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Nursing Experience and the Care of Dying Patients

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Purpose/Objectives: To examine relationships among demographic variables and nurses' attitudes toward death and caring for dying patients.

Design: Descriptive and correlational.

Setting: Two metropolitan hospitals in Detroit, MI.

Sample: 58 RNs practicing in oncology and medical/surgical nursing. The majority was female and white, with a mean age of 41 years.

Methods: Completed survey of three measurement tools: a demographic survey, Frommelt Attitudes Toward Care of the Dying (FATCOD) Scale, and Death Attitude Profile–Revised (DAP-R) Scale. Of 60 surveys distributed, 58 were completed and returned.

Main Research Variables: Past experiences (level of education and death training), personal experiences (age, race, religion, and attitudes toward death), professional experiences (months or years of nursing experience and the percentage of time spent in contact with terminally ill or dying patients), and attitudes toward caring for dying patients.

Findings: Most respondents demonstrated a positive attitude about caring for dying patients. Nurses who reported spending a higher percentage of time in contact with terminally ill or dying patients reported more positive attitudes. No significant relationship was found between nurses' attitudes toward death and nurses' attitudes about caring for dying patients. Statistically significant relationships were found among certain demographic variables, DAP-R subscales, and FATCOD Scale.

Conclusions: Regardless of how the nurses felt about death, providing professional and quality care to dying patients and their families was salient.

Implications for Nursing: Developing continuing education programs that teach effective coping strategies to prevent death anxiety and identifying barriers that can make caring for dying patients difficult may make the journey from novice to expert nurse a gratifying and rewarding experience.

Key Points . . .

- ➤ The more experience that nurses have with dying patients, the more positive the care experience becomes.
- ➤ Regardless of how nurses felt about death, providing professional and quality care to dying patients and families was salient.
- ➤ Findings from this study support Benner's (1984) proposition that practical knowledge learned from professional experience may influence how nurses care for patients.

Death is inevitable for all living beings (Haisfield-Wolfe, 1996) and, as healthcare providers, nurses play a principle role in the care of dying individuals and their families. Consequently, the care that nurses provide to terminal or dying patients may be affected by their own attitudes toward death (Rooda, Clements, & Jordan, 1999). According to Rooda et al., "Determinants of attitudes toward death and dying encompass not only cultural, societal, philosophical, and religious belief systems, but also personal and cognitive frameworks from which individual attitudes toward death and dying are formulated and interpreted" (p. 1683). Therefore, nurses' personal feelings also may influence how they cope with dying patients.

The average life expectancy of Americans has increased dramatically since the early 1900s, from 49 years of age to 79 and 74 years of age for women and men, respectively. Census bureau projections for the United States estimate that by the year 2030, the older than 65 age group will double to approximately 70 million, with the fastest growth rate to occur in the older than 85 age group (e.g., nine million) (Federal Interagency Forum on Aging Related Statistics, 2000). According to the National Cancer Institute (n.d.) Surveillance, Epidemiology and End Results (SEER) Cancer Statistics Review 1975–2001, more than half (57%) of the reported cases of cancer in the United States are among older adults, with the median age of death from cancer occurring at age 72. These statistics suggest that nurses will be responsible for the care of a larger population of dying patients in the future and, therefore, the need to be educated about death is warranted. Thus, the aim of this pilot study was to replicate the findings from Rooda et al. (1999) to provide rationale for the development of proactive educational programs designed to improve the quality of care of dying patients and their families.

Literature Review

A review of the research literature to determine what effect death education may have on working nurses' attitudes toward care of dying patients revealed very few recently published

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studies. Hainsworth (1996) examined the effects of an educational program on nurses' attitudes, subjective norms, and behavioral intentions toward care of dying people and their families using an experimental pretest/post-test design. The focus of the intervention was to improve nurses' personal death awareness, communication with dying patients and families, and care provided to caregivers. The educational intervention was found to significantly improve the experimental groups' subjective norms (e.g., nurses' perceptions of their supervisors' approval or disapproval of a specific behavior) directly after implementation. This significant effect, however, disappeared over time. No statistically significant effect was found between the experimental group and the control groups' attitudes and their intentions to perform specific behaviors related to the care of dying patients and their families. These researchers identified that the small sample size could have been the reason for the effect of the intervention not reaching significance.

