Nurse Attitudes

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Attitudes and Associated Factors Towards Palliative Care among Non-Palliative Care Nurses, Yogyakarta, Indonesia

Abstract

The increment of terminal health problems causes the demand for palliative care to increase. Nurses' attitudes toward palliative care have critical implications on the quality of care for terminally ill patients. This study aimed to investigate non-palliative care nurses' attitudes towards death and dying in the context of palliative care in Indonesia. A cross-sectional design was performed in four general hospitals, five primary health centers, and three nursing homes in Yogyakarta. Systematic random sampling was the method employed to the respondents. Research instrument used Frommelt Attitudes towards Care of the Dying (FATCOD), FATCOD is a 30-item tool using a five-point Likert scale to indicate respondents' attitudes toward caring for dying patients. 217 non-palliative care nurses completed the FATCOD and a ten-item demographic questionnaire. The data analysis used descriptive statistics, chi-square and linear regression. The total FATCOD score achieved in this study was 111.29±9.44 (range 30–150). Concerning nurses' attitudes towards the family members of terminally ill dying patients, the score was 39.85 (±4.12) out of a possible 50. Besides, in relation to attitudes towards the provision of care to patients, the score was 71.43 (±6.39) out of a possible 100. Of significance, working experience variables were associated with attitudes in the total FATCOD and patient FATCOD. Working experience and level of education were associated with attitudes towards the family FATCOD. Non-palliative care nurses had a favorable attitude towards palliative care. The ministry of health should give awareness by providing various training, workshop, formal and informal education about PC for nurses.

Keywords: attitude, nurses, palliative care, Yogyakarta, FATCOD.

INTRODUCTION

The challenges for palliative care in South-East Asia have been identified as limited palliative care services, lack of understanding and negative perceptions about palliative care, constraints on available resources, poor symptom management, and late referrals (Wright et al, 2008). Lim (2017) stated that World Palliative Care Alliance (WPCA) mapped Indonesia's palliative care services in the third category, which means the provision of isolated palliative care with the development of palliative care was not well supported and was limited in number compared to the size of the population. There are serious deficits in this field in many countries, and the need for PCs will further increase as a result of demographic developments with increasing numbers of older people with incurable chronic disease and multiple morbidities (Kassa et al, 2014).

The UN has predicted that the percentage of Indonesians over 60 years will reach 25 percent by 2050 or nearly 74 million elderly people. Several provinces have a higher number of elderly people than the national average, and Yogyakarta has the nation's largest elderly population (Mahendradhata, 2017). Based on a review of palliative care services in Yogyakarta, only one health institution was provided with palliative care services. In addition, the haste to develop palliative care units has resulted in many services being run by doctors and nurses who have limited knowledge and understanding of palliative care (Lim et al, 2003).

Staff who provide end-of-life care are more likely to experience high levels of emotional exhaustion (McConnel, 2017; Namasivayam et al, 2013; Yang et al, 2017). Many report feelings of emotional distress, anxiety, and a lack of preparation to provide care to patients at the end of life and their families. It has been reported that end-of-life care is one of the most common sources of stress for nurses. A study reported that 91% of nurses were unsure how to react when patients talked about death and dying. Some nurses may choose to avoid discussing the emotional issues with patients, and some may choose not to tell the truth about the patient's condition. The differences in reactions may be attributed to factors such as personal attitudes to death, experiences, understanding of end-of-life care, and others. The factors will finally shape the care provided, whether the nurses are aware of it or not. Understanding the factors that affect nurses' attitudes will help develop strategies and resources they need to use to cope with stressful situations (Yang et al, 2017).

To provide quality care at the end of life or for chronically ill patients, nurses must have good knowledge, attitudes, and practices about palliative care to meet the needs of patients and their families adequately (Kassa et al, 2014, Lewis et al, 2016). Traditionally, high-quality care at the end of life has mainly been provided for cancer patients in inpatient hospices, but this kind of care now needs to be provided for those with a broader range of diseases.

Countries need to develop health care services to meet the medical and social needs of palliative care. An effective care must reach the hospital, people's homes and nursing, and residential homes within the community. The role of care staff during the period near the end of life is essential. In order to clarify the present status and future assignment of palliative care in these countries, the attitudes of non-palliative nurses about views on terminal care, life, and death were surveyed.

