Original Article

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Factors associated with a positive attitude to nursing practice of nurses engaged in terminal cancer care

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Abstract

Cancer medicine is becoming more sophisticated and complex, and therefore it is becoming more difficult to care for people at the end of life. This study was performed to identify the nature of positive attitudes to nursing practice of nurses in general hospitals, and to examine their associations with various different factors. The participants were 683 nurses working in 41 wards in eight regional general hospitals. The survey was carried out as an anonymous self-administered questionnaire. Four factors were identified as constituents of nurses' positive attitudes to nursing practice. These consisted of three factors concerning attitudes and knowledge, comprising [The practice of specialist end-of-life specific care], [Making the best arrangements until the end], and [Spiritual care], and one affirmative sentiment, that of [The confidence to nurse someone at the end of life]. The mean score for factors related to knowledge of nursing practice was > 4 points on a 6-point scale, corresponding to "Somewhat applicable," whereas the mean score for the sentiment [The confidence to nurse someone at the end of life] was > 3 points, corresponding to "Not really applicable." In terms of related factors, for all factors other than spiritual care, positive attitudes to nursing practice increased significantly with increasing experience. There was no association with having cared for a dying family member. Although having experienced an educational opportunity was not associated with the practice of case conferences for deceased patients, it was significantly associated with the experience of having been able to talk at length about the care they had provided and their own thoughts in venues such as case conferences, receiving recognition by colleagues at their own level of seniority or above, and reflection. Improving nurses' positive attitudes to nursing practice in end-of-life care in general hospitals, therefore, depended not on personal characteristics, such as having taken care of a dying family member, but rather on having repeatedly overcome difficulties in the course of nursing experience. Talking at length about care and expressing one's own thoughts, receiving recognition from colleagues at one's own level of seniority or above, and reflection on nursing practice were all important in this process.

KEY WORDS

General hospitals , terminal cancer care , positive attitudes to nursing practice , case conferences for deceased patients , reflection

Introduction

With the recent increase in the number of cancer patients, increasing sophistication and complexity of cancer treatment, and widespread availability of healthcare information, the treatment choices faced by patients and their families are becoming more difficult, as are healthcare choices in general[1)]. The higher the expectations of treatment, the harder it is to accept a terminal diagnosis,

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and this makes the transition from active treatment to best supportive care (BSC) more difficult. In practice, disagreements and conflict between patients and their family members, or between patients and their families on the one hand and medical professionals on the other, are not uncommon when patients themselves or their family members are having difficulty in accepting the medical situation. In other words, they have difficulty facing death as the endpoint of terminal care[2].

Starting in the early 1980s, end-of-life care in Japan has aimed to enable patients to spend the time remaining to them in tranquility and with a good quality of life (QOL), with patients, their families, and medical professionals all squarely facing up to the prospect of death. As death-related care makes demands both on the skills of nurses who are treating individuals suffering from holistic pain and distress, and on their views of life and death, the possibility of burnout was predicted from the beginning, and studies focusing on the difficulties felt by nurses were begun in Japan in the late 1980s. Kango no naka no shi ("Death in the context of nursing")[3], written by Sister Teramoto Matsuno and published in 1985, was a highly influential publication that described the respect for the human person and the profound skills involved in the practice of nursing dying individuals.

A search of the Japan Medical Abstracts Society database returned 143 previous studies of the emotions felt by nurses engaged in end-of-life care. Their content focused mainly on difficulties and stress, with only 29 positive studies of aspects such as motivation and satisfaction. This tendency was also evident in overseas publications, with a search of the Cumulative Index to Nursing and Allied Health Literature (CINAHL) database for "terminal care" with the key words "positive" and "attitude" returning only 32 hits. The content analysis studies included one by Strang et al.[4] in which the investigators held group reflection sessions with the aim of describing nurses' reflections on existential questions arising in the course of communicating with dying patients, and indicated the importance of talking about existential questions and of a supportive environment. Lange et al.[5] also carried out a questionnaire survey of nurses working in cancer centers, and found that those with longer practical experience had more positive attitudes toward death and caring for dying patients. In Japan, Iwase et al.[6] surveyed nurses' satisfaction with patient care, and explained that this was associated with the duration of hospitalization and length of experience. In terms of the development of scales, Sato et al.[7] developed the Terminal Phase Patient Support Cognitive-Behavioral Scale for medical professionals, and carried out an analysis including medical professional conflict. The factors concerned are "helplessness" and "patient-directed support." Nishida[8] also used the Finding Benefits Scale to analyze the personal development of nurses who had experienced a patient's death, and suggested that engaging in a range of coping behaviors is effective in leading to personal development.

