Attitudes Toward Death, Dying, End-of-Life Palliative Care, and Interdisciplinary Practice in Long Term Care Workers

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attitude to death
long term care
nursing homes
palliative care
patient care team

Abstract

Background: Besides personal and professional experiences, long term care providers’ own attitudes toward death may affect the care given to dying residents.

Objectives: To assess beliefs, values, and attitudes toward death, dying, palliative, and interdisciplinary care in long term care workers and identify any differences between different job categories and places of work.

Design: Descriptive cross-sectional survey study.

Setting: Five public long term care facilities.

Participants: One thousand one hundred seventy volunteers, clinical managers, and all categories of residential long term care workers.

Measurements and Methods: An anonymous paper or electronic self-administered survey questionnaire consisting of 24 items, answered on a 4-point bipolar Likert scale. Between-group differences were compared with the analysis of variance test after adjustment for the multiple post-hoc comparisons.

Results: Healthcare workers had a relatively positive attitude toward more than one-half of the selected aspects of interdisciplinary practice and end-of-life palliative care for long-term residents. However, attitudes were more mixed about 10 other aspects and a higher percentage of respondents indicated negative attitudes toward them. Overall, there are significant differences between upper-level professionals and managers (registered nurses, physicians, rehabilitation staff, and clinical managers) vs the hands-on caregivers (nursing assistants, patient assistants, and volunteers) with regard to some aspects of the care of the dying.

Conclusions: The results suggest that healthcare workers’ attitudes need to be taken into account in long term care facilities. Patient assistants, volunteers, and nursing assistants seem most likely to above all benefit from training and support programs.

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The authors declare no conflicts of interest.

In Quebec, as elsewhere in the world, demographic aging and societal changes that lead to decreased co-residence of elderly with their families will increase demand on long term care (LTC) facilities. Nursing homes and LTC facilities often represent the last place people will live before they die. About one-third of residents die each year in these settings.

Many guidelines and policies from developed countries recommend the implementation of end-of-life palliative care to provide quality of life for patients and families, achieved through an interdisciplinary approach. Work-related continuing education and training opportunities are also recommended to everyone involved in
Palliative care is not restricted to special places. Ideally, this care should be available to people where appropriate, which may range from the person’s home to specialized hospices. Nursing homes and LTC residents have multiple, chronic conditions, such as dementia or Alzheimer’s. These individuals should also benefit from palliative care.

Unfortunately, the approaches to end-of-life palliative care are generally absent or poorly developed in these settings. The services being given by the usual care teams having received no special training. Endevours to design, test, and implement such a palliative care or training program to the particular needs of LTC residents and their families are still in their early stages. Since 2008, the University Institute of Geriatrics of Montreal has established an interprofessional training program on end-of-life palliative care in LTC facilities, to train those who will in turn teach others in their own institution.

Effective end-of-life palliative care requires long term care staff to readjust their focus and acquire skills and knowledge beyond those attainable through books or school instruction alone. Palliative care practice and education is not just a matter of knowledge but also attitudes. It is acknowledged that attitudes of healthcare workers toward death and dying patients may influence the quality of care they provide them and the relationships they establish with their families. As the literature suggests, implementing an educational program tailored to workers’ needs may be useful in helping to foster more positive attitudes toward end-of-life care.

Of the previous studies exploring attitudes toward death, dying, and end-of-life palliative care, most have focused on nurses and primarily examined homecare, hospice, medical-surgical, pediatric, and cancer settings. There is a gap in research regarding other settings such as dementia or Alzheimer’s. These individuals should influence the quality of care they provide them and the relationships they establish with their families.

