UNIVERSITY OF SOUTHAMPTON

ABSTRACT

FACULTY OF SOCIAL SCIENCE

SOCIAL WORK STUDIES

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NURSE STRESS AND PATIENT DEATH

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Sixty-nine nurses were asked about their experience of caring for dying patients, the areas of distress, management of their own feelings and the availability and use of formal and informal support. The nurses worked in one of three settings chosen to reflect a high, medium and low number of patient deaths : a palliative care unit; the acute assessment wards of a geriatric department ; and the continuing care (long-stay) wards of the same geriatric department.

The incidence of anxiety and stress were measured using the McMordie version of Templar's Death Anxiety Scale, and a number of instruments designed to assess reported stress in the nursing task. Short and longer term costs of stress were assessed using Goldberg's General Health Questionnaire, the nature of G.P. consultations and illness reports.

Experience of stress was not directly related to the number of deaths. Night staff in the palliative care unit reported higher levels of stress than day staff in caring for dying patients, and continuing care staff reported more stress than acute ward staff. Night staff generally felt less appreciated and were less well supported at work than day staff. As stress increased, so did the number of coping methods used. No long-term costs were identified and it was concluded that the methods used by these staff to manage the experience of stress were successful, and this was a competent, coping group.

A number of recommendations in relation to the training and support of staff are made, together with indications for further research.

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INTRODUCTION

The expansion of the modern Hospice movement in the last twenty or so years has coincided with a growing interest, at least among some professions, with the subject of death. Hospice care of the seriously ill and dying equates with the principle of total patient care : that is care of the patient's material, physical, psychological and spiritual needs, together with those of his family.

At the same time, the appearance of literature and research about the psychological needs of dying patients began to make its impact on the field of patient care. Kubler-Ross (1970) found that when she succeeded in penetrating the reserves of the medical profession, and began to talk with dying patients, they frequently welcomed the opportunity. An awareness of the psychological comfort brought to patients who were able to discuss fears and anxieties, and the isolation that results from a "conspiracy of silence" led to a growing identification in the hospice movement of the importance of promoting an atmosphere of open awareness. In conjunction with this there developed also an understanding of the potential stress to nursing staff who worked closely with dying patients and were required to manage conversations of this nature, particularly if they were without the appropriate training and support.

Terminal care nursing in a hospice context became synonymous with the provision of an open ethos, and whilst the potential benefits and stresses were recognised, in general the assumption has been made that hospice care is good care and that the programme devised is right : for patients, families and staff. In particular, the stressful nature of the work has been recognised and, it is claimed, provided for.

In adopting what may be regarded as something of a pioneering role in promoting quality of total care rather than cure in nursing the dying, hospice care challenges the traditional medical view of death as a failure. However, it may also come to be regarded as somewhat select, enjoying perhaps better material surroundings and staff to patient ratios than many hospital wards. Whilst it may be hoped that the experience and knowledge gained in these specialist settings will usefully inform the care of dying patients elsewhere, there is also a danger that hospices become regarded as privileged elite areas of care, which have little relevance to the general day-to-day realities of patient care.

Although much anecdotal material has been reported about the stressful nature of working with terminal illness and death, there have been no previous British studies which examine this topic in depth, and little research in this area in any country which uses a comparison group.

The present study set out to explore some of the issues referred to above, by examining the experience of staff who are involved in nursing dying patients in three settings. The first was a National Health Service palliative care unit which was set up and runs in accordance with hospice ideals and practice. The other two were the acute - assessment wards, and long-stay (or as staff preferred, continuing - care) wards of a geriatric department. The three settings between them represented respectively a high, medium and low rate of monthly deaths. The researcher was interested to understand the experience of these nurses in caring for dying patients, to see what was happening and how they coped.

The study starts with an overview of the general literature on the nature and meaning of stress, its potential consequences as well as possible mediating factors, and a review of some research instruments designed for its measurement. It proceeds to a review of the literature and research relating to occupational stress in nursing; the meaning and impact of patient death and death anxiety; the hypothesized costs of this kind of stress; and a variety of methods which have been recommended to mediate its effects.

The methodology followed in the study can be found in Chapter 3, which describes the instruments used, how the results were analysed and the hypotheses which were tested.

This is followed by a report of the study itself, starting with the experience of the researcher on the wards, as a participant - observer, before moving on to compare in greater detail the demographic characteristics of the subjects. This leads into a more detailed consideration, in the next chapters, of descriptive and qualitative data relating to the care of the dying, reactions to death, management of conversations with patients about their situation, and management of respondents' own feelings.

The results of statistical analyses in the testing of hypotheses are reported in Chapter 10, before proceeding to a summary, which is followed by a more in - depth discussion, of the findings. The study concludes in Chapter 13 with a look at the implications of the research findings, upon which are based the main recommendations, together with suggestions for future research. The instruments used, together with additional supporting data appear in the appendices.

For ease of reading, the protocol has been adopted throughout of referring to staff as she and patients as he. In addition, the following abbreviations have been commonly used in the text :

SRN - State Registered Nurse; SN - Staff Nurse;
SEN / EN - State Enrolled Nurse;
NA - Auxiliary Nurse;
GP - General Practitioner;
JBCNS - Joint Board of Clinical Nursing Studies.

Other abbreviations are explained in the text when they are used.

CHAPTER 1

THE NATURE OF STRESS

Introduction

Since the early work of Hans Selye and others in the 1930's, a massive body of writing and research has been produced on the subject of stress.Over recent years it has become popularised as a topic of interest and concern,and articles may as equally be found in weekly magazines as in weighty scientific journals, offering stress measurement scales and advice on stress reduction. Stress has become a fashionable subject for research with many areas of modern life seen as potential stress research material. Terminology, such as 'Type-A behaviour' and 'burnout', originating in stress research has become part of everyday language; and there has been a gradual acceptance of the existence of a relationship between stress and health.

From the plethora of research that has already been carried out on stress, apart from major works, the writings and research to be referenced here will be limited primarily to those which date from 1970. Unless otherwise indicated,they will be of American origin.

Defining Stress

The term stress has been widely and variably used, and it is by no means easy to reach a comprehensive definition or framework. Indeed, Singleton (1974) suggested that such an attempt was undesirable at the then present stage of knowledge, while Mason (1975) pointed to the existing confusion over terminology. Definitions of stress have included reference to external and internal stimuli, and/or responses at the level of physiological / biological, psychological and / or psychosocial behaviour, depending on the interests and orientation of the researcher; whilst in everyday language stress most usually is taken to be some force or stimulus external to and acting upon the subject, or to indicate an emotional state. However stress is defined, Monat and Lazarus (1977) gave emphasis to the importance that in any study its meaning should be clearly defined.

Positive and Negative Aspects of Stress

It may be useful to start by recalling that Selye (1974) suggested that stress cannot be avoided. Its absence, in fact, is death. He further suggested that stress is not a uniformly negative concept, but may give rise to feelings of pleasure, satisfaction, and enjoyment, for which he coined the term "eustress". Stress may equally be associated with unpleasant or damaging consequences, which Selye distinguished as "distress". These have generally received more research attention, and stress tends to be equated with the occurrence of noxious stimuli and harmful consequences. Selye (1979) noted that an insufficiency of stimulation may be as harmful as an excess. Unused muscles may undergo atrophy, too little input to the sensory nervous system may lead to boredom and, in extreme cases,to hallucinations and other mental disturbance. He pointed out that stress "possesses prophylactic and therapeutic value; it can induce non-specific resistance to a great variety of potential pathogens". In other words, the experience of stress can have a protective and immunising function.

A Response-Based Definition of Stress

One approach to the study and definition of stress has been the specification of a class or classes of response which can be used reliably as evidence of stress. Selye (1974) defined stress as the "non-specific response of the body to any demand". In early experimental work with animals he noted a stereotyped physiological response pattern to a range of different stimuli. Selye's observations of the stress reponse led him to ascribe the term "General Adaptation Syndrome" to what he suggested was in fact a sequence of responses, which he was able to relate to concomitant measurable physiological with biological changes. In the study of stress in human subjects, responses involving changes in affect, cognitive functioning, motor behaviour and physiology have been used as measures of stress. Theorell and Rahe (1974) reported the use of measures of biochemical composition of urinary output, in a study of myocardial infarction, while Fenz (1975) used a combination of measures of cognitive and physiological responses. Lindemann (1944),in a study of acute grief, reported response patterns involving physiological, behavioural, affective and cognitive changes. Other researchers, Parkes (1975) in a study of adult grief, Kubler-Ross (1970) in a study of awareness of impending death, and Bowlby (1953) in research into childhood separation, have all identified sequential response patterns which seem to closely parallel at the level of psychological response the physiological response pattern described by Selye. However, although these would seem therefore to be fairly universal psychological phenomena, Selye's concept of stress as a non-specific physiological response has been questioned (Mason, 1975). Moreover, low correlations have been found between different measures of arousal used to indicate stress and Schalling (1975) is not alone in suggesting there may be systematic individual differences in the experience of, and response to, stress.

There are, therefore considerable difficulties in defining stress in terms of a response that can be measured. Knowledge of the complex physiological and biological mechanisms involved in responding to stress is in its infancy, although it seems unlikely that all responses are totally undifferentiated. Nor is it yet possible to be sure to what extent and how response is mediated by defense mechanisms, repetition or persistence of stress over time, either at a biophysiological or psychological level. In short, stress defined in terms of a global response is difficult to test since there is no certainty that what is being measured is the same on all occasions and for all subjects.

A Situational Perspective to Defining Stress

An alternative approach to the study of stress has been to use a situational definition. A wide range of real - life and experimentally contrived situations have been studied. Some, by the very nature of the extreme and life-threatening experiences to which people are exposed, will be unanimously identified as highly stressful. Bettelheim's (1943) account of life in a concentration camp, or a disaster such as that experienced by some of Lindemann's subjects, readily meet such a criterion. Other situational stresses described include the threat of surgery (Janis, 1958) and making a voluntary parachute jump (Fenz).

Within the laboratory, a wide range of artificially induced stimuli have been designated stressful by the researcher. Physical stresses such as the use of electric shocks reported by Meichenbaum (1975), and the manipulation of ischaemic pain (Johnson, 1975) have been used by some researchers. Others have focused their attention on manipulating situations which might be described as psychologically stressful. Steiner (1970) reported on psychological discomfort in the form of discordance; while Sales (1970) reported on the experimentally induced fear of failure.

However, one important characteristic which distinguishes the situational stresses described above, and particularly the real-life from the laboratory situations, relates to the degree of choice the individual has over his presence and participation. The power that an individual can exercise to remove himself from an unpleasant experience, or the extent to which he is powerless to influence events over which he has no control, will give rise to very different experiences of anxiety, and perhaps lead to very different behavioural responses. In this sense the experience of stress in a concentration camp will be very different from that in a laboratory or when about to undergo surgery. However, although serious illness was one of the life events identified by Paykel, Myers, Dienelt, Klerman, Lindenthal and Pepper (1969) as discriminating significantly between depressed patients and controls, the degree to which an individual remains at the mercy of events can influence the experience of stress and perhaps its outcome. Janis, for instance, was able to demonstrate that an experimental group of patients about to undergo an operation who were given advice and information regarding post-operative pain, but otherwise treated no differently from a control group, achieved better post-operative recovery.

In a similar way, in the research to be described here, the nurses working on the ward with the highest number of deaths had all chosen to work in that situation, in full awareness of the high number of deaths they would experience. Moreover, death of patients was also defined as part of the nursing task. It seems probable that these nurses would be less likely to experience feelings of powerlessness than staff on other wards where death is not expected and where goals are more cure, maintenance or discharge oriented. On those wards death may be seen, less as part of the task than failure of the task. The feelings of stress may therefore be both qualitatively as well as quantitively different.

The study of stress using a purely situational perspective is therefore problematic. Individual appraisal of a situation as stressful has been related to the process of evaluating the degree of threat or potential harm,which might include the imminence of threat, the degree of ambiguity associated with it, and its power for harm. The inherent stress in one situation, such as life in a concentration camp, would seem to be very different qualitatively and quantitatively from that of an operation, a laboratory experiment or a parachute jump. At the very least, the situational approach would seem to require the development of a hierarchy or scale of severity of stress. A number of such scales have been constructed which deal with the problem in this way, and these will be reviewed later. The problem of individual variations in response to stressful situations still remains, however. As Janis observed, the intensity of individual pre-operative fears had little to do with the objective seriousness of the operation.

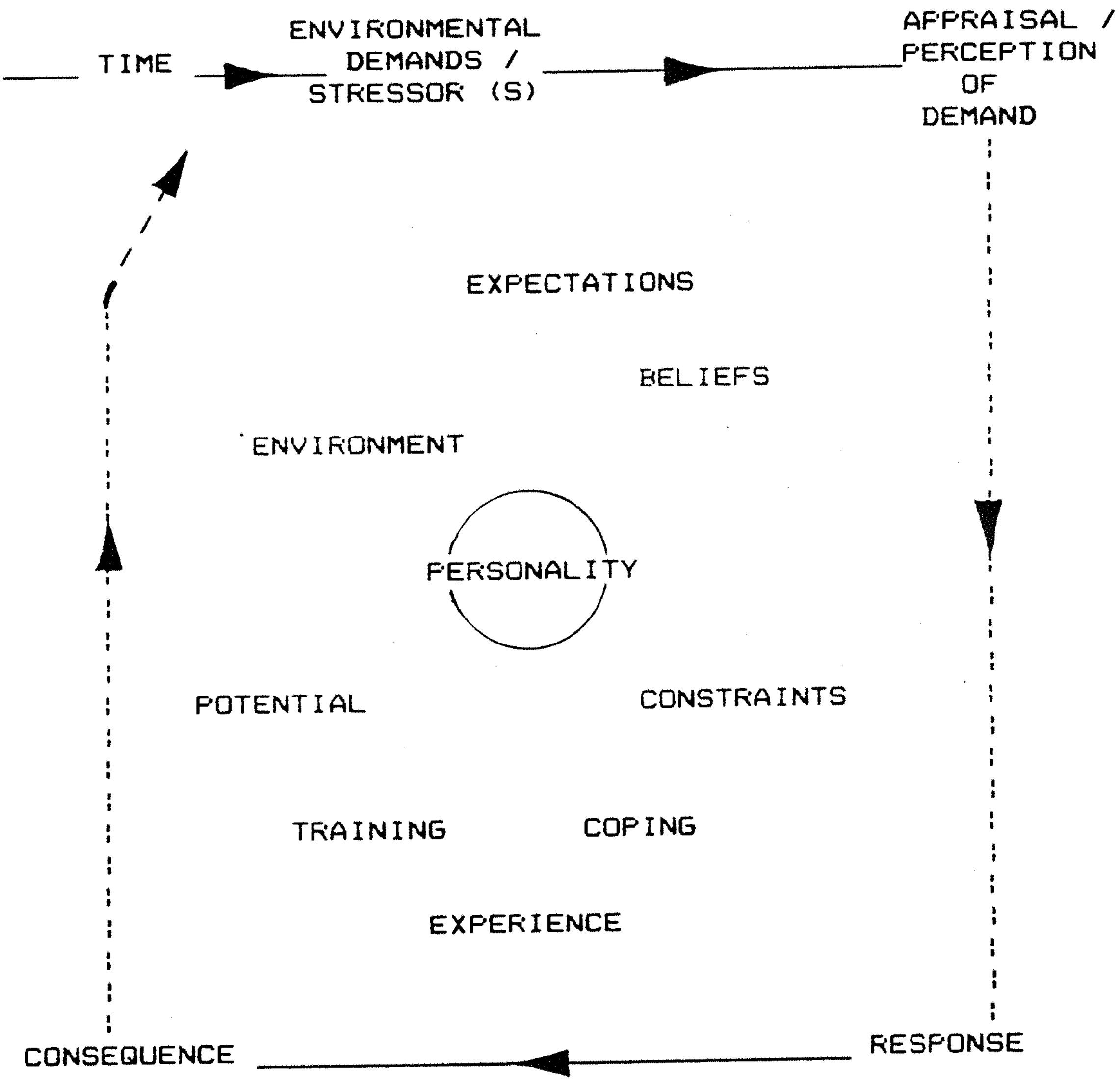
A Psychological Definition of Stress

Attempts to account for individual variations in response have led to an elaboration of the concept of stress, with the introduction of a psychological perspective and the specification of intervening or interacting variables. In these terms,stress has been defined as a transactional process between the individual and the environment. Personality factors such as intelligence, ability to learn from experience, coping dispositions, level of training and skills have all been considered important. McGrath (1970) and Mechanic (1970) both defined stress in terms of a "substantial imbalance" or "discrepancy" between the demands of the situation and the ability or capacity of the individual to meet them. Mechanic and Sells (1970) considered motivation important. The individual's beliefs, goals and value systems and the consequences for these of an ineffective response were seen as determining the nature and intensity of the individual's involvement in the situation and its relative definition as stressful. Mechanic suggested a definition which also takes account of the "socio-emotional" level of the subject, his confidence and esteem, while Sells and McGrath also highlighted factors external to the individual, including social pressure, demands and constraints relative to the freedom to choose between behaviours that are required, permitted and forbidden.

A Paradigm

McGrath proposed a four-stage sequence of events, incorporating the various aspects of stress which have been discussed, and in which time was regarded also an important parameter. This might be illustrated figuratively as in the model in figure 1.

Fig. 1 : A Four - Stage Model :



It seems clear that any definition of stress which fails to take account of the complex interaction between situation, response and the many possible intervening variables has limited applicability in reality. However, the model illustrated in fig 1, based on McGrath's four stages, incorporates the various parameters of stress already discussed in the definitions of stress : the objective or external demand or stress which may then be subjectively appraised as stressful, or not, depending on the balance between the demand and the subject's ability or capacity to meet it - his personality, including beliefs, values past experience and so on; the temporal aspects of stress are included in anticipatory worrying, planning and preventive coping; in the duration of stress; previous experience, and future learning. It is this four stage model which forms the basis of the present study.

Coping Behaviours

The way in which stress is coped with may be as important in determining the consequences as the stress itself. Coping may take place before, during and after the condition of stress, and is directed toward preventing, alleviating or responding to the consequences of stress. McGrath incorporated a feed - back loop into his conceptualisation, and regarded time as a important element, through which response and consequence were evaluated, leading to further coping behaviours. Thus man is seen as essentially active, adaptive and coping rather than merely passive or reactive. Monat and Lazarus (1977) defined two main categories of coping response : direct action, such as fight or flight, which alters the relationship with the environment; and palliative modes, involving defensive reappraisal, aimed at relieving the emotional impact of stress. Direct action might involve avoiding the consequences or meeting the demands at a tolerable cost. Palliative modes might alter the subject's perception of the demand, his capabilities, and / or the consequences. They might be intrapsychic, such as the use of denial and repression, or somatic, such as the use of drugs and relaxation.

Pearlin and Schooler (1978), in a study of potential strains in four major life roles, identified three groups of response : those which changed the situation; those which controlled the meaning of the event before it became stressful; and those which functioned to accomodate the stress when it emerged.

Coping Dispositions and Strategies

Since personality is thought to be relatively stable over time, some researchers have considered that a knowledge of underlying personality traits should facilitate the prediction of coping responses, and that these behaviours would be relatively stable from one stressful situation to another. A number of personality traits have been researched, including : ego control;conformity to group pressure; and coping versus avoiding tendencies. Findings have been contradictory at times and Cohen and Lazarus (1973), in a study of active, ongoing coping strategies in stressful situations concluded that psychological traits including coping styles showed limited ability to predict behaviour.

Multiple and Single Coping Techniques

Having identified a variety of coping strategies and dispositions, a logical question would seem to be whether subjects who use a single or preferred coping technique have an advantage over those who use a range of strategies. In this respect, the research evidence is equivocal. Steiner (1970) identified a group of subjects who showed a consistent preference for one of four coping responses, and a second group who showed no clear preference, but used a range of responses. When faced with a situation of interpersonal disagreement, the first group experienced less psychological stress, measured by galvanic skin response, than did the second group. However, Pearlin and Schooler found that the most effective response depended on the area / source of stress, and that people seemed to experience less stress where they had a variety of coping mechanisms in their repertoire. Burke and Belcourt (1974) identified five categories of coping response but found that responses were both effective and ineffective under different conditions. This would seem to suggest that a repertoire of coping responses was necessary. However, most studies use very different measures of stress as well as stressful stimuli, and Lacey (1949) found that the correlations between different measures of arousal used to indicate stress tended to vary both within and between subjects.

To a large extent therefore, the evidence relating to the significance of factors thought to have a bearing on outcome appears inconclusive, particularly in relation to aspects of personality. Similarly, whilst common sense would seem to dictate that subjects with a variety of coping behaviours at their disposal would have an advantage, the research evidence is equivocal.

Coping Outcomes

The degree to which harmful consequences can be mitigated, avoided or prevented would seem a reasonable criterion against which coping could be assessed. However, Monat and Lazarus (1977) cautioned as to the problematic nature of such judgements, suggesting that they depend on the time perspective taken, the level of analysis, for example, physiological, psychological or sociological, and the values held by the person making the judgement. McGrath also warned that normative dichotomies such as healthy - unhealthy are more complex than might appear at first sight. Apparently effective responses might have short or long-term secondary consequences. Wolff, Friedman, Hofer and Mason (1964), in a study of 31 parents of fatally ill children, found that denial was effective in reducing stress, as measured by levels of hormone secretion in the urine, only in the short term. Similarly, Janis found that the group exhibiting anxiety-free behaviours pre-operatively were the only group to show overt hostility and aggression toward staff post-operatively.

Burnout

Selye observed that continued exposure to stress reduced the capacity of the subject to adapt, so that resistance lowered, leading to exhaustion and/or death. In recent years, much research attention has been directed toward identifying signs and symptoms of this particular stage in the sequence in human subjects, for which the term burnout is popularly used. Interest has been directed toward subjects whose occupation, for example policeman or air traffic controller, or personality are thought to expose them to intense and recurring risk. Occupations involving the delivery of personal health and welfare services have received particular attention. Maslach (1976) suggested that people working intensely with the problems of others were particularly at risk of burnout. She identified patterns of response which included distancing, cynicism and loss of concern for others. Freudenberger (1975) described physical signs of burnout such as fatigue, headache and minor illness; behavioural signs such as loss of temper, over-confidence and lability; and psychological signs such as boredom, resentment and discouragement. Cherniss (1980) focused on motivation, defining burnout as "psychological withdrawal from work", so that what was once regarded as a calling becomes a job. Maslach and Jackson (1979) identified high personal cost including physical illness, frequent use of drugs and alcohol, and damage to personal and family relationships. Institutional costs included low morale, impaired performance, absenteeism and high turnover.

Successful Coping Strategies

Given the potentially high costs of failure to cope, much of the research literature also seeks to identify both successful coping behaviours and external resources available to the individual to potentiate coping. Hall (1972), quoted by Burke and Weir (1980), in a study of role conflict in university-educated married working women, found that behaviour which involved altering the expectations of others regarding appropriate behaviour for oneself (Type I behaviour) was positively correlated with satisfaction. Type III behaviour,which involved changing the quantity and/or quality of one's own behaviour to meet all expectations correlated negatively with satisfaction. Howard, Rechnitzer and Cunningham (1975) found less stress among groups who made greater use of techniques to build resistance to stress, such as sleep and exercise, and who talked things through with peers on the job.

Support

The availability of support, both at work and home has been extensively researched for its role in enhancing coping capacity or buffering the effects of stress. The evidence suggests the relationship is not straightforward. Payne (1980) suggested support can be divided into two categories : material, such as money, machines and equipment; and psychosocial, which might be cognitive, emotional or behavioural. Provision of support might be formal and/or informal. Formal provision,he suggested required rules, regulations and specialists and is usually feasible only in a relatively large organisation. Informal support is more feasible in smaller organisations, where size facilitates interaction and caring, but it also would depend on whether people want it to happen. Payne found that managers viewed as most supportive those aspects of their work environment that were psychologically close to them, such as the work itself, colleagues,boss and secretary.

Burke, Weir and Duncan (1976), in a Canadian study of informal helping relationships in work organizations found that status dictated to whom an individual would go for help, and that the prevailing ethos was one of non-involvement. In the same setting, Burke and Weir (1976) found the typical profile of the effective helper was someone younger, of the opposite sex and outside the work organisation. However, Firth (1982) in a study of supportive behaviour among nurses, found that such behaviours were perceived primarily in relation to personal rather than organizational support. Effective support was described in the context firstly of communication skills, in particular, attentiveness and positive, constructive responses, rather than position or experience; and only secondarily in terms of the action taken. However, it may be that any study which looks at the nature of support at work also needs to take account of the prevailing culture or organizational climate. Burke et al (1976) suggested that informal helping would be both more valued and more prevalent in a participative organizational system. Whilst the size and hierarchical structure of both hospitals and manufacturing organizations may militate against participation, stable ward or departmental teams in either field may promote it, given a favourable management ethos. However, the consequences of not feeling valued or consulted in a service industry such as a hospital may be more serious and more immediate in human terms, since it may be harder to care for others.

Caplan (1976) described the role of the family, indeed its primary function, as being to provide personal social support, providing its members with emotional, practical and material help in a network of reciprocal obligations and acceptance. Cobb (1976) conceived three categories of social support : relating to emotional support, the sense of being cared for; esteem support, that one is valued; and the sense of belonging to a network of communication and mutual obligation - social support.

The Efficacy of Social Supports

McKinlay (1973) in a study in Scotland, found that the availability of social networks influenced the use of health service facilities in pregnancy. Utilizers of services were found to have a less readily available network of supports, in which they were less tightly embedded, while the friends and relatives of under-utilizers functioned as lay consultants. This would seem to suggest that the availability of formal networks may make good the lack of, or complement, informal supports but does not displace them. Gore (1978), in a longitudinal study of unemployed married men found evidence of greater stress in men with lower levels of social support and concluded that social support appears to have a buffering effect. However, Mettlin and Woelfel (1974) suggested that a large social network may be counter-productive. They found that respondents with an extensive and diverse communication network experienced higher levels of stress than those whose network was less diverse amd less extensive.

Social Support and Illness

A number of studies have suggested that social supports have a moderating effect on life stress and illness. Lin, Ensel, Simeone and Kuo (1979) found a strong negative correlation between social supports and illness symptoms. In a British study, Brown and Harris (1978) found that the presence or lack of a close confidant was crucial for women who had to weather a crisis. Women with no confidant ran a risk nearly ten times greater than women who had a confidant. Finlayson (1976) in a study in Scotland, found evidence to suggest that the long-term favourable outcome following myocardial infarction was related to the availablity of an extended support network, including lay consultants. Nuckolls, Cassell and Kaplan (1972) found that where women had high life event scores for a period before and during pregnancy, those with high psychosocial assets had significantly fewer complications than women with low psychosocial assets. However, Schaefer, Coyne and Lazarus (1981) found their data questioned that social supports mediate the effects of stressful events. In a year long study, they measured separate aspects of social support, which they identified as social network, emotional, informational and tangible support. Their data showed that perceived social support and non - loss life events had direct and additive effects on levels of depression and negative morale. Emotional support correlated significantly and inversely with negative morale; informational support correlated with positive morale; and tangible support correlated significantly and inversely with negative morale and depression. They concluded that the concept and measurement of social support needed to be considerably refined.

It may be concluded that a simple Stimulus --> Response model will not suffice for research into stress. While exposure to certain sets of events may tend towards increased vulnerability, the final outcome in terms of individual gain or loss, mastery or suffering, will depend on the complex interaction of many factors, biological, physical, psychological and social.

Measurements of Stress

Stress research has concerned itself with the observation and / or measurement of stressful stimuli, of short-term physiological and other changes, and the supposed longer term consequences for individual well-being. McGrath considered these to be different classes of event, and the purpose of stress research to look for links between them. Such links have at times been difficult to discern. Levi (1974) suggested there was evidence for the effect of psychosocial as well as physical stimuli on neuro-endocrine function which can in turn influence a large number of physiological processes. It is thought to be through this pathway that stress and emotions which are coped with maladaptively can lead to the longer term consequences of physical or mental ill-health. It is the purpose of this section to look at measures which have been developed to quantify stress at opposite ends of this spectrum - stressful stimuli in the form of life events; and stressful outcome in the form of mental health.

Life Events

The usefulness of a life chart as a tool in medical diagnosis was advocated by Adolph Meyer as early as the 1930's. However, it was the work of Holmes and Rahe in the 1950's and 60's that stimulated interest in life events as a quantitative measure of stress and their possible use as a tool in establishing predictive and causative links, which would contribute to understanding the aetiology of various somatic and psychiatric illnesses. The two main methods of assessment of life events have been the use of a standard check-list and a semi-structured interview.

Although a number of checklists have been compiled, a major issue concerns the conceptualisation of stress : its measurement and meaning. Holmes and Masuda (1974) commented that although there was wide variety in the psychological significance and emotion that respondents attached to events in their Schedule of Recent Experiences (SRE), each event had in common that it made necessary or was associated with some sort of adaptive or coping behaviour on the part of the individual. In constructing the Social Readjustment Rating Scale (SRRS), therefore, the stressfulness of an event was conceptualised as the degree of change or adjustment necessary to accomodate to the event. The 42 items each had a weighting assigned to them, based on a group mean score calculated when the SRRS was developed. The weighting of all items experienced by an individual was summed to give a total stress score expressed as life change units (LCU's).

The SRE has been used extensively to investigate the association of life changes with illness. Early studies in particular were retrospective. Rahe and Arthur (1968), in a study of illness experience and life change, collected information from naval personnel for the previous four years, scoring their data in six month periods. They found that life change scores gradually increased over the two six-month periods prior to illness and remained elevated for the two six-month periods after illness. Wyler, Masuda and Holmes (1971) investigated the relationship between quantity of life change and seriousness of illness, where illness fell into certain defined categories and was of recent onset or recent exacerbation of a chronic illness. They found a highly significant positive correlation between life events and illness 'magnitude' for chronic illness only. Rahe and Romo (1974) compared the life change scores of survivors of coronary heart disease (CHD) with no previous illness, survivors with a history of previous illness and subjects who had died from CHD. Life change scores for all three groups were found to be significantly elevated for the six-month period prior to illness when compared to the six-month period a year earlier. Subjects who died from CHD had significantly higher scores than the other two groups, while survivors with previous illness had significantly higher scores than those with no previous illness.

However, retrospective studies have a number of short - comings. Brown (1973) criticised them in general for what he termed "direct contamination", where knowledge of the predicted variable, illness, might influence measurement of the independent variable, life events. Although causal or predictive links between both variables may exist, contamination of this sort would invalidate any claim to have estaolished a link.

A number of studies have been designed to overcome the problem of retrospective bias. In a retrospective study of multiple sclerosis in Israel, Antonovsky and Kats (1967) used matched controls, limited their questionnaire to items dealing with primarily objective, factual data and carried out a separate analysis of what they termed "serious crisis" data. Rahe (1972) reported two prospective studies. In the first,American naval personnel provided information on recent life changes, and illness information was collected later from medical records during a six - month cruise. Life change scores were found to be predictive of near-illness reporting. Highest correlations were found for older, usually married subjects. Although younger, single personnel reported more illness episodes, this was least well predicted by their life change scores. In a second study, of underwater demolition team trainees, mostly young and single, attention was paid to the kinds of illness, and particularly the severity, that subjects reported. Life change scores were found to best predict relatively severe illnesses, but not minor ones.

Other researchers have designed longitudinal studies to overcome problems of retrospective bias. Myers, Lindenthal, Pepper and Ostrander (1972) examined the relationship between life events and mental status, using a 62-item checklist. They interviewed subjects twice, with a two-year interval, although at each point in time, information was gathered retrospectively. They found a clear relationship between changes in the occurence of life events in the two-year period and changes in psychiatric symptomatology. Using a tighter prospective design, Theorell (1974) carried out a week by week study in Sweden, using a revised version of the SRE to calculate weekly life adjustment scores. These were related to weekly measurements of catecholamine output in urine. Significant positive correlations were found between catecholamine output and life change scores, but the effects varied with personality.

A number of criticisms of the selection of items in the SRE has also been made. Ander, Lindstrom and Tibblin (1974) cautioned that the maximum score obtainable by men in their study depended on their social situations, particularly whether they were married, had children and were working. Hence the scale might not be a very accurate measure for certain age groups, such as the young and elderly. Ander et al suggested calculating a percentage score based on the number of events applicable. Hudgens (1974) also criticised the items selected, suggesting contamination of results could occur using the SRE because as many as 29 out of the 43 items could be regarded as either symptoms or consequences of illness. In a similar vein, Dohrenwend (1974) identified three categories of events: those which are confounded with a psychiatric condition; those which consist of physical illness or injury; and those which are independent of either physical or mental health. He suggested that if one is interested in the aetiology of illness these classes of event should be kept separate analytically.

The Meaning of an Event

A number of researchers have criticised checklists in general for their failure to take account of the meaning an event might have to the individual, and hence the uncertainty whether like is being compared with like. A number of alternatives have been proposed, and meaning has been variously conceptualised as upset, desirability and threat over both short and long-term, as opposed to the amount of change / adjustment criterion used by Rahe and his colleagues. Johnson and Sarason (1979) criticised the SRE for ignoring the meaning and impact of life events on the subject and for the loss of individual variability when a group rating is used. They constructed a scale to reflect both the impact and desirability of items, which were rated on a scale from -3 to +3, yielding a total positive and negative change score. Brown also criticised the SRE for the vagueness of its items and identified two further sources of error which would invalidate research results of both retrospective and prospective studies - indirect contamination and spuriousness. He considered much life event research, by ignoring the meaning of events, to be vulnerable on both counts. Since the psychological meaning of an event cannot be avoided, he suggested it must be controlled for in the research design. Following a British study on depression and schizophrenia, he reported the development of a scale in which the class of event was recorded on a standard schedule, and the surrounding circumstances about which information was to be gathered were specified in advance, to avoid respondent and interviewer bias. The additional information gathered at interview was then used by a committee to rate each event for degree of severity based on the "contextual threat", in the long and the short term. Thus the meaning of an event was excluded at the interview stage and reintroduced in a controlled way at the rating stage. Brown and Harris (1978), in a study of psychiatric in- and out-patients, and a random control sample of women drawn from the same local population as the patients, found that only events rated severe on long-term contextual threat were related to the onset of depression.

Paykel and his colleagues conceptualised the meaning of life events in terms of upset, rather than change / adjustment. In a matched control study with depressed patients, Paykel, Myers, Dienelt, Klerman, Lindenthal and Pepper (1969) questioned whether certain events might be more significant than others in relation to subsequent mental health outcomes. Using a 61-item modified version of the SRE, it was found that depressed patients reported three times as many events as controls. However, the significant differences between the two groups were in the more frequent reporting by the patient group of events classed as exits from the social field (losses), and events classed as undesirable, rather than entrance events. In a further study, Paykel, Prusoff and Uhlenhuth (1971) found considerable agreement between subjects rating exit events as high for "upset"and entrance events as low. When the same events were rated and compared for both degree of upset and adjustment, (Paykel and Uhlenhuth, 1972), all entrance events were scaled significantly higher for adjustment than upset. They concluded that "upset" was a parameter more relevant to the consideration of events as a precipitant of depression, and that adjustment might be more relevant in considering psychosomatic disorders. In a further study to validate the 61-item scale cross-culturally, Paykel, McGuiness and Comez (1975) compared the ratings ascribed by two matched samples of American and English subjects. Overall, the two groups ranked events very similarly, and they concluded that a single scale would suffice for either population. English subjects tended to scale events more highly than Americans but to have experienced fewer in the last year. They considered that differences between the two countries on individual events could be understood in terms of known differences in life patterns.

Finally, a number of researchers have compared these various approaches to the conceptualisation and measurement of stressful life events. Ross and Mirowsky (1979) compared a number of life-event weighting schemes, including those used to measure for change and undesirability. They found that simply adding the number of undesirable events was the best predictor of ill health measured by psychiatric symptomatology. However, Dohrenwend (1973), in another study to compare different ways of conceptualising and scoring items, found that the weighted social change measure yielded the highest correlations with psychiatric symptomatology.

In summary, the scales that have been developed to measure stressful stimuli defined as life events can be divided into those which conceptualise stress as related to the degree of change or adjustment involved, and those which conceptualise stress in terms of its psychological impact -

upset, desirability or undesirability. A number of significant criticisms have been levelled at some of the studies, particularly earlier ones. In general, however stress has been conceptualised and measured, a correlation has been found with life events and a variety of health outcomes.

Measurement of Outcome - Mental Health Measures.

Although the studies on life events have shown that stress is implicated in a range of psychiatric disorders, the relationship is by no means straightforward. A better understanding of why some people seem to be more at risk, and how such risk is distributed in the community, together with the advantages of being able to identify high-risk subjects, in the interests of preventive medicine, has contributed to a focus in some research on the development of mental health rating / screening scales. There are a wide range of instruments for the measuremennt of mental health in existence, which seem to have been developed in one of two ways. Some have been developed within the context of epidemiological field studies, and have been designed and tested for their ability to discriminate mental illness in the general population. Other measures have been developed for use primarily as diagnostic and research instruments with known psychiatric patients and, although they may also discriminate "well" people, usually they have not been designed or tested for this. The advantage to stress research is that such tools provide a means of measuring one aspect of the outcome or consequences of stress.

Epidemiological Studies

Langner and Michael (1963) investigated the relationship between mental disorder and sociocultural factors in an urban community. Data was gathered using the Home Interview Survey, which included 120 mental health items. Rating I, made by two psychiatrists, was based on answers to these questions. This rating was then used in conjunction with sociocultural and demographic details to yield Rating II. Interview material was also used to rate respondents for "Gross Typology", such as neurotic traits. The same 120 items were also presented to two groups of "known well" and "known ill" respondents. Twenty two items were identified as clearly discriminating between the two groups at a level of confidence equal to or better than .01. These items also discriminated between non-patients and out-patients identified in the community sample. Langner (1962) reported the scale was developed to provide "an indication of where people lie on a continuum of impairment in life functioning." Respondents in the community were divided into well and impaired groups on the basis of Rating II. Using a cut-off score of 3 / 4 the scale was found to correctly identify 84.4% of respondents as impaired, and misclassified 1% of well respondents. However, Goldberg (1972) calculated an overall misclassification rate for Langner's 22-Item Scale of 20%,based on a 25% incidence of mental ill-health in the population.

Leighton, Harding, Macklin, Macmillan and Leighton (1963) used trained research assistants to gather data using a structured interview which included 75 health oriented questions, the Macmillan Health Opinion Survey (HOS). Interviewers also made their own assessment of the respondent's manner. Data was assessed by four psychiatrists to yield a joint evaluation of mental health status. The HOS was standardized on a group of psychiatric in-patients and a group of respondents from a farming community. Sixty-four rspondents from the main survey were also given a thirty minute psychiatric interview. These respondents were assigned two ratings, categorizing them as well, doubtful or sick on the basis of the psychiatric interview and the HOS score. Comparison of the two ratings yielded a misclassification rate of 14% if ratings of doubtful were excluded, but this would otherwise have been much higher.

Gurin, Veroff and Feld (1960) reported a nationwide American survey in which respondents were interviewed about major sources of satisfaction and dissatisfaction in the roles of marriage, parenthood and work. Experience of psychosomatic and anxiety symptoms was also recorded. Mental health assessments were made from a checklist of 20 items drawn from Macmillan's HOS and the Langner and Michael study. However, they decided not to use the checklist as a screening device as it had not been validated on a national population, performing instead a factor analysis on significant subgroups within the sample. They identified two factors which seemed to represent psychological expressions of dysfunction and two which represented somatization of distress. Amongst other things, they found that women expressed more symptoms than men on all four factors; and older people expressed more symptoms on the somatization factors than the young.

Crown and Crisp (1966) developed a 48-item self-rating scale designed for use as a diagnostic, prognostic and research tool. The scale, the Middlesex Hospital Questionnaire (MHQ), builds a symptom profile based on six subscales of eight items each. It was calibrated against a British population of psychiatric out-patients, and a normal group comprising medical and ancillary staff. The MHQ was developed primarily as a psychiatric tool rather than as a screening device for use on a community population. The authors did not report a misclassification rate.

Derogatis, Lipman and Covi (1973) reported on the development of the SCL-90, a self-report clinical rating scale, consisting of 90 items reflecting nine "primary symptom dimensions". The scale was designed as a clinical and research tool to tap symptomatic behaviour in psychiatric out-patients. It was not designed for use on a community population.

Goldberg (1972) reported on the development of a self - administered questionnaire, the General Health Questionnaire (GHQ), designed to identify non-psychotic psychiatric illness in an English population. The original questionnaire of 140 items was presented to three groups of 100 respondents each, identified as normal, mildly ill and severely ill. A factor analysis was carried out on 93 items selected for their ability to discriminate reliably between the well and severely ill groups, and on this basis a final list of 60 items was constructed. The questionnaire was administered in a number of versions of different lengths to over 6000 respondents. Of these, 650 were also given a psychiatric interview, to establish the questionnaire's validity and reliability. Goldberg reported an overall misclassification rate of 9.7% based on a 25% incident rate for the 60-item version.

Mental health / ill-health has been regarded as one indication of stress. Mental health measures can be divided into two types : those which have been developed in a survey of the general population for use as a screening device; and those which have been developed primarily on psychiatric patients for use as a clinical tool. Goldberg's General Health Questionnaire is one of the former, and has been developed using a British population.

CHAPTER 2

OCCUPATIONAL STRESS IN NURSING

Occupational Stress and Nursing

Nursing has in common with many other occupations that it is carried out within an hierarchical and bureaucratic organisation. Hence, its staff are likely to experience stresses not unique to nursing, including conflicts relating to the delivery of a professional service within a bureaucratic setting. Other stresses may be more inherent to the nature of the work itself.

Studies of other occupations have shown stress to be associated, among other things, with role conflict,overload and ambiguity (Kahn, 1973); workload and overload (Sales, 1970); low status, inadequate technical resources and stress related to responsibility for people rather than things (Parasuraman and Alutto, 1981); leadership style and organizational practices (Rizzo, House and Lirtzman, 1970); lack of variety, poor information and learning opportunities (Sarata and Jeppeson, 1977); and task level (Herrick, 1972).

Brief, Van Sell, Aldag and Melone (1979) and Kramer (1974) found role conflict in nurses associated with the discrepancy between their expectations of their role and those of their supervisors and the organisation. Pearlin (1962) found that the way authority was exercised, and the accessibility of authority figures, was related in some nurses to feelings of powerlessness; and Lyons (1971) found a significant correlation between role clarity and voluntary turnover, propensity to leave, work satisfaction and job tension.

That nursing is regarded as a stressful occupation is evidenced by a growing body of research literature, which describes both the sources and the results of stress. In a British study, Menzies (1966), reporting on a detailed study of the problems of student nurses, noted high rates of sickness, absenteeism, anxiety, depression and voluntary withdrawal from nursing. She concluded that these resulted from the psychological distress associated with the nature of the work, in particular learning to cope with illness and death; and from interpersonal and organizational strains within the system. Although many changes have been made in nursing since then, a number of more recent studies have also shown nursing to be stressful relative to other occupational groups. In two American studies, Colligan, Smith and Hurrell (1977) found a disproportionate incidence of mental health out-patient consultations among hospital and health care professionals including nurses; whilst Sterling and Weinkam (1976), in a study of the incidence of smoking by oocupation, found that nursing ranked 15th. out of more than seventy female occupations. In a British study of self- poisoning and self-injury, Bancroft, Skrimshire, Reynolds, Simkins and Smith (1975) found that, in women, nurses ranked among those occupations with the highest rates.

While the results of these studies suggest that nursing is a stressful occupation relative to others, most of the research and literature on the sources of stress in nursing appears to have emanated from the United States. A particularly common approach to the study of nursing stress has been to look at areas of nursing care in which stress is generally considered to be high, such as critical / intensive care nursing, and more recently, hospice and terminal care. Hay and Oken (1972) and Skinner (1980) documented a range of environmental, physical and psychological stresses in critical care nursing, including high standards of competence and autonomy, a heavy and fluctuating workload,responsibility for critically ill patients, interpersonal stress with other staff and with patients' families, and frequent deaths. Campbell (1980) reported similar stresses on a coronary care unit, but suggested that the more concrete problems were superimposed on the more pervasive, underlying problem of death anxiety, which was less readily acknowledged. Leatt and Schneck (1980) carried out a study which called into question the uniqueness of critical care stress. They found considerable agreement among head nurses from a number of specialties as to the sources of stress on their wards.

However, Stehle (1981) criticised much critical care research literature for a number of shortcomings, including the use of anecdotal evidence, lack of a theoretical base, failure to use objective measurements of stress or to make broad comparisons with other areas of nursing. She challenged the sometimes unquestioned assumption that critical care nursing is stressful, or more stressful, than other areas of nursing.

The findings of a number of comparative studies, in which stress is more carefully measured, call into question the inherent stress of critical care nursing, but suggest a number of factors which may have a mitigating influence. Duxbury and Thiessen (1979), in a comparative study of turnover rates, found identical patterns between adult and neo-natal intensive care and general infant care units. Considerable variations between a number of neo-natal intensive care units in different hospitals suggested local factors might be important, though these were not identified. Given the very few studies which have used objective measures of stress, one such was carried out by Johnson (1979), using a measure devised by Spielberger, Gorsch and Lushene, the State-Trait Anxiety Inventory (STAI), which defined two types of anxiety. State Anxiety was conceptualised as a transitory emotional state, which might vary in intensity and fluctuate over time. Trait Anxiety referred to relatively stable individual differences in proneness to anxiety and hence a tendency to respond to situations perceived as threatening with a raised State Anxiety. In a comparative study of the effect of anxiety on self-disclosure between patients and staff on surgical, medical, psychiatric and critical care wards, she found both types of anxiety to be higher among staff on medical and surgical wards than on the critical care ward, although the difference did not apparently reach the level of statistical significance. Possible reasons for the differences between these wards were not discussed. Although not all correlations were statistically significant, Johnson found a consistent trend toward an association between higher levels of anxiety and lower levels of disclosure.

In a comparative British study of staff from four intensive care units, four general specialties, three renal units, and a number of medical and a surgical ward, Nichols, Springford and Searle (1981) found high levels of satisfaction on all wards except one, which was known to be experiencing difficulties. There was broad agreement between wards as to sources of dissatisfaction, with most reported in relation to lack of support from superiors, reactions to mistakes,workload and feedback. On the unit known to be having problems they found poor relationships with medical staff, lack of sense of support and self-worth, a feeling of being treated badly when mistakes occurred and that the ward organization was seen as breaking down. They concluded that psychosocial factors including group cohesiveness, the structure and acceptibility of authority, and the quality of communication and support were as important determinants of job satisfaction as type of ward. Mohl, Denny, Mote and Coldwater (1982), in a study of two intensive care units and two general medical units found that one intensive care unit was significantly dissimilar from all three other units, with consistently more favourable scores on more than half the subscales. They concluded the only variable to distinguish this unit from the others related to staff support, and in particular to the attitude of the head nurse, who was known to openly recognise the stressful nature of the work, to encourage mutual support, and to respect the professionalism of her staff. In a six-month longitudinal study of stress, Parkes (1980a and 1980b) followed first year students in a British School of Nursing through two allocations to medical and surgical wards. She found significantly higher levels of anxiety and depression in students on medical wards, who also reported less satisfaction with their work. Parkes suggested that these differences might be accounted for by inherent differences in the nature of the work on the surgical and medical wards. Patients on the latter required longer periods of care, were less likely to improve, and more likely to die. She suggested that the "affective role" is more important on medical wards, but also it makes greater emotional demands on the nurse, with fewer tangible rewards.

The literature would seem, therefore, to suggest that a proper understanding of nurse stress demands that it be placed in the overall context of the job, including the ward and its organization, coping techniques and resources. Some studies, however, suggest that certain stresses may be inherent in the nature of the work, particularly in the need to relate to seriously ill and dying patients. The prevailing atmosphere of support or lack of it, and the attitude and leadership style of the nurse in charge of the ward seem to be significant factors discriminating "good" wards and "less stressed" wards.

The Affective Role

Quint (1973) described how students learnt to manage what could be regarded as the affective role in relation to dying patients. In an examination of the curriculum of five schools of nursing, she found that most courses focused on teaching life-saving goals and techniques. Students were taught to observe and report on physical signs and symptoms. Although most courses had some teaching on psychological care, there was no requirement for students to report on this, and the separation between classroom teaching and ward practice meant that the teaching often led less experienced students into conversational difficulties with patients. Students tended to underestimate the intense feelings of grief they would experience when they became involved with dying patients. Few found support from other staff, but turned toward classmates or boyfriends as a sounding board and for advice. Quint pointed to the tension that existed between the role and behaviour associated with feelings of grief, and the expected role behaviour of the "emergent nurse". More experienced students had well-developed strategies for handling such situations, which included contact and conversation management, guarding or avoiding tactics.

The need for the nurse to examine her own feelings and attitudes if she is to meet the psychological needs of the patient is emphasized in a study by Gow (1982) of trained graduate nurses. One of the most frequently reported unhelpful responses identified by these nurses was "Felt inadequate to enter into patient's problem because had not personally resolved the issue". Along with "felt guilty but could not communicate" and "felt pressured (within self) into doing things rather than coping with feeling elements", it was the most frequently mentioned response seen as unhelpful in situations involving dying patients.

Death as a Stressor

Medical and scientific advances this century have brought about considerable changes in the pattern of mortality as well as a reduction in mortality rates for significant parts of the population. It is no longer common, in this country, for a child to die before reaching adulthood, and most of us can expect to live not only longer, but also to a healthier old age. Together with increased geographic mobility and changes in the pattern of family living, these factors mean it is not unusual for an individual to reach middle age before he experiences his first personal loss through death of someone close to him. Kastenbaum (1977) stated that larger numbers of the population in this than any previous generation have little or no experience of death.

The Meaning of Death

In spite of modern man's increasing ability to exert control over his environment, Wahl (1965) commented that death remains the one area where he is ultimately powerless. Perhaps because the boundaries of death have been pushed back, in our culture we are able to talk of the death of a young person as "untimely" and "tragic", but to accept as more natural that of an old person. Kastenbaum suggested that we have a sense of the rightness of death, of there being "a first in line", which enables us to distance it from ourselves. Wahl suggested that this distancing and repression of death leads in adults to an associated magical thinking usually more typical of childhood. Many adults live their lives as if death will never happen to them, and equally hold onto a feeling that it can be controlled, that it is somehow caused, deserved or earned, and therefore is avoidable. Hence the need perhaps in staff and families to be sure that "we did all that we could", or the angry searching to explain "why me". It is perhaps in this sense that Feifel (1965) suggested that the critical factor for each of us will be "how each of us relates to the knowledge that death is certain", and that this will set the pattern of our lives.

Philosophies have attempted to rationalize, explain and remove the fear of death throughout time. Some, taking a religious or mystical view, see death as a doorway to another form of existence. Wahl regarded this approach as a form of denial, while Tillich (1965) argued that this approach must be based on an acceptance of the reality of death if we are truly to live. Carl Jung (1965) also argued that death was not a meaningless cessation, but without adopting a specifically religious viewpoint, talked of man's psyche as capable of reaching into "obscurities far beyond the scope of our understanding."

Other groups, like the stoics of ancient times, regard death as the end. This has been variously used to justify a "live for today" approach to life, and as the guiding principle behind the humanists' view of man's coming of age, his responsibility for himself. For others, however, the meaning of life and death is confused and uncertain. Doubtful belief and unfamiliarity, perhaps, conspire to make death into, what some writers have referred to as, the modern taboo. No culture remains static, however, and just as the nuclear bomb can force confrontation with the reality of death, so a growing body of literature about death and our manner of caring for the dying, highlights a reaction against the taboo.

Care of the Dying

Concomitant with an increasing ability to postpone death have come changes in the way in which death and dying is managed. Technological advances have led to the growth of new specialisms, and the expectation that the medical and nursing professions, the new experts, will use these skills to prolong life and cure the previously incurable. Intrinsically, however, death then becomes imbued with a sense of professional failure. Cartwright, Hockey and Anderson (1973) reported that over half of all deaths in the U.K. occur in NHS hospitals rather than at home, further distancing the experience of death for the surviving family. In 1984 and 1985 (OPCS Monitor) the picture was similar, with only 32% and 31% of deaths respectively occurring in private homes, and just over 58% in NHS hospitals. With the growth of nursing and rest homes to provide for the care of the elderly, it seems likely that the number of deaths in private homes will continue to decrease.

The implications for health-care professionals are twofold. Few will have had any contact with death prior to entering their chosen profession. Their attitudes, reflecting as they will, those of their families and of society in general, may be unhelpful and inhibiting, and this may be further reinforced by the prevailing professional ethos surrounding death. However, as more people than ever die in hospital, the care of the dying and the management of death become increasingly the province of groups of professionals - a specialism with its own mystique which serves to set them apart. Reynolds and Kalish (1974) suggested that the social and psychological costs for post-holders were high, involving social stigmatization; facing the holder with the need to deal with anxiety associated with reminders of his own mortality; and requiring him to deal with emotionally upset clients. Kasper (1965) identified one way of cooing used by medical students, in the development of counterphobic defenses, through which they desensitized themselves, if not to death, at least to "the symbols of death which most people find disturbing"; a training which stresses "scientific objectivity" and "inhuman perspective".

Many writers have recorded the isolation and conspiracy of silence which can surround the dying in hospital, as they become an uncomfortable reminder to staff of their failure to cure. Earle, Argondizzo and Kutscher (1976) suggested that in order to function effectively in meeting the needs of the dying, care-givers needed to examine their own attitudes to death. They must, said Kubler-Ross, be able to face their own dying with equanimity. In contrast to the isolation, Benoliel (1976) described very clearly the nursing role in caring for the dying : the nurse providing the patient with continuity of contact with at least one person who cares for him as a human being; with an opportunity to know, understand and participate in decisions; being a source of confidence and trust, concerned to understand the subjective meaning of the disease experience for the patient.

Much of the literature about death tends to make the assumption that death is stressful, and that this has been further increased by a variety of cultural, epidemiological and demographic changes over the last century.Givers of care to the dying are thought to be particularly vulnerable, therefore, because they are caught between professional expectations and their own and societies' attitudes to death.

Death Attitudes and Anxiety

Techniques for the measurement of attitudes and anxiety about death and dying were identified by Kurlychek (1978/9) as falling into one of four types : projective techniques, and physiological measures, both of which have tended to be used to assess subconscious attitudes or fears, and neither of which is easily administered; questionnaire and interview procedures, which tend to make interpretation and standardization difficult; and rating scales of various kinds. The latter two have been the most commonly used. Various factors or dimensions of death anxiety have been taken into account by researchers, including fear of dying, fear of death of self and of others. Typically, however, attitude toward death has been treated as unidimensional, in terms of fear, anxiety or concern, rather than as multi - dimensional, having perhaps positive and negative aspects.

Death anxiety and attitudes have been researched in a wide variety of groups in relation to a number of parameters thought to be significant. Feifel (1956) noted a religious trend among elderly male veterans who said death was most feared in old age, whilst Gibbs and Achterberg - Lawlis (1978) found that strength of religious belief was associated with a decrease in conscious fear of death. Feifel (1965) and Kubler-Ross both reported anecdotal evidence that nearness of death in itself was not associated with greater anxiety. They both found that subjects welcomed the opportunity to discuss openly the seriousness of their illness and their feelings regarding death. However, Hinton (1963) in a British study which matched seriously ill with dying patients, found that the latter group were more commonly depressed and anxious than the controls, and that depression was more common in patients who were aware that their illness might be fatal. However, the Gibbs and Achterberg - Lawlis study also used a matched control group. Cancer patients were found to score significantly lower on death anxiety, measured by Templar's Death Anxiety Scale, (DAS).

Lonetto, Fleming and Mercer (1979) administered the DAS to five groups - Canadian and Northern Ireland students, graduate nursing students, funeral service students and members of the Unitarian Fellowship, the groups being chosen to represent different experience of and attitude towards death which might be thought to influence death anxiety. Although a number of concerns unique to some groups were found, death anxiety was not significantly different between the groups. Lattaner and Hayslip (1984-5) similarly found no significant differences in death anxiety between subjects working in death - related and non - death-related occupations. McMordie (1979), in a comparative study of the DAS and two modifications of it, found that females scored higher on all versions than did males, whilst Lester (1984-5) found few differences between the sexes using the Lester - Collett scale. Templer, Ruff and Franks (1971) also found significantly higher scores in female groups but no differences in relation to age.

Assessment of attitudes toward death has, then, been undertaken in a number of ways - physiological and projective techniques being used when the focus has been on unconscious attitudes; and interview / questionnaire data and rating scales at other times. While these latter have been more commonly used, rating scales also have the additional advantage that they allow for comparison between groups. In general, the approach to measurement has been to regard attitudes toward death as negative and unidimensional.

Death Attitudes and Anxiety in Nurses

Campbell (1980), in an American study, suggested that anxiety about one's own death was "the most ubiquitous and intense personal response in those caring for critically ill patients". In a similar vein, Cundey (1981), in an article on nursing in Britain, considered that an "inability to cope with dying, death and bereavement is a major contributor to stress."

Folta (1963) found nurses perceived death as predominantly peaceful, controllable and predictable, "a natural termination of the life process". However, it was also perceived with a high degree of anxiety, and Folta suggested that the scales used tapped different aspects of death anxiety, relating to death of other and death of self. Hopping (1977) found that positive attitudes to death correlated with belief in a "supreme being". However, nurses who had opted for a course on malignancy were also found to have more positive attitudes to death than a control group, suggesting that attitudes may be an important variable in self - selecting for work with the dying. Stoller (1980), and Pearlman, Stotsky and Dominick (1969), found that more highly qualified nurses evidenced more unease in handling situations related to dying patients. Pearlman also found that staff with less experience of death showed less unease and a more open attitude toward handling situations involving dying patients. However, Denton and Wisenbaker (1977) and Hopping found a negative relationship between personal experience of death and death attitudes or anxiety. Ross (1978), and Gow and Williams in a Canadian study (1977), found that older subjects showed less death anxiety than younger nurses.

The degree to which death is a stressor for nurses remains uncertain and the evidence of these studies is conflicting. In general there has been a lack of agreement in the way measurement of death anxiety has been conceptualised, and researchers have been interested to explore different variables thought to influence experience of stress in this area.

The Hospice Concept

The hospice movement is concerned primarily with the provision of care for patients with a terminal illness, mostly cancer, but also neurological disease, where the emphasis has moved from cure to care. In the provision of a comfortable and relaxed atmosphere and environment, the aim is to achieve "something between a hospital and the patient's own home; combining the skills of one with the warmth and welcome, the time available .... of the other", (Saunders, 1977). Dying is accepted as a natural and dignified process, in which careful diagnosis and treatment of symptoms, including pain, are of prime importance (Baines, 1981), without recourse to dehumanizing, life-prolonging technology, (Ryder and Ross, 1977). A hallmark of hospice care is the creation of an atmosphere in which patients and staff are free to be open and honest with each other, (Manning, 1984). High standards of physical care and total patient care including emotional support and recognition of the needs of the family are all valued goals, (Saunders, 1977; Saunders, Walsh and Smith, 1981; Manning, 1984).

Stress in Terminal Care Nursing

The encouragement of staff involvement with patients and families, the high number of deaths and the high ideals all contribute to make staff potentially highly vulnerable to stress. A number of studies have identified a range of both satisfying and stressful experiences in terminal care nursing, though few have used objective measures of stress.

Vachon (1978) suggested that stressors external to the individual combine with motivations for entering the work to influence the experience of stress. She also commented that constant exposure to death can affect personal and social life and relationships. Thomas (1983) defined some of the satisfactions and stresses in this work, counting among the latter poor symptom control, helplessness in the face of death and repeated loss through death of patients one had become involved with. Moser and Krikorian (1982) found that staff identified care of patient and family as sources of both most stress and most satisfaction, while Donovan (1981) found that interpersonal conflicts accounted for 26% of the stress responses, a high proportion relating to patient and family care. Friel and Tehan (1980) conceptualised stressors as exogenous and endogenous. Among the former, they considered the nature of terminal illness, including distressing symptoms and dying patients; among the latter, high ideals, exaggerated expectations held by the nurse of herself and her role, the pressure of limited time in which to achieve goals, reminder of one's own mortality, and conflict between ideals and reality particularly when death does not fit with the accepted ideal.

A number of other studies have attempted to measure stress more objectively, with the use of a variety of rating scales. Wilson (1983) asked hospice nurses to rate 55 nursing tasks for degree of stress. The two areas rated most stressful as a group were those tasks which required staff to meet the emotional needs of patients, and duties relating to the death of a patient. Vachon, Lyall and Freeman (1978) compared stress on two active cancer treatment wards and a newly opened palliative care unit (PCU), using Goldberg's General Health Questionnaire. Staff on the PCU were found to have levels of stress twice as high as nurses on the other two wards, one of which was also new. Levels of stress were nearly as high as those found among a group of newly widowed women. In contrast, Barstow (1980) found that levels of stress, measured by Spielberger's State-Trait Anxiety Index (STAI), were lower than the established norms in a group in-patient and a group of home - care nurses. Stewart, Meyerowitz, Jackson, Yarkin and Harvey (1982), in a comparative study of stress in oncology, intensive care and cardiac wards and in operating theatre staff, found similarities between all groups on short - term stress such as physical and emotional tiredness. Oncology nurses, however, were found to experience more stress on long-term factors such as influence of the job on personal relationships than did other nurses.

Studies of stress in terminal care nursing can be divided into those which are anecdotal, tending to assume the work is stressful, and those which use objective measures of stress and hence lend themselves more readily to comparison with other areas of nursing. The findings are somewhat contradictory.

Care of the Elderly

The medical care of the elderly was established as a speciality in its own right following the introduction of the National Health Service in 1948. At that time, geriatric departments took over what Hodkinson (1975) referred to as a two-tier system of care, with higher standards and greater prestige in the acute care facilities compared to the relative neglect of chronic care areas.

The integration of each into one department of geriatric medicine led to a more unified approach and philosophy to the provision of care. This was reflected in the development of new and effective methods of care, depending on careful investigation, treatment and rehabilitation (Exton - Smith and Crockett, 1949; Amulree, 1951;), directed toward improving or maintaining abilities.

More recent trends toward greater emphasis on domiciliary and community care of the elderly seem a natural extension of this responsibility. A variety of facilities including day hospitals, out - patient clinics, home visiting and liaison with primary care teams, and of supportive community services, have developed with the aim of preventing hospital admission or minimising length of stay.

Against this background, Hodkinson emphasized the importance of the therapeutic environment in which the individual patient's wishes and goals have special importance; the creation of as home - like an atmosphere as possible, particularly in long - stay wards; a maximum of human interest and a minimum of regimentation. Friedenberg (1976), however, considered that much energy was expended on geriatric long - stay wards in denying the reality that they were places for patients to go and die. Accepting this fact, a second goal of patient care should be the creation of an environment in which the patient can die in peace and dignity. At the stage of terminal illness, Denham (1983) also emphasized good nursing care, that life should not be inappropriately prolonged, an open, unembarrassed attitude toward death and death with dignity. Thus, the role of the nurse on the geriatric ward is frequently seen as similar to that of the hospice nurse, meeting the total needs of her patients - social, psychological and physical.

