SELECTED AVOIDANCE BEHAVIORS EMPLOYED BY THE NURSE WHILE CARING FOR A DYING PATIENT

A THESIS

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CHAPTER I

INTRODUCTION

Death is an intensely poignant event, one which touches the deepest sources of human anguish, one which each of us yearns to be spared (Engel, 1964:93). Death is also a basic element of human existence and a reality in the hospital milieu. Yet, the modern world functions as if death does not exist. The prospect of death does not fit into the dominant values of the American culture. In our future-oriented society death is suppressed everywhere: in political pronouncements, commercial advertising, public morality, and popular customs (Fulton, 1965:389). Death overshadows everything man undertakes, and though undisputed master of his physical world in an age of truimph and success, man is powerless. Contemporary man may postpone death, he may assuage its physical pains, he may rationalize away or deny its very existence, but escape it he cannot (Wahl, 1965:17).

Nurses are continuously confronted with the many sorrows of human existence. Quint (1967:xiii) states that death and dying is only one of the many stress producing problems which nurses meet in practice. Current information

indicates that the majority of deaths now occur in hospitals, nursing homes, or similar institutions and that number is growing (Brim, 1970:xvii; Morison, 1973:57; Quint, 1966:49). As a consequence, nurses are more and more confronted with the process of dying.

Although taught to give specialized nursing care to medical or terminal patients, much of the nurse's behavior toward death resembles the layman's (Glaser and Strauss, 1966:4). Educational preparation and a commitment to life-saving goals unconsciously encourages nurses to avoid any situation that is in direct opposition to this commitment. In reality, direct experience with death is kept at arm's length; for in effect, death offends the medical and nursing professions.

Nurses should be experts about death, but the contrary appears to be true. Provision of care for the dying is not an easy task for most nurses (Kubler-Ross, 1971:54; and Quint, 1967:3). Facing death is difficult and helping others face it is trying. As a result, nurses have developed mechanisms suitable for avoiding emotional involvement and reducing the stress of caring for a dying patient, especially in the final hours of life (Quint, 1967:163).

Statement of Problem

The problem considered in this study was the identification and description of selected avoidance behaviors employed by the nurse while caring for a dying patient.

Purposes

The following purposes were considered in this study.

1. Identify and describe behaviors the nurse employes to limit conversation with the dying patient.
2. Identify and describe behaviors the nurse employes to limit the amount of time spent in contact with the dying patient.

Background and Significance

It is without question that death is one of the essential realities of life (Fiefel, 1965:115). A hallmark of contemporary man is his ability to alter and govern his physical environment.

> This is the age of man and his truimphs, and we have come to accept as a certain and established thing that man can surmount any obstacle and is equal to the solution of any problem which may confront him. Success has become a habit of the species. It is therefore not surprising that we should be so strongly and universally impelled to the belief that there can be no problem that can remain unyielding to our concerted and determined efforts. . . .
>
> But there is a glaring exception to this paean of man's conquests, one problem where all his assurance, ingenuity, and wit avail him nothing; an area which

> stands in bold contrast to the rest of nature which is so malleable to his will. I refer, of course, to the phenomenon of death (Wahl, 1965:17).

Referring to this essential reality of life, the psalmist in the Old Testament asked; "What man shall live and not see death?" (Psalm 89:49). Considering the fact that death is a phenomenon which is a part of life itself with deep personal significance, knowledge of how contemporary man relates to death is meager indeed (Riley, 1970:30).

Modern man tends to push the thought of death aside, for it is difficult to imagine the prospect of non-being (Tillich, 1965:31; Kubler-Ross, 1971:54; Aronson, 1965: 255; and Fulton, 1965:33). In a society that places so much emphasis on the future, the prospect of not having any future, becomes too dismal to face (Spiegel, 1964:297). Morison (1973:55) declares that the prospect of death is rewarded by the high probability of complete recovery and a long, happy and productive life. This same trend of thought is expounded upon by Quint (1967:29) in that the high value accorded to life-saving activities reinforces the societal value of avoiding the reality of death.

Quint (1967:xiii) claims that nursing reflects the values, beliefs and practices of the wider society in which it is immersed, and as a profession, nursing has not been isolated from death as is true of many other fields of

work. American nurses bring to the profession already established attitudes in which death is essentially denied. Nurses have always had to deal with death because sick people do not always recover (Quint, 1967:10). Nurses are expected to provide physical, mental and emotional comfort to sick and dying patients. This concept is often stressed in nursing textbooks, but the transfer of this idea into action terms is generally missing, especially in the area of emotional comfort. Death is a fact of which hospital personnel are well aware; yet, understandably, they prefer not to dwell on it (Strauss, Glaser and Quint, 1964:73). In nursing, as in other avenues of life, the circumstances of death and dying are ignored and denied when they should be most illuminated (Editorial, Nursing Outlook, January, 1964:23).

Glaser and Strauss (1966:15) have observed that hospital personnel who are in contact with dying patients are often disturbed by their own ineptness in helping the patient near death. Quint (1967:7) reinforces this finding by stating that nurses are not well prepared for the work they are expected to do when they provide care for those who are dying. Strauss, Glaser and Quint (1964:74) have ascertained that nurses are not taught many of the details of working around patients who are dying. "Working around"

encompasses the delicate psychological interplay which inevitably occurs between a terminal patient and the nurse.

Glaser and Strauss (1966:178) assert that the highest professional reward is the patient's recovery and return to his normal personal and social life. These same authors also point out that the staff members' strongest incentive to become absorbed in patient care is the possibility of curing the patient. The patient who is categorized as "nothing more to do for" has less valid claim on the nurses' time. In this same study, Glaser and Strauss (1966: 205) report, that not aiming for the goal of recovery and a higher nursing reward, often results in less involvement and effort in terminal care.

With strong emphasis on life-saving rewards and the necessary techniques of nursing, it is understandable that providing care for the dying is especially stressful and not an easy task for most nurses. Even though seen as a place for recovery, the hospital frequently serves as a locus for dying (Glaser and Strauss, 1968:33). Preparation for the social-psychological problems of dying are not as adequate as those for recovery (Glaser and Strauss, 1968:34; Quint, 1967:10; Brim, 1970:xvi; and Benson, 1972:53). Facing death is difficult and constant exposure to dying, occurring

over a period of time, is a trying problem that nurses must encouter daily.

Hinton (1972) quotes an observation by de La Rochefoucauld; "Neither the sun nor death can be looked at with a steady eye." Wahl (1965:26) describes death as involving aspects of reality inadmissible to the omnipotent and narcissistic self, and therefore strong defenses are developed against its recognition. It is a known and accepted fact that most people have emotional problems and fears about death. It is only natural that such fears and concerns are intensified by continued contact with the dying. The almost automatic reaction on the part of the nurse to avoid such an unpleasant situation appears natural, for death only serves to remind the nurse that the reality of dying must someday be faced (Quint, 1967:159; Weisman and Hackett, 1961:242). Nursing personnel readily admit, according to Pearson (1969:110), that working with and around dying patients is upsetting and sometimes traumatic. Aasterud (1962:40) concurs with this concept by explaining that our cultural and social defense system fosters evasion--it is oriented toward helping the nurse avoid anxiety. Jourard (1964:112) agrees with this idea and states that interpersonal behavior patterns are acquired as a means for satisfying needs and reducing anxiety.

The tendency to withdraw from these situations which are personally threatening is supported by the value system in nursing (Quint, 1967:229). Nurses receive their professional rewards and satisfactions principally from participating in activities associated with the preservation of life (Quint, 1967:196). Glaser and Strauss (1966:231) remark that nurses have been trained to regard saving a patient as one of the highest achievements in nursing. The contemporary hospital and nursing culture support the primacy of recovery goals and commitment to the living. These values are further reinforced by expectations of the public who hold in esteem the life-saving activities of doctors and nurses (Quint, 1967:199). Nursing reflects the values of the wider society of which it is a part--a modern society where death is viewed as a technical failure, and in effect, is an insult to the healing profession.

It has been mentioned that death is an intensely poignant event, one which each of us yearns to be spared. Yet, as nurses, death is a constant companion (Engel, 1964: 93). If encounters with dying patients precipitate thoughts about personal death and create feelings of anxiety, it is not surprising to find that nurses whose work brings them in frequent contact with death should guard themselves against loss of composure. In order for the nurse to

function on the health team and be of assistance to other staff members, it is necessary to develop "out mechanisms" while in the stressful business of caring for the dying (Quint, 1967:163). Such mechanisms serve to manage emotional involvement, minimize exposure to the reality of death, and assist in coping with a situation that creates anxiety and discomfort.

Death and dying are two attributes of the human condition with which every individual must come to terms. If those who care for the dying patient feel too much uneasiness in his presence, they cannot tend him as completely as they should (Hinton, 1972:14). The nurse has a role in providing dignity in death and in meeting the physical and emotional needs of the person in the process of dying. In order to achieve this goal, management of composure by various modes of behavior must be identified and accepted by the individual.

Although it is generally recognized that the dying are avoided, the relative degree to which they are avoided has been a matter of speculation (Kalish, 1966:154). It is in first identifying and describing specific avoidance behaviors the nurse employs while caring for the dying patient, that the nurse will be able to meet the challenge

of caring for the person near death in a more effective and understanding manner.

Definition of Terms

Nurse--a person who is currently licensed to practice professional nursing by the State Board of Nurse Examiners in the state where she is practicing.

Tactic--a mechanism employed to accomplish a desired end.

Management of composure--attempting to cope with a situation that threatens to destroy one's ability to maintain equanimity.

Contact management--ways of minimizing time spent with the patient.

Expressive management--ways of controlling conversation which threatens one's composure.

Dying patient--a person who no longer has the chance of recovery either through natural processes or medical assistance and is in the process of living with impending death.

Behavior--the manner in which a person responds to external stimuli or to internal need or to a combination thereof.

Limitations

The following limitations were considered in this study.

1. The closed-ended questionnaire required that the respondent's answer be limited to the choices offered.
2. The registered professional nurse could answer any item on the questionnaire in accord with her individual behavior, or how she thought she should respond in keeping with the expectations of the public and the nursing profession.
3. The closed-ended questionnaire elicited a response that was subjective in nature.

Delimitations

The following delimitations were selected for the purpose of this study.

1. Registered professional nurses employed at two proprietary hospitals and one nonproprietary hospital were asked to participate.
2. The participant nurses were currently caring for or recently cared for an adult dying patient.
3. The nurses were employed in a medical-surgical area where death is frequently encountered.

Assumptions

The following assumptions were formulated for the purpose of this study.

1. Death is a basic feature of human existence.
2. Providing care for a dying patient reminds the nurse of her own mortality.
3. All human beings experience some degree of anxiety and use some form of protective behavior when confronted with the reality of death.

Summary

Death, as an essential reality of life, confronts the nurse daily. Avoidance of death and dying on the part of the nurse reflects the beliefs of a culture that views death as a technical failure. Stress and conflict result from the discrepancy of the nurse's role, as viewed by the profession and society, and the reality of caring for the dying patient. It is within this framework that the present study was undertaken to identify and describe selected avoidance behaviors that hinder the process of helping the dying patient.

Chapter II presents a review of literature concerned with contemporary dimensions of dying, the fear of death, stages of grief and dying, nurses and the problem of death,

the behavior of professionals toward death, and the sequence of events in the dying trajectory. The procedure for collection and treatment of data is presented in Chapter III. Chapter IV contains an analysis of the obtained data and findings. Chapter I through IV provide a more meaningful framework for the summary, recommendations and implications, and conclusion presented in Chapter V.

CHAPTER II

REVIEW OF LITERATURE

Introduction

Death, as an inevitable constituent of human existence, is a constant companion to members of the healing profession. A review of literature was conducted to present contemporary dimensions of dying and general views on the fear of death. The stages of grief and the dying process are discussed, as well as the problem that death presents to the nurse. The behavior of professionals toward death is described, and suggestions are presented for the supportive role of the nurse in the dying trajectory.

Contemporary Dimensions of Dying

Death is a biological and existential fact that affects every human society (Blauner, 1966:378). But, our modern secular society, according to Levine and Scotch (1970:211), regards death and dying only as something to be avoided. People turn their backs on death as much as possible, for our society esteems the value of health, and a long, happy and productive life. Fulton (1965:389)

describes the present era as a century of health, hygiene and contraceptives, miracle drugs and synthetic foods. An inspection and analysis of present trends discloses that death is not a central feature in the lives of most people. Even in this society's well-organized, well-exploited anxiety about heart disease, cancer, and stroke, the concern is not in the mastery of the event, but in simply avoiding death from these major causes (Brim, 1970:xv).