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The studied facilities are public, secular, non-profit institutions. They are parts of a same local territorial community-governed health organization that includes two local community health centers that provide primary health care, health promotion and community development services, which as a whole forms a single university affiliated organization. In total, the five facilities have a capacity of 987 beds, distributed as follows: 398, 140, 147, 282, and 20 beds, respectively. The smallest center hosts people with Alzheimer’s type dementia. The largest center includes a specialized 10-bed palliative unit whose workers were specifically excluded from the survey. A total of 629 of the 1170 participants completed and returned the questionnaires (54%), from which 580 of the 1050 (55%) paper questionnaires were returned and 49 of the 120 (41%) respondents contacted electronically completed the online questionnaire. A simple random sample size of ours (n = 629) would give estimates with a maximal margin of error of 4% with a 95% confidence interval.

**Methods**

**Studied Setting**

We only approached five LTC facilities of a given multi-ethnic district of Montreal and all five institutions agreed to participate. The studied facilities are public, secular, non-profit institutions. They are parts of a same local territorial community-governed health organization that includes two local community health centers that provide primary health care, health promotion and community development services, which as a whole forms a single university affiliated organization. In total, the five facilities have a capacity of 987 beds, distributed as follows: 398, 140, 147, 282, and 20 beds, respectively. The smallest center hosts people with Alzheimer’s type dementia. The largest center includes a specialized 10-bed palliative unit whose workers were specifically excluded from the survey.

We conducted a cross-sectional descriptive survey among all healthcare workers and volunteers who have direct contact with the disabled and chronically ill adult residents from the LTC facilities. Nursing assistants, registered nurses, dieticians, occupational therapists, physiotherapists, psychologists, social workers, spiritual advisors, patient assistants, volunteers, and managers (including clinical officers and heads of unit) were invited by the director of each LTC facility to complete a voluntary and anonymous self-administered questionnaire during working time. These workers were also encouraged to participate via an initial invitation and a subsequent reminder on closed-circuit television and local weekly electronic newsletter as well as via email sent by the president of the local council of nurses, the multidisciplinary council, and the group of volunteers to their respective members. Physicians were contacted via the administrative secretary of the Department of Family Medicine and General Practice.

In LTC facilities in Quebec, we find 2 types of hands-on caregiver job with a secondary-level training that provide basic care in healthcare facilities: patient assistant and nursing assistant. A nursing assistant is a person who provides residents with bedside care and performs the duties and tasks planned by the nursing and medical staff (eg, prepare and administer medications, take patients’ blood

**General Procedure of Administration**

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pressure and temperature). A patient assistant is a person who helps residents with meals, dressing, personal hygiene, mobility, and other daily activities.

The list of employees was provided by the human resources department of the institution and the list of volunteers by the head of the volunteer service. The questionnaire was administrated from mid-May to mid-June 2013 in French, which is the official working language in Quebec, using a web-based version through LimeSurvey for all professionals with an institutional email address and a paper-based version for nursing assistants, patient assistants, volunteers, and physicians. Completed paper-version questionnaires were placed in a pre-addressed return envelope and subsequently in a labeled box. Completion of the questionnaire took approximately 10–15 minutes, and no compensation was provided to the participants.

The study was approved by the executive director of the institution and conducted in the context of the legal mandate of the governmental act respecting health services and social services and in accordance with the ethical standards of the university institution. The participants were clearly informed that their participation was voluntary and that no names or identifying features were needed.

Questionnaire

Attitudes are composed of ideas and beliefs that are attached to specific emotions.27 A belief is an internal feeling that something is true, a value is a stable and enduring belief about the importance a person attaches to something, and an attitude is the way a person expresses beliefs and values through words and behavior. Despite this possible distinction, these interrelated concepts are considered as a whole (employees’ view or way of seeing) and no attempt is made to distinguish them in our study.

