = 4.13), whereas issues associated with funeral planning had the lowest score ($\bar{X}$ = 3.51). The multiple linear regression analysis showed that three factors may have influenced the nurses' needs in death education: educational background, previous training about death education, and hospital size.

Conclusions: Nurses had high levels of need in the content of death education, particularly regarding knowledge and skills in coping with death and dying patients (e.g., caring for patients and their families physically and psychologically).

Implications for Nursing: Educators and administrators should strive to provide high-quality training for nurses and consider the roles of culture, religion, and sociodemographic characteristics when designing death education programs.

Although death is an inevitable shared experience, people often fail to recognize the proper grief, bereavement, and mourning practices prescribed within a cultural context (Bonura, Fender, Roesler, & Pacquiao, 2001; Hattori, McCubbin, & Ishida, 2006). As the healthcare providers who spend the most time with patients at the end of life (EOL), nurses find caring for dying patients to be emotionally painful, distressing, and sometimes threatening because the illness is incurable and death is imminent. Many nurses and nursing students have reported difficulty managing death (Schlairet, 2009; Van Rooyen, Laing, & Kotzé, 2005; White, Coyne, & Patel, 2001). Nurses are inadequately prepared to care for patients at the EOL; many reasons contribute to this failure, including deficits in the professional and continuing education of healthcare providers. Nurses lack formal education during their undergraduate curriculum and sufficient on-the-job training regarding death and EOL care (Brazil & Vohra, 2005; Robinson, 2004).

In Chinese culture, death is a taboo topic and families are expected to decide whether the diagnosis should be disclosed to patients. Open discussion of terminal illness and impending death with patients present is not promoted (Chan, Lam, Chun, Dai, & Leung, 1998). Avoiding the discussion of death with patients in Chinese culture further increases nurses' anxiety. However, death education in the curriculum of medical students in mainland China has been limited (Zhang, 2007). Among RNs in mainland China, continuing education and other forms of training regarding death and EOL also are insufficient.

The current study used a self-report questionnaire to examine the needs of death education content of RNs in Shanghai, China. The aim of evaluating those needs was to improve the development of death education and training for nurses in China.

Background

The perception of death and dying differs between individuals, varying with sociocultural background, time and place of death, individual values, philosophy, and behaviors toward life (Cicirelli, 1999; Depaola, Griffin, Young, & Neimeyer, 2003; Yeun, 2005). In the 19th and 20th centuries, people's interest in their lives increased

and existential philosophy emerged, resulting in the perception of death as an event to be confronted rather than avoided (Field & Copp, 1999). The care of dying patients is an art most fully expressed as providing patients with the knowledge and skills needed to cope with the complicated medical environment surrounding EOL.

Most nurses will encounter death and dying patients at some time during their careers. Nurses spend more time with patients than any other healthcare professionals and are expected to acknowledge and cope with death while providing support to patients and their families (Kwekkeboom, Vahl, & Eland, 2005). However, caring for dying individuals is stressful, difficult, and a significant issue for nurses because the death of a patient may awaken intense personal feelings such as grief, anxiety, depression, relief that the patient's suffering has ended, anger, and guilt (Kuuppelomäki, 2000). If nurses cannot accept and cope with death and dying patients, they may experience conflict between their professional and personal roles. Negative feelings could affect nurse's quality of life, as well as the quality of care delivered to patients. The results of a survey of more than 15,000 nurses suggested that their anxiety in caring for dying patients was strongly related to fears of their own death (Simington, 1996). The affect of this anxiety was directly related to the avoidance and rejection behavior. Nurses may have issues with meeting and talking with relatives of dying patients. Nurses have reported feelings of inadequacy and inability to cope with pain management, symptom control, and emotional support of dying patients because of a lack in knowledge, skills, and time (Kuuppelomäki, 2000; Van Rooyen et al., 2005). In a descriptive survey of practicing members of the Oncology Nursing Society in Georgia, Virginia, Washington, and Wisconsin, the most common competency reported missing in nursing education was learning how to talk to patients and families about dying (White et al., 2001). Nurses require strategies such as continuing education to help them extend and refine their knowledge regarding death and EOL care (Schlairet, 2009).

Death education refers to a variety of educational activities and experiences associated with death and embraces those core topics as meanings and attitudes toward death, processes of death, bereavement, and care for dying people. Leviton (1977) defined death education as a developmental process in which death-related knowledge and the implications resulting from that knowledge were transmitted. He identified the following goals of death education: primary prevention (preparing individuals for eventual death events), intervention (helping people face personal aspects of death), and rehabilitation (understanding and learning from death-related crises). More specific goals included promoting comfortable interactions with the dying, removing taboos, and reducing anxiety (Leviton, 1977). According to Dagi (1991), the purpose of death education is to teach healthcare personnel about the following topics.