Apparently it has become the fashion among American families, as observed by Brim (1970:xvii), to delegate the care of their dying relatives to someone else. The more common scene of "natural death" has shifted, and is continuing to shift from the home to the institution. Strauss and Glaser (1970:129) present findings indicating that people elect to die in institutions--or that families make such choices for them, thus delegating responsibility for taking care of the dying during their last days or hours to outsiders. Brim (1970:xviii) reveals that close scrutiny of health professionals and their institutions is that professionals are quite unprepared to cope with the needs of the dying patient. Yeaworth, Kapp, and Winget (1974:20) concur with this viewpoint by stating that previous training has rarely prepared health professionals to cope

with the realities of death. Health professionals are trained to deal with life--yet, death is a constant companion.

The subject of death has been and is being written about by many theologians, philosophers, and social scientists. Until recently, incorporation of that ancient "taboo" which man seems to have placed on thoughts about death, has permeated the areas of art, literature, religion, and without question, the American culture. For reasons not at all that easy to identify, the past few years have seen an astonishing increase in public attention to death and dying (Morison, 1973:57). A reawakened interest in death and dying appears to be developing, however, as if man now has found time (or reason?) to examine a subject that he felt justified in putting aside during a period of rapid scientific progress and social change (Brim, 1970: xvi).

> Indeed there are indications that what has seemed to be a pervasive silence about death was nothing more than a public silence. Today under the influence of technological, cultural, and social changes, even that public silence may be in the process of being broken (Riley, 1970:30).

Feifel (1965:v) states that after looking hard in the literature, it is surprising how meager is the systematized knowledge about death. Empirical studies of the individual's relationship to death have been comparatively few and

comparatively recent. Elmore (1967:35) maintains that "natural death" in our society is an unpopular theme, shrouded in a cloak of secrecy, and presents several reasons for the paucity of research studies in the area of death and dying.

1. Man is capable of reflecting upon the fact that he will one day no longer exist as a being. . . . Death and physical decomposition become too threatening to contemplate.
2. Probing into the private world of the dying person evokes anxiety in the researcher.
3. Medical personnel prefer to avoid the common feelings of futility and professional helplessness which eventually arise in contact with the dying.
4. The tools with which to study the phenomenon of death are limited and thus present a methodological problem (Elmore, 1967:35).

The past few years have seen a growing awareness and increased attention to death and dying. The examples of growing literature on death testify to the emergence of new questions for systematic research within a broader conceptual framework. Knutson (1970:42) declares that the very existence of death has an empirical unknown, urgent in its demands.

Fear of Death and Dying

Examination of cultural, social, and historical development over the years reveals that death has always been distasteful to man. Kubler-Ross (1971:54) remarks that death has always been a fearful thing to man. The

thought of death is accompanied by unpleasurable emotions, and the dominant one is fear (Rheingold, 1967:60). The emotional component is predominant as described by Hinton:

> The emotions aroused by death are legion--fear, sorrow, anger, despair, resentment, resignation, defiance, pity, avarice, triumph, helplessness, and to some degree, practically any emotion that there is. The commonest one is fear (Hinton, 1972:22).

Death is fantasized and felt, not thought, and the images and emotions endow death with meaning (Rheingold, 1967:1).

In considering death, and the impact of this inevitable constituent of human existence, Weisman and Hackett distinguish between three dimensions in the experience of death:

> . . . impersonal death is stripped of the human element, and the dead are simply bodies classified and discarded according to various categories.
>
> Interpersonal death is concerned with the objective fact of death of the other one. Our subjective death is not involved . . . interpersonal death means someone else is dead.
>
> Intrapersonal death is important because it incorporates subjective death--"I am dead." Intrapersonal death has double significance in that it applies both to the process of dying, particularly to the fear of dying, and to the fact of subjective death (Weisman and Hackett, 1961:242).

The terms death and dying are frequently interchanged in daily conversation. Levine and Scotch (1970:213) contend that:

> . . . the process of dying and the eventual actual occurrence of death are so intertwined in our

> thinking that it is easy to blur them in our analysis and to treat them as a single phenomenon.

Death and dying vary significantly in the problems they pose and the fear that is generated. Death signifies the finitude of human existence (Quint, 1969:287), while dying is a process occurring over a period of time prior to the termination of life. The fear of death is a universal reaction and no one is free from it (Feifel, 1965:114; Kubler-Ross, 1969:4). Death has an empirical unknown, and fear prevails for it is our basic nature to fear the unknown (Barrocas, 1973:38). Davidson (1966:74) states that death has no being or existence, but is, rather a negation of being--incomprehensible to the mind of man. Following a similar trend of thought, Kubler-Ross (1969:2) explains that in our unconscious, death is never possible in regard to ourselves.

The temporal process of dying is evidently more fearsome than death itself (Weisman and Hackett, 1961:244). Schoenberg (1970:241) agrees that most patients seem to fear the process of dying more than death itself and bases such fear on the fact that the process of dying implies pain, deterioration, helplessness, dependency, humiliation, loss of loved ones, and loss of control. Hinton (1972:65) presents physical distress as a source of fear, and explicitly states that pain is the symptom that many people

commonly fear will be the dreadful accompaniment of their dying illness.

The fear of death and dying does not have a unitary causation. In reality, according to Rheingold (1967:62), the genesis of the fear of death is a complex problem, comprising universal elements and a wide range of individual experiences. Murphy (1965:335) states that the fear of death is a very complex thing with conscious, preconscious, and unconscious aspects and all sorts of predetermining cultural, historical, and religions factors.

Switzer (1970:14) points out that there is a tendency of human beings to withdraw from serious contemplation of death and the painful memories and emotions which surround it. It is understandable that man has a hard time conceiving of his own death if he continuously imagines it as a fearful, frightening event. Fulton (1965:33) maintains that man's inability to imagine death is a component of an elaborate circle of denial--the profound inner need of human beings to make believe that they will never die. This isolation of the possibility of one's own death is referred to as personal invulnerability by Wahl (1965:23). Man looks upon death as did the psalmist David, who said, "A thousand shall fall at thy right hand and ten thousand at thy left, but it shall not come nigh thee" (Psalm 91:7).

The democracy of death encompasses all mankind. Even before its actual arrival it is an absent present (Feifel, 1965:123). Death, the inevitable end, is an emotional experience of such intensity, that man is unable to remain open to it for any length of time (Fulton, 1965:14). There are many reasons for the flight away from facing death calmly. Kubler-Ross (1969:7) suggests that one of the most important facts is that dying nowadays is more gruesome in many ways, namely, more lonely, mechanical, and dehumanized. The need for psychological defense is strong, and this is clearly evident when one considers the lengths to which man goes to avoid the reality of death.

Contemporary man does not even refer to death as death, but instead employs cumbersome and elaborate euphemisms such as "passed away" or "passed on" or "departed" (Wahl, 1965:17). This pattern is traceable throughout the development of the history of mankind. Since primitive times, man has been both frightened and challenged by death and has engaged in a continuous search to understand it, to find means of adaption or control (Knutson, 1970: 42). When man can no longer deny his finiteness, Kubler-Ross (1969:13) explains, man attempts to master death by challenging it.

> More and more people are kept alive by machines replacing vital organs . . . and by freezing the

> deceased--awaiting the day when science and technology have advanced enough to defrost them, to return them to life and back into society (Kubler-Ross, 1969:14).

Death is held as a fearful and unwelcomed venture, an inevitable and inescapable event of human existence. Man flees from the reality of eventual death with such determination that, according to Wahl (1965:58), he employs defenses so potently magical and regressive that these would be ludicrously obvious if they were employed to such a degree in any other area of human conflict. The reality of death, the potent fear that is generated, impels man to employ the heavy artillery of defense.

Empirical studies on death are comparatively few. Murphy (1965:333) in discussing the contents of Feifel's book, The Meaning of Death, points out that there were common factors evident in the studies presented in this work, all of which are directly related to fear. Riley (1970:34) reports that thoughts of death intrude upon the everyday lives of people relatively infrequently. A study using a word association task to assess concern of affective involvement with the concept of death by Alexander, Colley, and Alderstein (1965:86), revealed that normal subjects, in a period of life characterized by activity and vigor, respond to words related to death with greater emotional intensity than to equivalent words drawn from the general

language sample. Cappon (1965:46) supports the association of death and fear, and points out that a striking aspect revealed in questioning people near death was that their over-protective custodians--the doctors and nurses, showed the greatest disturbance. Quint (1967:220) offers an explanation for such a response in that it is not easy to let another person express his fears about dying because such talk tends to trigger one's own fears about death.

The Stages of Grief and the Dying Process

Grief is no stranger to nurses. Gray (1974:25) contemplates if nurses know how to cope with grief comfortably. Grief has been taken for granted by most people; yet, grief is almost a universal emotion and few people escape its experience.

Nurses are frequently confronted with the grief accompanying a physical loss: amputation, colostomy, blindness, or extensive scarring (Gray, 1974:25). Loss is an integral part of human experience, and nurses must constantly deal with the diverse reactions to various forms of loss, especially death. The most profound grief nurses encounter occurs in patients who have just learned their illness is terminal and in the family of a patient who has just died. Although grief is often thought of in relation to an occurred loss, the fact is often overlooked

that the dying patient, too, is experiencing some form of grief (Peretz, 1970:21). Kubler-Ross (1969:76) describes this condition as a preparatory grief that the terminally-ill patient has to undergo in order to prepare himself for his final separation from this world. Peretz (1970:25) describes an analogous state as anticipatory grief, a situation in which the person is faced with declining health and may grieve in much the same way as when actual loss is sustained.

People need help in dying and grieving, just as they often do in living. The nurse frequently is called on to minister to those experiencing grief. A clear understanding of the process of grief and dying will prove beneficial in enabling the nurse to extend herself professionally beyond her status as a humane person (Engel, 1964:98). For nurses to cope with the psychodynamics of grief, and especially death, it is essential to have a basic understanding of the stages a dying person and his family go through (Barrocas, 1973:39). Dr. Elizabeth Kubler-Ross and others have clearly documented the several stages of the grief and dying process.

The reality of death arouses within an individual numerous and varied emotions. In an attempt to manage the accompanying pain and stress, the individual resorts to

the use of various mechanisms. Kubler-Ross (1969) describes the reaction to terminal illness or death as the stage of denial and isolation. In an attempt to deal with an uncomfortable and painful situation this stage serves a specific purpose. "Denial functions as a buffer after unexpected shocking news, and allows the person to collect himself and, with time, mobilize other less radical defenses" (Kubler-Ross, 1969:35). Engel (1964:94) describes this initial response as shock and disbelief, a stage in which the grief-stricken person does not permit himself any thoughts or feelings which acknowledge the reality of death. In referring to the process of adaptation, Crate (1973:211) presents a similar state as disbelief and denial, a protective maneuver in response to threat.

Schoenberg and Senescu do not name a specific stage or phase, but, describe the process of denial as:

> . . . a process common to a greater or lesser degree, in all patients with fatal disease. The mechanism is one of avoidance that is integrated into the adaptive system of the individual and serves the temporary function of negating intolerable and painful stimuli and rendering it unconscious (Schoenberg and Senescu, 1970:231).

In referring to this adaptive process, Kavanaugh (1974:38) asserts that, human beings have a magnificent filtering system built into their perceptual sense. Such a system sifts out any data that the mind is not ready to know, for the human mind resists acceptance until it is ready.

From the initial position of denial and disbelief, the patient moves into the second stage--anger. When the operation of denial is no longer effective, it is supplanted by feelings of anger, rage, envy and resentment. Kubler-Ross (1969:45) presents the thought that we too would be angry if all our life activities were interrupted so prematurely. This phase is described by Moidel (1971:58) as an expression of the patient's inability and helplessness to control, manipulate or adapt to the unknown.

An analogous state is depicted by Engel as, developing awareness. Engel characterizes this state as:

> . . . the reality of death and its meaning as a loss begins more and more to penetrate consciousness in the form of an acute and increasing awareness of the anguish of the loss. . . . Anger may erupt towards persons or circumstances held to be responsible for the death (Engel, 1964:95).

Crate (1973:212) employs identical terminology and describes the anger as open and diffuse. The stage of developing awareness as described by Engel and Crate includes the stage of bargaining and depression which Kubler-Ross handles as separate entities.

The stage of bargaining is less well known, but is equally beneficial to the person. The time component is brief, but it allows the person to make a promise, a deal, an arrangement, in exchange for prolongation of life.

> Bargaining is really an attempt to postpone; it has to offer a prize for good behavior, it is also a self-imposed deadline, and includes an implicit promise that the person will not ask more if this one postponement is granted (Kubler-Ross, 1969:72).

Gray (1974:26) portrays this stage as the person trying to make a deal with God or fate, promising some act in an exchange for more time.

Feelings of grief and depression gradually emerge, in the next phase, as the person acknowledges the potential loss of life and loved ones. To protect himself from the painful feelings of separation and loss, the person tends to withdraw from important relationships (Schoenberg and Senescu, 1970:232). Kubler-Ross describes this stage as a time of silence.

> It's a kind of grief which is difficult for us to accept--where they don't talk anymore, where they don't want anymore visitors . . . the dying patient is about to lose not just one beloved person but everyone he has ever loved and everything that has been meaningful to him (Kubler-Ross, 1971:58).

