

Critical care nurses' experience of the sudden
unexpected death of a patient.

A Phenomenological study.

by

Roseanne Elizabeth Turner

A dissertation submitted to the
Faculty of Health Sciences, University of Cape Town
in fulfillment of the requirement for the degree
Master of Science (Nursing).

February 2003

The copyright of this thesis vests in the author. No quotation from it or information derived from it is to be published without full acknowledgement of the source. The thesis is to be used for private study or non-commercial research purposes only.

Published by the University of Cape Town (UCT) in terms of the non-exclusive license granted to UCT by the author.

DECLARATION

I, Roseanne Elizabeth Turner, hereby declare that the work on which this dissertation is based is original (except where acknowledgments indicate otherwise) and that neither the whole work or any part of it has been, is being or is to be submitted for another degree in this or any other University.

I hereby empower the University of Cape Town to reproduce for the purpose of research either the whole or any portion of the contents of this dissertation in any manner whatsoever.



Roseanne E Turner

14 - 2 - 2003

Date

DEDICATION

To Critical Care Nurses everywhere.

University of Cape Town

*To laugh often and much;
To win the respect of intelligent people and the affection of children;
To earn the appreciation of honest critics;
To appreciate beauty, to find the best in others;
To leave the world a bit better whether by a healthy child, a garden patch, or a redeemed
social condition;
To know even one life breathed easier because you lived.
This is to have succeeded.*

Ralph Waldo Emerson

ACKNOWLEDGMENTS

To the critical care nurses, for so willingly giving up their precious off-duty time, and for being so honest about their experiences.

To John, my husband and inspiration.

To Caitlin, my daughter who has had to share me with this research project for the whole of her young life!

To my Mother, for always believing in me and for her help with the final checking of this report.

To my supervisors:

- Pat Mayers for bailing me out and for her support and patience, and
- Beverly Oskowitz for getting me to see the trees.

To Jane Roe who started me on this journey, for her inspiration and support.

To Wendy McLeod for her constant support and encouragement as well as her critical and constructive review of this report.

To Professor Rosalie Thompson for her editorial eye.

To the Critical Care Society [Cape Western Branch], who provided me with the funding to purchase a transcribing system, which greatly aided the tedious transcription process.

To DENOSA for the small bursary, which helped with the enormous photocopy costs.

And finally, while all these people may have encouraged or advised me, any errors or heresies are entirely my own.

ABSTRACT***Critical care nurses' experience of the sudden unexpected death of a patient.***

This phenomenological study explores the lived experiences of five critical care nurses who have had patients die suddenly and unexpectedly. The critical care nurse practices within a highly technological environment, where the focus of her care is on the preservation of life. Despite this she is exposed to death more frequently than nurses working in other areas. A small proportion of deaths that occur within the intensive care unit (ICU), are sudden, unexpected and preceded by an unsuccessful resuscitation attempt. These deaths challenge the critical care nurse's control over her technological environment as well as her ability to effectively care for her patient.

In depth interviews were conducted with five critical care nurses who had previously experienced the sudden unexpected death of a patient and who worked within a single ICU in a private sector South African hospital. The interviews were audiotaped, transcribed verbatim and analysed. This thematic analysis revealed five themes, which describe the lived experience of these nurses. They are: 1) the shock of it; 2) the burden of guilt; 3) dealing with the relatives; 4) denial of self; and 5) regaining emotional equilibrium. The themes were then reflected upon in relation to the available literature and related to the four life world themes or existentials as described by van Manen (1990).

Having a patient die suddenly and unexpectedly is a highly stressful and emotive event as it exposes the essential powerlessness of the critical care nurse, which is often disguised by her environment and technical knowledge. When her patient dies suddenly and unexpectedly the nurse has failed to predict and prepare for this crisis

event and as a result has been ineffective in both her caring and her techno-medical roles. She is left feeling a failure, powerless and guilty that she may have directly or indirectly contributed to the death.

