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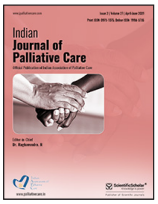

Original Article

Attitude and Associated Factors Toward end of Life Care among Nurses Working in Kuwait Hospitals: A Cross-sectional Study

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ABSTRACT

Objective: The current study assessed the attitude toward end of life (EOL) care among nurses working in Kuwait hospitals.

Material and Methods: A descriptive, cross-sectional design was used to recruit 900 nurses from nine public, private and military hospitals in Kuwait. Data were collected using a self-administered questionnaire of the Frommelt Attitude Toward the Care of Dying questionnaire.

Results: The results showed that nurses in Kuwait had a favourable and supportive attitude towards EOL care, mainly toward the families' need for emotional support, care for the dying patients, involving the family in care, and accepting death. Further, attitude scores differed significantly based on nurses' age, year of experience, education level, nationality, type of hospital, and place of work.

Conclusion: Nurses working in Kuwait have a favourable attitude toward care for dying patients but an unfavourable perception toward making conversation with patients about death. Hence, providing appropriate awareness to nurses about death and dying in Kuwait might be a promising intervention to improve their attitude and sensitise the concept of death among them.

Keywords: Attitude to death, End of life, Kuwait, Nurses, Terminal care

INTRODUCTION

Background

The term end of life (EOL) has been used interchangeably with many terms, such as hospice, terminal phase, and actively dying. The terminal phase was identified as the inevitable period of functional failure before death; this period could be days or weeks.[1] In the same context, EOL care involves the treatment, care, and support for people who are near the end of their lives, including physical, emotional, social, and spiritual support for patients and their families. To the EOL care is provided to control pain and other symptoms so the patient can be as comfortable as possible.[2]

Nurses are considered vital members of palliative care teams.[3] Their knowledge and attitudes play an essential role in delivering successful and efficient EOL care.[4] Attitude is a behaviour based on conscious or unconscious mental views developed through cumulative experiences; it is a response to a stimulus that influences an individual's choice of action.[5] Nurses learn the required attitudes of nursing through training as part of their socialisation into the profession.

According to White and Coyne,[6] nurses feel that they are not well prepared to deliver EOL care. Sometimes, they find it emotionally challenging to provide the service; they often feel incompetent and are not confident to care for dying patients and discuss death and dying with the patients and their families.[6-8]

Palliative care service in Kuwait is a relatively new subspecialty. According to Lynch *et al.*,[9] Kuwait has limited palliative care provision, which is intermittent in scope and not well supported. It is also characterised by an inadequate number of hospice-palliative care services based on population.[9] The first palliative care centre in Kuwait was launched in 2010. It provides different palliative care services, including inpatient hospitalisations, an outpatient department, a day visit department, and outreach consultants.[10] Addressing nurses' attitudes toward EOL care is essential to the provision of palliative care across healthcare institutions.

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Aim

According to the reviewed literature, no published studies have examined the attitude towards EOL care among nurses working in Kuwait. Therefore, this study aimed to address this gap. The current study is a part of a Master's degree thesis that examined nurses' knowledge about palliative care and their attitude toward EOL care. However, the present paper only reports the level of attitude toward EOL care among nurses working in Kuwait hospitals. The secondary objective is to examine differences in nurses' attitudes toward EOL care based on their demographic characteristics. This study will help understand nurses' attitudes toward EOL care; thus, it will help improve patients' experience of EOL care.

Research question

The current study answered the following research questions:

1. What is the level of attitude toward EOL care among nurses working in Kuwait hospitals?
2. What are the differences in nurses' attitudes toward EOL care based on their demographic characteristics?

MATERIAL AND METHODS

Design

A descriptive cross-sectional design was used to collect data from registered nurses working in Kuwait hospitals.

Sample and participants

Eligible nurses were recruited using convenience sampling according to the following criteria: (1) Registered nurses who completed a 4-years Bachelor's degree program, (2) work in Kuwaiti hospitals, and (3) have a minimum of one year of experience as a direct care nurse. Exclusion criteria were: (1) Nurses who work in the emergency room, operation room, and outpatient departments. The sample size was calculated using the G power computer software program; to achieve alpha (α) of 0.05 and power (β) of 80%, a minimum of 420 participants is needed.

