THE ROLE AND RESPONSIBILITY OF THE NURSE
IN CARING FOR THE DYING PATIENT

by

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has been approved
July, 1965

[Signatures]

Head, Supervisory Committee

[Signatures]

Head, Major
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CHAPTER I

INTRODUCTION

To what extent are registered nurses prepared to care for, comfort, and support the dying patient? Are nurses usually able to verbalize clearly their feelings and attitudes toward death? How much understanding and insight do they have into the emotional and spiritual needs of terminally ill patients?

Although nurses are dedicated to the promotion of health and to the rehabilitation of the sick, it is often their responsibility to care for the dying patient. Good nursing care of the dying patient is based upon a knowledge of scientific, sociological, and psychological principles and a recognition and understanding of the needs of the patient and his family. After assessing the needs of the dying patient and his family a nurse must determine which of these needs she can adequately meet. It is then her responsibility as a liaison person to contact appropriate persons who are prepared to meet those needs she cannot fulfill.

Ideally the curriculum of the basic program in nursing should include learning activities which provide opportunity for the discussion and understanding of the principles of care pertaining to the dying patient and an opportunity to apply these principles in a supervised situation. The classroom climate should enable the student to explore facts and principles relative to the sociological, psychological,
theological, and physical factors inherent in the concept of death and
dying and to express and examine her own feelings and attitudes on
death and dying. The clinical situation should afford opportunity
for the student to observe skilled professional nurses give care to
the dying patient and his family. Following this the student should
progress from supervised practice in the care of the terminally ill
patient to full responsibility for his care.

The above ideal situation differs markedly from the real
situation. Support for this statement was gained from a review of the
literature on the topic, through discussion with instructors of basic
nursing students, and from the personal experience of the writer in
teaching in basic nursing programs. In the basic sciences and in the
medical-surgical nursing course, principles relative to providing
physical care for the dying patient were found to be stressed. There
was some content devoted to the religious beliefs and practices of the
major faiths in relation to death.

It was not surprising to find this situation. Nurses as members
of a healing profession are oriented toward the preservation of life
and the prevention of disease. The profession, in turn, is a part of
Western culture, a culture in which death as a subject is socially taboo,
a set of statistics, a life phenomenon immeasurable by scientific
parameters.  

1 Jeanne E. Blumberg and Eleanor E. Drummond, Nursing Care of
the Long-Term Patient (New York: Springer Publishing Company, Inc.,
1963), p. 95.
The sociological and psychological principles as they relate to the dying patient appeared to be neglected in nursing school curricula. In the sociology texts used in schools of nursing, little or no reference was made to socio-cultural practices relative to death and dying. In the basic psychology courses and in the basic psychiatric nursing courses nurses were taught personality development and emotional responses along with their underlying dynamics, but very little reference was made as to how these concepts may be related and applied in the care of the dying patient. In interpersonal relations courses and in clinical practice in psychiatric nursing, basic students were given an opportunity to identify emotional responses and their underlying dynamics in themselves and in patients. There was little evidence, though, that these were often focused upon or associated with the responses and needs of the dying patient.

It appears that increasing demands are being placed on nurses in the area of care of the dying patient. There is evidence that the number of deaths, occurring in institutions for the sick, is increasing. A review of literature indicated that increasing longevity, with a concomitant increase in chronic illness, modern medical treatment, and socio-cultural factors tend to remove a terminally ill person from the home. The sick and dying patient is placed in a dependent role and it is the nurse, by her unique position, who must meet certain of the patient's physical, emotional, and spiritual needs.

Adequate preparation of the nurse is of primary importance in the maintenance of high standards of nursing care. The review of
literature indicated that curriculum changes are needed if physical, emotional, and spiritual needs of the dying patient and the special skills needed by nurses for meeting these needs are to be brought into sharper focus.

I. THE PROBLEM

The problem undertaken in this study was to learn the specific nursing functions a selected sample of registered nurses performed in an effort to meet the needs of the dying patient and how adequate they felt in performing these functions.

For the sample studied, to what extent did the nurses believe the preparation they received in the basic program prepared them to meet the needs of the dying patient? Was there adequate theoretical preparation, adequate clinical supervision in assisting the student to apply acquired knowledge, and sufficient opportunity for the student to explore in conjunction with others her own feelings and attitudes toward death and dying?

The writer believed that the data might give some indication of the areas in which nurses of the intermountain region need more preparation in order to have a sense of adequacy when caring for the dying patient. The writer was aware that findings might differ from one geographic area to another.
II. HYPOTHESES

On the basis of the review of literature, observing nurses in the clinical setting, and listening to nurses discuss their nursing problems, the writer evolved the following hypotheses.

1. Nurses will exhibit measurable differences in functions they recall and identify as having been performed in meeting the physical, emotional, and spiritual needs of the dying patient.

2. The majority of nurses will indicate some inadequacy in attempting to meet the needs of the dying patient.

3. At least one-half of the nurses will indicate that the preparation in the basic program in this area was adequate.

III. DELIMITATIONS

This study was limited to forty-two registered nurses engaged in giving nursing care to medical-surgical patients in four general hospitals in one metropolitan area. The sample may not be representative of the country as a whole, nor of any other metropolitan area, but, on the other hand, it may be a highly typical sample.

The study is also limited by the subjective nature of some of the questions asked and by the limited ability of many individuals to do abstract thinking and to put into effective written form the products of their thinking. If death is associated with unpleasant thoughts,
the study may suffer from the haste with which respondents try to escape from an uncomfortable subject.

IV. DEFINITION OF TERMS

For clarity and mutuality of understanding, the following terms used throughout the study are defined below:

**Dying patient.** A dying patient is one who is diagnosed as having a severe progressive disease from which there is little or no hope of recovery. The patient may be in the early or late stages of the disease or may be moribund, i.e., in the actual process of dying and within the last 24-72 hours of life.

**Emotional needs.** Emotional needs are those psycho-social needs arising out of a change in the individual's relationship to his environment.

**Physical needs.** Physical needs are those needs arising out of a disturbance in the equilibrium of the biological functions of the individual.

**Role.** Role is a "patterned sequence of learned actions or deeds performed by a person in the interaction situation."²

**Responsibility.** Responsibility, in relation to nursing functions performed for the dying patient, is used to include those moral, ethical, professional, and legal commitments that are assumed as part of the nurse's role.

Spiritual needs. Spiritual needs are those needs that contribute to and support the individual's desired total fulfillment of his potential existence according to his particular philosophical orientation or religious faith.
CHAPTER II

REVIEW OF THE LITERATURE

From the beginning of writing on nursing topics, articles have appeared in nursing journals discussing the nursing care of the dying patient, but little specific research related to such care has been published.

