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Associations Between Oncology Nurses' Attitudes Toward Death and Caring for Dying Patients

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In the past, most people died at home surrounded by their loved ones, and although inevitable, death was perceived as an integral part of life. This perception has changed in recent decades, and death now is perceived more commonly as an enemy that should be defeated (Haisfield-Wolfe, 1996). Denial of death is common in western cultures, and most people now die in hospitals or in institutional settings rather than at home (Da Silva & Schork, 1985; Haisfield-Wolfe). Cancer is a leading cause of death; 10,000 people died from malignant diseases in Israel in 2005, accounting for 27% of all deaths that year (World Health Organization, 2007).

Treatment of dying patients represents a large and significant part of the oncology nurse role (Haisfield-Wolfe, 1996). Oncology nurses are in the front line of healthcare providers who care for dying patients and accompany them in their final journey in life toward death (Ellershaw & Ward, 2003; Fairbrother & Paice, 2005; White, Coyne, & Patel, 2001). The quality of care delivered by oncology nurses could be influenced by their personal attitudes toward the care of dying patients and death itself (Costello, 2006; Deffner & Bell, 2005; Haisfield-Wolfe; Rooda, Clements, & Jordan, 1999). Attitudes are composed of ideas and beliefs that are attached to specific emotions, which together are connected to an action being taken in association with the object of the attitude, such as death (Neimeyer, 1994). Attitudes give people a sense of order and control and help them build their world perception and their own identity (Durlak & Riesenber, 1991).

Of the few studies that have examined attitudes toward caring for dying patients, most have focused on nurses. The different variables investigated that may influence these attitudes included gender (Roman, Sorribes, & Ezquerro, 2001; Servaty, Krejci, & Hayslip, 1996), age, years working as an RN, years employed at a cancer center (Lange, Thom, & Kline, 2008), exposure to dying patients (Brent, Speece, Gates, Mood, & Kaul, 1991; Dunn, Otten, & Stephens, 2005; Hare & Pratt, 1989;

Purpose/Objectives: To examine relationships between oncology nurses' attitudes toward death and caring for dying patients.

Design: Cross-sectional, descriptive, and correlational.

Setting: Israeli Oncology Nurses Society annual conference in June 2006.

Sample: A convenience sample of 147 Israeli nurses who were exposed to death in their daily work. Most worked in oncology departments and were of Jewish faith.

Methods: Completion of the Frommelt Attitude Toward Care of the Dying Scale, Death Attitude Profile-Revised Scale, and a demographic questionnaire.

Main Research Variables: Attitudes toward caring for dying patients, attitudes toward death (fear of death, death avoidance, and types of death acceptance), and demographic variables (e.g., religiosity).

Findings: Nurses demonstrated positive attitudes toward care of dying patients. The attitudes were significantly negatively correlated with death avoidance, fear of death, and approach acceptance of death. A mediating role of death avoidance was found between fear of death and attitudes toward caring for dying patients.

Conclusions: Nurses' personal attitudes toward death were associated with their attitudes toward the care of dying patients. The mediating model suggests that some nurses may use avoidance to cope with their own personal fears of death. Inconsistency between the current results and previous studies of associations between acceptance of death and attitudes toward care for dying patients imply that culture and religion might play important roles in the development of these attitudes.

Implications for Nursing: Training and support programs for oncology nurses should take into consideration nurses' personal attitudes toward death as well as their religious and cultural backgrounds.

Rooda et al., 1999), and nurses' training in the area of death and dying (Brent et al.; Demmer, 1999; Frommelt, 1991; Hainsworth, 1996; Mallory, 2003; Mok, Lee, & Wong, 2002; Wong, Lee, & Mok, 2001).

Another variable that might influence attitudes toward caring for dying patients is personal attitudes toward death. The attitudes a person holds toward death are dependant on the meaning that death has for him or her (Kuuppelomaki, 2000), which is influenced by personal, religious, cultural, social, and philosophical belief systems (Rooda et al., 1999). Studies have found that people have widely varying attitudes toward death, some positive and some negative, with fear of death being the attitude investigated most frequently (Neimeyer, 1994; Yalom, 1980).