- The history of rituals related to death in the populations nurses are likely to serve
- Cultural, religious, and philosophical differences in the interpretation of death
- Literary, anthropologic, sociologic, and psychological observations

Death education is critical for healthcare professionals to advance their field and achieve their aims. Through education, nurses can perceive death and dying positively and provide high-quality care to their patients. Death education can influence nurses' attitudes toward death, dying, and EOL care and enhance their knowledge, self-efficacy, and competency levels in EOL nursing care (Ferrell, Virani, Smith, Juarez, & National Cancer Policy Board and Institute of Medicine, 2003; Hwang, Lin, & Chen, 2005; Mallory, 2003; Malloy et al., 2006; Schlairet, 2009; Thompson, 2005).

Awareness regarding the importance of death education is increasing. In a mailed survey of 122 medical schools and 580 bachelor of nursing programs, all medical schools and 99% of nursing schools reported providing education on death and dying, with more than 90% of students in those programs participating in the United States (Dickinson, 2007). Death education has been in the curricula of nursing programs in the United Kingdom for more than 25 years. Topics covering more than 90% of the courses in the curriculum are attitudes toward death and dying, communication with terminally ill patients and their families, pain and symptom management, and grief and bereavement (Dickinson, Clark, & Sque, 2008). The nine modules of the American Association of Colleges of Nursing and the City of Hope National Medical Center's End-of-Life Nursing Education Consortium (ELNEC) program addressed critical aspects of EOL care (Malloy, Paice, Virani, Ferrell, & Bednash, 2008; Matzo, Sherman, Penn, & Ferrell, 2003; Matzo, Sherman, Nelson-Marten, Rhome, & Grant, 2004). The modules included the topics of nursing care at EOL; pain and symptom management; ethical and legal issues; cultural considerations in EOL care; communication; grief, loss, and bereavement; preparation and care for the time of death; and achieving quality care at the end of life (Malloy et al., 2008; Matzo et al., 2004).

In Hong Kong, death education for nurses commonly comprises knowledge-based and clinical training components. Teaching tends to focus primarily on knowledge rather than attitudes and skills (Mok, Lee, & Wong, 2002). Although death education has been recognized in mainland China since the 1980s, discussions were limited to theoretical research, surveys of needs or attitudes, and some case studies in practice (Zeng & Zeng, 2007; Zou & Chen, 2007). Formal death education in school or continuing education for medical staff was uncommon (Wang, Cao, & Yang, 2007). Wang et al. (2007) implemented death

education in the Medical College of Shangdong University in China and found that the courses could relieve undergraduates' mental stress and help them understand life and death appropriately. The content of death education should be adapted to different educational populations, time, location, and objectives. Nurses with different experiences or educational backgrounds may have different needs regarding the content of death education (Malloy et al., 2008; Thompson, 2005). Regarding the differences in cultural contexts between China and other countries, some topics or themes in death education may have different meanings and importance to nurses (Kao & Lusk, 1997). However, no systematic study has explored RNs' needs regarding the content of death education and the possible factors associated with their needs in mainland China. The identification of nurses' needs regarding the topics of death education is reasonable when Chinese educators and administrators design a training or education program. As a result, the current study surveyed RNs in Shanghai to elicit what they wanted to know most about death education, which could be used as baseline data for establishing formal death education for nurses.

Methods

Questionnaire Development

On the basis of a literature review (Dagi, 1991; Dickinson et al., 2008; Ferrell et al., 2003, 2007; Leviton, 1977; Matzo, Sherman, Penn, & Ferrel, 2003; Sherman, Matzo, Pitorak, Ferrell, & Malloy, 2005; Tseng & Chi, 2000; Zhang, 1998), a self-report questionnaire was developed to elicit nurses' needs regarding death education content. All items were measured with a five-point Likert-type scale, ranging from 1 (no need) to 5 (badly in need). Then a group discussion was conducted to revise the questionnaire. Ten experts (five specialist nurses, a nursing manager, three nursing education specialists, and a psychologist) discussed and evaluated the questionnaire for content, wording, relevance, and completeness. Items found to be duplicative, unnecessary, or improper were deleted from the questionnaire, and other items considered to be important in death education were added. In addition, items determined to be unclear were revised. The final questionnaire consisted of 50 items. To test reliability, the questionnaire was given to 100 respondents in five departments from one hospital before the formal survey. All 100 copies were eligible for analysis. Finally, Cronbach alpha coefficient and Guttman split-half coefficient were calculated to test the reliability and split-half reliability of the questionnaire.