In a convenience sample of 403 working nurses, Rooda et al. (1999) found that nurses who cared for a greater percentage of terminally ill patients had more positive attitudes toward caring for dying patients than nurses who cared for a lesser percentage of terminally ill patients. Nurses with a greater fear of death had less positive attitudes toward caring for dying patients than did nurses with a lesser fear of death ($r = –0.34$, $p < 0.001$). Nurses who reported a tendency toward avoiding the topic of death had less positive attitudes about caring for dying patients than nurses who did not avoid the topic of death ($r = –0.37$, $p < 0.001$). Nurses who had neutral attitudes toward death reported having more positive attitudes about caring for people who are dying than nurses who did not report neutral attitudes ($r = 0.22$, $p < 0.001$). Finally, nurses who viewed death as the gateway to a happy afterlife had more positive attitudes toward caring for dying patients ($r = 0.21$, $p < 0.001$) than nurses who did not share this view. These researchers concluded that nurse educators incorporate into their curricula an assessment of death attitudes, discussion of how these attitudes relate to care of dying patients, and interventions that increase positive attitudes toward caring for dying patients.

Other related studies examined the relationships between nurses' experiences and care of dying patients. Stoller (1980) found that licensed practical nurses (LPNs) with more experience caring for dying patients reported less uneasiness interacting with these patients than LPNs with less experience. Stoller hypothesized that with experience, these LPNs developed coping and defense mechanisms to help them deal with death anxiety. Irvin (2000) found that nurses caring for older adults dying from cancer in a nursing home reported developing both positive (e.g., need for social support) and negative (e.g., avoidance) coping strategies to help them deal with death anxiety. Payne, Dean, and Kalus (1998) compared the level of death anxiety between nurses working in an accident and emergency (A&E) department and nurses working in hospice. They found that A&E nurses were more likely to avoid thinking about death, had a greater fear of death, and had less acceptance of death than the hospice nurses. The authors concluded that A&E nurses had minimal contact with dying patients and their families. In acute care settings, the main focus is curing disease and patient deaths are viewed as failures, whereas hospice nurses care for dying patients on a daily basis. They provide holistic, palliative care that focuses not only on patients' physical needs but also their social, psychological, and spiritual needs.

In Catalonia, Spain, Román, Sorribes, and Ezquerro (2001) found that older nurses, nurses working on the day shift, and nurses having 17–21 years of experience reported more favorable attitudes toward caring for dying patients than younger nurses, nurses on afternoon and night shifts, and nurses with less experience.

In summary, death education programs that include an assessment of death attitudes with interventions that increase positive attitudes toward the care of dying patients as well as increasing experiences with dying patients may have an influence on the care that nurses provide to dying patients and their families. Hence, the purpose of this study was to examine the relationships among demographic variables (e.g., gender, age, race, religious affiliation, level of education, years of nursing experience, contact with terminally ill or dying patients) and nurses' attitudes toward death and caring for dying patients.

Conceptual Framework

Concepts from Benners' (1984) *From Novice to Expert* were used to operationalize the research variables and develop the research questions in this study. Benner adopted and modified the Dreyfus Model of Skill Acquisition (Dreyfus & Dreyfus, 1980) to explain how nurses develop expertise in clinical practice. According to Benner, nurses acquire clinical knowledge through experiential learning characterized in five stages—novice, advanced beginner, competent, proficient, and expert. In the novice stage, nurses have no experience, therefore relying on a set of given rules and guidelines to aid their performance. Advanced beginners are starting to use knowledge that has been learned from performing procedures and real clinical situations. Competent nurses have coping strategies to help them manage clinical problems and develop long-term goals or plans of action that are efficient and organized. The proficient nurse is able to recognize the important aspects of a clinical situation using holistic perspectives. In the final stage, nurses become expert performers. In this stage, past experience and theoretical knowledge influence care given to patients and guide the nurses' understanding of disease processes. Unlike the beginner, the expert nurse has developed an intuitive awareness of clinical situations and is able to immediately and accurately diagnose and prioritize problems (Benner).