In terms of qualitative studies, Onishi[9] carried out a study to identify "positive awareness" and the process of changes in attitude on the part of nurses. She conceptualized "positive awareness" in the context of end-of-life care as "the attitude of not running away from death," and schematized the process of change from the attitude of running away from death and the factors that influenced this in terms of length of experience, life history experience, and enjoyable experience of educational opportunities. Most of those studies identified the importance of educational opportunities.

All the other studies of satisfaction with end-of-life care were case studies describing positive emotions about caring for a dying patient or nurses' personal development as a result of nursing practice, response, or motivation.

The objectives of the present study were to identify nurses' positive attitudes to terminal cancer care, the extent to which they were engaged in practices specific to end-of-life care, and factors associated with these attitudes and practices, specifically their association with reflection and case conferences for deceased patients.

Operational Definitions of Terms

・Positive attitudes to nursing practice: These comprised two elements. The first was nursing practice for terminal cancer that was understood positively by nurses. This referred to practices that tailored to the specific circumstances of end-of-life care. The types of practice that were regarded positively included the assessment of patients who were close to death, family care, spiritual care, and mediation with relatives and friends. The second element consisted of positive feelings as a result of the reactions of patients and their families.

・Experience of an educational opportunity: This

referred to an experience with educational implications that influenced the knowledge and practice of nurses engaged in end-of-life care. Such experiences included opportunities to talk about feelings concerning death and bereavement, recognition from colleagues at one's own level of seniority or above, and reflection.

Study Methods

1. Study design: This was a quantitative descriptive study using a cross-sectional questionnaire survey.

2. Study participants: 722 nurses working in 41 wards for terminal cancer patients in eight general hospitals in a single Japanese prefecture.

3. Survey period: September–November 2016

4. Survey method: The survey was carried out as an anonymous self-administered questionnaire. Permission was obtained from the directors of nursing departments and head ward nurses before questionnaires were distributed in the wards. After they had been left for two weeks, they were collected in a collection box.

5. Survey items

1) Basic attributes

The survey asked about length of clinical experience (in years), age (in age groups increasing in 5-year increments from the age of 20), experience of caring for a dying family member, experience of supporting a family member who was battling disease, and experience of battling disease oneself.

2) Creation of questionnaire on nurses' positive attitudes in terminal cancer care

A questionnaire was first produced with reference to Iwase et al.'s satisfaction scale[6], with the following five subconcepts: "Patient assessment," "Spiritual communication," "Nursing care practice, including attitude," "Mediation," and "Positive feelings." Iwase et al.'s scale consists of 20 items on the subconcepts of "Relationship with patients," "Patient suffering," "Family care," "Team medicine," and "Abilities as a professional," but we devised our own schema to more clearly identify the content of practice.

As the next step, we isolated practices that were considered to lead to a positive attitude from ten published case studies[10-13] describing the practice of end-of-life care in general hospitals, and used these to produce a five-subconcept, 36-item questionnaire. The validity of the content was considered by researchers studying cancer nursing and end-of-life nursing as well as by nurses with clinical experience in cancer nursing, and three items with different levels of abstraction for positive attitude were excluded to leave 33 items in the questionnaire.

Each of the questionnaire items was graded on a six-point scale, as either "No experience or not at all applicable," "Hardly applicable," "Not really applicable," "Somewhat applicable," "Quite applicable," and "Highly applicable."

3) Experience of educational opportunities

Experience of educational opportunities was confirmed by asking whether any of the following were true for respondents: (1) case conferences for deceased patients were held in their ward; (2) they had been able to talk at length about the care they had provided and their own thoughts in such a case conference; (3) they had received recognition from colleagues of their own level of seniority or above; and (4) they engaged in regular reflection on care.

6. Analytical method

Descriptive statistics were generated for basic attributes, nurses' positive attitudes toward nursing practice, and educational opportunities. Exploratory factor analysis of nurses' positive attitudes toward nursing practice was performed.