Data collection procedure

The principal investigator obtained ethical approvals from the Research Ethics Committee of the University of Jordan, the Kuwait cultural office, and the Ministry of Health in Kuwait. Then, the researcher approached data collection sites, met with the hospital managers and medical wards directors, and discussed the research process, aim, and data collection procedure with them. Invitation posters were posted in the nursing documentations rooms and questionnaires were kept with the nurse managers to be distributed to eligible nurses.

Instruments

Data were collected using the Frommelt Attitude toward the care of dying (FATCOD) scale developed by Frommelt.[11] This scale consisted of 30 items designed to measure the participants' attitudes toward providing care to dying persons. The scores were graded from one (strongly disagree) to five (strongly agree). Fifteen items were worded positively, while 15 were worded negatively and were reverse coded to measure the total score and facilitate comparison between items. Total FATCOD score ranges from 30 to 150, with higher scores indicating more favourable attitudes. The internal consistency of the FATCOD in the current study was assessed and revealed a Cronbach's alpha equal to 0.726.

Ethical considerations

Ethical approval and permission to use the scale were granted before starting the study from the University of Jordan and the Ministry of Higher Education, the Kuwaiti cultural office under the Embassy of Al Kuwait, then the ministry of health in Kuwait. The Principal investigator informed the participants about the study's purposes, significance and the right to withdraw at any time. Those who were willing to participate voluntarily signed a consent form before filling out the questionnaire. To assure the confidentiality of participants, each questionnaire was given a code, all data were kept in a locked computer and no one had access to the data except the research team.

Data analysis

Data entry and the analysis were carried out using Statistical Package for the Social Sciences version 23. Descriptive statistics were conducted to describe the participants and their responses to the FATCOD questionnaire. The total score of the FATCOD was calculated after reverse coding for the negatively worded items. The differences in nurses' attitudes based on their demographics were examined using the Independent samples t-test and the One-way ANOVA test; *post hoc* analysis was conducted by Tukey HSD test. To examine predictors of nurses' attitudes, a multiple linear regression analysis was performed. The results were considered statistically significant at a level of significance <0.05.

RESULTS

In total, 1100 questionnaires were distributed to nurses across all public, military, and private hospitals in Kuwait. Only 900 nurses completed the questionnaires, with a response rate of 82%.

Participants' demographic characteristics

This study included 900 participants. The majority of the participants were female (n = 668, 74.2%), Indian (n = 614, 68.2%) and held a bachelor's degree (n = 588, 65.3%). Most frequently, the participants were 31–40 years old (62.1%). More than half of them (n = 453, 50.3%) had more than 11 years of nursing experience and worked in a medical-surgical ward (n = 654, 72.7%). A detailed summary of the participants' characteristics is shown in [Table 1].

Table 1: Characteristics of the study participants (*n*=900).

	n	%
Gender		
Female	668	74.2
Male	232	25.8
Age (year)		
20–30	84	9.3
31–40	559	62.1
41–50	205	22.8
More than 50	52	5.8
Years of experience (years)		
1–3	43	4.8
4–7	154	17.1
8–11	250	27.8
More than 11	453	50.3
Level of education		
MSN	19	2.1
BSN	588	65.3
Diploma	274	30.4
Certificate- less than a diploma	19	2.1
Nationality		
Indian	614	68.2
Filipino	128	14.2
Kuwaiti	76	8.4
Arab	76	8.4
Indonesian	2	0.2
Others	4	0.4
Work Facility		
Public hospitals	602	66.8
Kuwait Oil Company Hospital	100	11.2
Private/Alseef Hospital	100	11.2
Army Hospital	98	10.8
Work Area		
Medical/Surgical Wards	654	72.7
Intensive Care Units	144	16.0
Coronary Care Units	102	11.3
Receiving Palliative Care Training		
No	900	100
Yes	0	0

