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THE UNIVERSITY OF ALBERTA

ATTITUDE CHANGE OF STUDENT NURSES TOWARD DEATH AND DYING

by

CECILE BUSHKO

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE

OF MASTER OF EDUCATION

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October 5, 1984

Carolyn Winget
Department of Psychiatry
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Cincinnati, Ohio 45267

Dear Ms. Winget:

I am currently enrolled in a Master of Education program, with the intent of doing my thesis on the effectiveness of the curriculum in a School of Nursing program in teaching death education to nursing students.

I would like to use the questionnaire designed by you, R. Yeaworth and F. Kapp entitled "Understanding the Dying Person and His Family" as the instrument in my study. I located your questionnaire in the Instruments for Measuring Nursing Practice and Other Health Care Variables, edited by Ward and Lindeman, 1979. It lists you as copyright holder, and I am writing to formally seek your permission for its use. On September 28, 1984, I phoned your office and was told that you do grant permission for its use.

Perhaps you could inform me as to why the seventeen questions were not used for scoring, but for "filler." How do they contribute to the questionnaire? — useful in interpreting other results. Not scored because score values were not able to be determined.

I will gladly inform you of the results of my study if you wish.

Sincerely,

Cecile Bushko, Nursing Instructor

Permission granted
10/24/84

THE UNIVERSITY OF ALBERTA

RELEASE FORM

NAME OF AUTHOR: Cecile Bushko

TITLE OF THESIS: Attitude Change of Student Nurses Toward Death and Dying

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FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled ATTITUDE CHANGE OF STUDENT NURSES TOWARD DEATH AND DYING submitted by Cecile Bushko in partial fulfilment of the requirements for the degree of Master of Education.

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Date: September 26, 1986

ABSTRACT

This study examined the changing attitudes toward death and dying of nursing students as they progressed through their studies from program entry to program completion. It was concerned with determining whether attitudes became more positive toward caring for the dying person as the students neared graduation. It was also concerned with determining whether certain variables influenced the attitude change.

The methodology used was the distribution of a questionnaire adapted for this study, the "Questionnaire for Understanding the Dying Person and His Family" by Yeaworth, Kapp and Winget. One thousand and four nursing students from all levels in their diploma programs from three hospital-based Schools of Nursing answered the questionnaire.

Statistical analyses showed that the attitudes of nursing students do become more positive toward caring for the dying patient as they progress in their nursing programs. It was found that level of student, educational preparation, age, and personal experiences with death and dying influence attitudes toward death and dying.

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CHAPTER I

The study was designed to determine to what degree, if any, the attitudes of student nurses change toward death and dying throughout their nursing studies, and to discover if there are any common factors which may influence their attitude change.

Nurses are in the most continuous contact with the hospitalized dying person and that person's family. How nurses view death will influence the type of interaction they have with the dying patient. Nurses must examine their own discomforts and feelings concerning death and make an effort to change their behaviors if they are to be effective in providing care to the dying (Kubler-Ross, 1969; Epstein, 1975). Ross (1978) reported that exploration of one's personal concerns regarding death increases one's ability to respond more openly and to interact more effectively with dying persons and their families.

Research on and evaluation of death attitudes has been neglected as energies have been spent primarily on developing a sound rationale for programs and curriculum development (Wess, 1980). Lester, Getty and Kneisel (1974) and Coolbeth and Sullivan (1984) found that fear of death and dying decreased with increased academic preparation. Yeaworth, Kapp and Winget's (1974) research concerning attitudes of nursing students toward death and the dying patient, indicated an important shift to greater openness and receptivity as a result of studies in death education. Past experiences with death and dying persons also affects one's attitude

toward death (Benoliel, 1982). Student nurses should explore their attitudes and beliefs about death and dying during their studies. They should be aware that feelings influence care, that attitudes may block or facilitate care, even if one is not comfortable with those feelings (Hamric, 1977). Therefore it is important that Schools of Nursing include a comprehensive program in death education as part of the curriculum.

PURPOSE AND RESEARCH QUESTIONS

Purpose

The purpose of the study is to examine attitudes of student nurses toward death and dying, and the degree of attitude change, if any, as the students progress from the beginning to the completion of their nursing program.

Research Questions

1. To what degree do attitudes of the student nurses vary throughout their nursing program?
2. How does cognitive and affective learning in death and dying education influence change in students' attitudes toward death and the dying person?
3. What is the relationship between age and attitudes toward death and the dying person?
4. What is the relationship between personal experiences with death and dying and attitudes toward death and the dying person?
5. To what degree does religion influence attitudes toward death and the dying person?

6. How do the students in the different Schools of Nursing compare on each of the previous questions?

SIGNIFICANCE OF THE STUDY

The study will have value by contributing data to the literature concerning student nurses' attitudes, and change of attitudes, toward death and dying as they progress toward completion of their nursing programs. A review of the literature shows a lack of information pertaining to the development of attitudes of health care workers and student nurses toward death and dying. The study should be of significance to nurse educators to ascertain if their approach to teaching death and dying is effective in changing student attitudes to become more positive for interacting with the dying person. It may stimulate nursing instructors to become more aware of their own attitudes and feelings toward the dying person. Role modeling is an important teaching strategy, and students learn from their instructors' behaviors.

DEFINITION OF TERMS

Cognitive and affective learning is the acquisition of theoretical knowledge on death and dying, and the exploration of the students' feelings and emotions toward death and dying, as a result of the death education content that was presented during their nursing program.

Nursing program is the length of time, from entry until graduation, that a student is enrolled in a specific School of Nursing course of studies learning to become a Registered Nurse.

Personal experience with death and dying is the background of contact with and/or thought about death and the course of dying that a student brings with him/her on entry into the nursing program, and the experience with death and dying persons that one obtains during the practical component of studies.

Attitude is "...a complex, structured psychological tendency to respond in a consistent way to social objects or situations" (Yeaworth et al, 1974, p.20).

ORGANIZATION OF THE THESIS

Chapter I has described the purpose of the study, including the specific research questions, outlined the significance of the study, and included the definition of terms used in the study.

Chapter II contains a detailed review of the literature on attitudes of the graduate nurse and of the student nurse, and how these attitudes relate to the influences of education, age, sex, personal experience and religion on death and dying.

Chapter III describes the sample, the setting, the data collection tool, and the research methodology used to conduct the study.

Chapter IV presents the treatment of the data and a discussion of the findings as they relate to the research questions.

Chapter V provides a summary of the study, as well as the implications and suggestions for further research.

CHAPTER II

REVIEW OF RELATED LITERATURE

A great deal of research has been undertaken which examines attitudes toward death and dying. In this chapter, the following specific areas are examined: (a) attitude formation and change, (b) attitudes and change concerning death, (c) nurses' attitudes toward death and dying, (d) death education and attitudes toward death and dying, (e) personal experiences and attitude toward death and dying, (f) age and attitudes toward death and dying, (g) sex and attitude toward death and dying, and (h) religion and attitude toward death and dying.

Attitude Formation and Change

"Attitudes are learned predispositions to respond to an object or class of objects in a favorable or unfavorable way" (Fishbein, 1967, p.257). An attitude toward an object, person, or situation would include a person's feeling toward the subject, ideas about causes and implications, and the person's subsequent behavior toward it.

Attitudes are learned, enduring, and general, therefore implying that attitudes exist inside a person and exert some control over his overt behavior (Zimbardo & Ebbesen, 1969, p.6). If attitudes are learned, then techniques which are known to increase learning should be implemented in order to produce the desired attitude change. If attitudes are enduring, rather than temporary states, then it should be possible to produce long-lasting changes in attitude behavior. In order to produce lasting change,

underlying attitudes, or values, must be changed (Zimbardo & Ebbesen, 1969 and Reich & Adcock, 1976). Reich and Adcock describe values as standards which help to form positive or negative attitudes, and that values are less specific than attitudes. For instance, if one values "honesty", they may have a negative attitude toward people who do not tell the truth. One may value the quality of life, and therefore have a positive attitude toward caring for dying persons.

If attitudes are general, then they should have more than one component (Zimbardo & Ebbesen, 1969). By influencing the components, changes in attitude, and subsequently changes in behavior, may occur. These components have been divided into affective, cognitive and behavioral. The affective component consists of a person's evaluation or emotional response to an object or situation. The cognitive component is a person's beliefs about, or factual knowledge of an object or situation. The behavioral component involves a person's overt actions toward an object or situation. Techniques which produce change may be used to influence one or all components. To measure change in attitude, the components could be measured by verbal statements of like and dislike - affective; by the amount of knowledge a person has about a topic - cognitive; or by direct observation of how a person behaves in a specific situation - behavioral.

Change is dependent on many factors (Reich & Adcock, 1976). The greater the confidence one has in the change agent and the greater the interest and value one has in the change, the more motivated one is to change and the more enduring will be the change. The change is also more apt to occur if it is reinforced and strengthened by others. Group membership has a strong effect on attitudes and values (Reich & Adcock,

1976). Every group has appropriate behaviors, thoughts and attitudes which group members are expected to share. Little modification in the individual's behavior is necessary if the individual joins the group voluntarily, for example, choosing to work in nursing. Intelligence, personality and persuasibility are also factors which influence receivability of the change.

Attitudes and Change Concerning Death

Values and practices are not always blindly accepted by individuals. They are acted upon, reinterpreted and sometimes transformed through thought and action (Charmaz, 1980). The meanings and actions of individuals affected by death are viewed in relation to the social worlds in which they occur. What death means and how it is handled in everyday life within a social milieu is the basis from which an individual practices and draws his perceptions toward death and dying. If death is viewed as justified, i.e., Worlds Wars 1 & 11, it is acceptable, but if it is not viewed as justified, i.e., accidental or due to illness, then it is viewed as absurd or meaningless.

Values are also shaped by experiences. Death conceptions and individual experiences share a mutual relationship as each influences the other (Charmaz, 1980). Ordinarily death conceptions or beliefs shape experiences, but when the experiences differ radically from earlier conceptions, change can be expected. For example, student nurses, physicians and soldiers may be resocialized into new beliefs about death that make sense of recent experiences. To illustrate this concept, a physician may justify the decision to discontinue life-support to a young person with a projected

poor quality of life, a contradiction to the medical professions' belief that all must be done to sustain life.

Attitudinal changes toward death will not have much impact unless changes are made in the nature of care given to the dying. Society and the total health care profession must not only change their attitudes toward the dying, but must change their behavior toward death and dying is becoming more public as death and the process of dying is receiving more attention from health professionals and society in general, yet the dying are still institutionalized and 'hidden' from view. For change to occur, death must be made real, and viewed as a part of life (Charmaz, 1980).

Nurses' Attitudes Toward Death and Dying

Little is known about the shaping of one's attitude toward death. It is thought that feelings are affected by the death of a close person, and that the closer the relationship, the more acute are the feelings affected (Castronova, 1977). Death means different things to different people, but in our Western Society it shares one common attitude -- fear. Health professionals are a product of a death-fearing and death-denying society. They are educated and trained to preserve life, yet often must work with and care for the dying. While the dying person deserves the health professional's attention, the care-giver's attitude toward death and dying may preclude this attention. Nurses spend more time with the dying person than any other health care professional. Therefore it is very important that nurses have a positive attitude, and that they examine their personal concerns with death and dying if they are to be effective care-givers (Kubler-Ross, 1969).

"How Do You View Death?", a 70-item questionnaire, was published in Nursing magazine. Fifteen thousand four hundred and thirty Canadian and American nurse subscribers (7%) responded (Popoff, 1977). Nurses of differing ages, religions, work areas and years of experience sent in their questionnaires. The average respondent was 26 years old, and a moderately religious Protestant who attended church occasionally. This individual usually worked as a team leader on a medical-surgical ward. Although the percentage return is poor, the high number of respondents may be generally representative of the thoughts and feelings of nurses within the magazine subscriber numbers. This survey also reached many levels of nurses with varying demographics. This study was included in the literature review as there is a paucity of information available on attitudes of graduate nurses toward death and dying, and the questionnaire was judged by the writer to include most relevant issues in this subject.

The study found that those nurses that were less involved in frequency of caring for the dying were more likely to become discouraged and less certain of their ability to care effectively for the terminally ill patient. There was little difference between nurses who were more involved versus those who were less involved with the dying when it came to coming to terms with one's own death. Most felt saddened, depressed and discouraged at some point when working with a dying person. Nurses between the ages of 17 and 22 showed the greatest tendency to feel these emotions, while male nurses were the least likely to do so.

A high percentage of those nurses who had cared for terminally ill patients reported feeling fulfillment and gratification working with the dying. Most received support from the patient. Confidence in their

ability to meet the psychological and physical needs of patients lead to personal satisfaction with work. Nurses who did not experience satisfaction in caring for the terminally ill had difficulty dealing with families of the dying and talking about dying with the patients. The majority of respondents identified caring for dying children, adolescents and mothers of small children as the most difficult times to come to terms with their own feelings about death. Other findings were: that 26% said nurses tended to avoid call lights of terminally ill patients, 77% agreed that priority care should be given to the dying but not at the expense of other patients, 60% felt that patients should be told they have a terminal illness at the time of diagnosis, 21% said patients should be told only when they ask, and 67% were relieved when patients broached the topic of impending death as opposed to ignoring it. Eighty-five percent of the nurses wrote that it was very difficult to care for patients when the patients had not been told they have a terminal illness. An overwhelming majority agreed that a patient has the right to refuse treatment, but very few believed in active euthanasia. In response to the question on withholding life-sustaining treatments at the request of the patient and/or family, one nurse wrote that "...it was frustrating not to have our I.V.'s, our medications, to satisfy our needs to do something." (p.173).

In summary, one could conclude from Popoff's study that working with the terminally ill can be a satisfying experience, and that the nurses' emotional discomfort may be dependent on the situation and on the attitude of the patient.

Other studies have been done on nursing attitudes toward death and dying. Quint (1966) claimed that nurses had a general distaste for death,

that they withdrew from talking openly with patients about the process of death and put emphasis on technical skills to mask the presence of death in order to protect themselves. This assertion is in contrast with Popoff's findings that most nurses found that working with dying persons could be a satisfying experience. Given that nine years exists between Popoff's and Quint's studies, the difference may be due to the growing acknowledgement that the dying have special needs, and death education courses are being implemented to meet this demand. In a study to find if nurses spend more/less time with dying patients versus non-dying patients, and to find if this time was utilised differently with the different patient groups, Keck (1977) found that nurses spend more time meeting the emotional needs of the very ill and of the terminally ill. Keck concluded this was so as non-dying patients are better able to communicate their needs than are the dying patients, thereby needing less of the nurses' time. Generally, nurses frequently encountering terminally ill patients did not think about working in another environment (Hogatt & Spilka, 1978-79). Two-thirds of the 162 surveyed said that they were not influenced whether they would be caring for dying patients when seeking employment, but 30% did state their choice was "somewhat" affected. An explanation was not given as to the meaning of "somewhat", and whether the choice was more positively or negatively affected. Therefore the conclusion of the study was that caring for the terminally ill did not appear too disturbing.

Studies, although very limited in number, on student nurses' attitudes have also been researched. Quint (1967) found that student nurses are embarrassed by patients who ask if they are dying. Conversation is most difficult when patients do not know their diagnosis and/or prognosis.

Quint also found that students preferred short clinical assignments so that they were not as likely to become involved with the patient who was dying.

Castronova (1977) investigated the attitudes of senior students to ascertain if the nursing education of a specific nursing school program instilled a positive attitude toward death and dying in its' students. Senior students were chosen for the study to increase the likelihood that all had cared for a dying patient. One-hundred and thirty-four of a possible three-hundred, or 45%, of the students responded. The students thought that the clinical assignment was the best method of learning to care for the terminally ill person, that more emphasis should be placed in the curriculum on introducing topics and questions that the dying may ask, and that caring for a dying patient should occur early in the nursing program. All students agreed that providing support to the patient and family caused the most difficulty, particularly if the patient had not been told his prognosis. The majority of the students had a positive attitude toward caring for the dying, and the more experience they had in caring for the terminally ill, the more positive their attitude became. Most did not feel that they had come to terms with fear of dying, but agreed that the process of dying was more fearful than death itself. The majority felt that the dying process can be a growth experience for the patient and nurse. As with the Quint and Popoff graduate nurses findings, a similar time difference also exists between the student nurses in Quint's 1967 and Castronova's 1977 studies. The students of the more recent study have a more positive attitude toward working with dying patients, again perhaps

because of the increasing emphasis on death and dying education in Schools of Nursing curriculums.

Patrylow (Ward & Lindeman, 1979) designed a study to determine if "person-oriented" or "nonperson-oriented" nursing students had a more favorable attitude toward caring for the dying. It was found that those students who were sensitive to psychological needs and felt reasonably competent with interpersonal techniques, more "person-oriented", were more positive in caring for the dying. In a study designed to investigate whether final year baccalaureate nursing students had concerns about nursing dying patients, emotional support for the grieving family and for the patient were identified as being the most problematic for the student (Milton, 1984). Other concerns were: provision of post-mortem care; psychological effects upon the student, feelings of grief, loss, personal involvement with the dying; maintenance of composure and provision of physical care to the dying patient.

Death Education and Attitudes Toward Death and Dying

The aim of death education programs is to bring about comfort with death and dying phenomena and with death and dying as a personal reality. Death education stresses understanding mortality (Sinacore, 1981). Health education places emphasis on treating diseases, in curing, and is in conflict with caring for the terminally ill patient who has special needs. The literature maintains that attitudes toward and awareness of feelings about death and dying, directly affect the nurse practitioner's ability to relate to and effectively care for the dying patient and family. To help nurses feel more secure and comfortable working with the terminally ill,

nursing education should include instruction on death and working with the dying (Hoggatt & Spilka, 1978-79).

Whereas there has been much written on death and dying, little has been devoted to the attitudes of health professionals and how these attitudes may affect the treatment of terminally ill patients. Most of this literature focuses on the effects of death education and its affect on the participants of the specific educational programs.

Kubler-Ross (1969), in conducting a workshop for graduate nurses on death and dying, concluded that many nurses felt a lack of training in the area of talking with the terminally ill and their families and in understanding the special needs of the dying. At completion of the workshop, the participants felt they understood the reasons for their feelings and how to work with the terminally ill as suffering human beings with special needs. The nurses attending the seminar experienced a gradual positive attitude change toward the dying patient and toward understanding their personal feelings toward death.

Laube (1971) conducted a two-day workshop on death and dying to determine if the seminar decreased the anxiety of the attending graduate nurses. The results showed no significant change immediately following the workshop, but did show a significant decrease one month and three months later. This is in contrast to Murray (1974) who conducted a 6-week course on reducing death anxiety. A test of death anxiety four weeks into the course found a significant decrease, but this decrease was not maintained when the graduate nurses attending the course were tested again at completion of the program. Murray concluded that death anxiety is not a fixed entity, but is senstive to environmental and therapeutic

interventions. The conclusion was based on the premise that the attendees had a chance to apply the information in their work setting and had time to contemplate their feelings and attitudes toward death.

A wealth of information is thought to improve the ability of nurses to treat and care for the dying. Yet information is only the beginning of the wisdom and skills needed to care for the dying patient. Before one can use the information, a therapeutic link must be made between the nurse and the patient (Quint, 1967). This link can be fashioned out of involvement in the processes that help students to anticipate their own reactions and reactions to others, to handle questions and solutions to problems, and thus ensure that students have something to choose from when placed in related situations. It is not fair to the students or to the patients if the students have a background of only required readings to begin the interactive process with the dying patient. Many answers can be found in experiences with the participants themselves. Trial and error may happen as one starts to learn on the job, but errors hurt, and are unfair to patients who are victims of repetitious errors. This learning process can begin in the classroom under trained instructors using a curriculum developed for instruction in death and caring for the dying (Quint, 1967).

Often students first confrontation with death is in the classroom (Wise, 1974). Not all students get to care for a dying patient during their nursing program; therefore the classroom must suffice and give students what is needed in order to care effectively for the patient. Wise tested the junior class of a university nursing program two months and 24 months after they received classes in death and dying. Ninety percent of the class stated that they were able to give better care to the dying

patient because of the classes. They stated that they were more able to cope with their own fears of dying and death, felt more acceptance for the dying, and knew more specific ways to interact with and care for the dying. One student stated "I feel that I can relate better to dying patients. I can now give care and not reject the patient to protect my own feelings." Another shared that "Because of classes on death, my attitude about patients is less fearful. I would never avoid a dying patient now" (Wise, 1974, p.44).

Yeaworth, Kapp and Winget (1974) measured the attitudes of freshmen and senior nursing students toward death and the dying patient. All of the participants had enrolled in a program designed to shape attitudes toward working with dying patients and their families. The results showed that important shifts in attitudes toward death and dying did occur. Senior student responses indicated greater acceptance of attitudes toward the terminally ill. Although the study did not attempt to attribute these changes to the death education classes or to the professional socialization that may have occurred to the senior students as they progressed through their nursing program, the seniors did indicate that they believed their professional education had positively influenced their attitudes. Bailey (1976) also found that instruction in death and dying education did make a positive difference in students' attitudes, and that these attitudes were sustained over a six-week period.

Campbell (1977) completed a study to determine if any signficant change in attitude toward death and dying occurred as a result of the nursing education process in an associate degree program of a nursing school. No significant differences in attitude were found to exist between

freshmen, graduating sophomores and graduate associate degree nurses, but a significant difference was found to exist in fear of dying of self. Freshmen were found to have the lowest anxiety in terms of fear of dying of self, while sophomores had the highest. As the freshman class did not have any clinical experience in caring for the dying, it was concluded that personal experiences did influence attitude toward death.

Snyder, Gertler and Ferneau (1973) tested the effectiveness of classroom and clinical experiences to change attitudes toward death and dying, by measuring the changes in attitudes between first-year and third-year students in a hospital-based School of Nursing program. It was found that first-year students suffered overwhelming fears of real and imagined failure about caring for the dying patient. Classes and clinical experiences in subsequent years reinforced the students' ability to cope with the complexities of caring for the dying and therefore decreased the students' fears. Similarly, Lester, Getty and Kneisl (1974), Robinson (1974), Miles (1977) and Swain and Cowles (1982) found that fear of death and caring for the dying decreased with increased academic preparation.

Not all studies have suggested a positive attitudinal change in nursing students as a result of death education in the classroom. Hopping (1977) found no significant differences between the study group of 20 senior students who were enrolled in a course which addressed death and dying, and a control group of 20 senior students who had not participated in the course.

