BELIEFS OF NURSES TOWARDS DEATH AND DYING OF PATIENTS IN KADUNA STATE

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Abstract

The beliefs of nurses towards death and dying of patients in Kaduna state, Nigeria, was investigated using survey research design. To achieve the purpose of the study, quantitative data were collected from a sample of 262 nurses working in either general or specialist hospitals in the state. The instrument for data collection was a questionnaire. The collected data were analyzed using mean arid t-test statistics. The only hypothesis stated for the study was tested at .05 level of significance. The findings of the study showed that nurses had positive beliefs about death and dying of patients gender and age had little influence on beliefs of nurses.

Introduction

Death though part of each living day has never been accepted by many this is because we read, write and talk about it whenever the chance is naturally provided. Instead of individuals ignoring il the subject needs to be included in the daily victuals of our lives. This is because; no one can escape it as it is part of life.

Death as described by Udoh (2,000) is the condition of the dying process, the termination of life, as we know it has remained the untouchable and taboo subject for open discussion in many societies, because of the fear of the unknown it conjures in the minds of hurnans. In spite of these fears, death remain a reality, the ultimate for all humans and the final phase of human existence

Describing dying Lamerton (1973) stated that it is a stage in which feelings are being transferred to the feeling of lost independence, burden and holding emotions. In like manner, Kastenbaum (1985) explained that dying is the act or process of ceasing to live. He added that dying refers to a more general sense of perishing, languishing and passing away.

Death and dying cannot in anyway be said to be a pleasant phenomenon, but for each person to accept its reality is an important aspect of a mature personality. As observed by Okafor (1994), it is likely that no day passes without, at least one or more Nigerians dying n each local government area of the country. He posited that current Nigeria attitudes towards death may be assumed to 'epresentation of avoidance and denial or aversion. While some people are within limit of their own death, yet death seem ignored and denied.

Despite general consensus on the meaning of death, people's perception of the phenomenon varies according to beliefs. Beliefs according to Green Kreu.ter, Deeds and Patridae (1980) are convictions that a phenomenon or object is true or real. They explained that faith, trust and truth are words used to express or imply belief. When these beliefs relate to death as is the case in the present study, they are called death beliefs.

Discussing on terminal illness Kubler - Ross (1981) pointed out that studies have indicated the overwhelming desire of dying cancer patients, non cancer patients and those at a cancer detection clinic to be told about their prognosis.

On the other hand, Adamo!ekum (1997-98) stressed that the patient does not typically wants to hear that he/she is dying of an illness. He expressed that in Nigeria, it is the tradition of doctor and nurses not to convey bad news and the patients do not see themselves as dying of illness. The doctors are not enthusiastic about informing the patients that their disease is terminal, though doctors and

nurses in Nigeria are of the opinion that patients or relatives should be informed of patients' diagnosis. The above indicated belief of doctors and nurses was a pointer for the need to determine whether or not a similar trend of belief currently existing among nurses in kaduna state.

Regrettably, Kasterbaum and Kasterbaurn (1989) observed that nurses do not sometimes find the care of terminally ill patients to *be* interesting or rewarding to them. Again, the dramatic attempted "death bed rescue" scenes are rare. Nurses are apt to believe that such efforts would not be successful in prolonging what they real "quality life". In addition, they expressed that* often involved is the further belief that the dying person is ready for the end, having suffered through a long, progressive loss of function and no longer finds much satisfaction in life.

Consequently upon these beliefs and attitudes of nurses and the resulting effects, it is implicit that certain factors yet unidentified are implicated in the trend. Again, available literature showed that very few reports on death an dying in Nigeria and even no published study on the subject using nurses as respondents in the area of the study exists. The foregoing assertions have therefore necessitated the study on. The beliefs of nurses towards death and dying of patients in Kaduna State.

The study answered the following research questions and on hypothesis.