Stress in Geriatric Nursing

A library search using the key words stress, nursing and elderly did not bring to light any studies on stress in staff caring for elderly patients, which suggests that it is not an area which has commanded research attention. One may of course hazard a guess as to what might be sources of stress : the comparatively low status of this area of nursing perhaps; the often poor resources; the lack of dramatic interventions and cures; the dead-end nature of the work; and the often mundane and routine nature of the care required for patients who may be cantankerous, unappreciative or unresponsive. Set against these less attractive features, geriatric nursing may be seen as an expandng and challenging field, offering opportunities for multi - disciplinary work in which the contribution of each member of the team is an essential and valued part; the satisfaction of working with the 'whole patient'; and the characters and wealth of experience of the elderly themselves. In the absence of any hard evidence, the dearth of stress research in geriatric nursing compared to an almost super - abundance of material on stress in intensive care nursing suggests that the nursing care of the elderly is generally assumed to be a low stress area.

Coping Strategies

Glaser and Strauss (1965) developed a conceptual framework which centred on the "awareness context" for understanding the interactions between staff and dying patients, and identified coping responses at several levels - psychological, interactional and organizational. Rules surrounding the hospital's policy about giving information to patients, and the organization of the delivery of care circumscribed and legitimated nursing behaviours such as avoidance and control of conversation. Nurses were considered to be most vulnerable in the "suspicion" and "open" awareness contexts. The development of "collective moods" helped staff anticipate and deal internally with patient death. This included various labelling and relabelling techniques, so that death was seen as desirable, inevitable, wrong or a relief. Knight and Field (1981) also noted that control of information was reinforced organizationally, by the division of labour on the wards, such that those who had the status and knowledge to answer patients' questions had least patient contact. This enabled staff to cope by maintaining a degree of distance from the threat of death and its implications.

Oskins (1979) identified four coping responses used more than 50% of the time by subjects in her study. The first tended toward "direct action" that clarified the perception of stress as understood by others, or used information acquired in previous similar situations. As the perception of stress increased, nurses' anxiety levels rose and staff increasingly reported the use of palliative modes of coping, including humour, rationalization, release of feelings and avoidance or suppression.

A number of writers, Hartl (1979), Stedeford (1984) and Vachon (1978) have emphasized that coping begins with a healthy concern for self, which includes acknowledging areas of personal vulnerability and stress. Hartl suggested a number of techniques which might be used to reduce stress, including exercise, relaxation and diet. Some of the coping strategies suggested require a combination of personal and organizational recognition of stress as well as a commitment to its alleviation. Warren (1982) outlined a stress management programme which incorporated sessions for teaching staff to recognise the sources and signs of stress, health maintenance, and stress - reducing techniques. Donovan (1981) recommended teaching of time management and conflict resolution strategies, use of relaxation and counselling. Others have suggested that high stress areas of nursing should be recognised in the pay structure, easy transfer to other wards, paid recovery days and, particularly popular in American studies, the provision of formal support groups. The use of support groups seems to be widely recommended as an interventionist and preventive method of coping which would allow and encourage the ventilation of feelings, teach better ways of handling interpersonal relationships, and enhance feelings of individual and group worth. Few studies, however, seem to use objective assessment criteria in recommending the benefits of group support. Among those that have, Epting (1981) reported that the use of peer group meetings reduced the number of paid recovery days used; Weiner and Caldwell

(1981) reported a reduced turnover in staff compared to the previous year, at a time when the hospital as a whole experienced an increase; and Sheehan, Donnell, Fitzgerald, Hervig and Ward (1981-2) found that the presence of social supports helped new nursing students cope with life changes and had a significant effect in minimizing accident / error rates.

Conclusions

Most of the research and literature on the sources of stress in nursing appears to have emanated from the United States. Many of the studies explore stress in particular, specialist areas of nursing in which stress is assumed to be high; typically, intensive care and cancer wards, where life and death issues are to the fore. Factors in the work environment, interpersonal relationships and patient care have been identified as frequent sources of stress, both in specialist and general areas of nursing. However, a high proportion of studies are anecdotal in nature, making an '*a priori*' assumption of high stress which is not always supported by the evidence of the relatively few comparative studies which have used objective measures. There is recurring evidence to suggest that staff, both medical and nursing, experience the care of dying patients as stressful, a situation which is commonly coped with by avoiding or minimising exposure to it. Various measures of death anxiety, which have been correlated with expected significant variables such as age,training and experience, have produced conflicting results. Levels of death anxiety among nurses do not appear to differ significantly from other groups, although unique areas of concern have been found.

Stress in Terminal Care

However, if the care of dying patients is stressful, then staff working exclusively in this area would be especially vulnerable, and one might expect to find significantly higher levels of stress. There are a number of American studies which describe the stresses and the satisfactions of nursing terminal cancer patients. Again, these are often anecdotal, and few use objective measures of stress. Where these are used, the evidence for high levels of stress appears equivocal.

The Applicability of American Research

The applicability of the results of American and Canadian research cannot be taken for granted when considering British nursing. Differences in training, in the organisation and delivery of health care, and in social attitudes and milieu, mean that the experience of stress may be very different. Comparisons, if they are made at all, must be made with caution and supported with evidence from British studies. What British research has been done tends to report high levels of stress, which has been related to interpersonal and organizational factors, to support and leadership style, and to the nature of the task. There is some evidence that British nurses, like their American counterparts, regard patient death as stressful and that they tend to cope by avoidance, minimising contact and controlling the conversation, methods which are often effectively supported by ward structure and organisation. However, such methods of coping would clearly be antipathetic to the goals of hospice care where open communication about death is encouraged. However, there is some research evidence that hospice nurses may find the care of dying patients no less distressing than their colleagues in other areas, though it would be premature to conclude that these nurses are highly stressed in the absence of other indicators.

Need for Research

In spite of the number of people who die in some form of institutional care, and the growth of units which specialise in caring for the dying, relatively little is known about the prevalence or nature of stress in this area of nursing. While an extensive body of literature attests to the stress inherent in this work, there has been limited systematic research, either in Britain or elsewhere. In general, in other areas of nursing care, where well - designed research has been carried out, previously held assumptions of high stress have not been consistently supported.

The last decade has witnessed a rapid and world-wide growth in the hospice movement. Research emenating from such units has made a significant contribution to medical knowledge about what constitutes good pain and symptom control, as well as to a better understanding of the psychological needs of dying patients and their families. Our understanding of staff needs, however, rests on largely untested assumptions about the source and nature of stress and how to manage it. Although there are a few American and Canadian studies which address themselves to this area of research, British studies appear to be virtually non-existent. There is a need for empirical evidence based on British research to test the validity of these assumptions and the effectiveness of stress management.

The Costs of Stress

The potential costs of stress are high, to the organisation, to staff themselves, and ultimately to the patients as well. There is evidence that stressful situations tend to be avoided, and the ultimate avoidance available to staff is to remove themselves from the work situation. This would be reflected in the level of sickness, absenteeism and staff turnover. Where these are high, so is the cost to the service, to the detriment of its efficiency and therefore the standard at which patient care can be provided.

Nurses who find care of the dying stressful may manage their anxiety by reducing patient contact, confining their care to meeting physical needs and the neglect of psychological needs. They may be less able to distinguish between their own needs and those of the patient, responding by jollying along patients and giving false reassurance when this is not appropriate. There is also some evidence that high levels of anxiety in nurses adds to the stress of hospitalisation for patients and adversely affects such factors as recovery rates (Revans, 1976). It seems likely, too, that nurses under stress will tend to see patients in categories rather than as individuals with their own anxieties and difficulties.

Future Developments

The current crisis in the National Health Service, with the continuing cut - back in funding and the low morale among nursing staff makes it more than ever imperative that a better understanding is achieved of the factors which contribute to nurse stress, and concomitantly to nurse work satisfaction. Nor are hospices, with their traditional supply of voluntary funding, immune from the problems which now beset the public sector service. As calls on voluntary funds become more numerous and diverse, their budgets too are suffering cuts and restrictions.

It seems unlikely that the rapid growth that has already taken place in the provision of hospice care will be able to continue, and certainly not at the same pace, in the present climate. Indeed, it may be that hospice nursing will also be hit by the staff cuts that are being experienced in the NHS generally. This has clear implications for the level of care that is provided, the ethos that surrounds it and the experience of stress among staff. It seems unavoidable that the provision of the as yet limited training facilities for this type of work, will increasingly have to vie for funds with patient care. In this situation, it becomes imperative to develop a better understanding of the costs to staff and the provision of appropriate back - up services, if the standards and goals of patient care are not to be put in jeopardy.

CHAPTER 3

METHODOLOGY

Introduction

As the review of the literature in the previous chapter has shown, there is a lack of soundly based empirical research to explore the often held assumption that caring for the terminally ill is stressful, or more stressful, than other areas of nursing. Much of the work that has taken place does not use objective measures of stress and is frequently anecdotal in nature. Although an understanding of the sources of satisfaction and stress, such as offered by Friel and Tehan (1980) or Thomas (1983) is important, they cannot in themselves be taken as sufficient evidence for the existence of stress. Among the few studies that have used objective measures, the results are somewhat contradictory, Vachon et al (1978) finding high levels of stress in a Canadian study, whilst in an American study Barstow (1980) found stress below the expected norm. However, differences in the social and cultural milieu and the delivery of health care make it unwise to generalise the findings of American and Canadian experiences to the British scene. Apart from the study by Wilson (1983) there appear to be very few British studies. The present study set out to fill this gap by looking at the experience of stress among nurses working in two different areas of nursing involving terminal care in two hospitals. Information was collected on social and professional data by interview, using a semi - structured questionnaire, and by standardised stress measures, in the form of pencil and paper ratings which were completed separately. It was hoped that a comparative study would yield evidence about the existence and nature of stress in this area of nursing, suggesting how the nursing task might be facilitated and stress, where it exists, alleviated.

I PROCEDURE

Two dilemmas presented themselves at the start of the study. The first was in relation to the size of the sample, which needed to be a manageable number, sufficiently large for meaningful analysis, but small enough for one person to carry out all the interviews. The second problem concerned the choice of hospitals. The National Health Service palliative care unit of Hospital 1 represented a natural choice both because of the nature of the work and the researcher's close working links with staff. Following a series of discussions with senior medical and nursing staff, agreement to proceed with the research was given, together with permission to interview staff while they were on duty. The Nursing Officer in charge of the geriatric unit on the same site agreed that members of her staff could be approached with a request to participate in a pilot study of the questionnaire.

Personal contact with a member of staff working on the geriatric wards of Hospital 2 who expressed an interest in the research led to a meeting with their nursing officer. Permission was negotiated to interview staff on the long-stay (continuing-care) and the acute assessment wards in the geriatric department, as well as night staff.

The Host Population : Hospital 1

At the time of the study, the palliative care team of Hospital 1 consisted of a total of 35 nursing staff, excluding the Nursing Officer. These included two sisters, staff nurses, state enrolled and auxiliary nurses. Twenty - two were day staff and thirteen were night staff. The latter group were employed to work exclusively in the palliative care unit. Although there were other units on the site, it was policy not to move staff to cover shortages elsewhere. It was also, at that time, part of the policy not to employ students and learners in the palliative care unit.

A decision was made to include the night staff as a separate group. It was the researcher's observation that, although regarded as an integral part of the palliative care team in Hospital 1, night staff lacked the variety of contact and potential support that was readily available to day staff, and seemed to function in some ways as a separate group. Additionally, night nursing has received very little attention in the literature and consequently there is scant knowledge about the stresses or otherwise for this group of nurses. However, it seemed possible they would be sufficiently different to warrant separate attention.

The Host Population : Hospital 2

The geriatric department consisted of 65 day staff including 8 sisters at the time of the study, and 42 night staff, including two night sisters. The department had seven wards, four of which were continuing - care (long - stay) and three acute assessment wards. There were also four nursing officers, one for the acute assessment wards, one for continuing - care and two night nursing officers, who had responsibility for the whole hospital. The nursing group included state registered nurses (SRN's); state enrolled nurses (SEN's); and auxiliary nurses (NA's). Day staff were appointed to work on either an acute ward or a continuing care ward. Although they could expect to be moved to cover shortages within their group of wards, in practice this was rare. There was also a policy of rotating day staff between the acute and continuing - care wards at approximately yearly intervals as a way of managing stress, although this seemed not to operate routinely. As it was thought that the experience of terminal care nursing on a long - stay ward would be different from that of an acute ward in several pertinent respects, it was decided to treat day staff in Hospital 2 initially as two separate groups.

As night staff from Hospital 1 were to be treated as a separate group from day staff in that hospital, a comparison group of night staff was required from Hospital 2. However, night staff in Hospital 2 were organised differently from both the other night staff group and their day time colleagues in Hospital 2. Although they regarded themselves as being appointed to one ward, in practice they were frequently moved to cover shortages on another ward within the department and on occasions outside the department. It was therefore not possible to treat night staff as assigned to one ward as with day staff. For this reason,it was decided to treat the 42 night staff within the geriatric department as one group and to disregard the ward to which they were (nominally) assigned.

A second constraint was placed on the selection of staff from Hospital 2 by Hospital 1's policy of not employing students and learner nurses. It was assumed that the nursing task on a teaching ward would be different in a number of important respects, such as the amount of direct patient contact / involvement for qualified staff. It was therefore decided to exclude the teaching wards within the geriatric deparment, two of which were acute assessment and two continuing - care wards. This left three wards, one acute assessment and two continuing care from which respondents were to be selected.

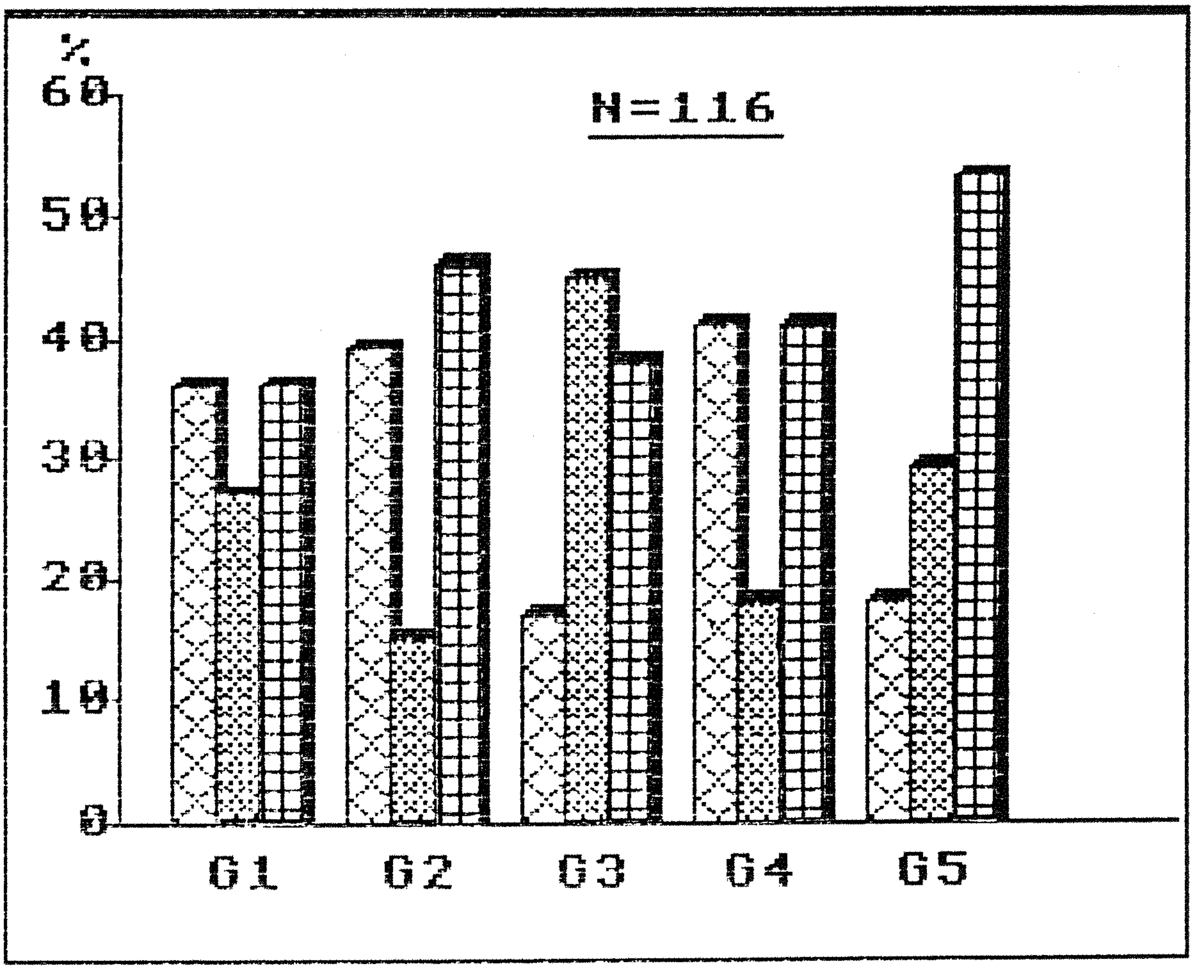
Selection

Based on the decisions described above, five staff groups were identified. Figures available for the staff groups of Hospital 1 and the continuing - care and night staff groups of Hospital 2 suggested that, apart from night staff in Hospital 1, it should be possible to obtain a sample size of 15 for each group, and 10 for the night staff group of Hospital 1. It subsequently became clear that it would not be possible to obtain a sample of 15 acute - assessment ward staff without including a teaching ward. It was decided, therefore to give priority in selection to staff from the non - teaching ward and to make numbers up to 15 from one of the teaching wards as necessary, excluding staff in training from selection. Day staff from Hospital 2

Fig. 2.

Percentage of Staff of Each Grade

In the Population Groups from which the Sample was Drawn :



Hospital 1

G1 : Group 1, N=22

G2 : Group 2, N=13

Hospital 2

G3 : Group 3, N=42

G4 : Group 4, N=22

G5 : Group 5, N=17

TOTAL = 116

▨ SRN

▒ SEN

▦ NA

were therefore finally selected from four wards, 2 acute and 2 continuing - care.

The host population for each group was further stratified according to qualification, in order that in this respect also the final sample should reflect as nearly as possible the proportions of qualified staff of both grades and unqualified staff in the population from which the sample was drawn. Figure 2 shows the population from which the five groups were drawn, and the break down of qualified to unqualified staff. Percentages were rounded up or down to the nearest whole number.

As can be seen from the size of each group, within the stratifications applied, random selection was only possible to any extent for group 3, night staff from Hospital 2. Within each group, the number of respondents of each grade necessary to reflect the distribution of qualified to unqualified staff in the host population was calculated. A dice was then thrown to determine the order in which subjects were to be approached until the required number for each grade in each group was obtained, including a reserve list in case of refusal. In the event, a total of 80 nurses were approached in order to obtain the intended sample size of 70. Nine nurses declined to take part, giving a refusal rate of just over 11% .They were :

1 day nurse from Hospital 1
4 night nurses from Hospital 2
3 acute ward nurses from Hospital 2
1 long-stay ward nurse from Hospital 2

In addition, the researcher failed to establish contact, beyond the sending of the introductory letter, with one night nurse from Hospital 2, by the approach used. Pencil and paper scales were not returned by four subjects, one from Group 2, 1 from Group 4 and 2 from Group 5. The difference in the rate of refusals between the two hospitals was not significant. The distribution of refusals across the groups suggests that the final sample may be regarded as representative of the population as a whole.

Of the 70 respondents who agreed to take part in the study, interview material was subsequently available for analysis from 69 subjects, and in respect of the standardised measures, from 65 respondents.

The research sample from Hospital 1 represents 71% of the total nursing population, day and night staff; and from hospital 2 the sample represents 56% of the geriatric nursing staff group, day and night staff from which the sample was drawn. Within each group, the size of the sample in relation to the total population from which it was drawn was as follows :

Group 1 - Hospital 1,15 Day staff - 68.2%
Group 2 - Hospital 1,10 Night staff - 76.9%
Group 3 - Hospital 2, All Wards,
15 Night staff - 35.7%
Group 4 - Hospital 2,Wards A and B,
15 Acute ward staff - 68.2%
Group 5 - Hospital 2,Wards C and D,
15 Continuing - care ward staff - 88.2% .

Initial Contact

All respondents were first contacted by a standard letter which introduced the research (Appendix 1). This was then followed by a telephone call, or occasionally by personal contact, when the nurse was on duty, giving an opportunity for questions, prior to being asked for a decision on their participation. If they agreed to take part, a date for the interview was arranged and the pencil and paper rating scales were sent to them. All but six of the paper and pencil scales were available for collection at the time of interview, and one was subsequently returned by post. In general, interviews lasted for between one and two hours, depending on the extent to which respondents expanded on their answers. On a number of occasions, an interview had to be ended prematurely due to unforeseen work pressures : once on the continuing - care ward; twice on the acute ward and once each for night and day staff in Hospital 1. It was not possible to complete two of these interviews, both on the acute ward; in one case repeated difficulties in finding a suitable time for the respondent were deemed unproductive by the researcher; in the second case due to illness.

II THE INSTRUMENTS USED

1. The Questionnaire

Development and Piloting of Questionnaire

The questionnaire was developed in consultation with palliative care medical and nursing staff and geriatric care nursing staff from Hospital 1. The pilot study was carried out during November / December 1983. Twelve nurses, representing all grades and including 3 night nurses, from the geriatric unit on the site of Hospital 1 were interviewed using the questionnaire. At the time of interview, they were also asked to complete a number of pencil / paper scales. These included Goldberg's General Health Questionnaire; Templer's Death Anxiety Scale items; and a life-events scale, based primarily on exit and loss events, as identified by Paykel et al (1969).

The pilot study showed that although good rapport was established, the interviews were longer than was generally acceptable. The wording and order of questions was satisfactory, but the use of a paper and pencil checklist for gathering information on life - events was unsatisfactory, since respondents interpreted items differently, seeking clarification from the interviewer.

It was therefore decided to gather the life-events information by interview rather than standard checklist, and to present the standardised stress measures for completion prior to the interview, including new material that became available from the study by Wilson (1983). The amendments were tested using a further group of five nurses. As well as a generally shorter interview time, the method of presentation of the pencil / paper scales was shown to be viable, the time taken to complete the tests ranging from 10 - 30 minutes. Reports from those involved suggested the time taken depended on whether the nurse was able to give the tests her undivided attention. Respondents who helped in the piloting of the questionnaire were not included in the final study.

The final version of the questionnaire (see appendix 2) was therefore designed to achieve a balance between gathering information that was as comprehensive as possible, but which would also be economical in use, particularly as regards interview time, which was a major constraint. The questionnaire was designed to collect information in the following areas :

a).demographic details;
b).material relating to the experience of nursing dying patients, including aspects of communication with and about the dying; experience of upset when a patient dies and ways of coping;
c).aspects of support at home and work,formal and informal;
d).other sources and signs of stress, such as job satisfaction, workload, and staff shortages.
e).life event stresses.

2.Measures of Stress

The range of measures used to assess the nature and effect of stress among nurses, with particular reference to the management of dying and death, can be grouped into five categories :

i).Self - Report measures of anxiety, situational stress, or upset:

Life Events Stress Score;
The Death Anxiety Scale;
The Nursing Situations Scale;
The Death Situations Scale;
Material Gathered at Interview Relating to Upset;

ii).Self - Report measures of the outcome / consequence of stress :

The General Health Questionnaire.

iii).Objective measures of the outcome / consequences of stress :

Sickness reports over one, three and twelve months,
Consultations with General Practitioner (GP) in the six months previous to interview;

iv).Ward statistical data from hospital medical records.

v).Interview data from semi - structured questionnaire.

Self - Report Measures

a). Life Events

Within the interview itself 13 questions, together with a number of supplementary questions about stressful life events were presented in the manner described by Brown and Harris (1978). The questions asked about the occurrence in the last year of events described by Paykel et al (1969) as either 1) undesirable and loss events, or as 2) entrance and exit events, such as birth, marriage or death. Additional information was gathered about the surrounding circumstances. The items checked were subsequently scored using the mean score of English respondents, reported by Paykel, McGuiness and Comez, (1975), for equivalent life events. (Appendix 2 and 9)

b).Death Anxiety

The level of stress experienced in nursing the dying might reasonably be thought to be related to the degree of anxiety about death / dying itself. Templer's Death Anxiety Scale (DAS) was used to measure death anxiety. The DAS is a 15 - item scale intended to reflect a wide variety of personal experiences, such as general concern about death, fear of corpses and fear of the process and manner of dying. Its design, validity and reliability were reported by Templar (1970). It has the advantage of being a widely used, tested and established scale, and has been assessed as having "the most normative data available of all death attitude measures" (Kurlychek, 1978). However, a search of the literature revealed few reports of the use of any death anxiety measure, including the DAS, with a British population. The one study found, reported by Lonetto et al (1979) incorporated a group of students from Northern Ireland, and four other groups of Canadian subjects. Results indicated more similarity than difference in the response patterns of all groups. However, in view of the political situation there, and cultural differences, the Northern Ireland group may not be representative of a U.K. or British population generally. However, as the DAS has been widely used and tested, it was decided to use it in preference to other scales. In its original form Templer's DAS was designed for a response using a true - false classification for each item. However, it was decided to present the scale in the Likert format tested by McMordie (1979). Each item was presented for rating on a scale from 1 - 7, but without the 'undecided ' option offered by McMordie. McMordie reports that the internal consistency of the scale was significantly improved in a Likert format and the scale was more sensitive in discriminating between high and low scorers. (Appendix 3)

c).Nursing Situations

Nurses were asked to rate a variety of work situations for the degree of stress associated with them. A modified version of the 55 - item scale, developed by Wilson (1983), with a British group of hospice nurses was used. Thirty - three items were selected to include a variety of tasks related to the management of various aspects of death / dying, and the emotional / psychological care of patients, both of which areas receive considerable emphasis in hospice philosophy. Additional items were chosen to reflect the overall range and content of the nursing task, and included items relating to general and administrative nursing duties. Respondents were also given space to include and rate any other task of their choosing. Rating was on a scale of 0 - 10, and respondents were also asked to indicate the frequency with which they dealt with each situation in their job, on a scale of 0 (never) to 3 (frequently), (Appendix 4). Items were grouped for analysis according to the nature of the task. The categories used are shown in Appendix 5.

d). Death - Related Nursing Tasks

Embedded within the 33 nursing situations were 7 items which referred to tasks specifically related to dying and death, which a nurse might be expected to meet and cope with.These items were treated as an additional measure of stress for the purposes of analysis,(Appendix 5)

e).Death Situations

Respondents were also asked to rate 20 situations, designed by the researcher to reflect the range and variety of deaths that the group of nurses in this study might encounter. Situations ranged from 'death of close relative, e.g. parent' to 'death of Russian leader Andropov', which it was anticipated would be rated, respectively, very high and very low, and included an 'any other' option. In effect, the first two items were expected to mark the boundaries of the scale for each respondent. The scale was from 0 - 10, and respondents were asked to tick those situations they had experienced. (Appendix 6)

f).Job Satisfaction

Nurses were asked to rate a number of statements, which were devised by the researcher, pertaining to job satisfaction, on a 7 - point scale similar to the DAS scale, (Appendix 7). Use of the statements as a scale was later abandonned, but individual statements have been used as an indication of job satisfaction.

Self - Report Measure - Outcome

g).The General Health Questionnaire

The 30 - item, shortened version of the General Health Questionnaire (GHQ), developed by Goldberg (1972) was used to assess the current level of psychological distress among nursing staff. The questionnaire was designed to be sensitive to recent changes in well - being, and has the advantage that it is a well - established measure, which has been developed and tested for use on a British population, including a general population. It was chosen because in addition, it has been shown to discriminate between well and non - well populations, and is easy to understand, use and score. It has also been used in at least two other studies which look at nurse stress, (Vachon et al, 1978; Parkes 1980a, 1980b) Goldberg reports on the testing of a number of versions of the GHQ, for which comprehensive test data are available. Using a cut - off point of 4/5, on a population of general practice patients, Goldberg reported an overall misclassification rate of 11% for the 30 - item version. As the measure was to be presented in conjunction with a number of other tests, a slight loss of accuracy was deemed to be acceptable for the saving in time, represented by choice of the 30 - item version. Respondents were asked to score each item according to their experience of it on a four - point scale ranging, for example, from 'more so than usual' to 'much less than usual'. The General Health Questionnaire (GHQ) scoring system, (0, 0, 1, 1) was used in the manner reported by Goldberg. (Appendix 8)

Objective Measures - Outcome

h). Illness Reports

The number of days illness reported over one, three and twelve months has been taken as an objective measure of general well - being among staff. It was intended to support this from records of staff sickness / absenteeism. However, as the information was recorded differently by each staff section, it proved difficult to extract the statistics in order to make meaningful comparisons, and the attempt was abandonned. Reliance therefore had to be placed on respondents' recollection of sick leave over these time periods, with consequent loss of some objectivity and reliability, (Appendix 2).

In addition, during the interview subjects were asked if they had consulted their GP in the last six months, and if so, the reason for the consultation. The reasons given were subsequently categorised according to whether they were probably, possibly or not stress - related by an independent GP. They represent his subjective opinion, and as such, might have been differently rated by someone with a different view of the relationship between illness and stress. (Appendix 12)

i).Statistical Data

Statistics relating to the number of admissions, discharges and deaths were collated for each ward in the study, together with bed occupancy rates, to gain an overall impression of activity on the ward, and the comparative exposure to the assumed stress of patient death, (Appendices 10, 11a, 11b, & 11c).

III ANALYSIS OF RESULTS

The results were prepared for computerisation and analysed using the Statistical Package for the Social Sciences, SPSSx (Norusis, 1983), in the first instance. For convenience, however, some additional analyses were run on micro - computer, using statistical programmes in Basic from the text by Cohen and Holliday (1982). Numerical data were variously analysed using, where appropriate, parametric or non - parametric tests. Where distributions approximated to normal, these included the One-Way Analysis of Variance, the T-Test and Pearson's Product Moment Correlation Coefficient. Where distributions were skewed or the sample size was small, the Mann-Whitney Test, the Kruskall-Wallis one way analysis of variance and Spearman's rank order correlation coefficient were employed. Probability levels reported on the Mann-Whitney test have all been corrected for ties.

Non numeric data were analysed using cross - tabulations; the Chi - Square (X^2) statistic was used to measure for the strength of association between variables. In reporting probability levels, Yates' correction has been employed throughout. Some primarily descriptive data was also available.

IV HYPOTHESES

A major assumption which this study sets out to test is that experience of patient death is stressful to nursing staff and will have consequences in terms of health and well - being unless dealt with appropriately. However, although staff may become close to and fond of patients it seems unlikely that patient death will have the same impact for staff as events which bear more directly on their personal lives and those of their families. Research on stressful life events has shown that these can have deleterious consequences for physical health (Wyler et al, 1971; Rahe and Romo, 1974; Ander et al, 1974), and for mental health (Paykel et al, 1969; Brown, 1973; Brown and

Harris, 1978). Therefore this study will first test the hypothesis that:

1. There will be a positive correlation between staff reports of stress and life events and that this will be particularly evident in relation to health measures.

In the literature on the sources of stress in nursing, there is considerable anecdotal material that patient death and repeated loss through death of patients is stressful to nurses, (Campbell, 1980; Cundey, 1981; Thomas 1983). Two studies of stress among hospice nurses which have used more objective measures of stress have shown contradictory results, (Vachon et al, 1978; Barstow, 1980). However, neither study used measures designed to tap for death anxiety. This study will therefore test the following hypothesis:

2. Nurses who are innately more fearful of death will experience greater stress in nursing situations involving death / dying.

Research on the effects of prolonged exposure to stress on staff involved in the delivery of personal health and welfare services suggests that these groups of workers are especially prone to burnout (Maslach, 1976) which is coped with by methods including avoidance and psychological withdrawal. This might indicate, therefore, that the more experience nurses have of death the more likely they are to begin to withdraw and to become innured to the associated stress. However, studies of the relationship between death anxiety and experience of death suggest a positive correlation between experience of death and death anxiety, (Denton and Wisenbaker, 1977). Pearlman et al (1969) found that nursing staff with more experience of death showed more unease and less open attitudes in handling situations involving dying patients, and Feifel (1963) found that doctors had a greater fear of death than medical students.

This would suggest that staff in the caring professions may not in fact become innured psychologically to the particular stress represented by patient death. The following hypotheses will be tested:

3.Nurses faced with death most frequently will experience greatest death anxiety.

4.Duties which require the nurse to deal with situations involving death / dying will be perceived as more stressful than other nursing duties.

The volume of literature on stress in some nursing specialties, such as intensive care, compared to the relative lack in other areas, suggests the possibility that not only number of deaths but perhaps type of death may be seen as affecting the experience of stress:

5.Certain deaths will be perceived as innately more stressful by some groups and not by others, and it will be possible to identify these.

6.Objective measures of the outcome of the subjective experience of stress will be directly related to the number of deaths experienced on the ward.

Both McGrath and Mechanic suggest that the experience of stress is related to an imbalance between the demands of the situation and the ability to meet those demands. Although one might expect trained nursing staff, therefore, to be better equipped than untrained staff, Pearlman et al (1969) found higher levels of anxiety about discussing death with dying patients among trained nurses. However, they also had more experience of death and were in favour of a greater training input in this area. It is therefore possible that nurses experience stress because they do not possess the appropriate skills for managing death / dying situations successfully, particularly in the area of psychological need. The study by Gow (1980) of trained nurses also tends to support this possibility, with respondents reports of feeling 'inadequate', 'unable to communicate' although wanting to and unable to deal with the feelings involved. In the context of this study, it is anticipated that Palliative Care (PCU) staff at all levels of grade, including NA's, will have had more opportunities for learning these skills, either by direct observation of good practice or classroom teaching. The following hypothesis will be tested:-

7.Trained nurses will be less stressed than unqualified staff, but across all grades PCU staff will be less stressed than nursing staff in the geriatric department.

Mechanic (1970) and Sells (1970) suggest that an individual's beliefs, goals and value systems contribute to the definition of a situation as stressful. The following hypothesis will be tested:-

8.Nurses with a strong religious belief will be less stressed than nurses with no religious belief, who will in turn be less stressed than nurses with uncertain belief.

Coping behaviours, repertoires and coping styles and their effectiveness, have received considerable research attention, although the results appear contradictory. Steiner (1970) found that subjects who used a single, preferred coping response were less stressed than those who used a range of behaviours; However, the results of studies by Burke and Belcourt (1974) and Pearlin and Schooler (1978) suggest that respondents who have a repertoire of coping mechanisms available to them, will be at an advantage in coping with the experience of stress. It seems, therefore that although there may exist a relationship between stress outcome and coping, the direction of the relationship is uncertain. The following hypotheses will therefore be tested :

9a). Staff who use a range of coping behaviours show less evidence of stress.

9b). Alternatively, staff who use a single method of coping will be less stressed.

In much of the literature on attitudes to death there is often an assumption, more or less implicit, that fear and denial of death is in some way destructive or harmful, (Kubler - Ross, 1970). Wolff et al (1964) demonstrated the longer - term benefits of a reality - based acceptance of death rather than denial. It seems likely therefore that the repression of death anxiety, for example in the form of denial or avoidance,will not only affect patient - staff interaction, but will also have deleterious consequences in the longer - term for the mental and physical well - being of staff themselves:

10. Staff who use denial or avoidance as a method of coping with stress will show greater evidence of death anxiety than colleagues who use any other means of coping, and this will further be shown both in the stress ratings assigned to situations involving death or dying and the longer - term health consequences.

In general, stress research suggests that social support is an important intervening variable in the perception and / or experience of stress and stress outcome (Caplan, 1976; Gore, 1978; Brown & Harris, 1978; etc). The results of some research, however question the role of support as a moderating variable (Schaefer et al, 1981; Mettlin & Woefel, 1974). However, these last two studies conceptualised support in terms of a network of helping / supportive relationships, whilst the Brown and Harris study found that vulnerability was related, amongst other factors, to the availability of an intimate and confiding relationship. Although by definition all the respondents in this study had work outside the home, in view of the nature of the hypothesized work stress, it was considered that the availability of the kind of relationship described by Brown and Harris might nevertheless be a crucial variable.

11. Nurses who have available support within an intimate confiding relationship will show less evidence of stress than staff who have no such relationship.

Although Howard et al (1975) reported that compartmental - ization of work and non - work life was associated with lower symptoms, it was considered that such compartmentalization by nurses in this study, who were having to manage emotionally distressing situations, would not be helpful. The better their own worries and stresses could be shared and understood across the boundaries between home and work, the less stress would be evidenced at work. The following hypotheses were tested:

12. Staff who feel able to seek support at work for home - related worries will be less stressed than those who keep home problems separate.

13. Staff who seek support at home for work - related stress will show less evidence of stress than those who keep work problems separate.

14. The highest levels of stress will be reported by staff who do not discuss their worries either at home or work; whilst the least stress will be reported by those who are able to discuss worries both at home and work.

It was the researcher's observation that day staff generally had a wider range and choice of support than was available to night staff. The numbers of night staff on duty on each ward were fewer than during the day, there was less contact with the night sisters who had responsibility for more wards, and other disciplines were not readily available. The following hypothesis was therefore tested:

15. Night staff will show greater evidence of stress than day staff and this will be especially so where deaths are high.

The research literature suggests that additional aspects of support which are also important in ameliorating the effects of stress include : availability and use of formal support groups (Epting, 1981; Weiner and Caldwell, 1981; Sheehan et al, 1982 - 3); and the relationship with, and support and understanding of, senior staff (Mohl et al, 1982; Nichols et al 1981). The following hypotheses will be tested:

16. Staff who do not attend formal support groups will show greater evidence of stress.

17. Nurses who receive support from senior staff will show less evidence of stress than nurses who do not receive, or who do not feel they receive, such support.

Finally, the esteem aspect of support, identified by Cobb (1976), was tested in relation to the respondent's role as a professional in the eyes of her colleagues :

18. Nurses who feel they have the esteem of their professional colleagues and feel appreciated at work will show less evidence of stress.

In addition to these hypotheses, the relationship between stress and a number of social and demographic variables will be tested against the anxiety / stress rating scales used. The variables will include age; marital status; presence or absence of dependent children; nursing qualification; number of years nursing experience; and number of years in present job.

CHAPTER 4

WARD OBSERVATION - PARTICIPATION

Introduction

Prior to carrying out the interviews, during May and June 1983, the researcher was able to spend a week on each of the three types of ward working alongside permanent staff as a nursing assistant. One night was worked in each setting. The researcher was therefore able to assist in or observe a comprehensive range of tasks constituting the nurses' and patients' routines. The tenor of the week on each ward was said by staff to be fairly typical, with Hospital 1 experiencing a recurring busy period.

During the three weeks, a record of experiences and impressions was kept which has been the main source of material for this chapter. It is not the intention to make invidious comparisons, but rather to look at how each of the wards functioned, and the ways in which they both resembled and differed from one another. For convenience, patients usually will be referred to as 'he' and nurse subjects as 'she'.

The wards were located in two hospitals, which were different from each other in several respects.Hospital 1, the palliative care unit was situated on a semi - rural site on the outskirts of town, offering a service exclusively to cancer patients drawn primarily though not completely from three health districts. Hospital 2 was in the centre of a town,offering a service to elderly patients in its health district. As cancer is predominantly a disease of old age, there was some overlap in the patient population of each hospital. Hospital 1 tended toward an older rather than a younger age group with patient referrals tending to peak in the 50 - 69 year old age range. However, patients referred to the geriatric department of Hospital 2 were by definition rarely under 65 and particularly on the continuing care wards were often in their 70's, 80's and even 90's. Some of these were likely to have cancer, possibly alongside other problems of old age.

Each of the wards was, therefore, part of a larger whole and was obliged to operate within the context of needs, policies and priorities of the community, as operationalised by the Regional Health Authority and the District hospital service. Thus, whilst some of the goals, difficulties and constraints were internal to the wards and susceptible to staff influence and control, others were imposed on them from outside.

It would be difficult and unfair to divorce the level of provision in the palliative care cancer unit and the geriatric wards from the relative emotional impact of each speciality on the community as a whole. Dying of cancer, with the attendant association of premature and painful death is and was more noteworthy than dying of old age. Voluntary cancer organisations come high in the league table of donations to charity. In the field of palliative cancer care such organisations, sometimes in partnership with the National Health Service, have been able to make a significant contribution both to the nature and the level of care, and the philosophy behind it. Along with the injection of funds to build and provide such specialist units came an extension of the philosophy of total patient care from the Hospice movement, with its emphasis on quality of life, and death with dignity; and accompanying it, a more scientific approach to, and experience of, symptom control pioneered within the modern hospice for this group of patients.

By contrast, the geriatric service has always tended to be the poor relation in the NHS in its share of the provision of resources. Not infrequently accomodated in buildings once the workhouse, and rarely top priority in the modernisation or provision of purpose - built facilities, its more limited resources have been further stretched, at a time when the NHS has to find a way of meeting the needs of an increasingly elderly population, by governmental cuts in expenditure. With the current trend toward community care, some areas are beginning to experiment creatively with provision for the elderly who might otherwise be in hospital. However, the level of needs of a substantial minority are likely to remain such that residential / hospital provision will remain the only viable means of meeting the amount of help required.

It is not the intention to imply that modern, purpose - built accomodation equates with better care; merely that how and where a community spends its money is a reflection of its priorities and concerns, and thereby perhaps indirectly of its support for the staff, as well as the patients, involved in various types of care.

Problems of Observer - Participation

The observation / participation weeks were arranged, at the request of the researcher, in consultation, primarily, with the nursing officers concerned, following a departmental meeting with the ward sisters attended by the researcher. Selection of the wards within the geriatric department was left entirely to the nursing officers, in consultation with their staff. It was agreed only that the wards should not have pupil nurses.

At this stage, several members of staff were expressing an enthusiasm and interest in the relevance of the research to their own needs within the department and were eager to co-operate. However, this may also have made it more difficult for them to express openly any doubts or reservations about allowing an outsider to see them at work. Although the same may have been true for the palliative care unit, where the researcher was a working member, in a different capacity, of the team, the fact that nursing staff knew the researcher was more likely to have made it easier for the palliative care team to accept someone who was not an outsider on this ward. Additionally, the palliative care nursing team were very used to interested visitors coming to work alongside them on the ward and this must have made it, not only easier to accept, but also easier to know how to involve the researcher.

In practice, there was some reservation and uncertainty from staff on the geriatric wards as to the researcher's presence. The planning meetings had taken place with the nursing officers and ward sisters, and it was the latter who conveyed to staff the explanation for the researcher's presence. It was therefore her understanding and acceptance which influenced the researcher's reception by the ward staff, and her presence on the ward at the start of the week which facilitated integration.

On the continuing care ward, the sister was on duty when the researcher arrived, and took responsibility for introducing her to the team and explaining the work of the ward. The researcher was given an opportunity to explain her presence and discuss her involvement on the ward. It was possible to re-emphasize the wish to become as actively involved as was feasible in working alongside staff, rather than to stand around observing, which would be,no doubt disconcerting and threatening to staff and patients. Staff were active in suggesting help with nursing tasks and anxious to provide the researcher with as wide a range of experience as possible. Thus, while sister made the initial suggestion to help with washing and dressing patients, and later with bathing, nursing auxiliaries also began to suggest help with feeding or toileting, and the researcher was gradually trusted to do more on her own. The process of integration and acceptance was further helped when sister invited the researcher, on the first morning, to talk about her own unit and work to staff over coffee, opening the possibility of a two - way exchange of experiences and difficulties, which subsequently became less formal.

By contrast, a staff nurse whom the researcher had not met was in charge of the acute assessment ward on arrival. She seemed very unclear about why the researcher was there or what to do with her, although she had been expecting someone who was coming "to observe what we do". The researcher sat for some time at the edge of the team while staff discussed and allocated nursing tasks, but was not introduced to the team and consequently there was no opportunity to explain her presence at that stage. The researcher having explained that she hoped she could be used as an extra pair of hands rather than merely observe, was taken onto the ward to help with breakfast. When the ward sister came on duty later in the day, the researcher was taken on an introductory tour of the ward, talking about their facilities, goals and difficulties. The researcher was given the freedom to decide what she wanted to see and to make suggestions as to what would be interesting or useful. However, the researcher found the idea of active participation more difficult to convey and frequently felt superfluous. As there was no formal introduction to the team as a group, the researcher had to introduce herself and explain her presence to each individual as the opportunity arose, and likewise had to actively search out opportunities to participate or make herself available. Consequently, much more time on this ward was spent in negotiating a place in the team, and it was not until the end of the week that a sharing of views and experiences began to take place.

By contrast, the researcher's experience on the palliative care ward was much easier. Firstly, because she was already known well to all members of staff as part of the extended / ancillary care team and therefore did not pose a threat as an outsider. Though junior nursing staff were not actively consulted as to whether she should work with them on the wards, they were clearly pleased that the researcher should be sufficiently interested in their contribution to the teamwork to want see it herself. Secondly,the team as a whole,and the nurses in particular, frequently had visitors from a variety of professional backgrounds, who came to learn by working as nursing assistants alongside them. Therefore they were more used to enabling an unqualified and inexperienced person to fit into the nursing team, showing them the ropes, and helping them with the unfamiliarity of the tasks. There was moreover, a limited blurring of roles on the palliative care unit. Some tasks such as talking to patients and families were not the exclusive province of any one discipline but would be performed by whoever was either available, felt able or had the relationship or appropriate knowledge. Other tasks, though differentiated by role would occassionally be performed by others because they were the nearest and most available. Thus, although not an every day occurrence, it was not unknown for the doctor or social worker to fetch a commode from the sluice, help with feeding or accompany a patient to the toilet.

Observer Bias

As a participant - observer, the aim was to observe, experience and record facts and feelings in an objective a way as possible. In practice, it was extremely difficult not to make value judgements, particularly having certain loyalties to one hospital and a commitment to its practice and philosophy. The experience of working on these three wards highlighted for the observer - researcher some of the values and beliefs by which she worked. The suspension of value - judgement was not uniform. Some things it was possible to tolerate which in other circumstances but similar settings, would have been abhorrent; other things made one uncomfortable to observe; some things it felt possible to question and others not. The different ways in which one observed and understood, or did not were undoubtedly due to a variety of influences : personality; professional background, training and experience; life experiences; work pressures and philosophy.

Nurses, both because of their uniform and their training, are sanctioned to cross the usual boundaries of physical closeness in the performance of their duties, often carrying out unpleasant or very personal tasks. Perhaps because of both personal and professional experience, the researcher found it less difficult to cope with the physical aspects of caring than she had anticipated. While there were some tasks that were not enjoyable, there was nevertheless a sense of achievement in having been able to carry them out - tasks such as bathing, feeding and toileting - and surprise that patients so readily allowed her to do it. Many aspects of the nursing role however are an extension of the mothering role, and all humans carry with them and share a common fund of the experience of being mothered: and in the case of many of the patients and of the researcher, also the complementary role of mothering. However, her acceptance by patients was undoubtedly aided also by the practice followed on all three wards of giving the researcher a white coat to wear, which became her uniform and in a sense perhaps passport to acceptance, although she also took the opportunity to explain to patients where possible why she was working on the ward.

The researcher was also surprised at her ready acceptance, at the time, of the practice on the geriatric wards of sometimes not putting underpants on patients during the day - a practice that in the role of a relative she had found particularly abhorrent, and, indeed demeaning. However, the difficulties facing staff where there are perhaps 17 out of 20 patients needing some help with toileting and only three staff available, are understandable.

It was also difficult as a participant - observer, coming with some knowledge of alternative approaches to patient and family care, and with a different professional training and perspective of people, to find others working in very different ways. It was difficult to hear patients responded to in terms of labels - the stroke in bed nine; that very little time was spent on the acute ward in getting to know the patient or in trying to understand why she might be difficult; and that very little time was given to relatives, to talk to them or to explain what was happening. At times staff were naturally rushed and had to do things quickly, and a difficult or demanding patient could cause extra work or problems for staff. Nevertheless, this happened less on the palliative care ward, where the work pressures were at least comparable to those on the acute ward. The difference seemed, therefore, to be one of expectation and perhaps lack of training in some areas. For example, on the acute ward the mornings appeared very rushed, but the afternoons, when visiting was allowed, were very quiet. However, even in the afternoons, when it would have been easier to spend time with patients, this did not seem to happen very often. Staff also seemed to experience difficulty in knowing how to approach families, and this was usually regarded as the task of the senior nurse on duty. Nevertheless, staff seemed aware of difficulty in this area and in the interview talking to patients and families was often mentoned as a gap in training.

The Ward Environment

Hospital 1 - The Palliative Care Unit

Hospital 1 was one of a number of similar units, purpose - built by the National Society for Cancer Relief in the 1970's and handed over to the National Health Service (NHS), which took responsibility for staffing and running costs. Charitable support was evidenced both by the high material level of the original provision, and the continued expansion of the existing service,and the provision of new facilities, for example in the areas of day - care and education. It comprised a single - storey building with 25 beds arranged in four bays of five beds and five single rooms. The hospital was sited in a semi - rural position, on the edge of a south coast town, in the grounds of a geriatric hospital. It was one of a growing number of similar NHS units, which espoused the hospice philosophy in offering care to patients in the terminal stages of illness. Unlike other hospices, Hospital 1, by the time of the study, was caring exclusively for cancer patients. Most of its patients were drawn from the three surrounding health districts, through referrals from hospital physicians and general practitioners.

Goals of Care

Good pain and symptom control were a top priority, together with support in its broadest sense, for patient and family, with a view to maximising the quality of life that remained to the patient, and to enable him to die with dignity,in his own way. Contrary to expectation, this did not always mean dying in a peaceful and accepting fashion, and although more difficult for staff, the ones they reminisced about were often those who had fought in their own way to the end. There was a strong rehabilitative input, which enabled many patients to return home for varying lengths of time, often more mobile, painfree and able to participate in family life than had been possible prior to admission. Drawing from the hospice philosophy of care, great importance was attached to recognising and treating each patient as an individual, and also as part of a family. In practice, this meant that each patient was greeted by name at the door of the unit on arrival, by a member of staff who would then spend time with the patient and his partner, helping the patient to settle in and feel welcome, to relax and allay some of his and his family's fears. The importance that was attached to not rushing a patient through a bath or dressing when he wanted to talk about his illness and anxieties was implicitly supported by the staffing levels, and recognised by the nurses in the way the workload was shared between them. Enquiring after the whereabouts of a nurse, one was as likely to be told that she was "sitting with Mr.W." as that she was doing his dressing.

Hospital 1 specialised in pain and symptom control. Patients, male and female, were admitted where appropriate, for a two - week programme of assessment, treatment and, rehabilitation; family relief; and terminal care. Patients might range in age from 18 years, upwards. Although nurses might care on any one day for patients of both sexes, the bays were not mixed - sex.

Staffing
At the time of the study, the multi - disciplinary team comprised 2 full- time consultant physicians; a part - time clinical assistant; nursing officer; 2 ward sisters; and a team of thirty - three state - registered, enrolled and auxiliary nurses to provide a full - time equivalent nurse : patient ratio of 1:1, over 24 hours. There were no student / learner nurses. Other staff included a part - time chaplain; 2 part - time social workers; part - time physiotherapist and 2 aides; full - time occupational therapist and 2 aides; together with reception, clerical and house - keeping staff. In addition to in - patient care, a team of 5 home - care nursing sisters provided support, advice and a link with the unit for approximately 70 patients currently in their own homes. Up to 8 of these patients might also attend the unit for day-care once a week. The home - care sisters were not included in the study.

The Patient Population
This ward had the most beds and the best staff : patient ratio, although unlike the other wards this included night staff. The workload fluctuated depending on how mobile and self - caring patients were. During the observation week, there were 20 patients, rising to 23 and then falling to 21 by the end of the week. Of these, only one was reasonably mobile and self - caring. Three were expected to die and required two - hourly turns, and during the week 6 others

began to deteriorate, and later died. During the week there were 4 deaths and 7 new admissions, both of which add to the nurses' workload, including time spent with relatives explaining procedures. The week spent on this ward was by far the busiest of the three : nursing staff had not finished washing, bathing and carrying out other necessary patient care by the end of their morning shift (1.30 p.m.), something which never happened on the other two wards, and which those staff when asked could not understand. Staff felt that the week was not entirely typical of the workload, although they regularly experienced similar busy times.

The Environment

Patient accomodation was light and spacious, giving onto a pleasant garden area equipped with garden furniture and children's play equipment. The building was designed to incorporate two internal planted courtyards, providing additional interest and light. A large day area was furnished with television, stereo and fish tank. The unit was carpeted throughout, and there were numerous pictures and plants around, with the aim of creating as relaxed and homelike an environment as possible. A light and pleasantly furnished room was available for staff coffee and lunch breaks, and at the time of the study was also used to give privacy to families following bereavement. Kitchen and canteen facilities were shared with the rest of the hospital, but the unit also had a small kitchen of its own, and a tea - bar run by volunteers, adjacent to the day area. Pharmacy and other services, including test and additional treatment facilities, were provided as necessary by the main hospitals in the nearby town.

Hospital 2

The geriatric department at Hospital 2 constituted part of a comprehensive range of facilities, centred on two large hospitals in a second town, providing for the medical care of the elderly within the NHS, for that Health District. Additional non - acute beds were available in local cottage hospitals. At the time of the study, the geriatric department consisted, in practice, of seven wards offering in - patient facilities, a day centre and out - patient clinic, for which two consultants had overall responsibility. A waiting list operated for the three acute assessment wards and the four long - stay wards, which had 71 and 80 beds respectively. A home assessment was offered by the consultants where necessary. Together with the other hospital, the department served the whole of the Health District.

The hospital was sited in the centre of the town and had developed on both sides of a main road, having, therefore, an east and west wing. The main hospital was on the western side, and the 3 acute - assessment wards were to be found here. The 4 continuing - care wards were located in the east wing, in what were originally isolation wards. There was some transfer of patients between the geriatric department and other specialties in the hospital, between the acute and the continuing - care wards within the department and in other hospitals, and between the department and the community - to patients' own homes,and to private and Local Authority residential accomodation.

The Acute Assessment Wards

The primary goal of the acute assessment wards was the careful diagnosis and treatment of elderly patients at an acute stage of illness, with a view to rehabilitation and return to the community. The more visible presence of medical and ancillary staff underlined the greater treatment orientation, on these wards. In addition to the two consultants, there were, at the time of the study, a registrar and junior houseman, physiotherapist, occupational therapist and social workers available at various times on the wards, although none of them worked exclusively on any one ward. Nursing staff comprised a nursing officer, and each ward had at least one sister, state registered, enrolled and auxiliary nurses. Two wards had student or learner nurses. Each ward had its own housekeeping staff and ward clerk. Each consultant held twice - weekly ward rounds, and there was a weekly multi - disciplinary meeting. The two wards taking part in this study will be described separately.

Ward A - The Environment

Ward A was a detached, single - storey building, situated at the perimeter of the hospital. Because of its location, it was only occasionally used for emergency admissions, such as heart or stroke cases. These were usually admitted to one of the other two wards, which were situated near to resuscitation facilities. The ward was located in what was previously a G.P. unit for mothers and babies. It was consequently modern, light and airy, with plenty of space in bathrooms and toilets. It had 20 beds, including one single room, which was used generally for more ill, though not necessarily dying, patients. Two beds were used to provide shared - care on a month in / month out basis. A large day room at one end of the ward was equipped with television, armchairs and tables, at which patients were encouraged to sit for meals. This room led onto a patio area. The room was also used for those patients receiving physiotherapy. Additional facilities on the ward included a relatives room and a self - contained flat, which was occasionally used as part of a rehabilitative programme. The latter was sometimes used by staff for coffee or lunch breaks, particularly if they wanted to smoke. Otherwise breaks were generally taken in sister's office, which although a reasonable size, was adjacent to the ward, with limited opportunity for privacy and relaxation. There were no students or learners on this ward.

The Patients

While patients on this ward often had similar disabilities to those on the continuing - care ward, there was a wider variation in the degree of incapacity. A substantial minority, eight, were virtually self - caring and had been admitted from home with a variety of problems, or sometimes several minor problems, which were troublesome rather than incapacitating at that stage - for example, blood pressure, fainting attacks and falls, dribbling incontinence and other urinary or bowel problems or a suspected cancer. All of these were expected to be discharged to their own homes and had been admitted for investigations. They needed no rehabilitative input. A second group of patients was rather more incapacitated, often with similar diagnoses which had been complicated, for example, by the effects of a stroke. These patients were generally expected to be able to return to the community and received most of the rehabilitation on the ward,both to maintain their current capabilities and to improve or restore others. A third group of patients, 3 in all, needed more help than one person could give and would not be able to return home. They had either been placed on a waiting list for a long - stay bed or were likely to be, and this might be in the same hospital, another hospital nearer their own home, and in some cases to a private or local authority home for the elderly. This group was fairly frail, unable to stand alone, transfer, wash or feed without help. There were 18 patients at the start of the observation week, and during it, one admission and one death.

Ward B

Ward B was a large, traditionally built ward on the first floor of the main hospital building. It had been divided so that its 24 beds were arranged in two side wards of six beds, with a single room and a number of offices on either side of a corridor. This led to a larger main ward, where the more ill patients were nursed. In general, moving to a side ward indicated that a patient was progressing well, whereas the single room was used for dying patients when possible. Ward B was the acute male ward and the only exclusively male ward in the study. Because of its central location, it regularly took emergency admissions and at any one time there might be a number of patients on drips or monitors. This ward had a number of student and learner nurses, who were not included in the study, and consequently fewer auxiliary nurses. The sister in particular was likely to spend more time in teaching and less in direct patient care than on Ward A. As with Ward A, there was a large day room at the end of the ward, which was used in a similar manner. A small office adjacent to the ward could be used for breaks, but as the ward was nearer to the staff canteen and coffee lounge these were more often used, and staff were able to be right away from the ward.

The Continuing-Care (Long-Stay) Wards

One male and three female wards, with 20 beds each, provided long - term care for elderly patients who were no longer able to care for themselves, or who needed more help than was available in the community. Staff preferred the name 'continuing - care', in order to get away from the idea that patients were admitted merely to await their death. In general, patients were much older than those on the acute wards. Although care was directed toward maintaining or improving the patient's general condition, staff regarded the ward as home for most patients, and the aim was also to create a home-like atmosphere. To this end, visiting hours were more relaxed; relatives could help with patient care; patients might go out with relatives for an afternoon or week - end at home; a hairdresser visited the wards regularly; and staff occasionally arranged trips in the hospital mini - bus. Although patients were rarely discharged to their own homes, a few improved sufficiently to be transferred to residential care in the community. A number of beds were used to provide shared - care, on a month in / month out basis.

Although the two consultants had overall responsibility for the wards, day to day medical cover was provided as required, by visiting General Practitioners, onto whose lists patients were placed, the aim being to minimize a hospital - like atmosphere. For the same reason, consultants did not hold ward rounds, avoiding interruptions to ward routine by their visits, unlike the acute wards. Physiotherapy was provided for a few selected patients in a room adjacent to one of the wards, and patients attending also had an opportunity for diversional therapy at the same time. Nursing staff comprised a nursing officer, and on each ward, state registered, enrolled and auxiliary nurses. One ward was without a sister at the time of the study. Student and learner nurses worked on two wards, which were not included in the study. The wards shared a ward clerk,and each had its own housekeeping staff. The two wards which participated are described separately below.

Ward C - The Environment

Ward C was a 20 bed female ward.The traditional long, high - ceilinged ward had been adapted to make two smaller areas, with a narrow nursing station and day room in the middle. The more alert patients were generally put one end and the more poorly or dependent ones the other. Each end had a bathroom and toilet, although as the latter were quite cramped, if a patient required help, this was usually at the expense of privacy, in the process of manoeuvring to and from wheelchair and toilet. The majority of patients required at least one and sometimes two helpers. Doors from each section opened onto a small grassed area and pavement alongside the hospital road. Not all patients could be fitted into the day room,which was quite small. Its use at mealtimes required considerable organisation by staff and more able patients tended to return to their bedside at other times. A number of patients left the ward, twice a week for physiotherapy, and these also received diversional therapy at the same time. Staff were very conscious of the lack of good facilities and spoke with longing of the more spacious day - rooms on other continuing care wards, as well as the more spacious facilities and modern equipment. Staff generally used the nursing station or an equally small staff changing room for their coffee break, and the former also tended to be used for sister's office. Two beds were used on a month in - month out shared care basis.

The Observation Week

This was said by staff to be fairly typical as far as the workload was concerned. Two patients were "poorly" and expected to die, one who had been on the ward for 6 years, the other only recently transferred. Both died during the week and two new patients were admitted. In general, patients on this ward were much older than those on the acute ward, and only one, a frail 92 year old, was ambulant and relatively self - caring. Tasks tended to be at a fixed part of the day. Thus most patients would be given bowls and helped to wash and dress before breakfast at 9a.m. The only exception to this was patients who were due for a bath, which was given later in the morning. To cut down on the workload, and to be more like home, sister had decided that patients should only be bathed twice a week, and beds were only stripped once a week unless soiled. All except one patient required help to get in and out of bed, and with dressing and toileting. The progress of bathing was regularly hampered by the supply of hot water running out when the boiler broke down. This happened twice during the observation week, and was not unusual. However, by 11a.m. most of the work would be complete and staff would put on records in the day room. Mealtimes were often long - drawn out because 4 - 5 patients required fairly constant or total help, and the majority were slow. Afternoons were quieter, with some patients having visitors or a rest, and one lady fairly regularly went out with her husband. Staff began to prepare patients for bed about 6 p.m., attending to the more poorly patients first, while the other patients stayed up beside their bed watching television until 10 p.m. As there were rarely more than two night staff on duty, and all these patients needed help, they were frequently quite tired and anxious to get to bed by the time the night staff had finished their routine of drinks and toileting.

On this ward one of sister's principles was that no patient was incontinent. By careful observation of the patients' routines staff should be able to know what time individual patients needed to be taken to the toilet. Although toileting was a laborious procedure, it was certainly less time - consuming than changing a wet patient and much less upsetting to the patient concerned.

Ward D

Ward D was also a female ward with 20 beds. Previously two long wards on each side of an entrance hall, one was used as a day room, from which doors opened onto a patio and grassed area. Patients were encouraged to sit at tables, which were laid in the day room at mealtimes, and to stay there during the day. A few patients left the ward for physiotherapy and diversional therapy. A number of rooms led off the entrance hall and were used for a variety of purposes, including office and staff rooms. At the time of the study, this ward was without a sister.

Night Nursing Staff

At the time of the study, 13 night nurses were employed at Hospital 1 and worked exclusively on this unit. It was policy not to move nurses either onto or away from the unit to cover staff shortages. These nurses were therefore regarded, and had been appointed solely, as part of the hospital team. However they did not have their own night nursing sister, and received this support from the two night sisters who were employed as part of the geriatric nursing team, and who had a roving brief on the site.

Forty - two night nurses were employed within the geriatric department of Hospital 2. This included 2 sisters, who worked to a night nursing officer (NNO) who had overall responsibility for the nursing care for the entire hospital. Although nurses were assigned to one ward they could expect to be moved to another ward within the department and occasionally elsewhere in the hospital, at short notice, to cover staff shortages. The NNO held nightly meetings with the sisters from all departments early in the shift, one function of which was to monitor staffing needs at ward level.

Although in general the pace on all wards at night was slower than during the day, more patients in Hospital 1 required attention and the night though slightly busier, also passed more quickly. It was also much later into the shift before all patients were settled, partly because staff also had to fit in a drug round at 10 p.m. Drugs were also given about 2 a.m. to some patients. The family of one patient who was dying stayed the night and required some staff attention. Otherwise, the routine on each ward was very similar. The night sister visited all wards at least once during the earlier part of the shift, and again towards morning. Staff started to wake patients about 6 o' clock with a drink and, in Hospital 1, the early morning drug round. On each ward the night started and finished with a hand - over meeting between nurses on each shift.