Gesser, Wong, and Reker (1987) developed a multi-dimensional measure of attitudes toward death called the Death Attitude Profile, which assesses fear of death, death avoidance, and death acceptance. Fear of death is described as a conscious and specific fear of death, whereas death anxiety is considered an unconscious and more generalized fear. Reasons to fear death reported in the literature include fear of the loss of the self, fear of the unknown, fear of pain and suffering, and fear of the anguish of remaining family members (Wong, Reker, & Gesser, 1994). Death avoidance, another negative attitude toward death, is when a person attempts to avoid thinking or talking about death; death avoidance contrasts with fear of death, in which a person confronts death and the emotions attached to it (Wong et al., 1994).

Death acceptance was defined by Kubler-Ross (1969) as the final and desirable stage of the process of coping with death. Wong et al. (1994) defined death acceptance as a psychological readiness for the final separation from life. Death acceptance consists of two components: the cognitive awareness of mortality and a positive emotional reaction to that awareness (Neimeyer, Wittkowski, & Moser, 2004; Wong et al., 1994). According to Wong et al. (1994), three different attitudes represent death acceptance. The first is neutral acceptance, in which a person perceives and accepts death as an integral part of life. He or she is not afraid of death but at the same time does not welcome it. The second attitude is approach acceptance, in which death is perceived as a passage to a better afterlife. Several studies have found that believing in the afterlife is significantly associated with degree of religiosity (Degner & Gow, 1988; Kuuppelomaki, 2000). The third attitude is escape acceptance, in which death is perceived as an escape from a life full of pain and sorrow and, therefore, is a desirable alternative to life.

Nurses' degree of death acceptance, fear of death, and death avoidance might influence their attitudes toward the care of dying patients (Dunn et al., 2005; Haisfield-Wolfe, 1996; Kaye, Gracely, & Loscalzo, 1994; Payne, Dean, & Kalus, 1998; Rooda et al., 1999; Wessel & Rutledge, 2005). Few studies have examined the association between personal attitudes toward death and caring for dying patients among nurses, and the research on this topic still is exploratory. Some studies have focused solely on death anxiety and demonstrated a positive association between higher death anxiety and negative attitudes to-

ward caring for dying patients among nurses (Deffner & Bell, 2005; Hare & Pratt, 1989; Mok et al., 2002).

Rooda et al. (1999) interviewed 403 nurses working in different departments who had little experience in caring for dying patients. They found that attitudes toward caring for dying patients were negatively associated with fear of death and death avoidance and positively associated with a neutral approach acceptance of death. Wessel and Rutledge (2005) conducted a similar study among 33 hospice and homecare nurses and found a significant association between personal attitudes toward death and caring for dying patients. More positive attitudes toward caring for dying patients were reported by nurses who had low fear of death, low death avoidance, and higher approach acceptance of death. Dunn et al. (2005) replicated the study in 2005 with 58 oncology and surgical nurses but failed to obtain associations between the variables.

The current study was designed to examine the association between personal attitudes toward death and caring for dying patients among Israeli oncology nurses. The current study is unique in that all participant nurses had experience working with dying patients, most in an oncology setting. Most studies of attitudes toward death have been set in the United States with Christian nurses; however, the current study was conducted in Israel and included mostly Jewish nurses, thus allowing for an examination of this issue from a different cultural and religious perspective.

Methods

Design, Sample, and Procedure

The study was cross-sectional, descriptive, and correlational. A convenience sample of Israeli oncology nurses, all members of the Israeli Oncology Nurses Society, was recruited at the society's annual conference in June 2006. Five hundred of 600 members attended the conference. On the day of the conference, each nurse who registered received a package from the research team that included a letter of invitation to participate in the current study and the study questionnaires. Participation was anonymous. In the opening meeting of the conference, the president of the society introduced the study. Each nurse who returned a completed questionnaire package was given a raffle ticket to encourage participation. Three prizes were raffled off, valued at \$75, \$50, and \$25.

