Nurses' attitudes toward palliative care in south-east Iran

Farideh Razban, Sedigheh Iranmanesh, Hossein Rafiei

Abstract

Background: Nurses are the element of the palliative care team who spend the most time with patients. Nurses' attitudes toward palliative care affect their behaviour toward their patients. ***Aim:*** This study sought to examine oncology and intensive care unit (ICU) nurses' attitudes toward palliative care in south-east Iran. ***Methods:*** A self-administered questionnaire was used to assess the palliative care attitudes of 140 oncology and ICU nurses from three hospitals supervised by Kerman University of Medical Science. ***Results:*** Participants had moderately negative to neutral attitudes toward palliative care (2.99±0.29 out of 5). Among all categories, the highest mean score came from the category of 'patient's preferences' (mean=3.66) and the lowest from the category of 'withholding and withdrawing treatment' (mean=2.42). A significant correlation was found between nurses' attitudes toward palliative care and some demographic characteristics, including marital status, type of ward, palliative care education, personal study about palliative care, level of education, and experience of caring for a dying family member. ***Conclusions:*** This study suggests that educational designers should include specific courses about death and palliative care in undergraduate and postgraduate nursing curricula. Educational programmes need to build on the specific experiences of death and dying among nurses and auxiliary nurses.

Key words: Iranian nurses ● Attitude ● Palliative care

Among the multidisciplinary palliative care team, nurses are often the first health professionals to assess patients and recognise their suffering (Ouimet Perrin et al, 2011). Nurses also spend the most time with patients (Thacker, 2008) and take part in related decision-making processes (Latour et al, 2009). To fulfil their responsibilities, palliative care nurses should show empathy, honesty, acceptance, and authenticity, which are strongly correlated with their attitudes (Simon et al, 2009). Attitudes are believed to be an important determinant of behaviour (Corner and Bailey, 2009), although a change in attitude will not necessarily lead to a change in behaviour (Fishbein and Ajzen, 2011). Attitudes toward palliative care are thus an important factor in the behaviour of nurses who are responsible for caring for people at the end of life.

Nurses who have negative attitudes toward death and dying avoid direct communication with dying patients and are reluctant to tell the truth and discuss disease and death openly with them (Smeltzer et al, 2009). These nurses transfer their own fear, anxiety, hopelessness, and helplessness to dying patients (Corner and Bailey, 2009). Negative attitudes toward palliative care may discourage nurses from seeking or accepting referrals to palliative care services until the patient's condition is very advanced (Hasson et al, 2010). Negative attitudes toward palliative care are also frequently mentioned as a barrier to its appropriate provision (Rhee et al, 2008; Lynch et al, 2009; Jünger et al, 2010; Gardiner et al, 2011). Latour et al (2009) reported that attitudes toward end-of-life care influenced nurses' decision making regarding palliative care.

Several studies have assessed nurses' attitudes toward different aspects of palliative care. Knapp et al (2011) assessed 279 nurses' attitudes toward hospice and palliative care and reported a positive correlation between education and different aspects of that care. Abu-Saad Huijer and Dimassi (2007) in Lebanon assessed nurses' and physicians' attitudes toward palliative care in different wards using a self-administered questionnaire. They found that acute critical care and oncology staff had more positive attitude scores than staff in other wards. Latour et al (2009) also used a self-administered questionnaire to examine the attitudes of European intensive care nurses toward end-of-life care. The majority of respondents reported that they were likely to provide continuous pain relief and endorse open visiting. They disagreed that dying patients should be transferred to a single room. Forty four per cent of the sample agreed that patients should be kept deeply sedated at the end of life, and 41.6% contested the continuation of nutritional support (Latour et al, 2009).

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'... end-of-life care is still a new topic in Iran ... In the whole of Iran ... there is no specific hospice care like that in Western countries.'

Three studies have examined Iranian nurses' and nursing students' attitudes toward caring for dying patients (Iranmanesh et al, 2008a; 2008b; 2010), using the Frommelt Attitudes Toward Care of the Dying (FATCOD) scale. These three studies found that Iranian nurses and nursing students do not have positive attitudes toward caring for people who are dying. The samples in this study were from Kerman province in south east Iran.