One-way analysis of variance (ANOVA) was carried out for nurses' positive attitudes toward nursing practice and length of experience, with 1–2 years of experience were classed as novices, those with 3–10 years as mid-career (divided into early and late), and those with ≥ 11 years as veterans. A t-test was used to investigate the association between nurses' positive attitudes toward nursing practice and whether or not they had experience in caring for a dying family member, supporting a family member battling disease, or battling disease themselves. The statistical software used for analysis was SPSS Statistics 22.

7. Ethical considerations

We explained the purpose and meaning of this study to individual participants both orally and in writing. We also explained that participation in this study was voluntary, and other ethical consideration such as personal information protection and the limitation of use of said personal information within this study. Return of the questionnaire responses was considered consent for participation in this study. This study was approved by

the Ethics Committee of the Medical School of the authors' university. (No. HS28-2-2)

Results

A total of 864 questionnaires were distributed, and 737 responses were received (a response rate of 85.3%). Of these, 683 were valid responses with no omissions (a valid response rate of 92.8%).

1. Basic attributes of participants (Table1)

The largest proportion of respondents were aged 25–29 (n = 212), followed by those aged 20–24 (n = 120) and 30–34 (n = 99). The mean length of clinical experience was 10.1 ± 8.5 years, with 101 nurses (14.9%) having 1–2 years of experience, 181 (26.8%) 3–5 years, 195 (28.9%) 6–10 years, and 198 (29.3 %) 11 years or longer. Total 376 nurses (55.9%) worked at advanced treatment hospitals, and among them, 300 nurses (43.9%) were at the completion level of university.

Table 1. Basic attributes of subject

Attribute classification			Number of respondents	rate(%)
Age	n=672	20~24	120	(17.6)
		25~29	212	(31.0)
		30~34	99	(14.5)
		35~39	76	(11.1)
		40~44	70	(10.2)
		45~49	61	(8.9)
		50~54	18	(2.6)
		55~59	15	(2.2)
Length of experience	n=675	10.1±8.5year		
Educational background	n=674	University	300	(43.9)
		Junior college	65	(9.5)
		Vocational school	292	(42.8)
		graduate school	11	(1.6)
		other	6	(0.9)

2. Factorial structure of positive attitudes toward nursing practice felt by nurses in terminal cancer care (Table2)

We carried out an exploratory factor analysis of the 33 items using maximum-likelihood estimation and varimax rotation. Items 2 and 9, for which the factor loading was ≥ 1, and Items 8 and 20, for which the factor loading was ≤ 0.4, were excluded. Although the factor loading for Item 31 was also ≤ 0.4, it was retained by the investigators as important, leaving 29 items in 4 factors. The cumulative contribution rate was 51.6% and the overall reliability coefficient (α coefficient) was 0.96.

The interpretation of the content of the items associated with each factor resulted in the four factors being named as follows: Factor I, [The practice of specialist end-of-life–specific care], Factor II, [Making the best arrangements until the end], Factor III [The confidence to nurse someone at the end of life], and Factor IV, [Spiritual care]. In this paper, the names of factors are indicated by [Square brackets] and questionnaire items are indicated by <Angular brackets>.

The mean scores for each factor were as follows: [The practice of specialist end-of-life–specific care], 4.2 ± 0.5; [Making the best arrangements until the end], 4.2 ± 0.6; [The confidence to nurse someone at the end of life], 3.5 ± 0.7; and [Spiritual care], 4.0 ± 0.7, with [Making the best arrangements until the end] having the lowest score of the four factors.

The highest mean score for a questionnaire item was 4.7 ± 0.9 for <Q22 Capable of consulting a doctor about pain control> in [Making the best arrangements until the end]. In terms of each individual factor, the highest mean score for an item related to [The practice of specialist end-of-life–specific care] was 4.6 ± 0.8 for <Q10 Capable of adopting a caring attitude towards patients>, and the lowest was 3.9 ± 0.8 for <Q3 Capable of supporting the ideas and wishes of patients' families]. For [Making the best arrangements until the end], the highest mean score was 4.5 ± 0.8 for <Q29 Creating an atmosphere in which patients find it easy to talk>. For the factor with the lowest score among the four, [The confidence to nurse someone at the end of life], the item with the lowest mean score was <Q15 Confident in all aspects of end-of-life care>.