Personal Experiences and Attitudes Toward Death and Dying

It is difficult to separate the influences of classroom and of work experience in the formation of attitudes toward death and dying persons

and their significant others. Professional socialization and personal (non-work) experiences with death and dying are other influences to be considered as contributing to attitude formation.

In a study addressing years of work experience and uneasiness with death, nurses were asked to report the degree of uneasiness they felt in a variety of work situations that involved the dying. Stoller (1980), found that uneasiness with death increased with increased work experience. Similarly, Denton and Wisenbaker (1977) found that graduate nurses had higher death anxiety than student nurses. From this finding they concluded that nurses with more work experience appeared to have higher death anxiety levels than those nurses with less work experience. Schifferle (1975) conducted a study of physicians' and nurses' attitudes toward the dying patient. The findings showed that years of experience in the medical and nursing occupation did not produce a positive attitude toward the terminally ill.

Golub and Reznikoff (1971) suggest that "...attitudinal changes are probably the result of an identification process in which the student nurse assumes the expected attitudes of her reference group and role models, the professional nurses" (p.507). This conclusion was based on a study of graduate nurses with differing years of work experience who worked in different nursing specialties and therefore encountered differing numbers of dying patients; for example, the school nurse who encounters almost no death at work and the intensive care nurse who is exposed to death daily. The authors found a surprising lack of difference in attitude among the graduate nurses, regardless of number of nursing years, but which differed significantly from that of the student nurses. Those students who

responded "undecided or don't know" to certain questions in the study were seen as likely to acquire attitudes similar to graduate nurses upon completion of their studies. Therefore it would seem likely that attitude formation occurred early in the nursing years, and probably during the student years (Golub & Reznikoff, 1971; Quint, 1967). Hoggatt and Spilka (1978-79) also found that graduate nurses felt that their profession shaped their attitudes toward death and dying to a greater degree than did their nursing education or work experience.

In contrast to the findings that graduate nurses felt more death anxiety the more often they worked with dying patients, Martin and Collier (1975), and Castronova (1977) found that the more student nurses cared for the dying, the more positive their attitude became to death and dying. Students still felt anxiety working with the dying, but not enough to not want to care for the dying patient. In her study, Castronova found that 73 percent of the students would like to care for the patient along with a staff nurse they could learn from and receive support. She also found that the effects from experiences with death that the students had prior to entering nursing were nonconclusive. In a study to determine if direct contact with dying patients had any effect on baccalaureate nursing students, Schrock and Swanson (1981) found that the students fear of death and dying was modified, but it was not known if the change was a positive or a negative change. The researchers did tend to think that the modification was a positive attitudinal change for the following reasons: fear decreases when "unknowns become known," the caregiver may realize that all was done to maintain the life and attain a peaceful death, and that a

decrease in the expression of fear could be due to increased use of coping mechanisms.

Age and Attitudes Toward Death and Dying

Little information is available on death attitudes and age, and even less is available on death attitudes, age and health professionals. Whether age influences attitudes toward death and dying remains controversial (Janz, 1983).

Age was found to be a factor in doctors' attitudes (Caty, Downs-Wamboldt & Tamlyn, 1982). Young doctors tended to consider death an "...outrage - to deny its inevitability": They used more measures to delay death (p.20). Middle-aged doctors tended to accept death more readily but remained detached emotionally. Older doctors seemed to accept death best. The researchers concluded that the difference in attitudes may reflect additional professional experience.

Kahana and Kahana, (1972) found that age did not appear to be an important factor as related to differences in death attitudes; Campbell (1976) and Shusterman and Sechrest (1973) concur.

In a study initiated to gain more knowledge about nurses abilities to face death, Ross (1978) examined graduate and practical nurses' responses to dying patient statements. The statements were selected from statements nurses and chaplains had difficulty responding to in interactions with terminally ill patients. It was found that younger subjects had the lowest death concern. This was thought to be so as younger nurses have become more familiar with their personal death concerns because of recent curriculum additions on death and dying and other exposure via the media. Ross questioned if younger nurses more freely

admitted to feelings about death then did older nurses who may not have had the theoretical exposure. He also speculated if perhaps older individuals had a greater concern with death since it is more likely to occur sooner to them than to the young.

Popoff's (1975) study found the following regarding age and care of the dying: 59 percent of the 17 to 22 year old nurses found themselves uncomfortable when caring for the dying young adult; nurses over 50 years were most likely to be uncomfortable caring for the dying mother or father of a young family; and no difference in age and comfort was identified when caring for the middle-aged and elderly person. Nurses under 28 years tended to be somewhat more uncomfortable caring for the elderly dying patient. Age also influenced attitude in that 57 percent of nurses over age 40 felt relieved when patients introduced the subject of their death, but nurses between 17 and 22 years felt uncomfortable and anxious when this happened. Two-thirds of the respondents over age 35 had come to terms with the inevitability of their own death. Perhaps this supports why older nurses were less uncomfortable than younger nurses when patients introduced the topic of their death.

Sex and Attitudes Toward Death

In searching the literature for sex and attitude toward death among nurses, few references were found in this specific area. Chandler (1980) also found this to be so. This may be due to the fact that there are few numbers of male nurses and comparison would be difficult for establishing significant statistics.

What literature was found on death attitudes and sex concerned non-health care workers. Lester (1972) found that males and females

expressed an equal fear of death anxiety, but that females scored slightly higher in the specific fears of death of self and death of others. No differences in death attitude between the sexes were found to exist in the studies completed by Kalish and Reynolds (1977), Janz (1983) or Kahana and Kahana (1972).

Religion and Attitudes Toward Death

Information on nursing, religion and death attitudes is very scarce. Information on the influence of religion and non-nursing personnel is more available in the literature.

Of the 15,000 nurses responding to Popoff's (1975) questionnaire, 51% were Protestant, 35% were Catholic, 2% were Jewish, 6% were Other and 6% had No Religion. Twelve percent rated themselves as very religious, 55% considered themselves moderately religious, 23% were slightly religious, 9% were not at all religious and 1% were anti-religious. The majority of nurses believed in some form of life after death. Very religious nurses and those believing in a continued existence after death, were more likely to have come to terms with the fear of their own death. Nurses who had experienced a near-death situation themselves, were now less anxious and less uncomfortable when discussing death with terminally ill patients and dealing with families of the dying. It was also found that more religious nurses were less in favor of euthanasia and of withholding treatment at the dying patient's request than were less religious nurses.

Religion does appear to play an important role in attitude formation as one-third of the nurses answering the survey stated that religious teachings had the greatest influence in shaping their present attitudes toward death and dying (Popoff, 1975). Students in Castronova's (1976) study,

identified religion and/or philosophy of life as important for helping them cope with death and dying more effectively.

In summarizing the review of the literature, it is apparent that little information exists as to the influence of age, sex and religion on attitudes toward death and dying and nursing personnel. Literature on death education is more prevalent as medical and nursing educators have come to realize the benefits of courses in the subject of death and dying. Personal and work experience with dying persons are also known to affect the attitudes of nursing students and other health care personnel.

Interest and studies in death and dying as it relates to nursing is relatively recent. The pioneering work of Kubler-Ross in that late 1960's brought the subject to the attention of health care workers and to the public. Around this same time period, Quint-Benoliel became a forerunner in preparing nurses to meet the challenge of providing effective care to dying persons and their families.

CHAPTER III

METHODOLOGY

This chapter outlines the research design and the procedures used in the study. The chapter begins with a description of the study setting and sample. This will be followed by a discussion of the research instrument used to gather the data, the methodology and the treatment of the data. The final section will discuss the delimitations, assumptions and limitations of the design.

THE STUDY SETTING AND SAMPLE

Study Setting

The setting for the study is the three hospital-based Schools of Nursing in Edmonton. The Schools draw their students from all of Alberta, although mainly from the northern and central areas, and minimally from other provinces and countries. Many of the beginning students are classified as adult learners, over age 21. Many enter with varying work experiences, for example registered nursing assistants, ambulance drivers, mothers with children, and many have left other careers or educational institutions to enter the nursing programs. The three Schools of Nursing have individual curricula but similar nursing content. In order to qualify for registration, all students write a common examination which is prepared and administered by the Canadian Nurses Association. The individual program lengths vary within a few months of one another.

The Sample

The sample for the study is the total population of nursing students enrolled in various levels and time periods in their programs in the Schools of Nursing. Figure 1 depicts this information. By surveying the total population, data was collected from students with differing levels of nursing education, varying personal and clinical experiences, religious affiliations, sex and age. The large sample also increases the validity of the study when uncontrollable variables are present, for example, experiences with death, and allows for generalization to a population involved in a time period (program entry to program completion) study.

The sample identified for the study consisted of the following:

1. Hospital 'A' School of Nursing
   (a) Ninety first year students on their second day into the nursing program,
   (b) Seventy-three junior nursing students who had nearly completed their first year of the program,
   (c) Thirty-nine intermediate students before completing a day of lectures in death and dying and midway through their second year of nursing studies,
   (d) Thirty-six intermediate students immediately after completing their lectures in death and dying and also midway through their second year of nursing studies, and
   (e) Fifty-one senior students with two months remaining until program completion.

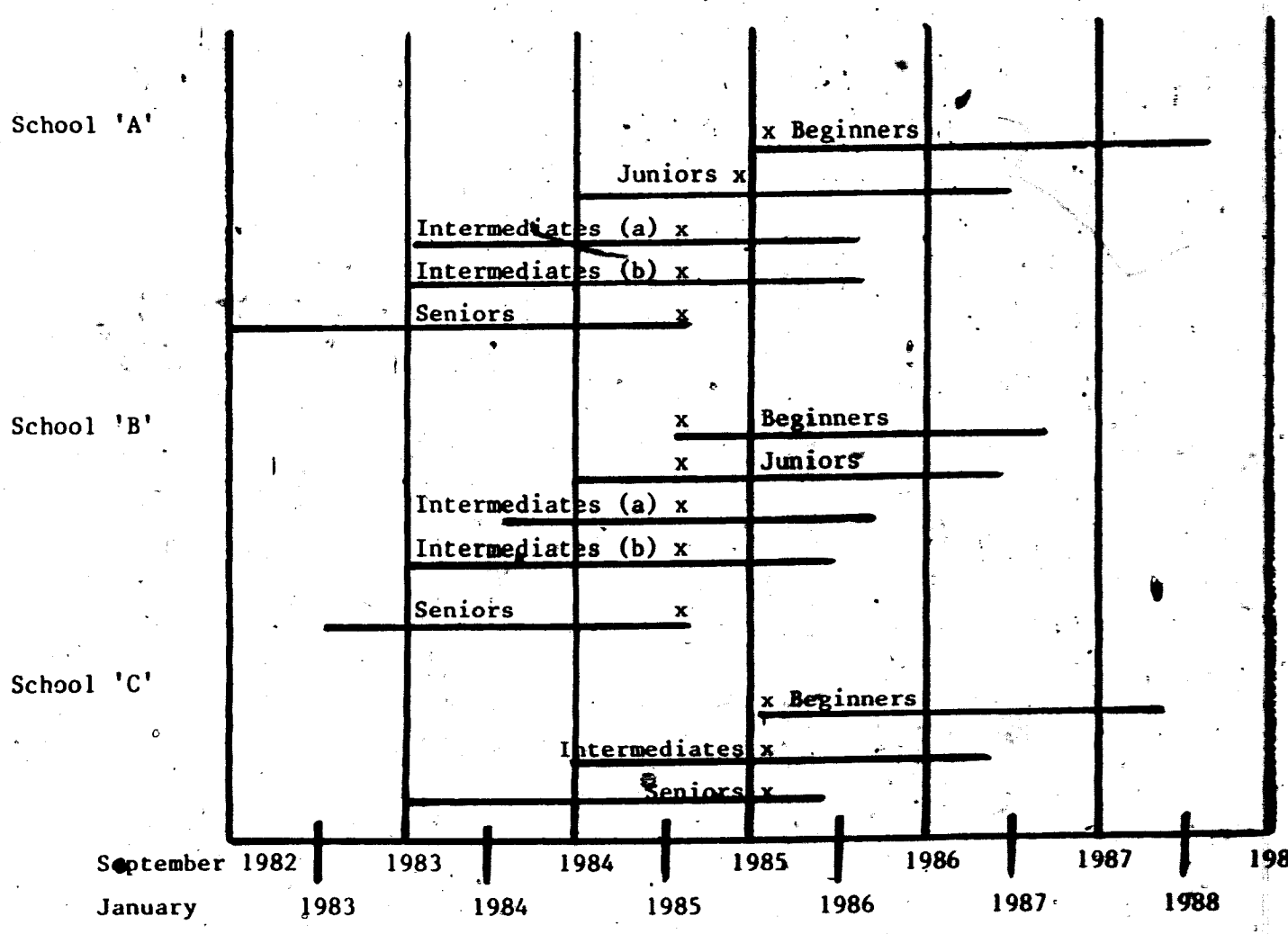

Figure 1. Time Line of Program Length from Entry to Graduation of Individual Classes from the Three Schools of Nursing

x - time in program questionnaires completed

2. Hospital 'B' School of Nursing

   (a) Eighty-two beginning students in their second month of the program,

   (b) Eighty-four junior students six months into their program, and with minimal clinical experience,

   (c) Sixty-eight intermediate students nearly a year into their program, and with no specific lectures in death and dying,

   (d) Seventy-five intermediate students more than half-way into their program and with lectures in death and dying, and

   (e) Eighty senior students with two months left until program completion.

3. Hospital 'C' School of Nursing

   (a) One hundred and twenty first year students well into their second month of studies,

   (b) One hundred and twenty-one intermediate students midway through their studies and with lectures in death and dying completed, and

   (c) Eighty-five third year students with less than one month left in their program.

RESEARCH INSTRUMENT

In reviewing the literature for a questionnaire to use as the measurement tool in this study, a lack of reliable and available instruments was obvious. Measures of death anxiety and death fear scales had been designed and used on health and nonhealth care personnel, for example,

the "Death Anxiety Scale" by Templer (1970) and "You and Death" by Shneidman (1970). These data collection tools were not chosen for use in this study as they did not address attitudes directed to caring for dying persons. Many other measures were designed specifically for purposes of a particular study.

Yeaworth, Kapp and Winget (1974) developed the "Questionnaire - Understanding the Dying Person and His Family" for a study measuring attitudinal and experiential data on death and dying of freshmen and senior baccalaureate nursing students. Attitudes toward death and dying were assessed in terms of greater acceptance of feelings, flexibility in interpersonal relations and desire for open communication about critical issues in relation to dying patients and their families. Experiences with death and dying included death-associated events in one's personal and work life.

Description of Original Instrument

The Yeaworth et al measurement tool was chosen as the attitude measurement tool for this study for the following reasons:

1. It appeared to have face validity. The measurement tool was identified as containing face validity by a nursing specialist in death and dying, and by a psychologist who had extensive expertise in this field;
2. Questions addressed death and dying from the perspective of self, of the care-giver and of the dying person and family, criteria that was significant to this study;

3. Many of the questions included family situations. Dealing effectively with the family of the dying has been identified in the literature as problematic for many nurses and health care workers;
4. As the scoring was reversed for some items, for example "strongly agree" could be counted as 1 or 5, it decreased the chances that the respondent was choosing the expected answer; and
5. The Likert scale has been widely used for attitude measurement. It can be summed to yield an individual score if desired.

The measurement tool consists of three sections. Part I contains 50 Likert-type items that are answered using a 5-point scale (strongly disagree to strongly agree). Thirty-three of the items contribute to the total score which determines if the attitude is flexible and open to caring for dying patients (low score), or if the attitude is rigid, focuses on the physical aspects of care and lacks insight into psychological factors which influence self and others (high score). Items were constructed "...to minimize the 'halo effect' in responding by using both negatively and positively worded questions on similar content" (Yeaworth et al, 1974, p.21). Part II consists of a combination of closed and open-ended questions toward personal and professional experiences; for example, "Have you ever been asked to talk to a person who is dying?" and, "If you answered yes to the above, please explain." Part III gathers demographic information about the respondent. The original instrument appears in Appendix A.

The original study showed discriminant validity of t=8.69 for mean scores ($p<0.001$). Internal consistency measured after a group of sophomore and senior students completed the questionnaire was found to have an alpha coefficient of 0.72 (Ward & Lindeman, 1979). Construct validity was assessed by administering the questionnaire, the Rotter I-E Scale and the Defense Mechanisms Inventory (DMI) to students enrolled in a death and dying evening course. Those students who had low scores on the questionnaire also had comparable scores on the DMI and Rotter I-E Scale. The DMI is designed to measure an individual's typical coping behavior to a number of conflict situations. It was found that similar patterns of behavior emerge when coping with conflict (Gleser & Sacks, 1973). The Rotter I-E Scale provides an index of conflict or maladjustment in a situation. A high score indicates increased conflict (Lefcourt & Rotter, 1981).

Statistical results from the original study showed that the freshmen class (N=108) had a mean score of 78.68, range of 57-98 and standard deviation of 8.52. The senior class (N=69) showed a mean score of 67.77, range of 51-83 and a standard deviation of 7.61. A significant difference ($p<.001$) between freshmen and seniors was reported; the freshmen were found to have a more rigid and less open attitude than the senior students toward death and caring for the dying.

Schifferle (1975) used this data collection tool to compare the attitudes of physicians and nurses as related to their education in and working experiences with care of the dying. Two hundred and eighty-four nurses and 121 physicians responded to the questionnaire "For Understanding the Dying Person and His Family." When comparing the 30 physicians and 124 nurses that were educated in care of the dying with the

group that had not received any special education in care of dying patients, significant differences were found between the educated and non-educated doctors and nurses in attitude score ($p < .05$). The findings also showed that those with high scores showing rigidity and inflexibility toward issues when caring for the dying person, also had the greatest number of years of practical experience. Therefore it was concluded that years of experience do not produce more flexible attitudes ($p < .05$). It was also found that those physicians and nurses educated in care of the dying and with many years of experience, did not differ significantly from doctors and nurses without the special education, but with similar numbers of years of work experience ($p < .05$). It was concluded that years of experience do influence attitudes toward death and dying, and that this may preclude any advantage received from educational preparation in death and dying.

It would appear that the Winget et al questionnaire was effective in the research study completed by Schifferle. Difficulties with use of the questionnaire, or with its effectiveness to the research, were not identified in the study.

Adaptation of Instrument for Present Study

This study is an expansion of Yeaworth, Kapp and Winget's (1974) original research which measured the attitudes toward death and dying persons and their families of an American University class of freshmen and class of seniors in a baccalaureate nursing program. The present study was expanded to include junior and intermediate nursing students as well as freshmen and senior students. A few minor revisions were made to the original questionnaire design. Additional questions were added and some

deleted in the demographic and personal experiences with death and dying persons sections of the questionnaire. For example, "Do you prefer: Traditional burial with an open casket, Cremation, etc." was omitted as it was not deemed pertinent to this study. "Have you ever been with a dying person within the last 24 hours before his death?" was added to the questionnaire as it was judged to be relevant in determining the types of experiences the student had with dying persons. Part I of the instrument used in this research was designed specifically for this study. The revised questionnaire appears in Appendix B.

The three-part questionnaire consists mainly of fixed-alternative questions, with some open-ended questions (Parts I and III) which provide additional information regarding religion, sex, personal experiences with death, and age. Part I contains the demographic information about the respondents. Part II was designed to "...measure flexibility/rigidity of attitude in terms of interpersonal relations, desire for open communication concerning critical issues, and insight into psychological factors in relation to the dying person and his family" (Ward & Lindeman, 1979), p.54). Of the 50 Likert-type questions ranging from strongly agree to strongly disagree, only 33 are used in the measurement of attititude score. Fourteen of the items are scored positively and nineteen are scored negatively. The remaining 17 questions are not scored but were maintained for consistency with the original instrument. The scoring key for Part II, rates the positively scored questions as reflecting openness and flexibility, while the negatively scored questions reflect rigidity and lack of insight. A low score is desirable. Part III addresses personal and work experiences with death and dying. The score key is illustrated in Appendix C.

Permission to use the "Questionnaire for Understanding the Dying Person and His Family" was received from Carolyn Winget, holder of the instrument copyright.

DATA COLLECTION PROCEDURES

Validation of the Instrument

The adapted questionnaire was administered to fifty-three graduate nurses from a medical ward, an intensive care unit and a palliative care unit for the terminally ill. The data collected from this group was used to determine the internal consistency of the questionnaire, as well as to compare the attitude scores between graduate nurses and student nurses. There was a concern about the reliability (internal consistency) of the questionnaire, as statistical information in this regard was rather scarce. The holder of the copyrights, and a member of the questionnaire design group, was hesitant to forward any reliability statistics for this apparently well-used measure of attitude of health care personnel toward death and caring for dying persons. The alpha reliability coefficient was 0.8027 for Part II of the questionnaire measuring attitude score (N=53 cases and 33 items), and the Guttman split-half reliability coefficient was 0.8122 (see Table 1).

TABLE 1

Reliability Scores of Four Groups of Graduate Nurses

ALL GROUPS	RELIABILITY	
	alpha	Guttman split-half
All graduates N=53	.8027	.8122
Palliative Care N=13	.8601	.8517
Intensive Care N=15	.8252	.8112
Medical Unit N=25	.7183	.7727

The internal consistency of the instrument was considered acceptable, and therefore it was assumed that the questionnaire was a reliable measure of attitudes of health care personnel toward death and dying. Winget had reported an internal consistency of alpha coefficient 0.72 (Ward & Lindeman, 1979) in the original study which measured the differences in attitudes toward death and dying of freshmen and senior nursing students.

As the measurement tool was developed in the United States, a preliminary testing was carried out by six nursing instructors from one of the sample Schools of Nursing to ascertain that the wording and content of the questionnaire was compatible with what was taught the students participating in this study. Subsequent changes were not required.