It was the opinion of several authors that although nurses are often called upon to stand by when death approaches, they have little preparation for this service. After interviewing newly graduated nurses, two investigators concluded that the preparation the nurse received relative to caring for a dying patient was far from standardized and, in some instances, was lacking. This lack of preparation relative to the dying patient may in part have been due to a lack of understanding of the nurse's own attitudes and behavior toward death and that of the patient and his family. It may also have been the result of inadequate treatment of this subject in the nursing curriculum as well as lack of sufficient experience with death and inadequate guidance and supervision of the nurse's early contacts with dying patients and their families.

Quint and Strauss found in schools of nursing that (a) little teaching was focused on death, (b) that which was taught centered on things for which the nurse may be held legally and morally accountable, and (c) students' encounters with the dying patient and death were variable and little attention was consistently directed toward this aspect of practice. 4

Feifel and others pointed out that there is a limited understanding of death and attitudes toward death on the part of individuals in our culture. 5 Kalkman stated that the thought of death was extremely distasteful to most people in our culture, which extols youth, health, and happiness. An effort is made to ignore death, to forget it, or if this is not possible, to gloss it over and get all evidence of it out of the way as quickly as possible. The dying person is usually removed from the family home to a hospital. 6

The findings of Krupp and Kligfeld support Kalkman as evidenced in the following excerpt:

"... fear, irrational behavior and mystery prevail in the area of dying, death and bereavement, there is a widespread denial of death's inevitability and finality. ... Much of our American culture conspires to remove death from our minds and even from our feelings. In television, the movies, and other expressions of our mores, emphasis is on the preservation of youth and the denial of aging. Death, though threatening and difficult to handle, is made remote. Social security and the proliferation

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of nursing homes have facilitated the removal of many elderly and severely sick persons from the family circle. Estranged by our civilization from the basic realities of life (of which death is a part), we lost contact with the daily struggle for life of animals in field and forest. We have less and less contact with nature, with the death of livestock, and with slaughtering of animals for food. Death has become foreboding, frightening, repugnant, and mysterious.7

The predominant attitudes toward death prevalent in the community were reflected in the professional nurse's limited understanding of death and her avoidance of facing the problem whenever possible.8

Blumberg and Drummond stated that "the nursing profession reflects Western tradition by denying and avoiding death." They further pointed out that "the Code of Ethics of the profession, revised in 1960 by the American Nurses Association, neither includes nor allows for a guide in fulfilling obligations to persons in the crises of death."9

The change in hospital populations is altering the picture of dying and death as a nursing experience.10 Blumberg and Drummond pointed out that six out of the ten leading causes of death were due to chronic conditions and most of these deaths occur in institutions.11

Also, advances in diagnostic and treatment techniques plus the changes

9Blumberg and Drummond, op. cit., p. 95.
11Blumberg and Drummond, op. cit., p. 94.
in surgical techniques that permit more radical surgery will bring more people to the hospital who have a negative prognosis.\textsuperscript{12}

By necessity, most of the care given to the terminally ill and dying patient must come from nurses. They have no opportunity to shift the responsibility and are, therefore, under obligation to perform certain functions to promote the well being of the terminally ill patient.

The specific ways nurses could be of therapeutic value to the dying patient, and their special responsibilities have not been clearly delineated. Clarification of the specific emotional and spiritual needs of the dying patient is needed. Texts and journals used in the teaching of nursing present briefly and in general terms the beliefs and practices of the major Christian religions and the Jewish religion. Information helpful to the understanding of particular religious beliefs and practices relative to death and dying and the expected emotional reactions of the dying patient and his family and their underlying cause is lacking.

Quint and Strauss emphasized that it was the assignment system which primarily determined when and how students met the problems of terminally ill patients. Variation in rotation pattern, combined with the variation among instructors in the focus of their assignments, resulted in different experiences for students with respect to dying and death.\textsuperscript{13} Student nurses may actually be somewhat protected from

\textsuperscript{12} Quint and Strauss, \textit{op. cit.}, p. 24.

\textsuperscript{13} \textit{Ibid.}, p. 15.
dying and death because of the rapid rotation system in schools of nursing and because of the focus of task assignment based on course criteria. Thus, though a student may frequently care for a patient at various stages of terminality, care of the dying, per se, is seldom part of the assignment.\footnote{\textit{Tbid.}, p. 25.}

Quint and Strauss continued: "Short term assignments lessen the opportunity for personal contact and curtain the student from dying and death by exposing her only to a small segment of his terminal illness." They pointed out that a non-protective characteristic of this type of assignment was that the student may be completely unaware of the patient's potential for dying, because of her brief contacts with medical and nursing personnel. Thus, in the first year the student may be faced with sudden impending death. Her limited knowledge and skill make her most vulnerable to a "feeling of inadequacy" or "immobilization." The instructor, because she must rely on personnel for information about patients, may unknowingly make an assignment beyond the student's ability.\footnote{\textit{Tbid.}}

In contrast, rotation patterns which keep students in one place for two or three months and which may assign them to practice periods of eight hours, result in prolonged contact between patient and student with resulting personal involvement. It may be severely traumatic to the young, inexperienced student when the patient dies, since the possibility of death is not built into her expectation.
Selection of patient assignment was frequently based on meeting certain course criteria or the particular kind of care or treatment the patient required. The fact that he was dying may have been secondary. This meant that encounters with death occurred more by chance than by planning. Although some instructors interviewed by Quint and Strauss saw value in assigning students to terminally ill patients, they could not always guarantee this experience for every student. These instructors defined terminal care as that care which immediately precedes and follows death.\textsuperscript{16}

Another assignment characteristic that influenced student contact with the dying patient was the instructor's expectations of a student's performance. One instructor focused on traditional procedure emphasizing nursing care tasks and work organization or, at the other extreme, another instructor gave major emphasis to interpersonal aspects of the nurse-patient encounter. (The majority combined these viewpoints in varying degrees.) Thus, the student was held accountable for what the instructor considered important and many things took place which the student did not have to report.\textsuperscript{17}

That care of the dying was not considered very important by instructors of basic nursing students may be supported by the following instructional practices: (a) holding the student responsible for perceiving the implications and possible prognosis of a patient's illness

\textsuperscript{16}Ibid.
\textsuperscript{17}Ibid., p. 26.
rather than pointing to its fatal outcome, (b) the failure to emphasize what the nurse can do to help a patient even though he may have only a short time to live, and (c) the complete oversight of initiating a discussion of death and the student's attitude toward it.\textsuperscript{18}

Students were seldom held accountable for their conversation with the dying patient. Even though the idea of "letting patients express their feelings" had become a fundamental learning practice, the "how" of managing this was usually left to the student's judgment. Few nursing practice guides for use in conversing with patients and families have been defined by basic nursing instructors, and those which are offered are far from precise. The use of written process recordings to analyze student-patient interactions were used infrequently in situations in which students were likely to encounter terminal patients.\textsuperscript{19}