3. Factors in nurses' positive attitudes to nursing practice and participants' length of experience (basic attributes)

In terms of the association between length of experience and the various factors in nurses' positive attitudes to nursing practice, length of experience was significantly associated with [The practice of specialist end-of-life–specific care] ($F(3,671) = 2.889$, $p < 0.05$), [Making the best arrangements until the end] ($F(3,671) = 13.893$, $p < 0.000$), and [The confidence to nurse someone at the end of life] ($F(3,671) = 12.817$, $p < 0.000$). For [The practice of specialist end-of-life–specific care], there was

a significant difference between nurses with 1–2 years of experience and those with ≥ 14 years, with the latter scoring higher. For [Making the best arrangements until the end], nurses with 1–2 years of experience had significantly lower scores. For [The confidence to nurse someone at the end of life], nurses with ≥ 14 years of experience scored significantly higher. There was no association between [Spiritual care] and length of experience. (Table3)

4. Association between life events and the four factors in nurses' positive attitudes to nursing practice

The associations with the life events of experience of caring for a dying family member, experience of supporting a family member who was battling disease, and experience of battling disease oneself were as follows. (Table4)

Of the respondents, 310 (46.1%) had the experience of caring for a dying family member, 206 (30.6%) of supporting a family member battling disease, and 61 (9.1%) of battling disease oneself. There was no significant

Table 2. Factorial structure of positive attitudes toward nursing practice felt by nurses in terminal cancer care n=683

Question item	Mean±Standard deviation	1	2	3	4
Factor1 [The practice of specialist end-of-life–specific care]		**4.2±0.5**			
4 Capable of intentional engagement that enables a change of mood	4.2±0.8	**.635**	.148	.147	.206
5 Capable of helping patients to achieve what they want to do	4.0±0.8	**.635**	.121	.306	.231
6 Highly regarded by patients and their family members	4.1±0.7	**.605**	.220	.232	.195
16 Capable of maintaining patients' self-respect by meeting their physiological needs	4.1±0.8	**.555**	.308	.238	.127
10 Capable of adopting a caring attitude towards patients	4.6±0.8	**.548**	.409	.105	.209
7 Capable of adopting an attitude of quiet support in times of great mental agitation	4.3±0.8	**.544**	.303	.187	.155
14 Capable of using physical contact for reassurance	4.4±0.8	**.515**	.313	.153	.175
12 Feeling that the distance between nurse and patient is being lessened	4.2±0.8	**.486**	.151	.250	.337
3 Capable of supporting the ideas and wishes of patients' families	3.9±0.8	**.477**	.207	.319	.175
17 Capable of creating an environment in which it is possible to relax with familiar people	4.1±0.8	**.475**	.355	.239	.256
1 Capable of inferring patients' thoughts and wishes	4.3±0.7	**.468**	.235	.215	.197
25 Capable of seeing patients as individual human beings	4.5±0.8	**.426**	.423	.030	.392
Factor2 [Making the best arrangements until the end]		**4.2±0.6**			
32 Capable of making arrangements for family members to be present at a patient's final moments	4.3±1.0	.155	**.633**	.353	.124
22 Capable of consulting a doctor about pain control	4.7±0.9	.247	**.609**	.139	.142
19 Capable of intentionally explaining a patient's condition or care to their family members	4.3±0.9	.376	**.539**	.217	.125
21 Capable of intentionally providing family members with opportunities to do things for patients	4.0±0.9	.264	**.444**	.283	.387
18 Capable of making the best effort to ensure that patients end their days in peace	4.0±0.9	.327	**.443**	.388	.209
28 Capable of supporting family members forced into making decisions	3.7±1.0	.175	**.441**	.432	.381
29 Creating an atmosphere in which patients find it easy to talk	4.5±0.8	.422	**.438**	.110	.318
11 Capable of anticipating changes in patients' conditions	4.3±0.8	.421	**.437**	.277	.104
31 Capable of responding immediately even to trivial complaints	3.9±0.8	.387	**.397**	.310	.228
Factor3 [The confidence to look after someone at the end of life]		**3.5±0.7**			
23 Satisfied overall with the end-of-life care I provide	3.1±1.0	.211	.232	**.773**	.142
15 Confident in all aspects of end-of-life care	3.0±1.0	.297	.166	**.760**	.160
30 Feeling that patients are satisfied with how they end their days	3.5±0.9	.199	.308	**.515**	.270
33 Feeling that people depend on me	3.9±0.9	.333	.352	**.493**	.227
13 Able to have opportunities to reflect on life together with patients	3.7±0.9	.384	.108	**.410**	.366
Factor4 [Spiritual care]		**4.0±0.7**			
27 Capable of talking with patients about things they are proud of or that are important to them	3.9±0.9	.367	.142	.278	**.696**
26 Capable of giving patients the opportunity to tell those around them what they are thinking	4.0±0.8	.312	.284	.245	**.652**
24 Capable of grasping situations to enable communication between patients and their family members	3.9±0.8	.282	.464	.292	**.468**
contribution rate		17.63	13.03	11.83	9.09
cumulative contribution rate		17.63	30.66	42.49	51.56
Cronbach's α coefficient		0.90	0.88	0.85	0.83