Collection of Data

Permission to use the students from the hospital-based Schools of Nursing as the subjects for this study was obtained from the Director of each School. Dates for presenting the questionnaire to the participating classes of nursing students was decided by appropriate personnel from the School involved. In order to reach all levels of students, it was necessary to start the data collection in the Winter of 1985 with completion in the Fall of 1985. Most questionnaires were then administered to the student nurses during class time. It was emphasized to the students that this was confidential and voluntary, and that they were not obligated to complete the questionnaire and could leave class for the allotted time period. In most cases the researcher was present to introduce and to explain the purpose of the study to the students immediately before they answered the questionnaire. Where this format was unable to be followed, the investigator explained the purpose and procedure to the nursing instructor responsible for the class and for administering the questionnaires to the students. Three classes of students completed the questionnaires on their own time, away from class, and returned the completed questionnaires to the instructor who was responsible for their collection. Two out of the three classes that completed the questionnaires away from the class had lower returns, 55% and 62%, as compared to the in-class completions. Table 2 provides a summary of the frequency and percentage completions of the questionnaires.

TABLE 2

Frequency and Percentage of Questionnaire Completions According to Program Level

LEVEL	POSSIBLE COMPLETIONS	ACTUAL COMPLETIONS f	%
BEGINNERS			
Hospital A	90	88	97.8
Hospital B	82	79	96.3
Hospital C	120	104	86.7
TOTAL	292	271	92.8
JUNIORS			
Hospital A	73	72	98.6
Hospital B	84	74	88.1
Hospital C	-	-	-
TOTAL	157	146	93.0
INTERMEDIATES			
Hospital A	75	63	84.0
Hospital B	143	105	73.4
Hospital C	121	27	22.3
TOTAL	339	195	57.5
SENIORS			
Hospital A	51	28	54.9
Hospital B	80	76	95.0
Hospital C	85	59	69.4
TOTAL	216	163	75.5
COMBINED TOTAL	1004	775	77.2

TREATMENT OF THE DATA

The Statistical Package for the Social Sciences ($SPSS_x$) was used for analysis of the data. The following is an outline of the procedures used in the treatment of the data:

1. The Cronbach Alpha Reliability was completed on the graduate nurses questionnaire data in order to determine internal consistency of the measurement tool. The same reliability test was completed on the data from student nurses from each School.
2. A frequency distribution of demographic and personal and work experience with death and dying was performed for each level of student nurse within the three Schools of Nursing.
3. Mean scores were computed to determine attitude scores on each level of nursing student from each of the three Schools of Nursing, as well as a total score from each School.
4. Analyses of variance were used to determine significant differences of attitude score for different groups of students, between levels and between Schools of Nursing.

DELIMITATIONS, ASSUMPTIONS AND LIMITATIONS

Delimitations

The study was delimited in the following ways:

1. The study was restricted to the three hospital-based Schools of Nursing in Edmonton.

2. Data was collected only once from students at a particular point in their nursing program, and was not a longitudinal study to find how each student's attitude changed during the course of nursing studies.

Assumptions

1. It was assumed that the questionnaire provided meaningful measures of attitude of health care personnel toward death and dying.
2. It was assumed that all respondents interpreted the questionnaire in the manner intended.
3. It was assumed that the respondents reflected their true feelings about death and the dying patient and family.

Limitations

The study was limited in the following way:

1. The findings should be applied only to present and potential students in the selected hospital-based Schools of Nursing.

This chapter described the research methodology of the study. Areas addressed included sample and setting; the data collection instrument; collection and treatment of data; and delimitations, assumptions and limitations of the study.

CHAPTER IV

RESEARCH FINDINGS

This chapter is divided into two sections. The first section describes the demographic characteristics of the respondents. The second section presents the analysis of the research questions.

PROFILE OF RESPONDENTS

The sample of nursing students in this study was stratified into four program levels of Beginners, Juniors, Intermediates and Seniors. The total number of students in the sample was 1004, with the number completing the questionnaire being 775, for a response rate of 77.2%. Thirty-five point two percent were Beginners, 18.3% were Juniors, 25.3% were Intermediates and 21.1% were Senior students. Frequency and percentage distributions of the demographic profiles of nursing students, according to program level, are summarized in Table 3.

The greatest percentage of students in all levels were females. The majority of students were between the ages of 21 and 29 years. Most students belonged to the Protestant (greatest percentage) or Catholic religions. Half of the students described themselves as being moderate in their religious intensity. Nearly all students received content on death and dying integrated with other course material as opposed to a separate

TABLE 3

Frequency and Percentage Distribution of Demographics and Personal Experiences of Student Nurses in Each Program Level (N=775)

	Beginner		Junior		Intermediate		Senior	
	f	%	f	%	f	%	f	%
SEX								
Female	249	(91.9)	139	(95.9)	[illegible]	(93.2)	155	(95.1)
Male	21	(7.7)	6	(4.1)	[illegible]	(6.2)	8	(4.9)
No response	1	(0.4)	1	(0.7)	1	(0.5)		
AGE								
20 and under	88	(33.8)	46	(32.0)	12	(6.3)	3	(1.9)
21-29	138	(53.0)	84	(58.3)	153	(79.7)	143	(87.5)
30-39	26	(10.1)	12	(9.4)	21	(10.9)	12	(7.5)
40 and over	8	(3.2)	2	(1.4)	6	(3.0)	5	(3.0)
No response	1	(0.4)	2	(1.4)	3	(1.5)	2	(1.2)
RELIGIOUS AFFILIATIONS								
Catholic	92	(34.1)	47	(32.4)	52	(26.8)	62	(38.0)
Protestant	112	(41.5)	69	(47.6)	107	(55.2)	69	(42.3)
Other	45	(16.7)	20	(13.8)	23	(11.9)	21	(12.9)
None	21	(7.8)	9	(6.2)	12	(6.2)	11	(6.7)
No response	1	(0.4)	1	(0.7)	1	(0.5)		

TABLE 3 (continued)

	Beginner		Junior		Intermediate		Senior	
	f	%	f	%	f	%	f	%
RELIGIOUS INTENSITY								
Strong	56	(20.8)	41	(28.3)	44	(22.8)	34	(20.9)
Moderate	144	(53.8)	67	(46.2)	91	(47.2)	78	(47.9)
Weak	56	(20.8)	32	(22.1)	44	(22.8)	45	(27.6)
None	13	(4.8)	5	(3.4)	14	(7.3)	6	(3.7)
No response	2	(0.7)	1	(0.7)	2	(1.0)		
EDUCATIONAL COURSES IN DEATH & DYING								
Integrated	33	(11.8)	98	(67.1)	142	(72.8)	149	(91.4)
Separate	2	(0.7)	10	(6.8)	26	(13.3)	16	(9.8)
Extra During	56	(20.7)	14	(9.6)	11	(5.6)	6	(3.7)
Before	4	(1.5)	7	(4.8)	47	(24.1)	11	(6.7)
Never	185	(68.3)	31	(21.2)	14	(7.2)	2	(1.2)
DISCUSSION								
Yes	240	(88.6)	140	(96.6)	175	(91.1)	157	(96.3)
No	31	(11.4)	5	(3.4)	17	(8.9)	6	(3.7)
No response			1	(0.7)	3	(1.5)		

TABLE 3 (continued)

	Beginner		Junior		Intermediate		Senior	
	f	%	f	%	f	%	f	%
WITH DYING DURING LAST LIVING DAY								
Yes	97	(35.8)	79	(54.5)	104	(54.2)	124	(76.1)
No	174	(64.2)	66	(45.5)	88	(45.8)	39	(23.9)
No response			1	(0.7)	3	(1.5)		
IDENTITY OF DYING PERSON								
Immediate Family	41	(15.1)	32	(21.9)	27	(13.8)	29	(17.8)
Other Relative	28	(10.3)	20	(13.7)	15	(7.7)	16	(9.8)
Friend	28	(10.3)	20	(13.7)	15	(7.7)	15	(9.2)
Patient	43	(15.9)	52	(35.6)	81	(41.5)	109	(66.9)
RELATIVE DIE IN PAST YEAR								
Yes	87	(32.5)	48	(33.1)	54	(28.3)	55	(34.0)
No	181	(67.5)	97	(66.9)	137	(71.7)	107	(66.0)
No response	11	(4.1)	1	(0.7)	4	(2.0)	1	(0.6)

TABLE 3 (continued)

	Beginner		Junior		Intermediate		Senior	
	f	%	f	%	f	%	f	%
# DYING PATIENTS CARED FOR DURING PAST YEAR								
None	204	(75.3)	60	(41.1)	60	(30.8)	17	(10.4)
1-5	25	(9.2)	63	(43.2)	116	(59.4)	110	(67.4)
6-10	8	(2.9)	10	(6.9)	4	(2.0)	23	(14.1)
11+	6	(2.2)	3	(2.1)	3	(1.5)	7	(4.2)
No response	28	(10.3)	10	(6.9)	12	(6.3)	6	(3.7)
EXPERIENCE TO INFLUENCE ATTITUDE								
Yes	157	(59.5)	80	(55.8)	97	(51.3)	105	(64.4)
No	107	(40.5)	64	(44.4)	92	(48.7)	58	(35.6)
No response	7	(2.5)	2	(1.4)	6	(3.0)		
WISH TO TELL FAMILY								
Yes	234	(89.7)	139	(97.2)	168	(90.3)	146	(90.7)
No	27	(10.3)	4	(2.8)	18	(9.7)	15	(9.3)
No response	10	(3.7)	3	(2.1)	9	(0.5)	2	(1.2)

course within their curriculum. As many students had been in related health care fields, for example, nursing assistants, prior to entering their present nursing program, many indicated they had received lectures on death and dying content previously.

DISCUSSION OF RESEARCH QUESTIONS

To what degree do attitudes of the student nurses vary throughout their nursing program?

Part II of the questionnaire was designed to measure rigidity or flexibility of attitude toward death and dying. Figure 2, a box-and-dot graph (Erickson and Nosanchuk, 1977), depicts the attitude scores of the different levels of student nurses. It is evident that as the students progress in their studies and in their program, their attitudes become more positive (lower scores) toward death and caring for the dying person. The Beginners have the highest (least positive) attitude score, while the Seniors have the lowest (more flexible and open) attitude score.

The Beginners have the greatest midspread of data scores. The Juniors and Intermediates have the next greatest midspread, while the Seniors had the smallest midspread. The Intermediate group has the most outliers, scores greater than 1.5 dq from the median (Erickson and Nosanchuk, 1977).

Table 4 depicts a one-way analysis of variance which compares attitude scores toward death and dying and the four student groups of Beginners, Juniors, Intermediates and Seniors. An overall significant F ratio was found ($p=.0000$). Significant differences ($p<.1$ Scheffe test) were found between Beginners (highest score, indicating the least positive

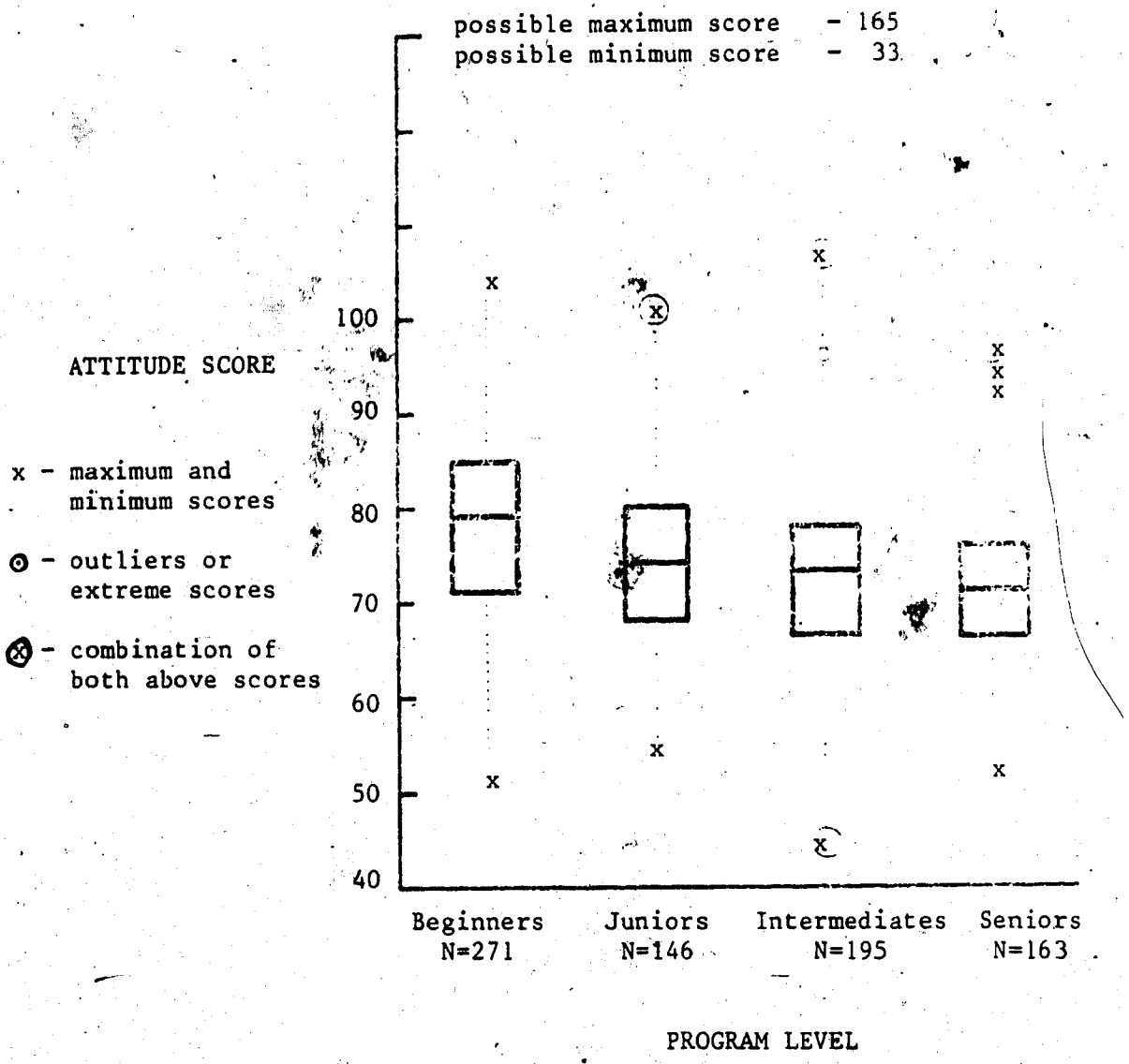

Figure 2. Attitude Scores of Student Nurses Toward Death and Dying According to Program Levels

TABLE 4

One-Way Analysis of Variance Between Attitude Scores and Four Student Groups

Source	DF	Sum of Squares	Mean Square	F Ratio	F Probability
Between Groups	3	6648.1444	2216.0481	30.0999	.0000*
Within Groups	771	56763.4350	73.6231		
TOTAL	774	63411.5794			

		Significant Differences ($p<.1$)[1]			
Mean	Groups	S	I	J	B
70.8282	Seniors				
72.6872	Intermediates				
74.0137	Juniors	*			
78.2325	Beginners	*	*	*	

Cochrans C for Homogeneity of Variances = .3309, p=.001

[1]Scheffe Procedure

attitude) and all other groups; the Juniors were also significantly different ($p \leq .1$ Scheffe test) from the Seniors (lowest score, and therefore the most positive attitude toward death and caring for the dying person).

It appears that the Beginner and Senior groups of students thought more strongly about issues than did other levels of students. These two groups chose more 'strongly agree' and 'strongly disagree' choices when responding to the questions measuring attitude score. The Intermediate levels chose 'undecided' more often than did other levels. Student responses to Part II of the questionnaire are summarized in Appendix D. One-way analysis of variance of student responses to questions which measure attitude score toward death and dying is found in Appendix E.

In summary, the median scores fell, as expected, as the students progressed to higher program levels. The Beginners, Juniors and Seniors grouped around the centre of their data batch. The Intermediate levels were the most unusual or deviant group with the highest and lowest individual scores, and grouped toward the bottom half (low scores) of the data. It is interesting to note that the higher levels of students also had the greater number of outliers of the four student groups.

The majority of students in each level had discussed attitudes toward death and dying with others, particularly so at the Junior and Senior levels. Most students had been with a dying person during that person's last day of living. This person was most often a patient or an immediate family member. A number of students in all levels had not cared for a dying person during the past year.

Over half the students in each level acknowledged having an experience which influenced their attitude toward death and dying, but not all

offered explanations about this experience or how it affected their attitude. A summary of responses is presented in Table 5. Beginners, Intermediates and Seniors identified deaths of family and friends as having the greatest influence on their attitude toward death and dying; Juniors identified caring for dying patients as the greatest influence.

Student explanations of the experience which influenced their attitudes are: the death of a relative was more "pleasant" than they had thought or expected; the death of parents, friends, relatives made them think about the reality of death and how death has to be accepted; working in a nursing home and experiencing the deaths of many patients made them more comfortable with death; belief in God or an afterlife made it easier to accept death; death can be a relief to suffering; and how patients accepted, or did not accept dying influenced how students accepted death. One student wrote, "I cared for a very active 93 year old lady, who was very happy but lonely. She died shortly after I cared for her, but because she was so active she dispelled my notion of the 'sick' dying patient in pain." Another student shared that "...depending on the situation your attitude may be changed." Explanations of the experience which influenced their attitude toward death and caring for the dying were similar in all program levels and Schools of Nursing.

The majority of students from each level favored telling their families that they have a fatal disease (Table 6). Upon learning that they have a fatal disease, all levels of students placed emphasis on doing what they had always wanted to do, but either did not have the time or money to do so now. Beginners also placed emphasis on the combination of 'emotional

TABLE 5

Responses to "Have you had or been aware of any particular experience that has influenced how you feel about death in general?" (According to Level)

RESPONSE	Beginner	Junior	Intermediate	Senior
Dying patients	24	*72	28	34
Religion	23	9	11	3
Death of family, friends	*70	29	*33	*35
Working in Nursing Home	7	2	0	0
Accidents respondent involved in	9	2	6	0
Other	22	4	10	15

* Most frequent response

TABLE 6

Responses to "If I learned today I have a fatal disease, I would probably . . . " (According to Level)

RESPONSE	Beginner	Junior	Intermediate	Senior
Emotional	36	32	41	27
Continue on	27	17	29	10
Do what always wanted	*70	*42	*45	*42
Religion	6	3	8	4
Combination doing & emotion	39	11	20	16
Being with family, friends	29	18	11	29
Other	32	18	23	16

* Most frequent response

and doing', i.e., after the shock they would travel. Juniors and Intermediates had emotional reactions as their next most frequent response. Examples are: go through the stages of grieving and loss, "be angry that my life was over before I could enjoy it", and "seek another opinion". Senior students emphasized spending quality time with family and friends. Spending time with family and friends was commonly integrated into the explanation of what one would do given that they have a fatal disease, although the Seniors often just had this answer in isolation.

Responses to Parts I and III of the questionnaire show that the students are very homogenous when comparing the respondents from different program levels.

How does cognitive and affective learning in death and dying education change students' attitudes toward the dying person?

As Figure 2 shows, the students' attitude scores generally decreased as they progressed in their nursing programs. This may be attributed to lectures in death education, and classroom and seminar discussions of feelings toward death and dying. Studies that support the claim that death education contributes to a more positive attitude toward death and dying in nursing students were completed by Yeaworth, Kapp and Winget (1974); Wise (1974); Castronova (1977); and Coolbeth and Sullivan (1984).

All levels of students except the Beginners, who had just entered their nursing program, had death education content presented in lectures integrated with other nursing content. (A specific class day was often assigned to content on death and dying, or loss and grieving, but generally death education content was integrated with other lectures).

An informal measure of the influence of death education in School 'A' was conducted by dividing the Intermediate class into two groups (see Figure 3). The questionnaires were administered to one group before a seminar on death and dying, and to the other group a few days after the seminar. A t-test was computed to determine if a significant difference existed between the pre-seminar and post-seminar groups. No significant difference was found (Table 7). The post-seminar group did have a lower median score (more positive attitude toward death and caring for the dying) than did the pre-seminar group. The difference may be attributed to the classes in death education.

In summary, it would appear that lectures and discussions in death and dying education do positively influence attitudes toward death and caring for the dying person.

What is the relationship between age and attitudes toward death and the dying person?

For analytic purposes, students were divided into three different age groupings of approximately equal numbers; 20 years and younger, 21 to 23 years of age and 24 years and older.

A one-way analysis of variance comparing student attitude scores and age showed a significant F ratio ($p=.0035$). Significant differences ($p<.1$ Scheffe procedure) were found between the 20 and under age group (highest score) and the two older age groups. Table 8 portrays the mean scores and significant differences of attitude scores and age groups.