Nurses' attitude toward the EOL care

The participants scored 104.60 (SD = 10.9) on the FATCOD total score (Range 72–144). To further understand the participants' responses, a detailed summary of each item is presented in [Table 2]. The mean score of each item is displayed; an asterisk marks the negatively worded statements. The average score for the reversed items was calculated after the recoding; therefore, a higher item score in [Table 2] indicates a more favourable attitude. Overall, the participants showed favourable and supportive attitudes toward EOL care. More than 50% of the nurses showed a favourable attitude toward 19 items (1, 4, 5, 7, 10, 12, 14-24, 27, and 28). The most favourable attitude among participants (87.5%) was toward the families' need for emotional support (item 16) and allowing the patients to verbalise their feelings (item 21). Further, nurses showed a favourable attitude toward care for dying patients (items 1, 5, 7, and 17), care of the family (items 4, 16, and 22), involving the family in care (items 12, 18, and 20) and accepting death (10 and 15). On the other hand, the participants showed an unfavourable attitude toward one item (6), which is talking about death with the dying person.

Factors associated with nurses' attitude toward the EOL care

According to [Table 3], there was a significant difference in attitude scores according to the level of nursing experience (F(3, 896) = 3.96, P = 0.008). More experienced nurses; (8–11 years) and (more than 11 years) showed a more favourable attitude toward the EOL care (M = 105.83, *SD* = 10.94) and (M = 104.91, *SD* = 10.30), respectively, than nurses who had an experience of 4–7 years (M = 102.27, *SD* = 12.28). In terms of education level, there was a statistically significant difference between group means as determined by one-way ANOVA (F(3,896) = 7.94, P < 0.001). Nurses who held a bachelor's degree had a more favourable attitude (M = 105.86, *SD* = 11.23) than those who held a diploma certificate (M = 102.16, *SD* = 9.93). A significant difference (F(5,894) = 21.06, P < 0.001) was also found according to nationality; Kuwaiti nurses' score had significantly lower scores (M = 100.97, *SD* = 9.40) than Filipino nurses' score (M = 112.18, *SD* = 11.53).

Nurses who worked in a public hospital or the Army hospital showed a significantly lower attitude scores ([M = 102.21, *SD* = 10.35] and [M = 105.29, *SD* = 8.18], respectively) than nurses from the KOC/petrol hospital (M = 112.79, *SD* = 10.31) and the private hospital (M= 110.21, *SD*= 11.59), (F(3,896)= 42.07, P < 0.001). Besides, nurses in the public hospitals had significantly lower scores than nurses in the Army hospital. Finally, a significant difference in attitude scores (F(2,897) = 8.45, P < 0.001) was also detected based on the work areas. The *post hoc* analysis showed that nurses who worked in the medical-surgical wards had lower attitude scores (M = 103.70, *SD* = 10.65) than those working in the CCU (M = 106.51, *SD* = 11.466) and the ICU (M = 107.37, *SD* = 11.43).

Predictors of FATCOD score

Multiple linear regression analysis examined the association between the demographic variables and nurses' total attitude score. Regression assumptions were verified, including normality, the independence of the residues through the Durbin-Watson statistic (DW = 0.49), and multicollinearity. The analysis indicated no collinearity problem among variables according to their VIF values (1.03–1.2). This regression model was built using the 'Forward method,' the final model was significant, (F (8, 891) = 26.563; P < 0.01; adjusted R^2 = 0.185). According to the results, 44% of the

Table 2: Nurse's responses to the FATCOD scale (attitude measure).