Implementation

The Committee on Ethics of Biomedicine Research of the Second Military Medical University in Shanghai, China, approved the study. All information gathered was treated confidentially and anonymously and will never be used for any purpose other than this research. All participants gave verbal informed consent before taking the survey.

Participants were recruited through purposive sampling. The questionnaires were distributed to 695 RNs from seven hospitals in Shanghai, China. The authors went to the wards to distribute the questionnaires, tell nurses about the study, and ask them in person whether they would be willing to participate. Those who agreed to participate were verbally informed of information on volunteering and confidentiality. The time to complete the questionnaire was estimated to be a maximum of 30 minutes. Six hundred and fifty-four copies of the questionnaire were collected (94% response rate), of which 617 were eligible.

Table 1. Sociodemographic Characteristics of Nurses in Mainland China

Characteristic	n	%
Age (years)		
25 or younger	279	45
26–35	257	42
36–45	76	12
46 or older	5	1
Time at current job (years)		
1–5	332	54
6–10	141	23
11–20	110	18
21 or more	34	6
Educational background		
Diploma	419	68
Secondary school	122	20
Bachelor's degree	73	12
Master's degree	3	< 1
Professional title		
Nurse	355	58
Primary nurse	230	37
Nurse-in-charge	32	5
Trained in death education before		
No	437	71
Yes	180	29
Training methods (N = 180)		
School education	131	73
Continuing education	36	20
Self-study	13	7
Religion		
No	570	92
Yes	47	8
How often do you nurse dying patients?		
Occasionally	330	54
Often	173	28
Never	114	19
Hospital size[a]		
First class	417	68
Second class	200	32

N = 617 unless otherwise noted

[a] In China, hospitals are ranked by overall levels, with second class indicating more beds and functions than first class.

Note. Because of rounding, not all percentages total 100.

Statistical Analysis

The reliability and split-half reliability of the questionnaire were measured with Cronbach alpha coefficient (0.987) and Guttman split-half coefficient (0.959). Factor analysis of the 50 items in the questionnaire was performed with principal components analysis and varimax orthogonal rotation method. The profile of the individual item and dimensional needs of death education content of the 617 nurses were analyzed and reported. The dimensional score was calculated as the mean of the items' scores of that dimension, whereas the total score was calculated as the mean of all the items' scores. To identify which factor of nurses' characteristics influenced the need of participants, the authors conducted multiple linear regression analysis. All statistical analyses were performed with SAS®, version 9.1.3 ($p \leq 0.05$).

Results

Sample

The demographic characteristics of the participants are summarized in Table 1. Among the 617 nurses recruited, 417 (68%) worked in first-class hospitals (less than 100 beds), whereas 200 (32%) worked in second-class hospitals (more than 100 beds). Most nurses did not have a religious belief (n = 570, 92%), and 47 (8%) were Buddhist or Christian.

Validation of the Questionnaire

The content validity of the questionnaire was evaluated by logic analysis. In the current study, factor analysis was used to test the construct validity of the questionnaire. Before the factor analysis, Ball Barlett and Kaiser-Meyer-Olkin (KMO) tests were performed to determine whether the data were suitable for factor analysis. The KMO value was 0.973. Ball Barlett test suggested that the data were not a unit correlation matrix ($p < 0.0001$). Principal components analysis with varimax rotation was used. The principles of factor extraction were (a) eigenvalue of 1 or higher, (b) complying with the Cartel steep-order test principles (Song & He, 2007), (c) explaining variance in total of 60% or higher, (d) each containing at least two items, (e) meaning of items being consistent with the professional context, and (f) being easier to be named. The analysis extracted eight factors that explained 80% of the variance and covered 50 items. The names and the descriptions of the factors are listed in Table 2.

Analysis of Variables

The participants had high levels of content needs for all 50 items in death education, and mean scores were higher than 3.5 for all items except for death concepts of Christianity, death concepts of Islam, and knowledge about how to plan for a funeral. Table 3 shows the top five rated topics. In the multiple linear regression analysis, the affect of each descriptive demographic characteristic on the need was analyzed. Three variables were entered in the regression: educational background (bachelor's and master's degrees) ($t = 2.32$, $p = 0.021$), previous training in death education ($t = 4.02$, $p < 0.001$), and hospital size (first-class hospital) ($t = -5.49$, $p < 0.001$) (see Table 4). The negative coefficient of hospital size showed that the need decreased as hospital size increased.