We developed an assessment tool on the basis of existing questionnaires and adapted the questions to our particular purpose, notably the questionnaire of Zapka et al28 about palliative and end-of-life care and the IPC65 questionnaire from Bédard et al29 about interdisciplinary clinical practice. Statements/questions were selected according to their perceived relevance based on the opinion of a group of concerned managers and long term care workers. A pre-test was conducted with a sample of 10 participants of different job categories to ensure the relevance and understanding of the survey questions for any respondent. A final 24-item questionnaire was created after minor modifications in the wording, which covers 5 key areas of issues related to “family-centered” end-of-life care (interdisciplinary, care for patient’s relatives, death and end-of-life care, psychological distress, and health worker’s feelings). It includes 10 positively and 14 negatively worded statements, to which respondents use a 4-point bipolar Likert scale of 1 strongly disagree, 2 disagree, 3 agree, and 4 strongly agree. In the context of this study, a positive attitude indicates a higher agreement rating of the positive perspectives and disagreement with more of the negative perspectives.

Data about the respondents’ place of work and job category were also collected, after an introduction that explained the nature and purpose of the survey and guaranteed anonymity and confidentiality of information obtained.

Data Analysis

Data entry of the paper-version of the questionnaire was made in Excel. A random sample of survey questionnaires was selected to cross-check the data entry. SPSS v.19.0 (SPSS Inc, Chicago, IL) was used for all statistical analysis. Two-tailed significance level was set at 0.05.

Descriptive statistics were used to summarize the data. Missing data (partial nonresponse) counted for less than 5%. They occurred more frequently in patient assistants and volunteers than in any other job categories. Item-by-item responses were arbitrarily separated into 3 categories to highlight the most important observations and trends: “polarized opinion” category (≥75% who agree or disagree with the statement, from which ≥50% who strongly agree or disagree), “strong consensus” category (≥75% who agree or disagree with the statement), and “mixed opinions” category (≥20% in at least three distinct response categories).

The negatively keyed items were reversed and items missing values was replaced using the “median of nearby points” imputation method before computing a total attitude score as the sum of the individual item scores. Thus, the average score for an individual item lies between a theoretical maximum positive attitude of 4 and a minimum negative attitude of 1. A missing value occurred in at least 1 item response of 25% of the sample of respondents. The median is calculated by using complete observation values under and above the missing data for the specific job category of the respondent, and this value is imputed instead of the missing data. Statistics calculated from the set of values including imputed data given substantially the same values than with the original data set, so that only the results from the former method are reported in the article. Possible total scores can range from 24 to 96. A higher score indicates a more positive attitude of healthcare workers toward caring for the LTC residents.

Five key area scores were computed in the same way as the total score as “interdisciplinary” (Q3, Q7, Q11, Q16, Q19, Q22), “care for patient’s relatives” (Q1, Q2 and Q10), “death and end-of-life care” (Q4, Q6, Q8, Q12, Q13, Q20, Q24), “psychological distress” (Q5, Q9, Q23), and “health worker’s feelings” (Q14, Q15, Q17, Q18, Q21). The group average differences were compared between facilities and job categories with the analysis of variance test. Post-hoc comparisons were performed using the Bonferroni or Tamhane correction after verification of the homogeneity of variance assumption by the Levene’s test.

Results

Study Participants

Respondents are mostly patient assistants (52%), nursing assistants (23%), and registered nurses (11%). Members of every other category taken individually counted for less than 4% or 14% if taken all together as a single group. Five percent worked in more than 1 establishment during the reporting period. The percentage of respondents from each LTC facility and job category included in the studied sample was proportional to the corresponding group from the target population sought.

Overall Results

Table 1 reports the percentage of Likert scale responses for each item and the corresponding average score.

Item responses in the “strong consensus” category attest to congruence among health workers in their personal beliefs, values and attitudes about “bereavement care responsibility” (Q2); see Table 1 for the exact wording of the statements/questions), “team plan of care” (Q3), “psychological suffering” (Q5), “pain medication hastening death” (Q6), “sufficiency of team communication” (Q7), “teamwork clarifying needs” (Q11), “preparation for death” (Q12), “guilt after death” (Q15), “teamwork vision for delivery” (Q16), “grief after death” (Q18), “sharing about patient’s difficulties” (Q19), “feeling of failure” (Q21), “teamwork benefits for residents” (Q22), and “obligation to inform about death” (Q24). Among these responses, even more than 50% of workers strongly agree or disagree (indicative of polarization) about Q3, Q5, Q6, Q11, Q15, Q16, Q21, Q22, and Q24. However, health workers surveyed have mixed opinions about “suffering of grief” (Q1), “prognosis and hope” (Q4), “talking about
Table 1
Attitudes About Death, Dying, End-of-Life Palliative Care, and Interdisciplinary Practice in Long Term Care Providers (n = 629)