Conversations with terminally ill patients may be upsetting to the emotional equilibrium of the nurse, so students and nurses generally protected themselves from this uncomfortable feeling by using the doctors' authority position for controlling conversation. Telling the patient to ask his doctor was a frequently used mechanism. There were indications that instructors were no more comfortable than students with this problem and had little preparation for dealing with it. "It is not easy to hold students accountable for conversations with patients

\textsuperscript{18} Ibid.
\textsuperscript{19} Ibid.
when instructors themselves do not know what to say to patients."\textsuperscript{20}

Another factor was the fact that nurse instructors have their own traumatic memories; thus, few were able or wanted to teach about death. More important, this aspect of nursing practice received little attention in the overall curriculum. Changes in hospital populations and practices make care of the dying a major nursing task.\textsuperscript{21}

\textbf{SUMMARY}

In summary, the review of literature seemed to justify the idea that, although nurses are increasingly involved in giving care to the dying patient, there was a variation in the functions they perform in meeting their needs and they did not feel adequately prepared to meet the total needs of the dying patient.

It appeared that there was a need for curriculum emphasis in this area. Changes in nursing care must come through changes in the education of nurses. This means that in order to prepare nurses to meet the needs of society, nursing curricula must be subject to constant evaluation and revision.

\textsuperscript{20}\textit{Ibid.}, pp. 26-27.

\textsuperscript{21}\textit{Ibid.}. 
CHAPTER III

METHOD

In analyzing the problem of whether or not the registered nurse in selected hospital settings performed the functions necessary to meet the needs of the dying patient, and to what extent she felt prepared to meet the situation, the investigator believed that it was necessary to seek the answers to the following questions:

1. What nursing functions did the nurse perform in caring for the dying patient?

2. Did she think that she was able to meet the needs of the dying patient?

3. What experiences did the nurse have in giving care in her first encounter with the dying patient? Did she have assistance in giving this care?

4. What formal preparation did the nurse recall as given in the basic program that prepared her to carry out nursing functions for the dying patient?

5. In the opinion of the nurse, what pre-graduation and post-graduation experiences would best prepare a nurse for giving care to the dying patient?

6. What did the nurse report as her current reaction to giving care to the dying patient?
A questionnaire, made up of two sections, was formulated in an effort to gather data needed to answer the above questions.

Section I was designed to collect biographical data to assure the writer that the participants met the criteria for the sample. This consisted of five items, three of them check-type in nature. (Appendix A.)

Section II consisted of two parts. Part I dealt with the experiences and reactions the nurse had in caring for the dying patient. It was made up of eight open-end and six check-type questions with space provided to support the answer checked or for adding any comment the nurse desired. Part II was designed to provide data relative to the manner in which the nurse met the emotional and spiritual needs of the dying patient. It was made up of six check-type questions with space provided for any comment the nurse might volunteer. (Appendix B.)

In summary, the questionnaire consisted of a total of twenty-four items: Five of these were biographical data items, twelve were related to the nurse's experiences and reactions in caring for the dying patient, and six dealt with the nursing functions performed to meet the needs of the dying patient.

Nursing functions performed in giving care to the dying patient may appropriately be classified under one of three major areas--the functions performed to meet the physical, the emotional, and the spiritual needs of the dying patient.

In Section II, questions 10-b to 10-h of Part I and questions 2, 3, 4, and 6-a to 6-d of Part II were designed to learn what were the
functions performed by the nurse to meet the emotional needs of the
dying patient. Question 10-a of Part I and question 1 of Part II were
included to find out what nurses do to meet the patient's spiritual
needs. Question 2 of Part I considered all three areas: the spiritual,
emotional, and physical.

Questions 8-a to 8-c of Part I were formulated to determine if
the nurse felt she was able to meet the needs of the dying patient.
Questions 1 and 3 of Part I were designed to learn what experiences
the nurse had with her first dying patient and whether or not she had
assistance in giving this care. The preparation received by the nurse
in her basic program and the preparation and experiences she had following
graduation which she believed helped to prepare her to give care to the
dying patient were brought out by question 7, Part I.

To gain a better understanding into the kind of pre-graduation
and post-graduation experiences that would prepare her to give care to
the dying patient, questions 4, 5, and 6 of Part I were included.

To elicit the nurse's current reactions when giving care to
the dying patient, questions 9, 11, and 12 of Part I were posed.

To validate whether or not the questions would elicit the infor-
mation sought, the questionnaire was submitted to a psychologist and
three nurse-educators. The nurse-educators were chosen because of
their awareness of current nursing problems and the impact these prob-
lems have on curriculum development. The questionnaire was then
revised to incorporate the suggestions made.
Description of the sample group. The participants were drawn from nurses employed in one governmental hospital and three private, church-affiliated general hospitals in one metropolitan area. They were graduate nurses employed full time in medical-surgical nursing, who had varying background experiences in caring for the dying patient and his family. Only those nurses who met the following criteria were included in the study: (a) a graduate of a three- or four-year basic program in nursing; (b) a registered nurse whose program included field practice in psychiatric nursing; (c) a registered nurse currently engaged in giving nursing care to patients in medical-surgical clinical areas. The writer believed that nurses with psychiatric nursing experience would be more likely to have a more extensive knowledge of the dynamics of behavior, the use of defense mechanisms, and the emotional needs and reactions of individuals than nurses who had not had psychiatric nursing experience.

Plan for collection of data. Arrangements were made with the director of nursing of the one governmental hospital and the directors of the three private, church-affiliated general hospitals to administer the questionnaire to graduate nurses employed in the medical-surgical areas. At the governmental hospital the director of nursing made arrangements with each of the supervisors to distribute the questionnaires to the nurses in her particular clinical area and to return the completed forms to her. At one private hospital the director of nursing service made arrangements to administer the questionnaires at a meeting of the selected group. At two of the hospitals permission
was given to the investigator to distribute and collect the questionnaires on an individual basis. Except in the institution where the nurses met for the express purpose of completing the questionnaires, it was completed by the nurse at her own convenience. The investigator collected the completed questionnaires from the director of nursing in the one hospital where they were distributed by the clinical supervisors and from the individual participants in the other institutions. A total of seventy questionnaires were distributed to nurses in four hospitals and fifty, or 70 per cent, were returned. Of these, only forty-two, or 60 per cent, met the established criteria.
CHAPTER IV

FINDINGS AND DISCUSSION

The data were reviewed to determine the nursing functions the nurse performed to meet the physical, emotional, and spiritual needs of the dying patient. The most frequently described nursing functions performed by the nurse in her first professional encounter with the dying patient were those related to meeting his physical needs. These included cleanliness and comfort measures, therapeutic measures ordered by the physician and performed by the nurse, and observation and recording of objective signs and symptoms. The functions performed to meet the emotional and spiritual needs of the patient were mentioned less frequently (Table 1). This may be an indication that the physical care of all patients, including the dying patient, receives more emphasis in the curriculum and, therefore, there is a tendency to remember and record this aspect of care or it may be an indication of what the doctor wishes to have reported to him.