The question could be raised as to whether older students have a more positive attitude toward death and dying because of age, or because

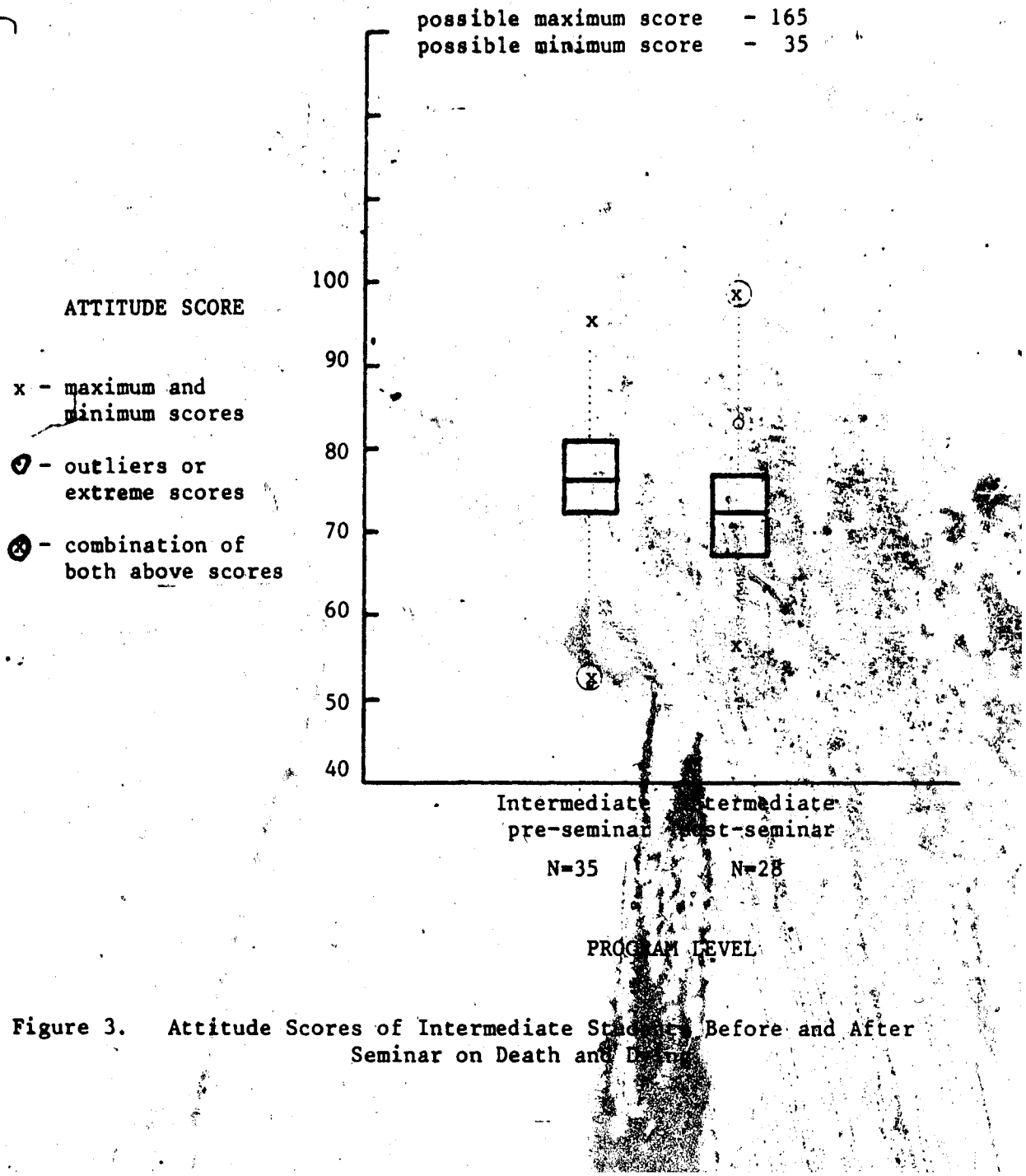

Figure 3. Attitude Scores of Intermediate Students Before and After Seminar on Death and Dying

TABLE 7

t-test for Differences Between Attitude Scores of Two Groups of Student Nurses Before and After a Seminar on Death and Dying ($p < .05$)

							Pooled Variance Estimate		
Group	N	Mean	Standard Deviation	Standard Error	F Value	2-Tail Prob.	T Value	Degrees of Freedom	2-Tail Prob.
Pre-seminar	35	75.5143	8.607	1.455	1.06	0.879	1.57	61	0.123
Post Seminar	28	72.1429	8.348	1.578					

TABLE 8

One-Way Analysis of Variance Between Attitude Score and Age

Source	DF	Sum of Squares	Mean Squares	F Ratio	F Probability
Between Groups	2	920.6617	460.3309	5.6831	.0035*
Within Groups	777	62937.0036	81.0000		
TOTAL	779	63857.6654			

Significant Differences ($p < .1$)[1]

Mean	Age Groups	24 & over	21-23	20 & under
73.4104	24 and over			
73.9469	21 to 23			
75.9101	20 and under	*	*	

[1]Scheffe procedure

they are more advanced in their program. [redacted] to test this question, a two-way analysis of variance was completed with age group and level as the independent variables, and attitude score as the dependent variable. As can be seen in Table 9, a significant main effect ($p < .05$) was found between program levels only. As significant differences ($p < .05$) were not found on 2-way interactions between age and level, it can be assumed that program level, and not age, contributes to a more positive attitude score in student nurses.

What is the relationship between personal experience with death and dying and attitudes toward death and the dying person?

Part III of the questionnaire sought answers to a number of questions about the personal experiences which the respondents had with death and dying persons. Many questions required a "yes" or "no" response. For each of these questions students were divided into two groups and t-tests were performed with attitude score on death and dying being the dependent variable. Many significant differences between attitude scores and personal experiences with death and dying were found.

Those students that discussed attitudes toward death and dying were found to have a significantly more positive attitude than did those students who did not have discussions on the subject (Table 10). Milton (1984) found that family attitudes toward the discussion of death seemed to influence the number of concerns students had about dying patients. If death was discussed openly, lower concerns were expressed by students; if death was a taboo subject and not discussed freely, students expressed a higher concern for caring for the dying.

TABLE 9

Two-Way Analysis of Variance Between
Attitude Scores and Age and Level of Student

Source of Variation	Sum of Squares	DF	Mean Squares	F	Signif of F
Main Effects	6920.412	5	1384.082	18.794	0.000*
Age	272.268	2	136.134	1.849	0.158
Level	6057.812	3	2019.271	27.419	0.000*
2-Way Interactions	300.988	6	50.165	0.681	0.665
Age Level	300.988	6	50.165	0.681	0.665
Explained	7221.400	11	656.491	8.914	0.000
Residual	56190.179	763	73.644		
TOTAL	63411.579	774	81.927		

* $p < .05$

TABLE 10

t-test for Differences in Attitude Scores Toward Death and Dying Between Means of Two Groups of Student Nurses and Experiences with Death and Dying ($p < .05$)

Experiences	Group	N	Mean	Standard Deviation	Standard Error	Pooled Variance Estimate T-value	DF	2-tail Probability
1. Have you ever discussed attitudes towards death and dying with your family, friends, classmates, colleagues or church members?	Yes	717	74.0962	8.883	0.332	-2.58	774	0.010*
	No	59	77.2203	9.489	1.235			
2. Have you ever been with a dying person within the last 24 hours before his death?	Yes	406	72.7291	8.864	0.440	-5.32	774	0.000*
	No	370	76.0946	8.748	0.455			
3. If you answered yes to the above, into which category(s) did this person(s) belong? (check all applicable)								
(a) Immediate Family	Yes	129	74.4729	8.936	0.787	0.05	778	0.958
	No	651	74.4270	9.084	0.356			

TABLE 10 (continued)

Experiences	Group	N	Mean	Standard Deviation	Standard Error	Pooled Variance Estimate T-value	DF	2-tail Probability
(b) Other Relative	Yes	79	73.7595	9.059	1.019	-0.70	778	0.485
	No	701	74.5102	9.057	0.342			
(c) Friend	Yes	79	73.9747	8.553	0.962	-0.48	778	0.634
	No	701	74.4864	9.113	0.344			
(d) Patient	Yes	287	72.1603	8.612	0.508	-5.45	778	0.000*
	No	493	75.7586	9.050	0.408			
4. Have you had any relatives die within the past year?	Yes	248	74.5927	9.258	0.588	0.76	769	0.450
	No	523	74.0746	8.721	0.381			
5. How many dying patients have you cared for during the past year?	Less Than 5	629	74.4626	8.851	0.353	2.95	722	0.003*
	5 or More	95	71.6211	8.122	0.833			

TABLE 10 (continued

Experiences	Group	N	Mean	Standard Deviation	Standard Error	Pooled Variance Estimate T-value	DF	2-tail Probability
6. Have you had or been aware of any particular experience that has influenced how you feel about death in general?	Yes	443	73.4786	8.703	0.414	-3.18	763	0.002*
	No	322	75.5373	9.010	0.502			
8. I would want my family to know that I have a fatal disease.	Yes	691	74.4399	8.787	0.334	0.47	753	0.637
	No	64	73.8906	10.212	1.277			

*Significantly different at p<.05

A significant difference ($p < .05$) in attitude score was also found between those students who had been with a dying person during that person's last living 24 hours, and those who had not: Students who had been with the dying during this time period had a lower score, or more positive attitude toward death and caring for the dying. Significant differences ($p < .05$) in attitude scores (more positive) were found when the dying person was a patient. There was also a significant difference ($p < .05$) between those students who had cared for more than five dying patients, and those students who had cared for less than five dying patients. Students who had cared for the greater number of dying patients obtained a lower, more positive attitude score. In the study conducted by Milton (1984), it was found that a pattern arose when contrasting those students who had cared for none, one, or more patients at the time of that person's death. Students who had cared for only one patient had more concerns about providing care to the dying than did those students who had cared for more than one patient, or who had not cared for a patient whose death was very imminent. Milton suggested that the initial experience is anxiety-producing, and an equilibrium is restored with further experience. Martin and Collier (1975) and Schrock and Swanson (1981) found that caring for the dying patient is the most important factor in producing attitudinal changes toward death and caring for dying patients.

Students that had or were aware of a particular experience that influenced their attitude had a lower score than students who had not had influencing experience. The influence was not always a positive one according to explanations identified in response to the open-ended question

requesting this information, more experiences were identified as being positive than negative. Two of the positive experiences were: talking with patients who were dying and who had accepted death, and realizing that death may be the solution to a long painful dying process helped the student to accept death better.

In summary, it appears that discussing attitudes toward death and dying yields a more positive attitude, as does being with a dying person during that person's final living day, especially if that person was a patient. Caring for many dying patients produced a more positive attitude toward death and caring for the dying person.

To what degree does religion influence attitudes toward death and the dying person?

A two-way ANOVA was computed on the dependent variable of attitude score and the independent variables of age and religion. Significant F ratios were found on the main effects of age ($p=.002$) and religion ($p=.019$). However, significant differences were not found on 2-way interactions when the main effects of age and religion were combined (Table 11).

The question could also be raised if intensity of religion contributes more than religion to a positive attitude score toward death and dying. In order to test this hypothesis, a two-way analysis of variance was computed between attitude scores, and the independent variables of religion and religious intensity. Significant F ratios were found on the main effects of religion ($p=.032$) and religious intensity ($p=.049$). Again, significant differences ($p<.05$) were not found on 2-way interactions of religion and religious intensity and the dependent variable of attitude score (Table 12).

TABLE 11

Three-way Analysis of Variance Between
Attitude Score and Personal Experiences with Death and Dying

Source of Variation	Sum of Squares	DF	Mean Squares	F	Signif of F
Main Effects	1596.638	4	399.160	5.074	0.000
Age	1056.278	2	528.139	6.173	0.001*
Discussed Death	509.794	1	509.794	6.480	0.011*
Dying Person - Immediate Family	27.554	1	27.554	0.350	0.554
2-Way Interactions	196.065	5	39.213	0.498	0.778
V2 V60	10.996	2	5.498	0.070	0.933
V2 V62	116.278	2	58.139	0.739	0.478
V60 V62	72.845	1	72.845	0.926	0.336
3-Way Interactions	275.319	1	275.319	3.500	0.062
V2 V60 V62	275.319	1	275.319	3.500	0.062

* p<.05

TABLE 12

Two-Way Analysis of Variance Between
Attitude Score and Religion and Religous Intensity

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
Main Effects	1503.074	6	250.512	3.194	0.004
V3 Religion	694.876	3	231.625	2.953	0.032*
V4 Religious Intensity	619.509	3	206.503	2.633	0.049*
2-way Interactions	1144.471	8	143.059	1.824	0.069
V3 V4	1144.471	8	143.059	1.824	0.069

* p<.05

In summary, it would appear that the interactions of age, religion and religious intensity together do not contribute significantly to influence the attitude scores of student nurses in this study, but each independent variable may contribute in isolation toward a more positive attitude score toward death and caring for the dying person.

How do the findings of this study compare across the Schools of Nursing surveyed?

The study sample was relatively homogenous when comparing the demographics of respondents from each School. School 'B' had more male students than Schools 'A' and 'C'. Schools 'B' and 'C' had equal numbers of students over 40 years of age. Table 13 depicts the sex and age of the respondents from each School of Nursing.

The student groups representing the three Schools of Nursing were relatively similar in their attitude scores, see Figure 4. Schools 'A' and 'C' had one outlier each, while School 'B' had three. An exception to the tendency of scores to decrease as level of student increases appears in the Junior level of School of Nursing 'A' (Figure 5). This particular class has a lower median score than the two Intermediate classes and is nearly equal to the Senior class median. The other exception to a continuous decrease in attitude score occurs in School of Nursing 'C' (Figure 6). The Intermediate class has a lower median score than the Senior class. Figure 7 depicts attitude scores of student nurses from School of Nursing 'B'. It is evident that the Juniors from School 'A' and the Seniors from Schools 'A' and 'C' have the smallest spread between high and low scores. Figures 8, 9, 10 and 11 are box-and-dot graphs depicting attitude scores toward

TABLE 13

Summary of Sex and Age of Respondents
According to School of Nursing

	School					
	'A'		'B'		'C'	
	f	%	f	%	f	%
Age						
20 and under	86	34.3	29	8.7	41	21.6
21 to 29	153	61.0	245	73.3	118	62.1
30 to 39	8	3.2	39	11.7	24	12.6
40 and over	4	1.6	11	3.3	6	3.2
Sex						
Female	242	96.4	308	92.2	178	93.7
Male	9	3.4	26	7.8	12	6.3
N	251		334		190	

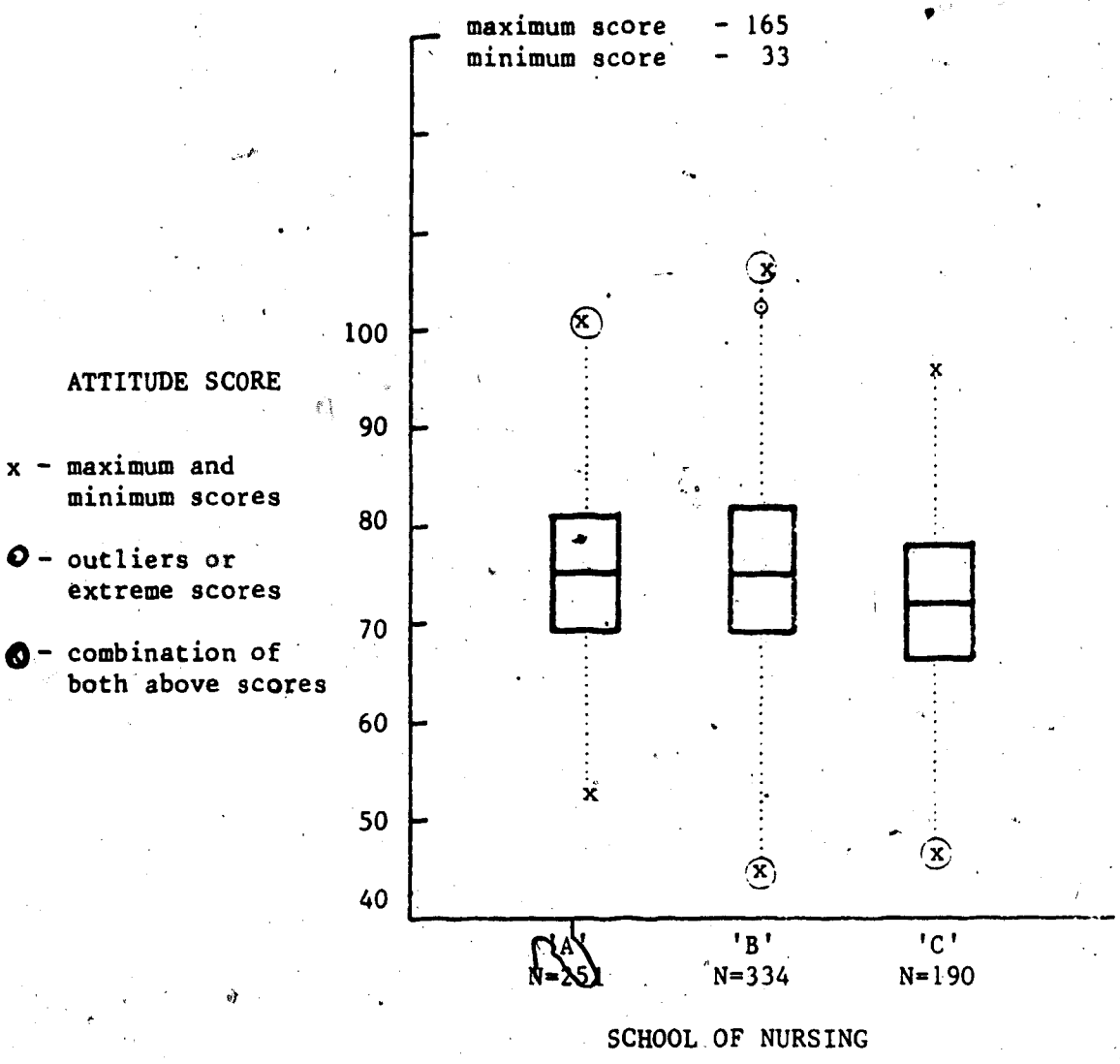

Figure 4. Attitude Scores Toward Death and Dying by School of Nursing

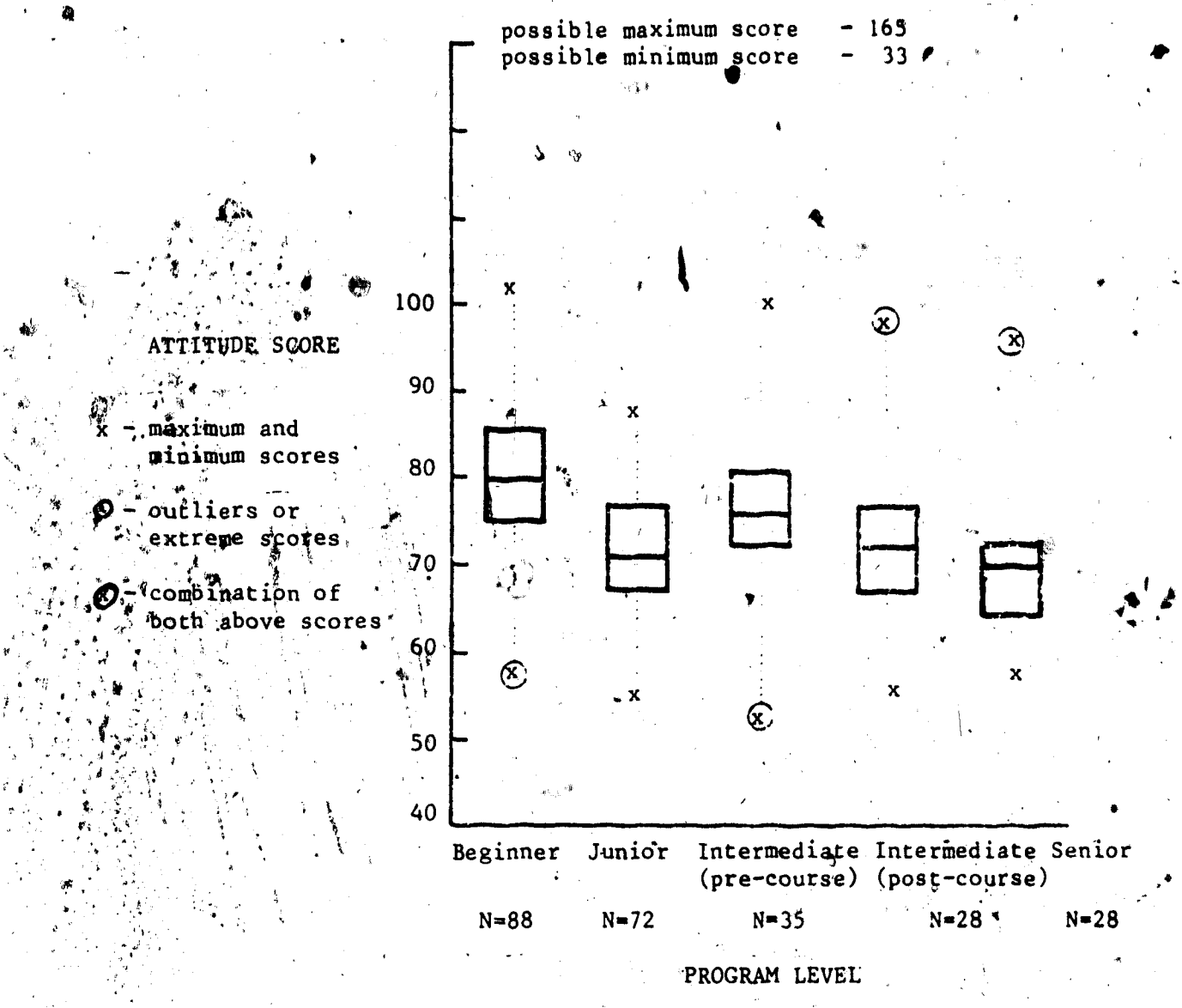

Figure 5. Attitude Scores of Student Nurses Toward Death and Dying in School of Nursing 'A'

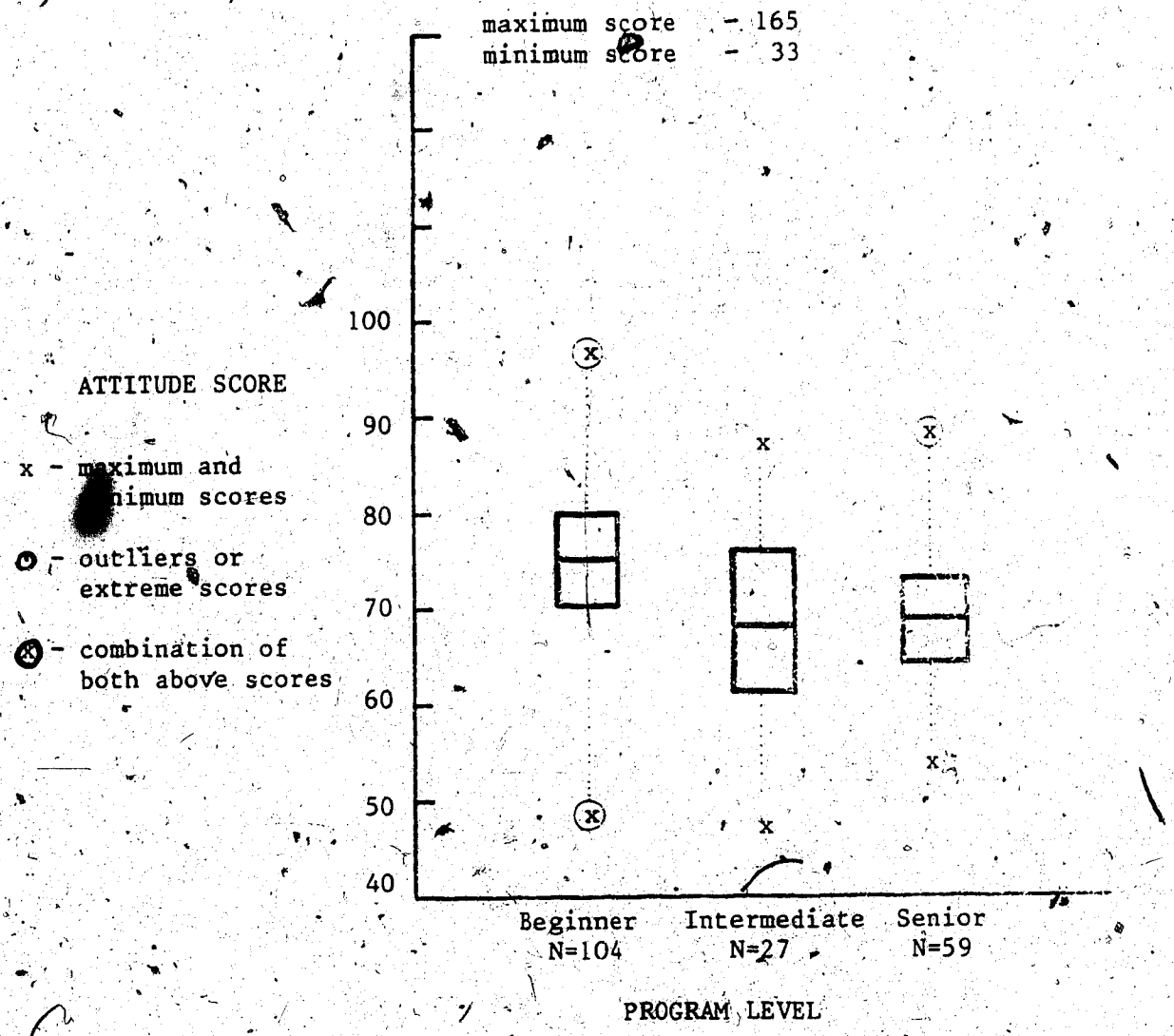

Figure 6. Attitude Scores of Student Nurses Toward Death and Dying in School of Nursing 'C'