Measures

Participants completed three questionnaires. The **Frommelt Attitude Toward Care of Dying Patients (FATCOD)** is a 30-item scale that assesses nurses' attitudes toward providing care for dying patients and their families (Frommelt, 1991). The FATCOD has an equal

number of positively and negatively worded items, which are rated on a five-point Likert scale. Negative items are reverse scored. Possible scores range from 30–150, with higher scores representing more positive attitudes. The FATCOD has demonstrated high reliability and validity (Frommelt). Its internal reliability was found to be high in the current study (Cronbach alpha = 0.85).

The **Death Attitude Profile–Revised** (DAP-R) is a 32-item scale that assesses attitudes toward death (Wong et al., 1994). The DAP-R is a multidimensional scale consisting of five subscales. Fear of death (seven items) measures negative thoughts about death and has multiple components, including fear of the process of dying and fear of the death of significant others. Death avoidance (five items) measures attempts to avoid thoughts about death. Natural acceptance (five items) measures the extent to which a person accepts death as a reality in a neutral manner; the person views death as a neutral part of life and accepts it as inevitable but neither fears nor welcomes it. Approach acceptance (ten items) measures the extent to which a person views death as an entry point to a better afterlife. Finally, escape acceptance (five items) measures the extent to which a person views death as an escape from a life filled with pain and suffering (Neimeyer, 1994). The score for each subscale is the mean score of its items; scores range from 1–7. The DAP-R subscales have demonstrated good validity and acceptable reliability (Wong et al., 1994). In the current study, subscale reliability was tested and was found to be acceptable for approach acceptance (Cronbach alpha = 0.87), fear of death (0.79), death avoidance (0.82), and escape acceptance (0.82). Neutral acceptance had low internal consistency (0.41), which has been found in other studies (Rooda et al., 1999). As a result, all analyses for the current study were performed excluding the neutral acceptance subscale.

A demographic questionnaire was developed by the study team and consisted of questions regarding personal variables, such as age, gender, education, religiosity (i.e., how much they are obligated to religious laws), and questions on professional experience, such as place of work, exposure to dying patients, and specialist professional training in the care of dying patients.

Statistical Analysis

Data were analyzed with SPSS® version 11.5. Missing data were examined and mean substitution was employed for missing total scores, which resulted in minimal, nonsignificant changes in standard deviations; analyses that were run without imputation demonstrated no change in the results. Statistical tests were two-tailed with alpha set at 0.05. Descriptive statistics were calculated to provide information about participants' characteristics, attitudes toward death and care for

dying patients, and the association between variables. Hierarchical regression was used to examine the main predictions.

Results

Sample Characteristics

Of the 500 nurses who participated in the conference, 170 returned the study questionnaire package (34% response rate); 147 of 170 completed all of the questionnaires (86%). Therefore, analyses were run on the sample of 147 nurses who provided complete data.

One hundred and forty-one nurses were women (96%), with a mean age of 46.2 years (SD = 10.5, range = 18–67). Most nurses were Jewish (89%), were married (75%), and had completed academic degrees (75%). About 56% described themselves as secular. Additional demographic characteristics are presented in Table 1.

Table 2 presents the professional characteristics of the sample. Mean number of years of nursing experience was 20.8 (SD = 10.6). Most nurses worked in oncology departments (82%), worked full time (71%), and were employed as staff nurses (67%). Eighty-seven percent had participated in a specialized course in oncology, and 51% had taken a specialized course in death and dying. All nurses reported being exposed to death in the course of their work; 19% were exposed to 6–10

Table 1. Sample Demographics

Characteristic	n	%
Gender		
Female	141	96
Male	6	4
Marital status		
Married	110	75
Single	19	13
Divorced	10	7
Widowed	6	4
Missing data	2	1
Religion		
Jewish	131	89
Muslim	7	5
Christian	4	3
Other	4	3
Missing data	1	1
Degree of religiosity		
Religious	24	16
Traditional	34	23
Secular	82	56
Missing data	7	5
Highest level of education		
High school	36	25
Bachelor's degree	70	48
Master's degree	40	27
Missing data	1	1