In meeting the emotional needs of the moribund patient, nurses indicated belief that their physical presence was important in providing emotional support for the patient who is alone but not for one who has his family present. They saw death as a possibly frightening experience for the individual and believed that the patient might feel isolated if left alone. The data also indicated that nurses verbally reassure the moribund patient who must be left alone that they will
TABLE 1
FUNCTIONS PERFORMED BY FORTY-TWO NURSES IN THEIR FIRST PROFESSIONAL ENCOUNTER WITH THE DYING PATIENT

<table>
<thead>
<tr>
<th>Function</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>The greatest number of functions listed</td>
<td>51</td>
</tr>
<tr>
<td>The smallest number of functions listed</td>
<td>1</td>
</tr>
<tr>
<td>The two functions most frequently listed</td>
<td></td>
</tr>
<tr>
<td>Functions performed to meet the physical needs of the dying patient</td>
<td>51</td>
</tr>
<tr>
<td>Functions performed to meet the emotional needs of the dying patient</td>
<td>22</td>
</tr>
</tbody>
</table>

return shortly. They indicated that they think it is important that the patient realize the nurse is concerned and thinking about him.

It was interesting to find that only two nurses specifically stated they would verbally reassure an unconscious patient.

In communicating with the moribund patient, the data indicated that nurses most frequently use verbal communication (86 per cent). They touch the patient less frequently (76 per cent) and utilize some prearranged signal, if the patient is unable to speak or his level of consciousness is questioned, even less frequently (57 per cent). That these nurses tended to use verbal methods of communication more frequently may be a reflection of cultural training.

Most of the nurses in the sample (86 per cent) stated that they still followed the traditional practice of removing the moribund patient to a private room. Currently there are two trends of thought as to
whether or not a dying patient should be removed from nearness to other patients. The most frequently repeated theme in literature is the traditional one of the patient being removed to a private room to allow for family privacy and to cause as little disturbance to other patients as possible. The findings are summarized in Table 2.

Are nurses aware of certain readily obtainable information that helps them to identify factors that might contribute to the dying patient's emotional response? It was interesting to note that approximately 90 per cent of the participants stated they were aware of the patient's religion, marital status, and age. Eighty per cent said they were cognizant of whether the family realized the seriousness of the patient's illness. Sixty-seven per cent said they made a point of learning whether or not the patient knew the seriousness of his illness, 60 per cent said they knew if the patient had living offspring, 45 per cent said they knew he was a charity patient but only 26 per cent knew whether he had hospitalization insurance. The findings are shown in Table 3.

Would the nurse contact the religious adviser of the moribund patient? Approximately 90 per cent said they would contact the religious adviser of either the conscious or unconscious Catholic patient and approximately 50 per cent for either the conscious or unconscious Jewish patient. Sixty-one per cent stated they would contact one for the conscious patient of the Latter Day Saints faith and 45 per cent for the unconscious one. For the conscious moribund patient of a religious faith other than those mentioned in the questionnaire,
TABLE 2
FUNCTIONS PERFORMED BY THE NURSE
TO MEET THE EMOTIONAL NEEDS
OF THE DYING PATIENT

<table>
<thead>
<tr>
<th>Item</th>
<th>Response</th>
<th>Per Cent of Total Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Stays with patient if family not present and time permits</td>
<td>Yes</td>
<td>95%</td>
</tr>
<tr>
<td>Stays with patient if family is present and time permits</td>
<td>Yes</td>
<td>36%</td>
</tr>
<tr>
<td>Verbally reassures patient who must be left alone that she will return within a short period of time</td>
<td>Yes</td>
<td>90%</td>
</tr>
<tr>
<td>Transfers dying patient to a private room</td>
<td>Yes</td>
<td>88%</td>
</tr>
<tr>
<td>Item</td>
<td>Response</td>
<td>Per Cent of Total Group</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>----------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Speaks slowly and distinctly at all times</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>0 10 20 30 40 50 60 70 80 90 100</td>
<td>86%</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Response</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Touches the patient by firmly grasping his shoulder or his arm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>0 10 20 30 40 50 60 70 80 90 100</td>
<td>76%</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Response</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilizes some prearranged signal if the patient is unable to speak or his level of consciousness is questioned</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>0 10 20 30 40 50 60 70 80 90 100</td>
<td>57%</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Response</td>
<td></td>
<td></td>
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</table>
### TABLE 3

**NURSE’S KNOWLEDGE OF CERTAIN READILY OBTAINABLE PERSONAL DATA ABOUT THE DYING PATIENT**

<table>
<thead>
<tr>
<th>Personal Data</th>
<th>Nurse’s Knowledge of Data</th>
<th>Per Cent Usually Know This</th>
<th>Per Cent Thinks Nurse Should Know It</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td>91</td>
<td>7</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td>91</td>
<td>2</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td>93</td>
<td>2</td>
</tr>
<tr>
<td>Whether or not family realizes the seriousness of his illness</td>
<td></td>
<td>79</td>
<td>19</td>
</tr>
<tr>
<td>Whether or not there are living offspring</td>
<td></td>
<td>60</td>
<td>31</td>
</tr>
<tr>
<td>Whether or not patient understands the seriousness of his illness</td>
<td></td>
<td>67</td>
<td>29</td>
</tr>
<tr>
<td>Whether he is a charity patient</td>
<td></td>
<td>45</td>
<td>48</td>
</tr>
<tr>
<td>Whether he has life insurance and health and hospitalization insurance</td>
<td></td>
<td>26</td>
<td>67</td>
</tr>
</tbody>
</table>
43 per cent said they would contact his religious adviser if the patient were conscious and 33 per cent stated they would if the patient were unconscious. The findings are presented in Table 4.

### TABLE 4

**FREQUENCY WITH WHICH NURSES CONTACT THE RELIGIOUS ADVISER OF THE DYING PATIENT**

<table>
<thead>
<tr>
<th>Dying Patient's Faith</th>
<th>Per Cent of Nurses Who Would Call Adviser</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Conscious Patient</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Catholic</td>
<td>91</td>
</tr>
<tr>
<td>Jewish</td>
<td>50</td>
</tr>
<tr>
<td>Latter Day Saints</td>
<td>61</td>
</tr>
<tr>
<td>Protestant</td>
<td>50</td>
</tr>
<tr>
<td>Other</td>
<td>43</td>
</tr>
</tbody>
</table>

The data showed that ninety per cent of the nurses stated they could meet the physical needs of the dying patient, 52 per cent believed they were able to meet the emotional needs of the dying patient, and 48 per cent said they could meet the spiritual needs (Table 5). The majority of the nurses who stated they could meet the physical needs of the dying patient said they gained the knowledge and skills necessary to give this type of care in their basic educational program and further perfected these as a graduate nurse. They stated there were usually adequate facilities and time to give this type of care.
The criteria used by the respondents to evaluate their ability to meet the emotional needs of the dying patient fell into five categories.