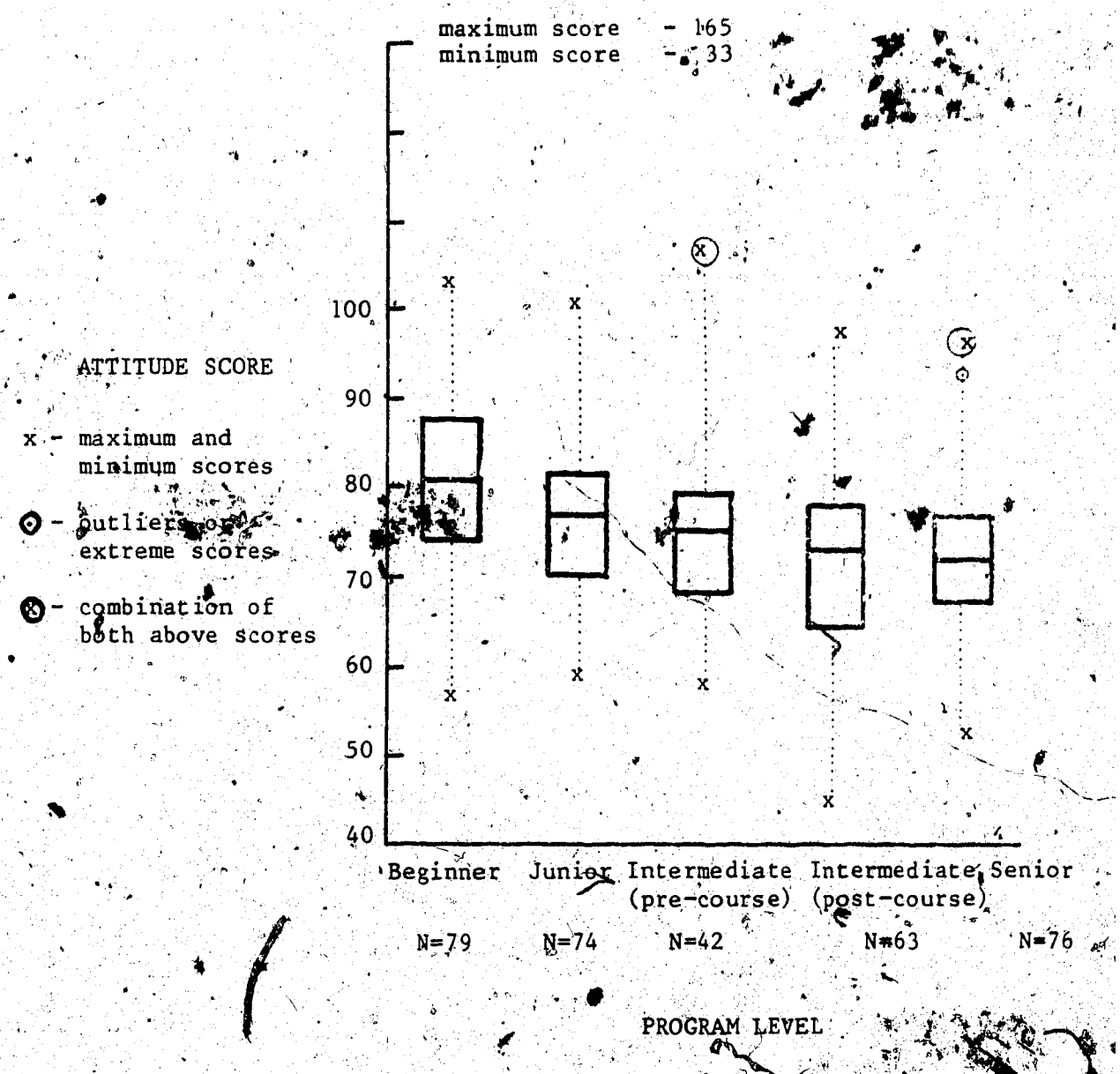

Figure 7. Attitude Scores of Student Nurses Toward Death and Dying in School of Nursing 'B'

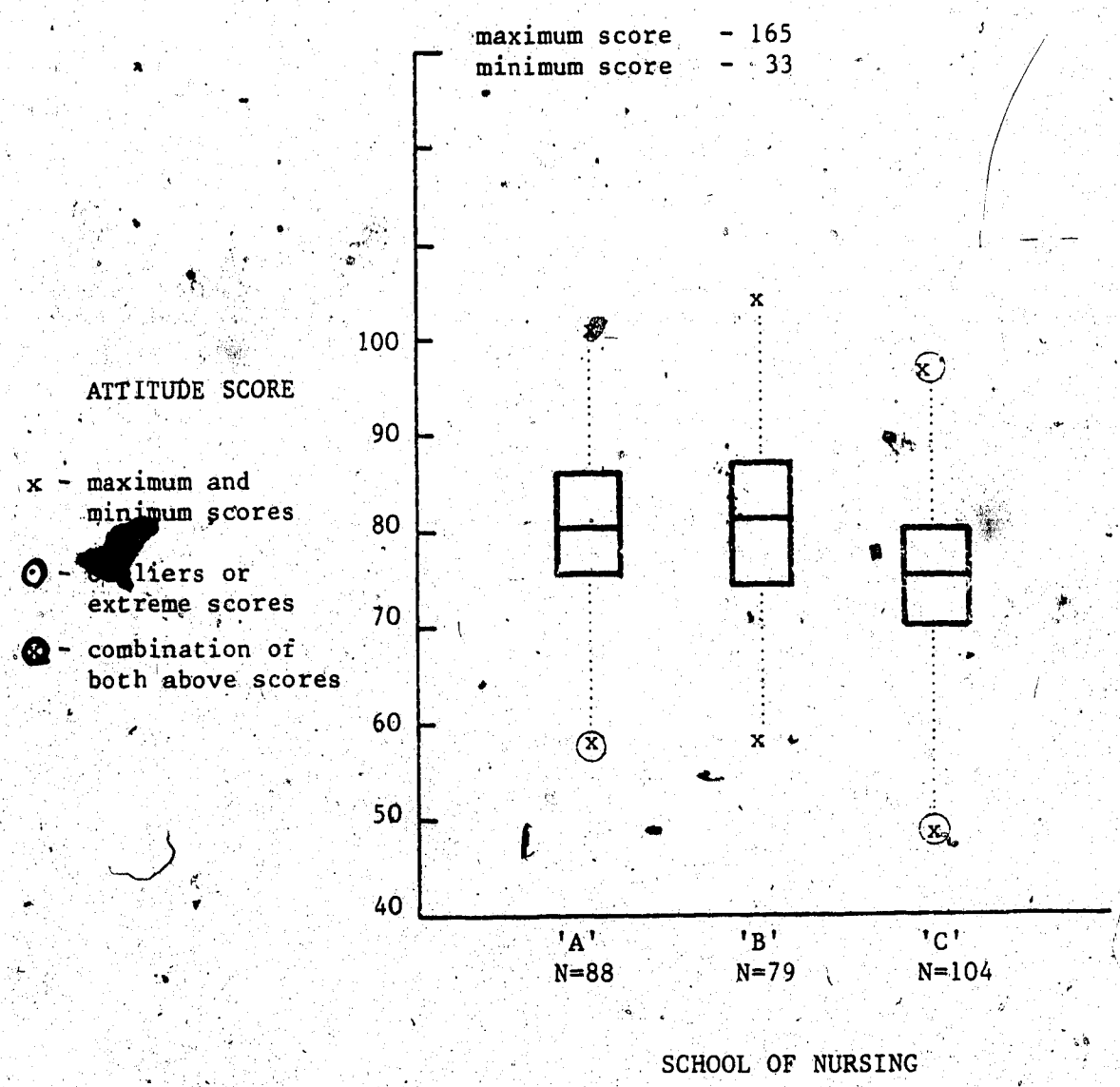

Figure 8. Attitude Scores Toward Death and Dying of Beginner Nursing Students

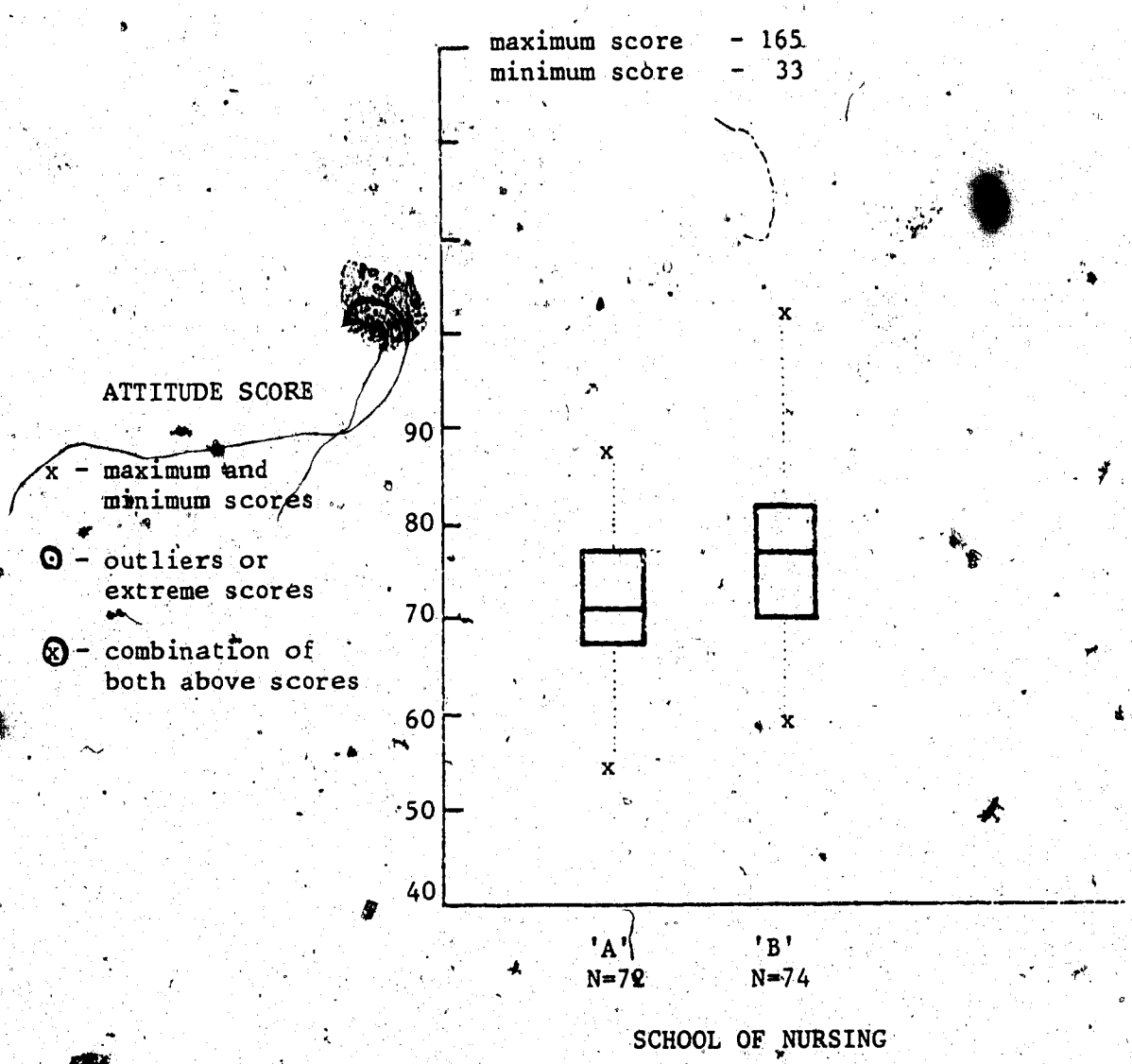

Figure 9. Attitude Scores Toward Death and Dying of Junior Nursing Students

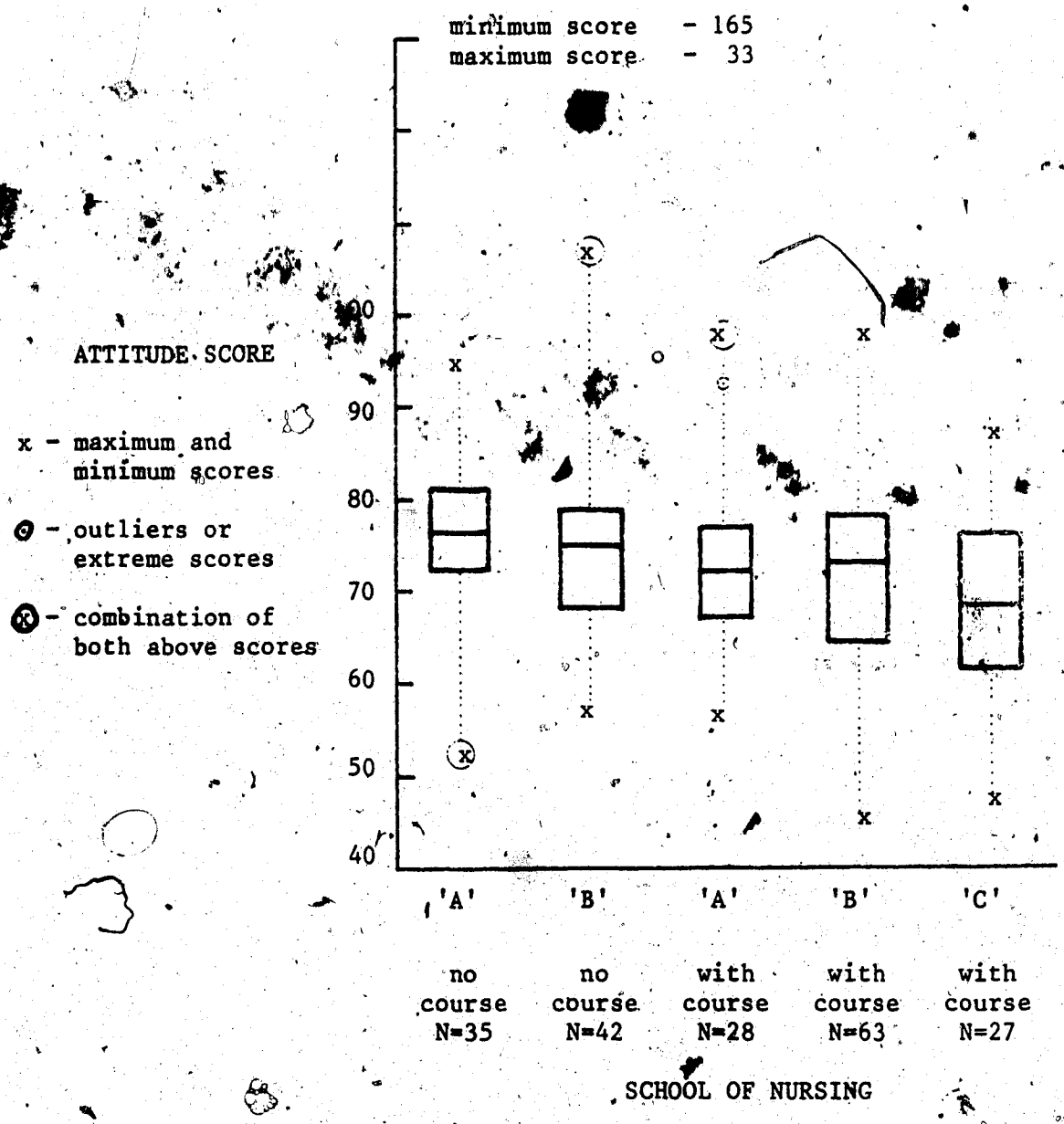

Figure 10. Attitude Scores Toward Death and Dying of Intermediate Nursing Students

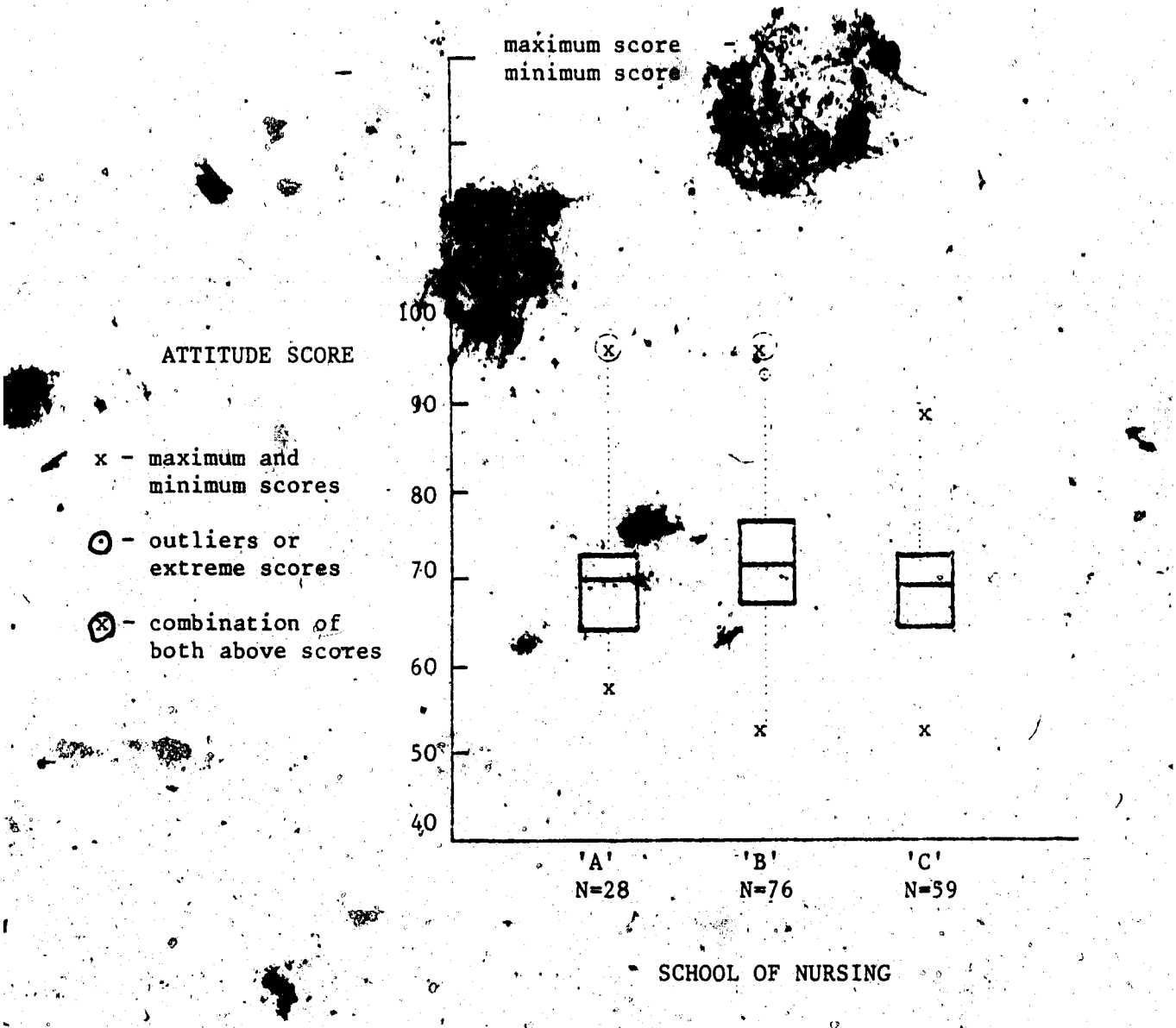

Figure 11. Attitude Scores Toward Death and Dying of Senior Nursing Students

death and dying of the four levels of student nurses from the three Schools of Nursing.

The differences in attitude change, by median score, from the beginners to the Seniors in each School of Nursing was greatest in School 'A' (10), then School 'B' (8), and School 'C' (6).

In order to test if a significant difference did exist between School and age of student, a two-way analysis of variance was computed. A significant F ratio was not found (Table 14). Therefore it may be concluded that there are no significant differences between student nurses enrolled in specific Schools of Nursing programs and age, and their attitude scores toward death and caring for the dying person.

Attitude Scores of Graduate Nurses

Graduate nurses' attitude scores were used for comparison with senior students' attitude scores. The attitude score of the senior nursing students is very similar to that of the graduate nurses, 70.8 and 69.3 respectively. Golub and Reznikoff (1971) and Hogatt and Spi[illegible] (1978-79) found that nursing students tended to adopt the attitudes of their reference group, the graduate nurses, and will therefore have similar attitudes toward death and dying. The findings regarding the attitude scores of the senior and graduate nurses in this study, tend to support the conclusions of the two cited studies.