<table>
<thead>
<tr>
<th>Items</th>
<th>Strongly Disagree %</th>
<th>Somewhat Disagree %</th>
<th>Somewhat Agree %</th>
<th>Strongly Agree %</th>
<th>Average Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Polarization of Opinion</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Psychological suffering can be as severe as physical suffering</td>
<td>1.8</td>
<td>2.2</td>
<td>14.7</td>
<td>81.3</td>
<td>3.76</td>
</tr>
<tr>
<td>22. Teamwork brings real benefits to residents at the end of life</td>
<td>1.3</td>
<td>2.5</td>
<td>28.2</td>
<td>68.0</td>
<td>3.64</td>
</tr>
<tr>
<td>16. A clear vision of the healthcare team helps to ensure better delivery of care and services</td>
<td>1.6</td>
<td>2.6</td>
<td>33.1</td>
<td>62.7</td>
<td>3.58</td>
</tr>
<tr>
<td>15. I feel guilty after the death of a resident</td>
<td>66.1</td>
<td>26.7</td>
<td>4.2</td>
<td>2.9</td>
<td>3.57</td>
</tr>
<tr>
<td>11. Team work can clarify and better target the different needs of the resident and family members</td>
<td>1.9</td>
<td>3.4</td>
<td>31.5</td>
<td>63.2</td>
<td>3.56</td>
</tr>
<tr>
<td>3. The plan of care must be built by rallying all stakeholders</td>
<td>2.6</td>
<td>5.2</td>
<td>33.8</td>
<td>58.3</td>
<td>3.49</td>
</tr>
<tr>
<td>21. When a resident dies, I feel as if I have failed as a healthcare provider</td>
<td>60.1</td>
<td>30.3</td>
<td>6.2</td>
<td>3.4</td>
<td>3.48</td>
</tr>
<tr>
<td>24. The care team has an obligation to tell residents and family members when death is imminent</td>
<td>5.2</td>
<td>12.0</td>
<td>31.0</td>
<td>51.8</td>
<td>3.31</td>
</tr>
<tr>
<td>6. At their request, residents at the end of life should be given whatever medication is necessary to relieve pain, even if it hastens death</td>
<td>5.0</td>
<td>9.8</td>
<td>27.7</td>
<td>57.4</td>
<td>1.62</td>
</tr>
<tr>
<td><strong>Consensus of Opinion</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Communication between members of the team is sufficient to allow true teamwork</td>
<td>4.5</td>
<td>11.1</td>
<td>40.7</td>
<td>43.6</td>
<td>3.23</td>
</tr>
<tr>
<td>2. The team has a responsibility to provide bereavement care to the resident's family after death</td>
<td>4.4</td>
<td>14.1</td>
<td>46.0</td>
<td>35.6</td>
<td>3.13</td>
</tr>
<tr>
<td>12. The care team has a responsibility to help residents prepare for death</td>