1. The respondent has gained self-confidence and emotional control.

2. She is able to create an accepting atmosphere in which the patient feels free to express his feelings.

3. She has worked through her own feelings toward death.

4. She feels comfortable in caring for the dying patient.

5. She has increased sensitivity to the emotional needs of the dying patient.

The nurses who said they could meet the spiritual needs of the dying patient stated they did this by acting as a liaison between the patient and religious adviser. The limited way in which these nurses viewed their role may indicate they are not aware of other functions they could perform to assist the dying patient to meet his spiritual needs.

The data were analyzed to discover (a) the emotional reaction the nurse had in her first professional encounter as a basic nursing student with the dying patient, and (b) to learn whether or not she had assistance in this experience.

Eighty-six per cent of the nurses described their first encounter with the dying patient. Twenty-four per cent of the nurses said the death occurred suddenly. They indicated by their remarks that they were unprepared for it either because the seriousness of the patient's
TABLE 5

ADEQUACY OF NURSES IN MEETING THE NEEDS OF THE DYING PATIENT

<table>
<thead>
<tr>
<th>Item</th>
<th>Response</th>
<th>Per Cent of Total Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical needs</td>
<td>Yes</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>2%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>8%</td>
</tr>
<tr>
<td></td>
<td>Response</td>
<td></td>
</tr>
<tr>
<td>Emotional needs</td>
<td>Yes</td>
<td>52%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>26%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>22%</td>
</tr>
<tr>
<td></td>
<td>Response</td>
<td></td>
</tr>
<tr>
<td>Spiritual needs</td>
<td>Yes</td>
<td>48%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>36%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>16%</td>
</tr>
<tr>
<td></td>
<td>Response</td>
<td></td>
</tr>
</tbody>
</table>

condition was unknown to the nurse or she could not accept the patient's prognosis.

As Cavanagh found in his study, the most detailed comments were made on the physical-medical aspects of the death scene.

22 John R. Cavanagh, "The Reaction of Student Nurses to their First Professional Experience with Death" (unpublished study, Washington, D. C. [n.d.]), p. 3. (Mimeographed.)
Seventy-seven per cent of the nurses described the physical condition of the patient prior to death. The place of death was mentioned by 43 per cent of the nurses, treatment procedures were mentioned by 14 per cent, and the death process was described by 21 per cent.

Psychological reactions were mentioned less frequently. Nineteen per cent of the nurses described their reactions to the death of the patient with the terms "helplessness," "inadequacy," "emptiness," or "depression." Seventeen per cent of the nurses remarked that they had feelings of fear. Five per cent of the nurses stated that they were "shocked" when the patient actually died.

Fifty per cent of the nurses indicated they received assistance from a professional nurse in their first encounter with the dying patient and thirty-six per cent indicated they had no assistance. The things considered most helpful by the group who had assistance were: (a) supervision and instruction of the nursing care being given along with an understanding attitude toward the student's feeling of anxiety, (b) reassurance and encouragement to talk about the situation, (c) preparation of the student to expect the patient's death, and (d) assistance in giving emotional support to the family.

The first encounter with the dying patient is a potentially traumatic experience for the young, inexperienced basic nursing student. Because of her lack of experiential knowledge and skill in meeting this situation she is subject to feelings of helplessness, inadequacy, and

\[\text{\textsuperscript{23}}
\text{Ibid., p. 4.}\]
fear. Ideally, the basic nursing student's first encounter with the dying patient should be as a participant-observer. Learning is influenced by a variety of internal and external factors. If the student has not worked through her own feelings of death, if she has not been prepared to expect the death of the patient, and if she has not developed the skills and knowledge necessary to handle the situation, the experience may be traumatic and unproductive, particularly if she is alone. The fact that thirty-six per cent of the nurses in this study did not have the assistance of a professional person in their first experience with the dying patient indicates that the ideal situation does not exist.

The data were reviewed to learn what basic nursing courses nurses believe best prepare them to carry out nursing functions for the dying patient. Although they did not indicate the specific content, 35 per cent of the nurses listed lecture and discussion on care of the dying as helpful. Twelve per cent indicated that lecture and discussion relative to the emotional and physical care of the dying patient was helpful. Five per cent stated they thought all basic nursing courses were helpful. It was of particular interest to note that 31 per cent could not recall anything that was specifically helpful and 12 per cent did not respond to the item. Five per cent of the respondents who listed lecture and discussion on post-mortem care as helpful obviously did not interpret the question correctly. A summary of the data appears in Table 6.

The fact that 31 per cent of the respondents could not recall anything as specifically helpful and 35 per cent of the nurses were
TABLE 6

FORMAL PREPARATION CONSIDERED HELPFUL BY THE NURSE TO PREPARE HER TO CARE FOR THE DYING PATIENT

<table>
<thead>
<tr>
<th>Preparation Considered Helpful</th>
<th>Number of Respondents</th>
<th>Per Cent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lecture and discussion in specific courses</td>
<td>15</td>
<td>35</td>
</tr>
<tr>
<td>Psychiatric nursing</td>
<td>(4)</td>
<td></td>
</tr>
<tr>
<td>Interpersonal relations and communications</td>
<td>(3)</td>
<td></td>
</tr>
<tr>
<td>Religion and ethics</td>
<td>(4)</td>
<td></td>
</tr>
<tr>
<td>Nursing principles</td>
<td>(3)</td>
<td></td>
</tr>
<tr>
<td>Medical nursing</td>
<td>(1)</td>
<td></td>
</tr>
<tr>
<td>No specific course or discussion recalled</td>
<td>13</td>
<td>31</td>
</tr>
<tr>
<td>Special lectures and discussion</td>
<td>7</td>
<td>17</td>
</tr>
<tr>
<td>Emotional and physical care</td>
<td>(5)</td>
<td></td>
</tr>
<tr>
<td>Post-mortem care</td>
<td>(2)</td>
<td></td>
</tr>
<tr>
<td>All courses helpful</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>No response to item</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>Total Number in Sample</td>
<td>42</td>
<td>100 per cent</td>
</tr>
</tbody>
</table>

not explicit as to the content of the lecture and discussion on care of dying they listed as helpful may indicate that curriculum content dealing with the care of the dying patient may be relatively limited and that which is taught is not too meaningful in terms of its usefulness. It may also indicate that the study of the care of the dying is an unpleasant area so nurses tend to forget it.
How might the nurse have been better prepared to handle her first encounter with the dying patient? Sixty-six per cent indicated the need for better preparation for their first encounter with the dying patient. Ten per cent thought that there is no helpful preparation for the student's first encounter with the dying patient. Nineteen per cent failed to respond to the item. The measures the nurses gave that might be used to better prepare them to handle their first encounter with the dying patient are categorized in Table 7.