N = 147

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

Table 2. Professional Characteristics of the Nurse Participants

Characteristic	n	%
Workplace		
Oncology department	95	65
Hospice	12	8
Pediatric oncology department	13	9
Pediatric department	13	9
Community	7	5
Other	5	3
Missing data	2	1
Nurse role		
Head nurse	38	26
Staff nurse	99	67
Coordinator nurse	10	7
Number of work hours		
Full-time	105	71
Part-time	39	27
Missing data	3	2
Participated in courses on death and dying		
Yes	75	51
No	69	47
Missing data	3	2
Exposed to death in the workplace		
Yes	147	100
Number of dying patients cared for per month		
1–5	75	51
6–10	28	19
More than 10	35	24
Missing data	9	6

N = 147

dying patients per month and 24% were exposed to more than 10 dying patients per month. Associations among the sample characteristics and the main study variables were examined with Pearson correlations and multivariate analysis of variance. The analyses did not yield any significant associations among sample characteristics and attitudes toward caring for dying patients. However, a significant difference was found in approach acceptance of death among nurses according to their degree of religiosity ($F_{2,136} = 8.19$, $p < 0.001$). Religious and traditional nurses reported more acceptance of death as an entry to better afterlife ($\bar{X} = 3.95$, $SD = 1.09$; $\bar{X} = 4.02$, $SD = 1.02$, respectively) in comparison to secular nurses ($\bar{X} = 3.18$, $SD = 1.21$). Differences in death avoidance were found among nurses with different amounts of exposure to dying patients ($F_{2,135} = 5.66$, $p < 0.01$). Nurses who cared for 0–5 dying patients per month had higher death avoidance scores ($\bar{X} = 3.22$, $SD = 1.36$) than nurses who cared for 6–10 dying patients per month ($\bar{X} = 2.83$, $SD = 1.35$) and nurses who cared for more than 10 dying patients per month ($\bar{X} = 2.34$, $SD = 1.03$). Death avoidance was negatively associated with nurses' age, but the correlation was low ($r = -0.16$, $p = 0.05$).

Attitudes Toward Death

Nurses in the sample reported moderate levels of fear of death ($\bar{X} = 4.11$, $SD = 1.3$), death avoidance ($\bar{X} = 2.93$, $SD = 1.33$), approach acceptance ($\bar{X} = 3.53$, $SD = 1.23$), and escape acceptance ($\bar{X} = 3.6$, $SD = 1.4$). Examination of associations among the DAP-R subscales with bivariate analyses resulted in few significant positive correlations. Fear of death was positively correlated with death avoidance and approach acceptance, and approach acceptance also was positively correlated with death avoidance and escape acceptance (see Table 3).

Attitudes Toward Death and Caring for Dying Patients

The mean score on the FATCOD was 125.7 ($SD = 12.4$). Overall, nurses in the sample demonstrated a positive attitude toward caring for dying patients and their families. Examining associations among DAP-R subscale scores and the FATCOD score with bivariate analyses revealed significant correlations. Attitudes toward caring for dying patients were negatively correlated with death avoidance, fear of death, and approach acceptance. Therefore, nurses who reported higher fear of death and death avoidance and those who perceived death as an entry point to a better afterlife held less positive attitudes toward caring for dying patients. A standard multiple regression analysis was used to determine to what extent attitudes toward death (as rated by the DAP-R subscales as the independent variables) contribute to the prediction of oncology nurses' attitudes toward caring for dying patients (as rated by the FATCOD scale as the dependent variable). Overall, the model explained a total of 22% of the variance in nurses' attitudes toward caring for dying patients, with only death avoidance and approach acceptance as significant predictors in this model (see Table 4).

Although the correlation between fear of death and attitudes toward caring for dying patients was significant, fear of death did not significantly contribute to the regression model. To examine a possible mediating role of death avoidance, a hierarchical regression analysis was employed. The β for fear of death concealed from step 1 to step 2 of the regression when avoidance of death was entered (see Table 5). Therefore, a mediating role of death avoidance was demonstrated between fear of death and attitudes toward caring for dying patients among oncology nurses.