Some 98% of Iranian people are Muslim (Curtis, 2010), and death is one of the core subjects of Islam. In Iran, death is culturally well reflected in Rumi's *Mathnavi*. According to Zahedi et al (2007), Rumi used the words 'dying' or 'being reborn in stages' to refer to the change of the human embryo from spiritless matter into the vegetative form, then into the animal form, and finally into the human form. However, end-of-life care is still a new topic in Iran and indeed at the Kerman University, where the education for registered nurses (RNs) is a 4-year training programme at Bachelor of Science level. The nursing education curriculum does not include any specific academic or clinical training about palliative care, even though the subjects of death and dying are included in other courses. In the whole of Iran, including Kerman province, there is no specific hospice care like that in Western countries (Cheraghi et al, 2005). However, there is a tendency that the hospitals provide palliative care for people at the end of life.

Some studies have assessed nurses' attitudes toward caring for dying people in Iran (Iranmanesh et al, 2008; 2009; 2010), but the authors are aware of no studies that have assessed Iranian health professionals' attitudes toward palliative care.

Aim

This study was conducted to examine the attitudes of RNs and auxiliary nurses (ANs) in oncology and intensive care toward palliative care in south-east Iran. In the Iranian health-care system, as stated by Nikbakht Nasrabadi and Emami (2006), RNs complete a 4-year Bachelor's degree at a university and then pass a national licensing examination. ANs complete a 3-year vocational training programme, which does not require a high school diploma.

Materials and methods

Design and ethical considerations

The study used a cross-sectional descriptive design. Because it involved human subjects, project approval was obtained from both Kerman University of Medical Science and the heads of the three hospitals the university supervises prior to the collection of any data.

Instruments

First a questionnaire was designed to obtain background information that was assumed to influence attitudes toward palliative care. It was developed based on four categories: personal characteristics such as gender, age, marital status, and education; professional characteristics such as previous education about palliative care, nursing experience, and experience of caring for dying people; experience of caring for a dying family member or previous personal study about palliative care; and religiosity index, consisting of intrinsic (belief in God) and extrinsic (attendance at religious services and activities) religiosity.

A self-designed questionnaire was developed to examine RNs' and ANs' attitudes toward palliative care. The items were formulated based on the literature, analysis of similar questionnaires (Frommelt, 1991; Bjarnason, 2007; Latour et al, 2009; Csikos et al, 2010), and the first author's experience in conducting qualitative studies in this area. The instrument was designed in Farsi and consisted of 34 items divided into 6 categories: truth telling (items 1–7), communication (items 8–12), advance directives (items 13–16), life-prolonging care (items 18–24), patient preferences (items 26–31), and withholding and withdrawing treatment (items 32–34, 17 and 25). The instrument was scored on a five-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Eleven items were worded negatively and 23 positively. Thus, the scores of negative items were reversed. Scores greater than 3 indicated positive attitudes and scores less than 3 indicated negative attitudes.

The questionnaire's content validity was assessed by ten members of the Razi Faculty of Nursing and Midwifery, who reviewed its representative and cultural aspects. These experts were also asked to rate each item based on relevance, clarity, and simplicity on a four-point scale. The researchers analysed the results. The content validity score was acceptable (96.8%). To assess the reliability of the scale, alpha coefficients of internal consistency (n=20) were computed. The alpha coefficient for this instrument was 0.92. The scale therefore had acceptable reliability and validity.

Setting and sample

The study sample comprised RNs and ANs from three hospitals supervised by Kerman University of Medical Science (Shahid Bahonar, Afzalipour, and Shafa Hospitals). Afzalipur is a general hospital with 364 active beds, Shahid Bahonar is a

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trauma hospital with 302 active beds, and Shafa is a public hospital with 368 active beds. These three hospitals are in a region known as Kerman in the centre of Kerman province and provide medical services for all parts of the province.

Nurses were required to have more than 6 months' experience of working in ICU and oncology wards. It was assumed that experienced nurses are more likely to be involved with palliative care.

Data collection

Potential participants were introduced to the researcher by the head of each ward between April and May 2012. To ensure that all eligible staff were provided with an opportunity to participate, the wards were repeatedly visited by a researcher, covering all three staff shifts (days, evenings, and nights). Some oral information about the study was also given by the second author. Participation in the study was voluntary and anonymity was assured. A total of 145 questionnaires were handed out by the first researcher, along with a letter providing information about the aims of the study. Completion indicated consent, and 121 completed questionnaires were returned. Within these, 89% of all questions were answered.