The pre-graduation clinical experiences the nurses in this study considered to be of most value in learning to give care to the dying patient are summarized in Table 8. Of the thirty-two nurses responding to the item, 40 per cent indicated that the opportunity to work with an experienced nurse either under her supervision or direction or by observing her perform certain functions for the dying patient in addition to the opportunity to express personal feelings on death and dying were valuable learning experiences. Seventeen per cent thought actual experience in giving care to the dying patient was valuable. Both groups indicated that opportunity to gain practical experience in the care of the dying is important in learning to give this care. The fact that 24 per cent could not recall anything in their basic preparation as definitely valuable might be an indication that that which was taught was not meaningful in terms of giving care to the dying patient, that nothing was actually taught, or that which was taught was suppressed as a conscious memory because it was unpleasant.
TABLE 7

EXPERIENCES CONSIDERED HELPFUL IN PREPARING NURSES FOR THEIR FIRST ENCOUNTER WITH THE DYING PATIENT

<table>
<thead>
<tr>
<th>Preparation Considered Helpful</th>
<th>Number of Respondents</th>
<th>Per Cent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous contact with patient with terminal prognosis</td>
<td>12</td>
<td>28</td>
</tr>
<tr>
<td>Being alerted to and briefed upon possible fatal prognosis of the patient</td>
<td>9</td>
<td>21</td>
</tr>
<tr>
<td>More knowledge and opportunity to develop skill in the methods used to meet the patient's emotional and physical needs and the family's emotional needs</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>The opportunity to discuss and examine one's own feelings on death</td>
<td>3</td>
<td>7</td>
</tr>
</tbody>
</table>

Total Number in Sample: 42

Total Number Indicating Need for Better Preparation: 28 66 per cent
### TABLE 8
CLINICAL EXPERIENCES IN THE BASIC NURSING PROGRAM
THE NURSE CONSIDERS VALUABLE IN PREPARING
HER TO CARE FOR THE DYING PATIENT

<table>
<thead>
<tr>
<th>Clinical Experiences</th>
<th>Number of Respondents</th>
<th>Per Cent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervision and direction from experienced nurses when giving care to the dying patient and observing the professional nurse perform certain functions in addition to the opportunity to express personal feelings on death and dying</td>
<td>17</td>
<td>40</td>
</tr>
<tr>
<td>Clinical conferences on death and dying</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Actual experience in giving care to the dying</td>
<td>7</td>
<td>17</td>
</tr>
<tr>
<td>A reading assignment on care of the dying</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Discussion with clinical instructor on effective means of communicating with the dying patient</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Observing the practices in care of the dying of the religious group conducting the hospital</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Total Number in Sample: 42

Total Number Reporting Valuable Clinical Learning Experiences 32 76 per cent
The post-graduation clinical experiences considered to be most valuable in learning to give care to the dying patient by 81 per cent of the nurses was the opportunity to have repeated experiences in giving care to the dying patient. This group identified other factors that contributed to increasing their ability to care for the dying patient. These factors were: (a) growth in maturity, (b) having to be the responsible and supportive person in the situation with the dying patient, (c) resolving earlier fears of death, (d) the realization that death may be welcomed by the very old or a release from suffering, (e) the opportunity to discuss death with other members of the medical team, (f) reading material on the subject, (g) gaining confidence in own nursing abilities with all patients, (h) increased understanding of differing religious beliefs and philosophies, (i) understanding the limits of medical care, (j) attending group conferences on the fearful dying patient, and (k) caring for a dying member of own family.

What additional formal instruction and/or clinical experience would the nurses in this study consider as helpful in increasing their ability to care for the dying patient? Of the 81 per cent who responded to the item, 40 per cent thought that additional instruction in care of the dying with an opportunity to examine one's own feelings and philosophy on death would be helpful, and 26 per cent stated that more actual experience with the dying patient was necessary. Fourteen per cent said they could not benefit from further instruction or experience.
If given a choice, would the nurse prefer not to give care to a dying patient. Sixty-two per cent of the participants said they would willingly care for the dying patient even if given an opportunity not to do so, 31 per cent said they would not, and 7 per cent did not respond to the item. The reasons given by those responding to the item for either not avoiding or avoiding caring for the dying patient appear in Table 9 and 10, respectively.

How would the nurse respond to the question, "Am I going to die?" The types of responses these nurses would give to the patient who verbalized this question appear in Table 11.

Over half of the nurses, 67 per cent, indicated they would give reflective-type responses either to find out how much the patient knew about his illness or to provide the patient with the opportunity to express and examine his own feelings. This may indicate that nurses are aware of the Rogerian theory and technique of communication.

The nurses who said they would answer truthfully, said they would also attempt to reassure the patient by telling him that everything was being done to preserve his life.

The data were reviewed to learn the effect care of the dying had on the nurse. All except one nurse responded to the item. The stated reactions of the nurses appear in Table 12.

The most frequently reported emotional responses to care of the dying patient were feelings of depression or sadness (33 per cent). The reasons the nurses gave for being depressed were: (a) tendency to identify with the patient, (b) patient represented a social loss
TABLE 9

REASONS FOR CHOOSING TO GIVE CARE TO THE DYING PATIENT

<table>
<thead>
<tr>
<th>Reason</th>
<th>Number of Respondents</th>
<th>Per Cent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is the nurse's responsibility</td>
<td>11</td>
<td>26</td>
</tr>
<tr>
<td>Recognizes the patient has needs, wants to meet them</td>
<td>8</td>
<td>19</td>
</tr>
<tr>
<td>It is a challenge to use all nursing skills</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>It is a learning experience</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Gains satisfaction in performing nursing functions for this type of patient</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Total Number Choosing to Give Care</td>
<td>26</td>
<td>62 per cent</td>
</tr>
</tbody>
</table>

TABLE 10

REASONS FOR CHOOSING NOT TO GIVE CARE TO THE DYING PATIENT

<table>
<thead>
<tr>
<th>Reason</th>
<th>Number of Respondents</th>
<th>Per Cent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>A depressing or unpleasant situation</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>Prefers working with patients who have a positive prognosis</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Cannot adequately meet the needs of the dying patient</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Finds the situation &quot;uncomfortable&quot;</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Total Number Choosing Not to Give Care</td>
<td>13</td>
<td>31 per cent</td>
</tr>
</tbody>
</table>
TABLE 11
TYPES OF RESPONSES OF THIRTY-NINE NURSES TO PATIENT'S QUESTION: "AM I GOING TO DIE?"