Three Days from a Diary

A selection of entries from the records kept of the researcher's week on each ward conveys a flavour of the experience, both the similarities and the differences. Day

4 on each ward, a Thursday, has been chosen because it was well into the week's placement on each ward, and in each case it was the last day worked before doing a night duty on Friday. On each ward, the shift worked was an early one, in the case of Hospital 1, from 7.45a.m. to 1.15p.m.; and on wards A and C of Hospital 2 from 7.30a.m. to 1.30p.m.

Week 1 : Ward C - Continuing Care
Arrive 7.30a.m. - Night nurse preparing to hand over to staff nurse when I arrive. Remainder of staff (3) prepare for first tasks of the day. Patients have already had a cup of tea and those able to wash themselves have been given bowls.

7.30 - Asked by SEN to help Mrs.A. to finish washing, commode and dress. Staff busy, seem happier to ask me and to let me get on with it today. While Mrs A. on commode, asked by NA to help take Miss F to toilet. Manouevring in and out of wheelchair takes some time. Return to Mrs.A., remove commode and return to help complete dressing. I am much slower than other staff.

When Mrs.A. ready, she sits in wheel chair by bed. Help Mrs.S. complete her dressing. More able than Mrs A., Mrs S. tells me she gets frustrated when she can't do things - especially needs help with pants and stockings. Shows me the equipment the OT has given her to help with stockings, zips and shoes. She hopes she will eventually be able to go home.

8.00 - 8.30 : Staff are already taking patients into the day room in readiness for breakfast, and this is almost complete by the time I have finished with Mrs.S. who decides to stay beside her bed. She will be going for Physiotherapy / occupational therapy at 9a.m. and is looking forward to this.

8.30 - 9.00a.m. Help give out cups of tea, cereal, porridge etc. Offer to feed E. whom I have also had quite a lot to do with and who has a reputation for throwing cups and food onto the floor. I am beginning to understand her speech and find she is quite capable of letting me know what she wants.

9.00a.m - 4 patients to physio. Clear breakfast things away. SN asks if I would like to help her bedbath a patient who is expected to die. Controlled horror at the physical wasting and paperiness of her skin. SN seemed very gentle. I felt quite clumsy. SN shows me how she dresses heels to alleviate bedsores and applies lotion to areas of skin.

The boiler has broken down and so there is not enough hot water to bath patients whose turn it is today, unless fixed by the afternoon.

SN has put on some old - time records in the day room. Some of the more alert patients read, occasionally some talk to each other, otherwise limited stimulation or activity.

10.30a.m - approx. Coffee break. I am in the middle of talking to a patient and NA comes to fetch me. We talk about getting fond of patients and having favourites. Staff feel this happens but also seem to think that it should not. We talk about a new patient who may be admitted today - staff are concerned that she may be too heavy to manage without a hoist. Nursing Officer is to assess. SN offers to take me to see the continuing - care wards and the physiotherapy department after coffee. She talks enthusiastically about the facilities on the other wards, where she spent time during training. Also what she would like to begin doing with the patients on C ward, such as occupational therapy and games, if they had more space.

12.00 - 12.30p.m. - Help give out lunch, again feed E and give assistance to Mrs M.

12.30 - Morning staff finish lunches, except SN, who gives report to afternoon staff, which I attend out of interest. Discussion of whether to move Mrs.T's bed - described as an intelligent but unhappy lady coming to terms with a mastectomy and CVA, frustrated by her considerably reduced abilities. Staff feel she will be better with more able and alert patients. Also wonder whether she should be referred for more physio, to give her hope.

Finish about 1.15p.m.

Comments - Felt quite tired today, but less so than Tuesday. The morning passed quite quickly. Found lack of stimulation and repetitiveness of tasks difficult to manage. Some patients show great fortitude - how do they bear it. Sense of freedom each time going off duty.

Much sadness, mostly unspoken, below the surface. When it is constantly on show and patient does not respond to kindness, comforting etc. as with Mrs.T. this became very difficult to bear though staff seemed not too worried by it - seemed to cope by doing what they could and then ignoring it? Also difficult and distressing for other patients to bear. This was probably the most difficult thing about this week.

Seems difficult to achieve balance between encouraging patients to do as much for themselves as they are able (firmness) and recognising when to give more help than is usually necessary. Role reversal in relation to relative age also difficult to adjust to. Finding balance of respect for individual without treating an 80 year old as a child.

Week 2 : Ward A

Arrive 7.30a.m - Night staff preparing to hand over to day staff. All attend - 5 on duty excluding self. Discussion of patients and tasks which are allotted. More mobile and ambulatory patients had already washed themselves and waiting for breakfast.

8.00 - 8.30a.m. : Staff go off to finish washing those patients who need help and to begin to move patients into dayroom for breakfast. As not given anything to do, felt at a bit of a loose end. Asked if any help needed - helped move less independent patients to day room.

8.30 - 9.00a.m. : Help to serve breakfasts and feed Mrs.D. who is very slow.

9.00 - 10.30a.m. : Junior doctor on the ward again this morning. Offer to help NA with bed - making. She later asks if I would like to help with bathing a patient. Several patients not dressed. Help Mrs.P to dress and go to toilet. Sister busy preparing for doctor's ward round, which I was invited to attend on Tuesday. This doctor's patients stay on the ward. Others encouraged to go to day room if well enough. Feel a bit spare - so talk to Mrs.G who is waiting to see the doctor, and Mrs.J who is having radiotherapy on alternate days. Help NA to prop Mrs.B in her chair. She keeps slipping, is uncommunicative and has a reputation for being 'spiteful'

10.30a.m. - Realise staff, except sister, have gone for coffee break so join them. Still do not feel quite accepted by group. Staff are discussing a patient who was discharged - there seems to have been a muddle up in the arrangements made with her daughter who was not there when the ambulance arrived. Staff say this was sister's job - they don't have a lot to do with families.

11 - 12 noon : NA asks me to help bath Mrs.L. We talk about what I am doing on the ward, and why she is working there. She tells me there are very few jobs avalable elsewhere. She is looking for experience and plans to apply to train to become qualified. Try and talk to Mrs H. who is poorly and remains in bed. She appears quite distraught, whining

and crying but seems to become calmer. I am later told that she is always like that, she has a psychiatric history and should be in a mental hospital.

12 - 1.00p.m. : Help serve lunches and feed Mrs.H. who is meant to be able to feed herself but has great difficulty and is very slow. Patients and staff seem to find her difficult.

Finish approx. 1.15p.m.

Comments - More nursing procedures on this ward. Staff very busy all morning and especially when there is a doctor's round. Afternoons by contrast very slow. Some patients have visitors then but not all. Staff seemed to spend less time talking to patients, even in the afternoon when they were more free. They do not seem comfortable with relatives - there seems to be a 'them and us' divide and staff feel criticised by relatives. Difficult for researcher to comment from a different perspective because not feeling very much part of the group.

Patient group more mixed, some very alert and able, some less so and some very disabled physically and mentally. Much easier to spend time with the former than the latter group. Hard talking to patients who don't respond and very difficult when they appear unconsolable, especially if you can't find out why.

Felt torn between wanting to spend time talking to patients, two in particular, who seemed unhappy and were regarded as difficult, and feeling the disapproval of staff who thought they were playing to a new face. Both likely to become long - stay patients and hence also inappropriately placed on this ward. Possible conflict between the needs of long - term patients and how staff perceive their role on an acute assessment ward.

Night Duty

The night hours on both wards seemed very long and rather tedious, although not difficult to stay awake. Relief when it was time to start waking patients for tea and start of the day's routine. Night sister on my first night takes me to see some of the other acute wards and for a talk in her office.

Week 3 : Hospital 1

Arrive 7.45a.m. - All staff, 6 + sister and self, to sister's office for Night SN's report. Divide into two teams with team leader designated by sister. Each team takes one half of the unit.

8.00 a.m. - We sit down briefly on our own with team leader to discuss and allocate tasks. 12 patients for the team I am in. They include one young patient, fairly self - caring but in pain; one reasonably mobile and two who are able to go to the day room later. One new patient, confused; another with pain and anxiety; one paraplegic; one who needs help with everything because of severe pain which has not responded so far to treatment; and one who is dying.

Team leader goes to each patient to ask how they are - the rest of us help the housekeeping staff who have already started to serve breakfast to patients, in or beside the bed. Help feed Mrs.C. and then Mrs.O who is sleepy. Help clear breakfast trays.

9.00 - 12.30 : Helped with commodes;bathed Mrs.D with NA; gave two bed baths on my own ! including changing a colostomy ! Sat with Mrs. L for a while as she was confused and restless. Coffee break - later than usual and only ten minutes; very busy morning.

12-15 - 1.30 p.m. : Helped with lunches. Sat with Mrs.K and gave her some help until her husband arrived; and then took over from another nurse and fed Mrs.C.

Finish 1.30p.m. approx. Morning passed quickly, felt satisfied but tired.

Comments - Although this ward had more staff on duty, staff were busy all the time and on at least two mornings barely had time to stop for the coffee break. Several patients died during the week, one on the bay where the researcher was on duty and so very involved in caring for him.

As someone who was not a nurse but temporarily engaged in some of the nursing tasks, the most personally stressful areas were :

Caring for someone who was dying as they became less able to communicate their needs;

Sitting with a dying patient for any length of time, especially if they were uncomfortable, restless, or their breathing was noisy or erratic;

Being present when Mr.S died - this seemed very unreal and also very undramatic - one moment there, the next, gone. The sister's presence and concern for everyone, including the researcher was very reassuring.

Having to physically restrain a very confused patient who was previously a bright and alert gentleman which seemed humiliating (for him);

Although present at several deaths and helped straighten patient's body at the time of death of one patient ready for relative to see, the researcher was rather glad not to be asked to help with laying out and washing the body, which she personally would have found the most difficult of all tasks.

Night Duty

Night hours were also quite long on this ward, although it took staff much longer to settle all patients, and the task was not finished until after midnight. Several patients needed intermittent attention during the night, and the relatives of one patient who was dying also stayed the night. Because there was less activity than during the day and fewer staff about perhaps, surprisingly their presence felt somehow more intrusive to the researcher and also the responsibility for them seemed greater.

There was on all wards a greater sense of isolation, of being cut off or marooned from the rest of the world at night. This felt slightly different in Hospital 1 from Hospital 2, perhaps partly because there were three staff on duty rather than two, and this felt more of a group, and also because the researcher was allowed to help and felt welcomed in Hospital 1. Night staff were pleased to find a member of the day ancillary team taking an interest in their contribution. In Hospital 2 she felt more superfluous than on days and was probably at best tolerated. It felt strange to have less permission to become involved on wards where the researcher had worked during the week and knew the patients, but was treated as a stranger.

CHAPTER 5

THE SUBJECTS

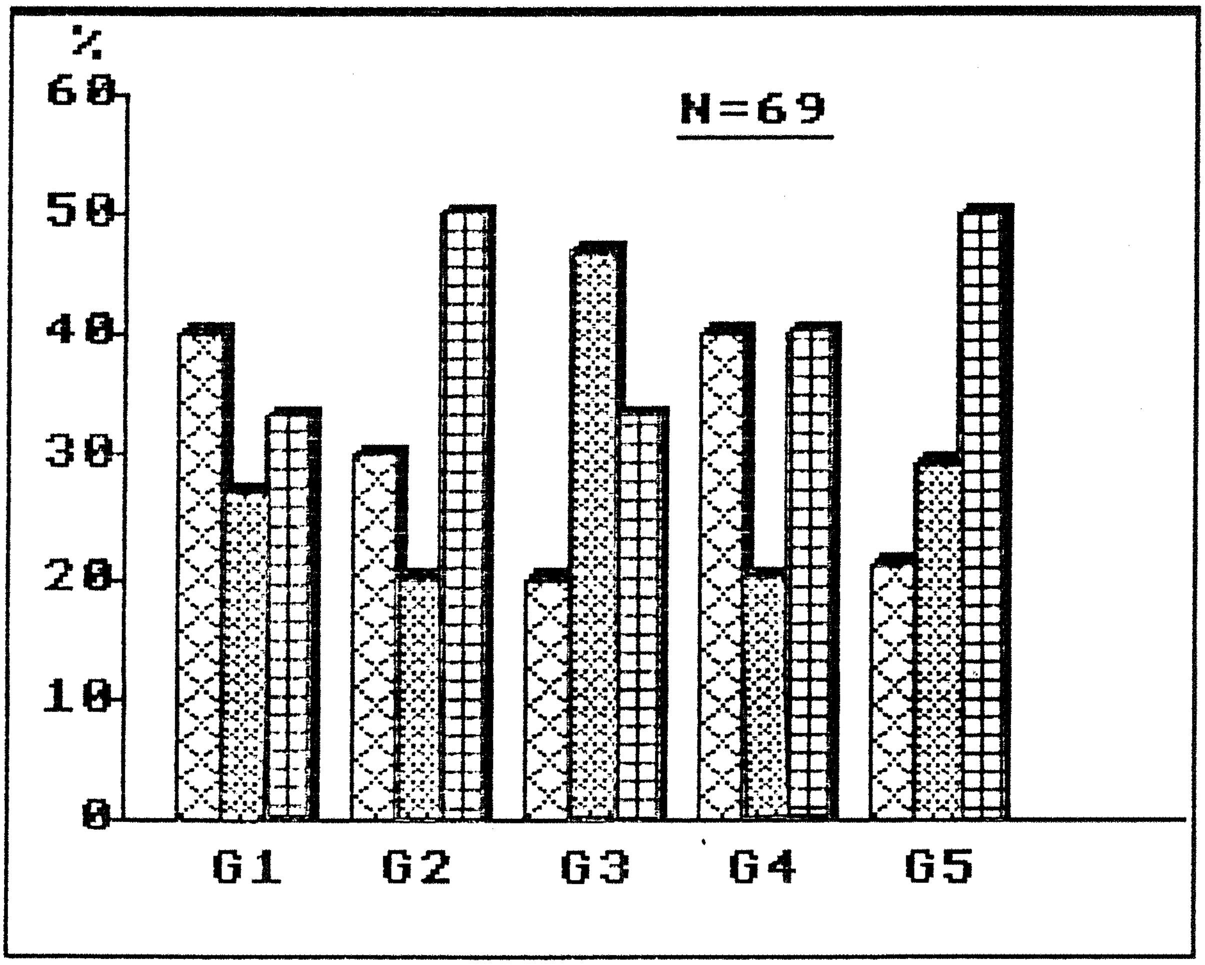
Having spent some time comparing and contrasting the environment and work of the two hospitals, it is proposed to examine some of the characteristics of the subjects themselves and some of what might be called their conditions of employment. In particular, attention will be given to examining factors which might be thought to either ameliorate or increase the experience of stress, and the extent to which the groups are either alike or dissimilar in these respects.

The final sample comprised 69 staff, twenty - five from Hospital 1 and forty - four from Hospital 2. It included one male nurse (SEN) in Hospital 2, and 4 sisters. As their numbers were small, in order to preserve anonymity these five subjects have been grouped by qualification and / or ward rather than treated separately. The sample was divided into five groups, two from Hospital 1 and three from Hospital 2. Although attention may be drawn to differences between the five groups, because numbers were small it was rarely possible to carry out any meaningful statistical comparison. For the purposes of analysis, therefore, comparisons always were made between each hospital and between day and night staff. Only the statistically significant findings will be reported in any detail. Figure 3 shows the number and percentage of staff in each of the five groups by grade in the final sample selected. Percentages have been rounded up or down to the nearest whole number. A comparison with Figure 1 on page 55 shows that the distribution of qualified and unqualified staff in the sample approximates closely that of the population from which the sample came.

Fig. 3.

Percentage of Staff of Each Grade

In Each of The Five Groups in the Sample Selected :



Hospital 1

G1 : Group 1, N=15

G2 : Group 2, N=10

Hospital 2

G3 : Group 3, N=15

G4 : Group 4, N=15

G5 : Group 5, N=14

TOTAL = 69

▨ SRN

░ SEN

▦ NA

Groups 3 and 5 have the lowest proportions of fully qualified staff (SRN's), but the ratio of qualified to unqualified staff is compensated by the inclusion of SEN's, who were to some extent used interchangeably with SRN's. There were no signficant differences found in the numbers of SRN's, SEN's and NA's between the two hospitals.

Balancing Demands and Capacity

McGrath (1970) and Mechanic (1970) suggest that stress may be defined as an imbalance between the demands made on the subject and the subject's capacity to meet the demands. Thus defined, a number of factors may be regarded as influencing individual capacity: training; experience; on-going training particularly that which is relevant to the present post; multipilicity of demands, particularly when these are in conflict; and personality (although this latter is outside the scope of the present study).

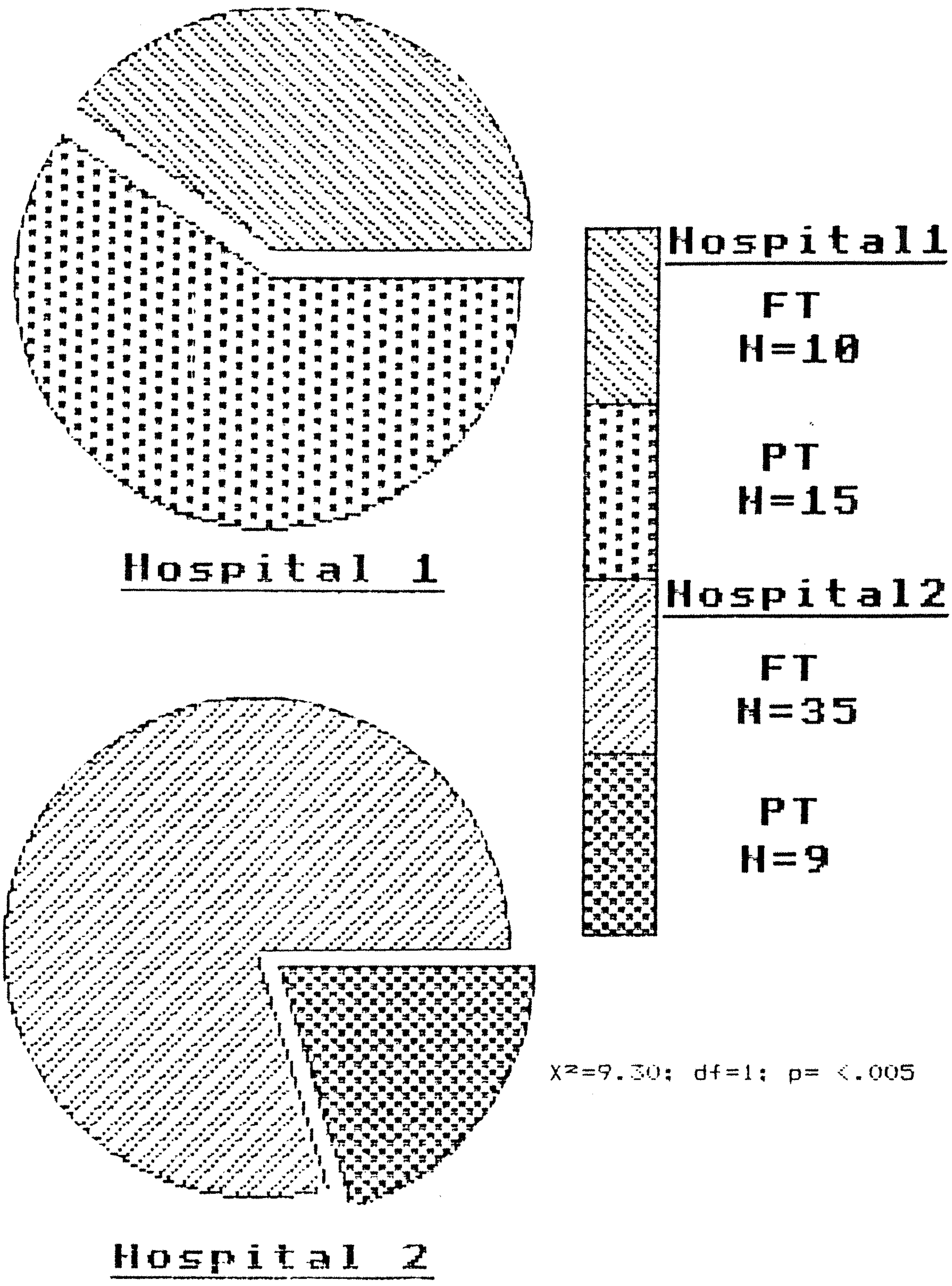
1.Comparison of Working Hours.

At the time of the study, day staff on all wards worked one of three shifts, an early, late or all - day shift, and all staff would work a combination of any of these three shifts. The hours were similar for all wards and in all cases the early shift was the shortest. Night staff in Hospital 1 worked a twelve hour shift and in Hospital 2 an eleven hour shift, each with a one hour break during the night. Full - time staff worked alternately three and four nights a week. For the purposes of this study, therefore part - time has been defined as less than three nights per week.

Twenty-four respondents in the sample (35%) were part-time staff, of whom 12 worked night duty and 12 worked a day shift. In each hospital, however, there were slightly more part - time staff on night duty than day shift; 5 were SRN's, 8 SEN's and 11 were NA's. The number and distribution of part - time (P/T) and full - time (F/T) staff is given in Figure 4:

Fig. 4.

Numbers of Full-Time (FT) and Part-Time (PT) Staff In Each Hospital :



$X^2=9.30$; df=1; p= <.005

There were significantly more part-time staff in the sample from Hospital 1 than from Hospital 2. Although the sample was not selected to reflect the proportion of part- to full-time staff in the host population, as the figures on page 57 show, the sample selected from each nursing group in the population as a whole, other than Group 3 represented well in excess of 50% of the total staff group on each ward. It seems probable, therefore, that the differences in the sample reflect real differences in the population of each hospital, and the policy in Hospital 1 of appointing part - time staff as a means of managing exposure to stress.

2. i).Age.

It might be anticipated that older staff, because of their greater maturity and experience of life would have developed more skills and therefore be better equipped to cope with stress, including stress in relation to death anxiety (Ross, 1978; Gow and Williams, 1977). Figure 5 shows the numbers of respondents by age group in each of the five sub-samples : a) under 30 years; b) 30 - 39 years; and c) 40 years or older, at the time of the study.

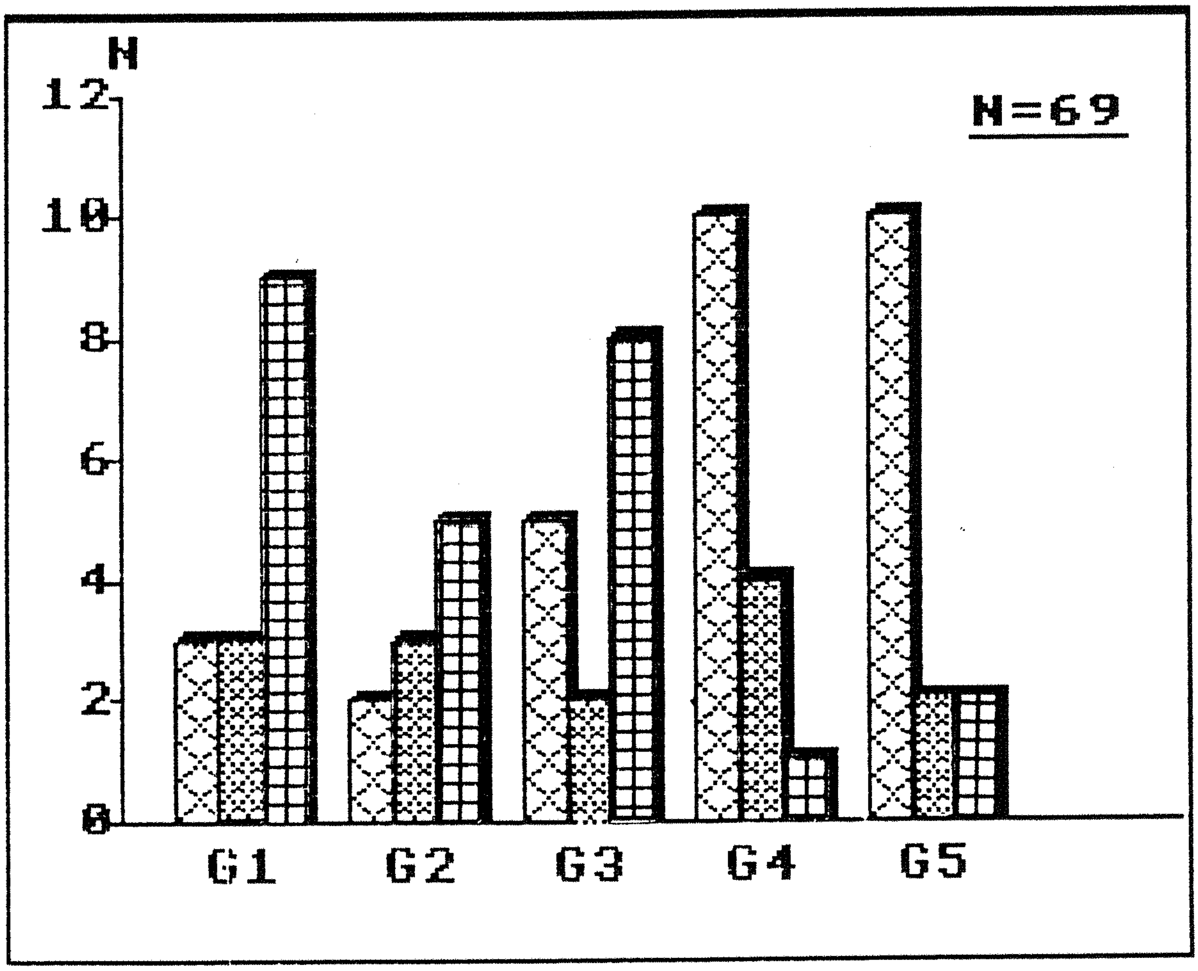
As Figure 5 shows there is a preponderance of younger staff on the continuing - care and acute assessment wards of Hospital 2. The mean ages for each group were :

Group 1, 39.9 years;
Group 2, 40.6 years;
Group 3, 38.6 years;
Group 4, 28.4 years;
Group 5, 27.4 years.

The differences between Hospital 1 and Hospital 2 are particularly marked between day staff of each hospital, whilst the night staff of Hospital 2 are more like Hospital 1 staff in respect of age distribution and mean age. Significantly more Hospital 2 than Hospital 1 staff were

Fig. 5.

Numbers of Respondents in Each Group by Age :



Hospital 1

G1 : Group 1, N=15

G2 : Group 2, N=10

Hospital 2

G3 : Group 3, N=15

G4 : Group 4, N=15

G5 : Group 5, N=14

TOTAL N=69

AGE

▨ Under 30

▒ 30 - 39

▦ 40 and over

found to be under the age of 30 years: X^2 = 7.45; df = 1; p = <.01; and significantly more Hospital 1 than Hospital 2 staff were aged 40 years or more: X^2 = 5.26; df = 1; p= <.025.

However, as the age distribution of the night staff group was more like that of Hospital 1 staff groups than the other two groups in Hospital 2, it was decided to run the same calculations amalgamating Group 3 night staff with Hospital 1 staff, thus : Groups 1,2 and 3 v Groups 4 and 5. There were significantly more staff under 30 in groups 4 and 5 than groups 1,2 and 3: X^2 = 11.53; df=1; p - <.005;, and significantly more staff 40 years and older in groups 1,2 and 3: X^2 = 12.62; df = 1; p = <.005. If the relationship between age and death anxiety reported in the studies by Ross (1978), and Gow and Williams (1977) is true for this sample, then it should be expected that Hospital 1 staff and night staff will report less stress in this respect than Hospital 2 day staff.

2 ii). Relationship between Qualification and Age

It was the researcher's impression that unqualified staff tended to be older than qualified staff in Hospital 1, although the X^2 showed that this was not true for the sample as a whole. The sample was therefore divided according to the hospital respondents worked in. Table 1, page 106, shows the numbers of Qualified (Qual) and Unqualified (Unqual) staff under 40 years and 40 years and over in i). Hospital 1; and ii) Hospital 2.

Across all grades, significantly more staff in Hospital 1 were age 40 years or older : X^2 = 5.49; df = 1; p = <.025; there was a strong trend toward more unqualified older staff : X^2 = 3.26; df = 1.

Differences in age were therefore related primarily to qualification, with Hospital 1 employing significantly more older, unqualified staff. This may be in part a reflection of the policy in Hospital 1 of employing more part - time staff which, like night duty, makes it more possible for older, married staff with families to work. It may also indicate a policy of employing older staff, to provide a balance between youth and qualification on the one hand and maturity and life experience on the other.

Table 1 :
Numbers of Hospital Staff Under 40 and 40 Years or More in Hospital 1 and Hospital 2 :

	Hospital 1			Hospital 2		
	Qual	Unqual	Total	Qual	Unqual	Total
Age						
< 40	9	2	11	19	14	33
40 +	6	8	14	7	4	11
Total	15	10	25	26	18	44

3. Multiplicity of Demands.

The number of demands external to the job to which the individual may be subject can be seen as a function of the complexity of his familial, social and community involvement. However, for the purposes of this part of the study, only interactions in which the subject has a responsibility and emotional involvement will be defined as a demand, with the potential to conflict with the demands of the job. As Mettlin and Woelfel (1974) point out, the presence of a strong or extensive social network may be a source of stress rather than act as a buffer against it. However, the research evidence is contradictory and others, for example Brown and Harris (1978), have found the presence of social supports have positive benefit. In conceptualising other demands and areas of potential conflict, respondents were asked about their marital status, the presence of children under 18 years, about their partner's attitude to their job, and whether they were full or part - time.

Like night duty, employment of part - time staff also makes it easier for married staff with families to work. Families and chidren represent additional demands on staff,which may at times be in conflict with the needs of the job. However, the relationship between the presence of family responsibilities and stress at work may not be straightforward since family needs may provide both a balance and a distraction to some of the stresses of nursing.

a).Marital Status

The sample included 48 married respondents (including cohabitation) representing 70% of the sample, and 21 unmarried staff (including separated, divorced or widowed). There were no differences between the two hospitals in the numbers of married to single staff. However, of 25 night staff, only 2 were single, whilst of 44 day staff 19 were single. There were significantly more married staff working night compared to day duties : $X^2 = 7.70$; $df = 1$; $p = <.01$. It would appear that night duty offers, if not a preferred way, at least one way of combining the responsibilities of work and family.

b).Dependent Children

There were 24 respondents who had dependent children, defined as under 18 years,living at home. (35% of the sample). There were no significant differences between the hospitals in the number of staff who had dependent children, nor, surprisingly perhaps, between day and night staff. The lack of difference between day and night staff in this respect may be partly due to the fact that night staff were also older, and more may have had children who were no longer dependent.

c).Working Hours of Respondents with Dependent Children

Of the 24 nurses who had children under 18 at home, 17 worked part - time, 11 in Hospital 1 and 6 in Hospital 2. The remaining 7 were full - time staff, and all were working in Hospital 2. This difference between the two hospitals in this employment pattern of staff with dependent children was found to be statistically significant: p = .025, Fisher's Exact Test. The seven staff with children who worked full - time may be regarded as potentially the most vulnerable to conflicting demands.

d).Other Dependents

Respondents were also asked whether they had anyone else dependent on them for practical, emotional or financial support. This question was designed to tap for the presence, for example, of elderly dependent relatives, the needs of whom might well pose additional and conflicting demands on the respondent. 9 nurses (13%) of the total had someone in this category, and came from all groups except Group 5. There was no difference between the groups, nor between hospitals.

e).Attitude of Family to the Job

Finally,all respondents were asked about the attitude of their family to their job and whether they minded them working.Conflict in this area was seen as another potential stress. Only 2 nurses answered this question in the affirmative, one from Group 2 and one from Group 5. A further 10 nurses said their families' attitude to their job was mixed, 2 from Hospital 1 and 8 from Hospital 2. There were no significant differences between the two hospitals.

In summary, with respect to the majority of potential stress factors examined here the groups and the hospitals are more alike than not. There were two exceptions to this - staff in hospital 1 and night staff tended to be older; and staff with dependent children at home were more likely to work part - time in Hospital 1, but full - time in Hospital 2. With respect to the impact of these factors on the level of stress experienced by staff, the difference is likely to be in the direction of minimising stress among Hospital 1 staff, the posited high stress group.

4.Training for Present Post.

As well as ascertaining the degree of training of respondents in terms of their nursing qualification if any, and their age and family responsibilities, subjects were asked what preparation they had received to cope with their present job, and when.

1).In Hospital 1 the practice was to assign a new nurse to the care of a more experienced member of staff and to introduce her gradually to the full range of work and the ward's approach to its task, including use of medication, talking to patients and families and management at the time of death. In practice, if the ward was very busy a new nurse was "thrown in at the deep end" and found out as she went along. Thus, 6 staff (40%) said they had not had a period of induction, while 9 (60%) had, in group 1. On the same ward, it was the practice for new night staff to spend usually 2 weeks working a day - time shift, prior to going onto nights. 8 night staff (80%) had been introduced in this way. In addition, a J.B.C.N.S. (now English Nursing Board, E.N.B.) course on the care of the terminally ill was introduced, for which qualified staff only were eligible. In Group 1, 9 (90%) and in Group 2, 1 (20%) of qualified staff had completed such a course at the time of interview. In this respect, day staff were better trained for the job than were night staff in Hospital 1.

ii). Eight staff (53%) in Group 3 said they had received some form of induction. This had been a month on day shift for one NA with 16 years experience , who thought she had been "lucky, as there were two good sisters who helped me a lot." The remainder had been on a course within a month received any form of induction, two had trained in the hospital and said they did not need it; and 3 had considerable previous experience. Four would still have welcomed a period of induction, and taking sole charge of a ward was spontaneously mentioned as a source of particular anxiety for which they would have welcomed some preparation.

iii). In Group 4, four respondents (27%) said they had had no induction of any sort. All were qualified staff, one SRN and three SEN's. Again, all spontaneously mentioned being left in charge while they were unfamiliar with either the ward or the requirements of the role as a source of anxiety. Of the remaining 11 who had received some form of induction, 6 were NA's and 5 SRN's. The auxiliaries had attended a 3 or 5 - day course in the School of Nursing, which covered basic nursing skills, including ward experience, care of the elderly, and aspects of safety. While the majority had attended the course within 6 months of starting, 2 had waited 18 months and 2 / 3years respectively, presumably because the course or a place on it was not available when they started. Of the qualified staff, 4 had attended a student to staff nurse course, while the fifth had spent a week designed to introduce her to the role of a ward sister, in particular, meeting heads of other departments. She had also attended a two - week course on 'Death, Dying and Bereavement' at the School of Nursing.

iv). In Group 5, nine staff (64%), five NA's, one SEN and three SRN's, had attended formal induction courses, similar to those outlined for Group 4. Of those who had not attended such a course, one NA had previous experience on the ward and a second was expecting to go on a course shortly; one SEN had previous experience and another had started before such courses were available.

There were no significant differences between the hospitals in the numbers of respondents who had / had not received a period of induction.

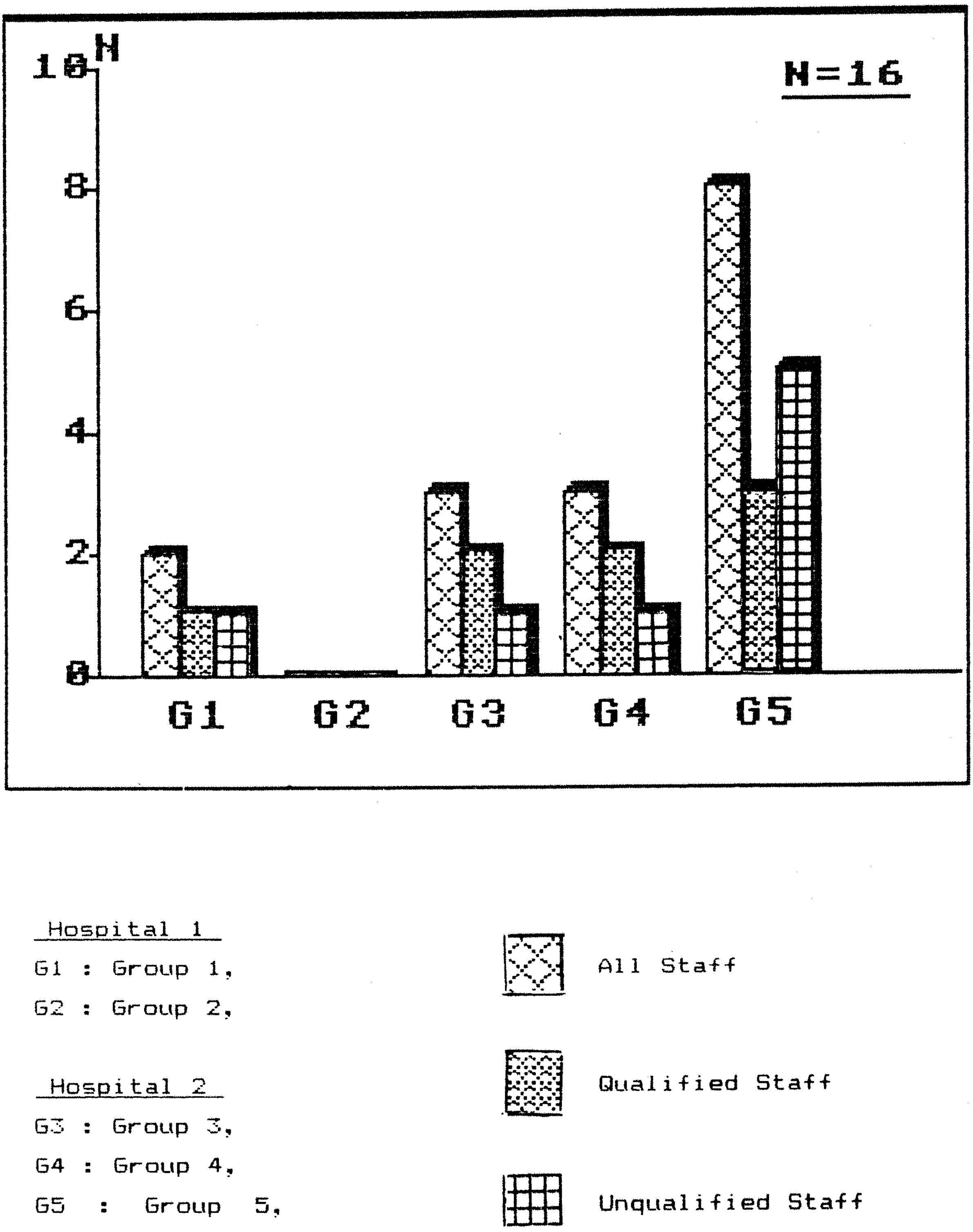
5. Nursing Experience.

a). Number of Years Nursing Experience

Respondents were also asked how many years nursing experience they had. For all groups, years spent away from nursing have been excluded, while for qualified staff, years in training have been included, in order that the totals may be more readily compared with those for unqualified staff. Figure 6 shows the numbers of staff in each of the five groups who had less than four years nursing experience, firstly regardless of qualification, and then taking qualification into account. SRN's and SEN's have again been combined into one group.

Fig. 6.

Number of Staff with Less than 4 Years Nursing Experience 1) In the Whole Sample, N = 16; 2) Among Qualified Staff, N=8; 3) Among Unqualified Staff, N=8 :



Only 16 out of 69 respondents had less than 4 years nursing experience. Half of these were in Group 5 which stands out in Figure 6 as having more than twice as many staff, (N=8),compared to any other group, with less than four years experience, both qualified and unqualified staff; and significantly more staff with less than 4 years experience than all other groups combined: $X^2 = 9.37$; df = 1; $p = <.005$. At the other extreme, Group 2, night staff from Hospital 1 are observed to be the most experienced group, having no staff with less than four years nursing experience,

b).Length of Time in Present Job

In addition to length of nursing experience generally, respondents were also asked how long they had been in their present job. Responses were categorised into a).less than one year; b). 1 - 4 years; and c). more than 4 years. Of 69 respondents, 11 (16%) had less than one year's experience in their present job. (Group 1, day staff Hospital 1 had no staff at that time with less than one year's experience in their present job). 51% of the 69 respondents (35 in all) had between 1 - 4 years experience, and the remaining 23, or 33% had more than 4 years experience. There were no significant differences between hospitals. All groups had at least 40% of staff in post for between 1 - 4 years.

All groups therefore, appear to have enjoyed a period of relative stability at the time of the study, and this applies particularly to Group 1. Additionally, each group had a core of staff with over four years experience. In some instances this included staff with many years experience in the same post. In Group 3, five nurses (33%) had ten or more years experience in their present job and of these two had been over 15 years in the same job. One nurse in Group 4 had 14 years experience, and one nurse in Group 5 reported 10 years in the same job. Hospital 1 had been open for only just 7 years at the time of the study. Three nurses from Group 2 and one from Group 1 had worked there from the beginning and all were part-time.

6.Voluntary and Involuntary Participation.

A number of researchers have suggested that in a situation of stress, the degree to which the subject's presence and participation is voluntary may influence the perception and experience of stress. It was known, prior to the study that all staff in Groups 1 and 2 would have elected to work in Hospital 1. However, it was thought likely that as staff in the other groups worked in a large general hospital, they might be subject to rotation to / from other wards possibly at short notice. In practice, for Groups 4 and 5 at least, this rarely happened.

All respondents were asked whether they had chosen their present job. Fifty-three respondents (77%) said they had; twenty - four or 96% of Hospital 1; twenty - nine or 61% of staff from Hospital 2. Fourteen respondents said it was the only job available at the time : one from Hospital 1, night staff group; the remaining thirteen from Hospital 2, of whom eight were night staff. Although these respondents would seem likely to be the least satisfied, in fact only one, from Group 5 said she did not enjoy her job and was ready to leave. A further 14% of the sample, ten respondents, all of whom were fairly recently qualified, said availability was the main reason they had taken the job, but it had also been included on their list of job preference, albeit not first choice. The nurses in this study, therefore, appeared to be fairly content with their jobs. There were no differences in this respect between the two hospitals.

In summary, with respect to the demographic data which it was thought might be associated with the experience of stress, few differences were found. Where significant differences did emerge, the direction of the difference was always in favour of potentially ameliorating stress in those groups where it was hypothesized stress would be highest; either Hospital 1, where the number of deaths was highest; and / or among night staff, who were likely to be more isolated.

CHAPTER 6

CARE OF THE DYING

Introduction

The next four chapters will look at the more descriptive and qualitative data that was gathered during the study. A number of open - ended questions were asked about the experience of nursing dying patients, the answers to which were often too diverse to classify for statistical analysis. These have been broken down into the main types of response in order to give an indication of both the frequency and range of responses. Direct quotes will be used to give a flavour of the replies, and to preserve anonymity respondents' identity numbers assigned at the start of the study will be reported. The groups from which the respondents quoted came may be identified as follows :

Hospital 1 - Group 1 : 001 - 020
Group 2 : 021 - 030
Hospital 2 - Group 3 : 301 - 320
Group 4 : 201 - 210 (Ward A)
211 - 220 (Ward B)
Group 5 : 101 - 110 (Ward D)
111 - 120 (Ward C)

NURSING CARE OF THE DYING

Of special interest in the interview was the nature of the nurse - patient relationship, and in particular the nurse's awareness of the psychological needs of dying patients.

Hospital 1 had been planned and set up to meet the needs of a specific group of dying patients,so defined by their medical diagnosis and prognosis. It held allegiance to a particular and well - defined philosophy of care in which the patient's psychological needs were regarded as having equal importance to his physical needs, each influencing the other, and in which the 'open - awareness' context of Glaser and Strauss was seen as the optimum, toward which one worked. As nursing staff were socialised into the ward's expectations and practice, one would expect staff in Hospital 1 to be more aware of these needs in their patients and more open in their management of conversations related to death and dying.

The orientation of Wards A and B was toward diagnosis and treatment, with the expectation that patients would either be discharged to the community, or if this were not compatible with their care - needs, to a long - term care environment. While some patients might be admitted in the last stage of a chronic illness to die, these wards, particularly ward B, also took emergency admissions, the might be unclear, but for whom active, interventionist procedures were likely to be tried in order to influence the outcome. At this stage the practical and physical rather than psychological needs of the patient were more likely to be uppermost, though the latter could become relevant as the patient recovered and became aware of what had been happening to him. An 'open - awareness' approach had not been institutionalised into the management of the wards, and hence not into death / dying - related conversations.

However, on wards C and D, patients were primarily admitted for long - term care and were rarely expected to be able to go home. The philosophy was one which emphasized the creation of a home - like environment, and at the time of the interviews this was still in the process of evolution. The status of patients was not that of 'dying', although all would become so, and there was no defined approach to the management of conversations about death and dying.

Definition of Dying Status

In the context of this research there are two definitions of the status of dying which may best be understood from the perspective of the concept of a dying trajectory, introduced by Glaser and Strauss (1965). There is a sense in which all the patients cared for by the respondents may be regarded as dying. Whether elderly or young, they have each entered hospital with either a disease of acute onset, or a chronic disease with recent symptoms of acute onset, all of which have implications for their future life expectancy. Their position on the dying trajectory is to some extent a matter of medical diagnosis, of treatment, palliative or curative, and of prognosis. It is also a matter of a range of other, less readily defined factors, including medical complications, life - style, physical strength, temperament, will-power and support. A patient's position on the dying trajectory may move in either direction as, for example, he responds or fails to respond to treatment, gives up or shows a determination to fight the illness. Thus, although one might expect a gradual deterioration toward death over time, the rate of this is less readily determined.

However, there comes a time when the likelihood of death becomes recognisably closer. The patient grows weaker and more poorly, perhaps stops eating, sleeps more and may be less easily roused, perhaps slipping into a state of unconsciousness. At this stage staff will be alert for changes in the pattern of breathing or pulse rate which indicate the imminence of death.

There was a sense in which respondents in both Hospital 1 and wards C and D recognised this longer dying trajectory and applied it to their patients. This was suggested by remarks such as "I have never nursed patients who were not dying", or "everyone is dying who comes in here" - staff from Hospital 1: and "it's a one way street" or "they must know they are not going out except dead" (staff from groups 4 and 5). However, perhaps because the dying trajectory was in general longer for patients on wards C and D than in Hospital 1, the former patients were not referred to as dying, unless they had moved into the last stage of the dying trajectory. Although patients in Hospital 1 were seen as dying, staff distinguished between those on an earlier and those on the later stage of the trajectory. For patients on the earlier part of the trajectory the goals of staff on Hospital 1 were frequently similar to those shared by staff on wards C and D, and wards A and B; that is, to maximise the patient's potential for independence, leading to discharge where possible.

Within the interview it was therefore important to be clear which stage was being discussed, since both were of interest in the context of the study.

Role Change

All respondents were asked whether their role changed and what aspects of their role were important when caring for dying patients. A majority of all staff thought their role did change. Nine respondents (13%) said their role did not change, three from Group 1: one from Group 2: one from Group 4; and four from Group 5. Six were N.A's, and three were E.N's.

R009: "No, we have the same responsibility for total care. I am often asked to sit with patients, but perhaps this happens a bit more at the end, especially if nobody is with them." (NA)

R114: "Not my role. I would like to spend more time with (dying) patients. I feel bad if someone dies on their own." (NA)

R304: "No special thing is made of it (dying). I like to see all patients look clean and comfortable. I talk to them even if they are unconscious." (NA)

Of those respondents who thought their role did change, a number of areas were mentioned.

1. General Care

Perhaps not surprisingly, many of the respondents thought they spent rather more time generally, caring for the patient, than they did at other times. There were no significant differences in how many respondents mentioned this aspect of care, either between hospitals, between grades or between day and night staff.

R210: "You take more time doing the patient. You make sure the patient looks nice and is not in pain, that they look cared for. You are trying to do as much as you can in the short time they have left." (NA)

R213: "The treatment is less active, more passive. The nursing role is to keep the patient comfortable,peaceful.I try to see the time spent with the patient is more relaxed, a slower pace." (SRN)

Although respondents often had a number of goals at this stage of care, perhaps uppermost and certainly easier to describe was the physical care. All combinations of groups were tested for association with this aspect of care and no significant differences were found.

R103: "If you know (they are dying) you spend a lot longer with them. You give them a thorough bed bath, mouth and eye care, things that are not done unless they are really necessary or the patient is dying." (NA)

R001: "I become more physically involved, with turning, mouth - care and so on ... I move nearer to the patient at the end stage. I feel a sense of responsibility that basic needs are carried out that the patient can't ask for."
(SRN)

2.Psychological Care

It seems likely that many respondents were also aware of the importance of providing for patients' psychological needs, and this would seem to be reflected in the number of respondents who said they spent time sitting and

/ or talking with patients who were dying. 51% of the sample or 35 respondents spontaneously gave this reply, of whom 18 were from Hospital 1 and 17 from Hospital 2. Replies were tested for an association between response and hospital, grade and whether nurses worked as day or night staff. The only significant association was with hospital, with more staff from Hospital 1,perhaps predictably, giving this response : $X^2 = 5.77$; df =1; p= <.025.

R115: "If you know they are dying you try and find time to sit with them - it must be quite frightening, especially if they know they are dying. We usually manage to do this." (NA)

R004: "You spend more time sitting and talking ..... they need the comfort of having someone sitting with them because they may be frightened." (SRN)

An additional category was used to count respondents who referred spontaneously to the kinds of psychological need they were meeting, 28 respondents, representing 41% of the whole sample. The replies were also tested for association with hospital, grade, and whether a day or night duty was worked. No statistically significant associations were found.

R002: "The goals change.You are more concerned with patient comfort, that they should not be afraid, be peaceful. You give them plenty of opportunity to talk if they want to and are conscious - to reassure them what it will be like." (SRN)

Inferred Psychological Need

It was not always clear whether a particular nurse's response was in fact a reflection of her own needs,or what she thought her own needs might be, in this situation, and which she projected onto the patient.In categorising response to / awareness of psychological needs, an attempt was made to make this distinction. It was not, for instance, sufficient for a respondent to comment that the patient "must be frightened", and a further category, inferred psychological need, was created for comments like this. Fourteen respondents gave answers which could be construed as inferring psychological need, one from Hospital 1 and thirteen from Hospital 2.The association between this type of answer and hospital was statistically significant : $X^2 = 5.02$; $df = 1$; $p = <.025$; with significantly more staff from Hospital 2 making statements which inferred a psychological need from what they anticipated their own needs might be in the same situation.

R211: "If the patient is conscious,they might like you there. It must be awful to die alone, I would hate that myself." (NA)

R112: "I'd like someone to be with me if I was dying." (SEN)

Time Spent with Dying Patients

Twenty - eight respondents (41%) said they would like to be able to spend more time more time with dying patients. There were no differences between the hospitals in the numbers of nurses making this comment. Reasons most often given why a nurse was not able to do this were shortages of staff and the needs of other patients. It was clear from the way nurses talked about their work that they found some aspects of caring for the dying very satisfying, such as physical caring, and it was frustrating not to be able to do it in what they regarded as the proper way. As one nurse commented:

R303 : "Nursing the dying is the most important part of nursing. They can't do anything for themselves, it is important to keep them clean and comfortable. They are very important people." (SEN)

R112: "It would be nice to be able to spend more time sitting with patients who are dying, but with only three on you can't do it." (SEN)

R022: "If you can spend the time, the patient settles better ... it depends how many are poorly. I do like to sit with a dying patient, it upsets me that we can't always be with a patient." (NA)

Twenty - six respondents (38% of the total) commented that they would like more training input about talking to dying patients.These respondents came from all five staff groups and there was no statistically significant difference between hospitals,nor between grades.This suggests that, however experienced staff were,they were also eager to improve their skills.

3.Time with Relatives

Twenty-eight nurses spontaneously referred to spending more time with relatives when a patient was dying. (41% of the sample). The only difference found in how this question was answered by respondents related to qualification rather than ward. Table 2 shows how responses were distributed by grade regardless of hospital :

Table 2 : The Number of Staff in Each Grade Who Said They Spent More Time with Patients' Relatives :

	More Time	
	Mentioned	Not Mentioned
SRN	16	5
SEN	7	13
NA	5	23

SRN's were the most likely to say their role changed in this way, followed by SEN's, while NA's were least likely to give this answer : $X^2 = 17.43$; df = 2; $p = <.005$. This may of course be a reflection of the amount of time already spent by NA's with patients, or that talking to relatives was regarded as the staff nurse or sister's duty, but from comments made it seems also that priorities changed:

R003: " You spend more time with the relatives, keeping them in touch with the situation, getting to know them...we try and give the relatives a break, make sure they are prepared, and that the rest of the family are aware." (SN)

Talking to relatives of a dying patient was most usually seen as the responsibility of the most senior nurse on duty. However, seventeen respondents, 25% of the sample, recognised this as a gap in their knowledge and said they would like more help / training about how to talk to relatives. Five of these worked in Hospital 1; 2 SRN's, 1 SEN and 2 NA's; the remaining 13 were from Hospital 2; 2 SRN's, 8 SEN's, and 2 NA's. Perhaps surprisingly, given the higher emphasis on this area at Hospital 1 and the greater learning opportunities, the lower number of Hospital 1 staff was not statistically significant. However, as Hypothesis 4 shows, the Nursing Situation items relating to the giving of emotional care were ranked high on stress, second highest by four groups, and highest by Group 1.

4.Other Changes in Role

Four respondents referred specifically to their role in relation to their own work colleagues. In particular, they made it their business to be aware if a colleague was particularly fond of a patient, and so might be upset when death occurred. They were also aware when this might be a first experience of death for a staff member, being prepared to give them time and help to deal with the feelings involved.

R105: "You help younger staff who may not have seen a death before. It can be a shock, especially if you've nursed them a long time." (SRN)

R018: "A large part of my role is also to support staff, by being, I hope, approachable, talking to one another. If I realised someone was vulnerable I would take the initiative in making myself available. We do it for each other."
(SRN)

Finally, although not a role change, a number of nurses also said that their attitude to the patient changed. Nine nurses in all mentioned this spontaneously, all from Hospital 2. This change in attitude was accompanied by a change in behaviour toward the patient in keeping with the altering goals of patient care. Staff felt able to relax and be 'softer' with patients, more free to do tasks for them which at other times might seem contrary to treatment or long - term care goals.

R202: "Yes, you act more sympathetically. You are a lot quieter when nursing the patient. You try and get what they want, go out of your way, for example, if they want a cup of tea." (SRN)

R308: "You are more caring - you know it's their last few days. You are more sympathetic, both in what you feel and what you do. You know the patients who always want things but when they are dying you become softer with them." (SEN)

It is clear that many of these nurses regarded the time before death as a special time and that often they found satisfaction in being able to give that extra bit of care, particularly physical care.

CHAPTER 7

REACTIONS TO DEATH

Introduction

The researcher was particularly interested to understand from respondents the feelings they did or did not experience when a patient died.Questions were formulated in two ways : open - ended questioning, in which respondents were ased how they felt when a patient died;and also closed questioning,when respondents were asked specifically whether they felt upset. Responses to the open - ended questioning were too diverse to classify for statistical analysis, but have been grouped under a number of headings to give an indication of the frequency and range of response. Answers about feelings of upset fell into one of the following groups : 1) yes; sometimes; 2) no; not this group of patients; only once; and 3) mixed, such as feelings of upset, sadness and of relief. These responses were categorised for analysis into ' predominantly 'yes ' (N = 51) and ' predominantly no ' (N = 18).

The majority of respondents, 74% acknowledged being affected by patient deaths either usually or sometimes; 'predominantly yes'. The proportion of respondents answering in this way was similar in three of the groups: Group 1 - 10 (67%); Group 3 - 9 (60%); and Group 4 - 11 (73%). However, although the difference is not statistically significant, it is interesting to note that a higher proportion of respondents 9 (90%) in Group 2, Hospital 1 night staff, and 12 (86%) in Group 5, continuing - care staff, responded positively to this question. It might be expected, therefore, that these respondents would show greater evidence of stress and anxiety than the other groups, and this will be explored further in the testing of Hypothesis 3, which examines and compares reports of stress in each group.

The remaining 18 respondents gave answers which were categorised as 'predominantly no'. It would,of course, be difficult to ascertain whether respondents answering in this category genuinely were not upset or whether they were coping by the use of denial. However, as much of the literature into stress and burnout suggests, denial of feelings rather than acknowledgment and appropriate coping action can lead to physical and mental signs of stress (Maslach, 1976; Hartl, 1979). If subjects were using denial, therefore, one would expect to identify other reactions on the health measures usd. This will be explored further in Hypothesis 10.

Of the 18 respondents who fell within the 'predominantly no' category, ten gave an unqualified 'no', and eight said they experienced a range of feelings, other than upset, from sadness to relief and gladness when the patient was seen as having suffered. One nurse expressed this range very eloquently:

R001 : I feel very moved, but often more by things families have said. I feel sadness for a fellow human being, but I also often see a triumph over the disease - they stamped through what was left of their lives as best they knew now. I lay them out and feel 'well done, good for you.' (SRN)

A total of twelve respondents (17%) talked spontaneously about one particular death which had had an impact on them, of whom five were from the group of eighteen who said they did not feel upset. Thus, 5 of the 18 (28%) said they had only once been upset by the death of a patient. A number of these talked very movingly about, usually, their first professional experience of death. They had most often been closely involved with the patient prior to death and so very much affected by it.

R302: "I try not to get involved. I did during training and regretted it ever since ... it was 14 years ago. I was very upset. I felt like I wanted to give in nursing and it took me quite a while to get over it." (SEN)

R310: "I'd never seen anyone old before. It upset me more to know that he knew ... I try and treat them all alike. The relationship you have doesn't really affect how you feel. I think geriatrics, if they've been ill, if they go, it's a happy release. I don't get upset." (SEN)

Respondents were also asked if they were affected by a death which occurred when they were off duty. Of the total sample (N=69), 25 or 36% said 'yes' or 'sometimes', and 64% (44) said they were either not affected or were less affected than when a death occurred while they were on duty. Only two nurses, both in Group 1 said they were at least equally affected by a death which occurred when they were off-duty. One nurse, with strong religious convictions, talked of the relationship she made with patients and why it affected her, thus :

R003: "If you know and love someone well you would like to be there and they would be on my mind off duty. I would think and pray for them more - and you check as soon as you come on duty." (SRN)

The second respondent in this category said she felt more upset about a death that occurred when she was off-duty:

R015: "I accept death as natural. If you are on duty for a long period, you are there when the patient dies and you see the relatives the next day. That helps. You see it through and finish it. I find I am more upset if I am not there." (SRN)

The idea that being present at the death in some way helps a nurse to round things off is reiterated by a number of respondents in other categories:

R102: "Sometimes I am affected. There was a patient I was fond of who died when I was off - duty. I would have liked to be there." (SEN)

R001: "Sometimes I feel cheated. If you have become very close, very involved in the physical care,I would like to be part of the end. Sometimes I haven't said my personal good-bye, or I wasn't prepared for it." (SRN)

Not all respondents felt like this however:

R014: "Sometimes it affects me, if I'm fond of a patient - but I wouldn't want to be there when they died. I would want to nurse them, but I would hope they didn't die while I'm here." (SEN)

R305: "It affects me less if I'm off. I'm pleased if they go while I'm off. They get to be - well, not like your parents, but they look for you,although they can't talk." (NA)

Explanations that Ameliorate the Impact of Death

Respondents mentioned a variety of feelings and thoughts which were evoked by the death of a patient. Many of these could be regarded as contributing to a reduction of the impact of death on themselves, making it more acceptable and less upsetting.

i). 'They've had their life'

Of the 44 staff who worked with the elderly, 18 (41%) said they felt less upset or not upset when an elderly patient died unless there were some other factor involved. Death was seen as more acceptable when the person was elderly :

R205: "It's easier to accept the death of an elderly patient ... They are often lonely, and they've had a good life, so it's not so upsetting." (SEN)

R103: "They have lived their life, had their innings. They must know they are not going out of here except dead. They must have accepted that ... they know they are going to die." (NA)

2). 'A happy release'

A number of staff (17) from all groups described death as a happy release from a life that was miserable, or from suffering or pain. These represented 25% of all respondents:

R304: "Death is sad anyway - it's a life gone. Then I think it's a happy release. Many of them are riddled with arthritis, or in a lot of pain. Lots are generally miserable, they have given up their home, they feel it's the end." (NA)

R206: "You feel sorry to lose them, but you also think it's for the best, there's no more suffering ... I just accept it as part of the life cycle." (NA)

R022: " Usually I wish for them to die becaue it is distressing to see them alive. Then they are out of pain and at peace ... By the time they die ... they are not the same person. That makes it easier." (SRN)

3).'A peaceful death'

Not unnaturally, a peaceful death, was more easily accepted than one that had been difficult and distressing:

R106: "The whole thing, being there to comfort the patient,if you've done your best and they die peacefully, it's a nice feeling." (SEN)

R030: "If we haven't got the medicines right and you feel it's been a mess, that is more distressing. You feel you have failed." (SRN)

4).'God's will'

Of those with a religious faith, one respondent explained how this helped her cope with death:-

R003: "I don't believe God allows anyone to die unless it's the right time." (SRN)

The Emotional Impact of Death on Staff

1. Fear of Death

While no nurse acknowledged she was afraid of death, only seven spontaneously said they were not afraid of death, four from group 1, one from group 2, and two from group 5. Four of these had a very committed Christian faith, one a firm belief in an afterlife, one a more ontological and the seventh a humanistic philosophy of life and death:

R009: "It's part of life - we are all born, live and die. I believe life goes on afterwards, but for everything, birds, trees etc. Why should I be better than that ?" (NA)

A further two nurses considered that working with the dying had altered their attitude toward dying to a more positive one : one from Group 2 and one from Group 3. Neither of these had clear religious beliefs, but one said she believed in an afterlife.

R312: "I really believe there is an afterlife. Most of them look - nice, peaceful.It helped me to face the possibility of my own death. I dreaded nursing the deaths, I didn't know how I would react." (NA)

2.Feelings of Deference

It was clear that for many staff, death was regarded as a special time, which should be treated with deference as a mark of respect to the patient who had died. 18 respondents (26%), from all groups,spontaneously made comments that could be categorised in this way. In one way or another, all the comments related to management of the patient's body after death, including laying out the body. Several nurses from Hospital 2 commented on what they saw as the impersonal and hurried way in which the body was dealt with "nowadays".

R306: "There should be more respect for the dead body. It's parcelled up very quickly. There should be more time to lay out, to comb the hair, wash the hands and face. I try to do this, but you have to get them out to free the bed." (SRN)

A number commented with pride on the special efforts they made to make the body look nice, welcoming the chance to lay out the body of patients they were fond of as the last thing they could do for them, or perhaps as a way of saying good - bye, nine respondents, (13% of all staff) :

R028: "There was a young patient who died - we washed her and did her hair. Then we put on a white nighty.With her long hair, she looked lovely. Her brother wanted to see her early next morning and we wanted him to see how lovely she looked." (NA)

Others, again from Hospital 2 spoke with nostalgia of the old days, and would no doubt have envied the greater time with which staff from Hospital 1 were able to approach this part of the work :

R303: "Years ago you laid them out yourself and walked ahead of them to the mortuary, and left them with a flower in their hand ... I always comb and fluff up their hair, put their teeth in and try to make them look nice,and I always say a prayer." (SEN)

3.Self-Questioning

It was not unusual for respondents to go through a period of self - questioning, of thinking over what happened after a death. It sometimes seemed as if this was a necessary part of assuaging what might otherwise be a feeling of guilt, albeit inappropriate. A number of staff from each group, 19 in all, representing 28% of the total sample said they asked themselves if they had done enough,or all that could be done.