Item	Mean (SD)	% Disagree/ Strongly disagree	% Unsure	% Agree/ Strongly agree
Giving nursing care to the dying person is a worthwhile learning experience	3.71 (1.23)	19.8	7.8	**72.4**
Death is not the worst thing that can happen to a person	3.30 (1.32)	33	10.2	**56.8**
I would be uncomfortable talking about impending death with the dying person*	2.54 (1.09)	**22.4**	18.6	59
Nursing care for the patient's family should continue throughout the period of grief and bereavement	3.90 (1.04)	13.4	11	**75.6**
I would not want to be assigned to care for a dying person*	3.93 (1.04)	**75.8**	12.1	12.1
The nurse should not be the one to talk about death with the dying person*	2.23 (1.25)	**19.7**	9.2	71.1
The length of time required to give nursing care to a dying person would frustrate me*	3.67 (1.07)	**65.4**	17	17.6
I would be upset when the dying person I was caring for, gave up hope of getting better*	2.93 (1.17)	**37**	19	44
It is difficult to form a close relationship with the family of a dying person*	3.18 (1.06)	**44**	24.8	31.2
There are times when death is welcomed by the dying person	3.54 (0.99)	15.7	22.3	**62**
When a patient asks, 'Nurse am I dying?' I think it is best to change the subject to something cheerful*	2.64 (1.17)	**27.3**	11.3	61.4
The family should be involved in the physical care of the dying person	3.77 (1.11)	17.6	8.2	**74.2**
I would hope the person I'm caring for dies when I am not present*	3.16 (1.05)	**40.2**	31.4	23.2
I am afraid to become friends with a dying person*	3.87 (0.98)	**76.4**	12.6	11
I would feel like running away when the person actually died*	4.02 (1.06)	**80.3**	8.6	11.1
Families need emotional support to accept the behavior changes of the dying person	4.19 (0.91)	6.4	6.1	**87.5**
As a patient nears death, the nurse should withdraw from his/her involvement with the patient*	3.94 (1.04)	**76.7**	12.6	10.7
Families should be concerned about helping their dying member make the best of his/her remaining life	4.16 (0.98)	8.3	7.8	**83.9**
The dying person should not be allowed to make decisions about his/her physical care*	3.58 (1.21)	**63**	12.6	24.4
Families should maintain as normal an environment as possible for their dying	4.09 (.86)	6.3	8.4	**85.3**
It is beneficial for the dying person to verbalise his/her feelings	4.23 (0.87)	5.8	6.7	**87.5**
Nursing care should extend to the family of the dying person	3.68 (1.12)	18.4	14	**67.6**
Nurses should permit dying persons to have flexible visiting schedules	3.64 (1.06)	17.8	15.7	**66.5**
The dying person and his-her family should be the in-charge decision makers	3.39 (1.16)	26.4	16.9	**56.7**
Addiction to pain-relieving medication should not be a nursing concern when dealing with a dying person	2.89 (1.17)	43.2	19	**37.8**
I would be uncomfortable if I entered the room of a terminally ill person and found him/her crying*	3.16 (1.16)	**47.6**	15.2	37.2
Dying people should be given honest answers about their condition	3.53 (1.14)	21.7	18.7	**59.6**
Educating families about death and dying is not a nursing responsibility*	3.51 (1.23)	**62**	11	27
Family members who stay close to a dying person often interfere with the professional job of the patient*	2.84 (1.06)	**27**	31	42
It is possible for nurses for help patients prepare for death	3.41 (1.06)	22	21.4	**56.6**

*Negatively worded statements.[22,28] **Bolded** is the percentage of participants who had a favourable attitude to each specific item. Note: The mean score is calculated after reversed coding, while the percentage of responses are according to nurses' responses to the original questionnaire

total variation in the attitude score can be explained by knowledge scores, hospital type, work area, educational level, experience, and nationality [Table 4].

According to the results, nurses who worked in the KOC hospital and a private hospital have on average a mean score that is almost (0.029 and 0.022, respectively) higher

Table 3: Differences in nurses' attitudes toward EOL care (total scores), based on their demographic characteristics.