1. What are the beliefs of nurses towards death and dying of patients?
2. What is the influence of gender in the beliefs of nurses towards death and dying of patients?
3. What is the influence of age *on* the beliefs of nurses towards death and dying of patients?
4. HO_1, There is no significant difference between the beliefs of male and female nurses about death and dying of patients.

Methods

The survey research design was used. As pointed out by Ejifugha (1998) the survey research method is considered one of the best available designs to a researcher who is interested in collecting original data for the purpose of describing a population that is fairly large. The population of the study consisted of 883 nurses working in the state hospital owned by the government. The sampled was stratified according to gender and thirty percent of the populations were selected using proportionate sampling technique. A total of 271 respondents formed the sample size for the study.

A-2-part questionnaire was designed for the study as follows: Section A contained information on the demographic factors selected for the study (age and sex, and death). Section B had 13 statements regarding death and dying belief items most of which were modified and adopted from self inventory death beliefs scale as designed by Kastebaum (1991).

In scoring death belief, positive items, five points were assigned for strongly agree (SA), four for agree (A), three for neutral (N), two for disagree (DA) and one for strongly disagree(SD). For items with negative statements, the scores were applied in the reverse order, so that one point was for strongly agree, two for agree, three for neutral four for agree ad five for strongly agree. This means that the higher the aggregate score in this likert type of scale the more accepted the beliefs of the subject about death and dying.

The face validity of the instrument was certified by five professionals from health and Physical Educated and allied fields such as Educational psychology and Test and measurement Evaluation, all of the university of Nigeria, Nsukka. The instrument was later pre-tested on twenty nurses from plateau state who were either working in general or specialist hospitals. This gave a reliability coefficient of .72 which was considered appropriate for accepting the instrument as reliable.

To determine beliefs of the subjects about death and dying of patients, the grand mean score foreach variable in relation to beliefs investigated were compared with the average mean score of the grand mean. The average mean score was used as a criterion for evaluating the grand mean. The average mean. Score was obtained by adding all the scores assigned to the degrees of agreements and disagreements to the statement or item and dividing it by the number of possible response to that statement as follows $\frac{5+4+3+2+1}{5} = \frac{15}{5+5} = 3.0$

Thus, a belief was accepted as positive if the grand mean of the responses were equal to or greater than 3.0. The result is here by presented in Tables.

Result

Table 1 Beliefs of Nurses About Death and Dying of Patients (N = 262)

S/N	BELIEF	RESPONSES	
		X	SD
1.	Life after death	3.7*	1.5
2.	Tips should be told that they are dying	3.6*	1.2
3.	You die when your time comes up	4.0*	1.0
4.	Talking one's life is justified when terminally iii	3.7*	1.2
5.	Believe that dying patients should be: Told the truth their conditions Keep hopeful by sparing them the fact	 3.8* 2.0*	 1.2 1.4
6.	Certain drugs work for particular patients when Terminally iii	2.6	1.4
7.	Cancer is never curable	2.5	1.2
8.	AIDS patient are stigmatizcd	2.9	1.1
9.	Mere diagnosis and AIDS can trigger suicide	2.4	1.3
10.	Renal diseases can be contacted through Contact with patients	3.5*	1.3
11.	Diseases is the will of God	2.7	1.3
12.	Diseases are caused by spirits	3.4*	1.3
13.	Tips should not be told that they are dying	2.0	1.7
		3.0	1.0

*Accepted as nurses beliefs

The overall response shows that nurses had positive beliefs about death and dying 'which is equal to the criterion mean of 3.0.

Table 2: Beliefs of Nurses About Death and Dying of patients According to Gender.