R021: "We had three deaths in one night - they were all horrendous. You ask yourself if you could have done more, you feel guilty it happened." (NA)

R213: "You feel happier if you know you have done everything you can, you don't feel guilty." (SRN)

R115: "You think of all the things you could have done ... It's like a family, you say things, maybe you are a bit short ... " (NA)

Allied to this was a feeling of self - blame or personal responsibility for a death which happened unexpectedly, such as when a nurse was tending to a patient. Three nurses referred to such an incident, which in each case had been early in their nurse training.

4.Feelings of Relief

Of the total group, 14 respondents (20%) mentioned feeling a sense of relief after a death. This was invariably associated with the feeling that pain or suffering was also over. The respondents came equally from Groups 1,2,4 and 5. There were none from Group 3.

R018: "I feel relieved - they are no longer suffering - it's the final stage of what we are trying to achieve in our philosophy." (SRN)

R203: "Quite often with this age group you feel relieved when they die." (SRN)

R116: "I say I mustn't get upset, but I do, but I also have a feeling of relief." (NA)

5.Sense of Numbness

As well as a feeling of relief, respondents frequently mentioned a sense of disbelief, numbness or shock. This was particularly the case when a patient deteriorated and died unexpectedly. This was referred to by 15 participants, (22%), who came equally from all groups except Group 2, where none mentioned this feeling.

R313: "If it was unexpected, a good patient, someone who was really with it, it's a real shock, you can't take it in." (NA)

R004: "If it's sudden it shocks you, you feel numb." (SRN)

R019: "Sometimes I just feel numb and that is worse. They were special to someone and I feel nothing." (SEN)

R215: "There was a patient who died recently of leukaemia. He knew and kept saying 'I don't want to be a nuisance' ... It was still a shock when he died." (SEN)

6. Irritability and Sense of Unjustness

While only four respondents reacted with a sense of unjustness at times, two from Group 2, one each from Groups 1 and 5, a further 7 staff were aware that they felt moody or irritable after a death, sometimes on the ward, sometimes later, at home. No respondents from Groups 3 and 4 were in this category, which represents 16% of the total sample.

R107: "My family know when I get in. I take it home with me. I slam the door and they know." (NA)

R030: "If there has been a run of deaths ... you don't have a lot left to offer. Then silly little things at home set you crying over the cornflakes, or you become snappy." (SRN)

R019: "If you are sad and want to burst into tears, the bells are still going, you have to get on. It does affect you and you may be snappy at home later." (SEN)

There was also a feeling that it tended to affect the ward atmosphere generally, particularly if there had been a run of deaths, with staff tending to feel more dissatisfied,tired and irritable over little things.

7.Feeling Despondent

A further 15 respondents (22%), described feeling rather subdued, quiet and low or despondent after a death. They were aware of being quieter or less jolly for a while with other patients.

The responses given by these nurses will be taken up again in the discussion, and looked at in the light of the current knowledge available on bereavement.

CHAPTER 8

THE AWARENESS SITUATION

Much has been written about the isolation and pretence that surround the dying patient (Kubler-Ross, 1969; Glaser and Strauss, 1965), leaving him alone with unspoken fears and anxieties. One of the interests in this research was to see to what extent the respondents in this study felt comfortable to open up discussion of the otherwise taboo subject of dying / death.

Since it is part of the ethos of the hospice philosophy espoused by Hospital 1 that patients should be given the opportunity to ask about their illness, and to create an open atmosphere, one would expect staff in Groups 1 and 2 to be more aware of and more comfortable in meeting these needs than other groups, especially if they had also been on the appropriate JBCNS / ENB course. These courses were made available to qualified staff only. It was expected that more staff from Hospital 1 than Hospital 2 would have attended such a course because of its direct relevance to the nature of the work, and this was indeed so. In Hospital 1 all the SRN's and 2 out of 4 SEN's in Group 1 (day staff) had been on this course; but only 1 of 3 SRN's and no SEN's from Group 2,night staff. In Hospital 2,no night staff had been on this type of course; 2 SRN's, one from Group 4 and one from Group 5 had attended a similar course, whilst 1 SEN from Group 4 had attended an oncology course. It was unclear whether content of the latter course included management of psychological needs in patient care, which was included in the 'Death, Dying and Bereavement' course.

All respondents were asked whether there was any policy on their ward about what a dying patient should be told, and how they would respond if asked. It seemed at times that nurses were uncertain about whether there was a policy, suggesting that if there was one about how such situations should be managed, it was by no means clear to all staff. It may be also that respondents were confused by the reference to policy, and the formality that implied. Their answers show that respondents tended to manage in the manner with which they felt personally comfortable. Ten respondents, two from Hospital 1 and eight from Hospital 2 said they had not had the experience of patients wanting to talk about dying and five respondents from Hospital 2 qualified their answer by saying they had limited experience of patients asking. Although respondents frequently gave multitiple responses, nevertheless, it was possible to classify their answers firstly into one of three categories : those who would pursue the conversation with the patient; those who gave a qualified yes; and those who would not, for whatever reason. Table 3 shows the distribution of responses between each hospital. For simplicity, responses have been labelled as 'Yes', 'Conditional' and 'No'. Respondents who said they had no experience of patients wanting to talk about dying have been classified as saying 'No'.

Table 3 : Would You Confirm If a Dying Patient Asked if He was Dying ? Classification of Responses in Each Hospital :

	Hospital 1	Hospital 2
Yes	12	5
Conditional	8	11
No	5	28

The difference in pattern of response between the two hospitals is statistically highly significant,as might be expected given the different ethos and staff experience: $X^2 = 15.59$; df = 2; $p = <.005$. This difference remains significant when responses are re-categorised to group the 'Yes' and 'Conditional' responses together: $X^2 = 10.62$; df = 1; $p = <.005$.

The Range of Responses

The range of responses together with the numbers and percentage of subjects giving the category of response in each hospital, is discussed below. It should be borne in mind that respondents frequently gave multiple responses. For example, some said they would change the subject or say something to keep the mood light, but would also tell sister. These have been classified as 'No's. Others have said that they would tell a patient, but would also inform sister or doctor - categorised as 'Yes'; whilst others have said that they would prefer to tell but would have to talk to sister or doctor first,or that it would depend on what the patient already knew. These types of response were categorised as 'Conditional'.

I : Respondents Who Would Not Talk to Patients about Dying.

Thirty-three respondents (48%) gave answers which indicated they would not pursue a conversation about dying with a patient. As has been indicated already 10 of these (14%) said they had no experience of the situation, but usually indicated what they thought they would do. In the case of one nurse, an SEN from Hospital 1, it was clear she knew the way in which she would be expected to respond to a patient in this situation. However, much of the literature (Kubler-Ross, 1970; Glaser and Strauss, 1965) suggests that patients take their cues from staff as to whether a conversation about dying may be opened up, and this respondent has therefore been classified as a 'No'. The respondents included 4 SRN's, 11 SEN's and 18 NA's. Their responses were classified into the following categories :

Not my responsibility;
Change the subject.

1). Staff Who Regarded Talking about Dying as Not Their Responsibility

There were 12 respondents in this category. The three from Hospital 1 were all nursing auxiliaries. Of the 9 subjects from Hospital 2, none were SRN's; 5 were SEN's and 4 were NA's. All said they would refer the patient to a more senior nurse or to the doctor.

R107: "It upsets me if patients comment on dying. I pass it on to the staff nurse. I don't know what to say, and it's not our place to say anything." (NA)

R301: "Lots of doctors hide it from the patient. We have to go by what the doctor says." (EN)

2).Changing the Subject

Eighteen respondents gave answers which indicated their usual response to a comment about dying from a patient was to move the conversation onto another topic. The kinds of response given by these nurses were those which tended toward reassurance; and those which tended toward making a joke of things or generally trying to lighten the mood, and sometimes both. There were no respondents from Hospital 1 who gave answers in these categories. However, this does not mean that this approach was never used, and it may be that staff would be unwilling to admit responding in this way.

i).Reassurance.

Eight respondents dealt in this way with situatons in which patients started to talk about dying. They came from all three staff groups from Hospital 2,and included 2 SEN's and 6 NA's.

Since patients on wards A, B, C, and D tended to be seen as having a longer life expectancy than patients in Hospital 1 by virtue of the latters' medical diagnosis, it is possible that reassurance would frequently be the appropriate response. However, nurses in Hospital 1 also commented that they would reassure a patient that he was not going to die just yet, if they knew that to be the case. Since the question was asked in the context of response to patients thought to be dying, therefore, it seems legitimate to conclude that the reassurance given was contrary to what the nurse thought the real situation to be, and had the effect of closing further discussion.

R208: "I try to reassure them, give them a bit of hope. Sometimes patients get better again." (NA)

R308: "I comfort them, make them feel they won't be alone and that it'll be alright. I would reassure them they were not dying." (EN)

ii).Lighten the Mood

Twelve staff from Hospital 2 (17%) of the whole sample, responded in ways which they described as making light of the subject, making a joke and keeping the patient cheerful. Again, there are no respondents from Hospital 1 in this category. The twelve respondents came from all three staff groups in Hospital 2 and included 2 SRN's; 3 SEN's; and 7 NA's.

R214: "I tend to turn patients aside.Perhaps I maintain an air of false jollity, of bonnomie. I hope not.Your training conditions you. We had no guidelines as students. We always had to say we'd ask sister or doctor. Perhaps that's my defence mechanism." (SRN)

R304: "I had a patient who said she was going to die, and she did later that night. I tried to make light of it, not so much a joke. I said 'there's no space up there for you yet'. Personally, I think you should be able to tell a patient if they want to know." (NA)

This type of response would seem to be related more to Hospital than qualification, but bearing in mind the prevailing ethos of Hospital 1, one would not expect to find respondents answering in this way, and indeed in the context of ward expectations, this would be seen as a professionally undesirable response.

II Respondents Who gave Conditional Answers

There were 19 respondents who gave an answer which was a conditional 'yes' but which indicated that the way in which the situation was managed by the nurse depended on other factors or considerations. These included taking into account what the patient already knew or had been told by the doctor; whether the doctor in particular would agree to the nurse pursuing such a conversation;and whether the respondent herself felt competent to handle it. Respondents in this category included 4 SRN's, 7 SEN's and 8 NA's.

i). Six respondents said they would only pursue the conversation with the patient if the patient already knew that he was dying, and / or that it was not their place to be the first to tell the patient. Two of this group,both SEN's were from Hospital 1; the remaining four were from Hospital 2 - two SRN's, one SEN and one NA. A further two nurses, one SRN and one SEN, both from Hospital 2 said they would have to refer to the doctor first and would need his agreement before they would tell a patient.

R203: "If you know the patient really wants to know,I would tell, but I would have to refer back to the doctor first." (SRN)

R006: "I wouldn't tell a patient if he didn't already know, but I would pass it on to someone else ... I feel more confident than when I first started." (SEN)

R306: "I usually ask whether the patient is aware (he is dying). It's not our place to be the first to tell them,but if I was put in a corner I would personally tell. For instance, there was a lady last week who realised for herself. I knew she suspected, because of all the extra attention." (SRN)

2). Four respondents, one SRN and one SEN from Hospital 1, and two SEN's from Hospital 2 said it would depend on the patient; either on the relationship they had with the patient, or on how they thought the patient would react to being told. One of the SEN's also said it would depend on the doctor's agreement. A further six staff from Hospital 2 said they would explore why the patient was asking and depending on this might tell the patient or refer the patient to a more senior person. They were 3 NA's, 1 SEN and 2 SRN's.

R021: "Normally I would pass it over to a staff nurse, but if it is someone I've managed to relate to I would do it myself, depending on what they had aleady been told. Or I would suggest they see sister or a doctor." (NA)

3).Four NA's, all from Hospital 1, said they would answer the patient's questions to the best, or limit, of their knowledge before referring the patient to someone more senior if further explanation were required.

R009: "With new patients I always note what they know because I don't want to jump in with both feet. If the patient brings the conversation to me and starts talking about the illness,then I will talk about it if it's not too technical,otherwise I would ask sister to come and speak to them." (NA)

The respondents in this group set more conditions on their decision whether to talk to a patient about dying, saying that they would talk to the patient if he was already aware of his situation and had talked to a doctor or trained nurse. Otherwise, they would discuss with senior staff first. Sometimes, their reaction would also depend on the relationship the nurse had formed with the patient. Respondents in this group were less likely to have a first discussion with a patient, particularly without prior reference to a more senior member of staff, or a doctor, than the next group to be discussed.

III Respondents Who Would Talk to Patients about Dying

There were seventeen respondents, from all five groups, who said they would pursue a conversation about dying which a patient attempted to open up, and would tell a patient who asked whether he was dying. Only five of these respondents were from Hospital 2, and all were SRN's. Of the twelve from Hospital 1, 8 were SRN's, 2 were SEN's and 2 were NA's.

The seventeen respondents in this group felt most able to make a decision about talking to a patient who indicated a wish to discuss dying without immediate reference to other staff, although this did not mean they acted in isolation. They kept themselves informed and in turn informed others about the current state of the patients' insight / awareness. Among these staff,in talking about dying to a patient, the approach used was most usually one of gentle exploration of how much the patient knew, wanted to know or suspected.

R003: "Each patient is an individual so I wouldn't treat them the same. It would also depend on what had gone on before. I would ask them what they thought and why. If someone hasn't faced it before I ask why they think they are dying - you let them tell you. If I am unsure what they want to know, I try and get them to answer their own questions." (SRN)

R101: "It depends on the patient.I ask why they think they are dying. You should be honest but not blunt. I would ask how they feel and I would agree they're poorly." (SRN)

Conclusions

Whether a nurse felt able to pursue a conversation which the patient opened up therefore depended on a number of things : perceived ward policy; the relationship between nurse and patient; what the patient had been told or knew already and the nurse's experience or understanding.

Among Group 1 and 2 respondents, there were none who said they would have to refer to senior staff or the doctor if they felt the patient was wanting to talk and if they felt competent to respond. This clearly reflects the fact that in Hospital 1, predictably, the expectations about talking to patients about dying were more clear-cut. Staff already knew that they had the approval of medical staff in opening up conversations with patients who seemed to want to talk, and were more likely to be aware of what the patient already knew or was asking, since such information would be shared both formally, at the ward report, and informally.

Attitude to Talking about Dying. and Qualification

As was reported at the start of this chapter (pp.136-37), a significant relationship was found between the way in which respondents replied to this question and the Hospital where they worked. However, because of the different levels of training received by staff, it is possible that the way in which respondents answered was a reflection of their training rather than the Hospital and ethos in which they worked. Table 4 shows the distribution of responses in relation to the nurse's qualified status.

Table 4 : Nurse Qualification and Whether They Would Talk to Patients about Dying:

Response \ Status	SRN	SEN	NA	Total
Yes	12	2	2	16
Conditional	5	7	8	20
No	4	11	18	33
Total	21	20	28	69

$X^2 = 20.71$; df = 4; $p = < .005$.

The X^2 showed a strong association between response and qualification. A comparison of the residuals shows that the largest difference between the observed and the expected response rate was for SRN's answering 'Yes' (Residual = + 7.1); whilst NA's were the most likely to answer 'No' (Residual = + 4.6) and SRN's least likely to say 'No' (Residual = - 6).

The question that remained was whether Hospital or qualification was more strongly associated with response. This was not easy to answer because the size of the sample meant that the numbers of staff of each grade in each hospital were small when compared for type of response. Table 5 shows : 1). the percentage of respondents who said they would or might talk to a patient about dying

(Yes / Conditional); 2). the number who said they would or might; and 3). those who said 'No', for each grade in each hospital.

Table 5 : Staff Who Would / Might Pursue Conversation About Dying and Staff Who Would Not by Grade and Hospital :

	Hospital 1			Hospital 2		
Response	SRN	SEN	NA	SRN	SEN	NA
1.Would/Might As a %	100	83	60	75	21	22
2.Would/Might (N=)	9	5	6	9	3	4
3.Would Not (N=)	–	1	4	3	11	14

Although numbers were small in each group, when the figures are displayed as a percentage for each group a clearer trend emerges, showing that while the difference between hospitals is negligible for SRN's, considerably more SEN's and NA's in Hospital 1 than Hospital 2 either would or might pursue a conversation about dying with a patient who asks. It would seem therefore that although Hospital and grade influenced the way in which nurses answered this question, the grade of the respondent, in particular whether she was SRN, was more important in Hospital 2.

PATIENT AWARENESS

Although respondents were asked to relate their answers to actual experiences and how they had responded, it is of course possible that staff tended to give answers that they felt were either wanted or acceptable to the interviewer. However, a number of additional questions were asked which allow a degree of cross - checking of responses. All respondents were asked whether they thought dying patients were usually aware that they were dying (at the stage when they were conscious) and whether they ever wanted to talk about it. Their responses are shown in table 6, below. When grade and hospital are taken into account, the distribution pattern of responses to the Questions a). How would you respond if a dying patient asked you if he was dying; and b). In you experience,do dying patients want to talk about dying; is very similar, as comparison of Table 5 (p.146) and Table 7 (p.150) demonstrates.

Respondents were asked first whether they thought dying patients were aware of the fact they were dying. Table 6 shows the number of respondents in each group who replied 1). No / Rarely; 2). Sometimes; and 3). Mostly. One ' don't know' response was received, from a nurse in Group 4. This group of questions was therefore answered by only 68 nurses. Percentages are given in parenthesis.

Table 6 : The Awareness of Dying Patients as Perceived by Nursing Staff,Showing Number and Percentage in each Group :

Response	Hospital 1	Hospital 2
No/Rarely		
Sometimes	1 (4)	19 (43)
Mostly	24 (96)	25 (57)

X^2 = 9.92; df = 1; p = <.01.

A predominance of staff thought patients were mostly or sometimes aware of their dying status. The way in which respondents answered this question was significantly associated with Hospital. Twenty - four staff from Hospital 1 thought patients 'Mostly knew', one thought they 'Sometimes knew' but none thought they 'Rarely knew. Among Hospital 2 staff, three thought patients 'Rarely knew', sixteen thought they 'Sometimes knew' and twenty - five thought they 'Mostly knew'.

The means by which staff knew this were various and sometimes unclear. It might be by things the patient said, or did, or indeed stopped doing. Five respondents, two from Group 2 - Hospital 1, and three from Hospital 2, one in each group, said they just sensed that patients knew .

R202: "You just know. It's nothing they say." (SRN)

R022: "They see it all around them. It would be difficult not to have an inkling." (NA)

More usually however, respondents were able to expand on how they assessed whether a patient knew. A large number said the patient's attitude changed, they gave up, withdrew, stopped eating and drinking and so on, and these signs were interpreted by the nurse as indicating awareness. Of the 68 respondents, 36 answered in this way : 8 (32%) of Hospital 1 staff: and 28 (64%) of Hospital 2 staff. The difference between the Hospitals is significant : $p = <.025$: $df = 1$; $X^2 = 5.14$.

R005: "(They) pick up signals from the family, from seeing others poorly. Sometimes you know by things they say, or their attitude changes, they become very quiet and withdrawn, or verbally aggressive, they stop doing things or get cross with their families." (SEN)

However, 40 respondents also said they knew because of things the patient said: 18 of 25 Hospital 1 nurses (72%); and 22 of 43 staff from Hospital 2, (51%). The difference is not statistically significant; $X^2 = 2.04$; df=1.

R103: "Most say something in a roundabout way, for example 'I've seen my daughter for the last time'. Most have usually been right." (NA)

R018: "When they say ' the doctors have never told me what's the matter with me and if they did I wouldn't want to know', or they stop talking about home, or make only short-term plans." (SRN)

Respondents were also asked whether patients wanted to talk about dying, in their experience. Answers were categorised into :

1).No / Rarely / Not in my experience, N = 39 ; - (No)
2).Sometimes, N = 27; - (Yes)
3).Often . N = 3. - (Yes)

This was then further broken down into : 'No', N = 39; and
'Yes' N = 30.

Of the 30 respondents answering 'Yes', 17 were from Hospital 1 and 13 from Hospital 2. Eight nurses from Hospital 1, and 31 nurses from Hospital 2 said 'No'. The difference in response between Hospital 1 and Hospital 2 staff was significant, at $p = < .005$; $X^2 = 8.00$; df = 1. However, as Table 7 on page 150 shows, there were also differences in how trained and untrained staff replied to this question. The percentage of nurses of each grade answering yes and no is given in parenthesis.

Table 7 : Number and Percentage of Each Grade of Staff in Each Hospital Who Said Patients Wanted and Did Not Want to Talk About Death :

	Hospital 1			Hospital 2		
	GRADE					
	SRN	SEN	NA	SRN	SEN	NA
Response						
Yes	8 (89)	3 (50)	6 (60)	9 (75)	2 (14)	2 (11)
No	1 (11)	3 (50)	4 (40)	3 (25)	12 (86)	16 (89)

The response to this question by staff of different grades was tested using the X^2 measure of association, firstly by grade regardless of hospital. Four SRN's, fifteen SEN's and twenty NA's said 'No / Rarely': and seventeen SRN's, five SEN's and eight NA's said 'Often / Sometimes'. A strongly significant association was found between response and grade : $X^2 = 17.45$: df = 2: $p = <.005$. This was due in large measure to considerably more SRN's answering this question affirmatively, whilst SEN's and NA's were more likely to answer in the negative. However, as Table 7 illustrates, the difference between grades was contributed primarily by staff in Hospital 2. The difference in response between grades was also tested, therefore, taking hospital into account. Owing to the small numbers involved, and because of the marked difference between SRN and other grades in Hospital 2, it was decided to group together SEN and NA grades and to maintain SRN grade as a separate group for this analysis. Table 8 shows how many staff of each grade answered 'Yes / Sometimes' or 'No / Rarely' in each Hospital. Percentages for each group are again shown in parenthesis.

Table 8 : Number and Percentage of 1) SRN's and 2) SEN and NA Staff Saying Patients Wanted (Yes) / Did Not Want (No) to Talk about Dying in Each Hospital :

	Hospital 1		Hospital 2	
	SRN	SEN/NA	SRN	SEN/NA
Yes	8 (89)	9 (56)	9 (75)	4 (13)
No	1 (11)	7 (44)	3 (25)	28 (88)

The difference in response between grades was statistically significant only for staff in Hospital 2 : $X^2 = 13.82$; df = 1; $p = <.005$, with more SRN's answering 'Yes' than either SEN's or NA's.

In general, qualified staff of SRN grade in both hospitals experienced patients as wanting to talk about dying at least sometimes. The three respondents who replied 'often' were all SRN's from Hospital 1. In addition, staff of SEN and NA grades in Hospital 1 were far more likely than their counterparts in Hospital 2 to perceive or have experienced patients as wanting to talk about dying 'sometimes', as might be expected from the differing ethos. If, as the literature suggests, patients respond to cues from their carers that dying can be discussed ,then it would seem that the qualified (SRN) staff in this sample, and staff generally in Hospital 1, at least mostly felt competent to manage such a conversation. Although it cannot be ruled out that these staff were responding in a socially, or perhaps professionally acceptable way, respondents were encouraged to discuss actual experiences and not to talk hypothetically.

The Awareness of Other Patients

In order to broaden the assessment of the awareness situation on the wards, staff were also asked about the awareness of other patients when someone on the ward was dying. Only 2 nurses, both from Hospital 1, thought other patients were not aware. The majority of staff, fifty - two, or 75% of the sample, said other patients were aware; of whom 23 were from Hospital 1 and 29 from Hospital 2. 15 nurses, (22%), all from Hospital 2, thought they were sometimes aware - Most often, this was thought to depend on how 'with it' the other patient was and so able to comprehend the extra time, attention and bustle around the dying patient. Significantly more respondents in Hospital 2 replied 'no / sometimes' compared to Hospital 1, where a preponderence of staff said other patients were 'Mostly aware': $X^2 = 4.62$:df = 1;p = < .05 .

The ability of patients on the geriatric wards to take in and understand their surroundings might well have been generally more impaired than that of patients on the palliative care ward. However, this did not appear to be true during the weeks when the researcher was working on the wards. A more relevant difference lies perhaps in the approach of staff on those wards toward what those patients were or were not told, and perhaps how openly death could be talked about. All respondents were asked whether they would tell other patients when someone on the ward was dying. Their answers are shown in table 9 below :

Table 9 : Do You Tell Other Patients when Someone is Dying

Response	Hospital 1	Hospital 2
Yes	25	10
Conditional	-	30
No	-	4

Although the number of respondents saying they would not tell was very small, a large number of nurses said they would only tell if the patient asked (43% of the sample), all from Hospital 2. When 'Conditional' and 'No' responses were combined and compared with 'Yes' responses, the difference between hospitals was statistically significant : $X^2 = 34.94$; df = 1; p = <.001, as perhaps should be expected, given the ward ethos. It was in fact practice for staff in Hospital 1 to tell other patients when someone was dying in order to reassure or allow the expression of anxieties, since it was thought patients would be aware of what was happening. On the continuing care wards nurses were also far more likely to tell other patients, amongst whom friendships were often seen to have formed : 8 answering 'yes' compared to none on the acute wards, and only 2 in the night staff group.

Respondents were also asked whether other patients usually wanted to talk about dying. The replies are shown in table 10, and have been categorised into no, sometimes and yes.

Table 10 : Do Other Patients Want to Talk About Dying? :

Response	Hospital 1	Hospital 2	Total
No	4	17	21
Sometimes	13	22	35
Yes	8	5	13
Total	25	44	69

$X^2 = 6.32$; df = 2; $p = < .025$.

Conclusion

The failure to find a significant difference between staff of varying grades in Hospital 1, and the finding of significant differences generally between Hospital 1 and Hospital 2, suggest that Hospital 1 staff more often felt competent to manage death - related conversations, and that nursing qualification was not the only, nor the most important factor. Rather, in Hospital 1, all staff had been appointed knowing they would be working with terminally ill cancer patients in the first place. They had chosen to do this in full awareness of the approach used, and several said this had been one of the attractions of the post. Therefore, it seems reasonable to assume that they may have been more predisposed to talk about death any way. The ward ethos not only permitted but encouraged staff to allow patients to talk in this way. Additionally, the figures for the number of deaths on each ward (see appendix 10) clearly show that staff in Hospital 1 had much greater day to day experience of the management of dying, so that there would be more opportunity both to practice one's own skills and to observe and learn from others.

CHAPTER 9

FEELINGS AND THEIR MANAGEMENT

I Relationships with Patients and Experience of Upset

It might be expected that nurses who become involved with their patients, or with some patients, will be more upset when those patients die. All respondents were asked whether they found they became more involved with some patients or always formed a normal professional relationship, and whether they were upset when patients died. In coding, a distinction has been maintained between usual and once - off reactions. The range of responses received fell into the following categories:

i).Respondents who defined their relationship with patients as 'professional' and did not become involved. This group included respondents nevertheless who said they liked some patients more than others, (N=12):

ii).Respondents who said they became 'involved' with patients they nursed, or more involved with some patients, (N=57);

Nurses in the latter category talked of feeling close to and / or fond of patients. There were no differences in the proportions in each of the five staff groups between those who defined their relationship as 'professional' and those who defined it as 'involved'.

Having thus defined their relationship to patients, all respondents were then asked whether they usually felt upset when a patient died. Table 11 shows the breakdown of their responses.

Table 11 : Experience of Upset and Nature of Relationship with Patients :

	Involved	Professional	N =
No Upset	13	5	18
Upset	44	7	51
N =	57	12	69

$X^2 = 1.90$; df = 1;

The association between the nature of the relationship with patients and the experience of upset is not significant.

It is the purpose of this section to look at how respondents say they behave / react after a death. The first part looks at those who deny feeling upset at the time of death and the way they say they behave afterwards. The second section looks at the behaviours reported by respondents who said they did experience feeling upset. Table 12 shows the numbers in each staff group reporting 'upset' and 'not upset', with percentages for each group shown in parenthesis:

Table 12 : Numbers of Respondents Reporting 'Upset' and 'Not Upset' in Each Staff Group as a Percentage of that Group :

	Group				
	1 N=15	2 N=10	3 N=15	4 N=15	5 N=14
Upset	10 (67)	9 (90)	9 (60)	11 (73)	12 (86)
Not Upset	5 (33)	1 (10)	6 (40)	4 (27)	2 (14)

The responses of subjects who described their relationship as 'professional' and those who described it as 'involved' will be dealt with separately in each section.

Categorisation of Responses

Respondents were categorised depending on whether they said they felt upset or not when a patient died, and within each group were further divided according to the way they described themselves as normally behaving after a death. Table 13 shows the numbers in each category :

The 'No Reaction' group are the eight respondents classed as using zero coping responses in Hypothesis 8; and together with the ten avoiders constitute the 'No Reaction / Avoidance' group of Hypothesis 9.

Table 13 : Feelings of Upset and Subsequent Behaviour Following Patient Death :

	Not Upset	Upset	Total
Reaction	6	45	51
No Reaction	8	-	8
Avoidance Reaction	4	6	10
Total	18	51	69

1.Denial of Upset

18 respondents stated that they did not, or did not usually, experience upset when a patient died. They represent 26% of the total sample. Their responses were grouped into three categories : No Reaction, (N=8); Avoidance Reaction, (N=4): and Reaction, (N=6). Five described their relationship with patients as 'professional' and 13 as 'involved'.

a). The 'Professional' Group

These 5 respondents represent 7% of the total sample. Of the five, three talked about patient death in a way which suggested that, in spite of denying any feelings of upset, they did react to the death of patients. Reactions which were mentioned included introspection, prayer, talking to one's own family and humour. The other two respondents talked of carrying on as usual, and no ways of coping, such as thinking about it later, were identified.

R013: "I don't feel upset, but sometimes I think about it later. You think, have I done enough? Could I have done any more?" (NA)

R302: "I think you have come here to do a job and you shouldn't be here if you can't put it behind you." (SEN)

R311: "You do the necessary, pull the curtain and carry on as if nothing has happened." (NA)

b). The Involved Group

Of the 13 respondents in this group, 6 described patterns of behaviour that indicated they carried on as usual. These 6, together with the 2 respondents in the 'professional' group, above, who did not subsequently identify coping reactions constitute those classed as using zero coping reaction' group (N=8); and 8 of the 18 'no reaction / avoidance' group. Hypothesis 10.

R204: "I try to lay them out. Not because I like it but because it's my responsibilty. On a ward like this, you are busy, it's not a case of keeping busy. It may enter my mind later, but I really don't think about it a great deal." (SEN)

R009: "I feel sad when anything dies ... I don't go home and think about it. I don't become morbid ... I feel it is right, so it doesn't perturb me, although if it was somebody special I may think about it later - but I feel everybody has done their best." (NA)

The remaining 7 nurses in this group reported using one or more of the following behaviours, following a death :

Talking to colleagues; (N=2)
Talk to family or friends; (N=2)
Thinking about the death, either at the time or later; (N=4)
Taking a break if time permitted - Time-out; (N=1)
Prayer ; (N=1)
Keeping Busy; (N=4)

The 4 nurses who talked of keeping busy, did so in such a way that it was clear that this was a ploy used to avoid thinking of the death, not always successfully. They have been classed as using a predominantly 'avoidance response', and constitute 4 of the 18 'no reaction / avoidance' group of Hypothesis 10.

R301: "I try and keep busy. It's better to put it out of your mind, and not let yourself get upset about things at work." (SEN)

R117: "I keep busy ... It's not fair to show your emotions, not fair on patients or other staff. You've got to be hard, perhaps you get hardened to it. Maybe inside you feel more upset than you show. I usually find it comes back to me when I'm in bed. If I say a little prayer the picture disappears." (SEN)

To summarise the nature of response of the 18 nurses who said they did not experience feelings of upset, behaviours were categorised into :-

- 8 - No Reaction ;
- 4 - Avoidance Reaction ;
- 6 - Reaction .

2. Acknowledgement of Upset

Fifty - one respondents, 74% of the total sample acknowledged feeling upset when a patient died. Details of their distribution between the five staff groups is given in table 12, page 156; and the breakdown of coping categories in Table 13, page 157. Forty - four described their relationship to patients as 'involved', and 7 as 'professional'.

a).The 'Professional' Group

Of the seven staff who said they did not become involved with patients but were upset when a patient died, one said she coped by keeping busy at the time but thought about it later. Her response was considered to be qualitatively different from others who said they kept busy and she was therefore not classed as using predominantly an 'avoidance response'; three others also said they thought about it later;all seven said they talked to colleagues and three said they would also talk to family or friends.

R105: "I keep busy at the time. I tend to wait until I get home and then I think about it. Maybe talk it over the next day, at work. The busier you are the easier it is to push it aside, but I do think about it anyway ... you feel sad and your mind floats back to it." (SRN)

R021: "We are left to ourselves, we have to back each other on nights. I would talk to the night sister and we talk with each other. I don't usually take work home with me ... I can switch off unless it's a young person." (NA)

R008: "You have to carry on. It is harder to switch off if the death happens just before you go home.This is the right atmosphere to stay in when someone has just died. I don't feel it's my family's job to listen and support ... You've got to think about it - it will come back into your mind." (NA)

b).The 'Involved' Group - i). Avoidance

Forty-four respondents (64%) said they became involved with patients and often felt upset when they died. Of these, 6 or 9% of the total sample said they reacted by keeping busy at the time and trying to put it out of mind. They were classed as using a predominantly 'avoidance' response, and are 6 of the 18 'no reaction/avoidance' group in Hypothesis 10. This class of reaction did not always seem a sufficient response by itself. Other behaviours included feeling tearful (N=2); talking to colleagues (N=4); talking to family or friends (N=3); smoking (N=1).

R107: "My family know when I get in. I take it home with me - I slam the door. They know, and I might comment on it." (NA)

R304: "Death is sad any way. You don't worry about it. You see so many distressing things you would make yourself ill if you thought about it too much." (NA)

R206: "You have to cheer up the other patients. You can't harbour all the deaths you get ... but you feel a bit down if you haven't had time to put it out of your mind." (NA)

Altogether, ten respondents were classified as using a predominantly 'avoidance response', four denying upset and six who acknowledged upset, but reacted by using avoidance behaviour, such as keeping busy or trying not to think about it. Together with the 8 respondents in the 'no reaction' group, they make up the 'no reaction / avoidance' group (N=18) of Hypothesis 10. The 'reaction' group includes all remaining respondents who acknowledged feeling upset, whether they defined their relationship as 'involved' or 'professional', who did not subsequently behave by keeping busy as a way of avoiding thinking about the death. (N=51).

b). The 'Involved' Group - ii). Open Reaction

There were forty-five respondents in all, (65%) of the total sample, who said they became involved, and who often or usually felt upset when a patient died, who identified responses which did not indicate avoidance or attempted avoidance of these feelings. The distribution between the five staff groups is shown in table 14, with percentages shown in parenthesis.

Table 14 : Distribution of the 'Open Reaction' Involved Respondents According to Staff Group, by Percentage in Each Group :

Group	1	2	3	4	5
	(N=15)	(N=10)	(N=15)	(N=15)	(N=14)
	10 (67)	9 (90)	5 (33)	9 (60)	11 (79)

Overall, there were no significant differences between hospitals in the numbers of staff expressing an 'open reaction'. However, significantly fewer Group 3 respondents fell into this category than either their night counterparts in Hospital 1 : $X^2 = 5.68$; df = 1; p = <.025; and also fewer than their than their day - time colleagues in Hospital 2 : $X^2 = 4.85$; df = 1;p = <.05.

Although these nurses acknowledged that they felt upset when a patient died and did not deal with their feelings by trying to ignore them, this is not to say that they always showed their feelings openly at work. Rather, they were aware of those feelings and did find a way of expressing them. In fact, six respondents (14% of the group) said they tried not to show how they were feeling at work:

R211: "At the time I appear perfectly normal. I carry on and it doesn't show. I might cry later at home if it was someone I was fond of. I would talk to my husband ... If I knew other staff felt the same I might talk to them, and I would think it over by myself later, when there is more time to relax." (NA)

R303: "You mustn't show your feelings. You mustn't break down. I cry later, by myself, not at the time. I wouldn't talk about it at home." (SEN)

R024: "It's alright to show you're sad, but it doesn't do to show your feelings too much, especially to the other patients." (SRN)

Respondents categorised as using an open reaction in the involved group were asked about the timing of their reaction to a death, whether it was at the time or later:

45% said they reacted at the time; (N=20)
25% said they reacted later; (N=11)
30% said they reacted both at the time and later. (N=13)

Thirty-nine respondents (89% of this group) reported using more than one coping response. Table 15 shows the coping responses used and the frequency with which they were mentioned.

Table 15 : Coping Response and Frequency of Use :

Coping Response	Frequency (N=)
Talking to Colleagues	42
Talking to Family	24
Talking to Friends	12
Tears	24
Introspection	25
Prayer	8
Time - Out	8
Laying Out Body	4
Talk to Senior Staff/Doctor	4
Humour	6
Other	5

'Other' included having a glass of wine later, and talking to the patient's relatives.

In the five cases where a single response was reported, that response was introspection, either at the time or later. A selection of the range of answers is given below:

R030: "One advantage of being on nights - you do get a quiet period and you can talk about it. We quite often talk amongst ourselves ... We can talk and have a cry and then it's finished. I also talk to my husband. He's a good sounding board." (SRN)

R029: "I walk home – it's a long walk. It's a rule I have. Then I have a bath. If I go home quickly, have a bath and go to bed, I dream about it all again. I do a lot of walking and thinking while I walk." (SEN)

R312: "You think about it again later, especially on long – stay – it's like your gran. I talk to my family ... but we (staff) don't talk among ourselves very much." (NA)

R015: "My faith helps. I usually talk here more than at home. People are very supportive, they always know." (SRN)

R116: "I can talk to my friends, but I live alone. I have no – one at home to talk to. It sometimes helps if I lay them out." (NA)

R210: "If I have the cleaning up to do, see the body or the relatives off the ward, I don't cry much – but I feel sad ... sometimes I go home, I go to bed and try to sleep and can't. It keeps coming back to you.At home it's treated more as a joke." (NA)

II The Effect of a Death On Staff's Work

All respondents were asked whether they thought their work was affected when a death occurred. The majority of staff, (74%) said their work was not affected. A minority (N=18) thought it was. Table 16 shows how this question was answered by staff in each of the five groups. Answers have been categorised as 'Yes', 'Sometimes' and 'No'. Numbers are shown with percentages in parenthesis for each group:

Table 16: How Staff Thought Deaths Affected Their Work, Showing Numbers and Percentage for Each Group :

	Group				
	1 N=15	2 N=10	3 N=15	4 N=15	5 N=14
Effect On Work					
Yes	2 (13)	-	1 (7)	6 (40)	1 (7)
Sometimes	2 (13)	3 (30)	-	1 (7)	2 (14)
No	11 (74)	7 (70)	14 (93)	8 (53)	11 (79)

For the majority of respondents who said it affected how they worked, the effect was on their mood, and they were conscious of feeling sad or subdued as they carried out their nursing duties. Two respondents, both in Group 4, said they tried harder with other patients:

R212: "Yes, it's very traumatic. It takes longer to get back into the swing of things. You feel a bit dejected - keep thinking back to why and wondering if you had done all you could " (SRN)

R007: "Yes, for the rest of that day. It's not that you give any less care, just that you feel more drained, tired." (NA)

R111: "I go and talk to the other ladies more." (SRN)

Respondents were also asked whether patient-death affected how they felt about their work. Again, while a majority said 'no', a few, fourteen (20%) of the whole sample, said it did sometimes. The respondents giving this answer were to be found in all groups : two (13%) in Group 1; five or 50% in Group 2; three or 20% of Group 3; two (13%) of Group 4; and two (14%) of Group 5. While the actual numbers in each group are small, it is of interest to note that in Group 2, Hospital 1 night staff, there is a tendency for more nurses to report that patient death affected them in this way. Because of the small numbers involved, it was not possible to carry out a meaningful comparison between Group 2 and their day-time colleagues, nor with Group 3, the other night staff group. However, it was possible to compare responses of Group 2 staff with the remainder of the sample as a whole. Numbers with percentages in parenthesis answering 'Yes' affected, and 'No' not affected are shown in Table 17:

Table 17 : Number and Percentage of Respondents Who said Patient-Death Affected How They Felt About Their Work :

	Group 2	All Other Groups
Affected		
Yes	5 (50)	9 (15)
No	5 (50)	50 (85)

The difference in the number answering this question in the affirmative between Group 2 and all other groups was statistically significant : X^2 = 4.56; df = 1; p = $<$.05.

R029: "Sometimes I wonder why I do it, but it doesn't last long." (SEN)

R208: " ... it's nice to see patients get better and go home. Sometimes it makes me think of changing jobs, to another department." (NA)

R019: "It sometimes makes me feel I should be moving on. If I start feeling like that I think it's time for a change - I want to give my best." (SEN)

All staff were also asked whether there were ever times when they felt they had had enough .Two respondents thought they had not been on their ward long enough for that. Table 18 shows the number and proportion in each group who said they had never, sometimes and often felt they had had enough.

Table 18 : Number and Percentage of Staff in Each Group Who Had Never,Sometimes or Often Felt They Had Had Enough :

	Group				
	1 N=15	2 N=10	3 N=15	4 N=15	5 N=14
Response					
Never	6 (40)	4 (40)	8 (53)	6 (40)	9 (64)
Sometimes	7 (47)	5 (50)	6 (40)	9 (60)	2 (14)
Often	2 (13)	1 (10)	1 (7)	0	3 (21)

Thirty-six respondents (52%) answered this question in the affirmative. They were 10 SRN's, 10 SEN's and 16 NA's. There were no significant differences related to either hospital or qualification, although Group 5 nurses from the continuing care wards were slightly less likely to express these feelings. Respondents gave a variety of reasons for feeling as if they had had enough, and as some of the quotes show, it was usually a combination of circumstances which led staff to feel this way.

R209: "Only if I'm really tired and the patients are very demanding. I always manage to get myself out of it. I don't look at it too seriously." (NA)

R104: "Not when patients die, but because we are short - staffed, sometimes we can work 10 or 11 days on the trot ... I can't give my best. Things get on top of me. I carry on, but it's too long." (NA)

R101: "After a run of deaths you get depressed- there are new patients to get used to.The workload gets very heavy. It's frustrating - you can't give all the care you want." (SRN)

R025: "Occasionally. There have been periods when we have been particularly short - staffed, perhaps I've been under strain at home as well, or I have felt unwell." (NA)

R206: "When you've had a run of deaths - it seems to be all disposing of dead bodies.You feel down-hearted.I wonder why I am doing this job, and then something happens to make you glad you are." (NA)

R008 : "Sometimes I think I ought to get another job. It's not just the job, it's everything else as well. You can cope with anything if your private life is O.K." (NA)

Table 19, below, shows the range of reasons given by staff for feeling they had had enough and how often the response was given :

Table 19 : Factors Which Contributed to Staff Feeling they Had Had Enough :

Reason Given	Frequency
Run of Deaths	25
Workload/Staff Shortages	15
Tiredness	13
Lack of Consideration	8
Rundown/Unwell	4
Patient/Staff Attitudes	4
A Particular Death	3
Shiftwork	2

Clearly there were usually a number of factors which contributed to staff feeling ready to leave. Nevertheless, these staff had not yet acted on these feelings. Nurses frequently commented on the positive aspects of their job too, sometimes actively remembering or noticing these after a bad spell. Others commented on the importance of a break, or the use of holidays so that these feelings were kept in perspective:

R029: " I've reached a point when I feel I need a holiday, when I feel the whole world is dying of cancer, or is sick. I try to space my holidays so that I get a week every two months." (SEN)

That no staff have as yet acted on their feelings when they have had enough would seem to indicate that they were not long- lasting, especially as sixty - two respondents (90%) said they enjoyed or really enjoyed their job. Only seven (10%) of the sample continued to consistently express mixed feelings, about their job, three saying it was boring or lacked stimulation. All three worked in Hospital 2, two on the night staff.

CHAPTER 10

RESULTS OF HYPOTHESIS TESTING

HYPOTHESIS 1

There will be a positive correlation between staff reports of stress and life events and this will be particularly evident in relation to health measures.

All respondents were asked whether they had experienced in the last twelve months any of a number of life events which may be described as loss, exit or undesirable events, (see appendices 2 and 9)

Results were available for 68 respondents, with a minimum score of 0 and a maximum score of 65. The mean score was 23.56. A one - way analysis of variance showed there were no significant differences between the groups in scoring for life events.

Recent life event scores were correlated, using Pearson's product moment correlation coefficient, with General Health Questionnaire scores and with the number of days illness reported over one, three and twelve months. No significant correlations were found.

In addition, recent life event scores were correlated with the other stress measures used in this study - the Death Anxiety Scale; the Nursing Situations and Death - Related Nursing Situations scales; and the Death Situations scale, using Pearson's product moment correlation coefficient. Again no statistically significant correlations were found. However, there was a slight tendency for respondents who scored higher on life events (RLE) to score higher on the Death Anxiety Scale (DAS) and also to rate Death Situations (DSIT) higher :

RLE	with	DAS	$r = .169$	$p = .09$	$N = 64$
RLE	with	DSIT	$r = .195$	$p = .06$	$N = 64$

However, a strong positive corelation was found between recent life event scores and number of coping methods (COPING) :

RLE with COPING $r = .275$ $p = .012$ $N = 68$

This would indicate that respondents in this study who had higher RLE scores and had therefore experienced more life stresses also used more methods of coping in dealing with upset related to death at work. Why this should be is not immediately obvious. It might be that respondents with more experience of stress had learnt more methods of coping, or that they needed to use more methods in order to effectively deal with stress.

The failure to find any correlation between life events and the stress measures used here suggests either that any stress experienced by this group of respondents was being expressed in a way not susceptible to measurement by the instruments used here, or that the experience of stress was being successfully coped with. The hypothesis is not substantiated.

HYPOTHESIS 2

Nurses who are innately more fearful of death will experience greater stress in nursing situations involving death / dying.

Templar's Death Anxiety Scale (DAS), as modified by McMordie for presentation in the form of a seven - point scale, was used to assess innate fear of death, (Appendix 3). It was expected that nurses scoring high on the Death Anxiety Scale would experience greater stress in nursing situations on the ward, particularly those involving the care of dying patients. Nurses were therefore asked to rate for the degree of stress 19 situations involving the death of a patient, Death Situations Scale (DSIT) on a scale from 0 - 10, according to the degree of stress the situation would cause them, (Appendix 6). Additionally, subjects were asked to rate, on a scale from 0 - 10, 33 Nursing Situations (NSIT), embedded amongst which were 7 Death - Related Nursing Task items (DNT). These seven situations were item numbers 2, 10, 16, 20, 24, 26 and 32. (See Appendices 4 & 5). A total stress score was calculated on each scale for all respondents. The total Death Anxiety Scale score for each subject was then correlated, using Pearson's product moment correlation coefficient *r*, with the total Nursing Situation, Death Situations and Death - Related Nursing Task scores. For the sample as a whole, statistically significant correlations were found between the Death Anxiety Scale and each of the three other measures (Table 20):

Table 20 : Correlation of Death Anxiety Scale with Nursing Situation, Death Situation and Death-Related Nursing Task Scores Using Pearson's r, for the Whole Sample :

Variable	with	Variable	r =	P=
DAS		NSIT	0.3512	.01
DAS		DSIT	0.2834	.05
DAS		DNT	0.4119	.01

Pearson's *r* was calculated also for the same pairs of variables for each of the five sub-samples. No significant correlations were found for Groups 1, 2 (hospice day and night staff) and 5 (the geriatric department continuing care wards). The correlations for Groups 3(geriatric dept. night staff) and 4 (geriatric dept. acute ward staff) are shown in table 21 :

Table 21 : Correlation of Stress Scores Using Pearson's r for Sub-samples :

Group	Variable with	Variable	r =	P =
3	DAS	NSIT	0.5944	.05
3	DAS	DNT	0.7635	.01
4	DAS	DSIT	0.5665	.05

These data suggest that Hypothesis 2 is only partially substantiated, and that the experience of stress in working with death-related situations may be mediated by other factors, independent of the nurse's fear of death. This will be discussed later, in Chapter 12.

HYPOTHESIS 3

Nurses faced with death most frequently will experience greatest death anxiety.

Definition and Measurement of Stress Stimulus

In the context of this study, patient death is defined as the stressful stimulus or condition of threat. Two measures of exposure to patient death were used, both of which will be described here.

i).The number of deaths on each ward was recorded on a month by month basis from hospital records of deaths for a two year period, from January 1983 to December 1984, including the months when the research was being carried out. The table below, 22, shows the annual total for each ward for 1983 and 1984. For monthly totals, see appendix 10.

Table 22 : Total Annual Deaths on Each Ward for 1983 and 1984 :

	Hospital 1	Hospital 2 / Ward			
		A	B	C	D
1983	313	100	114	15	16
1984	340	61	126	16	17

In comparing the totals, the number of in - patient beds on each ward should be borne in mind : 25 in Hospital 1; 20 for wards A, C and D; 24 for ward B. An allowance must also be made for differential rates of bed occupancy (see appendix 11a). The number of deaths per bed for each year, taking into account bed occupancy is shown in Table 23 :

Table 23 : Number of Deaths Per Bed in Relation to Bed Occupancy in 1983 and 1984 Expressed as a Percentage :

	Hospital 1	Hospital 2 - Wards			
		A	B	C	D
1983	9.62	4.72	4.49	0.72	0.77
1984	11.12	2.81	4.93	0.78	0.8

As can be seen, the wards fall into three groups fairly readily,of high - Hospital 1; medium - wards A and B; and low - wards C and D. A marked difference can be seen between the annual totals in 1983 and 1984 for ward A, which stands out as the only one to show a drop in deaths. Although the reason for this remains uncertain, it may reflect a change in bed - use, perhaps an increasing tendency not to admit emergency cases to this ward.

2).The second method used was to ask each nurse how many deaths had occurred while she was on duty in the previous 2 and 4 weeks before the interview. (In the case of staff who had been on leave, the same period immediately preceding their leave). In practice, staff had no difficulty remembering deaths during the previous two weeks, but could not always remember over a longer period. A number of staff in Groups 1 and 2 in particular had difficulty in specifying how many, and this seemed particularly to be so when these had been fairly numerous. This method of measurement gives a more immediate and more individual measure of recent exposure to patient death. Table 24, on page 179 shows the number, with proportion in parenthesis, of staff and the number of deaths they reported as occuring in the two previous weeks, in each group. It should be remembered that day staff in Hospital 2 in fact came from four wards, and for this analysis the wards are also indicated.The 15 staff in Group 4 came from Wards A and B, reported in the table below as 4A and 4B; the fourteen staff in Group 5 came from wards C and D,shown as 5C and 5D. It should be borne in mind that recall may not be accurate. This is a factor which is examined further in Hypothesis 6.

Table 24 : Percentage of Staff and Deaths Reported in the Previous Two Weeks in Each Group and on Each Ward :

	Hospital 1		Hospital 2				
	Group (Ward)						
No.of Deaths Recalled	1 N=15	2 N=10	3 N=15	4(A) N=10	4(B) N=5	5(C) N=8	5(D) N=6
0 - 2	8(53)	4(40)	12(80)	9(90)	2(40)	8(100)	5(100)
3 - 5	4(27)	4(40)	3(20)	1(10)	2(40)	-	-
6 - 10	3(20)	2(20)	-	-	1(20)	-	-

As table 24 shows, the recent experience of Group 4 staff who worked on Ward B more nearly approximates that of Hospital 1 staff, Groups 1 and 2,than their Group 4 colleagues on Ward A. As it is hypothesized that Hospital 1 staff will experience greatest stress because of the much higher number of deaths on the ward.to combine staff from wards A and B into one group for the purpose of analysis was seen as providing a more stringent test. and therefore for the majority of the analyses in this study they have not been treated separately. The experience of Hospital 2 night staff,Group 3, is similar to that of Group 5 nurses, rated as a low ward. Significantly more nurses in Hospital 1 compared to Hospital 2 had experienced :

a).more than 2 deaths : X^2 = 10.27; df = 1; p = <.005; and
b).more than 5 deaths : X^2 = 6.16; df = 1; p = < .025.

It is clear from the variation of experience within groups that a high number of deaths on a ward does not automatically mean high direct exposure to patient death, although it increases the probability of it.On the other hand, even if the nurse is not on duty at the time of death, because of the way the work was organised, she will almost certainly have helped in the care of that patient at some time. Each ward operated a patient rather than task - oriented system of care where possible, but nurses did not work exclusively with any group of patients. Other than night staff in Group 3, who were more often moved between wards, they were therefore likely to know the majority of,if not all, patients on their ward. Thus, although direct involvement at the time of death may have a greater impact than a death which takes place in the nurse's absence, some psychological accomodation to the death may still have to be made.

If Hypothesis 3 is valid, then nurses in Hospital 1 will exhibit the greatest anxiety,as measured by the Death Anxiety Scale, and the scales used to rate for stress in nursing situations on the ward. Nurses on Wards A and B would have correspondingly lower scores on these scales, whilst nursing staff on Wards C and D would have the lowest scores. Where appropriate, night nursing staff have been treated separately.In Hospital 2, night staff might be assigned to work on any of seven wards in the department. It has been assumed that none of these wards had a death rate comparable to that of Hospital 1.

The T-Test for independent samples (pooled variance unless otherwise indicated), was used to test for differences between group means on the Death Anxiety Scale, Death Situation score and Death - Related Nursing Task scales. All possible combinations of groups was tested. The results found to be statistically significant are discussed below.

1.Comparison of the Death Anxiety Scale (DAS) Scores

i) A straight comparison of the DAS scores of nurses from Hospital 1 (H1) with those of nurses from Hospital 2 showed that the mean scores of Hospital 2 (H2) nurses,contrary to expectations, were higher although the difference just failed to reach the level of statistical significance. The T-Statistics reported will all be pooled variance and one-tailed probability unless otherwise stated:

Mean scores :	H1	H2	F=	T=	DF=	P=
	52.2	58.3	1.49	-1.57	63	.061

ii) In addition, DAS scores were compared for day staff only. Groups 1, 4 and 5 - rated respectively as high, medium and low for exposure to death. All night staff were excluded because of the difficulty in assigning Hospital 2 staff to a medium or low group. Table 25 shows the mean scores and the statistically significant differences :

Table 25 : Comparison of DAS Scores : Day Staff on High, Medium and Low Exposure Wards. Groups 1,4 and 5 :

Group	Mean	T=	DF	P=
1	49.0	-2.03	27	<.05
4	60.0			
1	49.0			
5	57.4	NS		
1	49.0	-2.0	39	.027
4 & 5	58.8			

a). Group 4 had a significantly higher Death Anxiety Scale scores than the nurses exposed to the high death rate - Group 1.
b).Day staff as a group in Hospital 2 were also found to score significantly higher on the DAS than day staff in Hospital 1.

Differences between nurses working 1). in the high-rated ward and low-rated wards, and 2). in the medium and low - rated wards. however, failed to reach significance.

2.Comparison of the scoring of the Death-Related Nursing Task items (see appendix 5) also showed that nurses working in Hospital 2 - Groups 3,4 and 5 (medium and low exposure) rated these items as significantly more stressful than nurses in Hospital 1 (high - exposure) - Groups 1 and 2 : T = -2.01 ; df = 62; p = .025; (one-tailed). The differences were also found to be highly significant when day staff only in each Hospital were compared. The findings are shown in Table 26 :

Table 26 : Comparison of Scoring on DNT Items - Day Staff, Groups 1,4 and 5 :

Group	Mean	DF	T=	P=
1	22.7	38	-2.44	.01
4 & 5	34.3			
1	22.7	24	-2.84	.005
5	39.1			
1	22.7	26	-1.698	NS
4	30.2			

In all cases, where significant differences were found they were consistently in the direction of higher reports of stress among Hospital 2 groups, the groups rated medium and low on exposure to patient-death. To summarise,where significant differences were found,they were in the opposite direction from that anticipated.No significant differences were found between the scores of staff on medium and low death-rate wards.

3.Comparison of the Death Situation scores confirmed the trend toward lower scores among Hospital 1 day staff against higher scores reported by Hospital 2 day staff: $T = -3.06$, $p = .002$; $df = 39$; (one-tailed). Significant differences were also found between the medium and low - rated groups, with day staff on low-rated wards scoring significantly higher than day staff on medium-rated wards, ($T = -2.21$, $p = .025$; $df = 24$; one-tailed), also contrary to expectation.

A One - Way Analysis of Variance showed the following items discriminated significantly between the groups indicated, $p = .05$:

Item 8 - Death of patient with young children;
Item 11 - Death of patient who remains conscious to the end

Both were rated as significantly more stressful by continuing-care staff than palliative care day staff.

Item 9 - Death of patient while washing or turning;

This was rated as significantly more stressful by continuing-care than geriatric night staff;

The T-Test was also carried out to look for significant differences between the continuing care and acute assessment ward staff in the scoring of individual Death Situation items. Table 27 shows the items which discriminated significantly between the two groups.

Table 27 : Death Situation Items Differentiating between Acute and Long-stay Staff in Hospital 2 (Groups 4 and 5) :

Item	Group	Mean Score	DF	T=	P= *
1	4	5.86	24	-2.29	0.03
	5	7.08			
7	4	4.43	24	-2.78	0.01
	5	6.00			
8	4	4.21	24	-2.80	0.01
	5	6.08			
17	4	3.86	24	-2.15	0.04
	5	5.17			
18	4	5.57	24	-2.19	0.04
	5	7.33			

*two-tailed probability.pooled variance.

Where a significant difference was found, respondents on the continuing care wards as a group consistently rated these items as significantly more stressful than their colleagues on the acute wards.Apart from experiencing death less frequently on the continuing care wards,one of the most obvious differences is in the average length of time patients stayed on these wards, (see Appendix 11c). It may be that stress is related to the closeness of the relationship between patient and nurse,and this is partly a function of time.

The general trend of the results suggests that, contrary to expectation, nurses exposed to highest rates of death experience less anxiety / upset than others, at least in this sample. It may be that staff who most frequently work with the dying have more opportunity to test out the reality against the fantasy, or that they find in practice they manage these situations satisfactorily, which in turn reduces anxiety.More frequent management also gives staff a chance to practice and enhance or reinforce their skills in this area. Other mediating factors may include the degree of support available to staff, their own expectations in the light of the prevailing philosophy, and the length of time staff have known the dying patient. Where significant differences were found between acute and continuing - care day staff on the Death Situation Scale score, and on individual items, it was nurses on the wards with the lowest exposure to patient-death who were found to have reported significantly higher stress. The reasons for these findings will be discussed in Chapter 12.

HYPOTHESIS 4

Duties which require the nurse to deal with situations involving death / dying will be perceived as more stressful than other nursing duties.

The Nursing Situation Scale consisted of 33 nursing tasks which respondents were asked to rate on a scale from 0 - 10 according to how stressful they found the situation / task described. Results were available from 64 repondents. As the groups were of unequal size, for each of the five staff groups,a mean rating was calculated for each item. Following Wilson,C., (1983), items comprising the Nursing

Situation Scale were grouped into 7 categories according to the nature of the task (see appendix 5):-

Category 1 - Physical Care -Items 3. 4,21 22,25,33.
Category 2 - Medical Care -Items 5,7,27
Category 3 - Emotional Care - Items 6 ,9 ,12,19,23,28.
Category 4 - Communication - Items 13,15.
Category 5 - Death-Related - Items 2,10,16,20,24,26,29,32.
Category 6 - Administration/Office Work - Items 8,11,17,18.
Category 7 - Miscellaneous - Items 1,14,30,31.

Hypothesis 4 was tested by calculating a mean score for each group of items, and ranking these for each of the five groups of respondents. The mean score for each group of items by respondent group is given in appendix 5a. Table 28 below compares the rank order of the categories across the respondent groups. The number of respondents from whom information was obtained in each group is given at the top of each column.

Table 28 : Categorised Nursing Situations Ranked Across Respondent Groups :

CATEGORY	RESPONDENT GROUP				
	1 (N=14)	2 (N=9)	3 (N=15)	4 (N=14)	5 (N=12)
1	5	5	5	4	5
2	6	4	4	5	3
3	1	2	2	2	2
4	4	6	6	6	7
5	2	1	1	1	1
6	7	7	7	7	6
7	3	3	3	3	4

The table shows a high degree of agreement between respondent groups in the rankings. Category 5, death - related items is ranked highest by 4 groups and second highest by the remaining group. Categories 3, emotional care, and 7, miscellaneous, are also almost unanimously ranked respectively second and third. There is similar concensus in the ranking of all other categories. This table tends, therefore to support the hypothesis that death - related duties are perceived as more stressful than other duties, although the high overall ranking of emotional - care related items is also interesting. If, as this finding seems to suggest, nurses find the giving of emotional care difficult or stressful, and if this remains an accepted and desirable part of the nursing role, this finding must have implications for the training and support of nursing staff.

For the purposes of this study, it was thought more appropriate to place Item 29, "Responding to the alarm of a monitoring machine" in category 5, Death - Related items. On the acute wards such machines were used to monitor heart - rate, signalling an alarm if this stopped, and these machines were not in use on any of the other wards. However, for the sake of comparison with rankings obtained by Wilson (1983), in a study of work - related stress in hospice nurses, it was decided to calculate and rank the mean scores again, with Item 29 placed in Category 7, Miscellaneous. If this is done, slightly less uniformity of rankings between respondent groups is achieved. The rankings thus obtained are shown in Table 29, on page 188 :

Table 29 : Nursing Situation Scale - Group Rankings of Mean Score, Item 29 Recategorised, for Comparison with CW.

CATEGORY	RESPONDENT GROUPS					
	1	2	3	4	5	CW *
	(N=14)	(N=9)	(N=15)	(N=14)	(N=12)	(N=16)
1	5	5	5	4	5	7
2	6	4	4	5	4	6
3	1	2	3	3	2	1
4	4	6	6	6	7	5
5	2	1	2	1	1	2
6	7	7	7	7	6	3
7	3	3	1	2	3	4

* Rankings obtained by Wilson, C., using a 54-item scale from which the items used here have been taken.

Of the Nursing Situation items, a T-Test shows only items 16, 20, 24, 26, and 29 discriminate between hospital 1 and Hospital 2 staff, in the direction of higher stress reported by Hospital 2 staff. All these items fall into category 5, Death - Related items. The statistically significant results are shown in table 30 :

Table 30 : T-Test Results,Individual Nursing Situation Items:

NSIT	T=	DF	P= *
16	-2.17	62	0.034
20	-2.32	62	0.024
24	-2.27	62	0.027
26	-2.08	62	0.042
29	-2.69	62	0.009

* p=,two-tailed probability.pooled variance.

The results show that across all groups except Group 1 death - related items are ranked as the most stressful. Group 1 staff rate this category as second most stressful. Emotional care items are ranked as second most stressful by all staff groups apart from Group 1, who rate this category as the most stressful. There is broad agreement in the ranking of categories by all staff groups. However, in addition, 5 of the 8 items in category 5, Death - Related Items, discriminate significantly between hospice and non - hospice staff, in the direction of greater stress experienced / reported by non-hospice staff. Hypothesis 4 is supported.

HYPOTHESIS 5

Certain deaths will be perceived as innately more stressful by some groups and not by others, and it will be possible to identify these.

The Death Situations Scale (appendix 6) comprised 19 items which respondents were asked to rate for degree of upset on a scale from 0 - 10. As with the Nursing Situations, for each of the five staff groups, a mean rating was calculated for each item, and the items were arranged in rank order for each staff group. Table 31 shows the five items ranked as most stressful, and the four ranked as least stressful by each group of respondents.