<table>
<thead>
<tr>
<th>Type of Response</th>
<th>Number of Respondents</th>
<th>Per Cent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reflective</td>
<td>26</td>
<td>62</td>
</tr>
<tr>
<td>Truthful but would not remove hope</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Philosophic</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Reassure patient in measures to preserve life</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Evaluate patient's knowledge of his condition and emotional state before answering</td>
<td>3</td>
<td>7</td>
</tr>
</tbody>
</table>

Total Number in Sample: 42
Total Number Responding 39 93 per cent

(a young person or a productive member of society), and (c) a tendency to identify with the family. It was surprising that 20 per cent reported they had little or no emotional reaction to caring for the dying patient.

Care of the dying patient may arouse in the nurse thoughts about her own death. If she has not worked through her own feelings on death, she may be overcome by feelings of sadness, depression, or sorrow.
TABLE 12

EMOTIONAL REACTIONS TO CARE OF THE DYING PATIENT

<table>
<thead>
<tr>
<th>Type of Emotional Response</th>
<th>Number of Respondents</th>
<th>Per Cent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feelings of depression, sadness, sorrow</td>
<td>14</td>
<td>33</td>
</tr>
<tr>
<td>Little or no emotional reaction</td>
<td>8</td>
<td>19</td>
</tr>
<tr>
<td>Particularly distressed by death of a young person</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>Feelings of inadequacy</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Arouses thoughts of personal death</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Accepting of death when it brings relief from pain and suffering</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Arouses a desire to preserve life</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>A welcome opportunity to assist the patient to enrich his spirituality</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Feelings of sympathy and pity</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Total Number in Sample: 42

Total Number Responding to Item 41 98 per cent

Relation of findings to hypotheses. Hypothesis 1, that the sample of nurses studied would exhibit measurable differences in the functions they would recall and identify as having been performed in meeting the physical, emotional, and spiritual needs of the dying patient, was supported by the findings.
Hypothesis 2, that the majority of nurses in the sample would indicate some inadequacy in attempting to meet the needs of the dying patient, was partially supported. A majority of the nurses stated they could meet the physical needs (90 per cent) and the emotional needs (52 per cent). Less than a majority (48 per cent) said they could meet the spiritual needs of the dying patient.

Hypothesis 3, that at least one-half of the nurses studied would indicate that the preparation in the basic program in this area was adequate, was not supported. Sixty-six per cent of the nurses indicated a need for better preparation for their first encounter with the dying patient. Sixty-six per cent indicated that additional post-graduation formal instruction and/or clinical experiences would increase their ability to care for the dying patient. The fact that 74 per cent of the nurses indicated they had either negatively oriented feelings or limited emotional reactions to caring for the dying patient may indicate that the opportunity was not provided in the basic nursing program for them to work through their feelings on death and dying nor have they made much progress in this area since graduation.
The central purpose of this study was to determine whether or not evaluation and revision of nursing curricula may be indicated to give nurses better preparation in the care of the dying and a sense of adequacy in giving this care.

It was hypothesized that (a) nurses would exhibit measurable differences in the functions they recalled and identified as having been performed in meeting the physical, emotional, and spiritual needs of the dying patient, (b) the majority of nurses would indicate some inadequacy in attempting to meet the needs of the dying patient, and (c) at least one-half of the nurses would indicate that the preparation in the basic program in this area was adequate.

In order to analyze the problem, a questionnaire designed to answer the following questions was constructed.

1. What nursing functions did the nurse perform in caring for the dying patient?
2. Did the nurse think that she was able to meet the needs of the dying patient?
3. What functions did the nurse perform in her first encounter with the dying patient? Did she have assistance in carrying out these functions?
4. What formal preparation did the nurse recall as given in the basic program that prepared her to carry out nursing functions for the dying patient?

5. In the opinion of the nurse, what pre-graduation and post-graduation experiences would best prepare a nurse for giving care to the dying patient?

6. What did the nurse report as her current reaction to giving care to the dying patient?

The first hypothesis relating to differences among the nurses studied was supported by the findings. The data indicated that the nursing functions most frequently performed in the nurse's early encounter with the dying patient were those related to meeting his physical needs.

The majority of the nurses said they would perform certain listed functions to meet the emotional needs of the dying patient such as (a) staying with the patient if the family is not present and time permits, (b) verbally reassuring a patient who must be left alone that she will return within a short period of time, (c) transferring the dying patient to a private room, and (d) utilizing some means of communicating with the dying patient.

Most of the nurses indicated they were aware of certain readily obtainable personal data about the dying patient that might help them identify factors that might contribute to the patient's emotional response.
More than half said they would contact the religious adviser of the conscious dying patient of the Catholic, Jewish, Latter Day Saint, and Protestant faiths. For the unconscious Catholic patient, a majority would call his religious adviser.

The second hypothesis was partially supported by the findings. Most of the nurses indicated they had a sense of adequacy in meeting the physical and emotional needs of the dying patient. Less than half said they could meet his spiritual needs.

The third hypothesis was not supported. Sixty-six per cent of the nurses indicated a need for better preparation for their first encounter with the dying patient. Sixty-six per cent indicated that additional post-graduation formal instruction and/or clinical experiences would increase their ability to care for the dying patient. The respondents tended to be vague in indicating what theoretical preparation they considered as helpful in preparing them to care for the dying patient. The fact that 74 per cent of the nurses indicated they had either negatively oriented feelings or little or no emotional reactions to caring for the dying patient may indicate that the opportunity was not provided in the basic nursing program for them to work through their feelings on death and dying.

Other findings that emerged from the data. It appears that there is a need for changes in the clinical supervision of basic nursing students in their experiences with dying patients. Although 50 per cent of the nurses studied stated they received assistance from a professional nurse in their first encounter with a dying
patient, thirty-six per cent indicated they had no assistance. Indications are that many nurses have not had the opportunity to work through their own feelings on death. Thirty-three per cent reported they had feelings of depression, sadness, or sorrow when caring for a dying patient and 20 per cent said they had little or no emotional reaction to this nursing experience.

In conversing with the dying patient, most nurses if asked by the patient, "Am I going to die?" said they would give a reflective response.

This study indicates that there is a need for further research into the best ways of preparing the nurse to meet the needs of the dying patient and the application of research findings to this area of nursing.

**Implications of findings.** The writer believes that the following implications emerge from the findings.

1. Nursing curricula should include greater emphasis on identifying the emotional and spiritual needs of the dying patient and the functions the nurse performs to meet these needs. This might assist the nurse to better define her role in the care of the dying patient and assume responsibility for his care.