Figure 12 depicts the attitude scores of the graduate nurses group. There is a difference among the graduate nurses from the different work areas. The Palliative Care nurses have the lowest attitude score, the Intensive Care nurses are next, and the Medical Unit nurses have the highest attitude score. Golub and Reznikoff (1971) found that graduate

TABLE 14

Two-Way Analysis of Variance Between
Attitude Score and Age and School of Nursing

Source of Variation	Sum of Squares		Mean Square	F	Signif of F
Main Effects	2292.083	4	573.021	7.187	0.000
V2 Age	924.051	2	462.026	5.795	0.003*
ID School	1429.483	2	714.741	8.965	0.000*
2-way Interactions	49.944	4	12.486	0.157	0.960
V2 ID	49.944	4	12.486	0.157	0.960

* $p < .05$

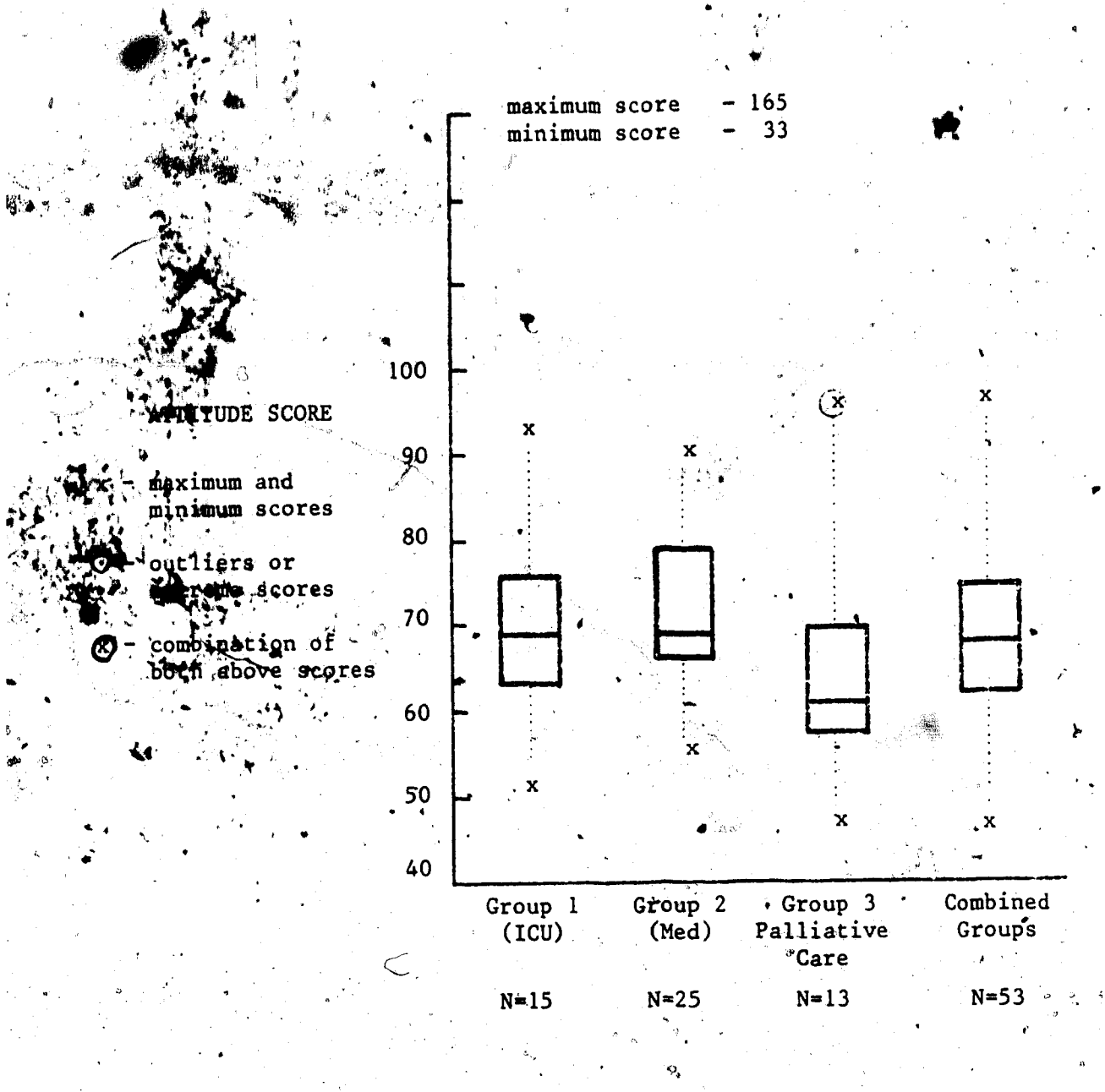

Figure 12. Attitude Scale of Graduate Nurses Toward Death and Dying

nurses had similar attitudes toward death and dying, and that no significant differences were found based on nursing specialty. Thompson (1985-86) found that there were differences in attitude in nurses from different specialty areas. He suggested that each area has a specific emotional climate which encourages a particular point of view toward working with the dying. He found that nurses working in palliative care approached their work with greater ease, may enter into a more personal relationship with the dying patients, and leave work with a rewarding feeling. The attitude scores of graduate nurses from the different specialty areas in this study support the Thompson study findings.

In summary, it is evident that attitude scores toward death and dying decrease as the students progress from Beginner to Senior, and then to graduate nurse. The scores for the four student levels and for the graduate nurses are 78.2 (Beginners), 74.0 (Juniors), 72.7 (Intermediates), 70.8 (Seniors) and 69.3 (Graduates) respectively.

Reliability Scores of Student Nurses

TABLE 15

Reliability Scores for Four Groups of Student Nurses

GROUPS	RELIABILITY	
	alpha	Guttman split-half
All Students N=775	.7058	.7250
School 'A' N=251	.6789	.6980
School 'B' N=334	.7299	.7500
School 'C' N=190	.6772	.6882

The reliability analysis showed an acceptable, although somewhat low, level of internal consistency among student nurses. In Winget's et al study of attitudes of senior and sophomore nursing students, the internal consistency was found to be 0.72, (N=134). The internal consistency of the original study (0.72) and of this study (0.7058) are similar.

CHAPTER V

SUMMARY, CONCLUSIONS AND IMPLICATIONS

This study examined the changing attitudes toward death and dying of nursing students as they progressed through their studies from program entry to program completion. It was concerned with determining whether attitudes became more positive toward caring for the dying patient as the students neared graduation. It was also concerned with determining whether certain variables influenced the attitude change.

This chapter contains a summary of the study, including a brief description of the purpose, the research methodology and review of the major findings. Conclusions are also included, as are implications for education and further research.

SUMMARY

Purpose

The study was designed to examine to what degree attitudes of student nurses varied toward death and the dying person throughout their nursing program. The findings of the study may affect how nursing education approaches teaching death and dying to student nurses. It was also designed to answer the following questions:

1. How does cognitive and affective learning in death and dying education change students' attitudes toward death and dying?

2. To what degree do attitudes of the student nurses vary throughout their nursing program?
3. What is the relationship between age and attitudes toward death and the dying person?
4. What is the relationship between personal experience with death and the dying person?
5. To what degree does religion influence attitudes toward death and the dying person?
6. How do the findings of this study compare across the Schools of Nursing surveyed?

Research Methodology

A questionnaire designed by Yeaworth, Kapp and Winget, and adapted for use in this study, was the data collection tool. The questionnaire was divided into three parts: Part I sought demographic and educational information on the respondents, Part II consisted of 50 Likert-type questions requesting degree of agreement or disagreement to statements reflecting attitudes toward death and dying persons and their families, and Part III sought data on personal and work experiences with death and dying.

The research population consisted of student nurses from the three hospital-based Schools of Nursing in Edmonton. Students at varying levels in their programs responded to the questionnaire. Seven hundred and seventy-five of a possible 1004 questionnaires were completed, resulting in a return rate of 77.2%.

Treatment of the Data

The Statistical Package for the Social Sciences ($SPSS_x$) was used for the treatment of the data.

1. Cronbach alpha reliability tests were completed on the questionnaires in order to determine the internal consistency and reliability of the measurement instrument.
2. Frequency and percentage distributions were utilized to summarize the demographic, educational and personal and work experiences with death and dying.
3. Mean scores were used to summarize the results of the responses to Part II of the questionnaire which determined attitude score toward death and dying.
4. One-way analysis of variance was utilized to determine differences between levels of students and attitude scores.
5. Analysis of variance was also computed to determine differences between means of attitude scores and personal experiences with death and dying, and between means of attitude scores and the independent variables.
6. T-tests were utilized to determine differences between student groups and personal experiences with death and dying.

Profile of the Respondents

Many similarities emerged among the levels of students and between the students from the different Schools of Nursing. Nearly all the students were female. The majority of respondents in all levels were between the age of 21 and 29 years. Most belonged to the Protestant religion, were of moderate religious intensity, and had received content on death and dying integrated with other material throughout their program. A small percentage of students from each program level indicated that they

had not ever had educational courses in death and dying. The question may not have been worded clearly, or may have been misinterpreted by some students. The writer suggests that many students checked the 'never' category as content in death and dying was not presented as a specific subject, but integrated with other educational content. The majority of students in all levels had discussed attitudes toward death and dying with others. Students in the beginning and intermediate levels tended to have discussed the subject less frequently than students in other levels. Perhaps the lack of discussions, and therefore less opportunity to express thoughts and feelings about their attitude, helped contribute to a higher, more rigid attitude score. Martin and Collier (1975) write, "Of the many factors which may influence attitudes toward death, two were selected most often: personal encounters with death, and situations which permit personal examination of attitudes and experiences related to death." (p.34). Thompson (1985-86) concurs, and found that experiences covary with willingness to share feelings about death and caring for dying patients. It was also found in this study that the group of students who had discussed attitudes toward death and dying had a significantly different ($p < .05$) lower mean attitude score than those students who had not had discussions on death and dying.

At least one-third of the Beginners, and over half of the Juniors, Intermediates and Seniors had been with a dying patient during that person's last living day. Students who had cared for, or were with a person during this time period, differed significantly ($p < .05$) from those students who had not had this experience. This person was most often a patient, and secondly, an immediate family member. A significant difference in

in attitude score occurred between the two groups of students only when this person was a patient. As Table 10 shows, caring for a patient during the patient's last living day, and being with a dying person during the final day of living, are main effects in contributing toward attitude formation. The contribution is mainly toward a positive attitude score. A significant difference in attitude score was not found if the dying person in the final day of living was an immediate family member, other relative or friend. A number of students in all levels had not cared for a dying patient during the past year. This may be explained by the placement of students in clinical rotations that offer limited opportunity to care for a dying patient, and by the very limited time that the Beginners were into their program.

Over half of the students in each level acknowledged that a particular experience influenced their attitude toward death and dying. There was a significant difference between those students that were aware of the influencing experience, and those students that had not had the experience. Not all experiences contributed to a positive attitude in the students. All levels cited death of family and friends and dying patients as most influential; three levels of students identified family most often, while the Junior level identified patients most often as the influence. Many of the responses did not include explanations as to how the experience influenced their attitudes.

CONCLUSIONS

All the variables examined in this study contributed to a change in attitude scores. The following conclusions are based on the findings from this study:

1. The level, and therefore the educational preparation, of the students as they advance in their nursing studies does influence attitudes toward death and dying. Attitudes of student nurses varied within and between levels. Attitude scores were highest, representing more rigid and inflexible attitudes, in students that were new to their nursing studies. As the students progressed, their attitude scores became less rigid, and more accepting of death and caring for the dying patient. Studies show that attitudes become more positive in caring for the dying as their experiences with terminally ill patients increase (Golub & Reznikoff, 1971; Snyder, Gertler & Ferneau, 1973; Martin & Collier, 1975; Bailey, 1976; Castronova, 1977; and Schrock & Swanson, 1981). Studies also show that death education tends to contribute to a more positive attitude toward death and dying (Yeaworth Kapp & Winget, 1974; Lester, Getty & Kneisl, 1974; Martin & Collier, 1975; Castronova, 1977; Milton, 1984; and Coolbeth & Sullivan, 1984). Therefore one could conclude that educational preparation does influence attitudes of student nurses toward death and dying.

2. Age was found to be an influence common to level of the students, to School of Nursing, and to religion, in regard to the mean attitude scores of the students. Beginning students tended to have a higher mean attitude score. The youngest students in each level generally had the highest mean attitude scores, while the older students generally had

the lowest scores. Therefore one could conclude that older students have a more positive attitude toward caring for the dying person.

3. Personal experiences with death and dying appear to influence attitudes toward death and dying. Significant differences were found between those students who had cared for a patient during the patient's final living day and those who had not. A significant difference was found between those students who had cared for more than 5 dying patients during the past year and those that had not.

IMPLICATIONS FOR FURTHER RESEARCH

Many studies have addressed the effects of specific death education courses on the attitudes of student nurses, but few studies have addressed the formation of students' attitudes toward death and dying. The following are suggestions for further research:

1. A longitudinal study to gather data on attitude changes as the students progress with their studies;
2. Use of the interview method to gather data, and thus allow the students to identify variables that contributed to a change in attitudes; and
3. A study to determine the influence on students' attitudes of personnel that the students worked with, for example, nursing instructors, staff nurses, clergy, and others, when caring for dying patients;
4. Replicating this study in another setting, for example, a non-hospital based School of Nursing.

RECOMMENDATIONS

Based on the literature review and the findings from the study, it is recommended that death and dying content be offered to students early in their nursing studies. Attitudes toward death and dying become more positive following lectures on death and dying, following discussions on death and dying, and following increased experiences with caring for the dying.

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APPENDIX A

ORIGINAL QUESTIONNAIRE

Winget, Carolyn, Yeaworth, Rosalie C., and Kapp, Fredric T.

QUESTIONNAIRE FOR UNDERSTANDING THE DYING PERSON AND HIS FAMILY

Subject # _____

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

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

SA A U D SD 1. Regardless of his age, disabilities, and personal preference, a person should be kept alive as long as possible.

SA A U D SD 2. Dying patients should be told they are dying.

SA A U D SD 3. Medical personnel find it more satisfying to work with patients who are expected to improve rather than with patients who are likely to die.

SA A U D SD 4. The dying patient is best served by a matter-of-fact focus on medical issues.

SA A U D SD 5. Discussion among doctors, nurses, and other health workers about the care of the dying may reveal differences in attitudes toward death and dying.

SA A U D SD 6. It is important in the treatment of the dying patient to discuss his feelings with him.

SA A U D SD 7. Doctors, nurses, family and friends, if they prefer, can keep knowledge about his status from the dying patient.

SA A U D SD 8. Fear of death is natural in all of us.

SA A U D SD 9. Feelings of depression in the dying patient are unusual.

SA A U D SD 10. The patient is better off not knowing his diagnosis even when it carries an implication of imminent death.

SA A U D SD 11. If a patient talks about his fear of death, his doctors and nurses should reassure him that he has little to worry about.

SA A U D SD 12. Nurses and doctors usually communicate easily with each other on issues relating to the needs of the dying patient.

SA A U D SD 13. Those who support the principle of "death with dignity" endorse active as well as passive euthanasia.

SA A U D SD 14. No matter what my personal beliefs, in my role as a medical professional I would fight to keep the patient alive.

SA A U D SD 15. The dying patient who talks about his future plans for work, family, trips, etc., does not realize the seriousness of his condition.

SA A U D SD 16. Individual freedom of choice ultimately should mean freedom of choice to live or die within a context of responsibility for self and others.

SA A U D SD 17. Even if they don't ask, relatives should be told when death is imminent in the ill patient.

SA A U D SD 18. Dealing with a dying patient makes one aware of his own feelings regarding death.

SA A U D SD 19. Family members who stay close to a dying patient often interfere with the professional's job with the patient.

SA A U D SD 20. Death means annihilation of the physical, social, and psychological self.

SA A U D SD 21. Dying in the United States is handled more humanely than it is in most other parts of the world.

SA A U D SD 22. If given a choice, I prefer to avoid contact with dying people.

SA A U D SD 23. It is natural for medical personnel to grieve for their patients who die.

SA A U D SD 24. I rarely think of dying.

SA A U D SD 25. The dying patient is physically ugly.

SA A U D SD 26. It is possible for medical personnel to help patients prepare for death.

SA A U D SD 27. Medical personnel tend to cut down on their visits to the dying patient if there is little that can be done for him medically.

SA A U D SD 28. Patients are better off dying in a hospital than at home.

SA A U D SD 29. Suicide is wrong.

SA A U D SD 30. When thinking of dying, I fear the idea of disability and pain more than death itself.

SA A U D SD 31. Dying patients feel less comfortable if they have frequent visitors during their final days.

SA A U D SD 32. Nurses should be the primary professionals equipped to deal with the reaction of a dying patient.

SA A U D SD 33. Some patients should be allowed to die without making heroic efforts to prolong their lives.

SA A U D SD 34. Relatives who know the prognosis of the terminally ill patient make patient management more difficult.

SA A U D SD 35. The terminally ill patient frequently turns to his doctor and nurse to discuss his feelings about dying.

SA A U D SD 36. Our imagination about dying is harder to handle than the reality.

SA A U D SD 37. The more intelligent a person is, the less he fears death.

SA A U D SD 38. The dying patient mourns his own coming death.

SA A U D SD 39. Dying is a painful process.

SA A U D SD 40. Training medical personnel on attitudes toward dying is inappropriate because helping people to live is their goal.

SA A U D SD 41. The dying patient should be separated from other patients during the final period.

SA A U D SD 42. Many patients prefer to be told when their death is near.

SA A U D SD 43. The term "pass away" is preferable to the term "die."

SA A U D SD 44. It is all right for people to whisper to one another in the presence of a dying person.

SA A U D SD 45. Doctors and nurses should be detached emotionally if they are to work in the best interests of the dying patient.

SA A U D SD 46. Sometimes patients give up on themselves because the medical personnel have given up on them.

SA A U D SD 47. It is a common tendency to "skip over" dying persons on teaching rounds.

SA A U D SD 48. I usually feel at ease talking with physicians about dying patients for whom they are responsible.

SA A U D SD 49. The physician ordinarily discusses frankly with the family the implications of a diagnosis of a usually fatal disease.

SA A U D SD 50. Suicide may be justified in the terminally ill.

Part II:

1. Have you ever discussed attitudes toward death and dying with your friends, classmates, or colleagues? Yes ____ No ____

2. Have you ever been asked to talk with a person who is dying? Yes ____ No ____

3. Do you usually go to the funerals of relatives, friends, and close colleagues? Yes ____ No ____

4. Do you usually pay condolence calls on the families of deceased relatives, friends, and close colleagues? Yes ____ No ____

5. Has anyone in your immediate family died? Yes ____ No ____

Relationship:		Your age then:
Father	____	____
Mother	____	____
Sister	____	____
Brother	____	____
Grandparent	____	____
Other close relative	____	____

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

	Yes	No
Suicide?	___	___
Accident?	___	___
Acute illness?	___	___
Chronic illness?	___	___
Old age?	___	___

7. Have you made a Will? Yes ___ No ___

8. Do you think funeral services are of value to the survivors? Yes ___ No ___

9. Do you prefer:
___ Traditional burial with open casket?
___ Traditional burial with closed casket?
___ Cremation
___ Placement in a mausoleum
___ Donate body to medical science
___ Doesn't matter

10. Necropsy (autopsy):

I (do/do not) prefer necropsy for myself.

I (do/do not) prefer necropsy for members of my family.

I (do/do not) prefer necropsy for my patients.

___ I have no personal opinion on this subject.

11. I (would/would not) want my family to know I have a fatal illness because _____

_____

_____

_____

12. If I learned today that I had a fatal illness, I would probably

_____

_____

_____

13. Would it be helpful if your training as a health professional included material on how to deal with the dying patient and his family?

	Yes	No
Lectures or seminars	____	____
Panels	____	____
Group discussions	____	____
Reading lists	____	____
Clinical conferences	____	____

APPENDIX B

STUDY QUESTIONNAIRE

Introduction

This questionnaire is designed to measure attitudes of health care workers toward death and dying. It will take about 30 minutes to complete. It consists of a variety of statements concerning attitudes towards death, the dying and their families, and some general background information.

Nearly all questions can be answered by simply checking or circling your answer. If you are not sure of an answer, please give your honest opinion or make an estimate. We are not interested in right or wrong answers. We want to know what you think and how you feel. Please give your own personal reactions, not the reactions you think are expected. Please work as rapidly as you can.

All information will be kept confidential.

Thank you again for your co-operation.

