

Differences in Attitudes Towards Dying Patients Due To Religion and Prior Experiences With Seriously Ill Patients

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Abstract

A study recently published by Weissman (2011) has a number of noteworthy strengths, including the use of instruments with very good measurement reliability and validity; a concise, focused, and well-defined intervention; and the use of appropriate statistical methods in the analysis. However, due to the misclassification of the study as quasi experimental rather than non experimental and the associated incorrect assumption of causality, the conclusion that the education program led to changes in the attitude of nursing students was not supported, and alternative conclusions are offered.

Weissman (2011) categorized their study as quasi experimental and concluded that a particular education program on caring for dying patients delivered to nursing students led to (1) a large change in attitude and (2) no change in self-efficacy in communicating with dying patients. This conclusion was not supported by their data however due to two shortcomings.

First, the study was actually non experimental rather than quasi experimental. The key feature of quasi experimental studies is the matching of participants in the intervention group (receive particular education program) and control group

(regular education program), usually by age, gender, and other characteristics. From their Table 2, it is apparent that matching was not used in the study, therefore it is non experimental in design.

Second, the differences in the attitude scores between the two groups shown in their Table 3 cannot be assumed to be due the different education programs provided to the two groups. These difference could be due to the major differences between the groups for many other factors. For example, 56% of the intervention group identified themselves as being something other than Protestant or Catholic, where only 13% of the control group identified themselves in this manner. Furthermore, 44% of the intervention group considered themselves to have strong religious beliefs compared to 75% for the control group. The

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alternative conclusion can be drawn that these religious differences accounted for the difference in attitude scores. The evidence in favor of this alternative conclusion is equally as strong as the evidence that it is due to the education program.

Another possibility is that the differences in attitude scores was due to differences in previous and outside experiences. Half or more of all students already had death education previously, which confounds the attempt to determine the effect of another round of education, with more students in the intervention group having had previous education than the control group. The intervention group also was also more likely to have a family member who was seriously ill at the time of the education program. The findings can thus be explained by the greater previous and outside experience in the intervention group.

The study has a number of noteworthy strengths, including the use of instruments with very good measurement reliability and validity; a concise, focused, and well-defined intervention; and the use

of appropriate statistical methods in the analysis. However, due to the shortcomings described above, nursing educators and health care providers should not implement the education program described in the study with the expectation of obtaining similar outcomes.

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