<td>5.3</td>
<td>12.7</td>
<td>45.7</td>
<td>36.3</td>
<td>3.13</td>
</tr>
<tr>
<td>18. When one of my residents dies, I grieve for them</td>
<td>38.2</td>
<td>40.0</td>
<td>17.9</td>
<td>3.9</td>
<td>3.12</td>
</tr>
<tr>
<td>19. I feel comfortable to share the difficulties faced by a resident at the end of life or their family members with my colleagues or documenting discussion them in the record</td>
<td>10.2</td>
<td>14.3</td>
<td>41.6</td>
<td>33.9</td>
<td>3.00</td>
</tr>
<tr>
<td><strong>Mixed Opinions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Caring for residents who are dying is depressing</td>
<td>32.6</td>
<td>37.9</td>
<td>22.2</td>
<td>7.3</td>
<td>2.96</td>
</tr>
<tr>
<td>1. There is little that can be done to ease the suffering of grief</td>
<td>33.4</td>
<td>31.6</td>
<td>24.1</td>
<td>10.9</td>
<td>2.88</td>
</tr>
<tr>
<td>8. Talking about death tends to make residents at the end of life more discouraged</td>
<td>23.5</td>
<td>43.8</td>
<td>21.7</td>
<td>11.1</td>
<td>2.80</td>
</tr>
<tr>
<td>17. I dread having to deal with the emotional distress of family members</td>
<td>19.8</td>
<td>36.7</td>
<td>33.8</td>
<td>9.7</td>
<td>2.68</td>
</tr>
<tr>
<td>4. It is not possible to tell residents or their families the truth about a terminal prognosis and maintain hope</td>
<td>13.0</td>
<td>27.4</td>
<td>24.0</td>
<td>19.5</td>
<td>2.33</td>
</tr>
<tr>
<td>13. It is easier to talk about death and dying with someone of my own cultural or religious group than with someone who is not</td>
<td>11.4</td>
<td>27.8</td>
<td>35.3</td>
<td>25.5</td>
<td>2.25</td>
</tr>
<tr>
<td>23. Depression is normal in residents at the end of life</td>
<td>11.2</td>
<td>25.9</td>
<td>36.1</td>
<td>26.7</td>
<td>2.21</td>
</tr>
<tr>
<td>10. Family members tend to interfere in the care of residents at the end of life</td>
<td>6.0</td>
<td>22.4</td>
<td>49.7</td>
<td>22.0</td>
<td>2.12</td>
</tr>
<tr>
<td>9. Depression is not treatable in residents at the end of life</td>
<td>26.8</td>
<td>46.6</td>
<td>16.7</td>
<td>9.9</td>
<td>2.09</td>
</tr>
<tr>
<td><strong>Unclassified Item</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Suggested procedures or treatments sometimes give residents/family false hope</td>
<td>15.5</td>
<td>45.4</td>
<td>32.1</td>
<td>7.1</td>
<td>2.71</td>
</tr>
</tbody>
</table>