Data analysis

The data from the questionnaires was analysed using the Statistical Package for the Social Sciences (SPSS 16). A Kolmogorov–Smirnov test indicated that the data was sampled from a population with a normal distribution. Descriptive statistics were computed for the study variables. Pearson's correlation coefficient was used to examine the correlation between the nurses' attitude toward palliative care scores and demographic factors such as age, nursing experience, experience of caring for a dying family member, and experience of caring for dying people. Pearson's correlation coefficient was used as a measure of the linear correlation between two variables. The independent T-test was used to examine correlations between nurses' attitude toward palliative care scores and some other demographic factors, including ward, gender, palliative care education, and previous personal study about palliative care. One-way ANOVA was used to assess the association between education and religiosity. The significance level was set at 0.05.

Results

Participant demographics

The participants were aged from 20 to 45 years (mean 31.6 years) and were mainly female (92.4%) and married (74.8%) (*Table 1*). Most had Bachelor of Science in nursing degrees (75.4%) but stated that they had received no formal education about palliative care (78.4%). 59.3% had undertaken no personal study about palliative care. 81.1% were working in ICU and 18.9% in oncology. The sample had 8.4 years' mean experience of nursing and 5.7 years' mean experience of caring for dying people. 13.7% had experience of caring for a dying family member. All respondents were Muslim and Shia. The

Table 1. Participant demographic data

Variable	Number	Percentage
Age: 20–30 years	40	36.3%
31–40 years	58	52.7%
>40 years	12	10.9%
Gender: male	9	7.6%
Female	109	92.4%
Education: diploma	20	16.9%
Bachelor of Science	89	75.4%
Master of Science	9	7.6%
Ward: oncology	21	18.9%
Intensive care unit	90	81.1%
Nursing experience: 1–5 years	51	47.6%
6–10 years	31	28.9%
11–15 years	10	9.3%
16–20 years	9	8.4%
>20 years	6	5.6%
Experience of caring for dying people: 1–5 years	58	58.0%
6–10 years	33	33.0%
11–15 years	4	4.0%
16–20 years	4	4.0%
>20 years	1	1.0%
Experience of caring for a dying family member: none	82	86.3%
1–5 months	11	11.6%
6–25 months	2	2.1%
Formal palliative care education: yes	24	21.6%
No	87	78.4%
Previous personal study about palliative care: yes	46	40.7%
No	67	59.3%
Religion: Shia	115	100%
Intrinsic religiosity: always	119	98.3%
Sometimes	2	1.7%
Never	0	0%
Extrinsic religiosity: daily	30	25%
Few times per week	39	32.5%
Few times per month	35	29.2%
Few times per year	16	13.3%
Never	0	0%

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Table 2. Nurses' attitudes toward palliative care

Categories	Questions	Mean score (SD)
Truth telling (overall mean 2.92; SD 0.38)	It is the patient's right to know about the prognosis of their terminal illness	4.01 (1.10)
	Knowing the prognosis of their terminal illness gives the patient and his/her family a sense of hopelessness	1.98 (0.99)
	The patient can be informed about the prognosis of their terminal illness if it is the physician's judgement that this would be beneficial	1.65 (0.87)
	The patient can be informed about the prognosis of their terminal illness if it is the nurse's judgement that this would be beneficial	2.20 (1.08)
	In a dilemma of whether or not to tell the patient the truth, the patient or family decision should be followed	3.23 (1.08)
	It is the physician's role to inform the patient/family about the prognosis	4.09 (0.95)
	It is the nurse's role to inform the patient/family about the prognosis	3.29 (0.95)
Communication (overall mean 3.11; SD 0.61)	When a patient asks, 'Nurse am I dying?', I think it is best to change the subject to something cheerful	2.87 (1.12)
	It is beneficial for the dying person to verbalise his/her feelings	4.03 (0.86)
	It is difficult for me to speak about death and dying with the patient/family	2.09 (0.90)
	It is difficult for me to make a close relationship with dying person and his/her family	2.62 (1.11)
	As a patient nears death, preferably the nurse should withdraw from him/her	3.93 (1.03)
Advance directives (overall mean 3.53; SD 0.75)	It is necessary to educate the dying patient about their right to choose the nature of their treatment	4.00 (1.02)
	Patients should be asked their opinion about being resuscitated	2.66 (1.32)
	Patients' suggestions about the nature of their treatment should be considered	3.76 (0.87)
	Patients' opinions about the progression of their palliative care should be considered	3.69 (1.10)
Life-prolonging care (overall mean 2.46; SD 0.54)	The terminally ill patient should not continue to receive fluid to maintain hydration	2.31 (0.86)
	If oro/endotracheal suction is causing distress it should not be continued to maintain the airway of the dying patient	2.58 (1.17)
	The terminally ill patient should not continue to receive all interventions to prevent pressure sores if these are invasive	2.65 (1.18)
	If the patient is able to breathe spontaneously, the endotracheal tube should be removed	3.04 (1.17)
	During end-of-life care, the nutritional support of the patient should be continued	1.66 (0.63)
	Nutritional support should be continued during palliative care	2.22 (0.93)
	Opioids are routinely administered insufficiently for dying patients in my unit	2.80 (1.15)
Patient's preferences (overall mean 3.66; SD 0.78)	The family and friends of the patient should be permitted to visit the patient at any time the patient prefers	3.98 (0.99)
	The terminally ill patient and his/her family should always be given the opportunity to receive rituals at any time	4.06 (1.03)
	Dying patients' favorite foods should be provided	3.91 (1.01)
	Dying patients' preferred place of death should be asked	3.19 (1.24)
	The patient should not be cared for in the privacy of a private room	3.47 (1.16)
	Analgaesic drugs should be administered according to patient request	3.33 (1.27)
Withholding and withdrawing treatment (overall mean 2.42; SD 0.65)	The most appropriate type of care for terminally ill patients is primarily palliative care	3.32 (1.23)
	When cure seems unfeasible, treatment should be stopped	2.39 (1.23)
	When cure seems unfeasible, treatment should not be started	2.38 (1.17)
	The most appropriate type of care for terminally ill patients is a combination of curative treatment and palliative care	1.85 (0.77)
	The most appropriate type of care for terminally ill patients is continuous curative treatment of the disease until death	2.14 (1.06)