Comportment, or the way that nurses enact caring for dying patients (Heidegger, 1962; Rittman, Paige, Rivera, Sutphin, & Godown, 1997), can be conceptualized as one aspect of the acquisition of clinical knowledge as described by Benner (1984). Clinical knowledge that is gained from personal and professional experience differs from theoretical knowledge taught in formal nursing educational programs. Past, personal, and professional experience may affect not only the care given to dying individuals but also the nurses' attitudes toward death. In this study, level of education and death training were conceptualized as past experiences; age, race, religion, and attitudes toward death were conceptualized as personal experiences; and months of nursing experience and the percentage of time spent in contact with terminally ill or dying patients were conceptualized as professional experience (see Figure 1). According to Benner, these variables should have an association with nurses' attitudes toward caring for dying patients.

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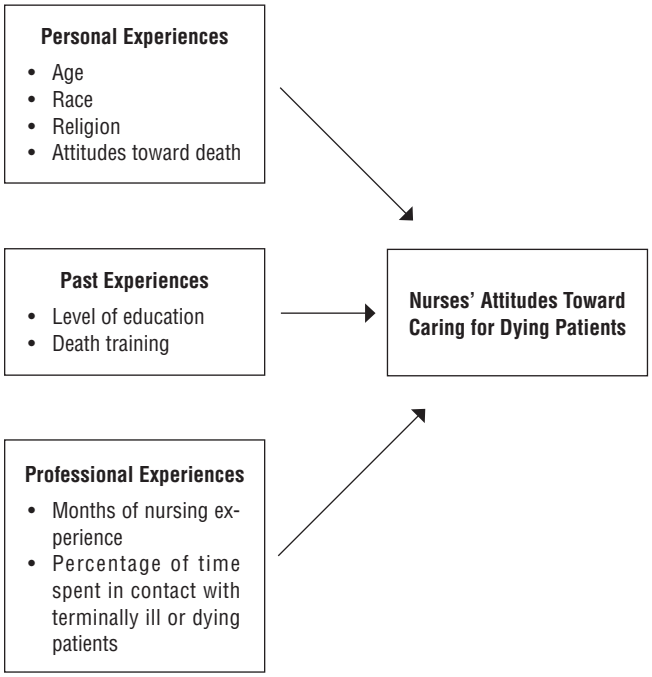

Figure 1. Nurses' Attitudes Toward Caring for Dying Patients

Methods

Procedures

The researchers obtained institutional review board approval from Oakland University and two metropolitan hospitals located in Detroit, MI, prior to data collection. They also obtained verbal agreement from unit managers to distribute questionnaires to medical-surgical and oncology floor nurses. The researchers then approached potential nurse participants and gave them an information sheet to review prior to providing written consent to participate in the study. Once consent was obtained, the researchers interviewed participants on unit floors and in break rooms. The questionnaires took 10–15 minutes to complete. Refreshments were supplied for those completing the survey.

Measures

Participants were asked to complete three measurement tools. The first tool was developed by the investigators to measure demographic data. This **demographic data tool** had 16 items regarding gender, age, martial status, race, religion, highest level of nursing education, educational training on death and dying, and current nursing position (i.e., medical-surgical or oncology). Race was recoded to a dichotomous variable (0 = white or 1 = nonwhite) for parsimony.