The items are classified according to the average score within each category.
Results expressed in percentage values are computed from the original response format of the statements and exclude the missing data (partial nonresponse), which always counted for less than 5%.
*Results expressed in percentage values are computed from the original response format of the statements and exclude the missing data (partial nonresponse), which always counted for less than 5%.

The average total score was 70.6 (standard deviation = 6.0). The median and modal total scores were 70.0 and 69.0, respectively. The individual total scores ranged from 52 to 88.

**Differences Between Facilities and Job Categories**

There is no difference in the attitude score between different facilities. However, as Table 2 shows, there are statistically significant differences across job categories. Overall, the attitudes of registered nurses, physicians, rehabilitation staff, and clinical managers were significantly more positive than the attitudes of nursing assistants, patient assistants, and volunteers.

**Discussion**

The results of this study indicate that healthcare workers had a relatively overall positive attitude toward interdisciplinary practice and end-of-life palliative care for LTC residents, as was found by Zapka et al,28 Lange et al,21 and Braun et al27 in other settings. Our

Table 2
Differences of Average Key Area Values About Attitudes Toward Death, End-of-Life Palliative Care, and Interdisciplinary Practice in Long Term Care Providers Between Facilities and Job Categories

<table>
<thead>
<tr>
<th>Key Area (Range of Possible Scores)</th>
<th>a Registered Nurses and Physicians n = 327</th>
<th>b Nursing Assistants n = 145</th>
<th>c Patient Assistants and Volunteers n = 69</th>
<th>d Rehabilitation Staff and Clinical Managers*</th>
<th>All Workers n = 629</th>
<th>P Values and Group Differences†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interdisciplinary (6–24)</td>
<td>21.7</td>
<td>20.6</td>
<td>20.0</td>
<td>21.7</td>
<td>20.5</td>
<td>a.d &gt; b.c</td>
</tr>
<tr>
<td>Care for patient's relatives (3–12)</td>
<td>9.3</td>
<td>8.1</td>
<td>7.7</td>
<td>9.4</td>
<td>8.1</td>
<td>a.d &gt; b &gt; c</td>
</tr>
<tr>
<td>Death and end-of-life care (7–28)</td>
<td>19.0</td>
<td>18.2</td>
<td>17.8</td>
<td>19.0</td>
<td>18.1</td>
<td>a.d &gt; c</td>
</tr>
<tr>
<td>Psychological distress (3–12)</td>
<td>7.9</td>
<td>7.8</td>
<td>8.1</td>
<td>8.3</td>
<td>8.1</td>
<td>c.d &gt; b</td>
</tr>
<tr>
<td>Health worker's feelings (5–20)</td>
<td>17.0</td>
<td>16.0</td>
<td>15.3</td>
<td>16.5</td>
<td>15.8</td>
<td>a &gt; b.c; d &gt; c</td>
</tr>
<tr>
<td>Total score (24–96)</td>
<td>74.9</td>
<td>70.7</td>
<td>69.0</td>
<td>74.9</td>
<td>70.6</td>
<td>a.d &gt; b &gt; c</td>
</tr>
</tbody>
</table>

Groupings were necessary given the small numbers of respondents in some categories.
*The “rehabilitation staff and clinical managers” category includes dieticians, occupational therapists, physiotherapists, psychologists, social workers, clinical officers, and heads of unit.
†The index indicates which groups are different from which other groups. The average differences are significant at the 0.05 level corrected for multiple comparisons.
results also showed moderate to strong positive attitudes toward more than one-half of the selected aspects of care. However, the attitudes were more mixed about 10 other aspects and a higher percentage of respondents (from 27% to 72% agree with the statements) indicated negative attitudes toward them. By reporting the key area scores on an equivalent basis of 100 to facilitate comparisons, we note that attitudes were more favorable for the items in the “inter-disciplinarity” (20.5/24 or 85%) and “health worker’s feelings” areas (15.8/20 or 79%) than for the other key areas.

A few findings merit comment. Interdisciplinary work seems to be an integrated value in the teamwork of healthcare workers. However, even if it is recognized as useful, there are still currently 15% of participants who find the present communication within their team does not allow for such work and 25% are not comfortable sharing the difficulties of residents with their colleagues. The majority of participants (72%) agree that relatives interfere in the care provided to the resident at the end of life. This result is surprising and unexpected. If respondents interpreted this term to the letter as “to be or create a hindrance or obstacle,” one would find this to be worrisome. Two explanations can be advanced if we consider that what is good quality of care is essentially a consensus decision between care staff, resident, and families. First, the managers and specialized clinical care advisors consulted to better understand this result explained it by saying that LTC residents display multiple problems that become increasingly complex as their families who sometimes also present problematic behaviors and dysfunctional situations that healthcare workers also have to deal with. Second, perhaps cultural differences between practitioners and residents/families may explain a part of the result. As hypothesized by Frahm et al.10,11 differences in decision-making practices (individual vs familial), language barriers between professionals and residents or family, or overall differences in trust or viewpoint about systems of care may be potential areas of conflict. Shared values, traditions, norms, customs, lived experiences, and the role of institutions (i.e., family, religion, marriage) of a group of people dictate how one will interact with service providers and whether one will chose to exercise control and autonomy in an end-of-life care process.12 When working with ethnic minority patients, who tend to rely more on informal supports than formal supports, family may be an even greater aspect of the care plan. For practitioners, who operate on a Western-based medical model of care, this may be a source of contention.13 Conflicts between the value systems of the healthcare provider and the resident/family arise and failure to deal with them properly may result in feeling that families are a barrier to care.