Discussion

The results showed that nurses' needs for death education content in all items were high. Of the 617 participants, only 29% had been trained in death education, whereas 82% had cared for patients at EOL. The mean score of all 50 items was 3.92, which supports the addition of death education into continuing education or further training for nurses. A possible explanation for low scores on the dimensions of death concepts of

Table 2. Nurses' Score of Needs on Dimensions of Death Education

Dimension	Items	Eigenvalue	Proportion	Score of Needs[a] $\bar{X}$	Score of Needs[a] SD
Managing issues associated with death and dying	15	11.04	22.08	4.13	0.66
Thanatopsis in philosophy, different regions, and folk customs	8	6.84	13.69	3.62	0.72
Issues associated with funeral planning	4	4.41	8.83	3.51	0.79
Ethical issues associated with death	5	4.23	8.46	3.87	0.72
Introduction of death and death education	6	4.21	8.42	3.94	0.64
Interventions of loss and sadness for patients and families	4	3.52	7.04	3.95	0.72
People's attitudes toward death and dying in different ages	4	2.95	5.91	4.01	0.7
Issues associated with suicide	4	2.77	5.55	4.07	0.72
Total[b]	50	–	79.98	3.92	0.82

N = 617

[a] All items were measured with a five-point Likert-type scale, ranging from 1 (no need) to 5 (badly in need).

[b] Cronbach alpha = 0.98

Table 3. Nurses' Top Five Desired Death Education Topics

Topic	$\bar{X}$	SD
Bereavement in sudden disasters (e.g., 2008 Wenchuan, China, earthquake; 9/11 terrorist attack)	4.24	0.76
How to communicate with dying patients and their families	4.21	0.77
Psychological self-adjustment when nursing dying patients	4.21	0.75
How to care for dying patients	4.2	0.76
Proper attitude when nursing dying patients	4.18	0.77

Note. All items were measured with a five-point Likert-type scale, ranging from 1 (no need) to 5 (badly in need).

Christianity, death concepts of Islam, and knowledge about funeral planning is that Christianity and Islam are not prevalent in mainland Chinese culture and may be attributed to the cultural background of the study sample (i.e., the respondents may have cared for fewer Christian or Islamic patients). The funeral is a private family affair in China; therefore, doctors and nurses are seldom involved in the planning of patients' funerals. As a result, the nurses paid less attention to those cultural aspects.

The results suggested that the content in the study questionnaire coincided with nurses' needs to a large extent. The current study addressed several unique characteristics compared to former studies in mainland China. In the current study, the top-ranked items involved bereavement in sudden disasters, how to communicate with dying patients and their families, psychological self-adjustment when nursing dying patients, how to care for dying patients, and proper attitude when nursing dying patients. In the late 2000s, nurses faced the deaths of many people because of disasters, particularly the 2008 Wenchuan earthquake in China. That may have led to nurses' contemplation about bereavement in sudden death. Grief support after a sudden death should address special factors (e.g., people's certain reactions, including shock and not accepting the reality) compared to a long-term illness. Although death education most commonly is discussed in caring for patients with life-limiting illness, it should not be limited to this aspect alone.

Nurses wanted to learn how to care for and communicate with dying patients and the proper attitude when nursing dying patients, which was similar to the findings of Tseng and Chi (2000). Durlak and Riesenberg (1991) asserted that one of the main purposes for death education was to help individuals face and cope with death more effectively. For example, a study of nurses concluded that those exposed to an EOL communication program felt more comfortable talking about EOL issues than nurses who did not participate in such programs (Deffner & Bell, 2005).

Zhang (1998) summarized the content of death education as five aspects: the nature and significance of death; attitudes toward death and dying; coping with issues associated with death, dying, and adjustment; discussions about some special issues (e.g., suicide, ethics and death, euthanasia, abortion, AIDS); and the implementation of death education. In terms of dimensions, the current study revealed nurses' needs in eight aspects of the content. The nurses expressed a high level of need regarding knowledge and skills in coping with death and dying. The need for education on managing issues associated with death and dying was

Table 4. Multiple Linear Regression Analysis for Needs in Death Education Content

Variable	β	t	p	Standard Regression Coefficient
Intercept	4.295	23.73	< 0.001	0
Age (years)				
36 or older	−0.079	−0.58	0.562	−0.045
26–35	−0.058	−0.70	0.487	−0.048
25 or younger	0			
Time at current job (years)				
21 or more	−0.181	−1.01	0.311	−0.07
11–20	−0.037	−0.34	0.735	−0.024
6–10	−0.016	−0.19	0.852	−0.011
1–5	0			
Educational background				
Diploma	0.03	0.48	0.629	0.023
Bachelor's and master's degrees	0.213	2.32	0.021	0.118
Secondary school	0			
Professional title				
Primary nurse	−0.011	−0.13	0.894	−0.009
Nurse-in-charge	0.013	0.08	0.936	0.005
Nurse	0			
Trained in death education before				
Yes	0.209	4.02	< 0.001	0.16
No	0			
Religion				
Yes	0.075	0.85	0.395	0.033
No	0			
How often do you nurse dying patients?				
Occasionally	−0.027	−0.42	0.673	−0.023
Often	0.098	1.36	0.174	0.074
Never	0			
Hospital size[a]				
First class	−0.285	−5.49	< 0.001	−0.224
Second class	0			