Following the sudden unexpected death of a patient the critical care nurse has difficulty effectively interacting with the bereaved family and relies heavily on prior personal and professional experiences during these interactions. The participants described how they constantly have to deny or ignore their own emotional needs. Many demonstrated symptoms of burnout, which results from ineffective coping. The critical care nurse usually has to deal with her emotions and insecurities on her own, as her colleagues are unable to give more than superficial support, and her family are unable to give her reassurance with regard her professional competence.

A number of recommendations were identified from the data, which may facilitate coping. These include:

- ◆ Nurses being given time to reflect on events surrounding the sudden unexpected death and being encouraged to discuss the emotional turmoil they may be feeling, within the safety of a supportive group or with a trusted colleague.
- ◆ Positive aspects of the situation, which may not always be apparent, need to be highlighted where appropriate.
- ◆ Nurses should to be trained in how best to interact with and support the family during this initial period of intense emotional disturbance.
- ◆ In addition critical care nurses need to recognise that they have a different role to the doctor, which is of equal importance and value. In this way they can be empowered and develop confidence within their unique role.

DEFINITION OF TERMS

Term	Definition
ICU	Intensive care unit
A & E	Accident and emergency
Meaning	This is the interpretation that the participants place on the rules, issues and behaviour of the culture (Field & Morse 1985).
Experience	An event about which the informant has direct knowledge because of personal participation.
Sudden unexpected death	Death that was neither expected nor anticipated.
Relatives	Loosely applied term that includes all people who play significant role in the life of the patient, and not merely those related by birth or marriage.

TABLE OF CONTENTS

DECLARATION	ii
DEDICATION	iii
ACKNOWLEDGEMENTS	iv
ABSTRACT	v
DEFINITION OF TERMS	vii
TABLE OF CONTENTS	viii
CHAPTER ONE – INTRODUCTION AND AIMS OF THE STUDY	
1.1 Introduction and background.	1
1.2 The researcher's personal experiences with sudden death.	3
1.3 Aim of the study.	6
1.4 Overview of the study.	7
CHAPTER TWO – REVIEW OF THE LITERATURE	
2.1 Stress.	8
2.2 Stress and Nursing.	10
2.3 Stress and the Critical care nurse.	11
2.4 Coping.	13
2.5 Burnout.	15
2.6 Death.	16
2.7 Death in the ICU.	17
2.8 Sudden death and the Critical care nurse.	20
CHAPTER THREE – METHODOLOGY	
3.1 Choosing a research paradigm.	24
3.2 Qualitative research methods.	26
3.2.1 Grounded Theory.	27
3.2.2 Phenomenology.	28
3.3 The Research Procedures.	31
3.3.1 The Participants.	31
3.3.1.1 Sample selection and sampling procedures.	33
3.3.1.2 Ethical considerations and Entry Issues.	33

3.3.1.2.1	Voluntary participation.	33
3.3.1.2.2	Informed consent.	34
3.3.1.2.3	Confidentiality and anonymity.	35
3.3.2	Data Collection Techniques and Strategies.	36
3.3.2.1	Free attitude in-depth interviews.	36
3.3.2.2	Focus group discussion.	39
3.3.2.3	Other strategies.	40
3.3.3	Data Analysis.	41
3.3.3.1	Transcriptions.	41
3.3.3.2	Interpretation of the data.	41
3.3.4	Ensuring rigor or trustworthiness.	45
3.3.4.1	Truth-value or credibility.	45
3.3.4.2	Applicability or transferability.	47
3.3.4.3	Consistency or dependability (auditability)	48
3.3.4.4	Neutrality or confirmability	49
 CHAPTER FOUR – DESCRIPTION OF THE THEMES.		
4.1	Introduction.	51
4.2	The types of deaths that occur in the ICU.	52
4.3	Factors that impact on the experience of a patient's death.	54
4.4	<i>Theme one:</i> The shock of it.	60
4.5	<i>Theme two:</i> The burden of guilt.	63
4.6	<i>Theme three:</i> Dealing with the relatives.	65
4.7	<i>Theme four:</i> Denial of self.	69
4.8	<i>Theme five:</i> Regaining emotional equilibrium.	72
4.8.1	Support at work.	72
4.8.2	Friends and family.	75
4.8.3	Doing it alone	76
 CHAPTER FIVE – REFLECTIONS ON THE THEMES		
5.1	Introduction.	81
5.2	Lived Space (Spatiality).	82
5.2.1	Technological space in the ICU.	83
5.2.2	Caring space in the ICU.	84
5.2.3	Sudden unexpected death and the ICU environment.	85