To determine the importance of religion, a religiosity index was developed by combining responses to five questions (i.e., religion type, importance of attending religious services, watch or listen to spiritual programs on television or radio, place of worship, attendance at place of worship). Religion type was recoded to a dichotomous variable (0 = no religion or 1 = have a religion). Frequency of attendance was measured using a five-point scale ranging from 0 (never) to 4 (daily). The importance of attendance item was scored using four categories of relative importance, ranging from 0 (not at all important) to 3 (very important).

The **Frommelt Attitudes Toward Care of the Dying (FATCOD)** Scale, (Frommelt, 1991) is a 30-item scale designed to measure participants' attitudes toward providing care to dying patients. The FATCOD is made up of an equal number of positively and negatively worded items. Positive items (e.g., "Giving nursing care to the dying person is a worthwhile learning experience.") and negative items (e.g., "I would not want to be assigned to care for a dying person.") were rated on a five-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Participants were asked to rate how much they agreed or disagreed with the item statements. Possible scores ranged from 30–150, with higher scores representing more positive attitudes toward providing care for dying patients.

Frommelt (1991) used the test-retest procedure to assess the reliability of the FATCOD. A sample of 18 oncology nurses was tested at two different times, with a computed Pearson product-moment correlation coefficient of r = 0.94. To strengthen the reliability, a second test-retest was conducted using a larger sample of 30 nurses from both an oncology and a surgical unit, with a computed Pearson product-moment correlation coefficient of r = 0.90. To assess validity of the FATCOD, a content validity index was computed to be 1.00. A determination of interrater agreement then was computed, yielding an interrater agreement of 0.98 (Frommelt).

The third measurement tool used was the **Death Attitude Profile–Revised (DAP-R)** (Wong, Reker, & Gesser, 1994). The DAP-R is a 32-item multidimensional scale that measures participants' attitudes toward death using a seven-point scale (1 = strongly disagree to 7 = strongly agree). This measure consists of five subscales: (a) fear of death (seven items that measure negative thoughts and feelings regarding death), (b) death avoidance (five items that measure attempts to avoid thought of death), (c) approach acceptance (10 items that measure to what extent a person views death as an entry point to a happy afterlife), (d) escape acceptance (five items that measure the extent to which a person views death as an opportunity to escape from a painful existence), and (e) neutral acceptance (five items that measure the extent to which a person views death in a neutral way, neither welcoming nor fearing death). Each subscale was scored individually by adding the respondents' scores on each of the items and then dividing the total by the number of items in that subscale.

To assess reliability of the DAP-R, Wong et al. (1994) computed alpha coefficients of internal consistency and four-week test-retest coefficients (n = 90) of stability. The alpha coefficients ranged from a low of 0.65 in neutral acceptance to a high of 0.97 in approach acceptance. The four-week test-retest coefficients of stability ranged from a low of 0.61 in death avoidance to a high of 0.95 in approach acceptance. When taken together, the DAP-R demonstrated acceptable reliability.

Data Analysis

Descriptive statistics of the sample and measures that were computed included frequencies, means, and reliability estimates. Bivariate correlations were used to examine relationships among the demographic variables (i.e., gender, age, race, religious affiliation, level of education, years of nursing experience, and contact with terminally ill or dying patients)

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and scores on the FATCOD and DAP-R. Data were analyzed using SPSS® (SPSS Inc., Chicago, IL) Base 11 software, and the level of significance for each test was preset at 0.05.

Results

Participants

The participants in this sample (58 RNs) were predominately female (98%), with a mean age of approximately 41 years (see Table 1). The majority of the nurses was white and married, and approximately one half of the sample was Catholic. Forty-five percent of the participants documented that attending religious services was very important, 43% watched or listened to religious or spiritual programs on television or radio, and 83% had a place of worship. Half (50%) of the nurses reported having a place of worship that they attended weekly (see Table 2).

Regarding level of education, 47% had a bachelor of science in nursing degree, 43% had an associate's degree, 7% had a nursing diploma, and 2% had a master's level degree. Seventy-four percent of the sample had no additional nursing credentials, certifications, or degrees.