SD, standard deviation

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majority of the participants (98.3%) stated that they always experience the existence of God in their daily living.

Descriptive findings

Descriptive analysis indicated that the participants had moderately negative to neutral attitudes toward palliative care, with a total mean score of 2.99 out of 5 (*Table 2*). Among the individual items, the highest mean score was 4.09 for item 6, 'It is the physician's role to inform the patient/family about the prognosis of their terminal illness'. The lowest mean score was 1.65 for item 3, 'The patient can be informed about the prognosis of their terminal illness if it is the physician's judgement that this would be beneficial'. Among the categories, the highest mean score was 3.66 for 'patient's preferences' and the lowest mean score was 2.42 for 'withholding and withdrawing treatment'.

The majority of the participants reported that they disagreed with discontinuation of care that could prolong a patient's life (81.8%). 77.7% of respondents had negative attitudes toward withholding or withdrawing treatments. Most of the participants (78.5%) reported that they were likely to follow the preferences of dying patients. Similar numbers had positive attitudes toward advance directives (71.9%). However, only 48.8% were likely to communicate with dying patients, and 46.3% were unlikely to tell the truth about the patient's illness to the patient or their families. As shown in *Table 3*, the RNs had more positive attitudes toward palliative care (total mean 3.01) than the ANs (total mean 2.80).

Table 3. Registered nurses' and auxiliary nurses' attitudes toward palliative care

Category	Registered nurses (*n*=98) (mean (SD))	Auxiliary nurses (*n*=18) (mean (SD))
Truth telling	2.88 (0.39)	3.05 (0.25)
Communication	3.14 (0.57)	2.99 (0.70)
Advance directives	3.56 (0.71)	3.17 (0.75)
Life-prolonging care	2.52 (0.52)	2.24 (0.60)
Patient's preferences	3.72 (0.67)	3.31 (1.21)
Withholding and withdrawing treatment	2.48 (0.62)	2.17 (0.75)
Total score	3.01 (0.26)	2.80 (0.33)

SD, standard deviation

Correlations

As shown in *Table 4*, a significant correlation was found between the nurses' attitudes toward palliative care and some of their demographic characteristics, including marital status, type of ward, palliative care education, personal study about palliative care, level of education, and experience of caring for a dying family member. Those who were an RN, single, and worked in ICU were more likely to have positive attitudes than those who were an AN, married, and worked in oncology units. More positive attitudes were also found among nurses who were more educated about palliative care and those who had carried out professional or personal study about palliative care.

Discussion

The aim of this study was to assess ICU and oncology nurses' attitudes toward different aspects of palliative care. The results indicate that the participants had moderately negative to neutral attitudes toward palliative care (total mean score 2.99 out of 5). Pevious studies have reported similar findings (Iranmanesh et al, 2008a; 2008b; 2010). Using the FATCOD scale, Iranmanesh et al (2008a) conducted a study among nursing students in Bam and Kerman. Using the same tool, Iranmanesh et al (2008b) examined nurses' attitudes toward caring for dying patients in a hospital in the capital of Iran, Tehran. The studies found that nurses and nursing students did not have positive attitudes toward caring for dying patients. In a study in 2010, Iranmanesh et al compared Iranian and Swedish nursing students' attitudes toward caring for dying patients. This study revealed that the Swedish nursing students had more positive attitudes than the Iranian nursing students.