Variable	Attitude			
	Mean (SD)	Statistics T/F	df	Sig
Gender		t=−0.08	898	0.932
Male	104.56 (11.27)			
Female	104.63 (10.86)			
Age (years)		F=2.518	3	0.057
20–30	101.94 (13.02)			
31–40	104.90 (11.02)			
41–50	105.35 (10.03)			
More than 50	102.92 (9.59)			
Years of experience (years)		F=3.963	3	**0.008**
1–3	102.67 (11.65)			
4–7	102.27 (12.28)			
8–11	105.83 (10.94)			
More than 11	104.91 (10.30)			
Education Level		F=7.94	3	**<0.001**
BSN	105.86 (11.23)			
MSN	104.79 (12.37)			
Diploma	102.16 (9.93)			
Certificate	101.11 (9.04)			
Nationality		F=21.06	5	**<0.001**
Kuwaiti	100.97 (9.40)			
Arab	98.46 (9.66)			
Philipino	112.18 (11.53)			
Indian	104.25 (10.35)			
Indonesian	98.00 (14.14)			
Others	106.25 (8.50)			
Work Facility		F=42.07	3	**<0.001**
Public	102.21 (10.35)			
KOC/petrol	112.79 (10.31)			
Army	105.29 (8.18)			
Private	110.21 (11.59)			
Work Area		F=8.45	2	**<0.001**
Medical-surgical ward	103.70 (10.65)			
ICU	107.37 (11.43)			
CCU	106.51 (11.46)			

compared to nurses who worked in a public hospital, after taking into account the other variables. Similarly, nurses who have 4–7 years of experience have lower attitude scores than nurses who have more than 11 years of experience by 0.012. In terms of nationality, the Kuwaiti nurses have an average score that is 0.021 higher than Arabs but 0.015 less than Filipinos. Bachelor's degree holders have a 0.009 higher score than those who hold a certificate less than a diploma. Further, nurses' attitude score increased 0.002 points for each point in the knowledge score.

DISCUSSION

Nurses in the current study had a favourable attitude towards caring for dying patients; the results are comparable with scores reported by the previous studies in Middle Eastern countries. For instance, the attitude scores were similar to those measured for 395 nurses from different nationalities working in Saudi Arabia; they showed a moderate attitude toward the care of dying patients.[12] On the other hand, our nurses had higher attitude scores than physicians from Kuwait[13] and nurses from Egypt.[14]

Table 4: Predictors of attitude score.

Predictors	Attitude toward EOL care (FATCOD)				
	B	SE	Beta	t	Sig.
(Constant)	2.010	0.002		813.10	0.000
Total knowledge score	0.002	0.001	0.125	4.029	0.000
Hospital Type (KOC)[a]	0.029	0.005	0.204	6.375	0.000
Hospital Type (Private)[a]	0.022	0.005	0.156	4.809	0.000
Experience (4-7 years)[b]	−0.012	0.004	−0.097	−3.096	0.002
Nationality (Arabs)[c]	−0.021	0.005	−0.132	−4.300	0.000
Nationality (Filipino)[c]	0.015	0.004	0.113	3.328	0.001
Certificate (BSN)[d]	0.009	0.003	0.099	2.987	0.003
Work unit (MICU)[e]	0.009	0.004	0.075	2.417	0.016

[a]Reference category: Public hospitals, [b]Reference category: Experience >11 years), [c]Reference category: Kuwaiti, [d]Reference category: Certificate less than a diploma, [e]Reference category: Medical-surgical

Caring for the family was one of the most supported factors among nurses in the current study. They believed that nurses should provide emotional support to the family and that nursing care should extend to the family and continue throughout the period of grief and bereavement. Similar findings were reported by Palestinian nurses.[15] This favourable attitude is essential to deliver family-cantered care and bereavement support that aim to decrease distress experienced by the family members while the patient was dying.[16,17] Further, the nurses favourably perceived that family members could be part of the care providers; this might be due to cultural factors, as generally, the family members have solid bonds and share cultural values.[18] Besides, most family members live in an extended family and have strong ties; the family members bring out these ties when there is an ill person in the family as they take a major role in the patients' care.

Another important finding of the current study was that nurses perceived death as a natural process. This was implied by 'viewing death as not the worst thing that can happen to the patient' (item 2) and that sometimes it is welcomed by the dying persons themselves (item 10). According to Peters

et al.,[19] personal acceptance and attitudes toward death are associated with attitudes toward caring for dying patients. This is supported by the favourable attitude of the nurses in this study, as in 'acceptance of being assigned to care for a dying person' (item 5), not being frustrated by the demand of care to a dying person; expressed as the length of time required to give nursing care (item 7) and accepting their presence when the person actually died (item 15). These items showed that nurses have favourable attitudes toward participating in caring for dying patients.