Lastly, the majority of the participants reported that they received previous educational training on death and dying through continuing education units, hospital in-service training, or basic nursing courses. However, 69% of the sample felt that their nursing education did not adequately prepare them to deal with death and dying.

Table 1. Background Characteristics of the Sample

Variable	n	%
Age (years)		
$\bar{X}$ = 40.8	–	–
SD = 9.0	–	–
Range = 25.9–57.9	–	–
Race		
White	44	76
Nonwhite	13	22
Did not respond	1	2
Marital status		
Married	43	74
Divorced or separated	9	16
Never married	5	9
Did not respond	1	2
Education		
Bachelor of science in nursing degree	27	47
Associate degree in nursing	25	43
Diploma	4	7
Master's degree	1	2
Did not respond	1	2
Credentials		
None	43	74
OCN®	10	17
Other	5	9
Care unit		
Medical-surgical	33	57
Oncology	25	43
Death education		
CEUs	23	40
BT	18	31
BT, CEUs	9	16
C, CEUs	3	5
C	2	3
BT, C	1	2
BT, C, CEUs	1	2
None	1	2

N = 58

BT—basic training; C—courses; CEUs—continuing education units

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

Table 2. Summary of Religious Variables and Religiosity Index

Variable	n	%
Religion		
Catholic	28	48
Protestant	21	36
Other	4	7
None	5	9
Importance of religious services		
Very important	26	45
Somewhat important	21	36
Not very important	4	7
Not important	5	9
Did not respond	2	3
Watch or listen to spiritual programs		
Yes	25	43
No	33	57
Place of worship		
Yes	48	83
No	10	17
Attendance		
Daily	2	3
Once per week	29	50
Once per month	10	17
Few times per year	7	12
Never	5	9
Did not respond	5	9
Religiosity index		
$\bar{X}$ = 5.24	–	–
SD = 1.14	–	–
Range = 0–8	–	–

N = 58

Descriptive Findings

Descriptive analyses were computed on the FATCOD and DAP-R subscales. The FATCOD was designed to measure nurses' attitudes regarding various issues associated with providing care to dying patients (see Table 3). Higher scores on the FATCOD are indicative of more positive attitudes about providing care for dying patients. On average, most participants demonstrated a positive attitude about providing care for dying patients ($\bar{X}$ = 130, SD = 12.7, range = 77–150). In addition, nurses in this study reported that providing care and emotional support should be given not only to dying patients but also their families. They further acknowledged that educating and preparing individuals for death are important. The nurses were not hesitant to develop relationships with dying patients.

On average, most participants did not have a fear of death and talking about life after death did not disturb them. The

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Table 3. Frommelt Attitudes Toward Care of the Dying Scale Scores