METHODS

A cross-sectional study was conducted with nurses at hospitals, primary health centers, and nursing homes in Yogyakarta from January 2020 to June 2020. This study confined to nurses working in a governmental hospital (1 hospital), non-governmental hospitals (3 hospitals), five primary health centers, and three nursing homes. The nurses serving in outpatient departments and wards of the selected hospitals were recruited to participate in the study. However, nurses working in the pediatric ward, operating room, and neonatal unit were excluded.

The sample size was determined using a single population proportion formula since the total sample size was less than 10.000. Multistage sampling was applied; thus, the initial sample size was 217 nurses. Hospitals found in Yogyakarta were stratified into governmental and non-governmental. Because the number of non-governmental hospitals was more than a governmental hospital, one governmental hospital and three non-governmental hospitals were selected using simple random sampling. The same method was used to select five primary health centers and three nursing homes. The number of subjects assigned was 166, 32, and 19 for the hospitals, primary health centers, and nursing homes, respectively, keeping proportionality into consideration. The attitude scale was adopted from Frommelt Attitude Toward Care of the Dying (FATCOD) and modified to fit the Indonesian context. Validitiy and reliability for FATCOB Indonesian version adopted from A'la (2016). The data collection instrument included two sections. Section one: A socio-demographic included (gender, institution, religion, level of education, working experience, home location, type of house, age, and family member). Section two: The Frommelt Attitude Toward Care of the Dying (FATCOD) Scale, Form B (Frommelt, 1991) is a 30-item tool using a five-point Likert scale to indicate respondents' attitudes toward caring for dying patients. Scores were reversed for negative items. Possible scores can range from 30–150. A higher score indicates a more positive attitude toward caring for this patient population. Twenty items in the FATCOD scale relate directly to the nurses' attitude towards the patient (possible range 20–100) and ten items relate directly to the nurses attitudes towards the patients' family (possible range 10–50). Data collection was conducted by four graduate nurses who received a half-day training on issues concerning the questionnaire.

The data were analyzed by SPSS version 16 statistical software packages. Descriptive analysis, student's t-test, chi-square, and linear regression were computed in order to summarize the data, examine the between-group differences on FATCOD scores, assess statistical association, and see the level of significance, respectively. All statistical tests were two-tailed with the alpha set at 0,05. Ethical clearance was obtained from the Institutional Review Board (IRB) of Faculty Medicine and Health Sciences

Universitas Muhammadiyah Yogyakarta. Approvals were also obtained from participating hospitals, primary health centers, and nursing homes. Verbal consent was obtained from each participant, and participants' anonymity and confidentiality were kept. The respondents had the right not to participate in or withdraw from the study at any stage.

RESULTS

A total of 217 completed questionnaires were analyzed. The research location was 12 places. There were four hospitals, three nursing homes, and five primary health centers. The majority of respondents were female (80.2%), working in a hospital (76.5%), and Muslim (95.4%). For the number of participants by their institution, the majority were from non-governmental hospital 124 (57.1%). 153 (70.5%) respondents stated that their highest level of education was a diploma degree, and the majority of working experience was more than ten years (32.3%). The majority of respondents were living in the village (70.5%), with the type of house were own house (82.5%). The mean age was 32.52 (SD = 7.37), with the mean of the family member was 3.94 (SD = 1.52) (See Table 1).

Table 1. Socio-demographic characteristics of participants (*n* = 217).

Characteristics	
Gender, n (%)	
Male	43 (19.8)
Female	174 (80.2)
Working place, n (%)	
Hospital	166 (76.5)
Nursing homes	19 (8.8)
Primary health center	32 (14.7)
Institution, n (%)	
Governmental hospital	42 (19.4)
Non-governmental hospital	124 (57.1)
Nursing homes	19 (8.8)
Primary health center	32 (14.7)
Religion	
Islam	207 (95.4)
Protestant	3 (1.4)
Catholic	6 (2.8)
Hindu	1 (0.5)
Highest level of education, n (%)	
Master's degree	3 (1.4)
Bachelor's degree	61 (28.1)
Vocational school	153 (70.5)
Working experience, n (%)	
Less than 1 years	7 (3.2)
1-2 years	29 (13.4)
2-3 years	25 (11.5)
3-5 years	29 (13.4)
5-10 years	57 (26.3)
More than 10 years	70 (32.3)
Home location, n (%)	
Downtown	17 (7.8)
Residential areas	19 (8.8)
Countryside Villages	153 (70.5)
Others	28 (12.9)
Type of house, n (%)	
Own house	179 (82.5)
Rented house	21 (9.7)
others	17 (7.8)

Characteristics	
Age, years mean (SD)	32.52 (7.37)
Family member, mean (SD)	3,94 (1,52)

The total FATCOD score achieved in this study was 111.29±9.44 (range 30–150). In relation to nurses' attitudes towards the family members of terminally ill dying patients, the score was 39.85 (±4.12) out of a possible 50. Besides, concerning attitudes towards the provision of care to patients, the score was 71.43 (±6.39) out of a possible 100 (Table 2).