Some cultural and organisational factors may cause Iranian nurses and student nurses to lack positive attitudes toward caring for palliative care. Among Iranian nurses, kinship relationships are an important factor that influences their caring behaviours (Iranmanesh et al, 2008a). In the Iranian context, the culture of kinship relationships or family relations and sentiments are so strong that being with a close dying family member may paralyse the family (Iranmanesh et al, 2008; 2010; Lange et al, 2008; Braun et al, 2010). In this regard, Cheraghi et al (2005) also described that the lack of development of end-of-life care could be related to the traditional cultural system in which, for instance, old people prefer to die at home with family around them rather than in hospital.

Another possible explanation of this finding may be the lack of palliative care education and specific training among Iranian nurses. The results of an earlier study showed that nurses in south-east Iran have a low level of knowledge

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Table 4. Correlation between the nurses' attitudes and aspects of their background information

Category	Marital status (T test/ significance)	Type of ward (T test/ significance)	Palliative care education (T test/ significance)	Personal study about palliative care (T test/significance)	Level of education (ANOVA test/ significance)	Experience of caring for a dying member of family (T test/significance)
Truth telling	T=0.26	T=-0.86	T=0.64	T=2.60**	F=2.43	T=-0.04
Communication	T=1.67	T=2.75**	T=-0.43	T=1.65	F=2.79	T=-1.00
Advance directives	T=2.04*	T=-1.15	T=-0.41	T=1.44	F=3.95*	T=-2.05*
Life-prolonging care	T=0.85	T=-1.50	T=-2.03*	T=-0.20	F=1.69	T=-1.26
Patient's preferences	T=2.37*	T=0.37	T=-2.32*	T=0.38	F=5.14**	T=-0.44
Withholding and withdrawing treatment	T=0.80	T=-1.44	T=-0.59	T=-0.39	F=1.80	T=-1.36
Total score	T=2.88**	T=-0.37	T=-2.17*	T=1.49	F=11.42**	T=-2.15*

T-test and ANOVA test significance was at the level of P≤0.05* and P≤0.01**

about palliative care (Iranmanesh et al, in press). Earlier studies in different contexts also showed a positive correlation between nurses' education on and knowledge about palliative care and their attitudes toward it (Frommelt, 1991; 2003; Fischer et al, 2003; Mallory, 2003; Wessel and Rutledge, 2005). In the present study, nurses who had previous education and/or had conducted personal study about palliative care and those with a higher level of education were more likely to have positive attitudes toward it than those without such education. The RNs had more positive attitudes toward palliative care than the ANs, who had a lower level of education. It is expected that nurses lacking knowledge about palliative care would have negative attitudes toward it.

Another possible reason for the participants' negative attitudes toward palliative care is their lack of autonomy in the Iranian health-care system (Zarea et al, 2009). Miyashita et al (2007) concluded that autonomy has a positive impact on nurses' attitudes toward caring for dying people. The lack of autonomy among Iranian nurses could be related to the Iranian public's views on the nursing profession: according to Emami and Nasrabadi (2007), the Iranian public views nursing not as an authoritative profession.

Among the questionnaire categories, the two lowest mean scores were for 'withholding and withdrawing treatment' (mean 2.42) and 'life-prolonging care' (mean 2.46). This could be related to the nurses' religious beliefs. Like most Iranians, the majority of the nurses considered themselves religious (Iranmanesh et al, 2008a), and religious beliefs are often explicitly integrated into views on caring for dying patients. Nurses are expected to pay attention to patients' religious beliefs and activities, such as worship and prayer, to improve the quality of care they provide for dying patients. In addition, the saving of a life is considered as one of the highest merits and imperatives in Islam (Hedayat and Pirzadeh, 2001). Life is seen as a gift of God, and so health-care providers must do everything possible to prevent premature death (Sachedina, 2005). Islam also does not recognise a patient's right to die voluntarily, because life is a divine trust and cannot be terminated by any form of active or passive human intervention, and because its term is fixed by an unalterable divine decree (Hedayat and Pirzadeh, 2001). However, resorting to futile treatments in an attempt to postpone death is not acceptable in Islam (Hedayat and Pirzadeh, 2001).