Scale Item	Cronbach's Alpha	$\bar{X}$[a]	SD
Frommelt Attitudes Toward Care of the Dying Scale	0.71	130.00	12.70
1. Giving nursing care to the dying person is a worthwhile learning experience.		4.52	0.86
2. Death is not the worst thing that can happen to a person.		4.09	1.10
3. I would be uncomfortable talking about impending death with the dying person.		2.24	1.20
4. Nursing care for the patient's family should continue throughout the period of grief and bereavement.		4.41	0.84
5. I would not want to be assigned to care for a dying person.		1.45	0.73
6. The nurse should not be the one to talk about death with the dying person.		1.74	0.88
7. The length of time required to give nursing care to a dying person would frustrate me.		1.81	0.98
8. I would be upset when the dying person I was caring for gave up hope of getting better.		1.95	0.10
9. It is difficult to form a close relationship with the family of a dying person.		1.53	0.68
10. There are times when death is welcomed by the dying person.		4.38	1.10
11. When a patient asks, "Nurse, am I dying?" I think it is best to change the subject to something cheerful.		1.43	0.62
12. The family should be involved in the physical care of the dying person.		4.00	1.10
13. I would hope the person I am caring for dies when I am not present.		1.98	0.95
14. I am afraid to become friends with a dying patient.		1.64	0.85
15. I would feel like running away when the person actually died.		1.57	0.75
16. Families need emotional support to accept the behavior changes of the dying person.		4.64	0.67
17. Families should be concerned about helping their dying member make the best of his or her remaining life.		4.16	1.00
18. The dying person should not be allowed to make decisions about his or her physical care.		1.31	0.86
19. Families should maintain as normal an environment as possible for their dying member.		4.02	1.00
20. It is beneficial for the dying person to verbalize his or her feelings.		4.64	0.83
21. Nursing care should extend to the family of the dying person.		4.55	0.86
22. Nurses should permit dying people to have flexible visiting schedules.		4.70	0.80
23. The dying person and his or her family should be the in charge decision makers.		4.41	0.92
24. Addiction to pain-relieving medication should not be a nursing concern when dealing with a dying person.		4.40	1.20
25. I would be uncomfortable if I entered the room of a terminally ill person and found him or her crying.		2.05	1.20
26. Dying people should be given honest answers about their conditions.		4.43	0.99
27. Educating families about death and dying is not a nursing responsibility.		1.38	0.52
28. Family members who stay close to a dying person often interfere with the professional's job with the patient.		2.19	1.10
29. It is possible for nurses to help patients prepare for death.		4.43	0.78
30. As a patient nears death, the nurse should withdraw from his or her involvement with the patient.		1.34	0.72

N = 58

[a] Total possible range = 30–150; individual item range = 1–5

prospect of the their own deaths, however, moderately aroused their anxiety (see Table 4). Nurses reported, on average, that death was not a subject to be avoided and they moderately accepted death as a reality in a neutral way. These nurses viewed death as a natural aspect of life and considered death as neither good nor bad. Participants disagreed that death provided an escape from this world; however, the nurses viewed death as a deliverance from pain and suffering. Finally, the nurses reported looking forward to life after death and believed that they would be in heaven after they died.

Bivariate Analysis

Results of this study found no significant relationships between the nurses' attitudes toward death (e.g., DAP-R subscales) and their attitudes toward caring for dying patients (e.g., FATCOD Scale). However, nurses who reported spending a higher percentage of time in contact with terminally ill or dying patients reported more positive attitudes about caring for dying patients than nurses who spent a lower percentage of time with terminally ill or dying patients (see Table 5). Other significant findings were found among certain demographic variables and the DAP-R subscales.

For example, older nurses viewed death as an opportunity to escape from a painful existence (escape acceptance) and accepted death as a reality in a neutral way (neutral acceptance) more often than younger nurses. Nonwhite nurses reported higher levels of internal religiosity and neither welcomed nor feared death (neutral acceptance) more often than white nurses. Nurses who scored higher on the religiosity index reported spending less time with terminally ill or dying patients than nurses who scored lower on the religiosity index. Nurses with higher levels of education and greater months of experience reported having more death education and training than nurses with lower levels of education and less experience.

Further significant findings were found between the DAP-R subscales. Nurses who viewed death as an opportunity to escape from a painful existence reported more years of nursing experience, accepted death as a reality in a neutral way, viewed death as the entry point to a happy afterlife (approach acceptance), and had lower levels of negative thoughts and feelings about death (fear of death) than nurses who did not view death as an escape. Nurses who reported more negative thoughts and feeling about death were more likely to avoid thinking about death (death avoidance) and did not view death

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Table 4. Death Attitude Profile–Revised Scores by Subscale