Table 3. Association of experience years with the four factors in nurses' positive attitudes to nursing practice

Factor / Length of experience (n,%)	[The practice of specialist end-of-life–specific care]	[Making the best arrangements until the end]	[The confidence to look after someone at the end of life]	[Spiritual care]
Total (675,100)	4.2±0.5	4.2±0.6	3.5±0.7	4.0±0.7
1～2 (101,14.9)	4.1±0.5	3.9±0.6	3.2±0.7	3.9±0.7
3～5 (181,26.8)	4.2±0.5	4.2±0.6	3.4±0.7	3.9±0.7
6～10 (195,28.9)	4.2±0.5	4.3±0.6	3.5±0.7	4.0±0.7
11≦ (198,29.3)	4.3±0.6	4.3±0.7	3.7±0.7	4.1±0.7

one-way ANOVA　**p <.00

association with the experiences of caring for a dying family member or of battling a disease oneself, but the experience of supporting a family member battling disease was significantly associated with scores for all four factors in nurses' positive attitudes toward nursing practice.

5. Association with the experience of educational opportunities

The most common form of educational opportunity was regularly reflecting on care, which was experienced by 561 of the respondents (82.4%). This was followed by holding case conferences for deceased patients (n = 411, 62.4%), having been able to talk at length about the care they had provided and their own thoughts (n = 364, 53.3%), and having received recognition from colleagues at their own level of seniority or above (n = 327, 48.2%). (Table5)

The experience of educational opportunities was significantly associated with three of the four factors in nurses' positive attitudes toward nursing practice, with nurses who had had these experiences having more positive attitudes toward nursing practice, i.e., having received recognition from colleagues at one's own level of seniority or above, regularly reflecting on care, and having been able to talk at length about the care one had provided and one's own thoughts. There was no significant association between the experience of holding case conferences for deceased patients and any of the four factors.

Discussion

1. Content of positive attitudes toward nursing practice of nurses in general hospitals

Positive attitudes toward the nursing practice faced by nurses engaged in terminal cancer care were categorized into four factors. These consisted of three factors concerning attitudes and knowledge, comprising [The practice of specialist end-of-life–specific care], [Making the best arrangements until the end], and [Spiritual care], and

Table 4. Association of life events with the four factors in nurses' positive attitudes to nursing practice

			Factor1 [The practice of specialist end-of-life–specific care]		Factor2 [Making the best arrangements until the end]		Factor3 [The confidence to look after someone at the end of life]		Factor4 [Spiritual care]	
Experience		n (%)	Mean±SD		Mean±SD		Mean±SD		Mean±SD	
Experience of caring for a dying family member	Yes	310 (46.1)	4.2	0.5	4.2	0.6	3.5	0.8	3.9	0.7
	No	362 (54.9)	4.2	0.5	4.2	0.6	3.4	0.7	4.0	0.7
Experience of supporting a family member who was battling disease	Yes	206 (30.6)	4.3	0.6	4.3	0.7	3.6	0.8	4.1	0.8
	No	468 (69.4)	4.2	0.5	4.2	0.6	3.4	0.7	3.9	0.7
Experience of battling disease oneself	Yes	61 (9.1)	4.3	0.6	4.3	0.7	3.5	0.9	4.1	0.8
	No	609 (90.9)	4.2	0.5	4.2	0.6	3.4	0.7	4.0	0.7

t-test　*p <.01

one affirmative sentiment, that of [The confidence to nurse someone at the end of life].