On the other hand, nurses in the current study were uncomfortable talking about death with the dying person. In general, nurses find talking about death a challenging task.[20] According to previous studies,[21-23] education and training significantly improve nurses' attitudes toward initiating conversations about death and caring for patients at the EOL. In the same context, Burgess *et al.*[24] suggested using a booklet as a cost-effective and practical way to disseminate information about death and dying to the patients. Accordingly, nurses in Kuwait would benefit from these activities to improve their attitude toward death discussions.

Factors associated with nurses' attitude toward EOL care

The current study identified several factors that affected the attitudes toward EOL care among nurses working in Kuwaiti hospitals. Nurses who worked in public hospitals showed a less favourable attitude toward the EOL, which contradicts a previous study where nurses working in public hospitals showed a more favourable attitude toward the EOL care.[25] The author of the previous study mentioned staff preparation and training as the reason for their results; however, this cannot be applied to nurses in the current studies as none of them received training about palliative care. Further, in the current study, nurses' attitudes varied according to their nationality. In particular, Kuwaiti nurses had lower scores than Filipino nurses. Similar findings were reported by Abudari *et al.*,[12] where nationality affected the level of attitude. Reasons for attitude differences in the current study could be due to the variation in years of experience between Kuwaiti and Filipino nurses who participate in the current study. Almost 89% (n = 113) of Filipino nurses had an experience of 8 years or more compared to only 41% of Kuwaiti nurses (n = 31); the longer the experience, the more exposure to dying patients and gaining better knowledge and attitude.[14]

In the same assertion, nurses' attitudes toward EOL care correlate with the years of experience; nurses with more experience developed a more favourable attitude toward death and dying. This affirms the findings from previous studies;[12,26,27] one possible explanation for this finding is that nurses with more experience might have cumulative skills and wider experiences in caring for dying patients while advancing in their careers. Novice nurses might need more time to cope with caring for dying patients.

Another correlate to nurses' attitude was education; a higher level of education correlates with higher favourable attitudes.[15,25] Nurses with higher education might better comprehend the FATCOD scale questions, hence answering the questions more appropriately. Another possible explanation for this result is that higher education graduates have more extended and more comprehensive training in hospitals, which will expose them to more patients and improve their experiences and attitude.

In terms of the working area, the findings of this study show that nurses working in the ICU and CCU have a more favourable attitude toward EOL care compared to nurses working in medical wards; this could be interpreted by considering the severity of patients' illness in ICU and CCU compared with the patients in the medical wards. Nurses working in ICU and CCU spend more time caring for critically ill patients and expose more frequently to dying patients and bereavement events. According to Lange *et al.*,[26] nurses with previous experience working with dying patients had a better attitude toward EOL care and dying. On the other hand, nurses without experience with those patients tend to express fear of death and have unfavourable attitudes toward EOL care.[14]

CONCLUSION

This study has shown that nurses working in Kuwaiti hospitals have a favourable attitude toward care for dying patients but an unfavourable perception toward making conversation with patients about death. Further, the current study identified nationality and type of hospital, age, year of experience, education level, and place of work as factors that affect the attitude toward caring for dying patients.

Implications and recommendations

The current study is the first to examine nurses' attitudes toward care for dying patients in Kuwait, which provides evidence about the required clinical modifications. Based on this study's results, it is essential to integrate the EOL care principles into the nursing curriculum (undergraduate and graduate), training, and orientation programs for nurses who care for terminally ill patients. Further, delivering education and awareness to nurses about death and dying in Kuwait might be a promising intervention to improve their attitude and sensitise the concept of death among them. The current study provides insight into several future research studies. For instance, future research should investigate the impact of nurses' attitudes on the quality of patients' outcomes and their satisfaction with nursing care.

Strength and limitations

The current study's main strength is that it is the first to assess the levels of attitude among nurses in Kuwait. Another significant strength is the large sample size and that participants were recruited from several sectors across

Kuwait. However, this study is not without limitations; the sampling technique used a convenient sampling to recruit participants, which may hinder the results' generalizability.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent.

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Conflicts of interest

There are no conflicts of interest.

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