There is little or no need for words when the person is in the process of contemplating impending loss. Engel (1964: 95) incorporates this stage in the phase of developing awareness, and testifies that it is during this period that the greatest degree of anguish or despair, within the limits imposed by cultural patterns, is experienced and expressed.

If the person has had sufficient time and support to work through the previous stages, he arrives at a stage of acceptance. It is a stage during which he is neither depressed nor angry about his fate. Acceptance should not be mistaken for a happy stage for it is one that is almost void of feeling (Kubler-Ross, 1969:99). In this stage the person is described as not happy, but neither is he sad. Gray (1974:27) interprets Engel's final stage of restitution and recovery, as one in which peace and well-being are reattained.

The stages that people go through, including the patient, the family and staff, in an attempt to deal with extremely difficult situations last for different periods of time and replace each other or exist concurrently. The one element that usually persists through all these stages is hope.

> It is this glimpse of hope that maintains the person through the days, weeks, or months of suffering. It is the feeling that all this must have some meaning, will pay off eventually if they can only endure it for a little while longer (Kubler-Ross, 1969:123).

The patient must not be permitted to die before his time--it is through hope that he can live with dignity while in the process of dying. Hopelessness is a state of mind, a giving up, a situation that must be avoided at all costs (Schoenberg, 1970:240).

Nurses and the Problem of Death

Death is the one sure event in everyone's life; yet it is also the one about which we know the least (Elmore, 1967:35). Kubler-Ross (1971:54) maintains that we should be experts about death for it is one thing that has been with mankind as long as man himself. It appears that a strange paradox has developed in twentieth century American society. Quint (1967:1) states that the present generation is exposed to violent death presented in brutal detail on television and in films. But present society has been identified as a death-denying society, and the opportunity to participate in the mourning process and family rituals of death is no longer a significant feature in one's life. Knutson (1970:49) presents findings of a previous study which suggests that exposure to death prior to professional training was very limited indeed for most health professionals. Yet, people entering the health fields in our contemporary society, must encounter and handle a significant human experience which has been hidden or disguised by the society in which they live (Quint, 1967:2).

Levine and Scotch (1970:213) express concern about the dying patient as a problem for medicine and health professionals and emphasize that the task of managing the dying patient is primarily a doctor's dilemma. Quint

(1967:36) exhibits similar concern, but contends that care for the dying is essentially a nursing problem, not a medical one. Strauss and Glaser (1970:129) predict that changing health practices and medical technology seem destined to bring about still further institutionalization of dying. With the hospital serving as a locus for dying, a central feature in the lives of nurses will be continuous encounters with death.

Nahm (1967:vii) mentions that the nursing profession has recently realized that little attention has been given in years past to preparing nurses to cope effectively with problems associated with dying. In referring to the educational preparation of nurses, Quint (1967:xiii) indicates that such educational programs reflect the dominant values and attitudes of the wider society in which they emanate. A similar thought is expressed by Knutson (1970:61) who recognizes that professional people dealing with illness and death receive their professional training on top of and much later in life than their early socialization and thus share with patients and other members of the public the early experiences, beliefs, ethical values and attitudes of the existing cultures.

The available literature provides meager evidence of research relating to nurses and the problem of death.

Several general studies (Riley, 1970; Rabin and Rabin, 1970; Pearson, 1969; Glaser and Strauss, 1966; Brim, 1970; Knutson, 1970; and Levine and Scotch, 1970) have investigated aspects of individual attitudes and feelings, the significance of death in everyday life, and social and cultural beliefs about death. Studies relating to nursing are comparatively few and noticeably sporadic.

Quint (1967) investigated the educational preparation of nurses in relation to death and published the results in a work entitled The Nurse and the Dying Patient. The findings of this study indicate that schools of nursing have provided insufficient training in preparing nurses to cope with the many problems associated with dying (Quint, 1967: 10). Glaser and Strauss (1966:4) support this fact with results from an investigation which disclosed that although doctors and nurses do have some experience with dying patients, the emphasis in education is on the necessary techniques of medicine or nursing, not on the fact of dying itself. A related study by these same authors provides information that hospital personnel are inadequately prepared to cope with either the medical treatment or the social-psychological aspects of the last days (Glaser and Strauss, 1968:149). Yeaworth, Kapp, and Winget (1974:20) present similar findings from recent studies supporting the fact

that members of the healing profession have difficulty coping with the realities of this inevitable human experience. Quint (1967:xiii) suggests that cultural values concerning death have created a gap in the education of nurses and, in turn, a gap in the nursing services available to patients who are dying.

Close scrutiny of the influences of dominant social and cultural values provides evidence that nurses experience conflict in their role and identity as a professional. The meaning of life and death to members of the health profession, is viewed by Peretz (1970:3), as intrinsically woven into the fabric of their identity. The core of the physician's and nurse's self-image is that of a "helping person." Brunner (1970:39) clearly states that nurses are deeply committed to life and health. Quint (1967:196) reports that nurses receive gratification from participating in activities associated with the preservation of life. Rabin and Rabin (1970:182) assert that helping people recover is clearly the preferred challenge of the medical and nursing profession. Our secular society has delegated life-saving responsibility to the healing profession and the hospital culture strongly supports the primacy of such goals. With a staunch commitment to life-saving and recovery goals, the dying patient is in direct opposition

to this commitment (Brunner, 1970:39). Rabin and Rabin (1970:180) present the dying patient as a negation of the physician's and nurse's role as comforter as well as healer. Physicians and nurses have difficulty facing and accepting the idea that some patients do not recover. With a deeply internalized commitment to life, nurses have difficulty coping with problems as different from that of getting patients well.

Behavior of Professionals Toward Death and Dying

Although the medical profession is dedicated to survival and health, it cannot indefinitely postpone death (Weisman and Hackett, 1961:248). Glaser and Strauss (1966) have identified some recurrent patterns of interaction which take place between dying patients and those who work in hospitals, and have described some emotionally distressing problems which nurses confront when they work around patients near death. Brunner (1970:40) claims that it is an emotional strain to nurse people who are dying. Sobel (1974:99) concurs with this idea and describes death as a difficult time for those who attend and who care for the dying person. Encounters with death, according to Quint (1967:34), serves as a reminder of the finiteness of human existence and, thus, arouses feelings of anxiety and fear.

Engel (1964:93) considers the question of how members of the healing profession can protect themselves from such repeated personal suffering. One way suggested by Engel (1964:93) is to develop a shell, to insulate one's self, to avoid engagement, to make out it does not exist or it is not your concern. Brunner (1970:40) asserts that nurses develop defenses against the full impact of repeated deaths and the stress encountered while caring for the dying. Glaser and Strauss (1966:226) report in their study concerning death that despite many adverse circumstances in the dying situation, a nurse must make every effort to maintain her professional composure, for both her own work and the assistance she gives other staff members depend on it. A study by Quint (1966:52) reveals that nurses develop composure tactics to protect themselves from situations which might cause them to become upset, and to lose control, or to perform inadequately as nurses. Maintaining composure is a complex problem in view of the multitude of disturbing conditions that nurses encounter.

The individual's response in a situation that is threatening, is determined according to Peretz (1970:4), by the methods of coping with the vicissitudes of pain, by cultural prescription available for handling the fact of death, and later by the structure of his professional

identity. Medical personnel prefer to treat dying persons as if they were expected to live, and view death, as reported by Blauner (1966:386), as an inconvenience and manage interactions as to minimize emotional reactions and fuss. Strauss, Glaser and Quint (1964:81) state that in such uncomfortable situations nurses tend not only to avoid certain conversational topics, but to avoid the patient himself. This behavior is consistent with the technical objectives of the medical profession, and the dominant avoidance attitudes of the society which they serve.

Two specific areas of defense have been identified by Glaser and Strauss (1966:227) as avoiding both the patient and the topic of dying and death. Quint (1967:105) acknowledges this finding and refers to such defenses as strategies to assist in maintaining composure. The two areas of concern in the management of composure are contact management or ways of minimizing time spent with the patient; and expressive management, ways of managing conversation which threatens to get out of hand (Quint, 1967:105).

Conversation has been identified as an avoidance maneuver by several authors. Glaser and Strauss (1966:58) in considering the basic education of nurses remark that

nurses are taught how to care for patients, physically and sometimes "psychologically," but rarely if ever are they taught how to handle conversation about death with patients. In another publication Glaser and Strauss (1966: 233) report that in order to maintain composure nurses control their conversation to keep themselves and the patient away from the subject of dying. Schoenberg and Senescu (1970:232), Brim (1970:xviii) and Knutson (1970:61) support this idea by agreeing that health professionals avoid discussions of impending death or distract a patient when he begins to discuss death.

An associated mechanism employed to manage composure is evading the dying person and spending more time with patients who will recover (Glaser and Strauss, 1966:134; Saunders, 1969:110). In another study Glaser and Strauss (1968:48) mention that nurses become adept at avoiding dying patients and their families in order to maintain composure. Schoenberg and Senescu (1970:230) propose similar ideas, and Kniesel (1967:38) adds that avoidance of the patient is employed in order to reduce personal involvement and escape being asked unanswerable questions.

Levine and Scotch (1970:214) concluding a study on societal customs report that society, in its wisdom, has developed efficient ways to shield itself from the daily

tragedies of the dying so that it can go on with its tasks, unperturbed and uninterrupted. Professional people share with patients and other members of the public various rituals and defenses in an attempt to seek refuge from the impact of death. Weisman and Hackett (1961:242) describe such behavior as "professional" attitudes and that such behavior is the only possible means of coping with this significant human experience continuously. Members of the healing profession set their own priorities in an attempt to support their need to deny. Peretz (1970:19) in considering the behavior used to ease the impact of death and loss states:

> Each time we confront death, we lose not only the loved or valued object but also suffer an eroding of our sense of immortality. Death is a cruel and current reminder of the limits of our power to save another or to save ourselves from the same fate (Peretz, 1970:19).

Glaser and Strauss (1966:57) specifically mention that nurses need to develop both composure and personal tactics more than physicians do, because they spend more time with the dying patient. Faber (1971:49) presents the idea that the right to live and live happily is increasingly regarded as one of the basic rights of man. Hence, we are more likely to rebel against suffering and death than to accept them as inevitable constituents of our existence.

The Nurse and the Dying Trajectory

The course of dying--or "dying trajectory," takes place over a period of time and is an open-ended process. Strauss and Glaser (1970:131) depict two outstanding properties of the dying trajectory: first, it has duration; and second, a trajectory has shape. The time component of the dying experience may be weeks, or days, or merely hours. The shape of the dying trajectory can be graphically illustrated:

> It plunges straight down, it moves slowly but steadily downward; it vacilates slowing, moving slightly up and down before diving downward radically; it moves slowly downward at first, then hits a long plateau, then plunges abruptly to death (Strauss and Glaser, 1970:131).

In a general hospital, dying characteristically appears in several forms. It can be quick, or it can be slow--sometimes dragging on almost indefinitely. The death may be expected or unexpected (Quint, 1967:764).

Whether death occurs within the hospital or at home, the course of dying normally follows a specific sequence of events as described by Quint (1967:765) and Strauss and Glaser (1970:131).

> First, the person must be defined as dying by others around him, perhaps also by himself. Second, at some point in time there must be a recognition of the fact that "nothing more can be done" to prevent death from occurring. Third, when death approaches, the death watch--a period of waiting

> begins. Fourth, when the person finally dies, someone must formally pronounce him dead. Finally, the family must be informed of the death.

Quint (1967:765) alludes to the dying trajectory in an earlier publication and clearly states that the work which nurses perform for and around the dying patient depends on where he is in the sequence of events, perhaps more precisely on where the nurse thinks he is. Members of the health team manage the care of the hospitalized dying patient by defining and redefining the dying trajectory.

Helping a person die is a difficult and trying situation. During the entire time it takes a patient to die the nurse attempts to maintain her composure and manage her emotional involvement with the patient (Glaser and Strauss, 1966:227). Emotional involvement presents the risk of pain, sorrow, frustration, helplessness, anger and tears, and the committed nurse cannot escape the possibility of such experiences. Cotter (1972:60) maintains that the fact that each of us is presently involved in the life processes which culminate in death, engenders in us a reaching out to share, to listen, and perhaps find ways to satisfy our desire to help those who are dying.

Barrocas (1973:39) suggests that one approach to helping the dying is through education and a basic understanding of the stages of dying. Education is the

foundation for assisting the dying person through the stages and events of the dying trajectory. Quint (1967:772) remarks that nurses need to establish open and regular two-way communication with physicians. Communication is essential in assisting the dying person through the stages of dying. Moidel (1971:59) views communication as the essence of any relationship and a necessary component of the collaborative role with all members of the health team. Communication with the patient opens an avenue for the expression of thoughts and feelings, and aids in the reduction of anxiety (Brunner, 1970:28). Listening is also an essential element in the process of communication. Schoenberg (1970:240) mentions that listening permits an opportunity for the person to express his thoughts and to allow his feelings toward others to return. It is all right to say nothing, for Kubler-Ross (1969:100) suggests that silence is the most meaningful communication.