Of the practical positive attitudes, the scores for [The practice of specialist end-of-life–specific care] and [Making the best arrangements until the end] were both 4.2 and that for [Spiritual care] was 4.0, corresponding to "Somewhat applicable" on the six-point scale. The items related to [The practice of specialist end-of-life–specific care] with the highest scores were <Q25 Capable of seeing patients as individual human beings> and <Q11 Capable of adopting a caring attitude toward patients>, and these items are basic to nursing as a whole, not only end-of-life care. The practices involved in these items, including touching, offering quiet support when patients are agitated, and actively listening to what patients have to say can also be described as human interactions or nursing interactions, and these responses suggested that nurses are capable of nursing practice rooted in the basics of care. These items have conventionally been explained in terms of the concept of communication, and in end-of-life care they are very strongly emphasized, with numerous studies pointing out that whether or not medical professionals are able to build a relationship that can also be described as "heart to heart" has a major effect on their satisfaction[10-13] .

[Making the best arrangements until the end] refers to making every effort to communicate and mediate with doctors, family members, and the other people around the patient, and is a means of support that signifies indirect care rather than caring directly for patients and their families. The item associated with this factor that scored most highly was the ability to consult with doctors on pain control. This result is indicative of the tendency toward the use of team medicine in wards in recent years, with efforts to control pain undertaken as part of a team. The lowest score was for <Q28 Capable of supporting family members forced into making decisions>. Of the items concerning family members, the score for <Q3 Capable of supporting the ideas and wishes of patients' families> was less than 4. Decision-making support and mediating within families was regarded as advanced nursing practice[14] , and their difficulty can be discerned here. In a previous study of difficulties, we have already shown that communicating and mediating with patients' relatives and friends is felt to be more difficult than direct care[15] . In this regard, other items related to trying to do one's best, including <Q31 Capable of responding immediately even to trivial complaints>, also scored less than 4, indicating the difficulty of these practices.

[Spiritual care] is a factor that concerns fundamental interactions, and items in this category included <Q26 Capable of giving patients the opportunity to tell those around them what they are thinking> and <Q27 Capable of talking with patients about things they are proud of or that are important to them>. How to deal with patients who are questioning the meaning of life is an issue for nurses. Strang et al. [4] reported that holding reflection sessions for nurses on existential issues in their communication with patients close to death was effective. In those sessions, participants discussed being present and confirming, how to use conversation techniques to open up communications, and the meaning of existential conversations for nurses themselves. Their study showed that the experience of talking about existential issues and

Table 5. Association of the educational opportunities with the four factors in nurses' positive attitudes to nursing practice

Experience of educational opportunities		n (%)	Factor1 [The practice of specialist end-of-life–specific care] Mean±SD		Factor2 [Making the best arrangements until the end] Mean±SD		Factor3 [The confidence to look after someone at the end of life] Mean±SD		Factor4 [Spiritual care] Mean±SD	
Recognition from colleagues at their own level of seniority or above	Yes	327 (48.2)	4.4 ±0.5	**	4.4 ±0.6	**	3.7 ±0.7	**	4.2 ±0.7	**
	No	352 (51.8)	4.1 ±0.5		4.0 ±0.6		3.2 ±0.7		3.8 ±0.7	
Regularly reflecting on care	Yes	561 (82.4)	4.3 ±0.5	**	4.3 0.6	**	3.5 ±0.7	**	4.0 ±0.7	**
	No	120 (17.6)	3.9 ±0.6		3.9 ±0.7		3.2 ±0.7		3.7 ±0.8	
Case conferences for deceased patients	Yes	411 (62.4)	4.2 ±0.5		4.2 ±0.6		3.5 ±0.7		4.0 ±0.7	
	No	248 (37.6)	4.2 ±0.6		4.1 ±0.7		3.4 ±0.8		3.9 ±0.8	
Capable of talking at length about the care (provided and their own thoughts)	Yes	319 (46.7)	4.3 ±0.5	**	4.3 ±0.6	**	3.6 ±0.7	**	4.1 ±0.6	**
	No	364 (53.3)	4.1 ±0.6		4.1 ±0.7		3.3 ±0.8		3.9 ±0.8	

t-test **p<.00

a supporting environment made nurses comfortable when counseling patients close to death. Having the courage to be present and confirming, having time and not trying to "solve" every existential problem were the most important factors in conversations with the patients close to death.

The mean score for the positive sentiment of [The confidence to nurse someone at the end of life] was 3.4, corresponding to "Not really applicable" on the six-point scale. Although the score for <Q33 Feeling that people depend on me> was 3.9, that for <Q23 Satisfied overall with the end-of-life care I provide> was only 3.1. In our previous study, we also found that while nurses had a positive attitude to patient support they also had feelings of helplessness, and nurses with these sentiments lacked confidence in their own strength and ability to respond, were confused about the best way to deal with patients, and were in a conflicted state. When they adopted the mindset of taking the initiative in assisting patients, on the other hand, nurses displayed a proactive attitude toward support, considering that patients should be able to continue to live their lives their way until the end and that they should be given total, forward-looking support in doing so, including support for families. Confidence and helplessness are two sides of the same coin, and can be conjectured to coexist in a constantly fluctuating state.