[a] In China, hospitals are ranked by overall levels, with second class indicating more beds and functions than first class.

particularly high in the nurses. In addition, the participants had high levels of need regarding content for issues associated with suicide and interventions for loss and sadness of patients and families. Death and dying cause a great sense of loss and sadness for patients and families, which arouses nurses' sympathy and frustration. Zhang (1998) believed suicide and self-destructive behaviors and accidental death including violence and homicide were special issues. Coping with loss and sadness in patients and families is a challenging and stressful issue for nurses, particularly in the event of accidental death and suicide. Unfortunately, nurses encounter those special issues in modern society, and nurses in the current study reported educational needs in those dimensions. Therefore, related training or education is necessary.

The survey also identified a high level of need for content involving ethical issues associated with death in general. In traditional Chinese culture, most people are reluctant to discuss death. Chinese doctors and nurses also have difficulty talking about ethical issues such as organ donation; therefore, nurses want more information in this area. Nurses also reported high levels of need regarding people's attitudes toward death and dying in different ages; introduction of death and death education; and Thanatopsis in philosophy, different regions, and folk customs. The findings indicated that nurses want to explore different meanings and attitudes toward death.

Culture plays an important role in people's attitudes toward death. Kao and Lusk (1997) surveyed attitudes toward death and dying and found that Asian graduate nursing students consistently had a higher level of death anxiety than American graduate nursing students. The results were similar among participants of different ages (Kao & Lusk, 1997). However, the attitudes of nurses of different ages could differ greatly. Cicirelli (2001) reported that fear of death and dying was relatively high among the young, peaked during middle age, and was lowest in older adults, indicating that older adults have the easiest acceptance of death. Nurses in the current study recognized that understanding people's perceptions of death and dying in different cultural contexts and age groups was important and practical.

Factors Associated With Education Needs

The current study also examined the association between nurses' characteristics and their death education content needs. According to the multiple linear regression analysis of the results, nurses' needs may have been influenced by educational background (bachelor's and master's degrees), having received previous death education, and hospital size (first-class hospital). Some studies revealed that death education or education in palliative care could positively influence attitudes toward death, dying, and palliative and EOL care (Hwang et al., 2005; Kwekkeboom et al., 2005; Malloy et al., 2008; Thompson, 2005). Nurses who had been trained in death education may have had more positive attitudes and high levels of death education needs because they understood its importance, which stimulated their interest in the topic. The negative coefficient of hospital size showed that education needs decreased as hospital size increased. One reason for that may be that nurses in bigger hospitals had more opportunities to care for dying patients. Therefore, they formed their own understanding of death education in clinical practice. However, additional investigation should be performed to explore the reasons. No previous studies were found that explored the association between educational background and the need for death education content. Nurses with different educational backgrounds (e.g., undergraduate or master's degrees) may use different information sources, which influences their needs in death education. In addition, nurses with bachelor's and master's degrees had received some formal or informal school education regarding death and dying.

Conclusion

RNs in hospitals in mainland China need death education. In the current study, survey respondents reported high levels of need in most items and dimensions of death education, particularly regarding knowledge and skills in coping with death and dying patients (e.g., caring for patients and their families physically and psychologically). Educators and administrators should strive to provide high-quality training and education to prepare nurses to respond to the many needs of patients at EOL and their families. Culture and religion play important roles in determining education content, and they should be considered when designing training and education programs for nurses in different regions or states. In addition, nurses paid close attention to sudden death caused by disasters and their own physical and psychological health. The findings suggest that teaching nurses how to cope with issues after a patient's sudden death and how to protect their own personal and professional responses should be prioritized. A possible relationship examined by the current study was the association between death education and content needs. Death education may inspire interest in nurses and positively influence their attitudes toward death, dying, and palliative and EOL care. However, the relationship between death education and content needs warrants additional study.

Implications for Nursing Practice

The current study's findings contribute to the understanding of nurses' needs and desired content in death education. Educators and administrators should strive to provide quality training and continuing education regarding death to nurses. The roles of culture and religion and nurses' sociodemographic characteristics should be considered when designing death education programs.

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