Table 2. Descriptive statistic score of the Frommelt attitudes towards care of the dying (FATCOD) (n=217)

Variables	**Min-Max**	**Mean ± SD**
Total FATCOD	71-139	111.29±9.44
Family FATCOD	20-50	39.85 ±4.12
Patient FATCOD	50-93	71.43 ±6.39

The mean scores for most of the individual items in the FATCOD scale were equal to or greater than 4 (range 1–5), while the mean scores for most of the individual items in the FATCOD scale were equal to or greater than 3. The lowest mean score could be found at number 5; the statement was, "I would not want to be assigned to care for a dying person". Meanwhile, the highest mean score could be found at number 1 with the statement, "Giving nursing care to the dying person is a worthwhile learning experience".

More than half of the participants strongly agreed that giving nursing care to the dying person was a worthwhile learning experience. Nearly half of the respondents disagreed that death was not the worst thing that could happen to a person. Likewise, forty-six (46.1%) agreed and that it would be uncomfortable talking about impending death with the dying person. Over half of respondents (52.5%) and one hundred and twenty-eight (59.0%) agreed that the family should be involved in the physical care of the dying person, and nursing care should extend to the family of the dying person, respectively. It was also confirmed by 55.8% of respondents who did not agree that educating families about death and dying was not a nursing responsibility (see Table 3).

Table 3. Distribution of health care staff attitude towards items of FATCOD in Yogyakarta (n=217)

No	**Statement**	**SD (%)**	**D (%)**	**U (%)**	**A (%)**	**SA (%)**
1	Giving nursing care to a dying person is a worthwhile learning experience.	2 (0.9)	1 (0.5)	0 (0)	90 (41.5)	124 (57.1)
2	Death is not the worst thing that can happen to a person.	32 (14.7)	92 (42.4)	21 (9.7)	53 (24.4)	19 (8.8)
3	I would be uncomfortable talking about impending death with the dying person.	9 (4.1)	55 (25.3)	23 (10.6)	100 (46.1)	30 (13.8)
4	Nursing care for the patient's family should continue throughout the period of grief.	2 (0.9)	17 (7.8)	12 (5.5)	144 (66.4)	42 (19.4)
5	I would not want to be assigned to care for a dying person.	54 (24.9)	133 (61.3)	12 (5.5)	14 (6.5)	4 (1.8)
6	The nurse should not be the one to talk about death with the dying person.	8 (3.7)	20 (9.2)	11 (5.1)	133 (61.3)	45 (20.7)

7	The length of time required to given nursing care to a dying person would frustrate me.	28 (12.9)	110 (50.7)	31 (14.3)	46 (21.2)	2 (0.9)
8	I would be upset when the dying person I was caring for gave up hope of getting better.	11 (5.1)	37 (17.1)	23 (10.6)	123 (56.7)	23 (10.6)
9	It is difficult to form a close relationship with the family of the dying person.	5 (2.3)	16 (7.4)	69 (31.8)	84 (38.7)	43 (19.8)
10	There are times when death is welcomed by the dying person.	2 (0.9)	8 (3.7)	13 (6.0)	159 (73.3)	35 (16.1)
11	When a patient asks, “Nurse, am I dying?” I think it is best to change the subject to something cheerful.	11 (5.1)	63 (29.0)	24 (11.1)	100 (46.1)	19 (8.8)
12	The family should be involved in the physical care of the dying person.	2 (0.9)	6 (2.8)	1 (0.5)	114 (52.5)	94 (43.3)
13	I would hope the person I am caring for dies when I am not present.	0 (0)	24 (11.1)	42 (19.4)	104 (47.9)	47 (21.7)
14	I am afraid to become friends with a dying person.	5 (2.3)	19 (8.8)	10 (4.6)	125 (57.6)	58 (26.7)
15	I would feel like running away when the person actually died.	9 (4.1)	13 (6.0)	5 (2.3)	110 (50.7)	80 (36.9)
16	Families need emotional support to accept the behavior changes of the dying person.	5 (2.3)	4 (1.8)	1 (0.5)	131 (60.4)	76 (35.0)
17	As a patient nears death, the nurse should withdraw from his/her involvement with the patient.	8 (3.7)	31 (14.3)	12 (5.5)	124 (57.1)	42 (19.4)
18	Families should be concerned about helping their dying member make the best of his/her remaining life.	3 (1.4)	3 (1.4)	5 (2.3)	95 (43.8)	111 (51.2)
19	The dying person should not be allowed to make decisions about his/her physical care.	5 (2.3)	40 (18.4)	33 (15.2)	96 (44.2)	43 (19.8)
20	Families should maintain as normal an environment as possible for their dying members.	0 (0)	6 (2.8)	9 (4.1)	142 (65.4)	60 (27.6)
21	It is beneficial for the dying person to verbalize his/her feelings.	2 (0.9)	3 (1.4)	4 (1.8)	135 (62.2)	73 (33.6)
22	Nursing care should extend to the family of the dying person	1 (0.5)	12 (5.5)	13 (6.0)	128 (59.0)	63 (29.0)
23	Nurses should permit dying persons to have flexible visiting schedules.	3 (1.4)	28 (12.9)	24 (11.1)	116 (53.5)	46 (21.2)