QUESTIONNAIRE FOR UNDERSTANDING THE DYING PERSON AND HIS FAMILY

Please check ( ) the appropriate response

Part I

Do not write in this column

1. To which sex do you belong? 1. ____ female 2. ____ male — 7

2. What is your year of birth? _____ — 8 9

3. To which religious affiliation do you belong?

1. ____ Catholic
2. ____ Protestant
3. ____ Other
4. ____ None

— 10

4. How would you describe your religious intensity?

1. ____ Strong
2. ____ Moderate
3. ____ Weak
4. ____ None

— 11

5. How have you had material on death and dying presented to you? (Check all applicable)

____ 1. Integrated with other material in your nursing program — 12

____ 2. As a separate course within your nursing program — 13

____ 3. As a separate course before you entered your nursing program — 14

____ 4. As a separate course while you were enrolled in nursing, but not as a formal part of your nursing program — 15

____ 5. Never had any presentation on death and dying — 16

6. If you had taken a separate course on death and dying during the time you were enrolled in the nursing program, during which level and term did this occur? 17 18 19

_____

_____

Part II

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

CODE:
- SA - Strongly Agree
- A - Agree
- U - Undecided
- D - Disagree
- SD - Strongly Disagree

			Do not write in this column
1.	Regardless of his age, physical condition and personal preference, a person should be kept alive as long as possible.	SA A U D SD	20
2.	Dying patients should be told they are dying.	SA A U D SD	21
3.	Health care personnel find it more satisfactory to work with patients who are expected to improve rather than with patients who are likely to die.	SA A U D SD	22
4.	The dying patient is best served by a matter of fact focus on medical issues.	SA A U D SD	23
5.	Discussion among physicians, nurses and other health care workers about the care of the dying may reveal differences in attitude toward death and dying.	SA A U D SD	24
6.	It is important in the treatment of the dying patient to discuss his feelings with him.	SA A U D SD	25
7.	Physicians, nurses, family and friends have the right to keep knowledge about his status from the dying patient.	SA A U D SD	26

8.	Fear of death is natural in all of us.	SA A U D SD	27
9.	Feelings of depression in the dying patient are unusual.	SA A U D SD	28
10.	The patient is better off not knowing his diagnosis even when it carries an implication of imminent death.	SA A U D SD	29
11.	If a dying patient talks about his fear of death, his physicians and nurses should reassure him that he has little to worry about.	SA A U D SD	30
12.	Nurses and physicians usually communicate easily with each other on issues relating to the needs of the dying patient.	SA A U D SD	31
13.	Those who support the principle of "death with dignity" endorse active euthanasia.	SA A U D SD	32
14.	No matter what my personal beliefs in my role as a professional, I would fight to keep the patient alive.	SA A U D SD	33
15.	The dying patient who talks about his future plans for work, family, trips, etc. does not realize the seriousness of his condition.	SA A U D SD	34
16.	Individual freedom of choice ultimately should mean freedom of choice to live or die within a context of responsibility for self and others.	SA A U D SD	35
17.	Even if they don't ask, relatives should be told when death is imminent in the dying person.	SA A U D SD	36
18.	Dealing with a dying patient makes one aware of his own feelings regarding death.	SA A U D SD	37
19.	Family members who stay close to a dying patient often interfere with the professional's care of the patient.	SA A U D SD	38
20.	Death means annihilation of the physical, social and psychological self.	SA A U D SD	39

21.	Dying in Canada is handled more humanely than it is in other parts of the world.	SA A U D SD	40
22.	If given a choice, I prefer to avoid contact with dying people.	SA A U D SD	41
23.	It is natural for health care personnel to grieve for their patients who die.	SA A U D SD	42
24.	I rarely think of dying.	SA A U D SD	43
25.	The dying patient is physically unattractive.	SA A U D SD	44
26.	It is possible for health care personnel to help patients prepare for death.	SA A U D SD	45
27.	Medical personnel tend to cut down on their visits to the dying patient if there is little than can be done for him medically.	SA A U D SD	46
28.	The needs of dying patients are better met in a hospital than at home.	SA A U D SD	47
29.	Suicide is wrong.	SA A U D SD	48
30.	When thinking of dying, I fear the idea of disability and pain more than death itself.	SA A U D SD	49
31.	Dying patients feel less comfortable if they have frequent visitors during their final days.	SA A U D SD	50
32.	Nurses should be the primary professionals equippped to deal with the emotional reaction of a dying patient.	SA A U D SD	51
33.	Some patients should be allowed to die without medical staff making heroic efforts to prolong their lives	SA A U D SD	52
34.	Relatives who know the prognosis of the terminally ill patient make patient management more difficult	SA A U D SD	53

35.	The terminally ill patient frequently turns to his physician and nurse to discuss his feelings about dying.	SA A U D SD	54
36.	Our imagination about dying is harder to handle than the reality.	SA A U D SD	55
37.	The more intelligent a person is, the less he fears death.	SA A U D SD	56
38.	The dying patient mourns his own coming death.	SA A U D SD	57
39.	Dying is a painful process.	SA A U D SD	58
40.	Training health care personnel on attitudes towards dying is inappropriate because helping people to live is their goal.	SA A U D SD	59
41.	The dying patient should be separated from other patients during the final period.	SA A U D SD	60
42.	Many patients prefer to be told when their death is near.	SA A U D SD	61
43.	The term "pass away" is preferable to the term "die".	SA A U D SD	62
44.	It is all right for people to whisper to one another in the presence of the dying person.	SA A U D SD	63
45.	Physicians and nurses should be detached emotionally if they are to work in the best interests of the dying patient.	SA A U D SD	64
46.	Sometimes dying patients give up on themselves because the health care personnel have given up on them.	SA A U D SD	65
47.	It is a common tendency to "skip over" dying patients on teaching rounds.	SA A U D SD	66
48.	I usually feel at ease talking with physicians about dying patients for whom they are responsible.	SA A U D SD	67

49. The physician ordinarily discusses frankly with the family the implications of a diagnosis of a usually fatal disease. SA A U D SD 68

50. Suicide may be justified in the terminally ill. SA A U D SD 69 _

Part III

Do not write in this column

1. Have you ever discussed attitudes towards death and dying with your family, friends, classmates, colleagues or church members?

1. ____ Yes 2. ____ No 70

2. Have you ever been with a dying person within the last 24 hours before his death?

1. ____ Yes 2. ____ No 71

3. If you answered yes to the above, into which category(s) did this person(s) belong? (check all applicable)

1. ____ Immediate family 72
2. ____ Other relative 73
3. ____ Friend 74
4. ____ Patient 75

4. Have you had any relatives die within the past year?

1. ____ Yes 2. ____ No 76

5. How many dying patients have you cared for during the past year? _____ 77 78

6. Have you had or been aware of any particular experience that has influenced how you feel about death in general?

1. ____ Yes 2. ____ No 79

7. If you answered yes to the above, please explain

_____

_____

_____

8. I would want my family to know that I have a fatal disease

1. ____ Yes 2. ____ No 80

9. If I learned today I have a fatal illness I would probably

_____

_____

_____

APPENDIX C

QUESTIONNAIRE SCORE KEY

QUESTIONNAIRE FOR UNDERSTANDING THE DYING PERSON AND HIS FAMILY

KEY

1. -	14. -	31. -	48.
2. +	15. -	32.	49.
3.	16. +	33. +	50. +
4. -	17. +	34. -	
5.	18. +	35.	
6. +	19. -	36. +	
7. -	20.	37. -	- = SA = 5
8. +	21. -	38. +	+ = SA = 1
9. -	22.	39.	= No score
10. -	23. +	40. -	
11. -	24.	41. -	Minimum - 33
12.	25.	42. +	Maximum - 165
13. -	26. +	43. -	
	27.	44. -	
	28.	45.	
	29. -	46. +	
	30.	47.	

APPENDIX D

FREQUENCY OF RESPONSES: PART II OF QUESTIONNAIRE

Number of Times Responses Chosen in Questionnaire Measuring Sudent Nurses' Attitudes Toward Understanding the Dying Person and His Family

(by frequency and percentage)

	CHOICE AND VALUE		Beginner		Junior		Intermediate		Senior	
			f	%	f	%	f	%	f	%
10. Regardless of his age, physical condition and personal preference, a person should be kept alive as long as possible.	SD	(1)	19	(7.1)	29	(19.9)	42	(21.5)	52	(31.9)
	D	(2)	122	(45.4)	67	(45.9)	87	(44.6)	83	(50.9)
	U	(3)	49	(18.2)	25	(17.1)	32	(16.4)	13	(8.0)
	A	(4)	55	(20.4)	18	(12.3)	28	(14.4)	12	(7.4)
	SA	(5)	24	(8.9)	7	(4.8)	6	(3.1)	3	(1.8)
11. Dying patients should be told they are dying.	SA	(1)	117	(43.2)	81	(55.5)	99	(50.8)	73	(44.8)
	A	(2)	119	(43.9)	52	(35.6)	74	(37.9)	67	(41.1)
	U	(3)	24	(8.9)	12	(8.2)	17	(8.7)	20	(12.3)
	D	(4)	10	(3.7)	1	(.7)	4	(2.1)	2	(1.2)
	SD	(5)	1	(.4)	-	-	1	(.5)	1	(.6)
13. The dying patient is best served by a matter fact focus on medical issues.	SD	(1)	19	(7.1)	20	(13.7)	31	(15.9)	38	(23.3)
	D	(2)	68	(25.3)	70	(47.9)	82	(42.1)	64	(39.3)
	U	(3)	91	(33.8)	31	(21.2)	50	(25.6)	33	(20.2)
	A	(4)	77	(28.6)	22	(15.1)	26	(13.3)	26	(16.0)
	SA	(5)	14	(5.2)	3	(2.1)	6	(3.1)	2	(1.2)
15. It is important in the treatment of the dying patient to discuss his feelings with him.	SA	(1)	197	(72.7)	122	(83.6)	152	(77.9)	130	(79.8)
	A	(2)	64	(23.6)	22	(15.1)	37	(19.0)	31	(19.0)
	U	(3)	10	(3.7)	2	(1.4)	6	(3.1)	1	(.6)
	D	(4)	-	-	-	-	-	-	1	(.6)
	SD	(5)	-	-	-	-	-	-	-	-

	CHOICE AND VALUE		Beginner		Junior		Intermediate		Senior	
			f	%	f	%	f	%	f	%
16. Physicians, nurses, family and friends have the right to keep knowledge about his status from the dying patient.	SD	(1)	109	(40.4)	45	(30.8)	84	(43.1)	59	(36.2)
	D	(2)	102	(37.8)	69	(47.3)	84	(43.1)	70	(42.9)
	U	(3)	34	(12.6)	19	(13.0)	19	(9.7)	23	(14.1)
	A	(4)	17	(6.3)	11	(7.5)	6	(3.1)	9	(5.5)
	SA	(5)	8	(3.0)	2	(1.4)	2	(1.0)	2	(1.2)
17. Fear of death is natural in all of us.	SA	(1)	111	(41.0)	53	(36.3)	53	(27.2)	70	(42.9)
	A	(2)	133	(49.1)	76	(52.1)	111	(56.9)	80	(49.1)
	U	(3)	6	(2.2)	8	(5.5)	11	(5.6)	6	(3.7)
	D	(4)	21	(7.7)	7	(4.8)	19	(9.7)	6	(3.7)
	SD	(5)	-	-	2	(1.4)	1	(.5)	1	(.6)
18. Feelings of depression in the dying are unusual.	SD	(1)	119	(43.9)	69	(47.3)	82	(42.1)	80	(49.1)
	D	(2)	128	(47.2)	67	(45.9)	93	(47.7)	75	(46.0)
	U	(3)	13	(4.8)	7	(4.8)	8	(4.1)	2	(1.2)
	A	(4)	10	(3.7)	1	(.7)	10	(5.1)	5	(3.1)
	SA	(5)	1	(0.4)	2	(1.4)	2	(1.0)	1	(.6)
19. The patient is better off not knowing his diagnosis even when it carries an implication of imminent death.	SD	(1)	115	(42.4)	64	(43.8)	100	(51.3)	87	(53.4)
	D	(2)	118	(43.5)	64	(43.8)	78	(40.0)	56	(34.4)
	U	(3)	23	(8.5)	6	(4.1)	4	(2.1)	10	(6.1)
	A	(4)	11	(4.1)	7	(4.8)	6	(3.1)	10	(6.1)
	SA	(5)	4	(1.5)	5	(3.4)	7	(3.6)	-	-
20. If a dying patient talks about his fear of death, his physicians and nurses should reassure him that he has little to worry about.	SD	(1)	71	(26.3)	48	(32.9)	92	(47.2)	101	(62.0)
	D	(2)	122	(45.2)	80	(54.8)	87	(44.6)	56	(34.4)
	U	(3)	45	(16.7)	9	(6.2)	13	(6.7)	5	(3.1)
	A	(4)	25	(9.3)	8	(5.5)	2	(1.0)	1	(.6)
	SA	(5)	7	(2.6)	1	(.7)	1	(.5)	-	-

	CHOICE AND VALUE		Beginner f	Beginner %	Junior f	Junior %	Intermediate f	Intermediate %	Senior f	Senior %
22. Those who support the principle of "death with dignity" endorse active euthanasia.	SD	(1)	20	(7.4)	11	(7.5)	32	(16.4)	37	(22.7)
	D	(2)	59	(21.8)	67	(45.9)	77	(39.5)	71	(43.6)
	U	(3)	104	(38.4)	38	(26.0)	50	(25.6)	29	(17.8)
	A	(4)	79	(29.2)	28	(19.2)	34	(17.4)	20	(12.3)
	SA	(5)	9	(3.3)	2	(1.4)	2	(1.0)	6	(3.7)
23. No matter what my personal beliefs in my role as a professional, I would fight to keep the patient alive.	SD	(1)	1	(0.4)	3	(2.1)	9	(4.6)	8	(4.9)
	D	(2)	22	(8.1)	27	(18.5)	51	(26.2)	59	(36.2)
	U	(3)	57	(21.0)	49	(33.6)	63	(32.3)	45	(27.6)
	A	(4)	122	(45.0)	49	(36.3)	63	(32.3)	42	(27.8)
	SA	(5)	69	(25.5)	14	(9.6)	20	(10.3)	9	(5.5)
24. The dying patient who talks about his future plans for work, family, trips, etc. does not realize the seriousness of his conditions.	SD	(1)	22	(8.1)	24	(16.4)	25	(12.8)	11	(6.7)
	D	(2)	156	(57.6)	87	(59.6)	117	(60.0)	109	(66.9)
	U	(3)	22	(8.1)	13	(8.9)	25	(12.8)	15	(9.2)
	A	(4)	66	(24.4)	19	(13.0)	27	(13.8)	26	(16.0)
	SA	(5)	5	(1.8)	3	(2.1)	1	(.5)	2	(1.2)
25. Individual freedom of choice ultimately should mean freedom of choice to live or die within a context of responsibility for self and others.	SA	(1)	40	(14.8)	32	(21.9)	34	(17.4)	28	(17.2)
	A	(2)	154	(56.8)	87	(59.6)	100	(51.3)	92	(56.4)
	U	(3)	44	(16.2)	17	(11.6)	40	(20.5)	28	(17.2)
	D	(4)	26	(9.6)	9	(6.2)	18	(9.2)	13	(8.0)
	SD	(5)	7	(2.6)	1	(.7)	3	(1.5)	2	(1.2)
26. Even if they don't ask, relatives should be told when death is imminent in the dying person.	SA	(1)	56	(20.7)	20	(13.7)	28	(14.4)	29	(17.8)
	A	(2)	156	(57.6)	84	(57.5)	98	(50.3)	80	(49.1)
	U	(3)	28	(10.3)	21	(14.4)	35	(17.9)	30	(18.4)
	D	(4)	29	(10.7)	18	(12.3)	30	(15.4)	21	(12.9)
	SD	(5)	2	(.7)	3	(2.1)	4	(2.1)	3	(1.3)

	CHOICE AND VALUE		Beginner		Junior		Intermediate		Senior	
			f	%	f	%	f	%	f	%
27. Dealing with a dying patient makes one aware of his own feelings regarding death.	SA	(1)	99	(36.5)	51	(34.9)	80	(41.0)	63	(38.7)
	A	(2)	159	(58.7)	82	(56.2)	99	(50.8)	85	(52.1)
	U	(3)	6	(2.2)	8	(5.5)	11	(5.6)	9	(5.5)
	D	(4)	7	(2.6)	4	(2.7)	5	(2.6)	6	(3.7)
	SD	(5)	-	-	1	(.7)	-	-	-	-
28. Family members who stay close to a dying patient often interfere with the professional care of the patient.	SD	(1)	67	(24.7)	42	(28.8)	61	(31.3)	62	(38.0)
	S	(2)	130	(48.0)	73	(50.0)	101	(51.8)	78	(47.9)
	U	(3)	52	(19.2)	19	(13.0)	22	(11.3)	10	(6.1)
	A	(4)	20	(7.4)	12	(8.2)	11	(5.6)	12	(7.4)
	SA	(5)	2	(.7)	-	-	-	-	1	(.6)
30. Dying in Canada is handled more humanely than it is in other parts of the world.	SD	(1)	9	(3.3)	4	(2.7)	13	(6.7)	14	(8.6)
	D	(2)	44	(16.2)	33	(22.6)	52	(26.7)	45	(27.6)
	U	(3)	140	(51.7)	75	(51.4)	105	(53.8)	64	(39.3)
	A	(4)	68	(25.1)	31	(21.2)	23	(11.8)	35	(21.5)
	SA	(5)	10	(3.7)	3	(2.1)	2	(1.0)	5	(3.1)
32. It is natural for health care personnel to grieve for their patients who die.	SA	(1)	16	(5.9)	21	(14.4)	34	(17.4)	37	(22.7)
	A	(2)	209	(77.1)	103	(70.5)	133	(68.2)	111	(68.1)
	U	(3)	27	(10.0)	11	(7.5)	23	(11.8)	7	(4.3)
	D	(4)	18	(6.6)	7	(4.8)	4	(2.1)	7	(4.3)
	SD	(5)	1	(.4)	4	(2.7)	1	(.5)	1	(.6)
35. It is possible for health care personnel to help patients prepare for death.	SA	(1)	87	(32.1)	55	(37.7)	80	(41.0)	64	(39.3)
	A	(2)	169	(62.4)	84	(57.5)	102	(52.3)	89	(54.6)
	U	(3)	10	(3.7)	4	(2.7)	9	(4.6)	5	(3.1)
	D	(4)	3	(1.1)	1	(.7)	3	(1.5)	3	(1.8)
	SD	(5)	2	(.7)	2	(1.4)	1	(.5)	2	(1.2)

	CHOICE AND VALUE		Beginner f	Beginner %	Junior f	Junior %	Intermediate f	Intermediate %	Senior f	Senior %
38. Suicide is wrong.	SD	(1)	4	(1.5)	2	(1.4)	8	(4.1)	1	(.6)
	D	(2)	26	(9.6)	15	(10.3)	14	(7.2)	21	(12.9)
	U	(3)	49	(18.1)	28	(19.2)	56	(28.7)	46	(28.2)
	A	(4)	77	(28.4)	45	(30.8)	64	(32.8)	46	(28.2)
	SA	(5)	115	(42.4)	56	(38.4)	53	(27.2)	49	(30.1)
40. Dying patients feel less comfortable if they have frequent visitors during their final days.	SD	(1)	40	(14.8)	22	(15.1)	28	(14.4)	24	(14.7)
	D	(2)	113	(41.2)	67	(45.9)	71	(36.4)	78	(47.9)
	U	(3)	80	(29.5)	43	(29.5)	77	(39.5)	46	(28.2)
	A	(4)	32	(11.8)	14	(9.6)	19	(9.7)	13	(8.0)
	SA	(5)	6	(2.2)	-	-	-	-	2	(1.2)
42. Some patients should be allowed to die without medical staff making heroic efforts to prolong their lives.	SA	(1)	55	(20.3)	50	(34.2)	71	(36.4)	75	(46.0)
	A	(2)	140	(51.7)	86	(58.9)	94	(48.2)	78	(47.9)
	U	(3)	36	(13.3)	7	(4.8)	23	(11.8)	4	(2.5)
	D	(4)	30	(11.1)	2	(1.4)	5	(2.6)	5	(3.1)
	SD	(5)	10	(3.7)	1	(.7)	2	(1.0)	1	(.6)
43. Relatives who know the prognosis of the terminally ill patient make patient management more difficult.	SD	(1)	17	(6.3)	13	(8.9)	24	(12.3)	20	(12.3)
	D	(2)	133	(49.1)	78	(53.4)	105	(53.8)	101	(62.0)
	U	(3)	96	(35.4)	47	(32.2)	54	(27.7)	32	(19.6)
	A	(4)	23	(8.5)	8	(5.5)	11	(5.6)	9	(5.5)
	SA	(5)	2	(.7)	-	-	1	(.5)	1	(.6)
45. Our imagination about dying is harder to handle than the reality.	SA	(1)	33	(12.2)	13	(8.9)	15	(7.7)	20	(12.3)
	A	(2)	138	(50.9)	73	(50.0)	93	(47.7)	81	(49.7)
	U	(3)	55	(20.3)	39	(26.7)	54	(27.7)	43	(26.4)
	D	(4)	36	(13.3)	20	(19.7)	31	(15.9)	16	(9.8)
	SD	(5)	9	(3.3)	1	(.7)	2	(1.0)	3	(1.8)

	CHOICE AND VALUE		Beginner f	Beginner %	Junior f	Junior %	Intermediate f	Intermediate %	Senior f	Senior %
46. The more intelligent a person is, the less he fears death.	SD	(1)	104	(38.4)	61	(48.1)	78	(40.0)	80	(49.1)
	D	(2)	146	(53.9)	75	(51.4)	97	(49.7)	72	(44.2)
	U	(3)	15	(5.5)	7	(4.8)	18	(19.2)	8	(4.9)
	A	(4)	3	(1.1)	3	(2.1)	2	(1.0)	3	(1.8)
	SA	(5)	3	(1.1)	–	–	–	–	–	–
47. The dying patient mourns his own death.	SA	(1)	14	(5.2)	9	(6.2)	17	(8.7)	30	(18.4)
	A	(2)	150	(55.4)	75	(51.4)	129	(66.2)	101	(62.0)
	U	(3)	68	(25.1)	44	(30.1)	37	(19.0)	21	(12.9)
	S	(4)	38	(14.0)	15	(10.3)	10	(5.1)	10	(6.1)
	SD	(5)	1	(.4)	3	(2.1)	2	(1.0)	1	(.6)
49. Training health care personnel on attitudes towards dying is inappropriate because helping people to live is their goal.	SD	(1)	55	(20.3)	73	(50.5)	113	(57.9)	102	(62.6)
	D	(2)	105	(38.7)	62	(42.5)	64	(32.8)	48	(29.4)
	U	(3)	56	(20.7)	5	(3.4)	12	(6.2)	4	(2.5)
	A	(4)	48	(17.7)	6	(4.1)	6	(3.1)	8	(4.9)
	SA	(5)	7	(2.6)	–	–	–	–	1	(.6)
50. The dying patient should be separated from other patients during the final period.	SD	(1)	55	(20.3)	36	(24.7)	49	(25.1)	28	(17.2)
	D	(2)	105	(38.7)	47	(32.2)	66	(33.8)	53	(32.5)
	U	(3)	56	(20.7)	22	(15.1)	33	(16.9)	30	(18.4)
	A	(4)	48	(17.7)	36	(24.7)	41	(21.0)	43	(26.9)
	SA	(5)	7	(2.6)	5	(3.4)	6	(3.1)	9	(5.5)
51. Many patients prefer to be told when their death is near.	SA	(1)	21	(7.7)	17	(11.6)	19	(9.7)	12	(7.4)
	A	(2)	166	(61.3)	79	(54.1)	110	(56.4)	86	(52.8)
	U	(3)	65	(24.0)	43	(29.5)	56	(28.7)	48	(29.4)
	D	(4)	18	(6.6)	5	(3.4)	9	(4.6)	17	(10.4)
	SD	(5)	1	(.4)	2	(1.4)	1	(.5)	–	–