Scale Item	Cronbach's Alpha	$\bar{X}$	SD
Fear of death	0.78	3.77	0.96
1. Death is no doubt a grim experience.		4.29	1.85
2. The prospect of my own death arouses anxiety in me.		4.66	1.80
3. I am disturbed by the finality of death.		3.16	1.90
4. I have an intense fear of death.		2.66	1.50
5. The subject of life after death troubles me greatly.		2.35	1.40
6. The fact that death will mean the end of everything as I know it frightens me.		3.52	1.80
7. The uncertainty of not knowing what happens after death worries me.		3.65	2.00
Death avoidance	0.87	2.53	1.20
1. I avoid death thoughts at all costs.		2.44	1.30
2. Whenever the thought of death enters my mind, I try to push it away.		2.84	1.60
3. I always try not to think about death.		2.88	1.60
4. I avoid thinking about death all together.		2.34	1.30
5. I try to have nothing to do with the subject of death.		2.12	1.10
Neutral acceptance	0.42	5.69	0.63
1. Death should be viewed as a natural, undeniable, and unavoidable event.		6.17	0.90
2. Death is a natural aspect of life.		6.52	0.66
3. I would neither fear death nor welcome it.		5.00	1.40
4. Death is simply a part of the process of life.		6.19	1.10
5. Death is neither good nor bad.		4.55	1.50
Escape acceptance	0.76	4.17	1.40
1. Death will bring an end to all my troubles.		3.93	2.30
2. Death provides an escape from this terrible world.		3.12	1.90
3. Death is deliverance from pain and suffering.		5.03	1.80
4. I view death as a relief from earthly suffering.		4.86	1.70
5. I see death as a relief from the burden of this life.		3.88	1.90
Approach acceptance	0.93	5.49	1.10
1. I believe that I will be in heaven after I die.		6.00	1.40
2. Death is an entrance to a place of ultimate satisfaction.		5.36	1.40
3. I believe that heaven will be a much better place than this world.		5.60	1.60
4. Death is a union with God and eternal bliss.		5.91	1.30
5. Death brings a promise of a new and glorious life.		5.53	1.40
6. I look forward to a reunion with my loved ones after I die.		5.62	1.20
7. I see death as a passage to an eternal and blessed place.		5.60	1.30
8. Death offers a wonderful release of the soul.		5.45	1.20
9. One thing that gives me comfort in facing death is my belief in the afterlife.		5.47	1.40
10. I look forward to life after death.		4.63	1.70

N = 58

as an entry point to a happy afterlife more often than nurses with less negative thoughts and feeling about death. Finally, nurses who viewed death as an entry point to a happy afterlife also accepted death as a reality in a neutral way more often than nurses who did not share this view.

Discussion

Similar and disparate findings were found between this pilot study and Rooda et al. (1999). Although the sample was substantially greater in the replicate study, participants in both studies were predominately middle-aged, white females with equal years of nursing practice. A higher percentage of nurses in the pilot study, however, was Catholic and reported having a bachelor's degree. Thus, nurses from the pilot study had a higher level of education.

On average, nurses in both studies reported having very positive attitudes toward providing care for dying patients. Similarly, nurses who had more contact with terminally ill or dying patients also reported more positive attitudes toward providing care for dying patients than nurses with less contact. These findings support other research that found positive relationships between experience and caring for dying patients (Irvin, 2000; Payne et al., 1998; Román et al., 2001; Stoller, 1980). Findings from this study also support Benner's (1984) proposition that practical knowledge learned from professional experience may have influenced how nurses care for patients. Future research studies, however, would have to test this hypothesis using a longitudinal design.

The most intriguing yet disparate finding was that no significant relationships were found between the nurses' feelings about death and their feelings about providing care for terminal or dying patients and their families. On average, the majority of nurses felt strongly that caring and interacting with dying patients and their families were worthwhile and important. These feelings appeared to have no relationship with the

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Table 5. Correlations Between Regression Model Variables