2. Causes of nurses' positive attitudes to nursing practice (length of experience, caring for a dying family member, supporting a family member battling disease, and battling disease oneself)

In terms of the association between nurses' positive attitudes to nursing practice and length of experience, there were significant differences between newcomers and veterans in [The practice of specialist end-of-life–specific care]; novices had the lowest score for [Making the best arrangements until the end], with competent, proficient, and expert nurses scoring significantly higher; and for [The confidence to nurse someone at the end of life], experts scored significantly higher than novices competent, and proficient nurses. In this study, there were 49% nurses in their twenties and 44% nurses with the high education background. In other words, half of the nurses were young, and the nurses were highly educated. The majority of highly educated nurses were novice, advanced beginner and competent. In previous studies, years of experience has been pointed out as a factor related to affirmation to practice [5-6] .On the other hand, a factor of academic background is not previously reported to link to nurses' positive attitudes toward nursing practice. The attitudes are at the root of things that are noticed during such practice[8-9] . Therefore, it was inferred that academic qualities do not affect positive attitudes.

There was no association between length of experience and [Spiritual care]. Nurses' positive attitudes toward nursing practice are at the root of things that are noticed during such practice[5) 6)] . Nishida[8)] regarded this as part of the personal development of nurses who have experienced the death of a patient, and described the phenomenon of nurses learning deeply about life and death from patients as a "reacknowledgment of life." The fact that positive attitudes to nursing practice intensify with increasing experience suggests that nurses build their own identity, and develop as people by accumulating clinical experience and reflecting on their engagement with and care for patients while they were still alive. Conversely, [Spiritual care] was not associated with length of experience. This result is understandable when it is conjectured that giving patients the opportunity to tell people what they are thinking and being capable of talking with patients about things they are proud of or that are important to them are associated with matters such as nurses' views of life and death rather than with experience.

Moving on to the association between the four factors constituting positive attitudes to nursing practice and the experience of caring for a dying family member, supporting a family member battling disease, or battling disease oneself, the only significant association was with supporting a family member who was battling disease. The absence of any association with the experience of battling a disease oneself may have been due to the small number of nurses with such experience, but the lack of correlation with the experience of caring for a dying family member differs from the results of many other studies. In a previous study, we found that nurses' awareness of caring for a dying person is associated with elements of their life history, such as caring for a dying relative. The reason for the absence of any such association in this study may have been that our previous studies were qualitative exploratory factor analysis studies, and that because its participants were nursing students, their life history was visible in closer focus. Our results in the present study showed that it is the length of experience in caring for dying patients that is associated

with positive attitudes to nursing practice, rather than the experience of being bereaved oneself.

3. Association between positive attitudes to nursing practice, case conferences for deceased patients, and reflection

As opportunities to develop positive attitudes to nursing practice in end-of-life care, we asked whether nurses had experienced taking part in case conferences for deceased patients in which they had had the opportunity to talk about their feelings about death and bereavement, or had been able to talk at length about the care they had provided themselves and their own thoughts. Around 60% of respondents had taken part in case conferences for deceased patients, and around 50% had had the opportunity to talk at length about care and their own thoughts in such conferences. Case conferences for deceased patients are said to be important in preventing burnout by nurses, but although they are held in many hospices and other institutions, the situation in general hospitals varies depending on the workplace. There was no significant association between case conferences for deceased patients and any of the four factors constituting positive attitudes. However, having had the opportunity to talk at length about the care one has provided and one's own thoughts did increase positive attitudes. Such discussion of end-of-life care has also been found to improve positive attitudes in a study by Boyd et al[16] . Originally, the case conference for deceased patients was performed to fully communicate the care and grief of the deceased patient, but it seemed that nurses of the target general hospital didn't enough talk about the deceased patient.

Receiving recognition from colleagues of one's own seniority or above was associated with all four factors constituting positive attitudes, but less than 50% of respondents had actually experienced this. Recognition from others has already been shown to be associated with nurses' job satisfaction, with recognition at work leading to enhanced self-esteem and higher motivation to work. Colleagues of one's own seniority or above are regarded as possessing both objectivity and an emotional connection as friends.