Discussion

Attitudes toward death and caring for dying patients may influence the behavior of caregivers (Deffner & Bell, 2005; Haisfield-Wolfe, 1996; Kaye et al., 1994; Payne et al., 1998). Few studies have examined these attitudes among nurses (Dunn et al., 2005; Lange et

Table 3. Correlations Between Attitudes Toward Caring for Dying Patients and Death

Variable	Caring for Dying Patients	Fear of Death	Death Avoidance	Approach Acceptance	Escape Acceptance
Caring for dying patients	–	–0.25*	–0.42**	–0.28**	–0.12
Fear of death	–	–	0.52**	0.19*	–0.05
Death avoidance	–	–	–	0.23*	0.02
Approach acceptance	–	–	–	–	0.4**

* $p < 0.01$; ** $p < 0.001$

al., 2008; Rooda et al., 1999; Wessel & Rutledge, 2005). The current study examined the relationship between attitudes toward death and caring for dying patients among oncology nurses in Israel. The current study had two unique characteristics that may have influenced the results. Most nurses who participated in the study were working with patients with cancer, and all were exposed to death in their daily work. This contrasts with the samples of previous studies; for example, the nurses in Rooda et al.'s sample had little or no experience working with dying patients. In addition, most nurses in the current study were Jewish, which allowed for examination of the attitudes from a unique cultural viewpoint. This characteristic is important because no past research has been conducted on these issues with non-Christian samples (Neimeyer et al., 2004).

Most nurses in the current study expressed positive attitudes toward caring for dying patients, as was found by Lange et al. (2008). Personal attitudes toward death were associated with attitudes toward caring for dying patients; specifically, fear of death and death avoidance were negatively correlated with positive attitudes toward caring for dying patients. In other words, nurses who had more fear of death and more death avoidance held less positive attitudes toward caring for dying patients. The findings are consistent with previous studies (Hare & Pratt, 1989; Kvale, Berg, Groff, & Lange, 1999; Mok et al., 2002; Rooda et al., 1999). However, although personal attitudes toward death were found to be significant in the prediction of attitudes toward caring for dying patients, personal attitudes explained only 22% of the variance, implying that other variables need to be considered to better understand what contributes to nurses' attitudes about caring for dying patients.

In a regression analysis predicting attitudes toward caring for dying patients, death avoidance remained a significant contributor to the model. A hierarchical regression also demonstrated that death avoidance mediated the association between fear of death and attitudes toward caring for dying patients in the current sample. Neimeyer (1994) stated that healthcare

specialists with high levels of death anxiety use more avoidance coping behavior. Some nurses may use avoidance to cope with their own personal fear of death, which may contribute to difficulty for some nurses in providing appropriate care for dying patients.

Another attitude toward death that was negatively associated with attitudes toward caring for dying patients in the current study was approach acceptance. Surprisingly, nurses in the sample who perceived death as a passage to a better afterlife held less positive attitudes toward caring for dying patients. This unexpected finding is not consistent with previous studies (Rooda et al., 1999; Wessel & Rutledge, 2005) in which positive associations between the two attitudes have been reported. Approach acceptance is considered a positive attitude toward death; other studies have demonstrated positive correlations between it and other positive attitudes toward death, such as escape acceptance (Dunn et al., 2005; Rooda et al.), as well as negative correlations between approach acceptance and negative attitudes toward death, such as fear of death (Dunn et al.; Rooda et al.). However, approach acceptance was positively associated with negative attitudes toward death (fear of death and death avoidance) as well as with positive attitudes toward death (escape acceptance) in the current study.