The concept of honesty is strongly advocated by Barrocas (1973:40) who states that honesty, above all, is the most important ingredient in the relationship with the dying patient. Many physicians and family members hold a strong belief that a patient should not be told he is dying. Kubler-Ross (1971:56) argues that the patient should not be told he is dying, but recommends that patients should, with

very few exceptions, be told when they have a serious illness. Cotter (1972:61) views this occasion of "telling the patient" as an intimate and delicate experience, a moment of meaningful communication that cannot be programmed. Honesty of the nurses and other professionals about their own fears and shortcomings is critical. Nurses must recognize when they are so emotionally involved that they cannot objectively care for the patient's needs (Barrocas, 1973:40). Honesty is of paramount importance, in what the nurse communicates to the patient, and in what the nurse allows the patient to communicate to her.

When the "nothing-more-to-do" stage is reached it is important that the care and comfort aspects of nursing occupy the forefront. Quint (1967:767) maintains that at this stage of dying, the fundamental goal of care changes from a recovery focus to a comfort focus. An essential element in the approach to any person is that it is individualized (Schoenberg, 1970:241). While the preservation of life is a noble goal, another goal of the profession seems to have been forgotten, that of providing comfort and relief of pain, be this pain physical or psychological (Barrocas, 1973:39).

> The act of death is singular and final, but the act of dying is variable in form and subject to human intervention. Each patient is a unique person with his own illness, his own reactions,

> his own inner world. And each patient is a person who needs the nurse's special help to live fully the days before his death, to die peacefully and well (Fox, 1966:1318).

An individual approach demands time and concern, and as pointed out by Lamberton (1973:57), what counts is not our doing--but our being. Your presence confirms that you will be around to the end and not leave the patient alone, not forgotten, when nothing else can be done (Kubler-Ross, 1969:100). Davidson (1966:75) supports this idea by suggesting that the most effective nursing that can be offered is just being with someone when words have no place and little meaning. Barrocas (1972:40) supports another aspect of care, and that is the importance of physical contact. Simply touching the person, holding or shaking his hand may tell him he is touchable and no different from other patients. Amacher (1973:854) after working with an aphasic patient states that she now believes that the laying on of hands is an essential part of treating many, if not all, patients.

Barrocas (1973:40) remarks that one must show empathy and demonstrate to the patient that one's understanding of the dilemma in which he finds himself. Empathy includes kindness and when communicated it forms the basis for a helping relationship between the patient and the nurse (Kalisch, 1973:1548). Awareness of the patient as a unique

individual is of primary concern at this time. He must be allowed to grieve, so that he can separate himself from his loved ones (Kubler-Ross, 1971:58). Supportive interaction with the patient and the family is a strong neutralizing force in such anxious moments. Reassurance may be impossible, even unrealistic, but empathy and a willingness to share the experience tends to aid the person in coping with and facing impending death (Moidel, 1971: 58). The patient should be visited frequently by the staff and the family for the need for inclusion is the need to feel the self is significant and worthwhile (Brunner, 1970:29). If, together with adequate physical care, the dying person had sufficient human companionship most of his anguish would be prevented, and he will know that those about him still have a warm interest in him (Hinton, 1972: 120). The family should be allowed to spend as much time together as they desire, and as Barrocas (1973:40) suggests, visiting regulations should be relaxed where the dying patient is concerned to permit this togetherness.

As the final hours of life are ebbing, the death watch commences. Glaser and Strauss (1968:197) describe the death watch as empty time, a period of waiting. Quint (1967:767) suggests that during this stage the patient should be observed frequently to keep him comfortable and

to prevent his dying alone. Dying alone is a frightening thought and many patients express concern about the loneliness and isolation associated with this experience (Kubler-Ross, 1969:46; Cotter, 1972:62; Strauss and Glaser, 1970:148). Isolation and alienation of the dying patient usually results from the natural, and most often unconscious desire, on the part of the nurse to protect self from an uncomfortable situation. The overwhelming sense of helplessness when watching a person die and not being able to prevent death, often causes conflict and a sense of failure. It is essential for the nurse to realize the dynamics of this process and strive to view dying as a meaningful part of life. The nurse should encourage contact with the dying patient for isolation and loneliness diminish the person's capacity for living during the last days (Schoenberg and Senescu, 1970:232). Such a situation also intensifies the patient's suffering (Cotter, 1972:63).

The death watch terminates with the patient's actual moment of "passing" (Glaser and Strauss, 1968:202). Once death has occurred, the doctor makes a formal pronouncement and the task remains of informing the family (Quint, 1967: 767). Such an announcement is usually difficult and often a painful experience. Such moments are filled with emotional stress and the manner in which the nurse approaches and

responds to the family should be one of concern, compassion, and support. Engel offers several guidelines of intervention for the intuitive and sympathetic nurse.

> First, news of death or impending death is best communicated to a family group rather than to an individual alone and should be done in a setting of privacy where the family can behave naturally without the restraint of public display.
>
> Second, the request to see or take leave of the dying or dead patient should not be denied on the ground that it may be too upsetting or that it will disturb the floor routine.
>
> Third, when confronted by an angry, bitter, accusatory relative . . . the nurse should keep in mind that he may be attempting to deal with his own aggression and guilt toward the dying person.
>
> Fourth, the nurse, knowing that shock and disbelief may be the first response to the news of death, should anticipate that some persons will behave in a grossly disturbed manner. The nurse will require patience, tact, and warm sympathy for the person who refuses to acknowledge the truth of the news as well as for the person who collapses or loses control.
>
> Fifth, one cannot over emphasize the importance of knowing about and exercising the respect for cultural, religious, and social customs of the mourners, no matter how strange they may be to some of us (Engel, 1964:97).

Eissler (1955:245) asks the question--Which is really harder, to die or to witness death? Both can be frightening and painful experiences, but certainly, the pain and fear can be eased. Cotter (1972:61) emphasizes that nurses are dealing with problems which do not have easy answers, with situations in which success is not always assured. If nursing really believes that people have the

right to a humane and dignified death, nurses must be willing to help create an environment in which the psychosocial needs of patients do not get lost because of high priorities and social rewards attached to saving life (Quint, 1969:289). The reality of death will continue to be part of the nurses' work world and to provide help for the dying, the nurse must be willing to commit herself to finding better ways of coping with this universal human problem. Desich (1964:45) firmly believes that giving emotional care to a human being who is facing death is the most difficult of all nursing functions. It is not a natural skill. There is no universal formula for providing the most effective help according to Rhoads (1965:77). But, the nurse who understands the patient's emotional response to serious illness is equipped to deal more directly with the majority of patient problems and is thus able to provide total nursing care (Cohen, 1974:62). Before the nurse can ever begin to give this emotional support, she must come to terms with her own natural aversion to death. And then, with time, the nurse can learn to accept death as a part of life. When this is learned, then maybe the nurse can help patients to learn it, too (Kubler-Ross, 1971:61).

Summary

A review of the literature revealed that institutionalization of dying necessitates a continuous exposure to death for health professionals. Infrequent contact with death prior to professional practice, inadequate educational preparation, the generalized fear of death, and emphasis on life-saving goals, creates a personal and professional problem for most nurses. Avoidance behavior, as a protective maneuver in uncomfortable and threatening situations, is frequently employed by members of the healing profession. Two areas of avoidance behavior discussed were conversation and time contact with the patient.

The stages of the grief and dying process, and events that occur in the dying trajectory were described. Recommendations were proposed as guidelines for the nurse in helping the patient and family through the dying process to a dignified and peaceful death.

The procedure for the collection of data and the development of a data-gathering instrument is described in Chapter III.

CHAPTER III

PROCEDURE FOR COLLECTION OF DATA

Introduction

A descriptive study was conducted utilizing the questionnaire as the research instrument. The setting for the collection of data was general medical-surgical units of two proprietary hospitals and one nonproprietary hospital.

Setting

This descriptive study was conducted on medical and surgical units of two proprietary and one nonproprietary hospital in the city of Dallas, Texas. These hospitals were selected to obtain an adequate size sample for the study and to encompass a broader population of nurses that frequently encounter dying patients.

A letter, accompanied by the agency permission forms, was sent to the Administrator or Director of Nursing of the three hospitals requesting permission to conduct research in that agency (Appendix A). Upon receipt of permission, an appointment was arranged with the Director of Nursing of the agency to establish a method of coordinating

activities within the institution to conduct the study. Cooperation on the part of all three institutions facilitated the collection of data.

Population

As this study was descriptive in nature the population was not confined to a specific number. The population of this study consisted of ninety-five registered professional nurses licensed to practice nursing in the State of Texas. The sampling design utilized was the convenient or incidental type. The population comprised those nurses on duty on the day selected for collection of data at the particular agency.

In order to view the data obtained within the confines of the participant group, a description of some characteristics of the population was obtained on a biographical data sheet.

Eighty-six of the participants were employed on a full-time basis, and nine were on part-time status. The length of employment on a particular unit ranged from four weeks to sixteen years. Of the total number of participants, sixty-eight held a staff nurse position; sixteen were head nurses; and eleven were in supervision. Of the total population twenty-eight were employed on a medical unit; twenty-two on a surgical unit; and forty-five on a

combined medical-surgical unit. General medical and surgical units were utilized where patients near death were encountered without the "acute care" atmosphere of the intensive or emergency areas.

The age range of the population demonstrated that fifty-nine participants were thirty-five years of age or less, with thirty-six respondents between the ages of thirty-six and sixty-five. The distribution of respondents by age is presented in Table 1.

TABLE 1

NUMBER AND PERCENT OF RESPONDENTS BY AGE

Age Range	Respondents	
	Number	Percent
20 - 25	21	22.0
26 - 30	24	25.2
31 - 35	14	15.6
36 - 40	11	11.4
41 - 45	10	10.4
46 - 50	5	5.2
51 - 55	6	6.1
56 - 60	3	3.1
61 - 65	1	1.0
Total	95	

Total years of nursing experience, as presented in Table 2, illustrates that the range of specified years of total experience was from less than one year to thirty years. The distribution of respondents indicating from one to ten years over-all nursing experience was fifty-seven nurses, more than one-half of the sample population.

TABLE 2

NUMBER AND PERCENT OF RESPONDENTS BY TOTAL YEARS OF NURSING EXPERIENCE

Years of Experience	Respondents	
	Number	Percent
Under 1 year	2	2.1
1 - 5	33	34.8
6 - 10	22	23.2
11 - 15	15	15.7
16 - 20	10	10.6
21 - 25	5	5.2
26 - 30	8	8.4
Total	95	

The distribution of respondents by type of basic nursing education received is presented in Table 3. Representation of respondents graduated from diploma

programs comprised forty-eight nurses; from Bacculaureate programs thirty-two nurses; and from Associate Degree programs fifteen nurses.

TABLE 3

NUMBER AND PERCENT OF RESPONDENTS BY TYPE OF BASIC NURSING EDUCATIONAL PROGRAM

Type of Program	Respondents	
	Number	Percent
Diploma	48	50.6
Bacculaureate	32	33.6
Associate	15	15.8
Total	95	

The marital status of the population indicated that thirty-five participants of the group were single; forty-eight married; eight separated or divorced; and four were widowed. Encounters with death prior to nursing was experienced by forty-eight participants of the total group. The number of nurses exposed to caring for a person near death on a frequent basis was fifty-three respondents. Of the total population forty-two respondents reported caring for a person in the process of dying on an occasional basis.

Description of Instrument

The data-gathering instrument employed in this descriptive study was in the form of a questionnaire. The instrument was designed by the researcher since a tool had not been found in the literature that would be appropriate for the specific purposes of this study.

The original draft of the questionnaire contained twenty-six items pertaining to specific avoidance behaviors the nurse utilizes while caring for the dying patient (Appendix B). The basic content of the listed items was primarily derived from the works of Quint (1967), Glaser and Strauss (1966; 1968), and Kubler-Ross (1969). The draft was submitted to a member of the Instructions Communication Department at Southwestern Medical School for consultation regarding content and structural format. The format of "yes" and "no" for response choices was utilized to facilitate ease in rating the responses. Several items were rephrased to facilitate structure and ease of reading. This form of the questionnaire was then submitted to twelve registered nurses enrolled in the graduate program at Texas Woman's University, Dallas, Texas, to discriminate between conversational items and time-contact items. Question 18 was reworded as it did not apply to either category in its initial form. Several items were added to the

questionnaire at the suggestion of the nurses who assisted in determining the classification of response items.

A second draft of the questionnaire resulted in a total of twenty-eight items, utilizing the "yes" and "no" response format (Appendix C). This draft was submitted for further consultation on content and structure to a member of the Texas Woman's University faculty, Graduate Nursing Division; and the same person in the Instruction Communication Department at Southwestern Medical School. This consultation resulted in the rewording of items for clarity, and the substitution of the word "I" in place of the word "you." The use of the word "you" in conjunction with the response "yes" or "no" was considered threatening and uncomfortable. The term "I" in connection with the response of "true" or "false" appeared less threatening, was easier to work with, and was more subjective. These changes were chosen to help elicit information concerning the individual nurse's behavior while caring for a person near death.