24	The dying person and his/her family should be the in-charge decision-makers.	2 (0.9)	6 (2.8)	1 (0.5)	126 (58.1)	82 (37.8)
25	Addiction to pain-relieving medication should not be a concern when dealing with a dying person.	9 (4.1)	62 (28.6)	48 (22.1)	82 (37.8)	16 (7.4)
26	I would be uncomfortable if I entered the room of a terminally ill person and found him/her crying.	15 (6.9)	51 (23.5)	20 (9.2)	110 (50.7)	21 (9.7)
27	Dying persons should be given honest answers about their condition.	5 (2.3)	22 (10.1)	39 (18.0)	117 (53.9)	34 (15.7)
28	Educating families about death and dying is not a nursing responsibility.	12 (5.5)	36 (16.6)	16 (7.4)	121 (55.8)	32 (14.7)
29	Family members who stay close to a dying person often interfere with the professionals' job with the patient.	12 (5.5)	71 (32.7)	36 (16.6)	84 (38.7)	14 (6.5)
30	It is possible for nurses to help patients prepare for death.	2 (0.9)	4 (1.8)	4 (1.8)	136 (62.7)	71 (32.7)

SD: strongly disagree, D: disagree, U: uncertain, A: agree, SA: strongly agree

For the total FATCOD, a significant relationship between working experience and attitude towards death and dying were observed (F = 2,06; P = 0,040). Similarly, for the patient-related items within the FATCOD, the working experience was variable that correlated with the attitude towards death and dying, which were observed (F = 2,83; P = 0,005). For the family FATCOD, a significant relationship between working experience and level of education variables were associated with attitudes towards the family FATCOD with p-value 0,037, and 0,020, respectively (see Table 3).

Table 4. Association between demographic characteristics of participants and attitudes towards death and dying (*n* = 217).

Variable		Total FATCOD		Patient FATCOD		Family FATCOD	
		F	p	F	p	F	p
Gender, n (%)		-1.45	0.146	-1.59	0.113	-0.79	0.426
Male	43 (19.8)						
Female	174 (80.2)						
Working place, n (%)		0.11	0.911	0.75	0.452	-0.92	0.360
Hospital	166 (76.5)						
Nursing homes	19 (8.8)						
Primary health center	32 (14.7)						
Institution, n (%)		-0.91	0,365	-1.30	0.194	-0.02	0.985
Governmental hospital	42 (19.4)						
Non-governmental hospital	124 (57.1)						
Nursing homes	19 (8.8)						
Primary health center	32 (14.7)						