A possible explanation for this finding might stem from the cultural background of the study sample. Most nurses in the current study were Jewish, whereas most nurses have been Christian in previous studies. Attitudes toward death might vary with ethnicity (DePaola,

Table 4. Multiple Regression Analysis Predicting Nurses' Attitudes Toward Caring for Dying Patients

Variable	B	Standard Error of β	β	t	p
Fear of death	–0.22	0.84	–0.02	–0.26	0.795
Death avoidance	–3.43	0.82	–0.37	–4.16	< 0.001
Approach acceptance	–1.75	0.85	–0.17	–2.06	0.041
Escape acceptance	–0.43	0.73	–0.05	–0.6	0.552

Table 5. Hierarchical Regression Analysis Predicting Nurses' Attitudes Toward Caring for Dying Patients

Attitude	β	B	Standard Error of β	R ²	R ² Change
Step 1					
Fear of death	-0.24*	-2.26	0.76	0.057	0.057*
Step 2					
Fear of death	-0.03	-0.28	0.84	0.174	0.117**
Death avoidance	-0.4**	-3.74	0.83	-	-

*p < 0.01; **p < 0.001

Griffin, Young, & Neimeyer, 2003; Neimeyer et al., 2004). In addition, attitudes of acceptance toward death seem to be associated with religious beliefs (Neimeyer et al., 2004). In the current study, approach acceptance of death was significantly associated with the degree of nurses' religiosity. A careful examination of the items on the DAP-R subscale assessing approach acceptance (e.g., "Death is a union with God and eternal bliss," "One thing that gives me comfort in facing death is my belief in the afterlife") revealed that the attitude is closely related to a religious worldview. *Afterlife* has different meanings and interpretations in Christianity and Judaism. The idea of an afterlife is central in Christianity, and the passage to heaven or hell is acknowledged widely and is described richly and graphically with a vision of celestial bliss or horrific underworld suffering (Obayashi, 2005). In contrast, afterlife is much vaguer in Judaism and rarely is cast into dogmatic or systematic form. Attitudes concerning heaven and hell are more common as folk beliefs and not as part of theologic discussions (Stern, 1987). Judaism emphasizes the current life, and the meaning of actions stem from their role in this world more so than praise or punishment in the afterlife (Stern). For Jewish people, the idea of death as a passage to a better afterlife may be less central and, therefore, may provide less meaning to death than in Christian beliefs. As a result, Jewish people may not associate passage to the afterlife with comfort and may not perceive it as a positive attitude toward death.

Of note, only negative associations were found between attitudes toward death and caring for dying patients in the current study. The finding implies that attitudes toward death might have only a negative influence on attitudes toward caring for dying patients.

The current study had a number of limitations. The cross-sectional nature limited the authors' ability to determine causal relationships. The study's oncology nurse sample is one of the largest reported in the literature, but the response rate was low. Nurses with a strong fear of death or death avoidance may have avoided participation in the study, which might bias the results. Although most of the study sample was Jewish (89%), nurses of

other religious backgrounds were included in the analyses. In addition, the questionnaires used in this study were developed by and for Christian populations and were not modified to take into account different cultural and religious points of view toward death.

Conclusions

Oncology nurses are among the frontline of healthcare providers who care for dying patients. Their work is challenging and needs to be performed with respect and compassion. Assuming that attitudes formulate behavior, nurses' attitudes toward caring for dying patients may have an important influence on the quality of the care they provide. A possible relationship examined by the current study was the association between attitudes toward death and caring for dying patients. Findings suggest that associations exist, particularly among fear of death, death avoidance, approach acceptance, and attitudes toward caring for dying patients. Training and support programs for oncology nurses should include discussions of attitudes toward death, such as fear of death and death avoidance. Discussions about these often unspoken issues might help nurses feel less alone in their challenging work and may help them develop more positive attitudes toward caring for dying patients. In addition, awareness of personal attitudes toward death might help nurses understand their own behavior when caring for and facing the deaths of their patients.

The current study highlights the important roles of culture and religion in the issues of death and dying, which should be accounted for when designing studies and interpreting results. Cross-cultural studies are required and could contribute much to the understanding and knowledge about issues related to death and dying (Neimeyer et al., 2004). The religious beliefs of patients as well as their nurses must be considered to better understand how attitudes toward death and caring for dying patients might influence actual caregiving behavior in the clinical setting.

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