After revision of the second draft, a third questionnaire of twenty-eight items was submitted to ten graduate students and the instructor of a course focusing on death and dying in the fall semester at Texas Woman's University College of Nursing (Appendix D). This group assisted in determining clarify of directions, relevancy of items to

the topic under study, format of the instrument, adequacy of response selection, and ease of use. Revisions were made in accord with the recommendations of the group. Questions 6, 11, 18, and 28 were reworded to elicit more specific information. Question 26 was omitted as the group considered this item biased. A question on touch was added as the group regarded such behavior an important aspect of care related to the dying patient.

The questionnaire was revised and submitted to a panel of judges. The factors considered by the panel were relevancy of the listed items to the problem under study, classification of the items into conversational and time-contact categories, clarity and conciseness of each item, and the response choice of "true" or "false." These factors were determined appropriate and relevant to the study by all members of the panel. The questionnaire was then viewed as adequate for utilization in a pilot study.

A pilot study sample was then conducted employing a small population of registered nurses (Appendix E). The results of the pilot study were reviewed and did not yield evidence indicating any major problems in the over-all procedure for the collection of data. Question 27 was eliminated as it overlapped with Question 2. Question 10 was omitted as it was the extreme opposite of item 9,

which was considered more relevant to the behavior of the nurse while caring for the dying patient. Question 14 was deleted due to varied interpretations of the item. The results of the data obtained in the pilot study was not included in the major project. The worth of the instrument was judged according to appropriateness and ease of use.

After consultation with the panel of judges and a review of the pilot study, the final form of the instrument was composed. The final form of the tool was divided into three sections: a cover letter, biographical data sheet, and questionnaire (Appendix F).

A cover letter accompanied the instrument stating the purpose of the questionnaire, the institution sanctioning the study, the importance of the participant's response, and the deadline date for return of the questionnaire. Appreciation for participating in the project was expressed, and anonymity throughout the study and in the report of the findings was assured. Anonymity was assured by not having the participants include their name on the questionnaire, and the instrument returned via mail in an unmarked envelope.

A biographical data sheet was enclosed to elicit information related to the population of this particular

study. This data permitted a more detailed and comprehensive description of the characteristics of the sample employed.

The final questionnaire consisted of twenty-five closed-ended items phrased to elicit a positive or negative response concerning specific behaviors employed by the nurse while caring for a dying patient. Instructions for completing the questionnaire preceded the listed items. Items number 1, 2, 3, 4, 5, 6, 7, 8, 11, 14, 16, 19, and 24 pertained to conversational behavior, and items numbered 9, 10, 12, 13, 15, 17, 18, 20, 21, 22, 23, and 25 were related to time contact with the patient. The respondent was directed to check either "true" or "false" in accord with how they viewed their behavior in relation to each item. The items were arranged according to a table of random numbers (Goldstein, 1964:234). The table was entered at the fourth column on the seventh row, progressing in a consistent vertical pattern, utilizing the first two digits of a five-digit number to arrange the items. A space for comments was provided on the questionnaire to permit the participant the freedom to add remarks if so desired.

Panel of Judges

The instrument for gathering information for this study was submitted to a panel of three judges. The purpose of this panel was to assist in determining various degrees of validity and appropriateness of the instrument. The panel consisted of Dr. Arthur Babick, Instructions Communication Department, Southwestern University Medical School, Dallas, Texas. Dr. Babick was considered an authority in the field of instruction, communication, and test media. The second member of the panel was Ms. Marilyn Chassie, Graduate Nursing Department, Texas Woman's University, Dallas, Texas. Ms. Marilyn Chassie was asked to be on the panel for her expertise in nursing and knowledge in the area of death and dying. The third panel member was Dr. Lawrence Malnig, Director, Counseling Center, St. Peter's College, Jersey City, New Jersey. Dr. Malnig was asked to join the panel for the contribution he could make as a result of vast experience in the areas of psychology, education and research. Content validity was determined by submitting the instrument to the panel of judges who estimated validity on the basis of their experience, knowledge and expertise.

Description of Pilot Study

A pilot study was conducted on September 26, 1974, before the final form of the research design was completed. This small preliminary investigation was of the same general character as the major study and designed to acquaint the researcher with problems that could be corrected in preparation for the larger research project (Treece and Treece, 1973:90). All steps in the pilot study were carried out in full in order to determine any weaknesses in the research instrument.

After the necessary permission was obtained, a pilot study was conducted employing a population of ten nurses at a small general hospital in Dallas, Texas. The size of the population was selected on the recommendation of Treece and Treece (1973:90) and in proportion to the anticipated total population. The pilot study population met the same criteria as set forth for the total population of the major project. The questionnaire was directly distributed to ten registered nurses on duty of the day the pilot study was conducted and were returned on that same day.

Description of Data Collection

The questionnaire was directly distributed to nurses working at one of the three hospitals on October 15, 1974,

October 17, 1974, and October 22, 1974. The questionnaires were enclosed in a business envelope stamped and addressed to the researcher. A total of 150 questionnaires were directly distributed to nurses on the dates indicated. The individual nurse had the option to participate and return the questionnaire, or to decline at will.

Procedure for Treatment and Analysis of Data

A binomial test was employed to indicate significant differences between the proportions obtained on avoidance and non-avoidance responses elicited by the questionnaire. The research use of the binomial theorem is in its usefulness as a model in a dichotomous situation (Fox, 1970:131).

Summary tables were provided composed of the proportions of avoidance behavior exhibited by the population as delineated by various biographic factors. Proportion is defined as the ratio of the frequency in a given category to the total frequency (Treece and Treece, 1973:193).

The individual items on the questionnaire were ordered by degree of avoidance in the sample population, noting each item as either conversational or time-contact avoidance behavior.

Summary

A descriptive study to identify and describe selected avoidance behaviors the nurse employed while caring for a dying patient was conducted. The setting was medical and surgical units of two proprietary and one nonproprietary hospital in the city of Dallas, Texas. The population consisted of registered nurses employed on general medical and surgical units. Data was obtained via a questionnaire on a total of 95 respondents out of 150 registered nurses.

Analysis of the data obtained appears in Chapter IV. Tables have been employed to facilitate conciseness of the presentation of the findings.

CHAPTER IV

ANALYSIS OF DATA

Introduction

A descriptive study was conducted to identify and describe selected avoidance behaviors employed by the nurse while caring for a dying patient. The binomial theorem, useful in a dichotomous situation, was employed to indicate the frequency of response in a given category to the total frequency. The individual items on the data-gathering instrument were arranged by degree of avoidance employed by the population in this particular study.

Analysis of the obtained data indicated that certain behaviors listed were avoided more than others by the sample population. Such items were ordered by degree of avoidance and categorized as significantly avoided behaviors, avoidance behaviors not significantly employed, and behaviors significantly not employed by the sample population. Avoidance behaviors as delineated by biographic factors were also presented.

Avoidance Behaviors Significantly Employed

Table 4 represents the questionnaire items ordered by degree of behaviors significantly avoided by the sample

population of this study. Ranking the order of items by degree of avoidance was determined on the basis of more than one-half the respondents of the population utilizing the listed avoidance behavior.

TABLE 4

RANK ORDER OF CONVERSATIONAL AND TIME AVOIDANCE BEHAVIORS SIGNIFICANTLY EMPLOYED

Behavior Category	Rank	Question	Proportion of Avoidance
C[a]	1	14	.979
C	2	7	.958
T[b]	3	18	.800
T	4	25	.790
C	5	6	.737
C	6	5	.684
C	7	16	.663
T	8	23	.653

[a]Conversation
[b]Time

The most frequently avoided action reported by the sample population was initiation of conversation concerning death with the dying patient on the part of the nurse (Question 14). Such outright avoidance is in accord with reports by Glaser and Strauss (1966:72) that dangerous

topics are avoided, and the most dangerous topic is the patient's death. Conversations about death create feelings of anxiety and fear. Avoidance of such conversation is consistent with the technical objectives of the health profession and the death-denying attitudes of the society which it serves (Brim, 1970:xviii).

Glaser and Strauss refer to "role-switching", or the delegation of responsibility or certain activities from one person to another. The respondent group indicated that more than 50 percent of the sample population called in others to talk with or console the family when a patient died (Question 7). Such action has been reported as an attempt to avoid disturbing scenes and to reduce involvement in the emotional plight of the family on the loss of a loved one. Quint (1967:108) maintains that this mode of behavior is a compensation for personal inadequacies, a common feeling when faced with the unknown.

A reported behavior indicating avoidance was pulling the curtain around the bed of the dying patient to screen him off from other patients (Question 18). Glaser and Strauss (1968:196) view this screening off of the patient as an attempt to prevent witnessing a disturbing death rehearsal. Such segregation of the dying patient aids in preventing erosion of the nurse's composure and reduces

constant exposure and participation in the death process. A proportion of .800 of the sample population indicated use of this behavior.

Moving a person near death to a private room is an avoidance behavior reported in the literature (Question 25). Strauss and Glaser (1970:147) disclose that in all countries they observed, a strong tendency existed to isolate the dying patient during his last days in the hospital. The response results as indicated by a proportion of .795 of the participant nurses coincides with the findings of Strauss and Glaser. The results on this item were also in accord with a previous study by Glaser and Strauss (1968:48) which revealed that this segregation of dying patients allows the staff to keep control of the work and sentiments surrounding the dying patient and to localize the death scene on the unit.

Question number 6, referring the patient to his physician if he asks about his terminal condition or death, was a mode of behavior included in the avoidance techniques employed by a proportion of .737 of the sample population. Quint (1967:105) presents evidence that nurses utilize this form of behavior. This particular behavior has also been labeled as a type of "role-switching" strategy by Glaser and Strauss (1966:241).

A proportion of .684 of the sample population disclosed a preference for the dying patient to be in an unconscious state (Question 5). Nurses apparently feel more comfortable in this situation which reduces the need for conversational involvement. Glaser and Strauss (1966:238) report similar results and explain such behavior as an endeavor to minimize feelings of helplessness and the risk of emotional involvement.

Abstaining from initiating conversation with the family about the patient's condition and impending death was observed as an employed behavior by a proportion of .663 of the respondent group (Question 16). Glaser and Strauss (1966:230) report the avoidance of the patient and family, as well as the topic of death and dying, as a standard activity on the part of the nurse. Brim (1970: xviii) supports this finding by stating that health professionals commonly avoid discussions of impending death with the patient or his relatives.

A reported behavior by a proportion of .653 of the total population was to limit time contact with the dying patient by assigning the care of this patient to an aide, attendant, or another nurse (Question 23). This particular mode of behavior has been reported by Quint (1967:105). Delegation of care to another, a form of "role-switching,"

directly reduces exposure to the dying process, and thus, minimizes the risk of emotional involvement, and aids in the maintenance of professional composure.

Avoidance Behaviors Not Significantly Employed

The data obtained via the questionnaire presented certain avoidance behaviors employed by the sample population, but not considered significant in relation to utilization of such behavior by greater than one-half the total respondent group. Table 5 presents the rank order of avoidance behaviors not significantly employed by nurses in this investigation. Although such behaviors have been identified as avoidance type activity, the relative degree of avoidance has not been documented in the literature.

Question number 13 elicited information concerning a desire on the part of the nurse to avoid death on the shift that she was working. A proportion of .568 of the respondent group indicated such a preference which is consistent with the professional and societal defense system which fosters evasion of unpleasant situations (Aasterud, 1962:40). Avoidance of death on a particular shift also reduces involvement with the family and the burdensome paper work required.

TABLE 5

RANK ORDER OF CONVERSATIONAL AND TIME AVOIDANCE BEHAVIORS NOT SIGNIFICANTLY EMPLOYED

Behavior Category	Rank	Question	Proportion of Avoidance
T[a]	9	13	.568
T	10	22	.547
C[b]	11	3	.537
T	12	17	.453
T	13	21	.432
C	14	11	.432
C	15	8	.432
C	16	4	.411

[a]Time
[b]Conversation

A form of avoidance behavior utilized by a proportion of .547 of the respondent group was to ask a family member to remain with the dying patient (Question 22). This mode of behavior has been reported as an avoidance management technique by Quint (1967:105) and Glaser and Strauss (1968:199). A situation of this type permits the nurse to be free to do other tasks and reduces the involvement of participating in the death watch.

The preference of performing mechanical tasks or rendering physical care to that of talking with the patient near death was a behavior reported to be utilized by a proportion of .537 of the total population (Question 3). Kubler-Ross (1969:18) testifies that the focusing of interest on equipment, rather than the patient as a person, is a frequently employed activity. A significant preference for one mode of behavior to the other was not clearly determined by the response results on this particular item.