On another topic, 82% of participants believe that it is their responsibility to help residents prepare for death. At the same time, 33% of respondents believe that talking about death with a resident at the end of life and/or his family tends to be discouraging. There is a need to improve communication with residents and families about diagnosis and prognosis to ensure that effective communication takes place.14

Responses are fairly mixed that sharing the same cultural and religious background facilitates discussion on the topic of death. The majority (61%) agrees with this idea. In this way, counseling offered to the resident should be based on the experience and cultural competencies of practitioners who provide care at the end of life and all should be capable of evoking death and reassure residents despite a differing cultural background. As pointed out by the World Health Organization, the patient and family is viewed as the “unit of care” when palliative care is required.15 Our result supports cultural competence training for healthcare professionals. Knowledge and awareness of cultural values, attitudes, and behaviors can assist practitioners in avoiding stereotypes and biases, while creating positive interactions with patients that lead to better patient outcomes than when the provider is less culturally aware.16

For 83% of participants, the care team should be obliged to inform the resident and family when death is imminent. Communication about prognosis has been associated with significantly fewer aggressive medical interventions near death and enhanced quality of life in patients and bereaved family members.17 In Quebec, the official Act Respecting Health Services and Social Services18 states that “every user of health services and social services is entitled to be informed of his state of health and welfare and to be acquainted with the various options open to him and the risks and consequences generally associated with each option.” Still, 17% of the participants do not share this idea.

As many as 63% of respondents find depression for a resident at the end of life is normal, whereas 73% of them are in agreement with the fact that depression is treatable. This demonstrates that most respondents agree that despite a poor prognosis, depression is a mental disorder that may require specific medication and psychotherapy conducted by a qualified professional. However, depression should not be considered normal for residents at the end of life and requires just as much attention to live the rest of their lives in the best possible conditions as for anyone.

Death is a taboo subject in our society. Workers need to demonstrate empathy with their residents, be compassionate, and be willing to take the risk of personal involvement.18 Dealing with residents and their families can be very emotionally demanding.30–40 Facing it every day requires a degree of distancing for LTC providers.37 Our study attempted to understand worker’s feelings and how they coped. A majority of stakeholders in LTC (70%) do not view the end of life as depressing; however, this means that about 30% find it to be the case. In addition, 22% of responders say they grieved when residents died.

It seems interesting to point out that many workers are not affected by the emotional distress of relatives. Indeed, 20% are completely unaffected by the situation, 37% do not really care much, but the other 44% do worry about the family’s sadness. One might wonder where empathy and compassion fit and if the lack of “distress/care” indicates lack of empathy and compassion. Each person reacts differently, so we can expect that training will help to understand this distress and balance the feelings of the workers.

We noted a relatively strong but, nevertheless, unexpected attitude about the administration of medications at the request of residents at the end of life, “even if the medications hasten death.” This response is surprising given that the World Health Organization policy on palliative care affirms life and regards dying as a normal process: it “neither hastens nor postpones death.”35 This result may be explained by the fact that some workers might have developed new concerns since the Quebec National Assembly36 established a select committee for the purpose of examining the issue of dying with dignity, which tabled its report at March 2012. Assistance in dying, euthanasia, and assisted suicide has become the subject of a broad public debate among Quebecers. The possibility to hasten death might become an acceptable option for a larger share of the population, which will lead to a change in social values.

However, healthcare workers of LTC facilities did not represent a homogenous group of people according to their attitudes. In general, registered nurses, physicians, rehabilitation staff, and clinical managers showed more favorable attitudes than all other professional groups and nursing assistants more favorable attitudes than patient assistants and volunteers. This is not the case for the “psychological distress” area. In this case, attendants and volunteers had more favorable attitudes than nursing assistants. Nursing assistants scored significantly higher on the overall scale as well as the “care for patient’s relatives” area than attendants and volunteers. The opposite is observed for the “psychological distress” area, where values were higher among patient assistants and volunteers than among nursing assistants.
Our results suggest that attitudes are not associated with the amount of time spent in close proximity with dying patients but with the academic postgraduate status of workers. Maybe the professional status and membership in a professional corporation offers more opportunities for continuing education, formal courses, scientific conferences, lectures, case discussions, journal clubs, and a wide range of professional activities that contribute to professional growth.