Table 31 : Ranking of Death Situation Items by Each Respondent Group :

	Rank Position	Respondent Group				
		1	2	3	4	5
		Death Situation No.				
most	1	4	4	4	4	4
stressful	2	13	13	13	13	13
	3	16	16	16	16	6
	4	3	6	6	12	16
	5	6	12	12	6	12
	.	.	.	.	.	.
	.	.	.	.	.	.
	.	.	.	.	.	.
	16	11	10	15	14	17
	17	8	8	19	19	15
least	18	15	15	14	15	14
stressful	19	2	2	2	2	2

The Most Stressful Deaths

Across all groups, there was a high level of agreement as to which items were among the five most stressful. These were, perhaps predictably :

DSIT4 - Death of close relative;
DSIT13 - Death of a child;
DSIT16 - Death of patient who has young children; and
DSIT6 - Death of patient who is similar age to you.

These were so rated by all five groups; and

DSIT12 - Death of patient who is distressed; so rated by four groups.

DSIT3 - Death of a Patient Who Has a Great Deal of Pain; stands out among the five most stressful death situations, as being so rated by Group 1 nurses only. It was ranked 7th. by Groups 3 and 5, and considerably lower on stress by Group 2, night staff who placed it 15th., and Group 4, acute-assessment ward staff who placed it 13th. The reason for the higher ranking by Group 1 staff may be that for this group of nurses in particular, such a death would be seen as failure - a failure to achieve one of the primary goals of patient care in their specialization. Why it was not similarly ranked by Group 2 night staff is less clear. It may be that they had less experience of patients dying in pain, perhaps because night medication was adjusted to ensure as far as possible a pain - free and comfortable night.

The Least Stressful Deaths

The greatest unanimity as to the least stressful deaths was found for items 2 and 15, which were ranked within the least 4 stressful situations by all groups :

DSIT2 - Death of Russian leader Andropov;
DSIT15 - Death of patient who wants to die.

DSIT14 - Death of patient within 3 days of admission; - was ranked as among the four least stressful by all

Hospital 2 groups only. One might speculate that the slightly greater stress attributed to this situation by Hospital 1 staff might be an indication of the value attached to getting to know the patient. When there is time to do this, staff would be in a better position to tailor the care to the patient's needs with greater certainty.

DSIT8 - Death of an elderly patient - similarly discriminates the two hospitals, being ranked within the four least stressful by both Hospital 1 groups only. It may be a reflection of the different patient populations of which the staff groups in each hospital had actual, current experience.

DSIT11 - Death of Patient Who Remains Conscious to the End. The staff in Group 1 are alone in ranking this among the four least stressful situations; whereas Groups 2 - 5 show a fair degree of agreement in the ranking of this item, ranging from 6th to 9th most stressful. Although the reason for this is unclear, one might hypothesize that on a ward where the prevailing ethos is one of being able and having the means at one's disposal, to help the dying patient, the continuing ability of the patient to communicate with staff is a positive advantage in achieving good pain control, and in being able to identify accurately and respond to other needs. This does not explain why this item should be ranked as considerably more stressful by night staff on the same ward. However, the easier availability of medical and ancillary staff during the day obviously increases the range of resources at hand for nursing staff, whereas night staff are more immediately dependent on their own resources. During the day there are more distractions available to patients, whether treatment, activities or talking to each other. More significant, however, may be the differing goals of day and night staff. The main goal of the latter is that the the patient to have a comfortable night's sleep. Consciousness may be equated with wakefulness and discomfort, distress or anxiety. This may be experienced by night staff as a failure to achieve good patient - care.

DSIT10 - A prolonged though not uncomfortable death - was ranked within the four least stressful by Group 2 only. Again, perhaps this is indicative of the particularly lonely responsibility of the night staff group. However, it was ranked as only slightly more stressful by the other groups, among which it ranged between 12th. and 15th.

Deaths About Which There was Least Agreement in Ranking

There was a wide disparity in the rankings of three situations - DSITs 3, 11 and 18, which had a range respectively of 11, 9 and 7 places apart overall. DSITs 3 and 11 have already been discussed.

DSIT18 - Death of a Patient While You are Washing / Turning Him - was ranked as more stressful by Groups 4 and 5 who placed it respectively as 8th and 6th most stressful. In the preparatory stages of the research, the researcher was told by a number of nurses that their own feelings, in a death like this, were of shock if the death was unexpected, and personal responsibility for causing the death. This was particularly so if the nurse concerned were relatively inexperienced at the time. It may be that staff in Groups 1 and 2 perceived this kind of death as less stressful because all patients were known to have a limited life expectancy. A similarly low ranking might be given to this item by Group 3, night staff, if they perceived themselves as fairly unlikely to experience a death in these circumstances, because they would be less likely than day staff to be washing such a patient.

In ranking items in the manner described, a considerable amount of information is inevitably lost. Therefore, the T statistic was calculated to identify items for which differences in scores between the groups were statistically significant. Of the Death Situations, only item 8, death of an elderly patient, was found to be scored significantly differently by Hospital 1 (H1) and Hospital 2 staff, with Hospital 2 (H2) staff scoring this as more stressful. When the total sample is divided according to whether they are day or night staff, then item 18, finding a patient dead unexpectedly, is the only item to be scored significantly differently, with day staff scoring this as more stressful. The results are shown in Table 32.

Table 32 : DSIT Items which Differentiate between Groups :

Item		Mean Score	DF	T=	P= *
8	H1	3.13	63	-2.68	0.009
	H2	4.39			
18	Day	5.78	63	2.02	0.048
	Night	4.54			

* pooled variance,two-tailed probability.

One may conclude, therefore, that some types of death are more stressful than others, that these can be identified and that there is broad agreement between groups as to those which are most and least stressful. However,within this broad consistency, there remains a considerable difference in the ranking of some situations, and a significant difference between subgroup scoring on some items. Hypothesis 5 is substantiated.

HYPOTHESIS 6

Objective measures of the outcome of the subjective experience of stress will be directly related to the number of deaths experienced on the ward.

The two methods used to measure experience of death were described in Hypothesis 3 : one relying on hospital statistics, the second on subject recall. Both approaches showed significant differences between groups / wards and /or hospitals. Outcome measures were tested against the results yielded by both these methods, and the relationship between recall and subjective experience will be discussed.

Accuracy of Recall

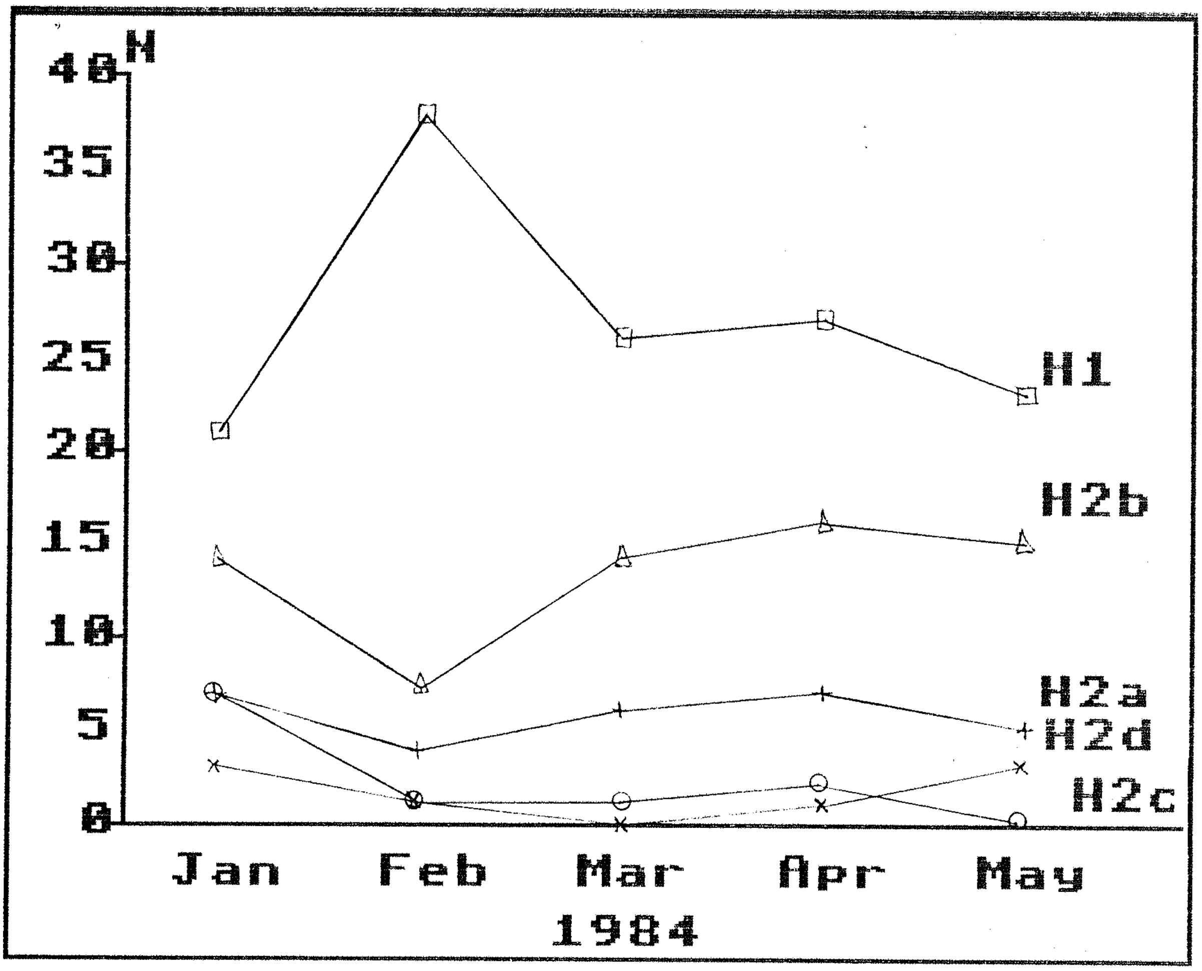
As the death - rate in relation to bed - occupancy figures have already been reported elsewhere (see appendix 11 and Hypothesis 3) these will not be discussed here. Interviews started at the end of January 1984. The monthly ward deaths from January to May, the months during which interviews were being conducted were as shown in Table 33, while Figure 7, on page 196 shows the average number of deaths for the same period for the palliative care group (Hospital 1); the acute-assessment groups (Hospital 2, wards A & B); and the continuing care groups (Hospital 2, wards C & D).

Table 33 : Monthly Deaths For Each Ward:

	Hospital 1	Hospital 2 / Ward			
		A	B	C	D
Month					
Jan	21	7	14	3	7
Feb	38	4	7	1	1
Mar	26	6	14	0	1
Apr	27	7	16	1	2
May	23	5	15	3	0

Fig. 7.
Monthly Deaths for Each Ward :

January to May - 1984



H1 - Hospital 1, Palliative Care Unit;

H2a - Hospital 2, Acute Assessment, Ward A;

H2b - Hospital 2, Acute Assessment, Ward B;

H2c - Hospital 2, Continuing - Care, Ward C;

H2d - Hospital 2, Continuing - Care, Ward D.

Since the dates of death were not recorded at the time of gathering these statistics, it was not possible to gauge the accuracy of recall of respondents. However, the subjective experience of a lot of deaths or few may be equally or more important than the actual numbers. A number of patterns emerged when the responses were examined :-

1) All nurses were able to give an answer that they regarded as a reasonable reflection of the fact when asked how many deaths they had nursed in the last two weeks.

2) Recall was less accurate over four weeks, and this appeared to be as much a function of the number of deaths as of time. Thus, eight day staff and four night staff working in Hospital 1 replied with a 'don't know' when asked the number of deaths they had worked with in the last four weeks, whereas there were only two 'don't know' responses from staff working in Hospital 2, one night staff, and one acute ward.

3) A comparison of the date of interview and the number of deaths recorded in the month of interview and the month before, showed that ten respondents overestimated the number of deaths they had worked with in the last month. Perhaps one would expect few, if any overestimates from Hospital 1 staff where the number of deaths was high. All ten overestimates were made by Hospital 2 respondents. Of these, one was night staff, two from the acute wards, and seven from the long - stay wards, where the number of deaths was lowest. Table 34 shows which respondents overestimated together with their estimate and the actual number of deaths, the ward worked on and the date of interview.

Table 34 : Estimates of Deaths:

Date of Interview	Ward	Respondent Number	Estimated	Actual
14.3.84	B	306	20	13
10.4.84	A	203	7	6
10.5.84	B	214	18	15
29.2.84	D	102	7	1
9.3.84	D	103	2	1
1.3.84	D	104	7	1
20.4.84	D	107	5	2
8.3.84	C	112	3	1
2.3.84	C	113	3	1
18.4.84	C	116	3	1

As exact figures on a daily basis were not recorded, the actual number of deaths was calculated as an average of the number of deaths recorded during the month of interview and the previous month, weighted to take account of the actual date of the interview. Thus, for an interview that took place in the middle of the month, half the number of deaths for the two months were added together. The assumption was made that deaths occurred evenly throughout the month.

Against the outcome measures used here, of the above respondents the following had scores that were more than 3 standard deviations above the mean for their staff group :

Group 3 R306 : General Health Questionnaire
Group 5 R214 : Illness reports over 3 months
R103 : Illness reports over 1.3 and 12 months
R116 : Illness reports over 3 and 12 months.

The objective measures of outcome used to test for the experience of general stress were :

1) The 30 - item, shortened version of the GHQ - General Health Questionnaire, as developed by David Goldberg, (See Appendix 8).

2) The number of days illness over the last month, the last three months, and the last year, as reported by respondents, (Appendix 2).

3) The nature of GP consultations in the last six months, (appendix 12).

These first four measures were correlated against the number of deaths reported by each respondent over two and four weeks, using Pearson's product moment correlation coefficient. 'Don't know' responses were excluded from the calculations. In none of the cases does the correlation reach the level of statistical significance.

With respect to GP consultations, respondents were divided into two groups :

1.those who had consulted their GP in the last six months for a problem that was rated as definitely, probably or possibly stress - related; and

2.those who had either not consulted their GP in the last six months, or who had consulted their GP for a problem rated as non-stress related.

Using a cut - off point firstly of up to two and over two deaths, and then up to five and over five deaths, the X^2 Test found no association between stress-related problems and number of deaths.

The hypothesis was further tested by running the Kruskal -

Wallis one - way analysis of variance procedure to test for significant differences between the means of the five groups on the General Health Questionnaire scores and the number of days illness over one, three and twelve months. The results did not reach the level of statistical significance, and it is concluded that the differences within the groups were greater than the differences between groups. In each group, there were a few respondents whose scoring on each scale was noticeably higher than the group norm. However, perhaps because their numbers were small, it was not possible to identify any other characteristics which significantly distinguished them from the sample as a whole.

Finally, the hypothesis was tested by running the Mann - Whitney test on the General Health Questionnaire (GHQ) scores and the number of days illness over one (ILL1), three (ILL2) and twelve (ILL3) months for the following sub-samples:

a).All hospice staff v. all geriatric staff : (H1 v H2);

b).Hospice day staff v. geriatric day staff : (Groups 1 v 4 & 5);

c).Hospice night staff v. geriatric night staff : (Groups 2 v 3)

It was expected that hospice staff, because of the higher number of deaths on the ward, would experience greater long-term stress as measured by these variables than would other staff groups.

Of these tests, three results reached the level of statistical significance. They are reported in Table 35.

Table 35 : Relationship Between Experience of Death and Stress Outcome Measures Using the Mann-Whitney Test :

Staff Group	Variable	N=	Mean Rank	Z=	P= *
1 v	GHQ	15	16.97	-1.84	.033
4 & 5		26	23.33		
2	GHQ	9	16.11	-2.42	.008
3		15	10.33		
2	ILL1	10	10.55	-1.72	.043
3		15	14.63		

* P = one-tailed probability;
Z - corrected for ties.

Of the results that were significant, day staff in Hospital 1 reported less stress on the General Health Questionnaire, than did Hospital 2 day staff. Among night staff, the direction was reversed on the General Health Questionnaire, with hospice staff reporting greater stress. However, Hospital 2 night staff reported more illness over one month than did Hospital 1 night staff. It would seem, therefore, that the level of stress, at least in relation to patient death, is not directly related to illness reporting.

In the light of these results it must be concluded that there is no evidence to suggest that the subjective stress reported by respondents has an outcome in illness or absence from work. It would appear that nurses found a way of coping. Hypothesis 6 is not supported.

HYPOTHESIS 7

Trained nurses will be less stressed than unqualified staff.

Using all possible groupings of staff, the T-Test was used to test for differences in the mean stress scores between qualified and unqualified staff on the following measures: Death Anxiety Scale; Nursing Situation Scale; Death Situation Scale; and the The Mann - Whitney to test for differences in the ranking of scores for the General Health Questionnaire; and the number of days illness reported over one, three and twelve months. No significant differences were found in the scores on the General Health Questionnaire, Death Situation Scale, Nursing Situation Scale and Death Anxiety Scales, nor in the number of days illness reported over three and twelve months. However, although there were no differences between qualified and unqualified staff as a whole, differences did emerge between subgroups within the sample on the number of days illness reported by qualified (qual'd) and unqualified (unqual'd) staff over one month only. These are shown in Table 36, on page 203.

The difference between qualified and unqualified staff appears to be true only for day staff. When the groups were further divided, the differences between qualified and unqualified staff remained significant only for day staff groups in Hospital 2. No differences were found for night staff groups, nor for Hospital 1 staff.

Table 36 : Mann-Whitney Test for Illness Reports over a Period of One Month :

Staff Group	N=	Mean Rank	Z=	P= *
All Qual'd Day Staff	25	19.26	-1.63	.052
v				
All Unqual'd Day Staff	17	24.79		
H2 - All Qual'd Staff	25	18.74	-2.002	.023
v				
H2 - All Unqual'd Staff	17	25.56		
H2 - Qual'd Day Staff	15	11.70	-1.904	.029
v				
Unqual'd Day Staff	12	16.88		

* p = one-tailed probability.

Z : corrected for ties.

These results suggest that, among staff working on the geriatric wards, unqualified staff reported having significantly more days off due to illness in the last month than qualified staff. However, when the number of days illness over one month is correlated with the Death Anxiety Scale, Death Situations Scale and General Health Questionnaire scores, using Pearson's Correlation Coefficient, the results do not reach a level of statistical significance. The failure to find a significant correlation between these measures suggests that the difference in number of days off due to illness between qualified and unqualified staff on the geriatric wards may be related to some factor other than death anxiety. It was not possible to identify this factor in the study carried out. No significant differences were found between qualified and unqualified staff in Hospital 1. Hypothesis 7 can be regarded as only partially supported.

HYPOTHESIS 8

Nurses with a strong religious belief will be less stressed than nurses with no religious belief, who will in turn be less stressed than nurses with uncertain belief.

All respondents were asked whether they held any religious belief, and if so how frequently they attended church. This yielded five response categories,distributed as shown in Figure 8, on page 205.

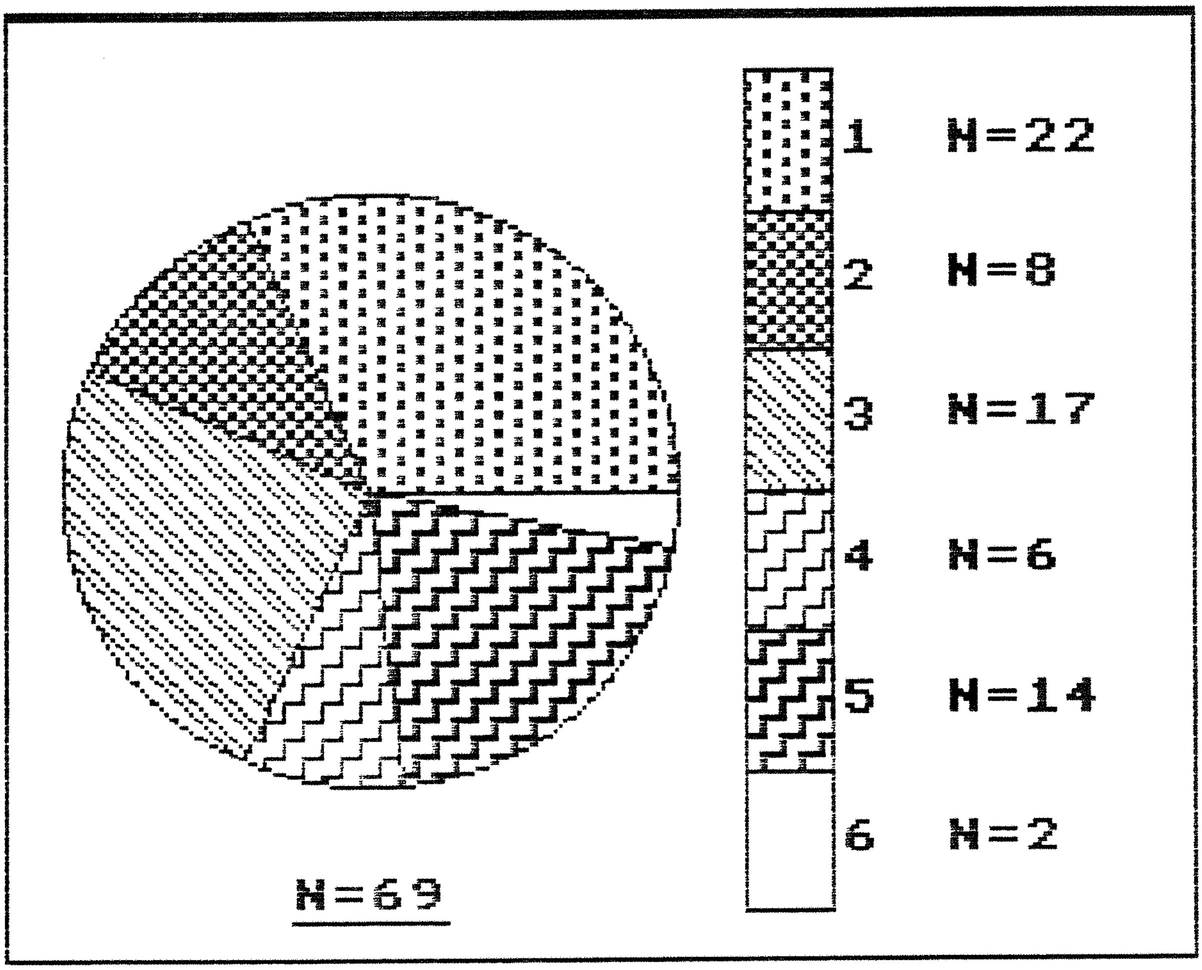
Four respondents in category 3 attended church at very infrequent intervals (2-3 times a year). All respondents in category 4 attended church at least once every two months and usually combined it with some other regular religious activity such as prayer.

All possible groupings were tried. The ones discussed below are those which showed the clearest patterns.

1.In order to test whether respondents with no religious beliefs (category 1) were more likely to experience anxiety when dealing with a dead or dying patient than respondents with a strong religious belief (category 5), the T statistic was calculated for the variables Death Anxiety Score (DAS), Death Situation Score (DSIT), and Death-Related Nursing Task (DNT). The Z statistic was calculated, using the Mann-Whitney to test the General Health Questionnaire scores (GHQ). A significant difference

Fig. 8.

Religious Belief - All Groups :



1 = No Belief

2 = Undecided

3 = Belief in After-Life - No Church Attendance

4 = Belief - Occasional Church Attendance

5 = Belief - At Least Weekly Church Attendance

6 = Missing

was found in the Death Anxiety Scores between these two groups. Data was available for 35 out of 36 possible respondents in these two categories for the DAS, DSIT, and DNT measures and for 34 respondents for the GHQ. The results are given in Table 37.

Table 37 : T-Test / Anxiety Scores for 1) Non-believers (N=21) v. 2) Weekly Chuch Attenders (N=14)

Variable	Statistic	P = *	DF
DAS	T= 1.833(pv)	.05	33
DSIT	T=-1.1085(pv)	NS	33
GHQ	U= 128		N1=20
	Z=-0.5422	NS	N2=14
DNT	T=-0.5522(pv)	NS	33

pv=pooled variance
* one-tailed

In addition, respondents' replies to the question "do you ever feel upset when a patient dies ?" were categorised into two groups, 'yes or sometimes', and 'no'. The chi - square test showed that the difference just failed to reach the level of statistical significance, although there was a tendency for those who held a strong religious belief to report feeling upset. The results are shown in table 38, over, page 207.

Table 38 : Self - Reported Upset and Strong Religious Belief v. No Belief.

	UPSET	NO UPSET	TOTAL
STRONG BELIEF	13	1	14
NO BELIEF	13	9	22
TOTALS	26	10	36

$X^2 = 3.35$, d.f.= 1, NS.

The results suggest that non - believers tend to experience greater free - floating death anxiety than those with a strong religious commitment. However, the other measures of anxiety used do not show the same trend. The Death Situation and Death - Related Nursing Task scores,designed to measure anxiety in the practical nursing situation, show no significant difference between the groups. This would seem to suggest that in the day - to - day care of patients who are dying, mechanisms for coping with anxiety are operative, or that anxiety is not experienced. On the other hand, respondents with a strong religious belief are more likely to report feeling upset by the death of a patient.

2.To test for differences in level of death anxiety between non - believers (Category 1, N=22) and those with uncertain belief (Categories 2 & 3, N=25) the T statistic was also calculated for the Death Anxiety Scale (DAS), Death Situation (DSIT), and Death - Related Nursing Task (DNT) scales, and the Mann-Whitney was used to calculate the Z statistic for the General Health Questionnaire (GHQ). In line with the findings of earlier research, it was anticipated that non - believers would show less anxiety than those who were uncertain. Data was available for 44 respondents on each measure except the DNT, for which 43 responents supplied information. The results are shown in Table 39 below :

Table 39 : Differences in Level of Death Anxiety - 1) Non - Believers 2) Those with Uncertain Belief :

Variable	Statistic	P= (one-tailed)	DF
DAS	T = -0.5555(pv)	NS	42
DSIT	T = -1.2671(pv)	NS	42
GHQ	U = 169.5		N1=20
	Z = -1.9102	.028	N2=24
DNT	T = =1.8522(pv)	.05	41

pv=pooled variance

Although equivocal, in line with other research, the results tend to suggest that respondents whose beliefs are uncertain experience greater anxiety than do those who hold no religious beliefs. This was true for both the death - related nursing tasks and also at the more generalised level of death anxiety measured by the Death Anxiety Scale. The X^2 test showed no significant difference in the report of upset between these two groups.

3. In order to assess the importance of how strongly a belief was held, as measured by church attendance, the T statistic was calculated for the Death Anxiety Score, Death Situation and Death - Related Nursing Tasks for respondents grouped as follows:

a).Those who expressed belief,regardless of church attendance, categories 3,4 and 5, N = 35;

b).Those who expressed belief and attended church occassionally, or weekly, categories 4 and 5, N = 19;

c).Those who expressed a belief and attended church weekly - category 5, N = 14;

against all others. Data was available on all measures for 63 respondents. Of these measures, only the Death Anxiety Scale distinguished significantly between the groups. The results are shown in table 40,below.

Table 40 : Importance of Belief and Church Attendance in Moderating Anxiety Levels

Definitive Characteristic	Variable	Mean Score	T= #	P= *	DF
a) Belief	DAS	53.77	-1.47	0.146	61
All Other		59.21			
b) Ch.Attendance	DAS	49.89	2.31	0.025	61
All Other		58.91			
c) Weekly church Attendance	DAS	48.57	2.27	0.027	61
All Other		58.37			

T = pooled variance;
* P = two-tailed probability.

These results suggest that to hold (or to state that one holds) a religious belief is not in itself sufficient to mediate against anxiety. Going to church, whether more or less regularly is more important in moderating the experience of anxiety in working with the dying.

In addition, the relationship, if any,between reported upset at the death of a patient and the holding of religious belief and church attendance was tested using the X^2. The results showed an association between upset and the holding of a religious belief (categories 3, 4 and 5) as opposed to no or uncertain religious belief (categories 1 and 2). The distribution of responses is presented in Table 41.

Table 41 : Relationship Between Religious Belief and Reported Experience of Upset at Patient Death :

	Upset	Not Upset
Belief		
Yes	33	4
No / Uncertain	18	12

$X^2 = 6.14$, df = 1, $p = < .025$.

Rather more respondents than might be expected, who held no or uncertain religious beliefs, reported no experience of upset, and more respondents than expected who held religious beliefs, regardless of church attendace, reported feelings of upset when a patient died. Church attendance in itself, whether weekly or less frequently, did not show a significant association with reported upset.

In conclusion, the results are somewhat equivocal. Respondents with no religious belief had significantly higher Death Anxiety Scores than weekly church attenders, but this was not reflected in higher anxiety scores on measures related to working with the dying. Respondents whose beliefs were uncertain reported significantly higher anxiety in the performance of death - related nursing tasks and had higher General Health Questionnaire scores, but only in relation to those who had no religious beliefs. However, the Death Anxiety Scores support the hypothesis, suggesting that respondents with a strong religious commitment experience less generalised death anxiety than non - believers, who in turn experience less anxiety in performing nursing tasks related to the dying than respondents whose beliefs are less certain. Strength of belief as measured by church attendance of at least once every two months, usually combined with some other religious activity, such as prayer, appears to be the important defining characteristic in moderating stress levels. Alternatively, it may be that church attendance reflects a higher degree of social participation, which in turn moderates against the experience of stress. In contrast,self - reported upset in relation to patient death was associated with presence or absence of religious belief but not with church attendance or non - attendance.

HYPOTHESIS 9

a).Staff who use a range of coping behaviours will show less evidence of stress.

b).Alternatively,staff who use a single method of coping will be less stressed.

Staff who said they were usually upset when a patient died were asked what they would normally do if they felt upset. Twelve methods of coping were identified and the number used by each respondent was counted. Figure 9, on page 213 shows the frequency of the number of coping methods used. A small group of nurses (N=8) indicated they were not affected, and carried on as usual. These are described as using zero coping methods, for this analysis only, the 'No Reaction' group.

Excluding respondents who reported no coping methods, the T statistic was then calculated to see whether staff who used more than one coping response were more likely to be successful in moderating the effects of stress than those who used only one coping response. None of the results approached the level of statistical significance.

The T-test was then run using a number of different cut-off points:-

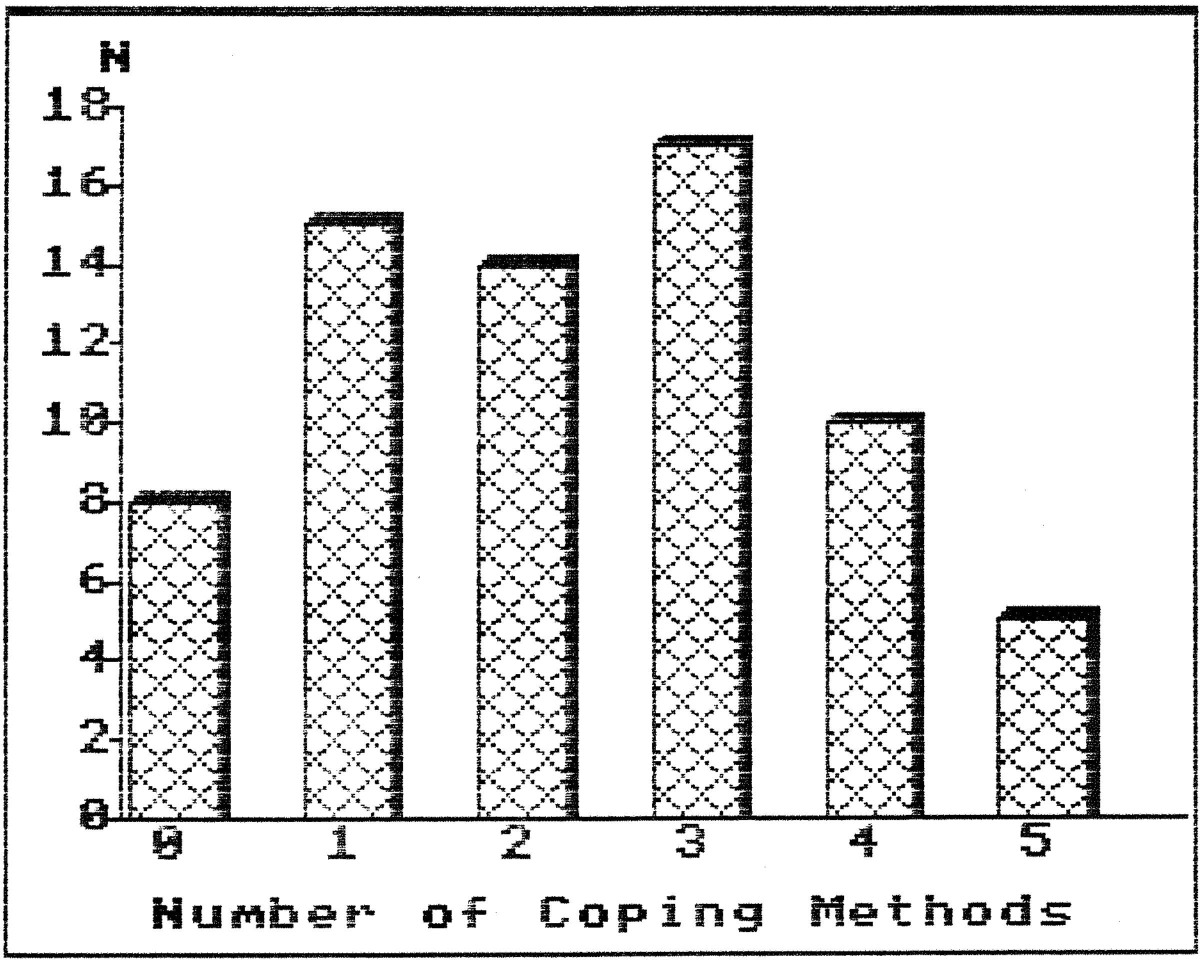
1-2 coping methods v more than two methods;
1-3 coping methods v more than three methods.

The stress measures tested included the Death Anxiety Scale (DAS), Death Situations Scale (DSIT), and Death - Related Nursing Tasks (DNT). The General Health Questionnaire (GHQ), was also tested, using the Mann-Whitney test. The results which approached significance or were significant are shown in Table 42. on page 214. Full data on these items was available for 58 respondents.

Fig. 9.

Number of Staff Identified as Using

0, 1, 2, 3, 4 and 5 Coping Methods :



N = Number of Staff

Table 42 : Relationship Between Number of Coping Methods and Stress Scores:

No. of Coping Methods	Variable	Mean	T=#	DF	P=*
1-2 > 2	DSIT	100.5 109.87	-2.06	56	.044
1-2 > 2	DNT	27.46 35.00	-1.95	56	.056
		Mean Rank	Z=*		
1-2 > 2	GHQ	24.96 33.73	-2.25	N=28 N=30	.025
1-3 > 3	GHQ	26.23 40.81	-3.12	N1=45 N2=13	.002

* two-tailed, # pooled variance.

Looked at from this perspective the results are more equivocal, and show that respondents who report the use of multiple methods of coping also report higher stress scores on some variables as shown in Table 42, above.

The question of whether individual coping methods in themselves would be protective against higher reported stress levels was then addressed. The T-test was used to compare the mean stress scores on the Death Anxiety Scale (DAS), Death - Related Nursing Tasks (DNT), and Death Situations (DSIT) for all respondents who reported using each of the coping methods recorded, with the mean scores of those who did not report use of that coping method. Additionally, the Mann-Whitney Z statistic was calculated to test for association between coping method used and the General Health Questionnaire (GHQ) and illness reports over one, three and twelve months. Of the coping methods tested, those found not to significantly discriminate stress scores, and which might be regarded therefore as neither ameliorating nor worsening the experience of stress were:

Talking to Friends
Humour.

Table 43a) shows the coping methods for which statistically significant differences were found using the Mann-Whitney test.The coping methods found to discriminate significantly included talking to family (TLKFAM); Introspection (INTRSPEC); and Prayer. The stress measures which were discriminated included General Health Questionnaire (GHQ); Death Anxiety and Illness over twelve months (ILL3). For each coping method the number of respondents using the method for whom data were available is the second of the two numbers shown under the column marked 'N='.

Table 43a : Relationship Between Coping Method and Stress Measures Using the Mann-Whitney:

Variable	Coping Method		N=	Mean Rank	Z	P= *
ILL3	INTRSPEC	Non Users	34	31.6	-2.14	.033
		Users	21	22.17		
GHQ	TLKFAM	Non Users	39	27.73	-2.21	.027
		Users	22	36.8		
DAS	PRAYER	Non Users	52	33.7	-3.06	.002
		Users	8	13.13		

* two-tailed probability

Table 43b) shows the coping methods which discriminated between the stress scores of users and non - users, and the stress variables for which statistically significant differences were found using the T-Test. A negative T value indicates a higher stress rating by those who used this method of coping. In the column headed 'N=' the number of respondents who used this method of coping for whom information was available for this analysis is the second number given.

Table 43b : Significance of Coping Methods in Protecting Against Stress :

Variable	Coping Method		N=	Mean	DF	T=	P= *
DAS	TLKCOL	Non Users	22	48.32	59	-3.24	.001
		Users	39	60.79			
DSIT	" "	Non Users	22	93.05	59	-3.32	.001
		Users	39	109.10			
DSIT	TEARS	Non Users	37	98.95	59	-2.23	.015
		Users	24	110.04			
DNT	"	Non Users	36	27.94	58	-1.84	.036
		Users	24	35.13			

* one-tailed,pooled variance

TLKCOL - Talking to colleagues

The results are somewhat equivocal, suggesting that some coping methods - Talking to colleagues; Talking to family; and Tears are associated with more stress, others - Prayer; and Introspection are associated with less stress. The two groups might be loosely labelled ' Externalised ' and 'Internalised ' types of coping response. Because of low numbers, it was not feasible to break down the results further to explore the possible effects of other factors. No other coping response was found to be significantly associated with the stress ratings.

It would seem that there is some evidence to support hypothesis 9b), suggesting that nurses who use fewer methods of coping experience,or at least report, lower levels of stress than those who use more. Some methods of coping were associated with higher reports of stress, whilst others were associated with lower levels.

HYPOTHESIS 10

Staff who use denial or avoidance as a method of coping with stress will show greater evidence of anxiety than colleagues who who use any other means of coping, and this will further be shown both in the stress ratings assigned to situations involving death or dying and the longer - term health consequences.

Nurses were asked whether they ever felt upset by the death of a patient and were classed as using denial or avoidance if they answered no, and no coping response was identified later (N=8), or if they said they reacted by keeping busy or putting it out of their minds (N=10). On occasions these two groups have been combined for analysis and will be referred to as the 'no reaction / avoidance group' (N=18). The respondents who identified other methods of coping, will be referred to as the 'reaction group' (N=51). Using the T test, significant differences were found in the stress ratings attributed by the 'reaction group' when compared to the 'no reaction / avoidance group; and using the Mann-Whitney, when compared with the 'no reaction' group. Data was not available for a small number of respondents who fell within these categories. The stress variables for which statistically significant differences were found are shown below in Table 44.

Table 44 : Results of Tests to Compare Levels of Stress in
1) The Reaction and No Reaction / Avoidance Groups ;
2) The Reaction (N=45) and No Reaction (N=7) Groups :

Test	Variable	T / Z =	DF / N	P= ✱
T-Test	DSIT	3.32	63	.001
T-Test	DNT	2.41	62	.02
M - W	DNT	-2.09	45 7	.036
M - W	DSIT	-3.43	45 7	.001

✱ P = pooled variance,
two-tailed probability

The results show that the higher Death Situation and Death - Related Nursing Task scores are among respondents in the 'reaction' group and that the difference is statistically significant.These nurses reported higher levels of stress / upset which they were aware they experienced at patient death or soon after and they found some way of expressing what they felt. This finding is reversed when the illness reports over three months are compared,using the Mann-Whitney test to compute the Z statistic.Although the results fail to reach the level of statistical significance (Z=-1.397, p=.081, one-tailed),they suggest there is a tendency for respondents in the 'no reaction' group to report more days illness. If this trend were substantiated,then it would suggest that reacting at the time or shortly after the death of a patient may tend to operate in a protective way in the longer term. However, the failure to find any statistically significant findings on the health / stress outcome measures suggests that in whatever way subjects chose to respond, they were a coping group.

HYPOTHESIS 11

Nurses who have available support within an intimate confiding relationship will show less evidence of stress than staff who have no such relationship.

All respondents were asked whether they had any specially close friend or person they could confide in, and also whether there was anyone within their family from whom this kind of support was available. They were also asked how frequently they would have contact with this person in each case.For each question, five categories of contact were identified :

Degree of Contact	Confidant/Friend	Family
None	9	8
Infrequent	9	9
1 - 2 Monthly	10	11
1 - 2 Weekly	35	26
Daily	5	12
Missing	1	3

The X^2 measure showed there were no significant differences in the availability of contact / support from either friend or family associated with Hospital, nor in relation to whether respondents worked on the day or night shift.

Information was available in relation to both questions for 66 respondents and of these only 3 reported minimal support in both areas. All three were night staff.1 from Group 2 and 2 from Group 3. One was married, worked part - time and was slightly older than the average for her group; the other two were single, worked full - time and were younger than the average for their group. Although all three tended to score above the average for their group on the Death Anxiety and Death Situation scales and below the average for the Death - Related Nursing Tasks scale, in no case did any of them score more than 1.5 standard deviations from the mean for their group.

The relationship of stress scores to each variable - close friend, and family support - was examined separately.

Close Friend / Confidant

The relationship between availability of a close friend and reports of stress was explored by testing a variety of combinations of the categories defined on page 219 :

1.A one-way analysis of variance was performed to test for significant differences between respondents who were grouped as follows :-

a) no or infrequent support;
b) at least monthly contact with support person; and
c) weekly or more than weekly contact.

No significant differences were found.

2. The Mann-Whitney test was used to examine for a relationship between all stress variables and availability of support for the following respondent groups :

a. i) respondents with no support; and
   ii) respondents with daily contact;
b. i) respondents with monthly or less contact; and
   ii) respondents with more than monthly contact;
c. i) respondents with less than weekly contact, including no or infrequent contact; and
   ii) respondents with weekly or more contact.

The results approaching statistical significance are presented in Table 45, which shows the number of respondents in each group for whom information was available for each analysis (N).

Table 45 : Association Between Availability of Close Friend and Stress Measures Using the Mann-Whitney Test:

Contact	Variable	N	Mean Rank	Z=	P= *
None	ILL3	9	5.78	-1.749	.04
Daily		4	9.75		

*one-tailed probability;
corrected for ties.

Family Support

The same combinations of frequency of contact were also tested for association between stress measures and family support, using either the T-Test or Mann-Whitney Test as appropriate. Table 46 shows those results which approached the level of statistical significance.

Table 46 : Association Between Availability of Family Support and Stress Measures Using the T-Test or Mann - Whitney:

Contact	Variable	N	Mean Rank	Z=	P= *
< Monthly	GHQ	9	34.22	-1.447	.074
Monthly +		46	26.78		
< Weekly	ILL3	19	21.92	-1.663	.048
Weekly +		46	29.14		

Contact	Variable	N	Mean	T=	DF	P=*
< Weekly	DAS	20	52.35	-1.49	53	.07 $
Weekly +		35	58.63			
< Weekly	DSIT	20	91.75	-2.22	53	.015 $
weekly +		35	104.60			

* one-tailed probability;
$ pooled variance.

The results are somewhat equivocal, suggesting a tendency for respondents who have more frequent contact with their sources of support also to report more stress. The exception to this was a tendency for respondents who had more frequent contact with family support to report lesser experience of recent general ill - health on the General Health Questionnaire (GHQ). However, this result did not reach the level of statistical significance. Whilst the results are difficult to interpret, and some association may have been found by chance, the findings suggest that respondents who have more frequent contact with their sources of support, whether close friend or family, tend to report more stress associated with the nursing task. However, availability of support from friend or family would seem to protect respondents against short - term health consequences, as reflected in the General health questionnaire. The longer-term consequences - over a period of twelve months - appear to be less favourable. In general, although only a few associations were found, the data tends not to support Hypothesis 11.

HYPOTHESIS 12

Staff who feel able to seek support at work for home - related worries will be less stressed than those who keep home problems separate.

Respondents were asked whether they would discuss home worries at work. since it was considered that staff would only feel able to do this if they saw themselves as relatively well supported in their job. Of 68 respondents who replied to this question,

two (2.9%) said they did not know;
twenty (29.4%),said no; - Group 1
forty six (67.7%)said yes,some with reservations - Group 2.

The T-Test was used to compare stress scores between Groups 1 and 2 for the Death Anxiety Scores (DAS), Death Situation (DSIT), and Death - Related Nursing Task (DNT), with the expectation that Group 2 scores would be lower. On all variables, Group 1 respondents tended to report lower scores, but the differences were statistically significant only for the variable DSIT (Table 47).

Table 47 : Relationship Between Stress Scores and Ability to Discuss Home Worries at Work :

Variable	Group	Mean	T=	DF	P= *
DSIT	1	91.5	-2.2	61	.032(pv)
	2	104.6			

* One-Tailed Probability
pv = pooled variance

It must be concluded, therefore that there is no evidence to support the hypothesis that nurses who would feel able to discuss home worries in their work setting experience less stress. In fact the reverse seems to be true. However, the possibility should not be ruled out that nurses who feel they could discuss their home worries at work would also feel more able to report their stress. It may be that these measures tap ability to report stress rather than reflect true experience of stress.

The Z statistic was also calculated to compare the rankings of the General Health Questionnaire and illness reports between these two groups. It was anticipated that Group 2 respondents' reports would achieve a lower mean rank. Only one variable, ILL2 - number of days illness in the last three months, reaches the level of statistical significance and the direction is as predicted. The result is shown in Table 48.

Table 48 : Short Term Illness Report and Ability to Discuss Home Worries at Work :

Variable	Group	Mean Rank	N=	Z=	P=*
ILL2	1	39.0	20	-1.79	.037
	2	30.3	45		

* one-tailed, corrected for ties.

Although these results should be treated with caution, taken together they suggest that staff who would seek support at work for home worries report higher stress scores in the nursing situation, and might therefore be seen as exhibiting greater anxiety. It could equally be suggested that they are more consciously aware of their anxieties / worries: more ready to report them and to take active steps to alleviate them, which is, in the slightly longer term, more effective,as suggested by the lower mean rank of the short - term illness score. The possibility that staff who have worries at home may have a lower threshold to stress experienced at work also cannot be ignored, although work may also be used as a way of coping with worries at home by helping to put them out of mind. However, respondents were not asked whether they had current worries at home, only what they would do IF they had.

HYPOTHESIS 13

Staff who seek support at home for work - related stress will show less evidence of stress than those those who keep work problems separate.

All respondents were asked whether they would discuss their work worries / upset at home. Of the 68 respondents who answered this question,

thirteen (19.1%). said they definitely would not - Group 1
fifty five (80.9%), said yes or yes - some things - Group 2

Comparison of the stress scores: Death Anxiety Score (DAS). Death Situation (DSIT) and Death - Related Nursing Task (DNT) between the two groups using the T-Test did not show any significant differences between the groups. However, there was a tendency toward higher scores for respondents who would discuss work worries at home, (Group 2) compared to those who did not. Looking at the General Health Questionnaire and illness reports in the short term, one to three months, the statistics suggested a tendency for a reversal of the above trend. Group 1 respondents reporting slightly higher scores. However, the results did not reach statistical significance and can be regarded as no more than an interesting trend.

Respondents were also asked whether they found it easy to switch off from work when they were at home. Using the T-test, differences between those who found it easy and those who did not failed to reach the level of statistical significance for the Death Anxiety Scores, Death Situation and Death - Related Nursing Task scores. However, the Mann-Whitney test showed statistically significant differences in the ranking of the General Health Questionnaire (GHQ) and short - term illness scores, but were somewhat contradictory. Those who found it easy to switch off achieved a lower mean rank on the GHQ scores, but had a higher mean rank on the number of days illness reported over one (ILL1) and three (ILL2) months. The results are set out in Table 49.

Table 49 : Stress Scores and Ability to Switch Off : Group 1 - Easy to switch off; Group 2 - Difficult.

Variable	Group	Mean Rank	Z=	P=*
GHQ	1	27.9	-2.74	.003
	2	39.2		
ILL1	1	37.1	-1.77	.038
	2	29.8		
ILL2	1	37.5	-1.82	.034
	2	29.1		

* One-Tailed Probability

There are a number of possible explanations for the interaction between these variables. Since the GHQ asks for an assessment of general health over recent weeks, one might expect more correspondence with short - term illness reports, particularly over one month. However, it may be that illness report is as much a method of coping as a measure of stress, and that reporting ill in some way serves to mitigate the experience of stress as measured by the GHQ.

HYPOTHESIS 14

The highest levels of stress will be reported by staff who do not discuss their worries either at home or work: whilst the least stress will be reported by those who are able to discuss worries both at home and work.

As described in Hypotheses 12 and 13, staff were asked whether they would discuss work worries at home and home worries at work. Respondents' replies to these two questions were used to divide them into a further four categories, as follows :

1). Would feel able to discuss work worries at home only N = 16

2). Would feel able to discuss home worries at work only N = 8

3). Would feel able to discusss home worries at work and Work worries at home N = 39

4). Would discuss neither home worries at work }
Nor work worries at home } N = 5

These four categories were grouped in all possible combinations. The mean scores and the rankings were tested using respectively the T-Test and the Mann-Whitney. The T-Test was carried out on the Death Anxiety Score (DAS), Death Situation (DSIT) and Death - Related Nursing Task (DNT), where the distribution was or approximated normal; and in all other cases the Z statistic was calculated, using the Mann-Whitney test. Table 50 shows those groupings in which the results reached the level of statistical significance, giving the Mean Score (MS) and Degrees of

Freedom (DF) where the T-Test was used; and the Rank (R) and Number (N) of respondents in each group where the Mann-Whitney was employed.

Table 50 : Discussion of Worries at Home and/or Work :

Category	MS/R	Variable	Statistic	DF/N	P= **
1 v	11.04	DNT	Z=-1.98	13	.024
4	5.50			5	
3 v	27.85	ILL2	Z =-1.57	37	.058
1 & 2	34.76			23	
3 v	106.53	DSIT	T = 2.61	56	.015*
1 & 2	91.40				

** One-Tailed Probability, pooled variance;
* separate variance.

Again the results are somewhat difficult to interpret. They suggest that respondents who talked about work worries at home only (category 1) experienced more stress than those who did not discuss work worries at home or home worries at work (category 4). This would suggest that a rigid boundary between home and work is helpful. The finding that those who discuss home worries at work AND work worries at home (category 3) report higher stress scores for death situations (DSIT), suggests one might expect to find an additive effect in the interplay of these two aspects of support across the work - home boundary. However, the results are contradictory, since the same group also report fewer days illness over the last three months (ILL2). However, the question is raised as to whether these various stress scores are all measuring the same thing. Neither the Death Situation score nor the Death - Related Nursing Task score reflect recent experience of nursing dying patients, and are perhaps better regarded as an estimate of how stressful the respondent would find a given situation or task, rather than a direct measure of current job stress in the described area/s. Nevertheless, whatever the level of stress reported and the method used to cope with it, overall the impression again is of a group of staff who are coping.

Finally, the T-Test was run to find out whether staff who used support at work faired any better than staff who did not seek support at work. Two approaches were used.

Firstly, categories 1. to 4., as listed on page 228, were regrouped in order to compare respondents in categories 2 & 3 (all those who would discuss their worries at work - N = 47); with those in categories 1 & 4 (all who would not discuss worries at work - N = 21). Full data were available for 63 subjects - Test 1 in table 51.

Secondly, respondents who were categorised within the "reaction" group of Hypothesis 10 were divided according to whether the coping methods they used (see appendix 13) included or did not include seeking support at work. Data were available for 50 respondents - Test 2 in Table 51, which shows the results which reached the level of statistical significance.

Table 51 : Relationship Between Support at Work and Stress

Test	Support at work	N=	Variable	DF	T=	P= *
1	1 = Yes	45	DSIT	61	2.132	.025
	2 = No	18				
2	1 = Yes	35	DSIT	48	2.012	.025
	2 = No	15				
2	1 = Yes	35	DAS	48	3.245	.005
	2 = No	15				

* P= pooled variance, one-tailed probability.

It was anticipated that staff who used support at work might experience less stress. However, as the findings in Table 51 show, while staff who used support at work reported higher stress on the Death Situations and Death Anxiety Scales, there were no significant differences in the short or long-term outcomes as measured by the General Health Questionnaire and illness reports over one, three and twelve months.

The results are somewhat complex and hence difficult to interpret. However, when looking at the management of stress / worries across the home - work boundary, superficially at least, there is some evidence in favour of maintaining a compartmentalization between the two areas. It was also found that staff who used support at work reported higher levels of stress. Nevertheless they did not differ significantly from other staff on the stress outcome measures. This suggests that staff who needed support sought it and were effective in ameliorating the possible consequences of stress. It may be that when higher levels of work stress are experienced, support at work is at least as, and perhaps more, effective as a way of mitigating the effects of stress. It may also be that staff who feel supported at work are more likely to be able to acknowledge their stress.

HYPOTHESIS 15

Night staff will show greater evidence of stress than day staff and this will be especially so where deaths are high.

For the night staff group as a whole, Pearson's product moment correlation co-efficient r showed a significant and positive correlation between Death Anxiety Scale, (DAS) scores; and the Nursing Situations (NSIT) and Death - Related Nursing Tasks (DNT) scores :

DAS with NSIT - $r = 0.585$; $df = 22$; $p = < .01$;
DAS with DNT - $r = 0.666$; $df = 22$; $p = < .01$.

1. Comparison of Day and Night Staff Regardless of Hospital

To test this hypothesis, the stress scores recorded by night staff from all groups were first compared with the stress measure reports of day staff regardless of hospital, using the T-Test. There were no significant differences between day and night staff groups as a whole on any of the total stress scale scores, although a number of individual items from the Death Anxiety Scale (DAS) and the Death Situations scale discriminated the two groups. These are shown in Table 52. The mean scores for day staff are reported first of each pair.

Table 52 : Individual DAS and DSIT Items which Discriminated Between Day and Night Staff :

Item		Mean	F=	T=	DF	P= *
DAS6	Day	4.76	2.3	-2.37	63	.011
	Night	5.92				
DAS8	Day	3.27	1.17	-2.37	63	.011
	Night	4.63				
DSIT8	Day	4.27	1.59	1.93	63	.029
	Night	3.33				
DSIT18	Day	5.78	1.41	2.02	63	.024
	Night	4.54				

* one-tailed probability:pooled variance.

These results suggest that night staff as a group experienced greater death anxiety associated with fear of getting cancer (DAS6) and the passage of time (DAS8) than day staff. However, these fears were not carried over into reports of stress / upset in relation to the Death Situations. where day staff recorded higher levels of stress on two items: DSIT8, death of an elderly patient; and DSIT18, death of a patient while you are washing or turning him. While some associations would be expected to occur by chance, for the sample as a whole, there were few differences between night and day staff on any of the measures used. However, it should be borne in mind that in testing a wide range of variables, some statistically significant differences would be expected to occur by chance, and it seems clear that the groups were more alike than not.

2. Comparison of Day and Night Staff Groups Within the Same Hospital. The question next to be asked was whether night staff in each hospital were more like or unlike their day-time colleagues in the same hospital.

Table 53a) : Stress Measure Items which Differentiate Hospital 1, Day and Night Staff:

Item	Group	Mean Score	DF	T=	P= *
DAS	Day	49.0	22	-1.59	0.064
	Night	57.6			
DSIT	Day	90.7	22	-1.9	0.036
	Night	109.2			
DSIT6	Day	6.13	22	-2.38	0.014
	Night	7.78			
DSIT11	Day	3.67	22	-2.57	0.009
	Night	6.33			
DAS6	Day	4.40	22	-2.38	.013
	Night	5.89			
NSIT52	Day	3.36	22	-2.18	.021
	Night	5.56			

* One-tailed probability, pooled variance.

Table 53b) : Stress Measure Items which Differentiate Hospital 2, Day and Night Staff :

Item	Group	Mean Score	DF	T=	P=*
DSIT	Day	109.7	39	3.34	0.001
	Night	90.4			
DSIT8	Day	5.08	39	3.19	0.002
	Night	3.20			
DSIT9	Day	6.19	39	2.43	0.01
	Night	4.47			
DSIT11	Day	6.46	39	2.72	0.005
	Night	4.47			
DSIT12	Day	7.04	39	2.13	0.02
	Night	5.60			
DSIT16	Day	8.04	39	2.60	0.007
	Night	7.0			
DSIT17	Day	4.46	39	2.20	0.017
	Night	3.27			
DSIT18	Day	6.38	39	3.72	0.0005
	Night	4.0			
DAS7	Day	4.46	39	2.28	0.014
	Night	3.0			

* One-tailed probability, pooled variance;

The T-Test was again used to test for differences in the stress measures between day and night staff in Hospital 1, and similarly in Hospital 2. A number of additional items were found to differentiate these groups of staff. However, although in both hospitals significant differences were found between the scores of night and day staff, the direction of the difference was not the same. In Hospital 1 the night staff group consistently reported significantly higher scores, whilst in Hospital 2, the night staff group scores on the stress measures were lower than those recorded for day staff. Table 53a), on page 234, shows those items for which responses were significantly different in Hospital 1; and Table 53b) on page 235 the items which significantly differentiated day and night staff groups in Hospital 2.

It would appear from these data, that the experience of stress among night staff was not the same for both groups and that they did not uniformly report less stress than their day-time colleagues. Hospital 1 night staff consistently recorded higher levels of stress than their day-time colleagues.

3. Comparison of a) Day Staff, and b) Night Staff, by Hospital :

The hypothesis was further tested by comparing the scores of day staff in Hospital 1 with those of day staff from Hospital 2; and night staff from Hospital 1 with night staff from Hospital 2. A number of interesting differences were found. It will be recalled that in Hypothesis 3, inspite of a lower number of deaths on the wards in Hospital 2, it was found that as a group these day staff reported significantly higher Death Anxiety Scale scores than the day staff of Hospital 1. They also scored significantly higher on the Death Situations (DSIT) and the

Death - Related Nursing Tasks (DNT) scales, Table 54 :

Table 54 : Comparison of Stress Measures Among Day Staff in Hospital 1 (H1) and Hospital 2 (H2) :

Group	Variable	Mean	F=	T=	DF	P= *
H1	DAS	49.0	1.56	-2.0	39	.014
H2		58.8				
H1	DSIT	90.7	2.13	-3.06	39	.001
H2		109.7				
H1	DNT	22.7	1.37	-2.44	39	.01
H2		34.3				

* one-tailed probability,pooled variance.

However, comparison of these scores between the two night staff groups in each hospital showed only one significant difference. That was in the scoring of the Death Situations scale (DSIT), and unlike the day staff groups, the higher scores were reported by Hospital 1 staff. P is one - tailed probability, pooled variance,:

Group	Variable	Mean	F=	T=	DF	P=
H1	DSIT	109.2	1.22	2.11	22	.024
H2		90.4				

DSIT items were further analysed to identify differences in response between day staff in Hospital 1 and Hospital 2, and between night staff in Hospital 1 and Hospital 2. Table 55a). shows the Death Situation items to which Night Staff groups in each hospital responded differently, where the differences reached the level of statistical significance. Table 55b) gives the same information on differences between the two Day staff groups.

Table 55a) : Differences between Night Staff, Hospital 1 (H1) and Hospital 2 (H2) on Death Situation Items, and Total Death Situation Score (DSIT):

Item		Mean	DF	T=	P= *
7	H1	5.78	22	2.52	0.02
	H2	4.27			
12	H1	7.56	22	2.72	0.01
	H2	5.60			
17	H1	5.56	22	3.37	0.003
	H2	3.27			
DSIT	H1	109.2	22	2.11	0.047
	H2	90.4			

* two-tailed probability,pooled variance.

As can be seen, there were more items which differentiated the two day staff groups from each hospital than the two night staff groups. Moreover, whereas Hospital 1 day staff reported lower stress scores than Hospital 2 day staff, among night staff the direction of stress was reversed, with Hospital 1 night staff reporting higher stress. This pattern in the direction of greater stress was identified almost consistently where a significant difference was found in the stress reports between day staff groups and between night staff groups in each hospital.

Table 55b) : Differences Between Day Staff, Hospital 1 (H1) and Hospital 2 (H2) on Death Situation Items :

Item		Mean Score	DF	T=	P = *
5	H1	4.80	39	-2.12	0.04
	H2	5.96			
6	H1	6.13	39	-3.00	0.005
	H2	7.73			
8	H1	2.87	39	-3.93	0.000
	H2	5.08			
10	H1	3.53	39	-2.17	0.04
	H2	4.92			
11	H1	3.67	39	-3.77	0.001
	H2	6.46			
15	H1	2.33	39	-2.26	0.03
	H2	3.73			
16	H1	7.07	39	-2.24	0.03
	H2	8.04			

* Two-tailed probability, pooled variance.

Conclusion

There were rather more items which differentiated between the day staff of each hospital than there were items which differentiated night staff. In addition, there were significantly different patterns between groups in the reports of stress. Whereas among day staff significantly greater stress was consistently reported by Hospital 2 staff, among night staff the direction of greater stress was reversed, being reported by Hospital 1 staff. Moreover, in Hospital 2, the night staff reported lower stress than day staff, whilst in Hospital 1 the night staff group reported higher stress than day staff. This would suggest that in this situation of potentially high stress there were mediating factors present which were operative for day staff only. The hypothesis that greater stress is experienced among night staff was therefore found to be true for night staff in Hospital 1 only.

HYPOTHESIS 16

Staff who do not attend formal support groups will show greater evidence of stress.

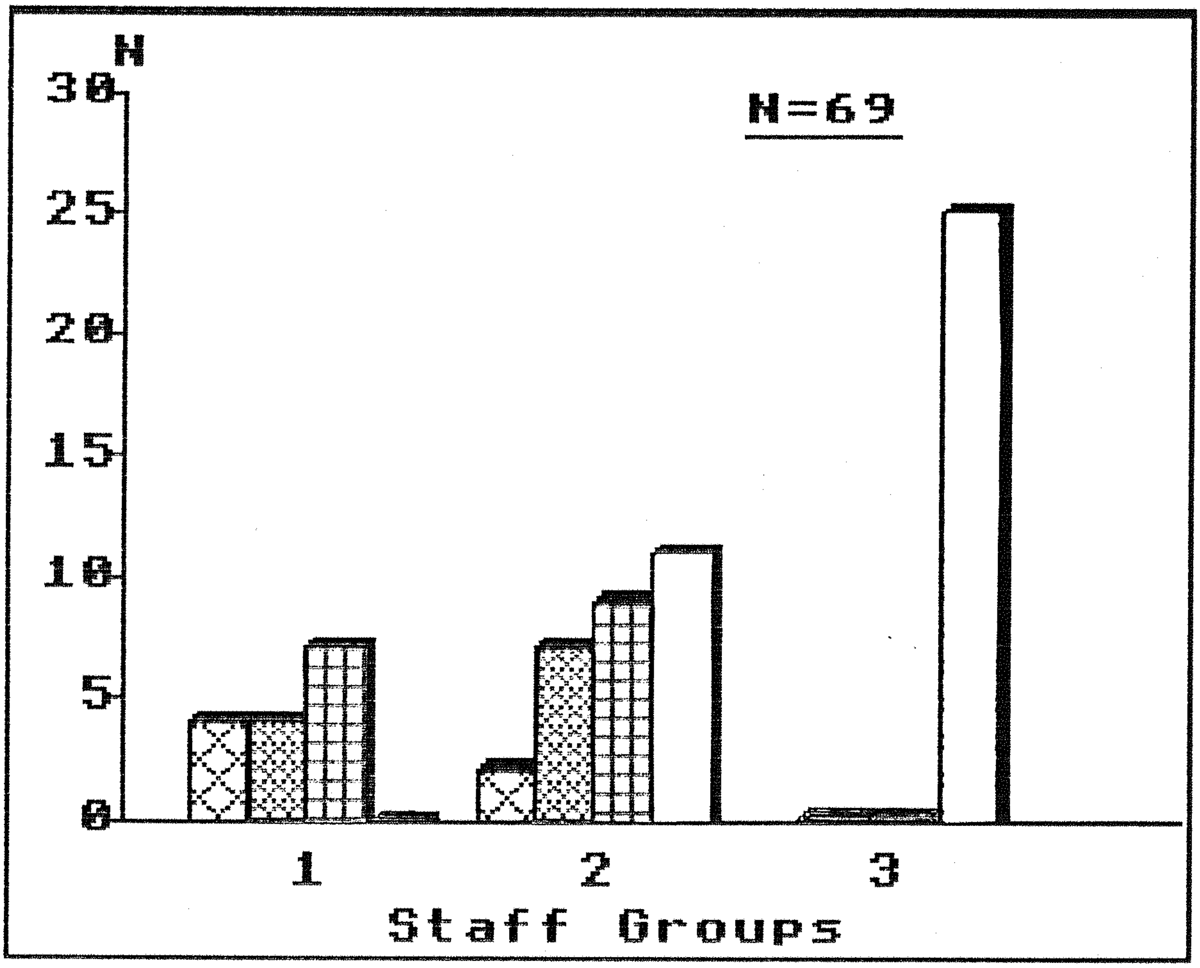
All respondents were asked whether they attended any meetings at work (other than hand - over or union meetings), and if so would they discuss work worries or upset at such a meeting. Just over fifty per cent of all staff did not attend meetings as defined. (100% of night staff) because no such meeting was available. Figure 10, on page 241, shows how the respondents in group answered this question. The following categories were defined :

1 = Attend meetings and would discuss work worries.
2 = Attend meetings and might discuss work worries.
3 = Attend meetings and would not discuss work worries.
4 = Do not attend such meetings.