In the present study, the participants showed moderately positive attitudes toward the general concept of advance directives and allowing patients to make decisions about the type of care and treatment they receive. They had moderately negative attitudes toward some specific aspects of advance directives such as do not resuscitate orders. Iranmanesh et al (2009) found that palliative care requires nurses to support patients' wellbeing through positive stimulation of all means of perceiving the world through human senses, e.g. by offering beautiful views and nice flavours. Palliative care nurses need to know patients' preferences, needs, and values regarding dying and that these are affected by their cultural and religious background (Smeltzer et al, 2009). Advance directives offer a means of recording patients' preferences in case of future loss of capacity or consciousness (Smeltzer et al, 2009). However, although advance directives have been in development in some Western countries

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since around 1991 (Swota, 2009), there is no equivalent in Islamic countries, including Iran (Al-Jahdali et al, 2012). Based on Islamic law, 'decisions about life belong to Allah, not to the person himself and documents to preserve or end personal life are not recognized' (Babgi, 2009). Nevertheless, the Islamic idea of humanity provides a provisional framework in which advance directives can generally be considered legitimate (Haker and Bentele, 2010).

The findings of the present study indicated that 46.3% of participants were unlikely to tell the truth about illness to patients and their families. Likewise, earlier studies in Iran (Iranmanesh et al, 2008a; Kazemi et al, 2010; Beyraghi et al, 2011), Japan (Mayer et al, 2005; Parsons et al, 2007), and Italy (Meñaca et al, 2012) concluded that disclosure of truths regarding terminally ill patients' prognosis is not accepted in these cultures. In Western countries, approximately 80–90% of patients are told the truth about their diagnosis (Zahedi, 2011). Iranmanesh et al (2009) reported that Iranian nurses expressed that cultural limitations and a lack of organisational support prevented them telling the truth to patients and their families. This study found that patients and their families are not prepared to hear about incurable diseases (Iranmanesh et al, 2009). Zahedi (2011) also asserted that nurses in non-Western cultural contexts may have a problem in telling the truth to patients and suggested that this could be related to their lack of skill in communicating bad news.

The results reported here indicate that experience of caring for a dying family member positively correlated with participants' attitudes toward palliative care. This is consistent with the findings of earlier studies (Dunn et al, 2005; Iranmanesh et al, 2008a; Lange et al, 2008). According to Dunn et al (2005), nurses' motivation to care for dying people is affected by their personal and professional experiences related to death and dying. According to Iranmanesh et al (2008a), Iranian nurses who had experience in caring for the dying were more likely to give care to dying persons than those who had not had such experiences. This result was supported by Franke and Durlak's (1990) study, which concluded that caregivers who had experienced the death of a close family member or a near death experience had less anxiety about death than people who had not had such experiences.

The results of the present study also indicated a significant correlation between marital status and attitudes toward palliative care. Single respondents had higher mean scores for their attitudes toward patients' preferences, advance directives, and palliative care. This could be related to death anxiety: the majority of participants were female (92.4%), and Cole (1978) revealed that married women with children had a higher level of death anxiety than single women, apparently because of their concern for the wellbeing of their children and spouse. Moreover, previous studies revealed a negative correlation between death anxiety and attitudes toward the care of dying people (Wessel and Rutledge, 2005; Iranmanesh et al, 2008a). The more positive attitude of single participants could be due to the role of married women in Iran. According to Taleghani et al (2005), in Eastern culture there is a dependency on family members, and in the Iranian culture mothers wanted to survive primarily for the sake of their children.

'More positive attitudes were found among nurses who were more educated about palliative care and those who had carried out professional or personal study about palliative care.'

Conclusion

This study showed that RNs and ANs in south-east Iran had moderately negative to neutral attitudes toward palliative care. The study suggests that educational designers should include specific courses about death and palliative care in undergraduate and postgraduate nursing curricula. The findings also suggest that nurses' attitudes toward palliative care could be improved by establishing a specific palliative care unit to focus on end-of-life care. Experience of caring for a dying family member positively affects nurses' attitudes about palliative care. Novice nurses and nursing students should gain experience in palliative care under experienced preceptorship during their education. Exposure to suitable narratives when under individual or group supervision during clinical practice offers serious prospects for developing a profound education, which at the same time can be seen as supporting essential personal maturation. Further research should examine the effect of the Iranian culture and religion on attitudes toward palliative care. IJPN

Declaration of interest
This study had no external sources of funding. The authors have no conflicts of interest to declare.