Some limitations should be considered when interpreting the results of the current study. First, we used the evaluation measures from existing questionnaires so further psychometric work is needed. Second, a number of variables not included in the study, such as education, sex, age, ethnicity, and work experience, were shown to affect attitudes.\textsuperscript{27} The lack of information about demographic composition of the respondent sample impedes the explanation of the origin of differences between occupational groups. This also may limit the generalizability of the study findings to other samples with different characteristics. Third, findings being self-reported measures may have been affected by a social desirability response bias. Despite the similarity in the pattern of job categories and places of work characteristics between our sample and the solicited staff, volunteer bias may affect our results as in any other study of this kind, and that, in a direction that is difficult to estimate. Volunteer bias is systematic error due to differences between those who choose to participate in studies and those who do not. For example, newer staff and staff who do not have strong written French language skills may be less likely to respond to written surveys. Staff perceiving their knowledge and attitudes toward death, dying, end-of-life palliative care, and interdisciplinary practice as good may be more likely to respond.

Fourth, we have not collected data about cultural variables of residents such as ethnicity, religion, language, nationality, or national/geographical origin. We know that the population living in private households on the local territory is multi-ethnic and one-half was born outside of Canada. The 2011 Canadian census top 10 of the more significant groups include Lebanese, Moroccan, Chinese, Greek, Egyptian, Algerian, Vietnamese, Haitian, Romanian, and SriLankan, respectively. However, according to the managers’ point of view, the ethnic and cultural origin of the sampled LTC residents would be less diverse than that of the surrounding territory’s population, but the diversity tends to increase. This demographic trend increases the likelihood that our patients’ values may not be consistent with those of traditional Western-based medicine.\textsuperscript{32} Some studies documented the differences in end-of-life preferences and decision-making between culturally diverse resident groups and pointed out the need to understand cultural values and beliefs that influence end-of-life care.\textsuperscript{33–35}

Lastly, there is a certain arbitrary polarization of the word statements between positive and negative. This is because of the quantitative nature of the questionnaire. Therefore, nuances can be reduced within a complex situation. It is not always clear whether the responses captured respondents’ attitude toward a particular aspect or his judgment about it based on his experience of care. It would be highly desirable to explore some aspects in more depth using personal interviews. A study of the attitudes of health workers will not be complete without adding qualitative methodology (eg, running of focus groups for the different grades of workers) to more clearly delineate what the issues are. This is important for future action. Nevertheless, our results could serve as an initial step toward a reflexive narrative environment in which workers can express their personal feelings and perceptions.

Conclusions

The current study addressed the issue of death, dying, end-of-life palliative care, and interdisciplinary practice in LTC facilities. Despite a consensus of positive attitudes for several aspects of care, we noted mixed opinions with respect to a significant number of other aspects. There are statistically significant differences across job categories. The results of this study suggest that beliefs, values, and attitudes, including communication among providers and between providers and residents and their families, need to be taken into account in LTC facilities. Education, training, and support programs for LTC providers should include discussions of attitudes toward death, dying, and end-of-life palliative care. Based on the data collected in the study, patient assistants, volunteers, and nursing assistants are most likely to benefit. Policy makers must prepare LTC workers for the challenges posed by growing populations facing end-of-life decisions.

The suggested remedies pass through an honest questioning of our practices, and of the observed differences of beliefs, values, and attitudes toward death, dying, palliative and interdisciplinary care in long term care workers. As well, the naive official call for interdisciplinary and work-related continuing education and training opportunities, proposed in the context of increasing pressures for cost and staff reduction, can be questioned.

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