1. When respondents were grouped according to whether they attended or did not attend meetings no statistically significant differences between the two groups were found on any of the stress measures used.

Fig. 10.

Attendance At and Use of Meetings to Discuss Worries at Work :



1 = Hospital 1, Day Staff (N=15)
2 = Hospital 2, Day Staff (N=29)
3 = All Night Staff, Groups 2 ahd 3 (N=25)

▩ Attend meetings and would discuss worries;

▒ Attend meetings and might discuss worries;

▦ Attend meetings and would not discuss worries;

☐ Do not attend such meetings.

2. Responses were also collapsed into the following combinations of two groups :

a) Respondents who said they would not discuss worries at meetings were compared with respondents who said they would or might discuss their worries;

b) Respondents who said they would not or that they might discuss their worries were compared with those who said they would discuss work worries;

c) Respondents who did not attend meetings or who did attend but would not use the meetings to discuss worries were compared to those who did attend and said they would or they might discuss worries.

For each of these combinations the T-Test was used to compare the Death Anxiety Scores; Death Situation; and Death-Related Nursing Task scores. General Health Questionaire scores and the number of days illness reported between groups were compared using the Mann-Whitney test. No statistically significant differences were found between the scores in any of these groups, either for attendance at, or use made of, meetings.

3.A one - way analysis of variance on the same stress variables also showed that,among staff who attended such meetings, the use they made of the meetings also did not significantly affect stress scores.

It would appear that,contrary to expectation and the literature on support groups, Hypothesis 16 is not supported by the data and should be rejected.

At the time of the interviews, three meetings were available to staff in Hospital 2, which were organised across wards according to grade. These meetings had been established only fairly recently and increased support was one of the goals stated by the nursing officer. It is clear from Figure 10, that very few nurses who attended meetings regarded them as somewhere they would choose to discuss ward / work difficulties. A variety of reasons were given :

Availability of viable alternative	N=2
Fear of standing out in group	N=3
Ward loyalty	N=3
Not purpose of meeting	N=1
Do not know others well enough	N=3
Group not seen as helpful	N=2
Prefer one to one	N=7

In addition, although there had been a staff support group available formally on a weekly basis to Group 1 respondents, which was intended as the comparison for this question, by the time of the study the group had more or less ceased to meet and support was provided either individually on a formal basis, or informally.

Therefore, all respondents were also asked whether they thought it would be helpful to have support meetings on the ward attended by staff of all grades. Table 56 shows the replies received :-

Table 56 : Wish for Provision of Support Meeting at Ward Level :

Response	N=
No	9
Yes	40
Already Available Informally	13
Missing	7

Thus, although little use seemed to be made of staff groups for support at the time of the interviews, there was fairly substantial enthusiasm for the provision of such meetings at ward level.

HYPOTHESIS 17

Nurses whoe receive support from senior staff will show less evidence of stress than nurses who do not receive, or who do not feel they receive, such support.

Nurses were asked to identify who in the hierarchy would be the appropriate person/s to look to for support and whether they would go to a senior colleague, defined as Nursing Officer or above if they were worried or upset. The responses to this question are presented in Figure 11. The following response categories were identified :

1 = Yes ; 2 = Qualified / Conditional Yes ;
3 = No ; 4 = No - one identified.

Responses were collapsed into three combinations of two groups :-

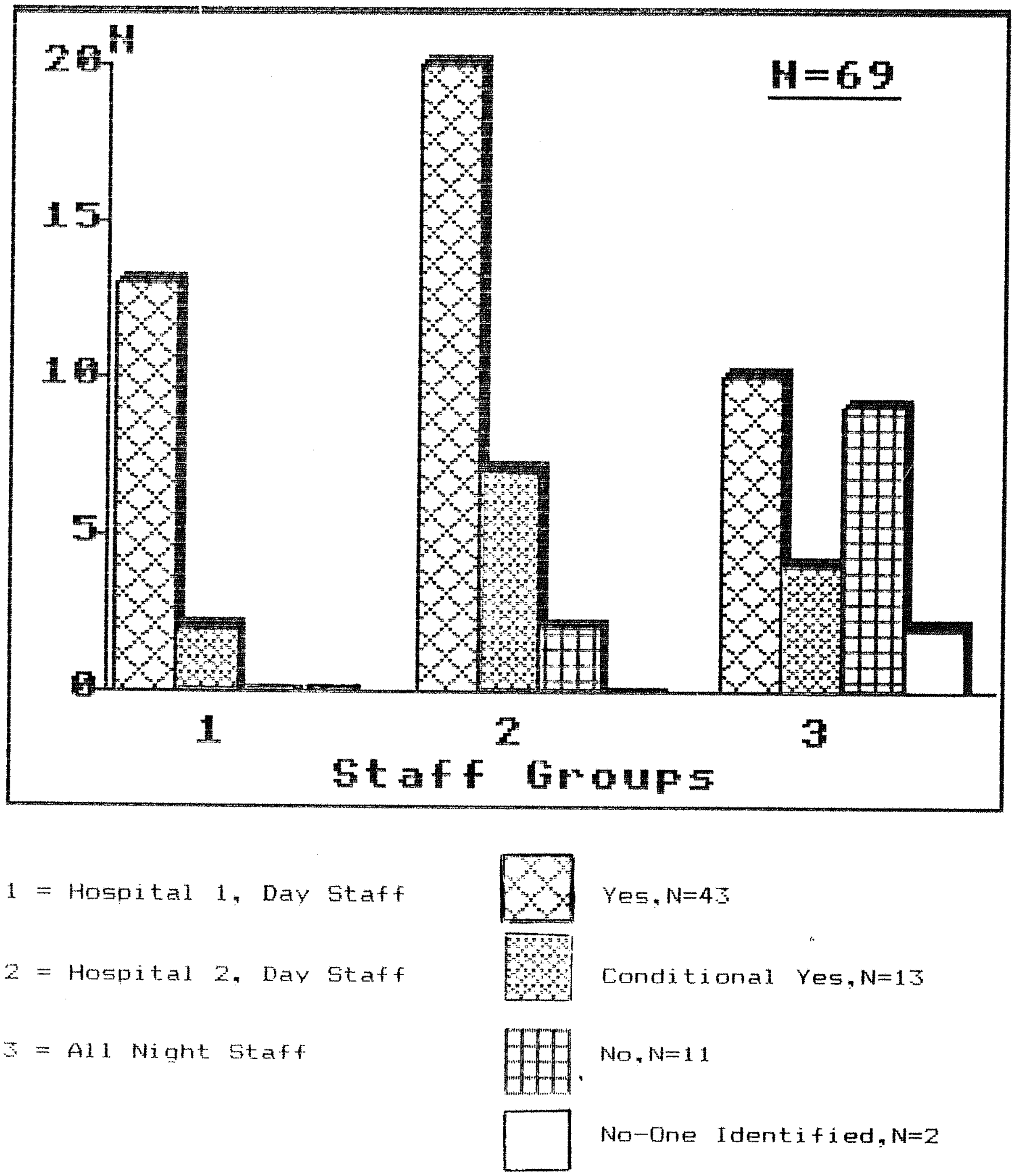
1). Yes (N=43) ; No (N=13).
2). Yes (N=43) ; No / Qualified Response (N=24).
3). Yes / Qualified Response (N=56) ; No (N=13).

An analysis of all the measures using both the T-Test or the Mann-Whitney as appropriate, did not show the support of senior staff to be statistically significant.

It was clear from the responses received in answer to this question, that respondents had not always thought of senior staff being available in such a formal way. Hence, thirteen said there was no-one whose job it was and four said they were not sure. However, in discussion, only two respondents failed to identify someone in the system who would / could be available, both from Group 3.

Fig. 11.

Use of Support from Senior Staff 'if Worried or Upset :



Knowing that someone was available, however, did not mean they would necessarily be used. 56 staff said they would or probably would feel able to talk to the person/s identified. In this respect, significantly fewer night staff identified someone they would talk to - Table 57.

Table 57 : Availability and Use of Staff Support for Day and Night Staff in the Sample as a Whole :

	Day Staff	Night Staff
Available & Would Use	42	14
Not Available or Would Not Use	2	11

$X^2 = 13.81$; df = 1; $p = < .005$.

In this respect the two hospitals were more alike than not, with both night staff groups feeling less supported than their day time colleagues. This will be discussed further in Chapter 12.

However, since there were no significant differences in the stress reports of staff who said they did receive support from senior staff compared to those who did not, it must be concluded that Hypothesis 17 is not supported by this data.

HYPOTHESIS 18

Nurses who feel they have the esteem of their professional colleagues and feel appreciated at work will show less evidence of stress.

The relative emphasis on social / emotional support, in this study is not to deny the relevance of esteem in the sense of professional esteem / worth in the eyes of one's colleagues. Respondents were asked if they felt appreciated by their work colleagues. Their answers, shown in Table 58, below, were categorised as yes / sometimes and no / predominantly no. Responses were available for 67 subjects.

Table 58 : Feeling Appreciated by Colleagues :

	Day Staff	Night Staff	Total
Yes	39	14	53
No	4	10	14
Total	43	24	67

$X^2 = 7.97$; df = 1; $p = <.005$.

In both hospitals, night staff were significantly less likely than day staff to say they felt appreciated. Being appreciated by their day staff colleagues seemed to be as equally important as being appreciated by other night staff. Overall, staff from all groups thought it was important to be appreciated by their colleagues, and strong feelings emerged about this aspect of staff support. Among the 14 staff who felt unappreciated, five said they felt appreciated by patients, and in both groups staff drew a distinction between appreciation by patients and by colleagues. Respondents seemed equally to be divided between saying it was important to feel appreciated, and that it should not be important even though it was. This will be discussed in greater depth in Chapter 12. However, no significant differences were found between the stress scores of staff who said they felt appreciated, and those who said they did not. Hypothesis 18 is not substantiated.

SOCIAL and DEMOGRAPHIC DATA

The availability of a range of social and demographic data for each respondent made it possible to examine whether these characteristics had an influence on stress scores.

1. Respondents were divided into two groups according to the following criteria :

Marital Status - Living with partner / Single
Children Under 18 at Home - Yes / No

The T statistic was calculated for the Death Anxiety Score; Death Situation; and Death - Related Nursing Task measures, to test for significant differences between the groups. In addition, the Mann-Whitney test was used to look for differences between the groups in response to the General Health Questionnaire and the one, three and twelve months illness reports. None of the differences between the groups was found to be statistically significant.

2. Additionally, the Pearson product moment correlation coefficient was calculated to measure the relationship between AGE, number of years nursing experience (EXPYRS), and number of years in present job (YRSINJOB) with the Death Anxiety Scale (DAS), Death Situation (DSIT) scores, and Death - Related Nursing Task (DNT) scores; while the same demographic data were tested using Spearman's rank order correlation with the (GHQ) General Health Questionnaire scores and number of days illness reported over one (ILL1), three (ILL2) and twelve (ILL3) months. In no case did the relationships reach the level of statistical significance, although in two cases a clear trend emerged, as shown in Table 59 :

Table 59 : Correlations Showing Strength of Relationship Between Demographic Data and Stress Measures :

Demographic Variable	Stress Variable	N=	corr =	P= ✱
EXPYRS *	DSIT	60	- .234	.061
YRSINJOB **	ILL2	67	.208	.092
AGE **	ILL2	67	.025	.843

✱ Two-Tailed Probability

* Pearson's r;

** Spearman's rho.

Respondents with more years nursing experience (EXPYRS) tended to score less on the Death Situation measure; but the longer the subject had been in her present job the more days illness she tended to have had in the last three monthd. As Table 59 also shows, this latter relationship could not be explained by the age of the respondent, (p = .843). However, again it must be borne in mind that the Death Situation score may be measuring a different aspect of stress from that measured by the illness reports.

The sample size was not sufficiently large to allow a more comprehensive analysis of the interaction of the various social / demographic variables.

CHAPTER 11

SUMMARY OF FINDINGS

I - FINDINGS THAT WERE AS EXPECTED

A majority of nurses in this study reported feeling upset, at least sometimes, when a patient died. This was true regardless of whether nurses defined their relationship with patients as predominantly professional, or as one in which they saw themselves as involved with patients in a more personal way.

Nurses who reported feeling upset were also more likely to have higher stress scores on the measures associated with nursing care of the dying. However, reactions to the death of a patient were varied and, perhaps surprisingly, were reminiscent of normal bereavement responses identified by other research.

A strong positive association was found between the holding of religious belief and reports of stress and upset when a patient died. With respect to death anxiety, the crucial variable seemed to be church attendance.

Death - Related nursing tasks were ranked as most stressful by four of the five groups of staff, the exception being day staff from Hospital 1 (Group 1), who ranked them as second most stressful. Items relating to emotional care were ranked as most stressful by Group 1 and as second most stressful by all other groups.

II a)- FINDINGS CONTRARY TO EXPECTATION

Coping measures which might be regarded as making use of social supports were associated with reports of higher rather than lower stress. Tears, Talking to Family / Friends, and Talking to Colleagues were all associated with higher stress scores; use of prayer was associated with lower death anxiety; and introspection with less illness over one year.

Across all groups, a surprising amount of agreement was found as to the deaths regarded as most and least stressful.

No direct relationship was found between number of deaths and stress. Day staff in Hospital 1 reported the least stress; while staff on the continuing care wards, who experienced the lowest number of monthly deaths, reported more stress than nurses on the acute wards.

II b) - HYPOTHESIZED RELATIONSHIPS THAT WERE NOT SUPPORTED

No association was found between the availability of support from close friend / confidant or family and any of the stress outcome variables.

There was no association found between either attendance at or use made of the available staff support groups and stress measures.

There was no evidence to substantiate the assumption that openness in the management of feelings was inherently "good", nor that denial / repression was "bad".

No correlation was found between either work stress in relation to patient death or recent life events, and any of the stress outcome variables.

No correlation was found in either direction between age and any of the stress variables, though there was a tendency for staff with more nursing experience to report lower stress in relation to situations involving death.

III - FINDINGS WHERE DIRECTION OF RELATIONSHIP WAS NOT PREDICTED

Reports of higher stress and high recent life event scores were associated with the reported use of more rather than fewer coping responses.

As a whole, significantly fewer night than day staff were able to identify someone in their hierarchy to whom they would feel able to talk if they had problems. Night staff were also significantly less likely to feel appreciated at work.

Night staff in Hospital 1 were more likely to report higher stress than either their day - time colleagues in the same hospital or the night staff from Hospital 2.

Staff who reported using methods of coping which included seeking support at work, and staff who said they would discuss their worries across the boundary between home and work showed a consistent trend toward higher stress scores on the death stress measures. A reverse trend was noted for these groups on the stress outcome measures. Staff who found it easy to switch off from work had significantly lower General Health Questionnaire scores, but also had significantly more days illness over one and three months.

CHAPTER 12

DISCUSSION OF FINDINGS

UNDERLYING ASSUMPTIONS

There are two fundamental assumptions that have been operative throughout the study and which form the backdrop against which the findings will be assessed. The first is that an "open" ethos is desirable. This is defined as an atmosphere in which staff and patients are free to engage in a dialogue about the implications and / or fears patients may have in relation to their illness and possible death. It is not identical to the "open awareness context" described by Glaser and Strauss (1965), though it certainly implies that potential. Rather, it signifies on the part of staff a readinesss to share information in relation to the illness, to enable patients and families to explore and make sense of what they are told to the extent that they want and need to do so. This places considerable responsibility on staff to understand and respond appropriately to the verbal and non - verbal cues that patients may give, in deciding how and when to help the patient verbalise previously unspoken, and so unconfirmed, fears. Though such an ethos is regarded as beneficial for patients and families (Glaser & Strauss, 1965; Kubler-Ross, 1970; Benoliel, 1976) the impact on staff of putting the psychological needs of patient and family before their own in this way may be less helpful. Indeed it may be highly stressful. This leads to the second assumption made. An open acknowledgment by staff of their own feelings of upset or stress is more desirable in relation to "healthy" outcome for themselves, than an attempt to deny or cover such feelings. The implications and consequences of these assumptions will be discussed in greater depth later in the chapter.

THE RESPONDENTS

Examination of the characteristics of staff in both hospitals showed that the groups were more alike than not.

Where there were differences these seemed more likely to operate in favour of optimising coping resources and minimising the experience of stress for staff in Hospital 1, the posited high stress group. Given this similarity between the staff in each hospital, the two groups differed primarily in relation to the nature of the nursing task in which each were engaged, and the way in which it was conceptualised.

In hospital 1 the primary task was the care, rather than cure, of patients in the terminal stages of cancer. In practice, nursing staff of all grades were required to be aware of, and / or to treat, both the physical and emotional pain of the patient and his family. In the management of emotional pain, opening up the channels of good and honest communication between patient and family, patient and staff, and family and staff were considered desirable and helpful goals. Service delivery, therefore, was conceptualised along the lines of the "open awareness" situation described by Glaser and Strauss (1965), and generally accepted as the hospice ideal. Due to the nature of the task, this hospital experienced a considerably higher number of deaths than did Hospital 2, and it was expected that this group of staff would be the most stressed. However, there were a number of measures incorporated into the system which were designed to ameliorate the effects of stress. These included a 1:1 staff : patient ratio; careful staff selection; no rotation to or from other hospitals; a balance between maturity, qualification and experience; no learner or student nurses; a generous ratio of part - time staff, including those with families; and organizational recognition of the importance of staff support, both formal and informal.

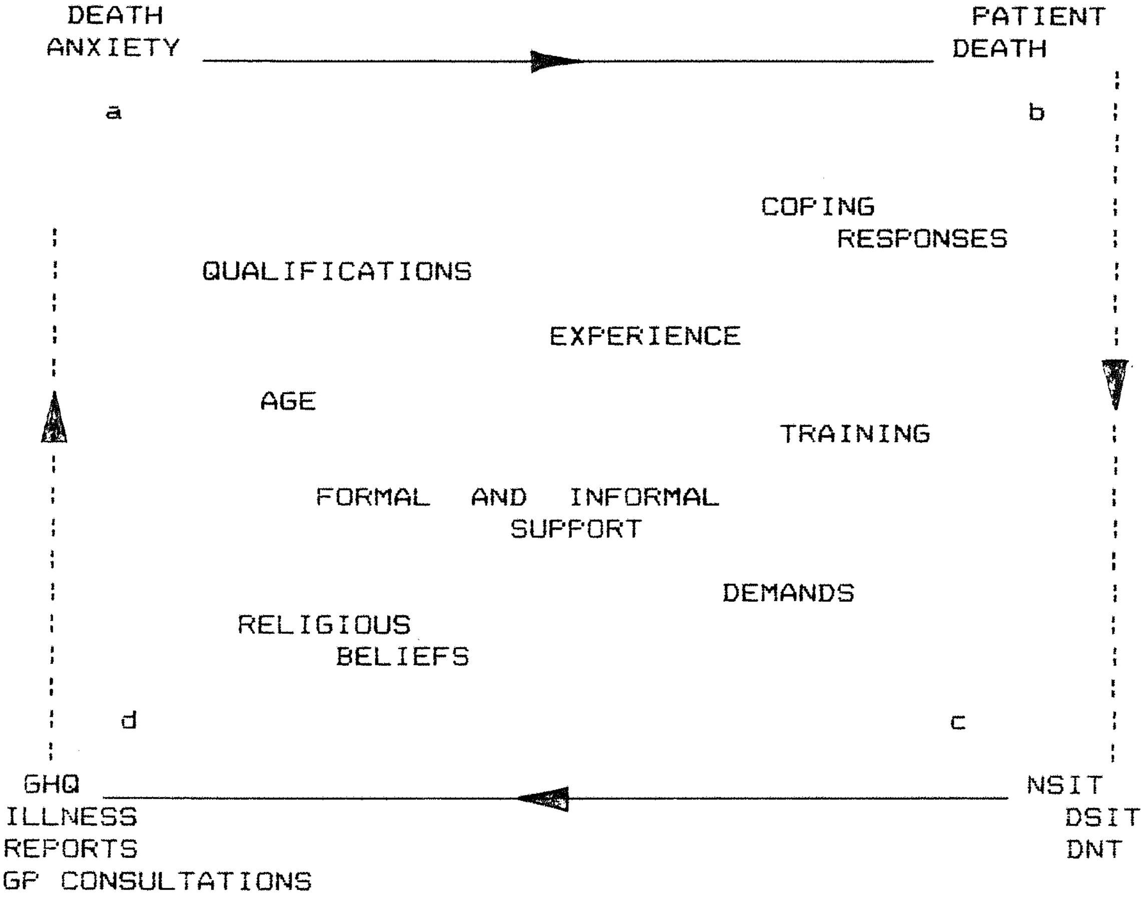
In Hospital 2, on the continuing - care side of the geriatric department, the goals were similar in many respects to those of Hospital 1: care rather than cure; creation of a homely atmosphere; maintaining optimum functioning; and the importance of family relationships to the patient. The main differences lay in the generally much longer time patients would be expected to remain in hospital, and the age of the patients. Staff expected that most, if not all patients would eventually die in hospital, but because of the generally slower deterioration the average length of stay was much longer and the number of deaths per month was low.

On the acute - assessment side,the task was in some ways less clear, involving as it did the assessment and treatment of medical conditions and their impact on functioning in elderly patients, and the treatment of medical emergency admissions in the same age group. Concurrent goals might also include maintenance of present levels of functioning or rehabilitation to an improved level, with a view to discharge back into the community, or where this was not possible, to a long - stay bed. In the latter case, this might involve an extended stay on the ward until an alternative bed became available. The ward ethos, however, was geared more toward treatment and rehabilitation than longer - term care. These wards had a higher number of deaths than on the continuing - care side, but nevertheless significantly fewer than Hospital 1.

This study set out to show that a strong positive relationship existed between a high number of patient deaths and the experience of stress in nursing. Much of the literature on the subject of stress in nursing (Cundey, 1981; Gow & Williams, 1977; Menzies, 1970; Parkes, 1980a; etc.), and on hospice nursing (Friel & Tehan, 1980; Glaser & Strauss, 1965; Manning, 1984; Stedeford, 1984; Vachon, 1978; etc.) assumes both care of the dying generally and hospice nursing in particular, to be very stressful areas.

Fig. 12.

Conceptualisation and Measurement of Stress :



Given the pre-existing level of death anxiety (a), stress was conceptualised interactively along a time - continuum, in which the originating stimulus was patient death (b). Respondents selected worked on wards which could be readily categorised as being low, medium and high on exposure to this stimulus. It was expected that the amount of stress (c) reported in response to patient death, and longer term outcome (d) would show a positive association with (a) and (b). It was hypothesized that a number of intervening variables would be related to both the experience of stress and its consequences.

NUMBER OF DEATHS AND MAGNITUDE OF STRESS.

Comparison with Other Hospice Research

The major finding of this study is that, although a majority of nurses from both hospitals reported feeling upset when a patient died, the magnitude of death anxiety and stress in caring for these patients was not in a direct relationship to the number of deaths. What emerged was a rather more complex pattern. In particular, the finding, in a Canadian comparative study, by Vachon et al (1978), that palliative care nurses were the most highly stressed group, is not supported by these results.

How then to explain the difference between the results of the Canadian study and this research, and what are the implications of these findings ?

The first possibility is that the two studies are not comparable, or that the results are not valid. In the report referenced (Vachon et al, 1978), neither the sample size nor the actual stress scores found were quoted. The authors noted, only, that staff on the palliative care unit obtained scores that were twice as high as staff on other units, and nearly as high as those obtained by a group of recently bereaved widows. In the present study, the possibilty of under - reporting was noted for some of the outcome measures used. However, both studies used a version of Goldberg's General Health Questionnaire in which a score of 5 or more indicated stress. Since it seems probable that the newly widowed would report scores at least at or around the cut - off point of 4 / 5 referred to by Vachon et al, it is safe to conclude that the palliative care staff in that study presented as considerably more stressed than those in the study reported here, where only three palliative care staff had General Health Questionnaire scores above the relevant cut - off point.

A second possibility is that the groups in these two studies are not comparable, and indeed this would appear to be so in a number of important respects. In this study staff were working in a unit which had been open for seven years at the time of the interviews, the respondents were a well - established staff group, with a good balance between levels of experience, maturity and qualification. By contrast, the staff in the Canadian study worked in a newly opened palliative care unit. However, it should be borne in mind also that whilst their initial scores were high, their distress was reported as decreasing over the ensuing year. In addition, the material reported in the present study was gathered some 7 - 10 years later than the Canadian study, and the results found here may also reflect the extra years of collective experience about how to cope with this kind of work stress, as well as how better to select and support staff.

The third possibility is that the staff interviewed in this study were a coping group. Overall, respondents from Hospital 1 were very clearly shown not to be significantly more stressed than Hospital 2 staff. On neither the General Health Questionnaire nor the Death Anxiety Scale were significant differences found between the hospitals.In fact the Death Anxiety scores of Hospital 1 staff tended to be lower,the difference only just failing to reach the level of statistical significance.In addition, the mean Death Anxiety Scale score for Hospital 1 staff was found to be significantly lower than that of McMordie's original sample for females (see appendix 3a). The mean score of hospital 2 staff more nearly approximated that of McMordie's subjects. Where significant differences were found in the other stress / anxiety scores between hospitals, the differences were consistently in the opposite direction from that expected, with higher stress reported by Hospital 2 staff. No significant differences were found between the hospitals on any of the stress outcome variables. The general trend of all the stress measures supports the supposition that this is a coping group.

It is fair to conclude, therefore, both that the groups from the Canadian and this study were not completely comparable, and that the respondents in Hospital 1 of this study were a coping group.

Comparison Between Hospitals 1 and 2

Although the staff from each hospital were known to be more alike than not on a number of variables, given the consistent trend toward lower stress reports by Hospital 1 staff,the possibility that the two groups differed in respect of some other important factor must be considered. There are a number of possible explanations as to why nurses in Hospital 1 were not significantly more stressed, in spite of higher exposure to patient death, than their colleagues in Hospital 2. Hopping (1977) suggested that a positive attitude to death may be an important variable which discriminates staff who choose to work with dying patients. The nurses in Hospital 1 were very much a selected and self - selecting group, in that all except two nurses had applied expressly to work there, knowing in advance that it entailed working with dying patients in a very particular way. Indeed, it was in order to have more time to spend with dying patients that many staff said they had chosen the job, feeling dissatisfied with the care they had been able to offer elsewhere. It may well be that one of the defining characteristics of such a group would be a low or lower anxiety about death than is present among other nurses. A comparison of the death anxiety scores of each group tends to confirm this supposition.

However, it has also been suggested (Vachon, 1978) that a desire for mastery over pain and death, previous personal experience and a suspicion that one might develop the disease are amongst the motives for working in this kind of unit. This would suggest that the job is in some way used as a means of managing death anxiety, in which case, anxiety might not be lower, or it might be managed at a higher level of awareness. Whether such motives were amongst the unspoken or unconscious ones in this group was not possible to determine. Apart from three nurses who had lost a friend or relative through cancer, they did not feature amongst the reasons given as influencing the decision to apply for a job in that hospital. The Death Anxiety Scale does not purport to measure unconscious anxiety. However, a small correlation with galvanic skin response, one test used to assess unconscious anxiety, was reported by Pollack (1979), which suggests some overlap between conscious and unconscious anxiety, as might be expected.

The Death Anxiety Scale reflects primarily conscious verbalized anxiety. It is possible that it does not give a true measure of death anxiety, which may be dealt with by repression and denial. These might indeed be considered likely coping mechanisms in a society where death is still a relatively taboo topic. On the other hand if, as Stedeford (1984) and Vachon (1978) recommend, it is important for staff to be aware of their own areas of vulnerability and stress, then a degree of self - knowledge and reflection might well be qualities sought at the stage of the initial interview. Since the subjects in Hospital 1 were working in an environment where they were constantly and openly confronting the taboo, it seems probable that these nurses would be less likely to cope by denial, and might in fact have found it necessary to think through their own feelings about death in the process of applying for their job. Whilst this might be true for anyone entering the nursing profession, once qualified, it is possible to select areas of greater or lesser exposure to patient death. Nurses who elect to work in a high exposure situation, therefore, may fall into one of three possible categories in terms of death anxiety: a) they have low anxiety; b) they have higher anxiety and a strong need / desire to manage their anxiety by confronting death; or

c) they have very strong defences against the anxiety so that they are not threatened by constant exposure. One must wonder, however, how easy it would be for respondents in the second and third categories to maintain a psychologically comfortable position for long, while sustaining the kind of relationship that would enable patients to deal with their own fears. Without some resolution to any underlying death anxiety, they would seem the least likely to stay.

However, in the short term at least, it would seem quite possible that a member of staff dealing with her own anxiety or upset about death by denial or repression could maintain sufficient competence in caring for patients. Certainly this would seem to be attainable at the level of physical care, and even at the level of psychological care, providing that the patient did not require a relationship that acknowledged the reality of his dying status. This latter need would threaten the psychological comfort of the nurse, whose needs at that point would be in conflict with those of the patient. Nevertheless, this situation might remain reasonably manageable and satisfactory to both providing the patient's needs could be referred to and met by another member of staff. However, in the longer term it seems likely that the nurse would experience an increasing degree of psychological discomfort that would require her to withdraw from patients. This might then take the form of recognising and meeting only or primarily physical needs; spending as brief a time as possible in direct patient contact; avoiding any discussion about the patient's illness and prognosis; perhaps increasing absence and / or illness; and finally, leaving - all behaviours which have been identified by other researchers (Glaser & Strauss, 1965; Menzies, 1970; Quint, 1973; Parkes, 1980a; Knight & Field, 1981) in relation to stress management in the nursing care of dying patients.

Although this study showed that Hospital 1 staff tended to have lower death anxiety scores than Hospital 2, it was not possible to know whether the level of subjects' death anxiety was higher at the time they started their present job, and had become lower, or whether those who had elected to stay rather than leave were those with lower anxiety. Only four respondents had scores that were more than one standard deviation above the mean, and only one was more than two standard deviations above. One had been in her current job for less than one year, and the other three for over four years; two were nursing auxiliaries; and three were night staff. No correlation was found between death anxiety and the length of time respondents had been in their job. There was a tendency, however, toward slightly more illness reports over a twelve - month period by respondents who had been longer in their jobs. While the implications of this cannot be stated with any certainty, it does suggest that in the longer term there may be indeed a toll on staff, which a larger study might be capable of detecting.

The differences in death anxiety scores suggests that the possibility that the staff groups from Hospitals 1 and 2 were not comparable with respect to their attitudes toward death cannot be ruled out.

However, as has already been suggested, the relationship between number of deaths and stress - reporting was not straightforward in this study. Differences were found to be dependent, not only on which hospital respondents worked in, but also whether they were day or night staff in that hospital.

STRESS AMONG NIGHT STAFF

The second major group of findings in this study relates to the pattern of stress identified in the night staff groups. Since a search of the literature did not bring to light any information about stress in night nurses, no criterion existed against which to judge the present findings, and no assumptions as to the extent or direction of stress were made.The findings reported here are new,therefore, and fill a gap in the literature in this area. The two night staff groups from Hospitals 1 and 2, were treated separately, and the results compared, firstly with those of each respective group of day staff, and secondly with each other.

A number of factors should be kept in mind when asessing the pattern of results in the night staff groups. Firstly, a comparison of the findings between day staff of the two hospitals showed that on all four stress measures staff in Hospital 1 scored significantly lower than than their counterparts in Hospital 2. Against this, therefore, the overall trend of night staff results is of interest. Secondly, where statistically significant differences were found for the night staff groups they related only to the Death Situations measure and its sub - items. It is possible that this scale does not relate to job stress in nursing the dying, and also that the differences found occurred by chance. Thirdly, no significant differences between groups were found on any of the stress outcome measures. Therefore, whatever the level of stress any of these groups reported on the job, they were nevertheless coping.

The Findings

1. Where significant differences were found between day and night staff in Hospital 2, they were consistently in the direction of lower stress among night staff. By contrast, night staff in Hospital 1 tended to score in the direction of higher stress than their day - time colleagues.

2. While day staff in Hospital 1 scored significantly lower on all four stress measures than day staff in Hospital 2, where significant differences were found between night staff, it was Hospital 1 staff who reported more stress. (see Hypothesis 15)

Extrapolating the pattern of results from Hospital 2 to Hospital 1, one might expect night staff to report less stress than their day - time colleagues, in Hospital 1. In fact they report more. However, first it should be remembered that, in spite of a considerably higher death rate than Hospital 2, night staff in Hospital 1, by and large, did not report significantly higher stress overall than nurses in Hospital 2. Nor were the outcome stress variables significantly different for any of the groups. Whatever the level of stress, therefore, it would seem to be sufficiently well managed by each of the staff groups, not to be reflected in the outcome measures used here.

Nevertheless, in spite of the fact that, as figure 6 on p.112 shows, Group 2 - night staff in Hospital 1 had the most nursing experience, they also reported the highest stress in the management of Death Situations. This requires some explanation.

A general mythology about time of death is that most deaths occur in the early hours of the morning when the hold on life is said to be at its most tenuous. One possibility might be that more patients died at night, so that night staff were exposed to more stress from this source than their day - time colleagues. Since night staff in Hospital 2 reported less stress than their day - time colleagues, it was decided to explore this possibility in greater depth for deaths in Hospital 1 only. Time of death was examined in greater detail for four months in 1988. No significant difference was found in the number of deaths to which staff on night shift were exposed, compared to day staff. For each 12 hour period, there was a total of 38 day - time deaths in the four months in question, and 31 night time deaths. However, although there were fewer deaths in the night shift periods, it should be borne in mind that night staff worked a longer shift of 12 hours, and there were always fewer of them on duty. Day staff worked one of three overlapping shifts of six or eight hours. Therefore, although there were slightly fewer deaths at night, nevertheless the effect on staff might be greater. Against this, however, the total number of hours worked overall during a two - week period would be the same for all full - time staff, and in addition a majority of night staff worked part - time. On balance, therefore, it must be concluded that the greater stress reported by night staff was not associated with more deaths occurring at night. Statistics relating to time of death are reported in detail in Appendix 14.

So what factors were there in operation which might help to explain the difference in the experience of stress reported by day and night staff? The task of the night nurse is of course different from that of her day - time colleague. Her concern is to settle the patient for a comfortable night's sleep. Apart from help in settling and waking in the morning when things are often fairly hectic, much of the night staff's contact with patients in fact will be because something is wrong. The night nurse is less likely to have the normalising contact with the patient that the day nurse will have, and which can serve to balance the times when patient - nurse contact has been brought about by patient distress and trauma.

It was the researcher's observation, too, that a much greater responsibility fell on the night nurse in Hospital 1 in attending to the needs of the family of a dying patient. It was common for families to stay overnight if death was thought to be imminent. Nevertheless, the night hours can seem long, with fewer distractions, and nowhere for the family to go when they need some respite. During the day time this responsibility is shared among both a greater number of nursing staff, including senior nurses, and also with other disciplines in a way that it is not at night. The availability of doctors, social workers and other ancillary staff in the day time means that the nurse can call directly on a more comprehensive range of specialist skills as an adjunct to her own. The night nurse, in contrast,has to carry the responsibility for answering the family's queries, anxieties and distress along with the responsibility towards the dying patient and the other patients, at potentially the most difficult time for the family. Unless dying is prolonged, she may not have met them before and is unlikely to know them well. Yet, although the emotional care of the family was regarded as equally part of the task as the care of the dying patient, these were also the areas rated as most stressful by staff in all groups. It seems hardly surprising that the group which simultaneously experienced both a high rate of patient death and minimal support should present as the most stressed group. Essentially, they were on their own.

Factors that were Similar For Each Night Staff Group

Of course, a number of these factors applied to night staff in Hospital 2. They also worked permanently on night shift; were less likely to come into contact with other disciplines; and tended at times to feel unvalued by day staff.

Working at night can be a lonely and isolated business. The number of staff on duty on each ward in both hospitals was smaller than the day - time staff group, usually two in Hospital 2, and three or sometimes four in Hospital 1. This can produce additional difficulties if staff do not happen to get on well with one another. Contact with day staff is limited to perhaps half an hour or so a day, briefly morning and evening, mostly to the nurse who "hands over" to those coming on duty. Night staff are even less likely to meet the staff from other disciplines, so that the range of contacts and sources of support available to them are considerably fewer than those available to day staff.

Night staff from both hospitals had a night sister who held a roving brief to them, calling in usually in the early part of the night and again towards morning. She was, therefore, their primary source of support in an emergency, unless it was necessary to contact or call in the doctor. Certainly the nurses in Hospital 1 spoke warmly of the support that was given them from these sources. The night staff of both hospitals said they knew that if they called for help / support, for example because they were "rushed off their feet" or there was a crisis, it would be given. Nevertheless, in both hospitals they seemed to be, or to feel, less well supported than day staff. Night staff groups as a whole, it will be recalled (see pp 246 / 7), were significantly less likely than day staff to say they would use the support available from senior staff, and significantly more felt unappreciated by their colleagues. In a highly stressful nursing situation this may well be crucial.

It would seem probable that the way in which the night nursing sisters, with a roving brief,would be able to be available to staff would be different from that of the day sisters, who had specific responsibility for one ward only. This would be even more true for nursing officers. Comments made by a number of respondents referring appreciatively to the readiness of senior staff to 'roll up their sleeves' and help when necessary, and their awareness and appreciation of staffs' needs, being interested and ready to listen, suggested that the availability and involvement of senior staff was also an important factor. This would be an area in which, because of the peripatetic nature of the night sisters' role, night staff in both hospitals would seem to be disadvantaged in comparison to day staff.

While staff in all groups were able to identify someone in the hierarchy who might be approached, among Hospital 1 night staff there was clearly uncertainty about whom they should approach. Seven named the day sister and / or nursing officer as available within the hierarchy, although four of these thought they would be unlikely to use these people, whilst five also additionally named the night sister or night nursing officer, and two named no - one. Although the provision of night sister cover was similar in both hospitals, and staff in Hospital 1 spoke appreciatively of the support given by her, there was nevertheless a sense in which she was not seen as being their night sister, and of it being nobody's job to be available specifically for them.

Differences Between the Night Staff Groups

In view of some similarities between the night staff groups in each hospital, how then can the differences in the experience of reported stress be accounted for. Most importantly, of course, night staff in Hospital 1 experienced a considerably higher rate of deaths than night staff in Hospital 2. In conjunction with this, Hospital 1 night staff shared a commitment to a culture of patient care which the literature consistently recognises as highly demanding both personally and professionally. Their expectations of themselves in relation to patient and family care would be commensurately high, and the sense of failure when these were not met therefore potentially more stressful. It is not the intention to devalue the care offered by Hospital 2 staff, but rather to point out the greater potential for stress when staff have been unable to achieve the goals to which they have committed themselves in adopting a particular philosophy of care.

Unlike Hospital 1, night staff in Hospital 2 were subject to be moved at short notice to other wards within the department, and on rare occasions, to a different department,to cover staff shortages. Perhaps this fact also contributes toward an explanation of the lower stress reported by night staff on the stress scales relating to care of dying patients. Where staff are moved about they are less likely to form close relationships with patients, nor to feel commitment to a particular ward ethos. In addition, it was uncommon for families to stay overnight in Hospital 2 when a patient was dying, so that responsibility for managing the anxieties and needs of families in addition to patient care was rare.

It may be, too, the way in which night staff in each hospital experienced the boundaries between "team" and "not team", between belonging and not belonging were less clear, or at least different in a way that was significant. Although all night staff worked permanently on nights in Hospital 1, and rotation between day and night shift was unusual, it was the practice for all night staff to work day duty for the first month of their appointment to the team, as a period of induction. They were also appointed to work only in Hospital 1, not on rotation or subject to being moved to another part of the site to cover shortages. In this sense they were very much regarded as full team members in a way their night sister, and perhaps night staff in Hospital 2, would not be. They were also aware that some of the "benefits" of team membership were less readily available to them than to day staff, and in this sense,their team membership was more tenuous. " I accept on nights, it's my lot, you are not quite one of the team ", said one nurse, whilst another commented, " we feel a bit out on a limb - a forgotten army - a bit them and us ". Therefore especially they valued and appreciated occasions when other disciplines in the team had made an effort to come and see them in their working hours. Meetings with one of the doctors and a home - care nurse were specifically mentioned, staff seeing in this a recognition of their needs and value to the team. Nevertheless, there was a feeling that on the whole night staff were expected to make the greater effort to belong. Thus, the staff support group, in theory open to night staff, was always during the afternoon in their off - duty, and similarly when events of importance to the whole team were arranged, such as the

Christmas party, these were at times more suitable to day than night staff.

As a group they were also not without their own ideas about how their situation could be helped. Seven thought that meetings, on not more than perhaps a monthly basis, either jointly with day staff at a time when they could attend, for example early evening, or which different members of various disciplines from the day staff would attend in rotation,would be helpful. Six thought they should have their own night sister appointed, whilst a further six thought that more planned regular contact with members of the day team, particularly the doctors and nursing officer would be helpful. At the same time, they recognised that finding a time early in the night shift might be difficult. Apart from the "hand - over", they were rarely able to sit down together before midnight.

THE EXPERIENCE OF STRESS IN THE NURSING TASK

1.Talking to Patients

Perhaps predictably given the ethos of Hospital 1, this group of staff felt more able to discuss patients' fears about illness and death with them, and some staff were clearly very experienced and very sensitive in this area. Whilst in Hospital 1, whatever their grade, staff were more likely to report having this kind of discussion with patients, in Hospital 2 this was more likely to be seen as the responsibility of senior nursing staff and / or the doctor. Given the sensitive nature of this area of patient care, it would seem unwise for a nurse to embark on this kind of conversation unless she was very sure of her own skills to do so, and had at least tacit support from her professional system. The implications of an open ethos are considered below.

It was not possible to be sure to what extent the answers given to this question reflected professional desirability. It would be perhaps less acceptable, especially in Hospital 1, to admit difficulty in this area. Similarly, it was not possible to be sure to what extent staff in Hospital 1 actually discussed with patients in the way they reported. Indeed, Wilson (1983) in her observation of staff - patient interaction in a similar unit reported that staff spent less time with patients who were known to be dying. Skills in talking to patients and / or relatives was an area identified by 17 respondents as one where they felt deficient and wanted to learn more. They represented 20% of Hospital 1 and 27% of Hospital 2 staff, and in this respect,surprisingly, there was no significant difference between hospitals.

There was also a tendency among some staff in Hospital 2 to see families as a "nuisance", and not to recognise the anxiety or concern which often underlies the demands that families make. Where a nurse's training and the ward orientation is primarily toward patient care staff may lack the skills, permission or understanding to respond more appropriately to the needs of relatives, losing an opportunity to teach them how to cope in a more positive or less anxious way to hospitalisation. However, knowing the right thing to say is not straightforward. Young nurses who retain their idealism, when faced with reality, may tend to judge situations and families as good or bad, lacking the experience and understanding to recognise the greyer complexities that exist for the family. Moreover, families may find that when they talk to staff they may be given different and conflicting advice. There needs to be good communication on the ward about what families have been told already, and the patient's current situation. However, talking to patients and families is equally, if not more, the art of listening; and of knowing how to respond and what to do with what is heard. This is a matter of modelling by senior staff, as well as training and experience.

Implications of An "Open" Ethos

It is generally accepted in the literature (Kubler - Ross 1970) that the right timing, in talking with a patient about his fears in relation to his illness and death, is crucial, and the right time for the patient is the time he chooses. The first lesson Kubler - Ross related learning was how, in trying to set up a time which suited the professional carers when a patient indicated he wanted to talk, the moment was lost. This means that if a patient indicates a desire to talk, this must be seen as having a higher priority than many other nursing tasks. On a busy ward it may also have implications for staffing levels.

Anecdotally, it is often related that patients choose to whom they will talk, who may or may not be a qualified member of staff. If an unqualified or non - nursing member of staff is chosen, this may indicate a wish to share fears without the risk of confirmation, or it may signal a preliminary "testing of the water". While the medical signs are open to anyone to interpret for themselves, patient, family and staff, traditionally in British hospitals only the doctor has the right to define the patient's condition. However, as Knight and Field (1981) found in their study of an acute surgical ward, the amount of direct patient contact and care relates inversely to seniority. The most junior staff are the ones who spend most time with patients, and so are most likely to be the personnel first approached by patients wishing to talk. Doctors, on the other hand, are usually the least available staff members.

Knight and Field described a routinization of communication between staff and patients, restricted mainly to technical matters. This, they suggested, ensured consistency in what patients were told; "absolved" the doctors from having to deal with patients as individuals which would necessitate making individual decisions; and ensured that members of staff did not come into conflict over what patients should be told.

Implicitly, the creation of an "open" ethos confronts and transforms the traditional medical and nursing attitudes to death and dying, in which death is seen, first as something to be fought, using all the medical and technological ingenuity available, and secondly as a failure. The philosophy of the "open" ethos within "hospice" care, however, proclaims death as a natural part of the process of life. Rather than regarding it as a failure of medical care, different goals are seen as becoming appropriate, in which staff work with patient and family toward a "good" end. What this means may vary from person to person, but it includes maximum freedom from pain, as well as maximising the autonomy and control the patient has over what is happening. That is the ideal. The day to day reality, however, may also represent a considerably more fraught struggle with the emotional and physical realities of the unacceptable, and sometimes the unachievable, which it may or may not be possible to voice.

The creation of an "open" ethos will require more open communication between staff of all levels; whilst the doctor may remain the one to define the patient's condition, he may have to give up the right to be the only one to share it with patient and family; decisions will need to be made about what is shared with patients by whom. Quint (1973) pointed out that although the staff she interviewed were taught how to care physically for the patient, and sometimes psychologically, they were rarely given any training and preparation in how to cope with conversations about death and dying, and their own feelings engendered by this different level of intimacy. Even though the degree to which staff are given responsibility may differ, some preparation will need to be made available to all staff, including domestics, if the right atmosphere of trust and support is to be engendered. Organizationally, some provision will need to be made which will recognise and legitimate both the presence and expression of a range of feelings which staff will experience, including those least easily expressed - protest and anger. This may mean a readiness sometimes to place the need for a member of staff to cry or talk above the needs of ward routine; to provide a space in the week when staff can question the doctor about decisions that have been taken; and perhaps a regular time for staff to meet and look after their own needs.

In Hospital 1 staff learnt first and foremost on the job from the modelling of more experienced staff, in particular nursing and medical staff, how to conduct conversations about their illness with patients. Further training on this aspect of care was offered only to qualified staff, of both SRN and EN status, when they attended the post - qualifying ENB course on caring for the terminally ill. Nine of the ten qualified day staff, and one of five elegible night staff had been on this course, or its equivalent.

In Hospital 1, of nine NA's for whom responses were available, two said that if a patient wanted to talk about his illness / death, they would refer the patient to the sister or doctor; two said they would talk with the patient; and five said they would talk things over with the patient to the extent of their own knowledge, but would ask the doctor or sister to see the patient if more specific medical information was required. Of four EN's who had had the experience of patients asking, all said they would pursue the conversation with the patient. However, in both groups there was a consensus of opinion that it was not their job to be the first to tell the patient. All said they would let trained staff know the patient had been asking. All nine SRN's said that, depending on the patient, they would tell what he wanted to know. Most often, they described conversations in which "you let them tell you".

However, while 96% of respondents in Hospital 1 thought that patients were mostly aware that they were dying, 32% said patients either did not want or rarely wanted to talk about the implications of their illness, and 60% said they only sometimes wanted to talk. Without talking to patients, it was not possible to know whether this was a reflection of staff sensibility to patients' actual wishes, or a misperception which indicates staff were less comfortable with such conversations than they were prepared to admit.

2.Aspects of Patient Care

An assessment of the degree of stress associated with the different aspects of the nursing task was made using 33 of the items developed and tested by Wilson (1983) on a group of hospice nurses. The items selected represented a cross - section of the nursing task (see appendix 4a). Twenty - three items related to direct patient care and were divided into four categories : physical, medical, emotional and death - related nursing tasks.

The findings of Wilson, whose subjects rated emotional care tasks, followed by death-related tasks as the most stressful, are supported by the findings in this study. The death - related nursing tasks were ranked as most stressful by four of the five groups, and as second most stressful by the fifth group, day staff in Hospital 1. Five of the eight death - related items were found to be scored significantly higher by Hospital 2 staff. Items relating to emotional care were ranked as most stressful by day staff in Hospital 1 and as second most stressful by all other groups. However, differences in the scoring of emotional care items by each group were not significant. For all staff,it would seem, the provision of good physical and emotional care when a patient was dying was regarded as highly stressful.

An examination of the mean scores of individual Nursing Situation items showed that the following situations were rated among the five most stressful by more than one group:

Nursing Situation	Staff Groups
2 - Informing relatives of death by phone	All
26 - Talking to bereaved relatives face to face.	2,3,4,5
23 - Dealing with an aggressive patient	1,2,4
29 - Responding to alarm of a monitoring machine	3,4,5
4 - Dealing with a breathless patient	1,2
12 - Dealing with an angry patient	1,2
22 - Nursing a patient connected to a machine	1,3
32 - Taking dead body from mortuary and preparing for relatives viewing	4,5

Apart from item 22 which was placed in Category 1, physical care, though perhaps also implies critical illness even though death may not occur, all the above items were in categories 3 (emotional care tasks) and 5 (death - related tasks).

The finding that these two areas are so unanimously regarded as most stressful would seem to have very clear indications for both the training and support needs of staff, particularly those working with the dying, but also wherever there is an expectation that the nurse should be aware of and able to respond to the emotional / psychological needs of patients and their families. It must be a high priority, surely, to ensure that all staff, in whatever branch of nursing they work, have the skills, understanding and support to respond appropriately, and not defensively or fearfully, to these demands. The fact that Hospital 1 staff did not differ significantly from Hospital 2 in the way they rated emotional care items, and that Hospital 1 night staff did not differ significantly from Hospital 2 in their rating of death-related nursing tasks suggests that these remain difficult areas of care for all staff.

In terms of the Death Situations seen as the most stressful, there was also considerable agreement across all groups in the ranked placements of the first six most stressful situations :

	Mean Rank
Death of close relative.	1
Death of a child.	2
Death of a patient who has young children.	3.2
Death of a patient of similar age to subject.	4.2
Death of a patient who is distressed.	5
Death of patient you have nursed a long time.	7

The agreement in the ranking of these situations, linked with the finding that emotional care and death - related nursing tasks are consistently rated by all groups as the most stressful aspects of nursing, suggests that it may be possible to construct a profile of vulnerability, and that there will be times, regardless of the type of ward worked on, when staff are more at risk.

3.Age, Qualification and Experience

The literature suggests that the relationship between age, qualification and experience, on the one hand, and stress in the management of death and dying is not clear. The experience offered by life is a variable factor. Younger nurses may have less experience of life and death, so being able to cope more successfully by the use of repression and denial. If this is so, when challenged by the experience of patient death they may feel greater psychological discomfort than older staff. The latter, in contrast, may have had to make some adjustment to the reality of death which experience and maturity bring. Apart from their nursing experience, all things being equal, it seems more likely that older staff will have experienced and coped with personal bereavement, and have made adjustments to the possibility of their own death than younger staff. On the other hand, the fact that their own deaths, relatively speaking, are nearer may make the experience of patient death more personally threatening to older staff. However, it may be also that staff who choose to work with the elderly and dying do so because they have some personal experience of death, which influenced their choice of job. In this case, the experience of stress will be mediated by other factors, such as the wish to prepare for future loss, to gain a sense of mastery, to make reparation or repayment of a feeling of indebtedness associated with a previous personal loss. Seven respondents, from all groups except Group 3, spontaneously mentioned the death of someone close to them as influencing their decision to take their present job. In addition, however, forty-one respondents had some personal experience of death. Surprisingly,in this study there was no indication that younger staff had less experience of death in their personal lives, and this was true for both hospitals.

Gow and Williams (1977) in a comparative study of attitudes toward death and dying, found that nurses 40 years and older had more positive reactions to the care of the dying than did their younger colleagues. This study found no such association with age. Although the reasons for this are unclear, it may be that any possible correlation was overshadowed by the stronger association with hospital.

The finding in the present study of a positive association between open attitudes and experience of nursing dying patients conflicts with the study reported by Pearlman et al (1969). They found that staff with more nursing experience of death felt more uneasy with regard to the management of dying patients than did less experienced staff. However, the respondents in the current study with most exposure to patient death, unlike Pearlman's subjects, worked in a context which specifically recognised the potential for stress and made efforts to support the staff involved. In the Pearlman study, staff with more experience of nursing the dying were also more likely to be qualified and to have longer nursing experience. The present study found a negative association between qualification and one of the stress measures, for Hospital 2 staff only, with unqualified staff tending to report more illness over one month. With the exception of night staff in Hospital 1 (see Fig.6, p.112, and discussion p.264 onwards), staff with longer nursing experience tended to report less stress in relation to death, but the longer they had been in their present job the more likely they were to report more days illness over one year. While these findings only partially conflict with those of Pearlman et al, they do suggest that the relationship between experience and stress is complex.

IMAGES OF NURSING

The complexity of the nursing role is encapsulated in the two prevailing images of the nursing ethos which simultaneously reflect an inherent and persisting paradox. This is also to be found in the character and figure of Florence Nightingale herself. On the one hand, historically, a "masculine", army - like efficiency and discipline, born with the origins of nursing alongside the battlefield, became the paradigm along which nurse training and management developed. The profile of this nurse is someone who retains strict control over her feelings and carries on with a trained and practised efficiency whatever the crisis, in a role that is primarily instrumental or goal - oriented, and concerned with getting people well. Coexisting with this is the softer mirror image of the nurse represented by "the lady of the lamp". This aspect of the role, traditionally associated with the more mothering attributes of emotional expressiveness, reflects the dimensions of caring and nurturance. In a society where, predominantly, girls continue to be socialised into expressing these latter aspects of their personality, it seems probable that it is the maternal, nurturing image of the nurse's role, and a desire to care for others, which has always attracted girls into the profession. There they then find themselves required to take on a more "masculine" role, holding back feelings that they may have been ill - prepared to experience, whilst working with optimum efficiency. For the individual as for the profession, the dilemma is one of how to maintain the two roles in balance. Whereas in families the dual but complementary aspects of these roles have traditionally been shared between husband and wife, in the nurse they have been brought together. For Florence Nightingale, the long - term health costs were high. In modern - day society it is becoming perhaps more acceptable for women to give expression to both the male and female parts of their personality. Nevertheless, the cost of holding both in balance, of moving from calm efficiency to expressive sympathy, to deal with both the physical and the emotional pain of the patient will be high without proper recognition and support. The alternative may be, as seems to be happening in some other professions, a growing split between the institutionalisation of efficiency, in the form of a bureaucratic organisation, distanced from the service user, and the nurturance of the service - provider whose position is at the bottom of the hierarchy.

Management of the Dual Role

Reflecting the apparent duality in the role described above, nurses were asked to define the nature of their relationship with patients as either "predominantly professional" or "predominantly involved ". A majority, 83%, described their relationship as "predominantly involved". Regardless of how they described their relationship, however, a majority of respondents, 74%, also said they felt upset, sometimes or often, when a patient died. The role of the nurse as someone in control of her feelings was epitomised by comments such as "You carry on because you have to" ; "There are other patients who need you"; and "You mustn't show your feelings, you mustn't upset the other patients". However, the number of respondents who denied feeling upset and did not identify some outlet for their feelings was small (N=8), whilst a further 10 who were identified as using a predominantly avoidance response, nevertheless found some outlet for their feelings in response to patient death. At the same time, respondents who did feel upset when a patient died frequently commented that they did not allow their feelings to interfere with the care of other patients. In the discussion that follows, a distinction is drawn between feelings and behaviours, which are examined separately.

COPING RESPONSES

Though there is general acceptance that the consequence of stress is to a greater or lesser extent determined by the way in which it is coped with, there is less agreement as to what constitute effective coping methods. Indeed, Wolff et al (1964) showed that what was successful in the short term was not necessarily so in the longer term. Coping has been conceptualised along a number of parameters. Monat and Lazarus (1977) defined two categories of coping response. The first, such as fight or flight they defined as altering the subject's relationship with the environment. This would seem to be the same as the first of the group of three categories identified by Pearlin and Schooler (1978), responses which change the situation. In the context of this study, since these subjects are still in their jobs, they have not, at least as yet, sought to change their environment by using the form of flight offered by leaving. However, the respondents who used avoidance responses may be regarded as representing a different form of flight from the anxiety of dealing with death. Since respondents were not observed in their management of dying patients, this study is dealing with reported behaviour rather than actual behaviour. This may not be the same. Had nurse - patient contact been observed, as it was by Wilson (1983), this study might also have found that in all groups flight in the form of avoidance was a more significant coping response than was reported. Or it may be that avoidance forms part of a repertoire of responses, which is used by most staff at some time. Only one ward, B, took emergency admissions where the medical and nursing procedures might be defined as fighting death. On all other wards, while staff might seek to influence the manner of a patient's death, it was not otherwise fought.

The second category defined by Monat and Lazarus was that of palliative coping, involving what they described as defensive reappraisal, such as denial, aimed at relieving the emotional impact of stress. Similar coping modes were identified by Pearlin and Schooler as those which control the meaning of the event, before it becomes stressful, and those which function to accomodate the stress when it emerges. Both these modes of coping were identified in this study. The use of denial, and comments such as, 'they've had their life', 'they had no - one', of the elderly; and 'it's a relief, they are free from pain' indicate the former kind of coping whilst tears, talking, praying and so on suggest the latter.

Denial as a Defence

In general, the attitude toward dying and death most advocated is one of openness and honesty in dealing with the reality, whilst an assumption seems to be made that denial is in some way "bad" or at least unhelpful. Whether in fact this is really so must surely be seen in relation to the overall context of care, including the sometimes competing and differing needs and perspectives of patient and staff, the short and longer term implications for each, and the degree of support available for the management of awareness and honesty. The usefulness of repression and denial of anxiety and upset should not be undervalued. Indeed, Freud (1900/1952) regarded this method of coping as having a positive function, in serving to protect the individual from the intense anxiety inherent in becoming aware of unresolved or unacceptable conflicts and thoughts. The need for denial, then, should not only be recognised but allowed for and respected. It is in this area that the psychological management of death and dying, for both staff and patients is at its most complex, and never more so than when verbal denial is accompanied by behavioural anxiety indicating the inadequacy of current defence mechanisms. Whether or not staff would express it in this way, in Hospital 1 this reasoning seemed to underly both the importance attached to discussing with applicants at the interview stage how they thought they would cope with so many deaths, and the policy of not rotating staff into the hospital from other units. Staff worked there because they were thought to be able to cope. There was, however, no policy for enabling staff to move on easily in the event that they should become less able to cope or had selection proved wrong. Were this to be the case, a member of staff would have to go through the process of applying and being accepted for another post.

Was there any indication from this research whether flight modes, represented by avoidance, control of meaning by use of denial, (the 'no reaction' group) or accomodation responses, used by the 'reaction group' were more or less effective ? Although the numbers of the 'no reaction' group and the combined 'no reaction / avoidance' group were small, there was no indication that staff who denied feeling upset, or whose first reaction was to avoid thinking about a death, managed less well or experienced adverse health consequences compared to their colleagues. In fact, the 'reaction' group were found to score significantly higher on the Death Situation and the Death - Related Nursing Task scales, that is, the short - term measures of stress associated with the care of the dying. No differences were found between the groups on the Death Anxiety Scale, the General Health Questionnaire scale, the nature of G.P. consultations, or in the number of days illness reported over one, three and twelve months. However, reports of illness relied on the memory of the respondents, which may or may not have been accurate. A more objective record of illness and a larger sample may have produced a more conclusive result in either direction. Nevertheless, regardless of the method used, the respondents in this study were competent and coping. The main difference between these groups, therefore, related only to the degree of awareness of feeling upset or stressed.

Feelings Aroused by Patient Death

Staff spontaneously identified a range of feelings when a death occurred, both at the time and later. Since these were not asked about specifically, the numbers referring to any one reaction were small. Nevertheless, it is interesting to note that the ways in which staff talked about their responses to patient death were reminiscent of the range of reactions identified by Parkes (1975) as typical of the normal bereavement response. These included: shock and disbelief; numbness; deference and awe; irritability and sense of unjustness; relief and acceptance; guilt and self - questioning; despondency and sadness. This suggests that when staff have been particularly close to a patient, or a death is regarded as especially stressful or upsetting to staff they may experience a mild form of bereavement. If this is so, it will be important to allow an opportunity for the expression of grief in the staff group. Failure to recognise and make provision for this need may have a detrimental effect on staff and ward morale. One nurse on Ward D reflected that after a succession of deaths morale was low and there had been a lot of bickering, which was only finally resolved by talking about the deaths that had taken place. A number of respondents (12, or 17% of the sample) also spontaneously referred back to their first experience of patient death in nursing. This had been frequently a formative event, influencing how they responded subsequently in similar situations. The management of staff feelings at this time would therefore seem to be a crucial but at times somewhat overlooked area.

COPING BEHAVIOURS

In order that the range and volume of data to be gathered by interview should be manageable, it was decided for practical reasons to simplify the concept of coping to a count of reported behavioural responses. Twelve coping behaviours following the death of a patient were identified by respondents. Only spontaneous replies were recorded, and when subjects had difficulty in formulating an answer they were invited to think back to what they did the last time a patient died, or the last time they had been upset by a death. In this way it was hoped to tap the subjects' usual or predominant response(s), though it may be that they also used other methods which were not mentioned. The range of coping methods identified can be found in Appendix 13.