Glaser and Strauss (1966:134) report that nurses tend to spend more time with patients they can help in an attempt to prevent feelings of helplessness that often overcome the nurse engaged in terminal care. The results obtained on Question 17 revealed that a proportion of .453 of the sample population employ this form of avoidance behavior. The data obtained on this particular item are not in complete agreement with the findings of Glaser and Strauss (1966).

Nurses prefer not to be present at the time of a patient's death as reported by Glaser and Strauss (1968: 202). The response to Question 21 suggests that less than one-half the sample population, a proportion of .432, avoided being present at the patient's bedside at the

expected time of death. This response is not in accord with the results disclosed by Glaser and Strauss (1968).

The number of respondents who administered pain medication to the dying patient whether they asked for it or not was reported by a proportion of .432 or less than one-half the sample population (Question 11). The use of medication as an avoidance behavior reported by Glaser and Strauss (1966:40) was not supported by this data.

A reported method of conversational management is to plead ignorance or to give assurance that all will be fine when a dying person directly asks if he is going to die (Glaser and Strauss, 1966:56). The response of the participant nurses to Question 8 revealed that a proportion of .432, less than one-half the total sample, employed this particular type of avoidance behavior.

Question 4 sought to determine whether or not the nurse encouraged a dying patient to continue talking if he directly brought up the subject of his impending death. The data obtained indicated that a proportion of .411 of the respondent group would not encourage the patient to pursue this topic of conversation. This form of behavior, although not consistent with the literature, has been recognized by Glaser and Strauss (1966:240). Results from the studies by these authors reveal that if conversation on

death has begun, other forms of management can be used to protect the nurse from involvement or distress.

Avoidance Behavior Significantly Not Employed

An extensive review of the literature revealed certain types of avoidance behaviors employed by the nurse while caring for a dying patient as reported by Glaser and Strauss (1966; 1968), Quint (1967), and Kubler-Ross (1969). The response choices of the sample population employed in this study indicated that some of these listed behaviors were significantly not avoided. Table 6 presents the rank order of avoidance behaviors significantly not employed by the respondent group.

Question 24 elicited information as to whether or not the nurse discussed the subject of death to any degree at all with a person who was dying. A large segment of the population reported that they did discuss the topic of death, and a proportion of .368 disclosed that they avoided discussing this subject. While the results to Question 14 revealed that the participants in this project did not initiate conversation on death, a significant proportion of the population did discuss the topic of death at times.

Sudnow (1970:195) reports that physicians and nurses make every effort to separate relatives from those about to die. The results to Question 20 disclosed that a majority

of the respondent group did not witness patients dying alone and unattended. Only a small porportion, .358 of the sample population, reported that this situation occurred.

TABLE 6

RANK ORDER OF CONVERSATIONAL AND TIME AVOIDANCE BEHAVIORS SIGNIFICANTLY NOT EMPLOYED

Behavior Category	Rank	Question	Proportion of Avoidance
C[a]	17	24	.368
T[b]	18	20	.358
C	19	2	.316
T	20	15	.274
T	21	10	.253
T	22	12	.211
C	23	1	.211
C	24	19	.179
T	25	9	.105

[a]Conversation
[b]Time

Changing the subject of impending death with a dying patient when brought up in the conversation was reported by a proportion of .316 of the respondent group (Question 2). This data was not in keeping with the findings of Quint

(1969:105) which disclosed that nurses do change the subject when death is mentioned as a means of maintaining composure.

Question 15 sought to determine if the nurse asked other patients in the room to watch the dying patient and to notify her if there was any change in the patient's condition. A proportion of .726 of the sample population reported that they did not engage in this particular mode of action, while a proportion of .274 of the group revealed that this behavior was utilized. Glaser and Strauss (1968:201) report the use of such behavior as a means of controlling participation in the death watch. The response to Question 22 revealed that some members of the sample population asked a family member to remain, but more than 50 percent of the sample group would not ask another patient to take responsibility of watching the patient near death.

A proportion of .253 of the respondents avoided contact by touch, while a proportion of .747 of the sample population indicated use of touch while caring for the person near death (Question 10). Touch may be viewed as a form of communication when the use of words is too threatening and uncomfortable in the face of death. Barrocas (1973:40) supports this aspect of care while ministering to a patient near death.

The response to Question 12 revealed that a proportion of .789 of the sample population made rounds to check the dying patient, and a proportion of .211 of the respondents sent an aide, attendant, or another nurse on rounds. This data does not coincide with the findings of Quint (1967: 105) which revealed that a nurse usually delegates such responsibility to other members of the health team.

While a greater proportion of the population, .789 of the group, disclosed that they discussed death in general with a dying patient, a proportion of .211 of the participants reported that they avoided this topic in general when talking with a person near death (Question 1). The obtained results are not in accord with Glaser and Strauss who report that with patients approaching death, nurses avoided the subject of death in general.

Question 19 sought to determine if the nurse took time to sit and listen when a dying patient expressed a desire to talk about his impending death. The respondent group who took such time was a proportion of .821 of the sample population. A small proportion, .179 of the participant group, revealed that they did not engage in such behavior. The results of this item revealed that this particular behavior was the least avoided conversational mode of behavior employed by the sample population.

Entering the room and standing near the bedside to check the patient near death was an action utilized by .895 of the respondents (Question 9). A proportion of .105, a small segment of the total population, indicated that they did not perform this action. The response results to this item indicated that this was the least frequently employed behavior of the sample population to limit time contact with the patient near death. These results are not in keeping with the data presented by Strauss and Glaser (1970:147) that nurses avoid the patient's room and bedside when death was approaching.

Biographic Characteristics and Avoidance Behaviors

Further analysis of the data obtained revealed interesting results in relationship to various biographic characteristics of the sample population. Table 7 presents a proportion of avoidance behaviors employed by registered nurses as revealed by basic educational preparation.

Behavior employed to limit time spent with the dying patient was utilized proportionately by graduates of the three basic nursing educational programs. Participants educated in diploma and associate degree programs employed proportionally similar degrees of conversational avoidance behaviors. A statistical significant difference, at the .05 level of significance, was observed in the baccalaureate

prepared participants in the area of conversational avoidance behavior. The results obtained indicate the need for further investigation of conversational behaviors of nurses educated on the bacculaureate level.

TABLE 7

PROPORTION OF AVOIDANCE BEHAVIORS OF REGISTERED NURSES BY BASIC EDUCATIONAL PROGRAM

Behavior Category	Diploma Program	Associate Program	Bacculaureate Program
C[a]	.593	.451	.882
T[b]	.535	.317	.409
	N = 48	N = 15	N = 32

[a]Conversation
[b]Time

Total years of nursing experience as reported by the respondent group was divided into time components of 0-15 years of experience, and 16-30 years of actual experience. Table 8 reports the proportion of avoidance behaviors employed by registered nurses by years of total nursing experience.

The data obtained by years of nursing experience revealed that there was a statistically significant difference at the .05 level of significance between conversational avoidance behavior and time-limiting behavior in both

TABLE 8

PROPORTION OF AVOIDANCE BEHAVIORS OF REGISTERED NURSES CATEGORIZED BY YEARS OF TOTAL NURSING EXPERIENCE

Behavior Category	0-15 years	16-30 years
C[a]	.533	.856
T[b]	.811	.420
	N = 72	N = 23

[a]Conversation
[b]Time

groups. The respondent population with 0-15 years of experience employed behavior that limited time spent with the dying patient more significantly than conversational avoidance behavior. This time-limiting behavior was utilized more significantly than by the group with more years of experience. A reverse trend was observed in the sample population with 16-30 years of nursing experience. Conversational avoidance behavior was employed by a greater proportion of this group than behaviors that limit the amount of time spent with the patient near death. This particular group utilized conversational avoidance more frequently than the group with less years of experience. Documentation supporting such results is lacking, and

this deficit indicates the need for further inquiry into the obtained results.

TABLE 9

PROPORTION OF AVOIDANCE BEHAVIORS BY EXPERIENCE WITH DEATH PRIOR TO NURSING

Behavior Category	Experience	No Experience
C[a]	.252	.599
T[b]	.418	.504
	N = 48	N = 47

[a]Conversation
[b]Time

The sample population was almost equally divided in experience with death prior to nursing. The data obtained in this category revealed that the participants with no experience with death prior to nursing utilized conversational avoidance behavior more frequently than the participants who had experience with death. The statistical significant difference was at the .05 level of significance. Participants who experienced death prior to nursing had the opportunity to participate in the mourning process and family rituals associated with death. This significant human experience and its impact was not a foreign experience when encountered in nursing. Behavior to limit time contact

with the dying patient was not significantly observed between these two groups of participants.

TABLE 10

PROPORTION OF AVOIDANCE BEHAVIOR CATEGORIZED BY AGE RANGE

Age	Number	Conversation	Time
20 - 25	N = 21	.392	.341
26 - 30	N = 24	.567	.528
31 - 35	N = 14	.604	.548
36 - 40	N = 11	.650	.515
41 - 45	N = 10	.546	.375
46 - 50	N = 5	.523	.400
51 - 60	N = 10	.492	.425

Age categorization did not yield statistically significant evidence in type of avoidance behavior employed by the sample population. A trend indicating increased use of both conversational and time-avoidance behavior was observed up to the age of forty, after which a decline was noted. The sample population in each specific age group was too small to obtain significant evidence within the population.

The type of nursing unit on which the participants worked did not yield significant results in relation to avoidance behaviors employed (see Table 11). The type of nursing unit did not exercise a significant influence on the behavior of the sample population.

TABLE 11

PROPORTION OF AVOIDANCE BEHAVIOR EMPLOYED BY TYPE OF NURSING UNIT

Behavior Category	Medical Unit	Surgical Unit	Medical-Surgical Unit
C[a]	.549	.615	.468
T[b]	.461	.526	.392
	N = 28	N = 22	N = 45

[a]Conversation
[b]Time

The data obtained and shown in Table 12 did not indicate a significant difference in type of avoidance behavior employed in relation to the frequency of encounters with death.

TABLE 12

PROPORTION OF AVOIDANCE BEHAVIOR BY FREQUENCY OF ENCOUNTERS WITH DEATH

Behavior Category	Frequent	Occasional
C[a]	.530	.520
T[b]	.465	.435
	N = 53	N = 42

[a]Conversation
[b]Time

Summary

The analysis of data obtained via the questionnaire in this descriptive study revealed that there was no significant difference in the use of conversational avoidance behavior and time-contact avoidance behavior employed by the sample population. A rank order of items by proportion of avoidance was presented. Results obtained by biographic characteristics of the population were also illustrated.

The results obtained in this study provided a framework for the summary, conclusions, implications, and recommendations in Chapter V.

CHAPTER V

SUMMARY, CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

Summary

The descriptive study undertaken in this research project was an investigation to identify and describe avoidance behaviors employed by the nurse to limit conversation and the amount of time spent with a patient in the process of dying. The population consisted of registered nurses employed on medical-surgical units from two proprietary and one nonproprietary hospital.

A review of literature revealed that the hospital although a center of recovery, also serves as a locus for dying, and thus, a central feature in the lives of most nurses is a continuous encounter with death and dying. Such exposure generates fear and anxiety in those who attend and care for the dying patient. In an attempt to manage such emotions and deal with this difficult situation, the nurse resorts to the use of various protective mechanisms. Such behavior is consistent with the death-denying attitudes of a society and a profession that view death as a technical failure. Dealing with

death is a problem that has no easy answer. The adoption of a supportive role by the nurse during the dying trajectory is only one way of assisting the patient to a dignified and peaceful death.

The data-gathering instrument was a closed-ended questionnaire comprised of twenty-five items related to behavior which limited conversation or time spent with the dying patient. The questionnaire was developed by the researcher and based on evidence in the literature relating to avoidance behavior associated with death and the dying process. The instrument was submitted to a panel of judges and a pilot study was performed prior to the administration of the questionnaire in the major research project. A total of 150 questionnaires were distributed to registered nurses using the convenience sampling design. A total of ninety-five respondents comprised the population that completed and returned the questionnaire.

Analysis of the data obtained indicated that of the conversational avoidance behaviors and time contact avoidance behaviors investigated, neither type was used more frequently than the other. A rank ordering, by proportion of the avoidance behaviors, disclosed that the most frequently employed conversational avoidance behavior

was that the participants did not initiate conversation about death with the dying person. The dominant mode of time avoidance behavior utilized by the population was segregation of the dying patient by pulling the curtain around the bed. Biographic factors that influenced the type of avoidance behavior employed by the respondent group were nursing education at the bacculaureate level, years of actual experience in nursing, and experience with death prior to nursing.

Conclusions

The analysis of the data obtained in this study provided the basis from which the following conclusions were derived:

1. The participant nurses in this study tended to use some form of avoidance behavior while caring for a dying person.
2. A difference was not observed in the degree of use of either conversational avoidance behavior or time limiting avoidance behavior.
3. Available literature implies that nurses used the listed avoidance behaviors while caring for the dying patient. The results of this study did not support extensive use of such behaviors.