S/N	BELIEFS	RESPONSES			
		MALE (N=72)		FEMALE (N=190)	
		X	SD	X	SD
1	Life after death	3.4	1.5	3.7	1.4
2	Tips should be told that they are dying	3.7	1.2	3.5	1.2
3	You die when your time comes up	4.0	1.0	3.9	1.0
4	Talking one's like is justified when terminally ill	3.0	1.2	3.6	1.3
5	Believe that dying patient should be Told that truth about their condition Kept hopefully by spacing them the fact	 3.7 2.8	 1.2 1.3	 3.4 2.6	 1.1 1.3
6	Certain drugs work for particular patients when Terminally ill	2.9	1.4	2.4	1.0
7	Cancer is never curable	2.8	1.2	2.4	1.0
8	Aids patients are stigmatized	2.0	1.1	2.9	1.1
9	Mere diagnosis of AIDS CAN trigger suicide	2.8	1.3	2.6	1.3
10	Reinal diseases can be contacted through casual contact with patient	3.0	1.2	3.5	1.3
11	Diseases is the will God	3.0	1.4	3.4	1.3
12	Diseases are caused by spirits	2.9	1.3	3.7 *	1.2
13	Tips should both be told that they are dying	1.9	9.2	1.9	8.5
	Overall means	3.0	3.1		

* Excursively accepted beliefs of nurses

On the average (x 3.0 and = 3.1 female) gender did not influence the beliefs of nurses about death and dying of patients since each of both male and female had an over all mean score equal to or greater than criterion mean of 3.0

Table 3 Nurses Beliefs About Death and Dying of Patients by Age

S/N	BELIEFS	RESPONSES					
		20-25 (n-62)		26-30 (N=60)		31 and above (N=140)	
		X	SD	X	SD	X	SD
1	Life after death	3.7	1.3	3.6	1.5	3.7	1.5
2	Tips should be told that they are dying .	3.6*	1.2	2.9	1.2	3.4*	1.1
3	You die when your time comes up	3.2	1.1	3.7	1.0	4.0	8.2
4	Talking one's like is justified when terminally ill	3.3*	1.1	2.7	1.2	3.7*	1.2
5	Believe that dying patient should be Told that truth about their condition Kept hopefully by spacing them the fact	 3.8 2.9	 1.1 1.2	 3.7 2.6	 1.2 1.3	 3.3 2.8	 1.3 1.1
6	Certain drugs work for particular patients when Terminally ill	2.6	1.0	1.6	1.3	2.6	1.3
7	Cancer is never curable	2.5	1.1	2.2	1.4	2.4	1.4
8	Aids patients are stigmatized	1.9	1.0	2.4	1.0	2.5	1.3
9	Mere diagnosis of AIDS CAN trigger suicide	2.4	1.0	2.0	1.2	2.8	1.1
10	Reinal diseases can be contacted through casual contact with patient	3.6*	1.1	2.8	1.4	3.5*	1.3
11	Diseases is the will God	2.5	1.4	3.3*	1.2	3.5*	1.3
12	Diseases are caused by spirits	3.5*	1.3	2.6	1.2	3.4*	1.3
13	Tips should both be told that they are dying	2.7	1.3	1.8	1.4	2.6	1.0
	Overall means	2.9		2.7		3.0	

Exclusively accepted beliefs of. nurses.

This outcome indicates that age. is to some extent. influential on death and dying. this is because age group 31 years and above had an overall mean response score equal to the criterion mean of 3,0 while the other age brackets had theirs less.

Table 4: Summary of t-Test verifying Nurses' Beliefs About Death and Dying of Patients base on Gender.

Gender	*N*	*X*	*SD*	*Calt.*	*Tablet*	*df*	*Level*	*Decision*
Male	72	3.0	04	55	1.96	260	05	Accepted

Table 4 reveals that the calculated t-value and the critical value were .55 and 1.96 at .05 level of significance. This means that there is no significant difference in nurses beliefs regarding death and dying of patients due to gender.

DISCUSSION

Table 1 showed that the nurses had positive beliefs about death and dying. The results were expected because where an individual has an accepted belief about a phenomenon, the person will do everything possible to stop or avoid any threat that may hinder him/her from achieving it. This is in line with the health belief model in which Galli (1978) explained that perceived threat to health are an individual's perceived vulnerability to the threat, the period severity of the threat and cost benefit pay off that is associated with adopting attitudes.