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13
1. Age	1.000												
2. Race	–0.050	1.000											
3. Religiosity index	0.120	0.440**	1.000										
4. Escape acceptance	0.370**	0.090	0.130	1.000									
5. Fear of death	–0.170	0.060	–0.000	–0.330*	1.000								
6. Death avoidance	–0.210	0.250	0.130	–0.060	0.480**	1.000							
7. Neutral acceptance	0.280*	0.320*	0.210	0.350**	–0.170	–0.230	1.000						
8. Approach acceptance	0.110	0.070	0.040	0.560**	–0.420**	–0.010	0.280*	1.000					
9. Level of education	0.000	0.110	0.060	0.190	–0.110	0.140	–0.110	0.220	1.000				
10. Months of experience	0.570**	0.170	0.150	0.340**	–0.200	–0.090	0.230	0.160	0.250	1.000			
11. Death education training	0.050	0.110	–0.020	0.170	–0.220	0.070	–0.010	0.180	0.280*	0.480**	1.000		
12. Care of terminally ill	0.050	–0.130	–0.280*	–0.190	0.200	0.120	0.220	–0.160	–0.060	–0.030	0.100	1.000	
13. FATCOD Scale	0.200	–0.210	–0.140	0.010	–0.140	–0.220	0.180	0.120	–0.180	0.150	0.070	0.270*	1.000

* p = 0.05 level (two-tailed)

** p = 0.01 level (two-tailed)

FATCOD—Frommelt Attitudes Toward Care of the Dying

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nurses' personal feelings concerning death. Most of the nurses reported feeling that death was a part of life and an acceptable means to relieving pain and suffering. Many were undecided about whether they feared death but felt that they did not avoid thinking about it. This finding suggests that regardless of how these nurses felt about death, providing professional and quality care to dying patients and their families was salient. Barriers to providing care to dying patients, however, have been reported. Kirchhoff and Beckstrand (2000) asked critical care nurses to rate the barriers they encountered when providing care to dying patients. Nurses from this study rated family barriers (i.e., lack of understanding regarding life support, not accepting a patient's poor prognosis, angry behaviors, and requesting more life-sustaining treatment against patients' wishes) and a lack of agreement among physicians about care as the most frequently encountered barriers. Nurses reported that providing care to dying patients was not difficult but, rather, having to deal with conflicts that arose between family and physicians was. Similarly, nurses caring for dying residents in a nursing home reported feeling frustrated with doctors' attitudes toward dying patients and organizational restrictions (Irvin, 2000). This nonsignificant finding also may have been related to the small sample size; thus, caution is warranted with its interpretation.

Limitations

Several of the pilot study's limitations warrant consideration. The convenience sample may not be representative of medical-surgical and oncology nurses at large, diminishing the generalizability of the findings. Second, the small sample was fairly homogenous with respect to race and gender, thereby limiting the ability to evaluate differences between nurses of the male gender and other racial backgrounds. Lastly, the sample size of 58 participants may have affected the ability to realize statistical significance.

Conclusions and Implications for Nursing Practice

As the growth of the older adult population continues to increase, the demand for nurses to develop expertise in caring for dying patients also will increase. Results from this study suggest that the more experience that nurses have with dying patients, the more positive the care experience becomes. According to Carper (1978), the more skilled that nurses become in perceiving and empathizing with patients, the more knowledge and understanding will be gained and the care provided to individuals will be enhanced. Although patient care skills may be taught and learned in undergraduate nursing curriculum, comportment, or "being toward death" (Heidegger, 1962; Rittmann et al., 1997), is acquired through practical knowledge (Benner, 1984). By gaining experience, new graduates or novices can move along a continuum toward acquiring practical knowledge that is needed to become expert nurses. This movement includes the use of past experiences and a shift from analytic, rule-based thinking to intuition. According to Stoller (1980), this movement also can include the development of coping strategies and defense mechanisms that can help nurses deal with the anxieties that come with caring for dying patients and their families. Developing continuing education programs that teach effective coping strategies that aim to prevent death anxiety may benefit nurses who have had little experience with dying patients and their families. In addition, identifying barriers that can make caring for dying patients difficult and developing interventions to prevent or eliminate unnecessary death anxiety may make the journey from novice to expert a gratifying and rewarding experience.

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