Given the number of coping methods and the range of stress variables against which they were being tested for significance, it is possible that some results would be shown to be significant by chance. Moreover, attempts to dichotomize the responses according to concepts considered pertinent to the overall method of coping were problematic. Whilst some responses such as talking to family or friends were obviously social and others such as introspection were not, responses such as prayer or tears could clearly come into either category. In the discussion that follows it was decided to classify responses according to whether they represented a method of managing feelings by externalising or internalising them. Ultimately, however, the only way of dividing into two groups reliably depends on the context within which feelings are managed. Thus, for example, prayer may be seen as an internalised way of managing feelings, but in the context of a prayer group, may become externalising.

With these reservations and difficulties in mind, a number of interesting trends emerged. Subjects who reported use of internalised methods of coping tended to do well : those who made use of prayer had significantly lower Death Anxiety Scale scores; whilst subjects who reported use of introspection reported significantly less illness in the last twelve months. Use of externalised methods of coping such as tears, talking to family and talking to colleagues were associated with higher stress scores (see pages 215 - 216). Subjects who sought support within their own work setting had significantly higher Death Anxiety Scale and Death Situation scores than those who mentioned other ways of coping. Overall, these results would seem to suggest that people who use externalised, and usually socially - oriented coping responses, and hence make use of their available network, experience greater stress. This would seem to confirm the findings of Mettlin and Woelfel (1974), that a large social network is counterproductive, and that these responses are less successful in ameliorating stress, or indeed that they may add to it, in a kind of group - escalation perhaps. Alternatively, it may be that respondents who use internalised ways of coping have greater inner resources. However, no significant associations were found between the types of coping behaviour used and longer - term outcome. Therefore, it must be concluded that, however staff responded to death, they did so in a way which they found effective for them. Moreover, staff who referred to the use of prayer or introspection rarely used only these methods. Relatively few staff used only one coping method, so that overlap between internalised and other ways of coping was not unusual. While these findings do not directly support the results of other research, such as that of Gore (1978), or of Lin et al (1979) that social supports have a buffering effect, again it should be remembered that very few respondents in this study appeared to be poorly supported, and any potential impact that might result from lack of support therefore is unlikely to show.

Use of Few versus Several Coping Behaviours

Contrary to expectation, the use of several coping responses was found to be neither more nor less effective than use of few. Use of several coping responses was associated with higher stress scores, on the Death Situations, Death - Related Nursing Tasks and General Health Questionnaire scales. However, since very few respondents scored 5 or more on the General Health Questionnaire, no significance can be attached to the last finding, paricularly since no association was found with any of the other outcome measures. It is not possible to do more than speculate as to the the meaning of the relationship found between stress and number of coping methods. It may be that one is observing here a trial and error effect, as people search for the most effective coping mechanism for them. If this were so one might also expect to find a negative correlation with age and / or experience, as people go through the process of identifying the strategies that they find most successful for them. However, no correlation was found with either age or experience. Alternatively,the results could be understood to suggest that individuals using one or two preferred coping strategies have an advantage over those who use several, as was suggested by the research of Steiner (1970). However, Steiner categorised coping strategies differently from the straight count used here, and measured stress using galvanic skin response in laboratory situations of interpersonal disagreement, a somewhat different research design from the present one. Had the coping behaviours counted here been categorised differently, it is possible that different results would have obtained. However, gathered and used as they were in this study, no association was found between number of coping strategies used and long - term outcome. It may be that for individuals who experience higher levels of stress, or perhaps generally as levels of stress increase, there is an advantage in using a broader range of coping strategies. For the respondents in this study at any rate, the evidence strongly affirms that they were a coping and competent group of nurses. As stress events increased, so did the number of coping mechanisms used, and for this group of subjects the strategies used, whether few or several, were largely effective.

One of the questions posed in this study has been whether open expression of feeling is either helpful or perhaps a disadvantage? Is an 'open' ethos more or less beneficial? This study was dealing with reported stress. What these results show is that staff who acknowledged feeling upset were also more likely to report upset or stress in connection with duties related to death and dying, as measured by the Death Situations and Death - Related Nursing Task scales. It also demonstrated that they were not significantly more or less anxious about death than staff who used denial or avoidance. In other words, those who reported more stress did so because they were in touch with their own feelings of stress. Those who did not report stress did not because they were not in touch with it, and so could not report it.

One of the dilemmas of any research into stress concerns the interpretation of the apparent absence of stress, and its overlap with repression and denial. However, since no significant differences were found on any of the outcome measures, this would suggest that the respondents in this study, whatever method they chose for managing stress, were successful in mediating its consequences. In this study, the assumptions made about the value of externalising the expression of feelings have not been substantiated but nor have they been shown to be fallacious. Rather, the results suggest that greater recognition should be given to the value and place of denial as a coping response. Support is lent to this view by recent research findings, reported in The Times (Jan. 16th. 1989), which suggest that persons infected with the AIDS virus and who tend to deny to some extent the seriousness of their situation by thinking positively may live longer.

However, in dividing the sample according to the use respondents made of denial or avoidance without regard to actual exposure to patient death, like was not being compared with like. It was not possible, because of the small numbers involved, to compare the stress scores of the "reaction" and "no reaction" groups in each hospital. It may well be that when exposure to death is high, as was the case in Hospital 1, that a "no reaction" or "avoidance" response would have more serious consequences for staff, and as has been pointed out, this staff group was both selected and self - selecting. This argument of course makes the implicit assumption that respondents who deny feeling upset are using denial as a way of coping with feelings of upset or stress that were nevertheless present but beyond the conscious experience of the respondent. Since more specialist instruments which purport to tap unconscious anxieties were not used, it was impossible to know to what extent this was so for these subjects. However, Pollack (1979/80) reported that Templer found a significant but small correlation between the Death Anxiety Scale and galvanic skin response to death related words, one measure used to tap unverbalized death anxiety at a level below conscious awareness. It may well be that subjects who said they were not upset or stressed by patient death in fact were not; or that whatever the degree of their anxiety, conscious and unconscious, at the level of patient death to which they were exposed, these subjects were coping.

Recent Life Events (RLE)

Undesirable and exit events only were recorded and scored using the weightings assigned by English subjects in the cross - cultural comparison study by Paykel et al (1975). Perhaps surprisingly, no significant correlations were found between recent life events and either the General Health Questionnaire scores or illness reports. However, other parts of the study show the respondents to be a well - supported group, who were less vulnerable on a number of factors which may be important in determining the outcome of trauma associated with life events. A significant positive correlation was found between RLE scores and number of coping methods used. This finding is in line with the positive correlation found between reports of stress in the nursing task and number of coping responses used, suggesting that degree of stress influences the range of coping responses used, and that the effect of learning from previous experience of stress is less significant.

Religious Belief, Church Attendance and Stress

A strong association was found between the holding of a religious belief and reports of feeling upset when a patient died. However, with respect to Death Anxiety Scale scores, church attendance, whether weekly or less frequently, appeared to be the crucial variable, rather than religious belief per se, non - church attenders scoring significantly higher on this variable. Although the difference between group means was not significant, respondents who were uncertain about their beliefs tended to have a higher Death Anxiety Scale score. These findings largely accord with those of Hinton (1967), who found among dying patients that those who had a strong religious faith and attended church frequently were most free of anxiety. Those who stated frankly that they had no religious faith were the next most confident group, whilst those who professed a faith without practical observance, the "tepid believers", were found to be significantly more anxious than either of the other two groups.

SUPPORT

The concept of support has been described by Caplan (1976) as comprising a variety of elements, including emotional, practical and tangible / material support. Cobb (1976) identified aspects of support that he labelled as emotional, esteem and network support, the latter implying a network of communication and mutual obligation, which may be regarded as related to belonging. In the context of the work setting, Payne (1980) also identified formal and informal support, suggesting that the former is usually only feasible in large organizations and depends on rules, regulations and specialists. Informal support, by contrast he regarded as more feasible in smaller organizations where size facilitates interaction and caring, whilst Burke et al (1976) suggested informal helping would be both more valued and more prevalent in an organization which valued participation.

The nature of the support on which this study focused was primarily emotional support, and its availability at work and outside. That other aspects of support, such as the the availability of proper and sufficient equipment for the task, and adequate staffing levels are important is not denied. Indeed, as a number of staff pointed out, it is the shortage of provision of practical and tangible supports such as these that can transform a tolerable degree of stress into the intolerable. However, whilst their importance is noted, these aspects of support have not been the object of enquiry in this study.

Formal and Informal Supports

Both hospitals were part of a sufficiently large organisation for formal supports to be available, with varying proximity to the staff concerned. In particular, beyond the level of the ward these were seen to include the senior nursing officer, the occupational health sister, and the nursing officer.Of the three, among day staff, the nursing officer was seen as the person most likely to be approached. She was also the one most likely regularly to be seen around on the wards by staff, and to know the staff by name. Among night staff, the night sister filled a similar role, while more senior staff were more distanced. Additional formal support was available through group meetings for some staff in both hospitals.

The organization into wards, with a stable and identifiable staff group, also facilitated the provision of both formal and informal support at ward level, at least for day staff. Among day staff, the ward sister was universally seen as someone to whom staff would be able to go for support. Approaching sister, however, was generally seen as more formal than talking things over with another nurse on the ward. Whether a nurse would use one, both or neither of these sources of potential support, however, seemed to be partly a matter of individual preference and partly also a function of the relationships staff formed at work. Whilst some made it clear they would be unlikely to turn to someone at work for support if they felt really upset about something concerning their professional lives, others said they would choose someone whom they felt close to. Still others preferred to sort out feelings related to the job at work, not seeing it as the responsibility of their family. Among the deciding factors quoted as influencing these subject's choice of person to approach, understanding, trust and confidentiality were the most often cited. Availability was also important.

The Work - Home Boundary

Although the results failed to reach the level of statistical significance, there was a consistent trend toward higher stress reports by respondents who said they would (or probably would) feel able to discuss home worries at work, and for those who said they would discuss work worries at home. The reverse trend was found for the stress outcome variables : the General Health Questionnaire and the number of days illness reported over one,three and twelve months, suggesting that as a way of coping, this tended to be effective. However, the only result that was statistically significant was for the number of days illness reported over three months, with subjects who would not discuss home worries at work reporting significantly more days illness.

Additionally, whether categorised by the coping method used or in relation to the home - work boundary as discussed here in relation to home and work worries, staff who sought support at work reported higher levels of stress than other staff. However, no significant differences were found in the outcome variables. Again, it must be concluded that staff who were aware of stress took action to deal with it effectively.

Staff who reported that generally they found it easy to switch off from work once they had finished also had significantly lower General Health Questionnaire scores, but significantly more days illness over one and three months than staff who found it less easy or difficult to switch off. No differences were found in the reports of Death Anxiety, nor on the Death Situation and Nursing Task scales. Respondents who said they would feel able to discuss worries in both directions across the boundary between home and work tended to report higher stress scores but lower stress outcome scores, suggesting that they coped effectively with the stress experienced. Very few respondents maintained a boundary between home and work that was impermeable in both directions. These findings would suggest that as stress increased, subjects possibly sought more ways of coping, and that they managed to do so effectively.

Support Networks

To a greater or lesser degree, these staff belonged to two networks - a professional network, and their kin and friendship network. Finlayson (1976) noted that while the wives in her study would accept practical help from a variety of sources, they, too, were more selective when choosing someone in whom to confide. In the present study no direct attempt was made to measure the extent of network support available to subjects. The focus, rather, was on the availability of a confidante, as was shown to be significant in the research of Brown and Harris (1978).

The usefulness or otherwise of a confiding relationship seems likely to depend to some extent on how it is used and the understanding upon which it is based. While the relationship may be based on an expectation of reciprocity, it is in other respects unconditional. It provides at one and the same time a ready and sympathetic "listening ear", which facilitates the ventilation of feelings, whilst counteracting what might in other circumstances be a sense of isolation. It may or may not provide an opportunity to reflect upon events from a different perspective, depending on the experience and sensitivity of the confidante. Used less positively, however, it is possible that a confiding relationship may fuel a sense of injustice, anger or upset, leading to an escalation rather than a relaxation of feelings, which may be less helpful.

This study did not explore how a confiding relationship was used, merely its availability. No association was found between the stress variables and the availability and frequency of contact with either a confidante, or with family support. This should not be surprising, perhaps. Brown and Harris identified having a job, whether full or part - time, outside the home as a protective factor in the presence of an existing vulnerability. All these subjects by definition fell into this category. Brown and Harris identified three major vulnerability factors : absence of a confiding relationship;loss of mother before the age of 11 (not recorded in this study); and the presence of three or more children under fourteen at home. Only three respondents in this study had either little or no support from either close friend or family; and only three subjects, all night staff, had three or more children who were aged 14 or under at home. Of these, two had four children under 10, both were part - time and one scored 23 on the General Health Questionnaire. The failure to find any correlation between stress and the vulnerability factors in this study may be because the number of subjects who were vulnerable on these factors was small. Nor was it possible to test whether working full - time or part - time with young children was actually protective, because relatively few respondents had children of that age. These subjects were, then, very different from those interviewed in the Brown and Harris study. Nevertheless, the use made of coping behaviours with a social support element, particularly as stress increased, indicates that support systems were equally important for this group too.

Support From Senior Staff

All but two staff were able to identify someone in their hierarchy whose job it was to be available in a support role. Of these, 56 staff said they would feel able to talk to the person(s) identified. However, significantly fewer night staff came into this category. In this respect the two hospitals were more alike than not, with both night staff groups feeling less supported than their day time colleagues. Neither group had a night sister who was immediately available to them on the ward, since in both hospitals the role of night sister was peripatetic in nature. If support was required, therefore, the onus was on the nurse to decide between sending for the night sister, or waiting until she came. While a night nurse would be inclined to ask for support in relation to patient care, it seems less likely that she would take this step if she were feeling upset and needing support for herself. Rather, it seems more likely that the extent to which senior staff, whether sisters or nursing officers, are regarded as offering / or used to provide this latter kind of support may be directly related to the time they are available on the ward.

Only four respondents said they would talk to senior staff (higher than sister) if upset following the death of a patient. Whilst the reason for this is unclear, it is possible that talking to the ward sister, who is more readily available, at least to day staff, may be seen as less formal, and hence perhaps more acceptable, than going to the nursing officer, which might involve the greater formality of leaving the ward, knocking on doors and perhaps making an appointment.

The relative emphasis on social / emotional support, however, is not to deny the relevance of esteem in the sense of professional esteem / worth in the eyes of one's colleagues. Respondents were asked if they felt appreciated by their work colleagues. In both hospitals, night staff were significantly less likely than day staff to say they felt appreciated. Being appreciated by their day staff colleagues seemed to be as equally important as being appreciated by other night staff. Overall, staff from all groups thought it was important to be appreciated by their colleagues. Although no significant differences were found in the stress scores of staff who felt unappreciated, strong feelings emerged about this aspect of staff support. Among the 14 staff who felt unappreciated, five said they felt appreciated by patients, and in both groups staff drew a distinction between appreciation by patients and by colleagues. Respondents seemed to be equally divided between saying it was important to feel appreciated and thinking that it should not be important, even though it was.

It is difficult to explain with any certainty why it was that the need for appreciation should have been so important. At one level,of course, it signifies recognition by one's professional peers and superiors of one's place in the team, and of one's professional competence and expertise. A second possibility, however, relates to the strong ethos that surrounds death, which traditionally in both medical and nursing training is seen as a failure. The hospice model espouses a positive attitude to death. Nevertheless, all staff have trained within the orbit of traditional medical and nursing attitudes and methods. Though they may have found them to some extent unsatisfactory, it is possible that they continue to experience a residual sense of failure when a patient dies, which may not normally become articulated. In this circumstance, it would be important to hear from others that you were doing a good job. It might also be expected that staff who had received additional specialised training in the care of the dying would see appreciation as being less important than untrained staff. In this study, staff were asked whether they felt appreciated, but a number also commented on its importance. Of those who did, there was no evidence to suggest that it was not equally important to trained as to untrained staff. This would seem to suggest that underlying professional attitudes to death are not greatly changed by the post - qualification ENB training course. If the supposition is correct, that there remains a residual sense of failure when a patient dies, for both trained and untrained staff, it will be crucial that management maintain a method of both monitoring and enhancing staff esteem.

Provision and Use of Support Groups

A number of American studies have demonstrated positive benefits to staff and organisation resulting from the provision of staff support groups. Epting (1981) found that the use by staff of paid recovery days declined following the introduction of weekly staff support groups; and Weiner and Caldwell (1981) found a reduction in staff turnover. However, there appears to be a dearth of British studies in this area, particularly those which use objective measures of assesssment. When this study was in the design stage, Hospital 1 had regular weekly staff meetings which were attended on a voluntary basis by any of the medical, nursing and ancillary staff. These were led by someone outside the unit with a psychotherapeutic background. It was thought unlikely that meetings on this basis would be available in most other hospitals, and the original intention was to compare a staff group where such meetings were available with one where they were not.

However, Hospital 2 had recently instigated meetings, run by the nursing officer, for staff of each grade on the continuing - care side,whilst on the acute assessment side only staff nurses and sisters had their own separate meetings. By the time the interviews took place, the meetings in Hospital 1 had become less regular, the external leader no longer attended, and the use to which they should be put was in the process of debate, not then resolved.

Contrary to expectation, neither attendance at these meetings, nor the way in which staff felt able to use them, appeared to be related to the stress variables. However, in the light of the developments described above, the final research design did not make it possible to test in a properly controlled way, the effectiveness or otherwise of support groups / meetings in providing a medium for the management of stress. This finding should therefore be treated with caution. The research nevertheless highlighted a number of issues which it may be relevant to consider when contemplating their provision.

While there is substantial support in the literature for the use of groups as a source of staff support (Hartl, 1979; Vachon, 1978; Vachon et al 1978; Weiner & Caldwell, 1981), in this study staff in both hospitals were reluctant to use the meetings to discuss other than patient or practical matters. They often said they felt exposed if they spoke out in the group, and there was a tendency to stay with what might be regarded as safe, or non - personal, issues. Many of the examples of use of groups in the literature come from American studies, and it is possible that this finding reflects in part a cultural difference. Of ten papers reviewed in the literature search which discussed the use of groups as a means of coping with nurse stress, only one was British. Most made reference to the use of a specialist with a mental health orientation to convene and run them. This person was most usually an outsider, though Vachon (1978) refers to the use of a specially trained team member. At the time of the study none of the groups was led by such a person. This, together with the lack of regularity, and the newness of the groups in Hospital 2, may also account for the reluctance to use the groups as compared to the reported usefulness of groups in other papers.

Comments made about use of groups suggest a number of concerns which need to be consciously addressed in setting up a support group. In professions such as medicine, nursing and social work where traditionally carers are expected to be strong, and a show of feelings may be associated with weakness, this part of the group contract needs to be openly and explicitly redefined. It may nevertheless remain difficult for senior members of staff to be more open about their feelings in front of junior staff; junior staff may feel over - awed and exposed in front of senior staff; while to provide a group for junior staff only may seem to imply that only they have a need for support, leaving the needs of other staff unmet.

If a group convener / facilitator is used from outside the nursing or medical hierarchy, that person's role and responsibility must be carefully and clearly negotiated and accepted by those who do not attend as well as those who do. The question of group confidentiality,the areas in which it can and cannot reach decisions, and what and how matters should be fed back into the hierarchy for action, will all need to be considered and agreed, by the group and those outside it.

How the group is used may well be affected both by who is or is not included and by the frequency of meetings. The less frequently a group meets, the longer it will take to build up the trust necessary for staff to share matters of importance. Since nurses work on a shift system, this will also be compounded by the changing group membership from one meeting to the next, unless staff are expected to give a commitment to attend regularly regardless of their shift, or will be given time off in lieu for attending when they are off - duty. Staff from Hospital 2 expressed reservations about talking in their groups for three primary reasons : fear of exposing themselves; not knowing the other group members very well; and disloyalty to their own ward. A majority thought that a meeting for all grades of staff on the ward would be preferable, and some indicated that this already happened informally during hand-over. In Hospital 1, while many of the staff who attended the group regretted its irregularity, there was also some feeling that it should be used more for discussing patients and for teaching purposes.

It was clear that in neither hospital were the groups available seen by staff as the first source of support, and for many they were not seen in that way at all. It seemed that anxieties about the use of groups in some way prevented respondents from seeing them as a resource. That they could be used to share and promote a flow of information, so that staff would not feel isolated in their anxiety, nor feel that they were the only ones to be anxious, was not mentioned. However, it is also possible that in the absence of groups which met this need, this kind of sharing took place informally. Moreover, as Shepherd and Barraclough (1979) pointed out, it may be that needs are identified as such only when they are not being met.

CHAPTER 13

CONCLUSIONS AND RECOMMENDATIONS

Summary of Findings

In the majority of the literature about hospice care, a general and recurring assumption is made, that this is a highly stressful area of nursing, due to the nature of the nursing task, the way in which it is expected to be carried out, and the high number of patient deaths to which staff are exposed. However, hospices are most usually established with these aspects of the care task in mind, and a number of steps to alleviate stress had been incorporated into the system in the course of establishing and managing Hospital 1.

This study set out, primarily, to examine whether the experience of stress in relation to patient death was indeed high, as suggested by the literature, and also whether the methods introduced to mediate the possible effects of stress were successful.

1. Experience of Stress

The most significant finding in this research was that day staff in Hospital 1 were the least stressed group. Night staff in Hospital 1 reported considerably more stress than day staff, and in this they were more like respondents from Hospital 2. No significant differences were found in the amount of death anxiety experienced by the subjects in any of the groups, although there was a tendency for day staff in Hospital 1 to report less. The findings suggest that the factors incorporated into the nursing structure in Hospital 1 to mediate the effects of exposure to a high number of patient deaths were successful for day staff only. Since the appointment policy and the staff characteristics were the same / similar for both day and night staff groups, the explanation has to be found elsewhere.

The second finding was that, overall, the continuing care ward staff reported significantly greater stress and upset in situations relating to the care of dying patients than did any other group. The number of deaths per month on the continuing care wards was considerably lower than either those of the acute wards or Hospital 1.

2.Experience of Support

The respondents in this sample in all groups were generally well supported by peers and family, and no significant correlations were found in relatiom to the stress measures. However, significantly more night staff than day staff from both Hospitals reported feeling less appreciated at work and were less able to identify someone in their hierarchy to whom they would be able to go for support than their day colleagues.

3.Stress in the Nursing Task

All groups reported that caring for the emotional needs of their patients, and caring for dying patients generally were among the most stressful parts of their job. This was true for both Hospitals, though day staff in Hospital 1 rated death - related nursing tasks as significantly less stressful than did other groups, and put these tasks second to meeting the emotional needs of patients. A high proportion of staff from both hospitals commented spontaneously on the importance of feeling appreciated. This was examined in greater depth for Hospital 1 staff. The expected differences between staff who had received post-qualifying training for their job and those who had not did not emerge.

4.Stress Management

Staff who reported higher levels of stress in the nursing task were more likely to turn to others for support, talking to family,friends and colleagues, and reporting the use of tears, than to use methods which were possibly of a more solitary or reflective nature, such as prayer or introspection. They were also more likely to report using more rather than fewer ways of responding to the experience of stress or upset following the death of a patient. This did not appear to be the result of a trial and error effect, and no correlation was found with either age or experience. It seemed that as stress increased, so did the need to use more rather than fewer coping responses.

5.Outcome of Stress Management

The respondents in this study were by and large a competent and coping group who predominantly acknowledged their feelings. However, regardless of whether the chosen coping method was acknowledgement or repression and denial, and whatever the number of coping responses used, these subjects were successful in ameliorating the longer - term consequences of stress.

Implications

As has been discussed, the respondents from Hospital 1 and Hospital 2 were more alike than not on a number of characteristics. Where differences were found, it was thought these would be more likely to operate in the direction of mediating the experience of stress for Hospital 1 staff, the group which experienced the highest number of deaths. The primary difference between Hospital 1 and Hospital 2 staff was in relation to the nature of the nursing task and the philosophy behind it.

That the day staff in Hospital 1 should be found to be so clearly reporting less stress than Hospital 2 staff in spite of the high number of deaths indicates that the policies and supports already built into the system were indeed effective, and this must be an encouragement to all concerned.

However, the same cannot be said for night staff. As a group they were subject to the same careful selection procedures and induction process. In regard to staff characteristics at the time of the study, the only way in which they differed noticeably from day staff was in the number who had attended the post - qualifying course on the care of the dying and bereaved. Although many staff from all groups said talking to patients and relatives was an area in which they would welcome more training, in view of the finding of higher levels of stress in the night staff group, they should perhaps be given priority over day staff where this is seen as an essential part of the nurse's role.

A comparison of the night staff groups showed that as a whole they felt significantly less appreciated, and less well - supported by their hierarchy than did their day time colleagues. The night staff in Hospital 2, however, presented as the least stressed group. It may well be that the sense of being unappreciated and poorly supported is not significant if the level of stress is low. An examination of the amount of support available to the night staff groups from close friends / confidante and family showed that they did not differ in this respect from their day time colleagues. Therefore, in a ward where there are factors suggesting high levels of stress, the appreciation and support of work colleagues and hierarchy become the crucial variables. The night staff in Hospital 1 did not have easy access to the broad range of support benefiting day staff. The elements of this included the ready availability of a wider range of professionals from the nursing hierarchy and other disciplines upon whose specialist skills day nursing staff could draw to help support patients and families; the provision, albeit sporadic at that time, of a staff support group; and their own nursing sister and nursing officer with whom they had regular, daily contact. Frequently the ward sisters could be observed to be involved in providing direct patient care during the day, which seemed to be an important factor in making them seem more approachable by staff for their own needs. There was, therefore, among night staff, a sense of not quite belonging, and also the feeling that there was something good that as a consequence they missed out on.

Staff who had attended the relevant post-qualifying training on the care of dying patients were found equally with staff who had not attended such a course to consider it important to feel appreciated by colleagues in their work. The suggestion was advanced that this reflected a residual but unarticulated sense of failure when patients died. If so, this would suggest that the existing courses, while effectively addressing the practical skills needed, are less successful in accomplishing more fundamental changes in attitude.

The second important finding to emerge from this study was that of higher stress reports in the management of patient death from the staff on the continuing care wards, which had by far the lowest number of monthly deaths, in comparison to the staff on the acute assessment wards. While staff on the acute wards tended to be younger, there were no other significant differences in the characteristics of these two staff groups, and the difference would again seem to be related more to the nature of the nursing task, in this case the provision of long - term care, substituting for home and family care.

Recommendations

These respondents as a group identified the following types of death which nurses might be required to manage as potentially the most stressful :

Death of a child;
Death of a patient with young children;
Death of patient of similar age to subject;
Death of a distressed patient;
Death of a patient nursed for a long time.

While not all these situations applied to the nurses in this sample, they may nevertheless be suggestive of the nursing specialties in which staff may be particularly vulnerable. In addition, nurses rated "death of relative" as the most stressful situation of all. Though one would not expect a member of staff to nurse a relative in a professional capacity, there may well be high expectations and demands from the family on a nurse at such a time. Together with the high rating given to "death of patient of similar age to self", this suggests that there may be times when individual nurses are more at risk. The provision of good support at work, where stress is high, has been shown to be a crucial factor in this study. Although not all respondents said they would talk about home worries at work, this is nevertheless one area where communication across the home - work boundary is most important. Among the few respondents who had experienced a personal loss, where there had been lack of support and understanding at work, they had been left feeling quite bitter. The challenge to management is not only to be aware but to respond in a way that values both their nursing skills and their coping abilities. Often this will require no more than a verbal recognition. However, there may be occasions when it will be helpful to move staff to a less stressful area of work, if this can be achieved without diminishing their informal support systems and professional esteem.

Returning to the night staff group in Hospital 1, while it may not be very practical to institute formal support groups, there are a number of measures which could be instigated to strengthen their support systems, ameliorate the effects of stress and reduce the sense of isolation reported by these staff. Perhaps the most dramatic step would be to do away with a separate group of night staff altogether, and implement a rotating shift system, at least for an experimental period. Failing this, there remain a number of alternatives. The first would be to appoint as a matter of routine, a night sister to have responsibility for this group of staff, so that there is a clearly identifiable person toward whom they can turn for support. It would seem to the researcher, in view of the stressful nature of the work, important that this person should also have some links built in to her peer / senior day staff colleagues so that her own support needs are recognised and do not go unmet.

A greater sense of belonging might be fostered by moving night staff onto day shift, and vice versa, for short periods at regular, perhaps six - monthly or yearly, intervals. In addition, it might become a recognised part of the duties of senior staff, and those from other disciplines, to take regular turns in working into the early part of the night shift, so that they become known and hence available to night staff. An arrangement could be agreed whereby this was a recognised part of the workload, with altered hours of work for the day(s) in question. Where this had happened informally, night staff were very appreciative, and saw this as recogition of their importance to the team. The fact that the researcher was seeking their views was similarly valued.

The role of groups in supporting staff is more problematic. They were not seen by these staff as an important source of support, which they felt able to use freely. However, this may in part reflect the fact that in Hospital 2 the groups had been set up only recently, whilst in Hospital 1 their history had been erratic. In spite of this, some members of staff spoke of missing their regularity, and it may be that if some of the problem areas identified in Chapter 12 could be resolved, staff would begin to lose some of their reserve about using these groups. In high - stress areas, however, it would seem desirable to have an outside convener for the groups, rather than for this task to fall without support on a member of the care team.

Finally, support to the night nursing team as well as to families outside of the 9 - 5 working day could be made available by bringing into operation an "on - call" system whereby the social worker would come in to support families at or around the time of death where such a need was identified. In this way skilled social work support to complement the skills of the nurse would be available at a crucial and perhaps formative stage in the process of loss and grieving. This is not in itself a new idea. Gill Lonsdale (1979), in a report on help offered to parents of handicapped children, described how she worked in this way for a twelve - month period. If this is recognised as an important part of the service in supporting families, it should be possible to make provision in the working week for time off in lieu, so that this does not become a source of stress for the social worker.

Indications for Further Research

The research reported here is the first comparative study of stress in hospice nursing staff in this country. The finding that the stress of patient death can be successfully mediated is important, but nevertheless requires corroboration from further studies. In addition, one of the features of "hospice" care is the heterogeneity of its provision, which besides free - standing buildings, includes hospital support and home care teams, run within both the National Health Service and the voluntary sector. Further research needs to be undertaken to identify the experience of stress and its management for these teams, whose characteristics may be very different from those of the unit described here.

The literature search highlighted an absence of information about the experience of stress among night nursing staff. While none of these staff worked the kinds of mixed shifts that have been identified in occupational research as highly stressful, little is known about the stress for night nursing staff, who in this group felt significantly less appreciated and supported than day staff. While in certain situations the relative isolation and different pace of night nursing may be welcome, there may be times when these, and other factors may be less than helpful.

Finally, this study also highlights the apparent absence of research or knowledge about the experience of stress and support needs of staff who work with elderly patients. Certainly, as the numbers of the elderly in the population increase, and the time they spend in some form of institutional care likewise lengthens, it will become increasingly important to understand more about the stresses and rewards of this area of nursing care.

APPENDIX 1

INTRODUCTORY LETTER

Dear ......

Care of the Dying - Staff Stress and Support

I am carrying out some research into stress in nursing and ways of dealing with it, during the course of which I shall be talking to nurses in a number of different types of unit. I am registered at Southampton University and the research will contribute to a higher degree.

__________ has kindly given permission for me to contact members of staff to invite them to be interviewed, and for the interviews to take place during working hours, provided this can be arranged at a time convenient to the needs of the wards.

The sample has been drawn at random from the staff list for the Unit and your name has come up in the sample. I would be very grateful for the opportunity of talking to you about your nursing experiences and your views, which will be very valuable. Naturally, your participation is voluntary, and if you decide to take part, your information will be treated in confidence.

I will contact you by phone on the ward, during the next few days and will be pleased to answer any questions you may have. If you are prepared for me to interview you, we can make arrangements at that time.

I can be contacted during the day at ______________________, telephone __________, internal extension ____ or most evenings, Fridays and weekends on __________ .

I look forward to meeting you.

Yours sincerely,

APPENDIX 2

QUESTIONNAIRE

PROFESSIONAL DATA

1.Date of Birth

2.Qualifications : Year Obtained

Educational Nursing

3.Number of years Nursing Experience

4.Length of Time in Present Job

5.Full or Part-time

6.What Factors attracted you to your present job?
Was present job chosen?

7.Did you have a period of induction when you started?

8.If no, would this have been welcomed?
In what areas?

9.With experience,is this a branch of nursing that you enjoy? Does it live up to your expectations?

MANAGEMENT OF THE DYING

One of the consequences of becoming a nurse is that there will be times when you have to look after dying patients. Would you mind if we talked a little bit about your experience of this aspect of nursing care?

10.How many patients have you nursed who have died :

a).Within the last 2 weeks?
b).Within the last 4 weeks?

11. Does your role change in any way when a patient is thought to be dying? How?

12. Is there any policy about what dying patients are told on your ward?

13. In your experience, are patients who are going to die aware of this, even though they may not have been told? How do you know?

Most Some None D/K

14. Do you find patients ever want to talk about it? What concerns them most?

Yes No Sometimes D/K

15. What about other patients - are they usually aware when someone is dying? What concerns them most?

Yes No Sometimes D/K

16. Do they ever want to talk about it? What concerns them most?

Yes No Sometimes D/K

17. In your experience, is it easier or more difficult to nurse someone who is dying, or is there no difference?

18. What if the patient knows he is dying?

19. Whatever your own views, when a patient dies who has the same religious views as your own, how do you feel?
Prompt :
Is it Easier to accept More upsetting
No different Don't think about it this way
D/K Other

20.Do you find that you sometimes get more INVOLVED with some patients, or do you always form a normal PROFESSIONAL relationship with all your patients?

21.Do you think the kind of relationship you have with a patient affects how you feel when a patient dies?

22.Do you ever feel upset when a patient dies?
Explore circumstances.

23.In what ways are you affected by the death of a patient which occurs when you are not on duty? Or are you not affected?

24.If YES to Q.22, What do you do when you are feeling upset by a patient's death? Perhaps it would help to think back to the last time you felt like this - what did you do then?

25.Does it affect your work?

26.Does it affect how you feel about your work?

27.Are there ever times when you feel you have had enough, when it really gets you down?

28.To what extent do you think your needs as a carer should be recognised, or do you think you should be expected to get on with the job?

29.In your experience of nursing dying patients, what do you think has helped you most? Least?

30.Are there any changes you would like to see made in the way this aspect of nursing care is managed in your branch of nursing?

31. In retrospect, do you think your own training in the care of the dying was adequate, or do you think there were gaps?

PART II - SUPPORT

I would like to move on now to talk about the kind of support you may or may not have available, and how relevant this is to your job.

32. If you are feeling bad about something, or you have a problem, is there anyone whose job it is to be available to talk things over with at work?

33. If NO, do you think it would be helpful to have someone like that available?

34. If YES, Would you ever use this person in this way?

35. If NO, why not?

36. If YES, what sort of problems would you feel able to approach this person with?

Prompt -	Personal	Patient
	Family	Colleague

37. Do you attend any meetings at work?

38. If you were worried or upset about something at work, would you talk about it at any of these / this meeting/s?

39. If NO, why not?

40. Do you think it would be helpful to have regular meetings on the ward where staff could discuss problems ?

41. Is there anyone else at work with whom you might talk things over if you had a worry / problem? Specify :

42. If yes, what particular qualities does this person possess?

43. Overall, is yours a good ward to work on?

44. If YES, what makes it good?

45. If NO, why is it not good, what would improve it?

46. Do you think you get good support on your ward, or could it be improved? E.g. ?

47. Do you feel appreciated at work?

Yes No Patients Staff

48. If you had any worries/problems at home, would you talk them over with anybody at work? Is there anyone you would confide in?

49. If you have any worries/problems at work, would you talk them over with anyone outside work - family ? Friends? Specify :

50. Would you mind if I asked you a few questions about your home and social life - away from work?

51. Are you married?

	Married	Single
	Widowed	Divorced
	Separated	Cohabiting
	Other	

52. Do you have children? At home Away

Number Married

53.How old are they?

54.Is there anyone else who is dependent on you or toward whom you have responsibilities?
Specify frequency of contact :

54.Do you see any of the staff you work with socially?

55.Do you have any specially close friends or people you might confide in? Specify frequency of contact :

56.What about within your family - do you have anyone there you would confide in or turn to for support? Who?
Specify frequency of contact :

57.Do your family mind you working?

58.Does your job infringe on your home life in any way?

59.To what extent are you able to switch off from work when you go home?

Easy Takes Time Not Able To

LIFE EVENT QUESTIONS

Would you mind if I asked you a few questions about events that may or may not have happened in your own life in the last 12 months - that is things not directly concerned with work?

60.Has anyone in your family been seriously ill in the last 12 months - yourself, husband, children, parents?
How serious was it?
Was it an emergency? Has anyone been in hospital?
How involved were you?
What changes were involved for you?

61.Has anyone in your immediate family died in the last 12 months? What about close friends?
How involved were you?
What changes were involved for you?

62.Have there been any changes in the composition of your household in the last 12 months?
Has anyone left home to - work? join the forces?
go to college?
What changes has that meant for you?
Has anyone married - what did you think about that?

63.Have any significant relationships within your family come to an end - for example by divorce or separation?
A broken engagement?
A close friend (someone you feel able to confide any worries or problems with complete trust) - whom you no longer see as much / or at all?

64.Have there been any difficulties in any of your relationships in the last year, e.g. tension or more arguments than usual - with family / boyfriend etc.?

65.Has anyone in the family had a baby / lost a baby through miscarriage / stillbirth?

66.Have you moved house in the last 12 months? Why was this - did it live up to expectations?
Have you made new friends / been able to keep in touch with old ones?
Has it led to changes in how often you see any significant persons (confidants)?
Has it meant taking out a larger mortgage - is this difficult or a worry?

67. May I ask a few questions about your financial circumstances?
Have you had any money worries in the last 12 months?
Have you had to go without things you need?
How have you tried to manage the problem - e.g. taking on a loan; not able to meet on-going commitments, such as rent or mortgage?

68. Has anyone in your family been unemployed in the last year? How long?
How easy will it be to find anything else?
What changes have been involved for you?

69. Has there been any crisis / emergency involving you or any other member of your family in the last year (e.g accident, burglary)?

70. Have you had any bad news, for example about an illness that has been going on for some time?

71. Has anything particularly disappointing happened over the last 12 months that you haven't already mentioned?

72. Have you had to make any important decisions in this time?

RELIGIOUS BELIEF

73. Would you mind if I asked you a few questions about religious belief?

Do you hold any religious belifs?
If YES, to what extent and in what way are these put into practice? Specify frequency :

Church attendance	Prayer	Other

GENERAL HEALTH

74.Have you consulted anyone about your health in the last 6 months? If YES, was that for anything in particular?

75.Do you have any special health problems?

76.How many days illness have you had :

In the last month
In the last 3 months
In the last year

77.Do you smoke? If YES, how many?
Has this increased recently?

78.Do you drink (alcohol)?
If YES, how regularly? Has this increased recently?

79.Do you normally finish work on time, or are there occasions when you have too much to do?
If YES, how often does this happen?
How do you feel about it? Do you get time off in lieu?

80.One way to manage a heavy workload is to establish priorities between things that must be done and things that can be safely left. Do you ever have to do this?

Most of the time Sometimes Rarely/Never

81.What sort of things get left? How do you feel about it?

82.What opportunity do you have to unwind when you get home from work? Explore.

83.How do you spend your spare time? Hobbies / interests.

84.Is there anything you would like to add?
Do you have any comments to make? Thankyou.

APPENDIX 3

TEMPLER'S DEATH ANXIETY SCALE

Please read the following statements and circle a number to indicate how strongly you agree or disagree that each statement is true for you.

Strongly Agree						Strongly Disagree
3	2	1	0	1	2	3

1.I am very much afraid to die.
2.The thought of death seldom enters my mind.
3.It doesn't make me nervous when people talk about death.
4.I dread to think about having to have an operation.
5.I am not at all afraid to die.
6.I am not particularly afraid of getting cancer.
7. The thought of death never bothers me.
8.I am often distressed by the way time flies so rapidly.
9.I fear dying a painful death.
10.The subject of life after death troubles me greatly.
11.I am really scared of having a heart attack.
12.I often think about how short life really is.
13.I shudder when I hear people talking about World War III.
14.The sight of a dead body is horrifying to me.
15.I feel that the future holds nothing for me to fear.

APPENDIX 3a.

MEAN DEATH ANXIETY SCALE SCORES.

The mean scores of each of the five groups of nursing staff in the sample is shown in Table 60, below, columns 1 - 5. Columns 6 and 7 give the mean scores for females reported by McMordie for the Templer/McMordie Scale, test and re-test, (McMordie (1979). The second row shows the standard deviations for the same groups:

Table 60 : Mean Scores on the Death Anxiety Scales :

1	2	3	4	5	6	7
49.00	57.60	54.47	60.00	57.40	62.20	60.37
13.02	12.39	16.38	16.21	16.87	12.81	14.72

APPENDIX 4

NURSING SITUATIONS

I would like to know about the kinds of situation in your work that you find stressful. You may not find all the situations listed below are stressful. Imagine a scale ranging from 0 - 10: 0 = no stress; 10 = very great stress. Please read each item carefully and decide how stressful it is to you. If you have not experienced the situation described, then try to imagine how stressful you might find it. If you think the situation described is not very stressful, assign a low number; if more stressful, then give it a higher number.

I would also like to know how frequently you encounter each situation in your work - some you may not have to deal with at all. Please put a number in the left-hand column labelled frequency :-

0 = not at all
1 = rarely (2/3 times a year at most)
2 = sometimes (once or twice a month)
3 = frequently (more than once a week)

Frequency	Situation	Rating 0 - 10
____	1.Having to answer the phone when already occupied with patient care.	____
____	*2.Informing relatives of the death of a patient (by phone).	____
____	3.Giving a bed-bath.	____
____	4.Dealing with a breathless patient.	____
____	5.Dressing a tumour that has broken through the skin surface.	____
____	6.Dealing with a withdrawn patient.	____
____	7.Manual removal of faeces from the bowel.	____
____	8.Office work	____
____	9.Dealing with a confused patient.	____
____	*10.Talking with a patient about their fears about dying.	____
____	11.Writing the Kardex.	____
____	12.Dealing with an angry patient.	____
____	13.Talking with a patient's relatives.	____
____	14.Communicating with a patient who is unable to speak.	____
____	15.Talking to a doctor about a patient.	____
____	*16.Spending time with a patient who is dying.	____
____	17.Giving the ward report.	____
____	18.Dealing with the admission of a patient.	____
____	19.Dealing with a tearful patient.	____
____	*20.Being present when a patient dies.	____
____	21.Dealing with a vomiting patient.	____
____	22.Nursing a patient connected to a machine (or monitor).	____
____	23.Dealing with an aggressive patient.	____
____	*24.Laying out a patient (last offices).	____
____	25.Dealing with a patient who can do nothing for himself (not dying).	____
____	*26.Talking to bereaved relatives (face to face).	____
____	27.Catheterizing a patient.	____

Frequency	Situations	Rating 0 - 10
___	28. Dealing with an anxious patient.	___
___	29. Responding to the alarm of a monitoring machine.	___
___	30. Dealing with a patient complaining of pain.	___
___	31. Answering a patient's buzzer alarm.	___
___	*32. Taking dead body from mortuary and preparing it for relatives viewing.	___
___	33. Dealing with incontinence.	___

Any other circumstance you would like to mention?
Please describe and rate :

Any comments you would like to make :

APPENDIX 5

NURSING TASKS GROUPED BY CATEGORY

Group 1 - Physical Care : Items 3, 4, 21, 22, 25, 33.

Giving a bed-bath.
Dealing with a breathless patient.
Dealing with a vomiting patient.
Nursing a patient connected to a machine (or monitor).
Dealing with a patient who can do nothing for himself (not dying).
Dealing with incontinence.

These tasks have been categorised according to the primary aspects of the intervention. However it is recognised that some of them may also contain an emotional-care component.

Group 2 - Medical care : Items 5, 7, 27.

Dressing a tumour that has broken through the skin surface.
Manual removal of faeces from the bowel.
Catheterizing a patient.

Group 3 - Emotional care : Items 6, 9, 12, 19, 23, 28.

Dealing with a withdrawn patient.
Dealing with a confused patient.
Dealing with a tearful patient.
Dealing with an aggressive patient.
Dealing with an anxious patient.

Group 4 - Communicating with doctors/relatives : Items 13,15.

Talking with a patient's relatives.
Talking to a doctor about a patient.

Group 5 - Death-Related Care : Items 2,10,16,20,24,26,32.

Informing relatives of death of patient (by phone).
Talking with a patient about their fears about dying.
Spending time with a patient who is dying.
Being present when a patient dies.
Laying out a patient (last offices).
Talking to bereaved relatives (face to face).
Taking a dead body from mortuary and preparing it for relatives viewing.

Group 6 - Admin/Office work : Items 8,11,17,18.

Office work.
Writing the Kardex.
Giving the ward report.
Dealing with the admission of a patient.

<u>Group 7</u> - Miscellaneous : Items 1,14,29*,30,31.

Having to answer phone when already occupied with patient care.

Communicating with a patient who is unable to speak.

Responding to the alarm of a monitoring machine *

Dealing with a patient complaining of pain.

Answering a patient's buzzer alarm.

*Also categorized with Group 5 and excluded from this group for analysis.

APPENDIX 5a.

MEAN SCORES / RANKINGS : NURSING SITUATION CATEGORIES

Table 61 shows the mean scores for each group of respondents on the Nursing Situation items, categorised as above, with NSIT 29 placed in category 5, death-related. Column 6 shows the mean ranks accorded by the nurse subjects in the study by Wilson (1983), but with NSIT 29 in category 7, miscellaneous.

Table 61 : Mean Scores : Nursing Situation Categories.

NSIT Category	Nurse Group					
	1	2	3	4	5	CW*
1	2.14	2.69	3.23	2.83	2.5	7
2	1.83	2.87	3.59	2.81	3.09	6
3	3.52	4.02	4.22	4.35	3.86	1
4	2.32	2.50	3.00	2.08	2.07	5
5	3.36	4.21	4.68	5.71	4.75	2
6	1.40	1.58	2.52	1.5	2.24	3
7	2.78	3.06	3.79	3.92	3.07	4

* Rank placings only.

APPENDIX 6

DEATH SITUATIONS

I would like to know about the kinds of death that are upsetting. Do you feel equally upset by all deaths, or do some upset you more than others. Please tick the box that applies to you.

☐ Equally upset by all ☐ Some more than others

The list below describes a number of different situations. They are not necessarily listed in order of how upsetting they might be. Imagine a scale ranging from 0 - 10: 0 = not at all upsetting; 10 = extremely upsetting. Read each item carefully and decide how upsetting it would be for you. If you would not find it very upsetting , then assign a low number; if more upsetting, then give it a higher number. If you have not experienced situations, try and imagine how upset you might feel. Please put a tick beside those situations with which you are familiar at work. The first item has been completed as an example.

DEATH SITUATIONS

Situation Experienced	Situation	Rating 0 - 10
____	Death of patient you are fond of	____

1. Death of patient you have nursed a long time.
2. Death of Russian leader Andropov.
3. Death of patient who has a great deal of pain.
4. Death of close relative(e.g.parent).
5. Death of patient who has no family.
6. Death of patient who is a similar age to you.

DEATH SITUATIONS

Situation Experienced	Situation	Rating 0 - 10

7. Death of a difficult patient.
8. Death of an elderly patient.
9. Finding a patient dead unexpectedly.
10. A prolonged though not uncomfortable death.
11. Death of patient who remains conscious till the end.
12. Death of patient who is distressed.
13. Death of a child.
14. Death of patient within 3 days of admission.
15. Death of patient who wants to die.
16. Death of patient who has young children.
17. Death of a confused patient.
18. Death of a patient while you are washing/turning him / her.
19. Death of patient within 2-3 hours of admission.

Any other circumstance you would like to mention ?
Please describe and rate :

Any comments you would like to make :

APPENDIX 7

JOB SATISFACTION

Below are a number of statements which describe how people might feel about their jobs. Read each statement carefully and decide how strongly you agree or disagree that the statement describes how you feel about your job. If you very strongly agree with the statement, circle 3 on the Agree side. If you strongly disagree, circle 3 on the

JOB SATISFACTION

Disagree side. If you only slightly agree or disagree, circle 1, and so on. If you neither agree nor disagree circle 0.

	Strongly Agree						Strongly Disagree
I really enjoy my job.	3	2	1	0	1	2	3
I used to enjoy my job but now it's an effort to come to work.	3	2	1	0	1	2	3
There are often times when I think of leaving	3	2	1	0	1	2	3
I would leave this job tomorrow if I could find something else.	3	2	1	0	1	2	3
On the whole I like my work.	3	2	1	0	1	2	3

APPENDIX 8

THE GENERAL HEALTH QUESTIONNAIRE - 30 ITEM VERSION

Please read this carefully:

We would like to know if you have had any medical complaints, and how your health has been in general, <u>over the last few weeks</u>. Please answer ALL questions on the following pages simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you had in the past.

It is important that you try to answer ALL the questions.

Thank you very much for your co-operation.

GENERAL HEALTH QUESTIONNAIRE

HAVE YOU RECENTLY:

1.- been able to concentrate on whatever you're doing?	Better than usual	Same as usual	Less than usual	Much Less than usual
2.- lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
3.- been having restless disturbed nights?	Not at all	No more than usual	Rather more than usual	Much more than usual
4.- been managing to keep yourself busy and occupied	More so than usual	Same as usual	Rather less than usual	Much less than usual
5.- been getting out of the house as much as usual?	More than usual	Same as usual	Less than usual	Much less than usual
6.- been managing as well as most people would in your shoes ?	Better than most	About the same	Rather less well	Much less well
7.- felt on the whole you were doing things well?	Better than usual	About the same	Less well than usual	Much less well

GENERAL HEALTH QUESTIONNAIRE

HAVE YOU RECENTLY

8.- been satisfied with the way you have carried out your tasks?	More Satisfied	About same as usual	Less satisfied than usual	Much less satisfied
9.- been able to feel warmth and affection for those near to you?	Better than usual	About the same as usual	Less well than usual	Much less well
10.- been finding it easy to get on with other people?	Better than usual	About the same as usual	Less well than usual	Much less well
11.- spent much time chatting with people?	More time than usual	About same as usual	Less than usual	Much less than usual
12.- felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
13.- felt capable of making decisions about things?	More so than usual	Same as usual	Less than usual	Much less capable
14.- felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual

GENERAL HEALTH QUESTIONNAIRE

HAVE YOU RECENTLY

15.- felt you couldn't overcome your difficulties?	Not at all	No more than usual	Rather more than usual	Much more than usual
16.- been finding life a struggle all the time	Not at all	No more than usual	Rather more than usual	Much more than usual
17.- been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
18.- been taking things hard?	Not at all	No more than usual	Rather more than usual	Much more than usual
19.- been getting scared and panicky for no good reason?	Not at all	No more than usual	Rather more than usual	Much more than usual
20.- been able to face up to your problems?	More so than usual	Same as usual	Less able than usual	Much less able

GENERAL HEALTH QUESTIONNAIRE

HAVE YOU RECENTLY

21.- found everything getting on top of you?	Not at all	No more than usual	Rather more than usual	Much more than usual
22.- been feeling unhappy and depressed?	Not at all	No more than usual	Rather more than usual	Much more than usual
23.- been losing confidence in yourself?	Not at all	No more than usual	Rather more than usual	Much more than usual
24.- been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
25.- felt that life is entirely hopeless?	Not at all	No more than usual	Rather more than usual	Much more than usual
26.- been feeling hopeful about your own future?	More so than usual	About the same as usual	Less so than usual	Much less than usual

GENERAL HEALTH QUESTIONNAIRE

<u>HAVE YOU RECENTLY</u>

27.- been feeling reasonably happy	More so than usual	About same as usual	Less so than usual	Much less than usual
28.- been feeling nervous and strung-up all the time?	Not at all	No more than usual	Rather more than usual	Much more than usual
29.- felt that life isn't worth living?	Not at all	No more than usual	Rather more than usual	Much more than usual
30.- found at times you couldn't do anything because your nerves were bad ?	Not at all	No more than usual	Rather more than usual	Much more than usual

Goldberg (1972) reported an overall misclassification rate of 11% for the 30 - item version of the General Health Questionnaire, with a cutting-off point of 4 / 5. This compares to a reported misclassification rate of 8.5% for the 60 - item version with a cuting-off point of 11 / 12. The GHQ method of scoring (0, 0, 1, 1) reported by Goldberg was used, that is scoring from left to right across the columns. The scores for each item were then summed to give a possible minimum score of zero, and a maximum of thirty.

APPENDIX 9

LIFE EVENTS SCORING

Used	Rank	Event	Mean Score
*	1	Death of child	19.53
*	2	Death of husband / wife	19.14
	3	Being sent to gaol	17.76
*	4	Death of close family member	17.65
*	5	Serious financial difficulties	17.58
	6	Husband or wife unfaithful	17.28
*	7	Miscarriage or stillbirth	16.96
	8	Court appearance for serious offence	16.94
	9	Business failure	16.68
*	10	Marital separation due to arguments	16.57
*	11	Unwanted pregnancy	16.48
*	12	Divorced	16.29
	13	Fired	15.93
*	14	Death of close friend	15.70
*	15	Serious illness of family member	15.52
*	16	Unemployed for one month	15.43
*	17	Increased arguments with husband or wife	15.01
*	18	Serious personal physical illness (in hospital or one momth off work)	14.67
	19	Involved in a lawsuit	14.47
	20	Fail important exam or course	14.38
	21	Losing or being robbed of personally valuableobject	14.34
	22	Demotion	14.33
*	23	Serious arguments with resident family member (eg children)	13.97
	24	Begin extramarital affair	13.70
*	25	Taking a large loan (more than half annual salary)	13.64
*	26	Increased arguments with fiance or boyfriend / girlfriend	13.29

LIFE EVENTS SCORING

Used	Rank	Event	Mean Score
*	27	Break engagement	13.12
*	28	Increased arguments with non - resident family member eg in-laws, relatives	12.69
*	29	Child marries without approval	12.69
	30	Increased arguments with boss and co-workers	12.28
*	31	Separation from significant person (eg close friend)	12.01
*	32	Moderate financial difficulties (eg increased expenses,debt collectors)	11.90
	33	Prepare for important exam	11.41
*	34	Marital separation not due to arguments	11.33
	35	Menopause	11.19
*	36	Move to another country	11.14
*	37	Son enlists or drafted in forces	10.82
*	38	New person moves into home (eg relative, lodger)	10.13
	39	Retirement	10.05
	40	Change in work hours (overtime, second job,less hours)	9.68
	41	Change in work conditions (new dept., new boss, reorganization)	9.46
*	42	Cease going out with steady boyfriend/ girlfriend (after at least 3 months)	9.36
	43	Change in line of work	9.24
*	44	Move to another city	8.57
	45	Minor legal offence (eg parking ticket, speeding)	8.31
*	46	Marital reconciliation	7.96
*	47	Child leaves home (eg college)	7.85
*	48	Wife becomes pregnant	7.08
*	49	Birth of child (for mother)	7.03

LIFE EVENTS SCORING

Used	Rank	Event	Mean Score
	50	Change school, college or university	6.79
*	51	Birth or adoption of child (for father)	6.49
	52	Begin full or part time education	5.91
	53	Promotion	5.89
*	54	Move within same city	5.50
*	55	Marriage	5.44
	56	Finish full time education	5.26
*	57	Minor personal physical illness (requiring doctor's attention)	5.20
*	58	Become engaged	4.25
*	59	Child engaged	3.72
*	60	Wanted pregnancy	3.70
*	61	Child marries (with approval)	3.14

The life event questions were presented within the interview in the format shown in the questionaire (see appendix 2). Answers were then compared and matched against the 61 items asterisked from the list above. The items marked with an asterisk (*) indicate those items which were matched, the scores of which were then assigned to the answers given by respondents in this study.

APPENDIX 10

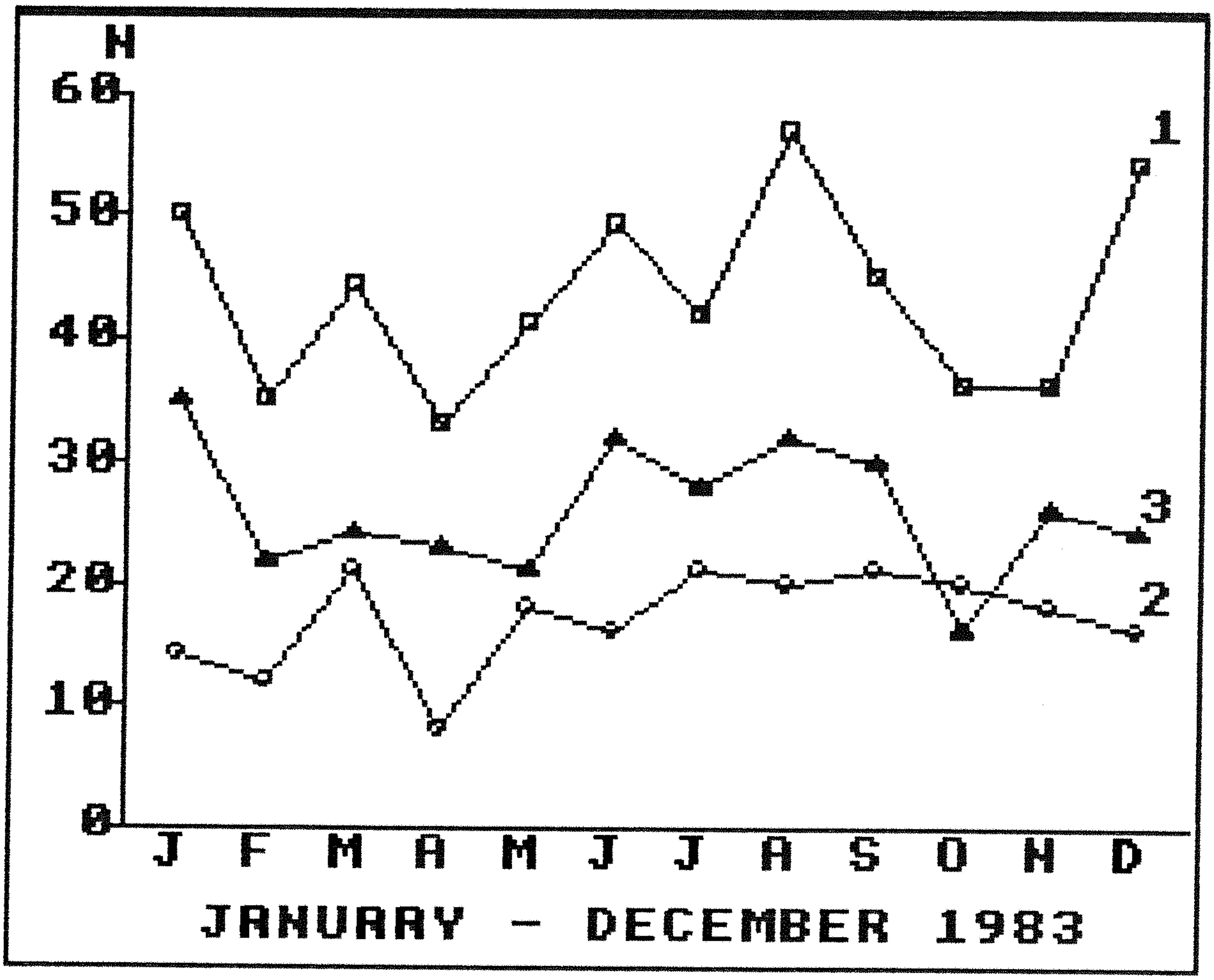
ADMISSIONS DISCHARGES AND DEATHS

Appendix 10a (1-5; figs. 13 - 17) shows the number of admissions, discharges and deaths for 1983, on each of the five wards on which subjects worked; while appendix 10b (1-5; figs. 18 - 22) gives the same information for 1984. It should be noted that, for the sake of clarity of presentation, the vertical scale of figures 17 and 22 has been reduced by 75%.

APPENDIX 10a - 1

Fig. 13.

Number of Admissions, Discharges and Deaths for 1983 : Hospital 1 - Palliative Care Unit.

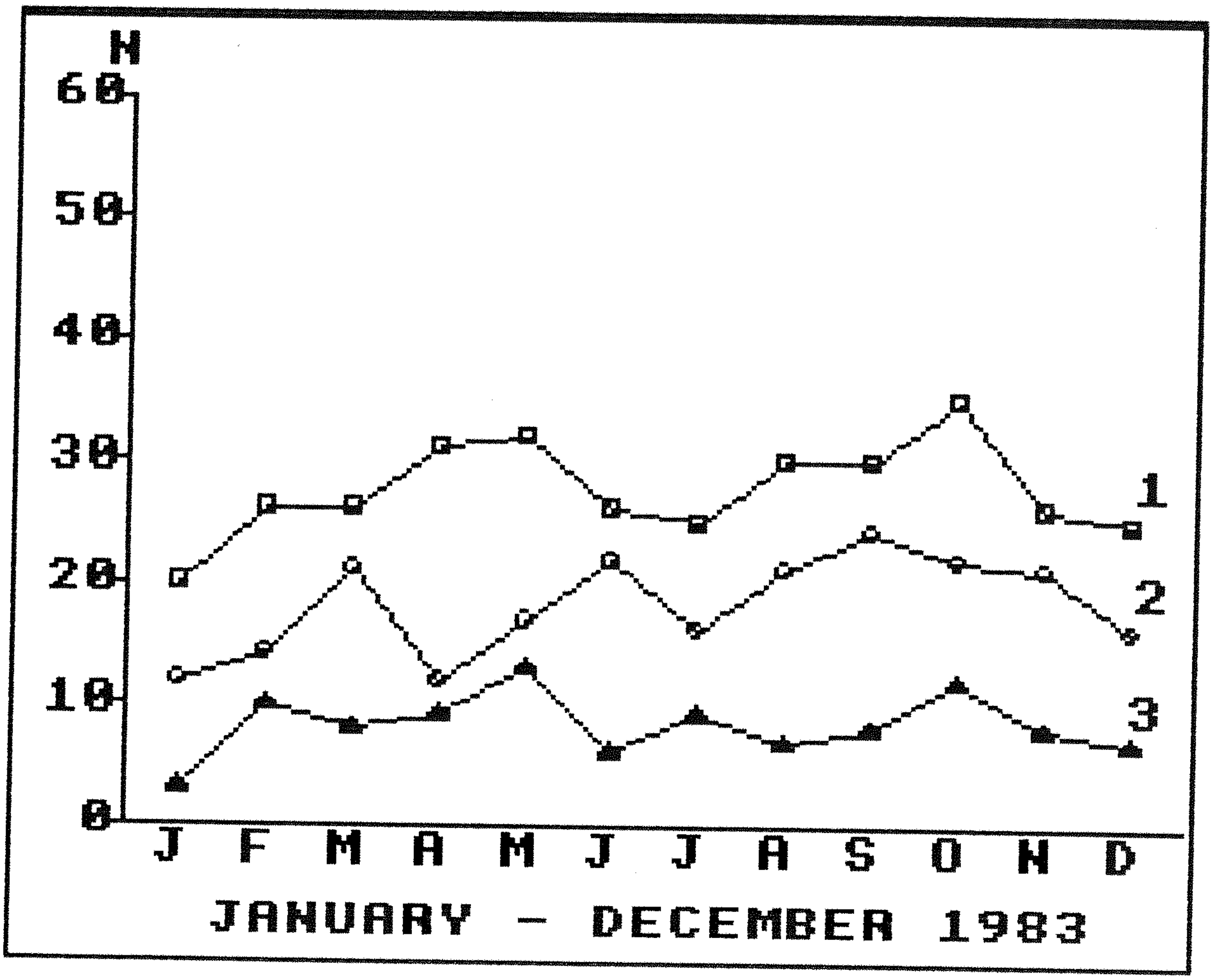


	Annual Total
1 = Admissions	522
2 = Discharges	205
3 = Deaths	313

APPENDIX 10a - 2

Fig. 14.