Religion		-0.49	0.618	-0.80	0.422	0.10	0.917
Islam	207 (95.4)						
Protestant	3 (1.4)						
Catholic	6 (2.8)						
Hindu	1 (0.5)						
Highest level of education, n (%)		-0.89	0.372	0.17	0.862	-2.34	**0.020**
Master's degree	3 (1.4)						
Bachelor's degree	61 (28.1)						
Vocational school	153 (70.5)						
Working experience, n (%)		2.06	**0.040**	2.83	**0.005**	2.09	**0.037**
Less than 1 years	7 (3.2)						
1-2 years	29 (13.4)						
2-3 years	25 (11.5)						
3-5 years	29 (13.4)						
5-10 years	57 (26.3)						
More than 10 years	70 (32.3)						
Home location, n (%)		0.68	0.496	0.67	0.500	0.51	0.607
Downtown	17 (7.8)						
Residential areas	19 (8.8)						
Countryside Villages	153 (70.5)						
Others	28 (12.9)						
Type of house, n (%)		-0.90	0.368	-1.02	0.056	0.44	0.659
Own house	179 (82.5)						
Rented house	21 (9.7)						
others	17 (7.8)						
Age, years mean (SD)	32.52 (7.37)	0.06	0.945	-0.06	0.952	0.25	0.800
Family member, mean (SD)	3,94 (1,52)	0.84	0.401	0.66	0.511	0.91	0.363

DISCUSSIONS

The total FATCOD score achieved in this study was 111.29±9.44 (range 30–150). The result of this study suggested that the majority of respondents had a favorable attitude.

The European Association for Palliative Care has recently described the core competencies of palliative care encompassing health professionals' abilities to meet patient's physical, social, psychological, and spiritual needs (Gamondi, 2013). Nurses' attitudes and coping skills were related to preparedness to practice in palliative care. According to the Knowledge, Attitude and Psychomotor (KAP) theory, practice is an individual's response to stimulation. It is an actual presentation that is closely related to an individual's knowledge and attitudes. As lack of knowledge has some influence on nursing staff's attitudes and practices toward Palliative Care Consultation Service (PCCS), it was suggested that education is especially important in changing these attitudes and practices. Being single was associated with positive direct effects (Pain et al, 2017).

The quality of palliative care given to terminally ill patients and their family members can be directly impacted by the attitudes that nurses hold towards palliative care (Tait, *et al*, 2017). Attitudes toward terminal care in nursing students were significantly correlated with communication competence (r=0.438, P 0.001), spirituality (r=0.374, P < 0.001), and gratitude (r=0.318, P < 0.001). Communication competence explained 18.7% of the variance in attitudes toward terminal care (Jo Myung-Ju et al, 2015).

The mean scores for most of the individual items in the FATCOD scale were equal to or greater than 4 (range 1–5). Meanwhile, the mean scores for most of the individual items in the FATCOD scale were equal to or greater than 3. The lowest mean score could be found at number 5, and the statement was, “I would not want to be assigned to care for a dying person”. In contrast, the highest mean score could be found at number 1 with the statement, “Giving nursing care to the dying person is a worthwhile learning experience.”

Many healthcare professionals working in general care areas did not feel confident delivering all aspects of palliative care and struggled with the communication skills required for end-of-life discussions. Nurses agreed that more could be done to help someone achieve a sense of peace at the end of life, that end of life need not be a time of great suffering and that families have the right to refuse treatment aimed at prolonging life (Monterosso et al, 2016). Attitude towards PC was influenced by awareness of death and personal characteristics (Nam et al, 2016).

Further analyses on other parameters showed that working experiences affected attitudes of non-palliative care nurses in Yogyakarta. Nurses with 11–15 years of experience had the lowest professional apprehension score, while those with 21 years of experience had the highest apprehension score. The researchers investigated the association of factors, including age, sex, marital status, religion, working experience, education level, working department, post, and titles with the attitudes toward hospice care (Yang et al, 2017).

Besides, the variance analysis showed that nurses with different education levels had significantly different scores (P,0.05) on personal apprehension and overall attitude toward hospice care; the higher the education level attained, the lower the personal and professional apprehension levels (Yang et al, 2017; Kang et al, 2014). Having a master’s degree had a positive, although indirect effect, on nurse practice through the influence on knowledge and attitude. It implies that nursing staff with a higher educational level would have more knowledge about PCCS, which indirectly resulted in a more favorable attitude and better practice toward palliative care to improve the provision of high-quality care Pan et al, 2017; Scott et al, 2016). Limitations of this study are that the researchers did not do the homogeneity of the respondents, a small amount of the sample, and the uneven distribution of respondents to all health institutions in Yogyakarta.

CONCLUSIONS

Hospital-nurses play a huge role in the provision of palliative nursing care so that they need training on how to become a palliative nurse in the settings of hospitals, the primary health centers, and nursing homes. The variables that most influenced the nurse's attitude in giving palliative nursing care were working experience and education level. The ministry of health should give awareness in this problem by providing various training, workshop, formal and informal education about PC for nurses.

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