2. Nursing curricula should provide the nurse with the opportunity to identify and discuss her feelings in relation to the care of the dying patient at the time of or before her first encounter with the dying patient. The nurse
might be better prepared for her first encounter with the dying patient if she had previous contact with the patient and was alerted to the fact that the patient has a fatal prognosis.

3. There is a need for nurses to work through their own philosophy on death. Nursing curricula could provide for this by bringing in qualified individuals from the fields of sociology, psychology, theology, and philosophy to participate in assisting the nurse to arrive at her own philosophy.

4. The reasons for the practice of isolating the dying patient should be explored.

5. There is need for further research in the best way of preparing the nurse to meet the needs of the dying patient.
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BIBLIOGRAPHY

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Wolff, Ilse S. "Am I Going to Die?", RN, XXV (September, 1962), pp. 91-96.

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E. UNPUBLISHED MATERIALS

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APPENDIX A
PERSONAL DATA

The following information is needed for completing the final analysis of the data collected in this study. All information will be kept confidential.

Directions: Complete the following as indicated.

1. Name

2. Address

3. Graduate of:
   ____ three-year basic program in nursing
   ____ bachelor's degree program in nursing
   ____ master's degree program in nursing

4. Did you have a psychiatric nursing affiliation in your basic nursing program?
   ____ yes
   ____ no

5. Would you like to receive an abstract of the completed study?
   ____ yes
   ____ no
THE ROLE AND RESPONSIBILITY OF THE NURSE
IN CARING FOR THE DYING PATIENT

PART I: Experiences and Reactions in Caring for the Dying Patient

The following questionnaire was designed to discover what some of your background experiences and personal reactions were in caring for the dying patient. The dying patient is defined as one who has been diagnosed as having a severe progressive disease condition from which there is little or no hope of recovery. The patient may be in the early or late stages of the disease or be moribund, i.e., in the actual process of dying and within the last 24-72 hours of life.

Directions: Read each question and answer as completely as possible. Some of the questions may be answered by placing a cross (X) in the space provided.

1. Describe, as you remember it, your first encounter with the dying while you were a nursing student. Indicate whether or not the patient was moribund, i.e., in the actual process of dying.

2. List specific nursing functions you performed at this time in helping the patient.

3. Did a clinical instructor (head nurse, supervisor, staff nurse, or other experienced person) assist you in your first experience with the dying patient?

   ___ yes

   ___ no

   If your answer is "yes" what specifically helpful things did she do that made this a meaningful experience?

4. How do you think you may have been better prepared to handle your first encounter with the dying patient?

5. What formal preparation and/or experiences, if any, in the clinical area in your (a) basic nursing program or (b) after graduation helped to prepare you for caring for the dying patient?
   a. Basic Nursing Student
   b. Graduate Nurse

6. What further preparation and/or experiences would have better enabled you to more effectively meet the needs of the dying patient?
7. List those courses (lectures, class discussions, seminars, etc.) in your basic nursing program that you believe were the most valuable in preparing you to care for the dying patient.

8. As a graduate nurse, do you believe that you are able to meet the needs of the dying patient? Give the reason for your answer.
   a. I am able to meet the physical needs.
      _____ yes
      _____ no
      Reason
   b. I am able to meet the emotional needs.
      _____ yes
      _____ no
      Reason
   c. I am able to meet the spiritual needs.
      _____ yes
      _____ no
      Reason

9. If you had a choice, would you elect to care for the dying patient? Give the reason for your answer.
   _____ yes
   _____ no
   Reason

10. Listed below are certain items usually included in the patient's personal data. Place a cross in the appropriate column to indicate whether you usually know this about the dying patient and whether or not you think the nurse should know it.
PART I

<table>
<thead>
<tr>
<th>Usually Think Nurse Know Should This Know It</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

- a. Religion.
- b. Marital status.
- c. Age.
- d. Whether or not the family realizes the seriousness of the illness.
- e. Whether or not there are living offspring.
- f. Whether or not the patient understands the probable outcome of his illness.
- g. Whether he has life insurance and health and hospitalization insurance.
- h. Whether he is a charity patient.

Comment

11. How would you respond to a patient who asked, "Am I going to die?"

12. How does caring for the dying patient affect you emotionally?

PART II: Meeting the Emotional and Spiritual Needs of the Dying Patient

Directions: Answer the following questions by "yes" or "no." Space is provided for additional comments should you wish to clarify your answer.

The questions refer only to the moribund patient, i.e., one who is in the actual process of dying and who is approximately 24-72 hours away from death.

1. Do you call the particular religious adviser of the dying patient in the following instances?

<table>
<thead>
<tr>
<th>Conscious Patient</th>
<th>Unconscious Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Latter Day Saints</td>
<td>Jewish</td>
</tr>
<tr>
<td>Other</td>
<td>Other</td>
</tr>
</tbody>
</table>

Comment

2. Do you stay with the patient if the family is not present and time permits?

   ____ yes
   ____ no

Comment
PART II

3. Do you stay with the patient if the family is present and time permits?
   ___ yes
   ___ no
   Comment

4. If time does not permit and the family is not present, do you verbally reassure the patient that you will return shortly?
   ___ yes
   ___ no
   Comment

5. Do you transfer the patient to a private room or some other area away from other patient contact?
   ___ yes
   ___ no
   Comment

6. In communicating with the patient do you,
   a. Speak slowly and distinctly at all times?
      ___ yes
      ___ no
      Comment
   b. Touch the patient by grasping his shoulder or hand firmly when speaking to him?
      ___ yes
      ___ no
      Comment
   c. Utilize some pre-arranged signal if the patient is unable to speak or you question his level of consciousness?
      ___ yes
      ___ no
      Comment
   d. List or indicate other means of communication you may use that are not mentioned above.
VITA

Julia Guenzi Marostica was born on May 12, 1932, in Sterling, Colorado. Her early childhood was spent in Oregon and Colorado. Her elementary and secondary education was obtained in the public schools of Oregon and Idaho. After graduating from Parma High School, Parma, Idaho, in June, 1950, she attended St. Alphonsus Hospital School of Nursing, Boise, Idaho, for three years. In 1955 she was awarded the Bachelor of Arts degree at Gonzaga University, Spokane, Washington.

Following her university graduation Miss Marostica taught at St. Alphonsus Hospital School of Nursing for three years.

She was next employed in the capacity of assistant director at Holy Cross Hospital School of Nursing, Salt Lake City, Utah, for three years. During this time she taught obstetrical nursing.

She enrolled at the University of Utah in September, 1962, and received her Master of Science degree in August of 1965.

She has been employed as an instructor of medical-surgical nursing and assistant director at Holy Cross Hospital School of Nursing since September, 1964.