Abu-Saad Huijer H, Dimassi H (2007) Palliative care in Lebanon: knowledge, attitudes and practices of physicians and nurses. *J Med Liban* **55**(3): 121–8

Al-Jahdali H, Baharoon S, Al Sayyari A, Al-Ahmad G (2012) Advance medical directives: a proposed new approach and terminology from an Islamic perspective. *Med Health Care Philos* **16**(2) 163–9

Babgi A (2009) Legal issues in end-of-life care: perspectives from Saudi Arabia and United States. *Am J Hosp Palliat Care* **26**(2): 119–27

Beyraghi N, Mottaghipour Y, Mehraban A, Eslamian E, Esfahani F (2011) Disclosure of cancer information in Iran: a perspective of patients, family members, and

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health professionals. *Iran J Cancer Prev* **4**(3): 130–4
Bjarnason D (2007) *Belief Systems and Patient Care: An Examination of the Relationship Between Nurse Religiosity and End-of-life Care*. University of Texas
Braun M, Gordon D, Uziely B (2010) Associations between oncology nurses' attitudes toward death and caring for dying patients. *Oncol Nurs Forum* **37**(1): 43–9
Cheraghi MA, Payne S, Salsali M (2005) Spiritual aspects of end-of-life care for Muslim patients: experiences from Iran. *Int J Palliat Nurs* **11**(9): 468–74
Cole MA (1978) Sex and marital status differences in death anxiety. *OMEGA J Death Dying* **9**(2): 139–47
Corner J, Bailey CD (2009) *Cancer Nursing: Care in Context*. Wiley-Blackwell
Csikos A, Mastrojohn J, Albanese T, Moeller JR, Radwany S, Busa C (2010) Physicians' beliefs and attitudes about end-of-life care: a comparison of selected regions in Hungary and the United States. *J Pain Symptom Manage* **39**(1): 76–87
Curtis EE (2010) *Encyclopedia of Muslim-American History*. Facts on File, New York
Dunn KS, Otten C, Stephens E (2005) Nursing experience and the care of dying patients. *Oncol Nurs Forum* **32**(1): 97–104
Emami A, Nasrabadi AN (2007) Two approaches to nursing: a study of Iranian nurses. *Int Nurs Rev* **54**(2): 137–43
Fischer SM, Gozansky WS, Kutner JS, Chomiak A, Kramer A (2003) Palliative care education: an intervention to improve medical residents' knowledge and attitudes. *J Palliat Med* **6**(3): 391–9
Fishbein M, Ajzen I (2011) *Predicting and Changing Behavior: The Reasoned Action Approach*. Taylor & Francis
Franke KJ, Durlak JA (1990) Impact of life factors upon attitudes toward death. *OMEGA J Death Dying* **21**(1): 41–9
Frommelt KHM (1991) The effects of death education on nurses' attitudes toward caring for terminally ill persons and their families. *Am J Hosp Palliat Care* **8**(5): 37–43
Frommelt KHM (2003) Attitudes toward care of the terminally ill: an educational intervention. *Am J Hosp Palliat Care* **20**(1): 13–22
Gardiner C, Cobb M, Gott M, Ingleton C (2011) Barriers to providing palliative care for older people in acute hospitals. *Age Ageing* 40(2): 233–8
Haker H, Bentele K (2010) *Medical Ethics in Health Care Chaplaincy*. LIT Verlag, Münster
Hasson F, Kernohan WG, McLaughlin M et al (2010) An exploration into the palliative and end-of-life experiences of carers of people with Parkinson's disease. *Palliat Med* **24**(7): 731–6
Hedayat KM, Pirzadeh R (2001) Issues in Islamic biomedical ethics: a primer for the pediatrician. *Pediatrics* **108**(4): 965–71
Iranmanesh S, Dargahi H, Abbaszadeh A (2008a) Attitudes of Iranian nurses toward caring for dying patients. *Palliat Support Care* **6**(4): 363–9
Iranmanesh S, Savenstedt S, Abbaszadeh A (2008b) Student nurses' attitudes towards death and dying in south-east Iran. *Int J Palliat Nurs* **14**(5): 214–9
Iranmanesh S, Axelsson K, Sävenstedt S, Häggström T (2009) A caring relationship with people who have cancer. *J Adv Nurs* **65**(6): 1300–8
Iranmanesh S, Axelsson K, Häggström T, Sävenstedt S (2010) Caring for dying people: attitudes among Iranian and Swedish nursing students. *Indian J Palliat Care* **16**(3): 147–53
Iranmanesh S, Razban F, Tirgari B, Ghazanfari Z (2013) Nurses knowledge about palliative care in South-East of Iran. *Palliat Support Care* (In Press)