4. The participant nurses educated at the bacculaureate level employed conversational avoidance behavior more than participants educated in an associate degree or diploma program.
5. The respondent group with 0-15 years of nursing experience tended to employ behaviors that limited time spent with the dying patient more than respondents with more years of experience.
6. The population of nurses with 16-30 years of nursing experience tended to employ conversational avoidance behavior more than participants with fewer years of experience.
7. The participant nurses who had experience with death prior to nursing utilized conversational avoidance behavior less frequently than participants with no prior experience with death.
8. The type of avoidance behavior utilized was not affected by the type of nursing unit or frequency of encounters with death.

Implications

The findings of this study present implications for the individual nurse who assumes an important and decisive role in caring for the patient near death. Each nurse must re-examine her position to determine the type of avoidance behavior she employs while caring for the dying patient. The type and extent of use of such behavior will assist the nurse in reappraisal of her role in providing care for the dying. Any behavior employed that fosters a positive and therapeutic relationship with the patient should be examined and strengthened. Awareness of behaviors used by the individual and factors that contribute to the development of such behaviors is essential, for protective behaviors deprive one of the opportunity of personal growth. The individual nurse must reflect on her basic educational preparation and make an effort to determine how and to what extent her education has helped or hindered her behavior personally or professionally while caring for a dying patient. The nurse must also consider how her total years of actual nursing experience have influenced her present behavior. If one mode of behavior is being employed more frequently than another, attentive introspection as to causes is essential. Any personal experience with death prior to nursing should be examined

to establish to what extent such an experience has influenced the nurse's ability to be able to discuss death more freely than other nurses. Effective solutions to present problems surrounding death and dying must originate with the individual before a hospital, an educational system or society at large can deal with the phenomena of death.

The findings of this study have definite and urgent implications for nursing education. The burden of responsibility for preparing nurses to give quality care rests with nursing educators. Nursing educators must give careful attention to the basic content of the curriculum in the area of death and dying that might possibly foster the development of avoidance behavior. The faculty of bacculaureate programs must re-evaluate not only basic content of the nursing curriculum, but must consider factors that foster conversational avoidance behaviors of bacculaureate graduates. Such factors to be considered would be the type of clinical experience provided for the student, the type of clinical assignment, and the amount of clinical experience per student each semester. Nursing educators must also give thought to how their own experience with death influences what and how death is presented to the students. The responsibility also rests

with the nursing faculty to encourage students to re-evaluate their personal and professional position in relation to death periodically after graduation. Nursing educators must support those elements of the curriculum that foster a healthy relationship toward death. The educational forces in nursing might lean toward more definite clinical research concerning death and dying. A point for commencing such investigations would be students who have had experience with death prior to nursing and who utilize conversational avoidance behavior less frequently than other students. Nursing must make attempts to discuss death in the open on a personal basis, in professional journals, and via any available avenues of communication media. Every attempt must be made on the part of nursing to bridge the gap that has existed between what is taught and the reality situation of facing death.

Implications for nursing service were also recognized as a result of this investigation. Individualized quality care is the prevailing goal of any health facility and administrators are in a unique position for initiating such care. Nursing service must first recognize that some mode of avoidance behavior is employed by the nurse while caring for a dying patient. An awareness of the educational preparation of graduates that are employed will assist in

establishing inservice programs that will be beneficial to all nurses and thus improve patient care. The establishment of programs to aid the nurse personally and professionally should be done in consideration of years of nursing experience, such as 0-15 years or 16-30 years of actual nursing experience. The recognition of the needs of the nurse as well as the patient should be an essential priority in the formation of any program. The establishment of other programs should be in the light of the nurse-patient interaction, and nurse-family interaction. The institutionalization of death must be eradicated by providing situations that view death as a reality of life and encourages the staff to remain with the patient and family in rendering support and care.

This study also holds implications for other health professionals as well as the nurse who might employ similar types of behavior while caring for the patient near death. The rewards and recognition for saving life must also be available to all those who provide a dignified and peaceful death for the patient. Programs must be instituted to instruct members of the hospital staff in the total needs of the dying patient. Avenues must be provided under competent leadership for members of the medical and nursing staff, chaplains, social workers, therapists, technicians,

and other staff members to arrive at a deeper understanding and sensitivity to the needs of the dying patient and each other. Such can only create an atmosphere of care that is individualized and human and is not overshadowed by the aura of institutionalization.

The moment of death is still the most important and most decisive in man's life, a singular and final act that is the unique final achievement of living. For the nurse, patient, and family who share in this poignant event, death provides a depth of growth far greater than any other human experience. There is a time to live . . . and a time to die. At all times, among all the ways of dealing with death, the most surely doomed to failure is the attempt to ignore it (Carstairs, 1972:8).

Recommendations

The identification and description of selected avoidance behaviors has a definite influence on the role of nurses--individually and collectively. Awareness of behaviors that might hinder the process of helping that patient near death necessitates that nurses re-define their professional and personal position in regard to death and dying within the realistic parameters of this inevitable constituent of human existence. This framework,

in conjunction with the analysis of data obtained in this descriptive study, provided a basis for the recommendations presented.

1. An investigation be conducted of the selected avoidance behaviors listed in this study utilizing an objective approach or a combined objective-subjective approach. Methods to be considered would be direct taping of conversations of the nurse and patient; observation of the nurse-patient interaction; and taping interviews based on open-ended questions.
2. An investigation be conducted to compare avoidance behaviors utilized by nurses in general medical-surgical areas and acute care areas.
3. An investigation be conducted employing a larger sample of nurses prepared at the bacculaureate level to determine if there is a significant increase in the utilization of conversational avoidance behavior over behavior that limits the amount of time spent with the dying patient. Facotrs to be considered in such an investigation would be basic content of

curriculum, type of clinical assignments, and amount of clinical experience per student per semester.

4. An investigation be conducted to determine the extent of influence that total years of nursing experience has on the use of conversational avoidance behavior and time contact avoidance behavior.
5. An inquiry be conducted into how experience with death prior to nursing contributes to the nurse's use of avoidance behaviors.
6. An investigation of the utilization of avoidance behavior while caring for a dying patient be conducted according to various age categories to determine if age influences such behavior.

APPENDIX A

1810 Inwood Road
Dallas, Texas 75235
September 23, 1974

Dear

In partial fulfillment of the requirements for the Master of Science Degree in Nursing at Texas Woman's University I am researching the behavior of the nurse while caring for a dying patient.

To identify the behavior of the nurse while caring for a patient near death nurses will be asked to complete a questionnaire designed to elicit data relevant to this topic. The collection of data will take place during the month of October, 1974.

I would like very much to include some of the nurses at your hospital in the total sample of registered nurses. Enclosed are the forms for agency permission as required by Texas Woman's University. Any conditions you state will be agreeable and acceptable.

Should you have any questions regarding this study I shall be happy to answer them.

Thank you for your time and assistance in this matter. Your cooperation is appreciated.

Sincerely,

Carol A. Carney, R.N.

Enclosures

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING
DENTON, TEXAS

DALLAS CENTER
1810 Inwood Road
Dallas, Tx. 75235

HOUSTON CENTER
1130 M.D. Anderson Blvd.
Houston, Tx. 77025

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE _____

GRANTS TO Carol Anne Carney

a student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem:

Selected Avoidance Behaviors Employed by the Nurse While Caring for a Dying Patient

The conditions mutually agreed upon are as follows:

1. The agency (may) (may not) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) (may not) be identified in the final report.
3. The agency (wants) (does not want) a conference with the student when the report is completed.
4. The agency is (willing) (unwilling) to allow the completed report to be circulated through interlibrary loan.
5. Other _____

_____

_____

Date _____ _____
Signature of Agency Personnel

_____ _____
Signature of student Signature of Faculty Advisor

*Fill out and sign three copies to be distributed as follows: Original-Student; first copy - agency; second copy - TWU College of Nursing.

BV/4/10/74/sic

1810 Inwood Road
Dallas, Texas 75235
September 19, 1974

Mrs. Marlene Hoare
Director of Nursing
Brookhaven General Hospital
12100 Webbs Chapel Road
Dallas, Texas 75234

Dear Mrs. Hoare,

In partial fulfillment of the requirements for the Master of Science Degree in Nursing at Texas Woman's University, I am researching the nurse's behavior while caring for a dying patient.

To identify the behavior of the nurse while caring for the patient near death a questionnaire has been developed to elicit relevant data. It is necessary that this tool be submitted to a pilot study to determine effectiveness and clarity.

I am writing to obtain your permission for such a pilot study at Brookhaven General Hospital. This preliminary project would involve approximately ten or twelve staff nurses.

I will be happy to answer any questions you might have concerning this project. Thank you for your time and assistance in this matter. Your cooperation is appreciated.

Sincerely,

Carol A. Carney, R. N.

Enclosures

September 22, 1974

Carol A. Carney
1810 Inwood Road
Dallas, Texas 75235

Dear Ms. Carney:

In regard to your letter of September 19, 1974, we would be pleased to have you conduct a pilot study to determine the effectiveness and clarity of your questionnaire.

Please feel free to call and arrange an appointment. I will be looking forward to meeting with you.

Sincerely,

Marlene Hoare RN

Marlene Hoare, R.N.
Director of Patient Care

MH/vc

APPENDIX B

QUESTIONNAIRE

1. If a patient brings up the subject of impending death do you permit him to continue? Yes___No___

2. Do you bring up the subject of impending death with the patient? Yes___No___

3. When the patient brings up the subject of death do you make an attempt to change the topic? Yes___No___

4. Do you sit and listen when the patient wants to talk about death? Yes___No___

5. If the patient asks about his death do you refer him to his doctor? Yes___No___

6. Do you talk with the family about the patient's impending death? Yes___No___

7. If you know a person is dying do you talk about getting better and the future? Yes___No___

8. Do you attempt to control the conversation when the patient brings up the topic of death? Yes___No___

9. Do you choose to perform mechanical tasks rather than talk with the person who is dying? Yes___No___

10. If a patient asks you about his condition do you plead ignorance? Yes___No___

11. Do you gear your conversation toward everyday social activity? Yes___No___

12. If the patient brings up the subject of death do you pretend to be very busy and have little time for conversation? Yes___No___

13. When the person is near death do you prefer to put them in a private room? Yes___No___

14. When the person is near death do you pull the curtains around the bed so he is screened off from other patients? Yes___No___

15. Do you find it easier to maintain your composure when the patient is sedated? Yes___No___

16. If medication is ordered on a p.r.n. basis for the patient who is dying, do you give it routinely? Yes___No___

17. If a person dies on your shift do you find yourself wishing he had died on another shift? Yes___No___

18. When a patient dies on your shift does it upset the routine of the unit? Yes___No___

19. If the person is in the last hours of life do you go <u>into</u> the room to check the patient? Yes___No___

20. Do you send an aide or attendant to make rounds and check the person who is dying? Yes___No___

21. If the person is near death do you find yourself standing at the door to check the patient? Yes___No___

22. In making out patient assignments do you assign the person who is dying to another nurse or aide? Yes___No___

23. In making out patient care assignments do you take the dying person as part of your assignment? Yes___No___

24. When a person dies on your shift do you call in others to talk with the family (minister, social worker, etc.)? Yes___No___

25. When the person is near death and a family member is present do you ask them to stay with the patient? Yes___No___

26. Do you ask another patient in the room to watch the person near death and to notify you if there is any change? Yes___No___

APPENDIX C

QUESTIONNAIRE

1. When conversing with a person who directly brings up the subject of his impending death do you find that some nurses permit him to continue? Yes___No___

2. Do you find that when some nurses are engaged in conversation with a person who is dying they bring up the subject of death? Yes___No___

3. If a dying person does bring up the subject of death do you find that some nurses make attempts to change the subject? Yes___No___

4. When a dying person expresses the desire to talk about death do you find that some nurses are willing to sit and listen? Yes___No___

5. If a dying person asks about his terminal condition or death, is it a common response for some nurses to refer him to his doctor for more information? Yes___No___

6. From your experience do some nurses take time to talk with the family about the patient's impending death? Yes___No___

7. When a person is near death do some nurses talk with him about the future and getting better? Yes___No___

8. If a dying person directly brings up the topic of death do some nurses make an attempt to control the conversation? Yes___No___

9. While performing mechanical tasks do some nurses encourage conversation with the dying patient? Yes___No___

10. When a dying person asks directly about his condition do you find that some nurses plead ignorance? Yes___No___

11. From your experience do you find that some nurses prefer the dying patient not to be sedated? Yes___No___

12. Do you find that some nurses tend to gear their conversation toward everyday social activity when talking with a dying patient? Yes___No___

13. When a patient dies do you find that some nurses call in others to talk with or comfort the family (minister, social worker, etc.)? Yes___No___

14. With the patient approaching death do you find that some nurses will bring up the subject of death in general? Yes___No___

15. If a person is near death do you find that some nurses will move him to a private room if possible? Yes___No___

16. Do you find that pulling the curtain around the bed of a dying person to screen him off from other patients is not a common practice with some nurses? Yes___No___

17. When sedation is ordered on a p.r.n. basis for a dying person do you find that some nurses will not give it routinely? Yes___No___

18. Do you find it a common trend that some nurses wish the patient to die on the shift they are working rather than another one? Yes___No___

19. If a person is near death do you find that some nurses enter into the room and stand at the bedside to check the patient? Yes___No___

20. Do some nurses send aides or attendants on rounds to check the dying patient rather than go themselves? Yes___No___

21. Do you find that some nurses just stand at the door or glance into the room to check the dying patient? Yes___No___

22. In making out patient care assignments is an aide or attendant assigned to the dying patient by some nurses? Yes___No___

23. In making out patient care assignments do you think that nurses prefer to take the dying patient as part of their assignment? Yes___No___

24. When a person is near death and a family member is present do you find that some nurses ask them to remain with the patient? Yes___No___

25. Do nurses ask other patients in the room to watch the dying person and to notify them if there is any change in condition? Yes___No___

26. If the dying person brings up the topic of death do some nurses pretend to be very busy and have little time to spend with the patient? Yes___No___

27. Do you feel from your experience that some nurses are available to be present at the time of death? Yes___No___

28. From your experience do many patients die alone and unattended? Yes___No___

APPENDIX D

QUESTIONNAIRE

Instructions:

Please check (x) either true or false for each of the following statements.