In connection with positive attitudes to nursing care, approximately 80% of respondents indicated that they regularly reflected on care, and those who did, scored higher on all four factors constituting positive attitudes. Reflecting on care is expected to have an effect on nursing practice by providing the opportunity to notice things and take a fresh look at oneself, and has been shown to be a learning experience that leads to specific future courses of action, improves motivation for practical activities, and maintains awareness in practice while enabling the prediction of changes in activity.

Our results showed that talking about care and expressing one's own thoughts in case conferences, receiving recognition from colleagues at one's own level of seniority or above, and reflection on nursing practice were significantly associated with positive attitudes to nursing practice in end-of-life care in general hospitals.

Study Limitations

This study was carried out in eight regional general hospitals. Although they had many aspects in common with hospitals in metropolitan areas, such as hospital functions, forms of nursing , and nurses' educational backgrounds, they may have differed in terms of aspects reflecting local culture, such as understandings of death and efforts to hold case conferences for deceased patients.

In addition, the subjects were decided by recommendation of the nursing manager. For this reason, the percentage of nurses with higher education level was higher for this time. This may be reflected in the results.

In the light of our results in this study, we intend, in the future, to carry out further studies of medical institutions in different regions, including metropolitan areas.

Conclusion

1. This study were to identify the nature of positive attitudes to nursing practice of nurses in general hospitals, and to examine their association with various different factors. The participants were 683 nurses working in 41 wards in eight regional general hospitals.

2. Four factors were identified as constituents of nurses' positive attitudes to nursing practice. These consisted of three factors concerning attitudes and knowledge, comprising [The practice of specialist end-of-life specific care], [Making the best arrangements until the end], and [Spiritual care], and one affirmative sentiment, that of [The confidence to nurse someone at the end of life].

The mean score for factors relating to knowledge of nursing practice was over 4 points on a six-point scale, corresponding to "Somewhat applicable," whereas the

mean score for the sentiment of [The confidence to nurse someone at the end of life] was over 3 points.

3. In terms of related factors, for every factor other than spiritual care, positive attitudes to nursing practice increased significantly with increasing length of experience. There was no association with having cared for a dying family member.

4. Although having experienced an educational opportunity was not associated with the practice of case conferences for deceased patients, it was significantly associated with the experience of having been able to talk at length about the care they had provided and their own thoughts in venues such as case conferences, receiving recognition by colleagues at their own level of seniority or above, and reflection.

5. Talking about care and expressing one's own thoughts in case conferences, receiving recognition from colleagues at one's own level of seniority or above, and reflection on nursing practice were all important in this process.

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Conflict of interest

The authors do not have a conflict of interest (COI) with any operator.

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がん終末期ケアにおける看護師の「実践への肯定感」と関連要因

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要　　旨

がん医療が高度・複雑化し、結果、人々が「死」を看取っていくことが難しくなっている。本研究の目的は、総合病院における看護師のがん終末期の実践への肯定感はどのようなものかを明らかにし、要因との関連を見ることとである。対象は地方の 8 つの総合病院 41 病棟 683 名の看護師である。自記式質問紙調査を行い、看護師の実践への肯定感は 4 因子の構造として見いだされた。それは【終末期固有の専門的ケア実践】、【最期までの最善の調整】、【スピリティアルなケア】という実践への態度や認識と、【最期を看取っていく自信】という肯定的心情であった。実践への認識の平均値は 6 段階中 4 点台で、「どちらかといえばできる」レベルであり、【最期を看取っていく自信】の心情は 3 点台で「どちらかといえば自信がない」であった。関連要因では、スピリティアルケアを除く全ての因子で、経験年数が増すと実践への肯定感が有意に高まっていた。また、身内の死の看取り経験は関連がなかった。一方、教育的働きかけを受けた経験との関連は、デスカンファレンス実施の有無とは関係がなかったが、自分の行ったケアや思いを十分に語った経験、先輩や同僚に認められた経験、そしてリフレクションが有意に関係していた。つまり、総合病院の終末期ケアにおいて、看護師の実践への肯定感の高まりは、身内の死の看取りなどの個人的特性ではなく、看護経験の中で、困難感からの転換の形で積み重ねられていた。その過程では、ケアや思いを十分に語り、先輩や同僚に認められ、そして実践をリフレクションすることが重要となる。