Jünger S, Vedder AE, Milde S, Fischbach T, Zernikow B, Radbruch L (2010) Pediatric palliative home care by general pediatricians: a multimethod study on perceived barriers and incentives. *BMC Palliat Care* **9**(11)
Kazemi A, Poursoleimani A, Madayen K (2010) Truth telling in medical filed in Tabriz university of medical sciences. *Iran J Med Ethics History Med* **3**(2): 54–63
Knapp CA, Madden V, Wang H et al (2011) Pediatric nurses' attitudes toward hospice and pediatric palliative care. *Pediatr Nurs* **37**(3): 121–6
Lange M, Thom B, Kline NE (2008) Assessing nurses' attitudes toward death and caring for dying patients in a comprehensive cancer center. *Onc Nurs Forum* **35**(6): 955–9
Latour JM, Fulbrook P, Albarran JW (2009) EfCCNa survey: European intensive care nurses' attitudes and beliefs towards end-of-life care. *Nurs Crit Care* **14**(3): 110–21
Lynch T, Clark D, Centeno C et al (2009) Barriers to the development of palliative care in the countries of Central and Eastern Europe and the Commonwealth of Independent States. *J Pain Symptom Manage* **37**(3): 305–15
Mallory JL (2003) The impact of a palliative care educational component on attitudes toward care of the dying in undergraduate nursing students. *J Prof Nurs* **19**(5): 305–12
Mayer DK, Parsons SK, Terrin N (2005) School re-entry after a cancer diagnosis: physician attitudes about truth telling and information sharing. *Child Care Health Dev* **31**(3): 355–63
Meñaca A, Evans N, Andrew EV et al (2012) End-of-life care across Southern Europe: a critical review of cultural similarities and differences between Italy, Spain and Portugal. *Crit Rev Oncol Hematol* **82**(3): 387–401
Miyashita M, Nakai Y, Sasahara T (2007) Nursing autonomy plays an important role in nurses' attitudes toward caring for dying patients. *Am J Hosp Palliat Care* **24**(3): 202–10
Nikbakht Nasrabadi A, Emami A (2006) Perceptions of nursing practice in Iran. *Nurs Outlook* **54**(6): 320–7
Ouimet Perrin K, Sheehan CA, Potter ML, Kazanowski MK (2011) *Palliative Care Nursing: Caring for Suffering Patients*. Jones and Bartlett Publishers
Parsons SK, Saiki-Craighill S, Mayer DK et al (2007) Telling children and adolescents about their cancer diagnosis: Cross-cultural comparisons between pediatric oncologists in the US and Japan. *Psychooncology* **16**(1): 60–8
Rhee JJ, Zwar N, Vagholkar S, Dennis S, Broadbent AM, Mitchell G (2008) Attitudes and barriers to involvement in palliative care by Australian urban general practitioners. *J Palliat Med* **11**(7): 980–5
Sachedina A (2005) End-of-life: the Islamic view. *Lancet* **366**(9487): 774–9
Simon ST, Ramsenthaler C, Bausewein C, Krischke N, Geiss G (2009) Core attitudes of professionals in palliative care: a qualitative study. *Int J Palliat Nurs* **15**(8): 405–11
Smeltzer SC, Bare BG, Hinkle JL, Cheever KH (2009) *Brunner and Suddarth's Textbook of Medical Surgical Nursing*. 12th edn. Lippincott Williams and Wilkins
Swota AH (2009) *Culture, Ethics, and Advance Care Planning*. Rowman and Littlefield
Taleghani F, Yekta ZP, Nasrabadi AN (2006) Coping with breast cancer in newly diagnosed Iranian women. *J Adv Nurs* **54**(3): 265–72
Thacker KS (2008) Nurses' advocacy behaviors in end-of-life nursing care. *Nurs Ethics* **15**(2): 174–85
Wessel EM, Rutledge DN (2005) Home care and hospice nurses' attitudes toward death and caring for the dying: effects of palliative care education. *J Hospice Palliat Nurs* **7**(4): 212–8
Zahedi F (2011) The challenge of truth telling across cultures: a case study. *J Med Ethics Hist Med* **4**: 11
Zahedi F, Larijani B, Tavakoly Bazzaz J (2007) End of life ethical issues and Islamic views. *Iran J Allergy Asthma Immunol* **6**(Suppl 5): 5–15
Zarea K, Negarandeh R, Dehghan-Nayeri N, Rezaei-Adaryani M (2009) Nursing staff shortages and job satisfaction in Iran: issues and challenges. *Nurs Health Sci* **11**(3): 326–31

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