Please answer each statement honestly as this is vital to the results of this study. There are no right or wrong answers for any of the statements.

If you wish to add any comments, please feel free to do so in the space provided.

Do not include your name on this questionnaire. You will remain anonymous throughout this study and in the report of the findings.

		Comments
1.	When talking with a person who directly brings up the subject of his impending death I permit him to continue. True__False__	
2.	I bring up the subject of death when talking with a dying person. True__False__	
3.	If a dying person does bring up the subject of his impending death, I try to change the subject to the weather, the news, etc. True__False__	
4.	When a dying person expresses a desire to talk about death I take time to sit and listen. True__False__	
5.	If a dying person asks about his terminal condition or death I tell him to ask his doctor. True__False__	

Comments

6. I take time to talk with the family about the patient's impending death. True__False__

7. When a person is near death I talk with him about the future and getting better. True__False__

8. When a person is near death I prefer not to bring up the subject of death with him in any way at all. True__False__

9. While performing mechanical tasks (B/P, TPR, etc.), I encourage conversation with the dying patient. True__False__

10. When a dying person asks directly about his condition I say, "I really don't know." True__False__

11. I prefer the dying patient being sedated. True__False__

12. I gear my conversation to everyday social activity when talking with a dying person. True__False__

13. When a patient dies I call in others (minister, social worker, etc.), to talk with and comfort the family. True__False__

14. When talking with a person near death I do bring up the topic of death in general. True__False__

Comments

15. If a person is near death I move him to a private room if possible. True__False__

16. I pull the curtain around the bed of the dying person to screen him off from other patients. True__False__

17. When sedation is ordered on a p.r.n. basis for a dying patient I give it automatically without the patient's request. True__False__

18. If a patient dies when I am in charge or for whom I am responsible, I wish the death had occurred on another shift. True__False__

19. If a person is near death I enter the room and stand at the bedside to check the patient. True__False__

20. I send an aide or attendant on rounds to check the dying patient rather than go myself. True__False__

21. I stand at the door and glance into the room to check the dying patient. True__False__

22. In making out patient care assignments I assign an aide or attendant to care for the dying patient. True__False__

Comments

23. In making out patient care assignments I take the dying patient as part of my assignment. True__False__

24. I ask a family member to stay with the dying person so that I can be free to do other things. True__False__

25. I ask other patients in the room to watch the dying person and to notify me if there is any change in his condition. True__False__

26. If the dying person brings up the subject of death I am usually very busy and need to be with other patients. True__False__

27. I make an effort to be at the patient's bedside at the time of death. True__False__

28. Many of my patients die alone and unattended. True__False__

APPENDIX E

September, 1974

Dear Nurse,

I am researching the nurse's behavior while caring for a dying patient. The topic of death is of great interest to me and a concern to every nurse. I am doing this project in partial fulfillment of the requirements for the Master of Science Degree in Nursing at Texas Woman's University.

To identify the behavior of the nurse while caring for the adult patient near death, you will be asked to complete the enclosed questionnaire and biographical data sheet developed to elicit relevant information on this topic. Your candid response to this questionnaire will be invaluable to the results of this study. Do not include your name on any of the enclosed forms. You will remain anonymous throughout this study and in the report of the findings.

Thank you for your time and assistance in this project. Your cooperation is greatly appreciated.

Sincerely,

Carol A. Carney, R. N.

Enclosures

BIOGRAPHICAL DATA SHEET

Please complete the following information by checking the appropriate space or filling in the data.

Number of years in nursing:_____ Age:_____

Single_____ Married_____ Separated_____ Divorced_____

Basic Education received:

Diploma_____ Associate_____ Bacculaureate_____

Highest Degree held:

Associate_____ Masters_____

Bacculaureate_____ Other_____

If Masters state area of specialization:_____

Type of nursing unit you work on. (If unit involves an area of specialization, please state.)

Medical_____ Medical-Surgical_____

Surgical_____ Other_____

Position held:

Staff nurse_____ Supervisor_____

Head nurse_____ Other_____

Employment: Full time_____ Part time_____

Shift: Rotation_____ 7-3_____ 3-11_____ 11-7_____

Have you had experience with death prior to nursing?

Yes_____ No_____

QUESTIONNAIRE

Instructions:

Please check (√) either true or false for each of the following statements.

Please answer each statement honestly as this is vital to the results of this study. It is important that you answer each item listed in the questionnaire. There are no right or wrong answers for any of the statements. Respond according to what you usually do in the stated situation.

Do not include your name on this questionnaire. You will remain anonymous throughout the study.

		Comments
1.	When talking with a person near death I will discuss the topic of death in general with him if brought up in the conversation. True__False__	
2.	When a dying person brings up the subject of his impending death, I try to change the subject to the weather, the news, or a more comfortable topic. True__False__	
3.	While caring for a dying patient, I'd rather talk with the person than perform mechanical tasks (B/P, TPR, etc.) or physical care. True__False__	
4.	When talking with a dying person who directly brings up the subject of his impending death I encourage him to continue. True__False__	

Comments

5. I work more comfortably with the dying patient when he is unconscious. True__ False__

6. If a dying patient asks directly about his terminal condition or death I tell him to ask his doctor. True__ False__

7. When a patient dies I call in others (minister, social worker, etc.), to talk with and console the family. True__ False__

8. When a dying person asks directly if he is going to die I say, "I really don't know," or "Don't worry everything is going to be fine. True__ False__

9. If a person is near death I enter the room and stand near the bedside to check the patient. True__ False__

10. I stand at the door and glance into the room to check the dying patient. True__ False__

11. I frequently hold the dying patient's hand, or place my hand on his arm or shoulder. True__ False__

12. When pain medication is ordered on a p.r.n. basis for a dying patient I give it automatically whether or not the patient asks for it. True__ False__

Comments

13. I send an aide, attendant, or another nurse on rounds to check the dying patient rather than go myself. True__ False__

14. When a person is near death I talk with him about the future and getting better. True__ False__

15. If a patient dies while I am in charge or for whom I am responsible, I wish the death had occurred on another shift. True__ False__

16. I bring up the subject of death when talking with a dying person. True__ False__

17. I ask other patients in the room to watch the dying person and to notify me if there is any change in the patient's condition. True__ False__

18. I initiate conversation with the family about the patient's condition and impending death. True__ False__

19. I tend to spend more time with the patients who will recover than the patient near death. True__ False__

20. I pull the curtain around the bed of the dying patient to screen him off from other patients. True__ False__

Comments

21. When a dying person expresses a desire to talk about his impending death I take time to sit and listen. True__False__

22. When I am on duty I find that many patients have expired alone and unattended. True__False__

23. I make an effort to be at the patient's bedside at the expected time of death. True__False__

24. I ask a family member to stay with the dying patient so that I can be free to do other things. True__False__

25. In making out patient care assignments I assign an aide, attendant, or another nurse to care for the dying patient. True__False__

26. When a person is near death I prefer not to discuss the subject of death with him in any way at all. True__False__

27. I gear my conversation to everyday social activity when talking with a dying patient. True__False__

28. When a person is near death I move him to a private room if possible. True__False__

APPENDIX F

October, 1974

Dear Nurse,

I am researching the nurse's behavior while caring for a dying patient. The topic of death is of great interest to me and a concern to every nurse. I am doing this project in partial fulfillment of the requirements for the Master of Science Degree in Nursing at Texas Woman's University.

To identify the behavior of the nurse while caring for the adult patient near death, you will be asked to complete the enclosed questionnaire and biographical data sheet developed to elicit relevant information on this topic. Your candid response to this questionnaire will be invaluable to the results of this study. Do not include your name on any of the enclosed forms. You will remain anonymous throughout this study and in the report of the findings.

Please return the questionnaire directly to me in person or by mail before October 25, 1974.

Thank you for your time and assistance in this project. Your cooperation is greatly appreciated.

Sincerely,

Carol A. Carney, R.N.

Enclosure

BIOGRAPHICAL DATA SHEET

Please complete the following information by checking the appropriate space or filling in the data.

Number of years in nursing_____ Age_____

Single_____ Married_____ Separated_____ Divorced_____

Basic Education received:

Diploma_____ Associate_____ Bacculaureate_____

Highest Degree held:

Associate_____ Masters_____

Bacculaureate_____ Other_____

If Masters, state area of specialization_____

Type of nursing unit you work on. (If unit involves an area of specialization, please state.)

Medical_____ Medical-Surgical_____

Surgical_____ Other_____

How long have you worked on this unit?_____

Position held:

Staff nurse_____ Supervisor_____

Head nurse_____ Other_____

Employment: Full time_____ Part time_____

Shift: Rotation_____ 7-3_____ 3-11_____ 11-7_____

Have you had experience with death prior to nursing?

Yes_____ No_____

How often do you encounter dying patients?

Frequently_____ Occasionally_____ Never_____

QUESTIONNAIRE

Please check (√) either true or false for each of the following statements.

Please answer each statement honestly as this is vital to the results of this study. It is important that you answer each item listed in the questionnaire. There are no right or wrong answers for any of the statements. Respond according to what you usually do in the stated situation.

Do not include your name on this questionnaire. You will remain anonymous throughout the study.

		Comments
1.	When talking with a person near death I will discuss the topic of death in general with him if brought up in the conversation. True__False__	
2.	When a dying person brings up the subject of his impending death, I try to change the subject to the weather, the news, or a more comfortable topic. True__False__	
3.	While caring for a dying patient I'd rather talk with the person than perform mechanical tasks (B/P, TPR, etc.) or physical care. True__False__	
4.	When talking with a dying person who directly brings up the subject of his impending death I encourage him to continue. True__False__	

Comments

5. I work more comfortably with the dying patient when he is unconscious. True__False__

6. If I know the patient is dying and he asks directly about his terminal condition or death I tell him to ask his doctor. True__False__

7. When a patient dies I call in others (minister, social worker, etc.) to talk with and console the family. True__False__

8. When a dying person asks directly if he is going to die I say, "I really don't know," or "Don't worry, everything is going to be fine." True__False__

9. If a person is near death, I enter the room and stand near the bedside to check the patient. True__False__

10. I frequently hold the dying patient's hand, or place my hand on his arm or shoulder. True__False__

11. When pain medication is ordered on a p.r.n. basis for a dying patient, I give it automatically whether or not the patient asks for it. True__False__

12. I send an aide, attendant, or another nurse on rounds to check the dying patient rather than go myself. True__False__

Comments

13. If a patient dies while I am in charge or for whom I am responsible, I wish the death had occurred on another shift. True__ False__

14. I bring up the subject of death when talking with a dying person. True__ False__

15. I ask other patients in the room to watch the dying patient and to notify me if there is any change in the patient's condition. True__ False__

16. I initiate conversation with the family about the patient's condition and impending death. True__ False__

17. I tend to spend more time with the patient who will recover than the patient near death. True__ False__

18. I pull the curtain around the bed of the dying patient to screen him off from other patients. True__ False__

19. When a dying person expresses a desire to talk about his impending death, I take time to sit and listen. True__ False__

20. When I am on duty I find that many patients have expired alone and unattended. True__ False__

21. I make an effort to be at the patient's bedside at the expected time of death. True__ False__

Comments

22. I ask a family member to stay with the dying patient so that I can be free to do other things. True__ False__

23. In making out patient care assignments I assign an aide, attendant, or another nurse to care for the dying patient. True__ False__

24. When a person is near death I prefer not to discuss the subject of death with him in any way at all. True__ False__

25. When a person is near death, I move him to a private room if possible. True__ False__

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