Number of Admissions, Discharges and Deaths for 1983 :
Hospital 2 - Ward A : Acute - Assessment.



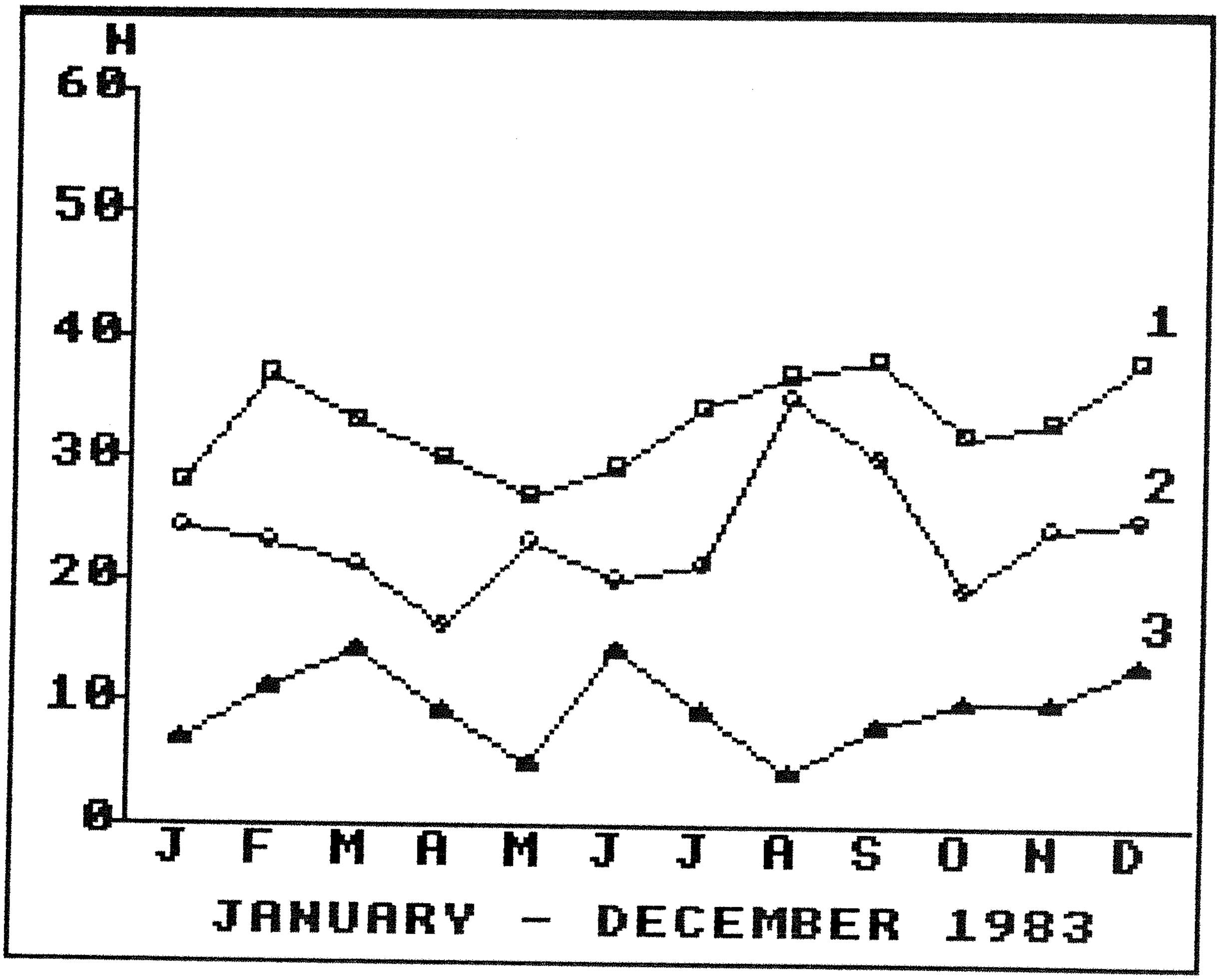
	Annual Total
1 = Admissions	332
2 = Discharges	218
3 = Deaths	100

APPENDIX 10a - 3

Fig. 15.

Number of Admissions, Discharges and Deaths for 1983 :

Hospital 2 - Ward B : Acute - Assessment.

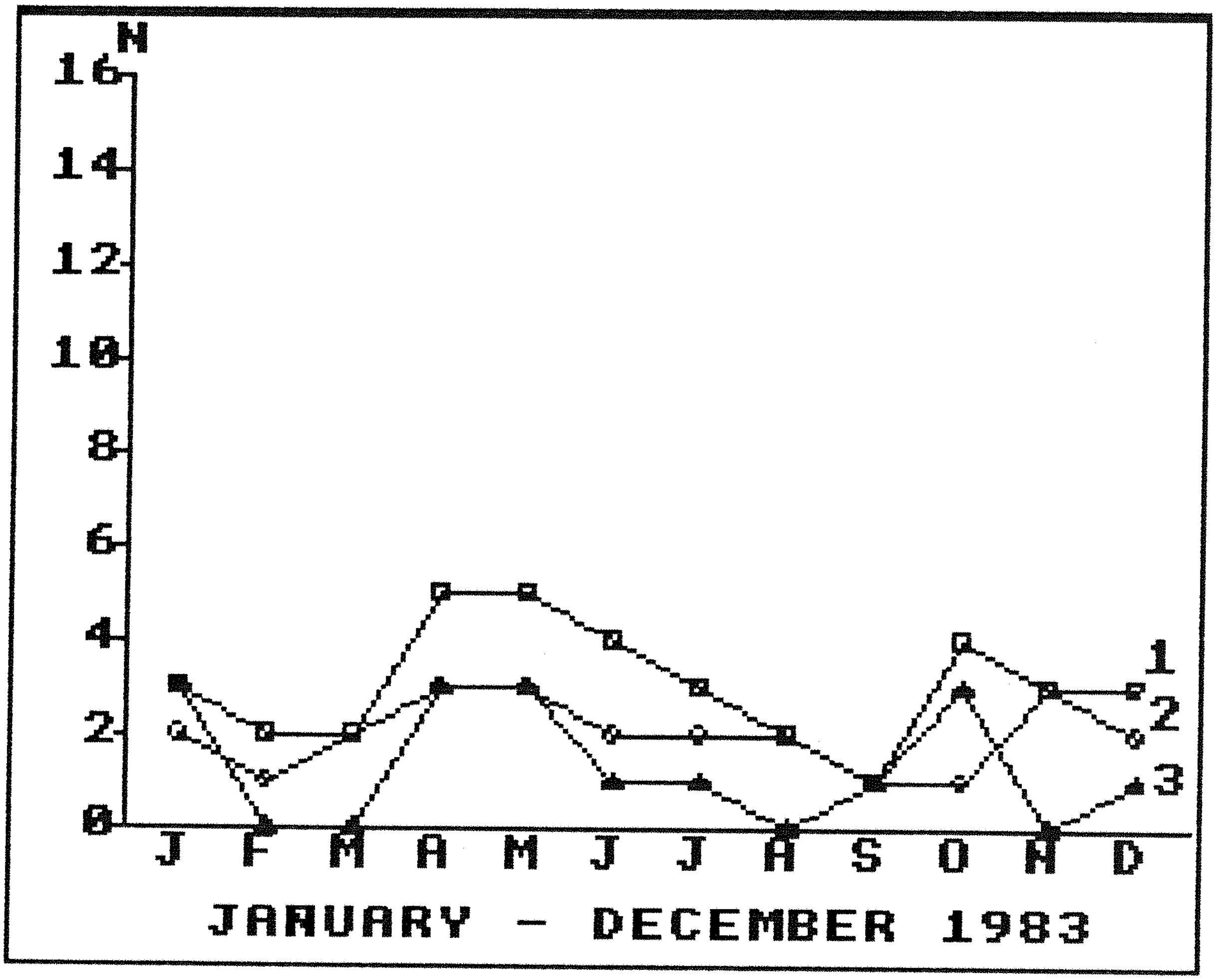


	Annual Total
1 = Admissions	396
2 = Discharges	281
3 = Deaths	114

APPENDIX 10a - 4

Fig. 16.

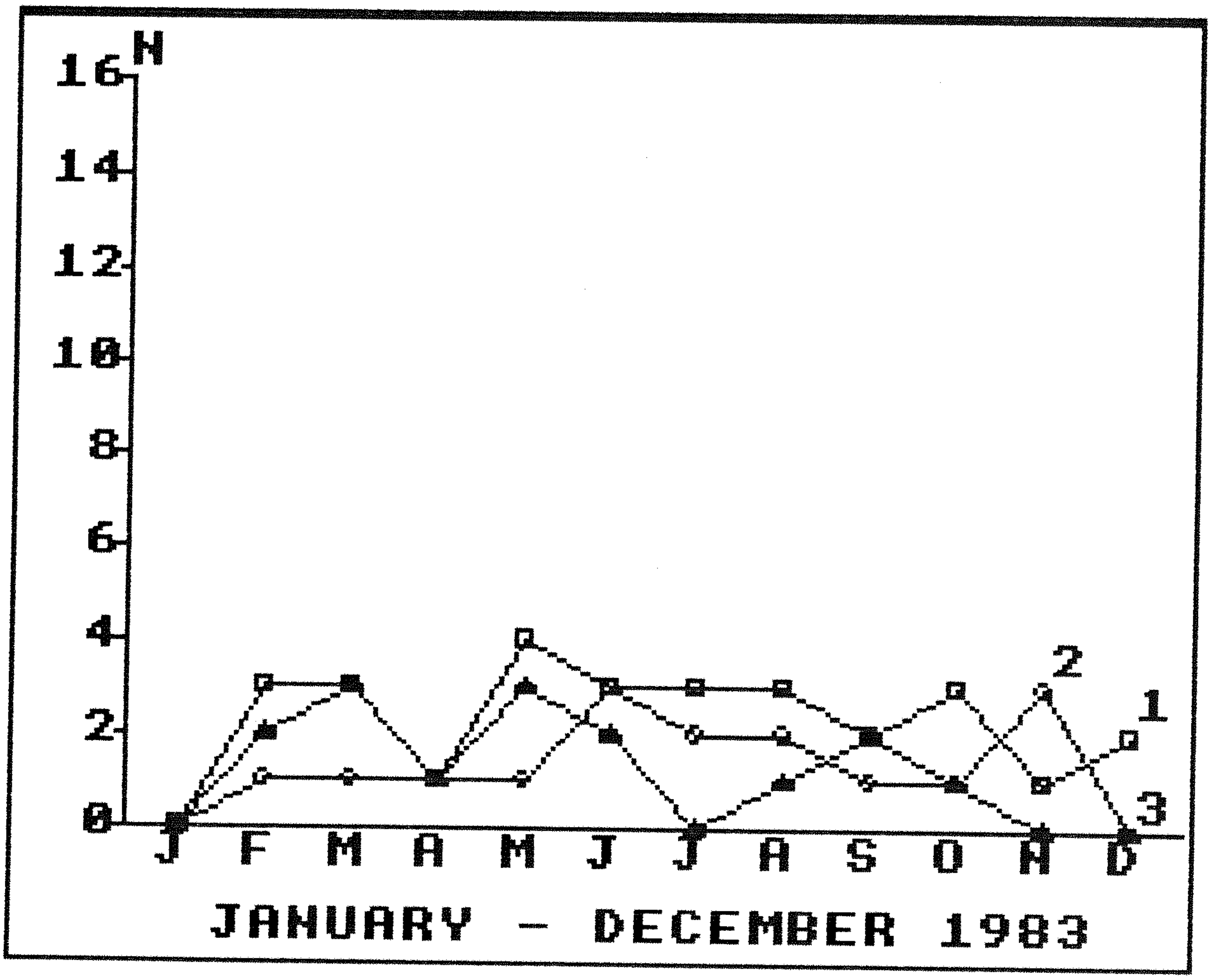
Number of Admissions, Discharges and Deaths for 1983 :
Hospital 2 - Ward C : Continuing - Care.



	Annual Total
1 = Admissions	37
2 = Discharges	24
3 = Deaths	16

Fig. 17.

Number of Admissions, Discharges and Deaths for 1983 :
Hospital 2 - Ward D : Continuing - Care.

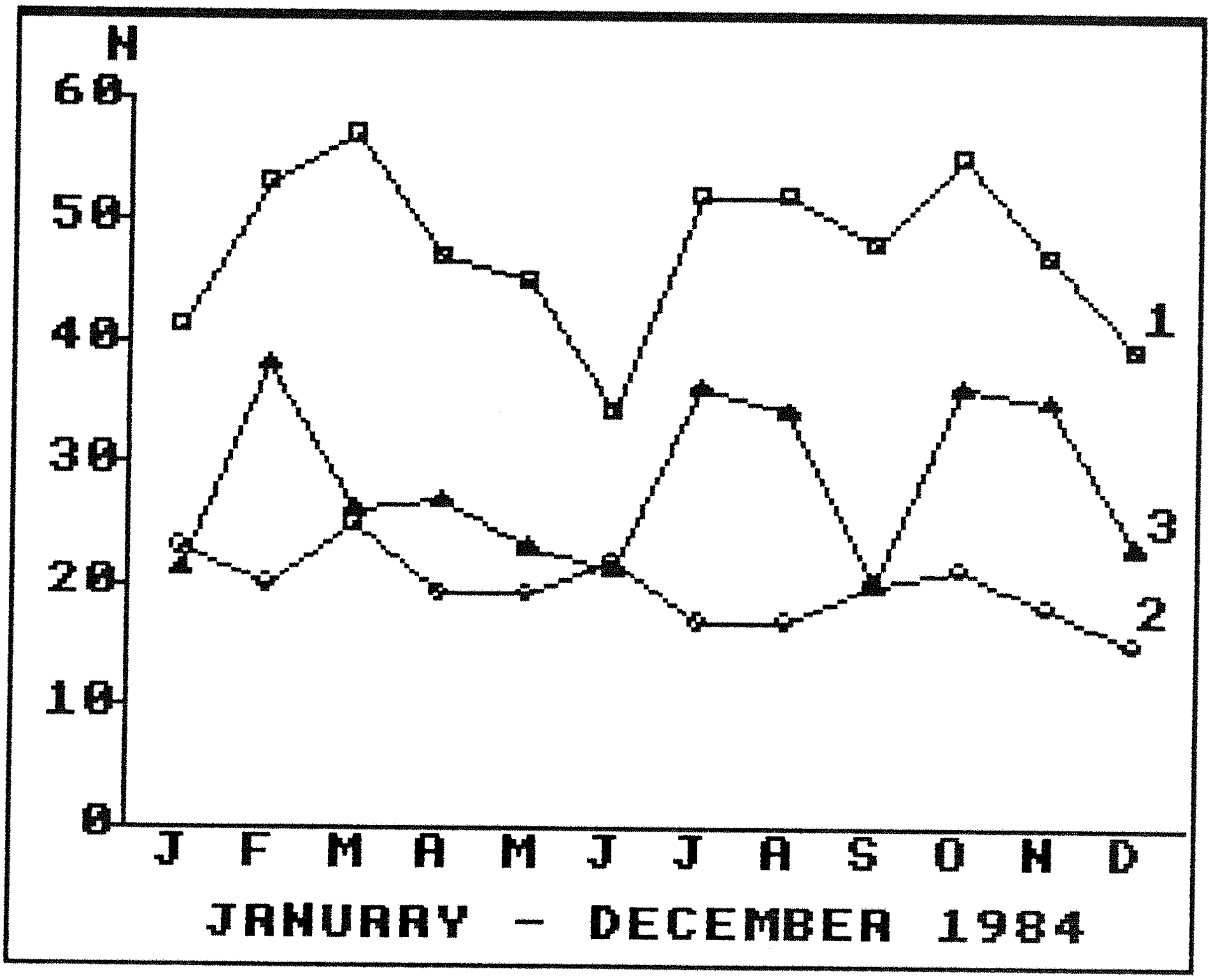


	Annual Total
1 = Admissions	28
2 = Discharges	16
3 = Deaths	15

APPENDIX 10b - 1

Fig. 18.

Number of Admissions, Discharges and Deaths for 1984 : Hospital 1 - Palliative Care Unit.

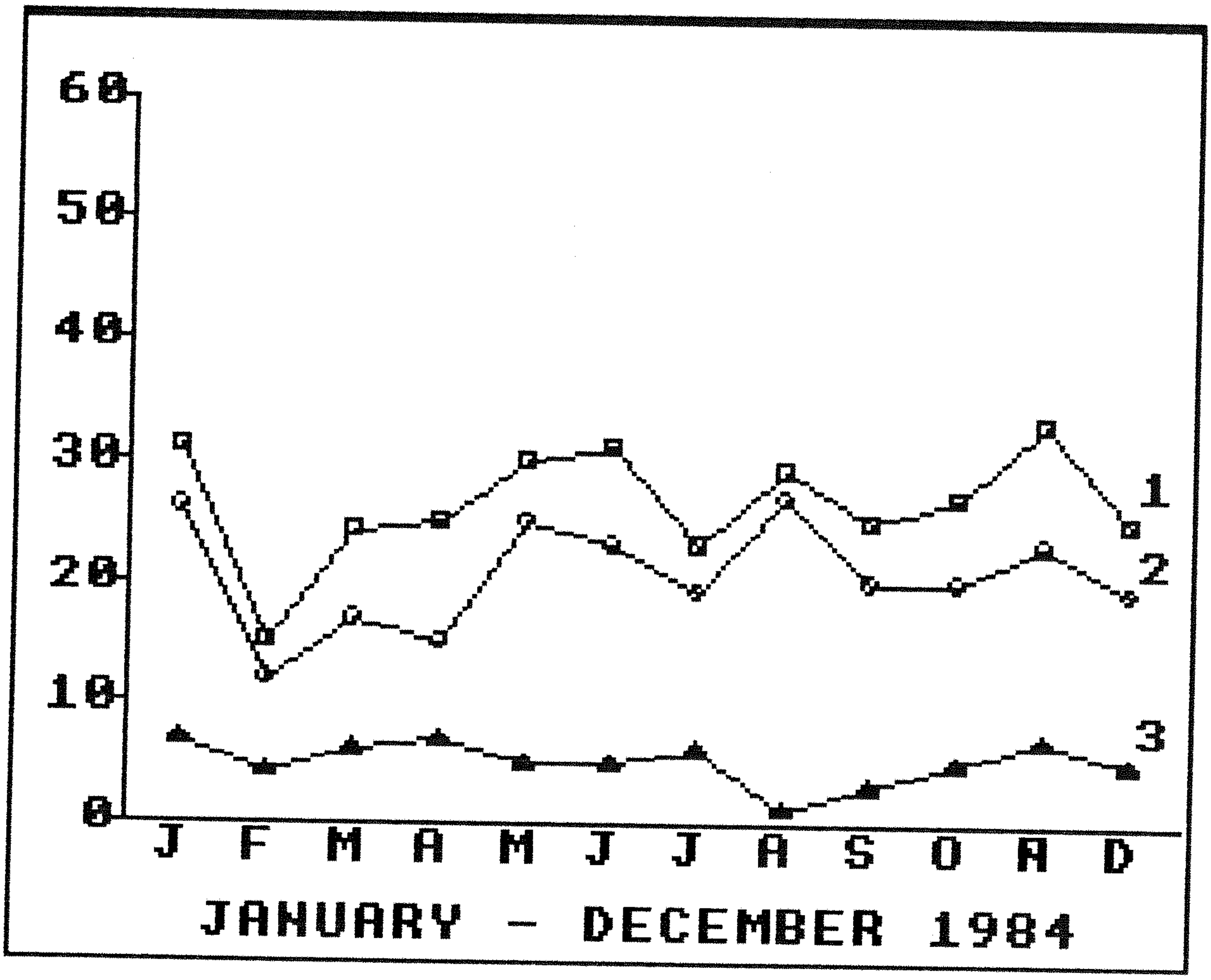


	Annual Total
1 = Admissions	570
2 = Discharges	236
3 = Deaths	340

APPENDIX 10b - 2

Fig. 19.

Number of Admissions, Discharges and Deaths for 1984 :
Hospital 2 - Ward A : Acute - Assessment.

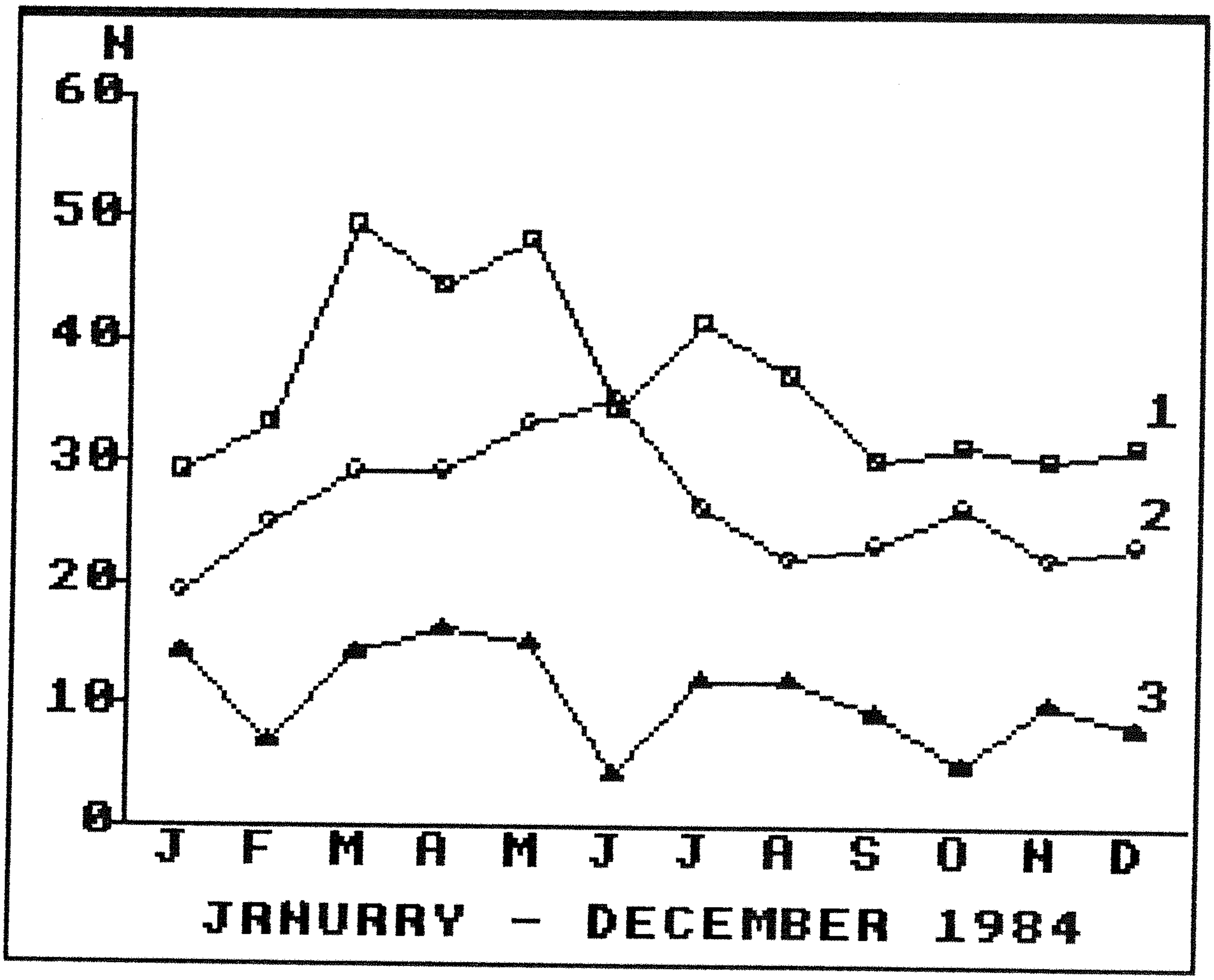


	Annual Total
1 = Admissions	318
2 = Discharges	246
3 = Deaths	61

APPENDIX 10b - 3

Fig. 20.

Number of Admissions, Discharges and Deaths for 1984 :
Hospital 2 - Ward B : Acute - Assessment.

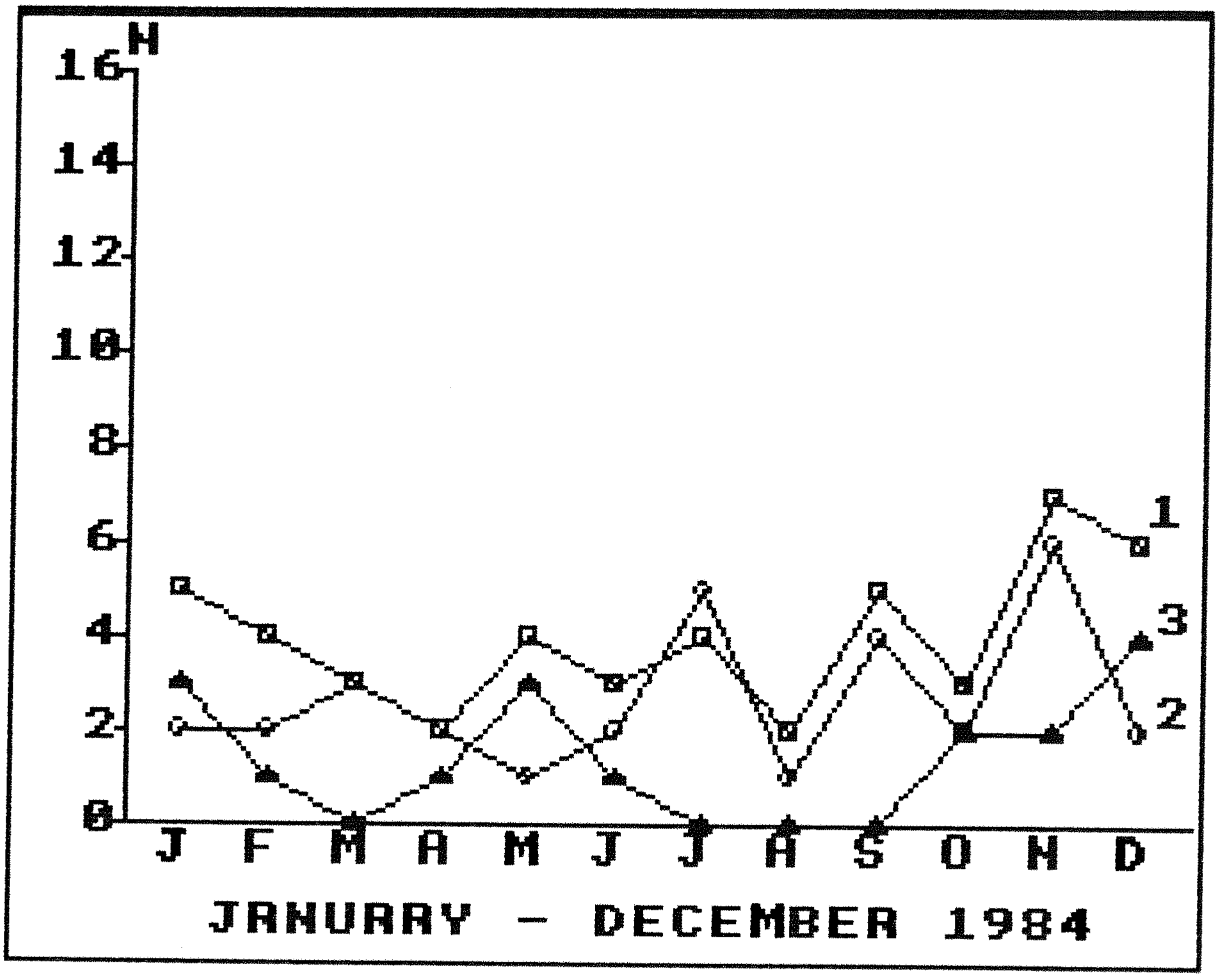


	Annual Total
1 = Admissions	437
2 = Discharges	312
3 = Deaths	126

APPENDIX 10b - 4

Fig. 21.

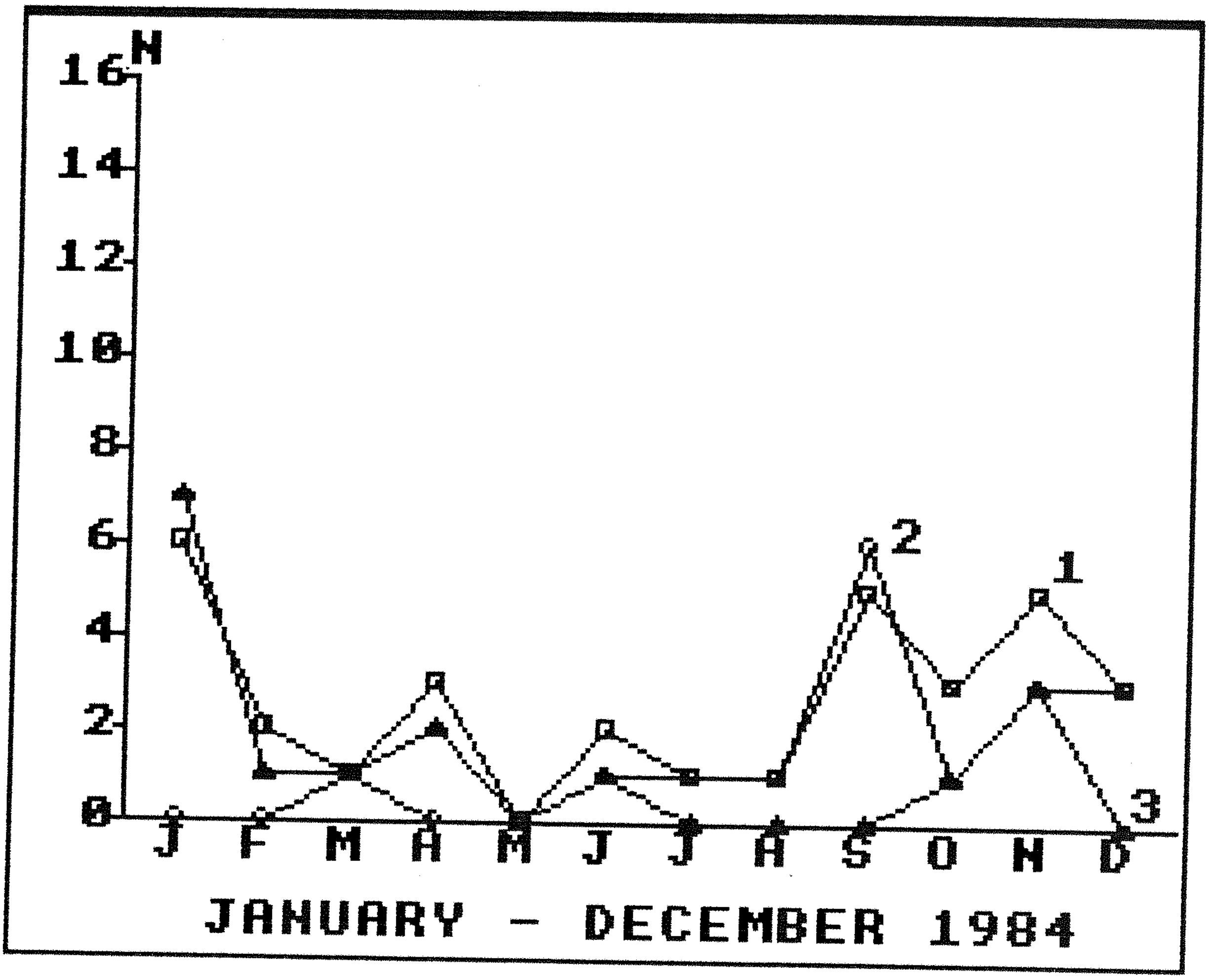
Number of Admissions, Discharges and Deaths for 1984 :
Hospital 2 - Ward C : Continuing - Care.



	Annual Total
1 = Admissions	48
2 = Discharges	32
3 = Deaths	17

APPENDIX 10b - 5

Fig. 22.
Number of Admissions, Discharges and Deaths for 1984 :
Hospital 2 - Ward D : Continuing - Care.



	Annual Total
1 = Admissions	32
2 = Discharges	17
3 = Deaths	16

APPENDIX 11a.

BED - OCCUPANCY AND LENGTH OF STAY

Statistics on the percentage bed occupancy were gathered from the medical records for each ward. They were :

Hospital		H 1	H 2 - Ward			
			A	B	C	D
No. of Beds		25	20	24	20	20
Bed Occupancy %	1983	76.8	96.7	94.5	96.7	95.7
Bed Occupancy %	1984	81.8	92.2	93.9	94.6	97.8

APPENDIX 11b.

NUMBER OF DEATHS PER BED

For the number of deaths to be truly comparable between wards of different size and occupancy, the number of deaths per bed was calculated taking these factors into account using the following formula :

$$\frac{\text{NO. OF DEATHS}}{\text{NO. OF BEDS}} \quad \text{X} \quad \text{BED OCCUPANCY \%}$$

APPENDIX 11b.

Number of Deaths Per Bed :

	Hospital 1	Hospital 2 - Ward			
		A	B	C	D
1983	9.62	4.72	4.49	0.77	0.72
1984	11.12	2.81	4.93	0.80	0.78

APPENDIX 11c.

AVERAGE LENGTH OF STAY

This was calculated using the formula :

$$\text{AVE. LENGTH / STAY} = \frac{\text{TOTAL NO. OF OCCUPIED BED DAYS}}{\text{TOTAL DISCHARGES (INCL. DEATHS)}}$$

Average Length of Stay in Days :

	Hospital 1	Hospital 2 - Ward			
		A	B	C	D
1983	13.53	21.67	20.96	176.48	225.35
1984	12.99	21.98	18.83	141.33	218.03

APPENDIX 12

GP CONSULTATIONS

The range of reasons for which subjects had consulted their GP in the last six months were rated by an independent GP for the possibility that they were stress - related as follows :

REASON GIVEN	RATING
Weight problem	Possibly
Migraine	Possibly
Arthritis	No
Asthma	No
Backache	No
Urinary / Kidney problem	No
Allergy	No
Hay fever	No
Headaches	Probably
Heart / Circulatory Problems	No
Tumour / cyst	No
Cough	No
Cold	No
Tension	Yes
Viral infection	No
Respiratory Tract infection	No
Knee / elbow pains	No
Eye infection	No
Middle ear infection / vertigo	No
D & C	No
Chicken pox	No
Hysterectomy	No
Routine check up	No

REASON GIVEN	RATING
Corneal ulcers	No
Palpitations related to menopause	Possibly
Mood Swings and headaches (on steroids post kidney transplant)	Possibly
Phlebitis	No
Cystitis	No
Skin rash	No
Blood pressure	No
Hyperlipidoemia	No
Varicose veins	No
Fibroids	No
Gallstones	No
Rib pains	No
Gynaecological problems	Possibly
Post menstrual tension	Possibly
Period problems	Possibly

APPENDIX 13

COPING METHODS

Coping methods which were classified as EXTERNALISING feelings :

TLKCOL - Talking to colleagues
TLKFAM - Talking to family
TLKFREN - Talking to friend/s
SNRSTAF - Talking to senior staff
TLKOTHST - Talking to other staff
TEARS - Tears
TEAMMEET - Discuss at team meeting

APPENDIX 13

COPING METHODS

INTERNALISED methods of coping :

INTRSPEC - Think it over/ introspection
PRAYER - Prayer

DIFFICULT TO CATEGORISE, less clear cut :

TIMEOUT - Taking a break / cigarette or coffee
HUMOUR - Use of humour, jokes
ALTMETH - Other methods

SUPPORT AT WORK these methods of coping included:

Talking to Colleagues;
Talking to Senior Staff;
Talking to Other Staff;
Using the Team Meeting.

'Other methods' was a catch-all category, and included talking to relatives of the patient; having a glass of wine.

Eight respondents gave an answer that was classified as "no reaction" - these were subjects who said they kept busy, or put it out of their mind, and who did not subsequently identify a reaction that suggested they were in fact coping with the death in some other way, usually later.

APPENDIX 14

TIME OF DEATH

At the time of the study, although time of death was recorded on nursing notes and the death certificate, it was not noted on the hospital's statistical returns. The researcher did not have access to these notes and no attempt was made to collect this information during the interview period. From April 1987, time of death started to be included on statistical returns, and it subsequently became possible to collect information on the time of death for seven months, from April to October 1988 for Hospital 1. In respect of three months, April, July and October, the information was missing for what was considered to be an unacceptably high number of deaths. A comparison of the numbers and time of death was therefore made only for the months of May, June, August and September. Table 62 shows the number of deaths for the 12 months in each of the years 1983 and 1984, and for seven months in 1988. Statistics on the numbers of deaths were not readily accessible to the researcher for the other five months in 1988.

Table 62 : Number of Deaths per Month for 1983, 1984 and 1988, Hospital 1 Only :

Year	APR	MAY	JUN	JUL	AUG	SEP	OCT	Total
1983	23	21	32	28	32	30	16	182
1984	27	23	21	36	34	20	36	197
1988	19	24	24	17	25	11	19	139

The X^2 showed that the number of deaths for these seven months in 1988 was significantly less than for the same seven months in 1983 and 1984 : X^2 = 10.5; df = 2; p = <.01. Although figures relating to the number of admissions were not collected, it was known to the researcher that a restriction had been placed on the admission of geriatric patients in response to financial stringencies in the Health Service. However, a comparison of the number of deaths over the twelve months in each year for 1983, and in 1984; and a comparison of the number of deaths for the seven months from April to October in each year for 1983, 1984 and 1988, showed that for none of the years in question did the number of deaths vary significantly in relation to the month of the year. It was therefore considered reasonable to use statistics for the four months, May, June, August and September, in 1988 to see whether there was a significant difference in the number of deaths experienced by night staff. Table 63 shows the distribution of deaths between day and night shifts, based on the null hypothesis that deaths were spread evenly and there would be no difference between the number of deaths for day or night staff:

Table 63 : Distribution of Deaths Between Day and Night Shifts :

	Day	Night	Total	Time Not Recorded
Observed	38	31	69	10
Expected	34.5	34.5		

X^2 = 0.72 ; Not significant

No significant difference was found between the number of deaths occurring on day and night shifts, nor when number of deaths was recorded and compared in two - hour blocks of time over twenty - four hours. The assumption has been made that time of death has been accurately, or relatively accurately recorded by day and night staff. This may not be so for the recording of deaths in the night. If the patient has been settled and is asleep, or assumed asleep, some time may well elapse before the death is discovered, and this seems more likely to be the case at night than during the day. Similarly, a vulnerable group of staff may be less likely to know the exact time of death because they may be less likely to check patients regularly. However, with the approach of the morning routines, it seems unlikely that a death would not be noticed before day staff came on duty. So while the exact time of deaths over 24 hours may not be totally reliable, the way in which they divide between the day and night shift should be, because part of the routine would be to check on patients in order to hand over accurate information.

It is therefore concluded that night staff were not exposed to a greater number of deaths than day staff, and the greater stress that they report cannot be explained in this way.

BIBLIOGRAPHY

Amulree Lord, Exton-Smith AN, Crockett GS. (1951) Proper use of the hospital in treatment of the aged sick. Lancet ; 1 : 123-126.

Ander S, Lindstrom B, Tibblin G. (1974) Life changes in random samples of midle-aged men. In: Gunderson EKE, Rahe RH eds. Life Stress and Illness. Springfield, Illinois: Charles C Thomas: 121-124.

Antonovsky A, Kats R. (1967) The life crisis history as a tool in epidemiological research. J Health and Social Behav; 8: 15-21.

Baines MJ. (1981) Symptom control in the dying patient. In: Saunders C, Summers DH, Teller N eds. Hospice:The Living Idea. London: Edward Arnold:93-101.

Bancroft JHJ, Skrimshire AM, Reynolds F, Simkin S, Smith J. (1975) Self-poisoning and self-injury in the Oxford area.Br J Prevent and Soc Med ; 29:170-177.

Barstow J. (1980) Stress variance in hospice nursing. Nurs Outlook ; Dec: 751-754.

Benoliel JQ. (1976) Overview : Care,cure and the challenge of choice. In: Earle AM, Argondizzo NT, Kutscher AH eds.The Nurse as Caregiver for thr Terminal Patient and his Family. New York: Columbia University Press:9-30.

Bettelheim B. (1943) Individual and mass behaviour in extreme situations. J Abnormal Social Psychol; 38: 417-452.

Bowlby J. (1953) Child Care and the Growth of Love. London: Penguin.

Brief AP, Aldag RJ, Van Sell M, Melone N. (1979) Anticipatory socialization and role stress among registered nurses. J Health and Soc Behav ; 20: 161-166.

Brown GW. Meaning Measurement and Stress of Life-Events. Paper presented to the Conference on Stressfulness of Life-Events: Their Nature and Effects. City University,New York: June 1973.

Brown GW, Harris TO. (1978) The Social Origins of Depression. London: Tavistock.

Bruyn ST. (1966) The Human Perspective in Sociology:The Methodology of Participant Observation. Prentice-Hall.

Burke RJ, Belcourt ML. (1974) Managerial role stress and coping responses. J Bus Admin; 5: 55-68. Ref in: Burke JR, Weir T. Coping with the stress of managerial occupations:305. In: Cooper CL, Payne R eds. Current Concerns in Occupational Stress.New York:John Wiley,1980: 299-335.

Burke RJ, Weir T. (1976) Managers' perceptions of effective, ineffective and non-helpers. J Bus Admin; 6: 59-78. Ref in: Burke RJ, Weir T. Coping with the stress of managerial occupations:313. In: Cooper CL, Payne R eds. Current Concerns in Occupational Stress. New York: John Wiley,1980: 299-335.

Burke RJ, Weir T, Duncan G. (1976) Informal helping processes in work settings. Acad Management J; 19: 370-377.

Campbell TW. (1980) Death anxiety on a coronary care unit. Psychosomatics; 21(2): 127-136.

Caplan G. (1976) The family as a support system. In: Caplan G, Killilea M eds. Support Systems and Mutual Help - Multidisciplinary Explorations. New York: Grune and Stratton: 19-36.

Cartwright A, Hockey L, Anderson JC. (1973) Life Before Death. London: Routledge & Kegan Paul.

Cherniss C. (1980) Staff Burnout-Job Stress in the Human Services. Beverly Hills,California: Sage Publications.

Cobb S. (1976) Social support as a moderator of life stress. Psychosom Med; 38(5): 300-314.

Cohen JB, Lazarus RS. (1973) Active coping processes, coping dispositions and recovery from surgery. Ref in: Monat A, Lazarus RS eds. Stress and Coping. New York:Columbia University Press, 1977:p 10-11.

Cohen L, Holliday M. (1982) Statistics for Social Scientists - An Introductory Text with Computer Programs in Basic. London: Harper and Rowe Ltd.

Colligan MJ, Smith MJ, Hurrell JJ. (1977) Occupational incidence rates of mental disorder. J Human Stress; 3(3): 34-42.

Crown S, Crisp AH. (1966) A short clinical diagnostic self-rating scale for psychoneurotic patients - The Middlesex Hospital Questionnaire. Br J Psychiatry; 112: 917-923.

Cullen MF. (1983) Nursing care. In: Denham MJ ed. Care of the Long-Stay Elderly Patient. London: Croom Helm: 42-70.

Cundey B. (1981) Coping with death- A time of stress. Nursing Mirror; June 3rd: 23-24.

Denham MJ ed. (1983) Care of the Long-Stay Elderly Patient. London: Croom Helm.

Denton JA, Wisenbaker Jr. VB. (1977) Death experience and death anxiety among nurses and nursing students. Nurs Res; 26(1): 61-64.

Derogatis LR, Lipman RS, Covi L. (1973) SCL-90: An outpatient psychiatric rating scale. Pharmacol Bull; 9: 13-17.

Dohrenwend BS. (1973) Life events as stressors: A methodological inquiry. J Health and Soc Behav; 14: 167-175.

Dohrenwend BP. (1974) Problems in defining and sampling the relevant population of stressful life events. In: Dohrenwend BS, Dohrenwend BP eds. Stressful Life Events-Their Nature and Effects. New York: John Wiley: 275-310.

Donovan MI. (1981) Stress at work: Cancer nurses report. Oncology Nursing Forum; 8(2): 22-25.

Duxbury ML, Thiessen V. (1979) Staff nurse turnover in neonatal intensive care units. J Advanced Nursing; 4: 591-602.

Earle AM, Argondizzo NT, Kutscher AH eds. (1976) The Nurse as Caregiver. New York: Columbia University Press.

Epting SP. (1981) Coping with stress through peer support. Topics in Clinical Nursing; 2(4): 47-59.

Exton-Smith AN. (1961) Terminal illness in the aged. Lancet; 2: 305-308.

Exton-Smith AN, Crockett GS. (1949) The chronic sick under new management. Lancet; 1: 1016-1018.

Feifel H. (1956) Older persons look at death. Geriatrics; 11: 127-130.

Feifel H ed. (1965) The Meaning of Death. New York: McGraw-Hill.

Fenz WD. (1975) Strategies for coping with stress. In: Sarason I, Spielberger CD eds. Stress and Anxiety, Vol II. New York: John Wiley:

Finlayson A. (1976) Social networks as coping resources. Soc Sci and Med; 10: 97-103.

Firth H. (1982) What makes for good staff support : Research Report 2. (Unpublished)

Folta JR. (1963) Nurses perceptions of role requirements and role action in situations involving death in hospitals. Unpublished PhD Thesis; University of Washington.

Freud S. (1952) A General Introduction to Psychoanalyis. New York: Washington Square Press. (Originally published 1900)

Freudenberger HJ. (1975) The staff burnout syndrome in alternative institutions. Psychotherapy; Spring: 73-82.

Friedenberg EC. (1976) Continuing education in ageing and long - term care. In: Earle AM, Argondizzo NT, Kutscher AH eds. The Nurse as Caregiver. New York: Columbia University Press:218-225.

Friel M, Tehan CB. (1980) Counteracting burnout for the hospice care-giver. Cancer Nursing; August: 285-293.

Gibbs HW, Achterberg-Lawlis J. (1978) Spiritual values and death anxiety: Implications for counselling with terminal cancer patients. J Counselling Psychology; 25(6): 563-569.

Glaser BG, Strauss AL. (1965) Awareness of Dying. Hawthorne,New York: Aldine Publications.

Goldberg DP. (1972) The Detection of Psychiatric Illness by Questionnaire. Oxford University Press.

Gore S. (1978) The effect of social support in moderating the health consequences of unemployment. J Health and Soc Behav; 19 (June): 157-165.

Gow CM, Williams JI. (1977) Nurses' attitudes toward death and dying: A causal interpretation. Soc Sci and Med; 11: 191-198.

Gow K. (1982)How Nurses' Emotions Affect Patient Care. New York: Springer.

Gunderson EKE, Rahe RH eds. (1979) Life Stress and Illness. Springfield: Thomas.

Gurin G, Veroff J, Feld S. (1960) Americans View Their Mental Health. New York: Basic Books.

Hall DT. (1972) A model of role conflict : The role behaviour of college educated women.Admin Sci Q; 17: 471-486. Ref in: Burke RJ, Weir T. Coping with the stress of managerial occupations: 306-307. In: Cooper CL, Payne R eds. Current Concerns in Occupational Stress. New York: John Wiley: 299-335.

Hartl DE. (1979) Stress management and the nurse. Advances in Nurs Sci; 1(4): 91-100.

Hay D, Oken D. (1972) The psychological stress of intensive care nursing. Psychosomatic Medicine; 34(2): 109-118.

Herrick N. (1972) Where Have All the Robots Gone? New York: Free Press.

Hinton JH. (1963) The physical and mental distress of the dying. Quarterly J Medicine; 32: 1-21.

Hodkinson HM. (1981) An Outline of Geriatrics. London: Academic Press.

Holmes TH, Masuda M. (1974) Life change and illness susceptibility. In: Dohrenwend BS, Dohrenwend BP eds. Stressful Life Events: Their Nature and Effects. New York: John Wiley: 45-72.

Hopping BL. (1977) Nursing students' attitudes toward death. Nurs Res; 26(6): 443-447.

Howard JH, Rechnitzer PA, Cunningham DA. (1975) Coping with job tension - effective and ineffective methods. Public Service Management; 4: 317-326.

Hudgens RW. (1974) Personal catastrophe and depression: A consideration of the subject with respect to medically ill adolescents, and a requiem for retrospective life-event studies. In: Dohrenwend BS, Dohrenwend BP eds. Stressful Life Events: Their Nature and Effects. New York: John Wiley: 119-134.

Jackson V. (1980) Reducing job stress by open meetings. Nephrology Nurse; Nov/Dec: 32-34.

Janis JL. (1958) Psychological Stress - Psychoanalytical and Behavioural Studies of Surgical Patients. New York: John Wiley.

Johnson JE. (1975) Stress reduction through sensation information. In: Sarason IG, Spielberger CD eds. Stress and Anxiety,Vol II .New York: John Wiley:

Johnson JH, Sarason IG. (1979) Recent developments in research on life stress. In: Hamilton V, Warburton DM eds. Human Stress and Cognition. Chichester: John Wiley: Ch 7.

Johnson MN. (1979) Anxiety/stress and the effects on disclosure between nurses and patients. Adv Nurs Sci; 1: 1-20.

Jung CG. (1965) The soul and death. In: Feifel H ed. The Meaning of Death. New York: McGraw-Hill:3-15.

Kahn RL. (1973) Conflict,ambiguity and overload:Three elements in job stress. Occupational Mental Health; 3: 2-9.

Kasper AM. (1965) The doctor and death. In: Fiefel H ed. The Meaning of Death. New York: McGraw-Hill:259-270.

Kastenbaum R. (1977) Death and development through the life span. In: Fiefel H ed. New Meanings of Death. New York: McGraw-Hill: 17-45.

Knight M, Field D. (1981) A silent conspiracy: Coping with dying cancer patients on an acute surgical ward. J Adv Nurs; 6: 221-229.

Kramer M. (1974) Reality Shock - Why Nurses Leave Nursing. St. Louis: CV Mosby Co.

Kubler-Ross E. (1970) On Death and Dying. London: Tavistock.

Kurlychek R. (1978/9) Assessment of attitudes toward death and dying: A critical review of some available methods. Omega; 9: 37-47.

Lacey JI. (1949) Individual differences in somatic response patterns. J Comp Physiol Psychol; 43: 338-350.

Langner TS. (1962) A twenty-two item screening score of psychiatric symptoms indicating impairment. J Health and Human Behav; 3 (Winter): 269-276.

Langner TS, Michael ST. (1963) Life Stress and Mental Health: The Midtown Manhatten Study, Vol II. New York: Free Press of Glencoe.

Lattaner B, Hayslip B. (1984-5) Occuoation-related differences in levels of death anxiety. Omega; 15(1): 53-66.

Leatt P, Schneck R. (1980) Differences in stress perceived by head nurses across specialities. J Adv Nurs; 5(1): 31-46.

Leighton DC, Harding JS, Macklin DB, MacMillan AM, Leighton AH. (1963) The Character of Danger. New York: Basic Books.

Lester D. (1984-5) The fear of death, sex and androgeny: A brief note. Omega; 15(3): 271-274.

Levi L. (1977) Psychosocial stress and disease: A conceptual model. In Gunderson EKE, Rahe RH eds. Life Stress and Illness. Springfield; Thomas: 8-33.

Lin N, Ensel WM, Simeone RS, Kuo W. (1979) Social support, stressful life-events and illness. J Health and Soc Behav; 20(2): 108-119.

Lindemann E. (1944) Symptomatology and management of acute grief. Am J Psychiatry; 101: 141-148.

Lonetto R, Fleming S, Mercer GW. (1979) The structure of death anxiety: A factor analytic study. J Personality Assessment. 43(4): 388-392.

Lonsdale G. (1979) Helping Parents at the Birth and Death of their Handicapped Child. In: Lonsdale G, Elfer P, Ballard R eds. Children Grief and Social Work. The Practice of Social Work (4). Oxford; Basil Blackwell.

Lyons TF. (1971) Role clarity, need for clarity, satisfaction, tension and withdrawal. Organizational Behaviour and Human Performance; 6: 99-110.

McGrath JE. (1970) Social and Psychological Factors in Stress. New York: Holt Rinehart and Winston.

McKinlay JB. (1973) Social networks,lay consultations and help - seeking behaviour. Social Forces; 51: 275-292.

McMordie WR. (1979) Improving measurement of death anxiety. Psychol Reports; 44: 975-980.

Manning M. (1984) The Hospice Alternative: Living with Dying. London: Souvenir Press.

Maslach C. (1976) Burned out. Human Behav; 5: 16-22.

Maslach C, Jackson S. (1979) Burned out cops and their families. Psychology Today; May: 58-62.

Mason JW. (1975) A historical view of the stress field - Part II. J Human Stress; 1 (June): 22-36.

Mechanic D. (1970) Some problems in developing a social psychology of adaptation to stress. In: McGrath JE ed. Social and Psychological Factors in Stress. New York: Holt Rinehart and Winston:

Meichenbaum D. (1975) A self-instructional approach to stress management:A proposal for stress inoculation training. In: Spielberger CD, Sarason IG eds. Stress and Anxiety Vol I. New York: John Wiley:237-263.

Menzies Isabel EP. (1970) The Functioning of Social Systems as a Defence Against Anxiety. London; Tavistock Institute of Human Relations.

Mettlin C, Woelfel J. (1974) Interpersonal influence and symptoms of stress. J Health and Soc Behav; 15(4): 311-319.

Mohl PC, Denny NR, Mote TA, Coldwater C. (1982) Hospital unit stressors that affect nurses:Primary task vs social factors. Psychosomatics; 23(4): 366-374.

Monat A, Lazarus RS. (1977) Stress and Coping. New York: Columbia University Press.

Moser DH, Krikorian DA. (1982) Satisfaction and stress incidents reported by hospice nurses:A pilot study. Nursing Leadership; 5(4): 9-17.

Myers JK, Lindenthal JJ, Pepper MP, Ostrander DR. (1972) Life events and mental status:A longitudinal study. J Health and Soc Behav; 13: 398-406.

Nichols KA, Springford V, Searle J. (1981) An investigation of distress and discontent in various types of nursing. J Adv Nurs; 6: 311-318.

Norusis MJ. (1983) SPSSX - Introductory Statistics Guide. New York: McGraw-Hill.

Nuckolls KB, Cassell J, Kaplan BH. (1972) Psychosocial assets,life crisis and the prognosis of pregnancy. Am J Epidemiology; 95:(5): 431-441.

OPCS. (1984) Mortality Statistics for England and Wales. HMSO.

OPCS. (1985) Mortality Statistics for England and Wales. HMSO.

OPCS Moniter (1985) Registrar General's weekly return for England and Wales. HMSO.

OPCS Moniter. (1986) Registrar General's weekly return for England and Wales. HMSO.

OPCS Moniter. (1987) Registrar General's weekly return for England and Wales. HMSO.

Oskins SL. (1979) Identification of situational stressors and coping methods by intensive care nurses. Heart and Lung; (Sept-Oct); 8(5): 953-960.

Parasuraman S, Alutto JA. (1981) An examination of the organizational antecedents of stressors at work. Acad of Management J; 24(1): 48-67.

Parkes CM. (1975) Bereavement : Studies of Grief in Adult Life. London: Penguin Books.

Parkes KR. (1980a) Occupational stress among student nurses - I: A comparison of medical and surgical wards. Nursing Times: Occasional Papers; 76(25): 113-116.

_________ (1980b) Occupational stress among student nurses -II: A comparison of male and female wards. Nursing Times:Occasional Papers; 76(26): 117-119.

Paykel ES, Myers JK, Dienelt MN, Klerman GL, Lindenthal JJ, Pepper MP. (1969) Life events and depression:A controlled study. Arch Gen Psychiatry; 21: 753-760.

Paykel ES, Prusoff BA, Uhlenhuth EH. (1971) Scaling of life events. Arch Gen Psychiatry; 25: 340-347.

Paykel ES, Uhlenhuth EH. (1972) Rating the magnitude of life stress. Canad Psychiatric Assoc J; 17: ss 93-100.

Paykel ES, McGuiness B, Comez J. (1975,Sept) An Anglo - American Comparison of the Scaling of Life Events. Unpublished MS.

Payne R. (1980) Organizational Stress and social support. In: Cooper CL, Payne R eds. Current Concerns in Occupational Stress. New York: John Wiley: 269-298.

Pearlin LI. (1962) Alienation from work:A study of nursing personnel. Am Sociol Review; 27: 314-326.

Pearlin LI, Schooler C. (1978) The structure of coping. J Health and Soc Behav; 19(1): 2-21.

Pearlman J, Stotsky BA, Dominick JR. (1969) Attitudes toward death among nursing home personnel. J Genetic Psychology; 114: 63-75.

Pollack Jerrold M. (1979) Correlates of death anxiety. Omega; 10 (2): 97 - 121.

Quint JC. (1973) The Nurse and the Dying Patient. New York: MacMillan.

Rahe RH. (1972) Subjects recent life changes and their near-future illness reports. Annals of Clinical Research; 4: 250-265.

Rahe RH, Arthur RJ. (1968) Life change patterns surrounding illness experience. J Psychsom Res; 11: 341-345.

Rahe RH, Romo M. (1974) Recent life changes and the onset of myocardial infarction and coronary death in Helsinki. In: Gunderson EKE, Rahe RH eds. Life Stress and Illness. Springfield: Thomas:105-124.

Revans RW. (1976) Action Learning in Hospitals. London: McGraw-Hill.

Reynolds DK, Kalish RA. (1974) Work roles in death-related occupations. J Vocational Behav; 4: 223-235.

Rizzo JR, House RT, Lirtzman SI. (1970) Role conflict and ambiguity in complex organizations. Admin Sci Quarterly; 15(2): 150-163.

Ross CW. (1978) Personal death concerns and responses to dying patient statements. Nurs Res; 27(1): 64-68.

Ross C, Mirowsky J. (1979) A comparison of life-event weighting schemes - change, undesirability and effect - proportional indices. J Health and Soc Behav; 20: 166-177.

Ryder CF, Ross DM. (1977) Terminal care - Issues and alternatives. Public Health Reports; 92(1) 20-29.

Sales SM. (1970) Some effects of role overload and role underload. Organizational Behav and Human Performance; 5: 592-608.

Sarata BP, Jeppeson JC. (1977) Job design and staff satisfaction in human service settings. Am J Community Psycholgy; 5(2): 229-236.

Saunders C. (1977) They live. In: Feifel H ed. New Meanings of Death. New York: McGraw-Hill:153-179.

Saunders C, Walsh TD, Smith M. (1981) Hospice care in motor neuron disease. In: Saunders Dame C, Summers DH, Teller N eds. Hospice:The Living Idea. London: Edward Arnold:126-155.

Schaefer C, Coyne JC, Lazarus RS. (1981) Health-related functions of social support. J Behavioural Medicine; 4(4): 381-406.

Schalling DS. (1975) Types of anxiety and types of stressors as related to personality. In: Spielberger CD, Sarason I eds. Stress and Anxiety Vol I:279-283.

Sells SB. (1970) On the nature of stress. In: McGrath JE ed. Social and Psychological Factors in Stress. New York: Holt Rinehart and Winston:

Selye H. (1974) Stress Without Distress. Philadelphia: Lippincott.

____________ (1979) The stress concept and some of its implications. In: Hamilton V, Warburton DM eds. Human Stress and Cognition - An Information-Processing Approach. Chichester: John Wiley:

Sheehan DV, O'Donnell J, Fitzgerald A, Hervig L, Ward H. (1981-2) Psycho-social predictors of accident / error rates in nursing students:A prospective study. Intl J Psychiatry in Medicine; 11(2): 125-136.

Shepherd DM, Barraclough BM. (1979) Help for those bereaved by suicide. Brit J Social Work; 9 (1): 67-74.

Singleton WT. (1974) Comment. In: Gunderson EKE, Rahe RH eds. Life Stress and Illness. Springfield,Illinois:Charles C Thomas:34-40.

Skinner K. (1980) Support groups for ICU nurses. Nursing Outlook; May: 296-299.

Stedeford A. (1984) Facing Death - Patients,Families and Professionals. London: Heinemann.

Stehle JL. (1981) Critical care nursing stress:The findings revisited. Nurs Res; 30(3): 182-186.

Steiner ID. (1970) Strategies for controlling stress in interpersonal situations. In: McGrath JE ed. Social and Psychological Factors in Stress. New York: McGraw-Hill:

Sterling TD, Weinkam JJ. (1976) Smoking characteristics by type of employment. J Occupational Medicine; 18(11): 743-750.

Stewart BE, Meyerowitz BE,Jackson LE, Yarkin KL, Harvey JH. (1982) Psychological stress associated with outpatient oncology nursing. Cancer Nursing; Oct: 383-387.

Stoller ED. (1980) Effect of experience on nurses' responses to dying and death in a hospital setting. Nurs Res; 29(1): 35-38.

Templer DI. (1970) The construction and validation of a death anxiety scale. J General Psychology; 82: 165-177.

Templer DI,Ruff CF, Franks CM. (1971) Death anxiety:Age,sex and parental resemblance in diverse populations. Developmental Psychology; 4(1): 108.

Templer DI, Lester D. (1974) An MMPI scale for assessing death anxiety. Psychological Reports; 34: 238.

Theorell T, Rahe RH. (1974) Psychosocial characteristics of subjects with myocarial infarction in Stockholm. In: Gunderson EKE, Rahe RH eds. Life Stress and Illness. Springfield: Thomas: 90-104.

Thomas VM. (1983) Hospice nursing - Reaping the rewards,dealing with the stress. Geriatric Nursing; Jan/Feb: 22-27.

Thompson JW. (1980) "Burnout" in group home houseparents. Am J Psychiatry; 137(6): 710-714.

Tillich P. (1965) The eternal now. In: Feifel H ed. The Meaning of Death. New York: McGraw-Hill:30-38.

Times The. American Association, Monday January 16th. 1989. Positive thought and less stress may curb Aids, say scientists.

Vachon MLS. (1978) Motivation and stress experienced by staff working with the terminally ill. Death Education; 2(1-2): 113-122.

Vachon MLS, Lyall WAL, Freeman SJJ. (1978) Measurement and management of stress in health professionals working with advanced cancer patients. Death Educaton; 1: 365-375.

Vachon MLS. (1987) Occupational Stress in the Care of the Critically Ill, the Dying and the Bereaved. Washington: Hemisphere.

Wahl CW. (1968) The fear of death. In: Feifel H ed. The Meaning of Death. New York: McGraw-Hill:16-29.

Warren JJ. (1982) Developing a stress management programme. Developments of Critical Care Nursing; Sept - Oct; 1(5): 307-312.

Weiner MF, Caldwell T. (1981) Stresses and coping in ICU nursing : II. Nurse support groups on intensive care units. General Hospital Psychiatry; 3: 129-134.

Wilson CM. (1983) Stress in Hospice Nursing. Unpublished MSc. Thesis, Dept. of Psychology, University of Birmingham.

Wolff CT, Friedman SB, Hofer MA, Mason JW. (1964) Relationship between psychological defenses and mean urinary 17-hydroxycorticosteroid excretion rates: I. A predictive study of parents of fatally ill children. Psychosom Med; 26: 576-591.

Wyler AR, Masuda M, Holmes TH. (1971) Magnitude of life events and seriousness of illness. Psychosom Med; 33: 115-122.