Also, in Table 1, the most spectacular and surprising response was the

respondents' indication of an accepted belief response to the statement that diseases are caused by spirits" One would have expected them to indicate that it was not so since they had obtained scientific knowledge as it concerns germs. This is a carry-over value of the common belief among many calculation Kaduna state; that certain health problems are cause by spirits. This negates the explanation given by Lambo (1993) that undoubtedly, the

scientific nature of the germ theory models and framework used by doctors, nurses and other allied health workers have their success to being closely linked to scientific areas of biology and chemistry among others. Rather it has favoured the multiple causality models which is non-scientific and is used by traditional healers, orallists and herbalists being closely linked to ethnicity and traditional beliefs.

The findings in Table 2 imply that both male and female respondents had no-divergent beliefs about death and dying of patients,' This result was not 'surprising because, there is a belief that if the right things were done, a beautiful scene, acceptable death can be ensured and that the exit will be made gracefully after well articulated-good byes. This is in line with the reason why Rando (1984) posited that the mutual participation relationship is the most desirable for the management of terminal and chronic: illness. In this relationship, she emphasized, the patient is responsible for his own behaviour and the outcome of the relationship.

It was not surprising that Adamolekun (1997-98) found out that (95% doctors and 96% nurses) believed that patients be told their conditions to pave way for improved quality of care for the remaining time of the terminally ill. This agreement may be attributed to the fact that the respondents for the present study were in the same profession and must have been dealing with patients of similar illnesses based on the same ideology.

Again, Table 2 revealed that the female respondents in addition to other accepted beliefs, exclusively indicated that "diseases were caused by spirits' (x = 3.70. It was not surprising because Kastenbaun (1991) expressed that people may have identical beliefs about particular phenomena. In addition, it is possible that majority of the female respondents are from cultures that believe that diseases are caused by spirits since same item was generally accepted. Furthermore, in. Kaduna state most of the women-folk tend to be committed to things they believe in. For example those that practice traditional religion are always seen visiting herbalists most times when they have a health problem; which those that are not, readily seek orthodox medical help whenever they have a health problem.

The result in Table 3 were expected because beliefs are our relative stable and broad interpretation of the world and our place in it. Individuals are bound to have divergent interpretation of phenomena that surround them. It is possible that the differences noticed could be attributed to the stages of the minds and sex-of the respondents as at the time the instrument was distributed to them. The table revealed that the different age groups of the respondents had divergent belief about death and dying. The result is expected in part because Lemming and Dickinson (1985) explained that one should expect that age will be less influential in explaining death conceptualization for adult population than other age groups. Based on the result in Table 3, age-bracket 20-25 years and 31 years and above showed acceptable response in the same two items in addition to other ones that were generally accepted, "renal diseases can be contacted though casual contact with patients" 31 years and above) and "diseases are cause by spirits" (20--25 years 3.4 (31 years and above, while "disease is the will of God" was exclusively accepted by age-bracket 26-30 years.

However, age bracket 31 years and above had a general mean response equal to the criterion mean of 3.0

This result agrees with that of Gesser, Wong and Redkef, (1987-88)^0 found out their elderly were significantly most accepting (t= 2.82 •-1.98) "there is 'life after death' compared to middle aged i't=1.72<1.98) respectively. However,the result negates the findings of Kinjaw and Dixon (1980) who found out that age was not specifically related to beliefs This may be because age right not necessarily influence beliefs but experience may.

Conclusions

In conclusion nurses' had positive beliefs about death and dying of patients based on gender and !hat age made no significant difference in nurses' beliefs about death and dying of patients based on gender.

Recommendation

1. To take care of the difference'; observed in the study, that is, on such demographic factors as sex, i.e. and death experience on beliefs of

nurses, the nurses should be exposed to workshops, conferences and seminars in the area of death education. This may help in providing *knowledge, in this way, improving the beliefs of the respondents.*

2. The ministry of Health, Kaduna State can help update the knowledge or nurses by sending those already working in the field on in-service training especially *in the area of health education to further improve their understanding of death and dying issues.*

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