	CHOICE AND VALUES		Beginner		Junior		Intermediate		Senior	
			f	%	f	%	f	%	f	%
52. The term "pass away" is preferable to the term "die".	SD	(1)	6	(2.2)	4	(2.7)	11	(5.6)	8	(4.9)
	D	(2)	37	(13.7)	25	(17.1)	45	(23.1)	45	(27.6)
	U	(3)	40	(14.8)	40	(27.4)	50	(25.6)	24	(14.7)
	A	(4)	155	(57.2)	65	(44.5)	75	(38.5)	75	(46.0)
	SA	(5)	33	(12.2)	12	(8.2)	14	(7.2)	11	(6.7)
53. It is all right for people to whisper to one another in the presence of the dying person.	SD	(1)	177	(43.2)	64	(43.8)	93	(47.7)	67	(41.1)
	D	(2)	120	(44.3)	63	(43.2)	80	(41.0)	80	(49.1)
	U	(3)	23	(8.5)	12	(8.2)	14	(7.2)	13	(8.0)
	A	(4)	11	(4.1)	6	(4.1)	7	(3.6)	3	(1.8)
	SA	(5)	-	-	1	(.7)	1	(.5)	-	-
55. Sometimes dying patients give up on themselves because the health care personnel have given up on them.	SA	(1)	26	(.6)	12	(8.2)	15	(7.7)	13	(8.0)
	A	(2)	159	(58.7)	102	(69.9)	122	(62.6)	104	(63.8)
	U	(3)	49	(18.1)	22	(15.1)	37	(19.0)	21	(12.9)
	D	(4)	32	(11.8)	8	(5.5)	19	(9.7)	25	(15.3)
	SD	(5)	5	(1.8)	2	(1.4)	2	(1.0)	_	_
59. Suicide may be justified in the terminally ill.	SA	(1)	9	(3.3)	4	(2.7)	8	(4.1)	5	(3.1)
	A	(2)	58	(21.4)	26	(17.8)	38	(18.5)	46	(28.2)
	U	(3)	68	(25.1)	40	(27.4)	64	(32.8)	49	(30.1)
	D	(4)	81	(29.9)	51	(34.9)	45	(23.1)	35	(21.5)
	SD	(5)	55	(20.3)	25	(17.1)	40	(20.5)	28	(17.5)

APPENDIX E

ANALYSIS OF VARIANCE BETWEEN RESPONSES AND LEVEL OF STUDENT NURSES

Analysis of Variance Between Levels of Student Nurses Responses to Individual Questions and Mean Attitude Scores

F-RATIO	F PROB	MEAN		S	I	J	B
10. Regardless of his age, physical condition and personal preference, a person should be kept alive as long as possible.							
21.4962	0.0000						
		1.9632	S				
		2.3282	I	*			
		2.3630	J	*			
		2.7881	B	*	*	*	
11. Dying patients should be told they are dying.							
2.5191	0.0569						
		1.5411	J				
		1.6359	I				
		1.7178	S				
		1.7417	B	*			
13. The dying patient is best served by a matter fact focus on medical issues.							
20.2242	.0000						
		2.3252	S				
		2.4384	J				
		2.4564	I				
		2.9963	B	*	*	*	
15. It is important in the treatment of the dying patient to discuss his feelings with him.							
2.5503	.0546						
		1.1781	J				
		1.2209	S				
		1.2513	I				
		1.3100	B	*			

F-RATIO F PROB MEAN

16. Physicians, nurses, family and friends have the right to keep knowledge about his status from the dying patient.

No significant differences

17. Fear of death is natural in all of us.

4.3879 .0045

		S	B	J	I
1.6994	S				
1.7675	B				
1.8288	J				
1.9949	I	*	*		

18. Feelings of depression in the dying is unusual.

No significant differences

19. The patient is better off not knowing his diagnosis even when it carries an implication of imminent death.

No significant differences

20. If a dying patient talks about his fear of death, his physicians and nurses should reassure him that he has little to worry about.

32.3811 .0000

		S	I	J	B
1.4233	S				
1.6308	I				
1.8630	J	*	*		
2.1667	B	*	*	*	

22. Those who support the principle of "death with dignity" endorse active euthansia.

19.5235 .0000

		S	I	J	B
2.3067	S				
2.4718	I				
2.6096	J	*			
2.9926	B	*	*	*	

	F-RATIO	F PROB	MEAN		S	I	J	B
23. No matter what my personal beliefs in my role as a professional, I would fight to keep the patient alive.	40.3641	.0000						
			2.9080	S				
			3.1179	I				
			3.3288	J	*			
			3.8708	B	*	*	*	
24. The dying patient who talks about his future plans for work, family, trips, etc. does not realize the seriousness of his conditions.	4.2294	.0056			J	I	S	B
			2.2466	J				
			2.2923	I				
			2.3804	S				
			2.5424	B	*	*	*	
25. Individual freedom of choice ultimately should mean freedom of choice to live or die within a context of responsibilty for self and others.	2.6412	.0484			J	S	I	B
			2.0411	J				
			2.1963	S				
			2.2615	I				
			2.2841	B	*			
26. Even if they don't ask, relatives should be told when death is imminent in the dying person.	3.5303	.0146			B	J	S	I
			2.1328	B				
			2.3151	J				
			2.3190	S				
			2.4051	I	*			

F-RATIO F PROB MEAN

27. Dealing with a dying patient makes one aware of his own feelings regarding death.

No significant differences

28. Family members who stay close to a dying patient often interfere with the professional care of the patient.

3.9193 .0086 S I J B

1.8466	S		
1.9128	I		
2.0068	J		
2.1144	B	*	

30. Dying in Canada is handled more humanely than it is in other parts of the world.

7.7346 .0000 I S J B

2.7385	I		
2.8282	S		
2.9726	J	*	
3.0959	B	*	*

32. It is natural for health care personnel to grieve for their patient who die.

5.8127 .0006 S I J B

1.9202	S		
2.0000	I		
2.1096	J		
2.1845	B	*	*

35. It is possible for health care personnel to help patients prepare for death.

No significant differences

	F-RATIO	F PROB	MEAN		I	S	J	B
38. Suicide is wrong.	3.8954	.0089						
			3.7179	I				
			3.7423	S				
			3.9452	J				
			4.0074	B	*	*		
40. Dying patients feel less comfortable if they have frequent visitors during their final days.	No significant differences							
42. Some patients should be allowed to die without medical staff making heroic efforts to prolong their lives.	22.6346	.0000			S	J	I	B
			1.6442	S				
			1.7534	J				
			1.8359	I				
			2.2620	B	*	*	*	
43. Relatives who know the prognosis of the terminally ill patient make patient management more difficult.	5.4117	.0011			S	I	J	B
			2.2025	S				
			2.2821	I				
			2.3425	J				
			2.4834	B	*	*		
45. Our imagination about dying is harder to handle than the reality.	No significant differences							

	F-RATIO	F PROB	MEAN					

46. The more intelligent a person is, the less he fears death.

No significant differences

47. The dying patient mourns his own death.

12.2289	.0000			S	I	B	J
		2.0859	S				
		2.2359	I				
		2.4908	B	*	*		
		2.5068	J	*	*		

49. Training health care personnel on attitudes towards dying is inappropriate because helping people to live is their goal.

No significant differences

50. The dying patient should be separated from other patients during the fir period.

No significant differences

51. Many patients prefer to be told when their death is near.

No significant differences

52. The term "pass away" is preferable to the term "die".

9.6824	.0000			I	S	J	B
		3.1846	I				
		3.2209	S				
		3.3836	J				
		3.6347	B	*	*		

	F-RATIO	F PROB	MEAN
53. It is all right for people to whisper to one another in the presence of the dying person.			
	No significant differences		
55. Sometimes dying patients give up on themselves because the health care personnel have given up on them.			
	No significant differences		
59. Suicide may be justified in the terminally ill.			
	No significant differences		

* p<.1 Scheffe Procedure

APPENDIX F

SUMMARY OF DEMOGRAPHICS AND EXPERIENCES WITH DEATH AND DYING OF STUDENT NURSES FROM SCHOOL OF NURSING 'A'

Demographic and Work Experience Summary
in Frequency and Percentage for School "A"

	Beginner		Junior		Intermediate pre-seminar		Intermediate post-seminar		Senior	
	f	%	f	%	f	%	f	%	f	%
SEX										
Female	81	(92)	71	(98.6)	35	(100)	27	(96.4)	28	(100)
Male	7	(8)	1	(1.4)			1	(3.6)		
AGE										
20 and under	51	(56.4)	30	(41.7)	4	(11.4)	1	(3.6)	0	
21-29	35	(41.4)	37	(51.4)	28	(80.1)	27	(96.4)	26	(92.8)
30-39	1	(1.2)	4	(5.6)	2		0	(5.8)	1	(3.6)
40 and over	1	(1.2)	1	(1.4)	1		0	(2.9)	1	(3.6)
No response	3	(3.5)								
RELIGIOUS AFFILIATION										
Catholic	35	(39.8)	27	(37.5)	13	(37.1)	10	(35.7)	13	(46.4)
Protestant	38	(43.2)	38	(52.8)	20	(57.1)	15	(53.6)	11	(39.3)
Other	11	(12.5)	7	(9.7)	2	(5.7)	1	(3.6)	3	(10.7)
None	4	(4.5)	0		0	(7.1)	2	(7.1)	1	(3.6)

	Beginner		Junior		Intermediate pre-seminar		Intermediate post-seminar		Senior	
	f	%	f	%	f	%	f	%	f	%
RELIGIOUS INTENSITY										
Strong	25	(28.4)	29	(40.3)	5	(14.3)	8	(28.6)	8	(28.6)
Moderate	49	(55.7)	32	(44.4)	22	(64.7)	15	(53.6)	15	(53.6)
Weak	12	(13.6)	9	(12.5)	7	(20.6)	3	(10.7)	3	(10.7)
None	2	(2.3)	2	(2.8)	0		2	(7.1)	2	(7.1)
No response							1	(2.9)		
EDUCATIONAL COURSES IN DEATH & DYING										
Integrated	4	(4.5)	67	(93.1)	29	(82.9)	24	(85.4)	28	(100)
Separate	0		8	(11.1)	2	(5.7)	4	(14.3)	6	(21.4)
Before	1	(1.1)	4	(5.6)	1	(2.9)	13	(46.4)	3	(10.7)
Extra During	21	(23.9)	4	(5.6)	1	(2.9)	0			
Never	64	(72.7)	1	(1.4)	2	(5.7)	0		0	
DISCUSSION										
Yes	77	(87.5)	71	(98.6)	33	(94.3)	25	(89.3)	28	(100)
No	11	(11.5)	1	(1.4)	2	(5.7)	3	(10.7)		
WITH DYING DURING LAST LIVING DAY										
Yes	28	(31.8)	52	(72.2)	25	(71.4)	15	(53.6)	25	(89.3)
No	60	(68.2)	20	(27.8)	10	(20.6)	13	(46.4)	3	(10.7)

	Beginner		Junior		Intermediate pre-seminar		Intermediate post-seminar		Senior	
	f	%	f	%	f	%	f	%	f	%
IDENTITY OF DYING PERSON										
Immediate family	12	(13.6)	17	(23.6)	2	(5.7)	7	(25.0)	6	(21.4)
Other relative	6	(6.8)	13	(18.1)	3	(8.6)	2	(7.1)	6	(21.4)
Friend	7	(8.4)	11	(15.3)	1	(2.9)	2	(7.1)	3	(10.7)
Patient	11	(12.5)	40	(55.6)	21	(60.0)	10	(35.7)	24	(85.7)
RELATIVE DIE IN PAST YEAR										
Yes	25	(28.7)	25	(34.7)	11	(31.4)	8	(28.6)	9	(32.1)
No	62	(71.3)	47	(65.3)	24	(68.6)	28	(71.4)	19	(67.9)
DYING PATIENTS CARED FOR DURING PAST YEAR										
none	77	(87.5)	3	(4.2)	12	(36.4)	10	(35.7)	1	(3.8)
1-5	7	(7.9)	59	(81.9)	15	(57.7)	15	(53.7)	18	(69.2)
6-10	2	(2.2)	8	(11.2)	1	(2.9)	0		5	(14.1)
11+	2	(2.2)	1	(1.4)	1	(2.9)	1	(3.6)	2	(7.6)
No response			1	(1.4)	2	(5.7)				

	Beginner		Junior		Intermediate pre-seminar		Intermediate post-seminar		Senior	
	f	%	f	%	f	%	f	%	f	%
EXPERIENCE TO INFLUENCE ATTITUDE										
Yes	52	(54.1)	38	(52.8)	16	(45.7)	16	(57.1)	20	(71.4)
No	36	(40.9)	34	(47.2)	19	(54.3)	12	(42.9)	8	(28.6)
WISH TO TELL FAMILY										
Yes	81	(93.1)	70	(97.2)	31	(88.6)	23	(85.2)	26	(92.9)
No	6	(6.9)	2	(2.8)	4	(11.4)	4	(14.8)	2	(7.1)
No response	1	(1.1)					1	(2.9)		
	N = 88		N = 72		N = 35		N = 28		N = 28	

APPENDIX G

SUMMARY OF DEMOGRAPHICS AND EXPERIENCE WITH DEATH AND DYING OF STUDENT NURSES FROM SCHOOL OF NURSING 'B'

Demographic and Work Experience Summary
in Frequency and Percentage for School "B"

	Beginner		Junior		Intermediate pre-course		Intermediate post-course		Senior	
	f	%	f	%	f	%	f	%	f	%
SEX										
Female	73	(92.4)	69	(93.3)	38	(90.2)	59	(93.7)	69	(90.8)
Male	6	(7.6)	5	(6.8)	4	(9.8)	4	(6.3)	7	(9.2)
AGE										
20 and under	12	(16.0)	16	(22.2)	1	(2.5)	0		0	
21-29	51	(67.9)	47	(65.3)	30	(75.0)	51	(82.3)	66	(87.4)
30-39	7	(9.2)	8	(11.2)	9	(22.5)	7	(11.8)	8	(10.6)
40 and over	5	(6.7)	1	(1.4)	0		4	(6.4)	1	(1.3)
No response	4	(5.1)	2	(2.7)	2	(4.8)	1	(1.6)	1	(1.3)
RELIGIOUS AFFILIATION										
Catholic	25	(32.1)	20	(27.4)	8	(19.5)	16	(25.4)	25	(32.9)
Protestant	27	(34.6)	31	(42.5)	19	(46.3)	38	(60.3)	36	(47.4)
Other	18	(23.1)	13	(17.8)	10	(24.4)	7	(11.1)	10	(13.2)
None	9	(11.3)	9	(12.3)	4	(9.8)	2	(3.2)	5	(6.6)
No response			1	(1.4)	1	(2.4)				

	Beginner		Junior		Intermediate pre-course		Intermediate post-course		Senior	
	f	%	f	%	f	%	f	%	f	%
RELIGIOUS INTENSITY										
Strong	19	(24.1)	12	(16.4)	10	(24.4)	18	(28.6)	16	(21.1)
Moderate	37	(46.8)	35	(47.9)	16	(39.0)	30	(47.6)	40	(52.6)
Weak	17	(21.5)	23	(31.5)	11	(26.8)	13	(20.6)	18	(23.7)
None	6	(7.6)	3	(4.1)	4	(9.8)	2	(3.2)	2	(2.6)
No response	4	(5.1)	2	(2.7)	2	(4.8)	1	(1.6)	1	(1.3)
EDUCATIONAL COURSES IN DEATH & DYING										
Integrated	4	(5.1)	31	(41.9)	24	(57.1)	49	(77.8)	65	(85.5)
Separate	2	(2.5)	2	(2.7)	7	(16.7)	13	(20.6)	10	(13.2)
Before	2	(2.5)	3	(4.1)	9	(21.4)	15	(23.8)	2	(2.6)
Extra During	16	(20.3)	10	(13.5)	2	(4.8)	5	(7.9)	5	(6.6)
Never	55	(69.6)	30	(40.5)	4	(9.5)	2	(3.2)	2	(2.6)
DISCUSSION										
Yes	67	(84.8)	69	(93.2)	36	(85.7)	58	(92.1)	72	(94.7)
No	12	(15.2)	5	(6.8)	6	(14.3)	5	(7.9)	4	(5.3)
WITH DYING DURING LAST LIVING DAY										
Yes	31	(39.2)	27	(36.5)	14	(33.3)	36	(58.1)	45	(59.2)
No	48	(60.8)	47	(63.6)	28	(66.7)	26	(41.9)	31	(40.8)
No response							1	(1.6)		

	Beginner		Junior		Intermediate pre-course		Intermediate post-course		Senior	
	f	%	f	%	f	%	f	%	f	%
IDENTITY OF DYING PERSON										
Immediate family	15	(19.0)	15	(20.3)	3	(7.1)	11	(17.5)	8	(10.5)
Other relative	10	(12.7)	7	(9.5)	2	(4.8)	6	(9.5)	2	(2.6)
Friend	10	(12.7)	9	(12.2)	2	(4.8)	10	(15.9)	7	(9.2)
Patient	15	(19.0)	12	(16.2)	12	(28.6)	27	(42.9)	37	(48.7)
RELATIVE DIE IN PAST YEAR										
Yes	27	(35.1)	23	(31.1)	13	(31.0)	18	(29.5)	24	(31.6)
No	50	(64.9)	51	(69.0)	29	(69.1)	43	(70.5)	51	(68.0)
No response	2	(2.5)					2	(1.3)	1	(1.3)
DYING PATIENTS CARED FOR DURING PAST YEAR										
none	39	(49.4)	57	(77)	13	(31.0)	17	(27.1)	12	(15.8)
1-5	9	(11.3)	4	(5.5)	24	(57.3)	41	(65.0)	50	(65.8)
6-10	2	(2.6)	2	(2.7)	1	(2.4)	1	(1.6)	8	(10.5)
11+	1	(1.3)	2	2.7)	0		0		2	(2.6)
No response					9	(9.5)	4	(6.3)	4	(5.3)

	Beginner		Junior		Intermediate pre-course		Intermediate post-course		Senior	
	f	%	f	%	f	%	f	%	f	%
EXPERIENCE TO INFLUENCE ATTITUDE										
Yes	40	(50.6)	42	(58.3)	20	(51.3)	29	(48.3)	48	(63.2)
No	35	(44.3)	30	(41.7)	19	(48.7)	31	(51.7)	28	(36.8)
No response	4	(5.1)	2	(2.7	3	(7.1)	3	(4.8)		
WISH TO TELL FAMILY										
Yes	66	(88.0)	69	(97.2)	33	(86.8)	57	(96.6)	67	(89.3)
No	9	(12.0)	2	(2.8)	5	(13.2)	2	(3.4)	8	(10.7)
No response	4	(54.0)	3	(4.1)	4	(9.5)	4	(6.3)	1	(1.3)
	N = 79		N = 74		N = 42		N = 63		N = 76	

APPENDIX H

SUMMARY OF DEMOGRAPHICS AND EXPERIENCES WITH DEATH AND DYING OF STUDENT NURSES FROM SCHOOL OF NURSING 'C'

Demographic and Work Experience Summary in Frequency and Percentage for School "C"

	Beginner		Intermediate		Senior	
	f	%	f	%	f	%
SEX						
Female	96	(92.3)	24	(88.9)	58	(98.3)
Male	8	(7.7)	3	(11.1)	1	(1.7)
AGE						
20 and under	32	(28.0)	6	(22.2)	3	(5.2)
21-29	52	(52.0)	17	(62.9)	49	(84.3)
30-39	18	(18.0)	3	(11.1)	3	(5.1)
40 and over	2	(2.0)	1	(3.7)	3	(5.1)
No response					1	(1.7)
RELIGIOUS AFFILIATION						
Catholic	32	(30.8)	5	(18.5)	24	(40.7)
Protestant	47	(45.2)	15	(55.6)	22	(37.3)
Other	16	(15.4)	3	(11.1)	8	(13.6)
None	9	(8.7)	4	(14.8)	5	(8.5)

	Beginner		Intermediate		Senior	
	f	%	f	%	f	%
RELIGIOUS INTENSITY						
Strong	12	(11.7)	3	(11.1)	13	(22.0)
Moderate	58	(56.3)	8	(29.6)	23	(39.0)
Weak	27	(26.2)	10	(37.0)	19	(32.2)
None	6	(5.8)	6	(22.2)	4	(6.8)
No response	1	(1.0)				
EDUCATIONAL COURSES IN DEATH & DYING						
Integrated	24	(23.1)	16	(59.3)	56	(94.9)
Separate	0		0		0	
Extra During	19	(18.3)	1	(3.7)	1	(1.7)
Before	1	(1.0)	9	(33.3)	6	(10.2)
Never	66	(63.5)	6	(22.2)	0	
DISCUSSION						
Yes	96	(92.3)	23	(85.2)	57	(96.6)
No	8	(7.7)	4	(14.8)	2	(3.4)
WITH DYING DURING LAST LIVING DAY						
Yes	38	(36.5)	14	(51.9)	54	(91.5)
No	66	(63.5)	13	(48.1)	5	(8.5)

	Beginner		Intermediate		Senior	
	f	%	f	%	f	%
IDENTITY OF DYING PERSON						
Immediate family	14	(13.5)	4	(14.8)	15	(25.4)
Other relative	12	(11.5)	2	(7.4)	8	(13.6)
Friend	11	(10.6)	0		5	(8.5)
Patient	17	(16.3)	11	(40.7)	48	(81.4)
RELATIVE DIE IN PAST YEAR						
Yes	35	(33.7)	4	(14.8)	22	(37.3)
No	69	(66.3)	23	(85.2)	37	(62.7)
[illegible]NG PATIENTS CARED FOR [illegible]G PAST YEAR						
none	88	(84.6)	8	(24.6)	4	(6.8)
1-5	9	(8.7)	17	(62.9)	42	(74.3)
6-10	4	(3.8)	2	(7.4)	10	(18.1)
11+	3	(3.0)	0		3	(5.4)
EXPERIENCE TO INFLUENCE ATTITUDE						
Yes	65	(64.4)	16	(59.3)	37	(62.7)
No	36	(35.6)	11	(40.7)	22	(37.3)
No response	5	(5.0)				

	Beginner		Intermediate		Senior	
	f	%	f	%	f	%
WISH TO TELL FAMILY						
Yes	87	(87.9)	24	(88.9)	53	(91.4)
No	12	(12.1)	3	(11.1)	5	(8.6)
No response					1	(1.7)
	N = 104		N = 27		N = 59	