5.2.3.1	A double knock?	86
5.3	Lived Time (Temporality)	88
5.3.1	Past experiences and losses.	88
5.3.2	The present.	89
5.3.3	The future.	90
5.4	Lived Human Relation (Relationality or Communality).	91
5.4.1	Nurse – patient relationships.	92
5.4.2	Nurse – relative relationships.	93
5.4.3	Nurse – nurse relationships.	96
5.4.3.1	The Nursing team.	97
5.4.4	Nurse – doctor relationships.	98
5.4.5	Outsiders (family and friends).	101
5.5	Lived Body (Corporeality).	101
5.5.1	Denial of self.	102
5.5.2	Moderation of emotional response.	103
5.5.3	Physical symptoms of stress.	104
5.5.4	Burnout.	104
5.5.5	Reconnecting with self.	105
5.5.5.1	Searching for an explanation.	108
5.5.5.2	Talking about it.	108
5.5.5.3	Comparing with others.	109
5.5.5.4	Positive interpretation.	109
5.6	Limitations of the study.	109
5.7	Recommendations for critical care nursing practice.	110
5.7.1	Recommendations for nursing practice.	111
5.7.2	Recommendations for nursing education.	111
5.7.3	Recommendations for future research.	112
5.8	Conclusions.	113
REFERENCES		115
APPENDICES		
Appendix A: Permission to conduct study – Research Ethics Committee.		
Appendix B: Permission to conduct study – Hospital Management.		
Appendix C: Information sheet and informed consent form.		
Appendix D: Confidentiality contract with the typist.		
Appendix E: Themes, categories and clusters that emerged from the data.		

CHAPTER ONE

Introduction and aims of the study.

1.1 Introduction and background.

Intensive care units (ICUs) were developed in the 1950s as areas where critically ill patients who required close observation could be placed together in a central location (Thelan et al. 1994). As a result of rapid advances in medical knowledge, ICUs have since developed into specialized areas filled with highly sophisticated technology that is used to observe closely, monitor and physiologically support extremely unstable patients who are at high risk of dying. The focus of efforts within the ICU is to save lives, yet nurses who work in these areas are paradoxically exposed to more deaths than nurses working in other areas (McClement & Degner 1995).

Nurses who work within the ICU are referred to as 'critical care' rather than 'intensive care' nurses as they are a highly skilled group who not only provide an intensive level of care but must also be able to critically evaluate complex data, make rational decisions about problems and then implement the most appropriate interventions. Benner, Hooper-Kyriakidis and Stannard (1991, p.2) eloquently describe nursing practice within the ICU as "intellectually and emotionally challenging because it requires quick judgments and responses to life-threatening conditions where there are narrow margins for error". Nurses who work within the ICU have different levels of training and competence. Some have attained an additional qualification in critical care nursing, while others are simply experienced in ICU nursing. Regardless of her level of training the critical care nurse has to function effectively and with relative autonomy in a highly technical environment. Although nursing is practised by both sexes it has traditionally been the domain of women, and females continue to outnumber males within the profession. In South Africa the current male: female ratio of registered

nurses is 1:18 (SANC 2002). It is for this reason that nurses in this report are ascribed a feminine gender.

The deaths that occur within the ICU can be divided into two categories: those patients who are expected to die either because life support has been withheld or withdrawn because further intervention would be futile, and those patients in whom death is sudden and unexpected. The deaths in the first group are anticipated and nurses are able to prepare the patient, their family and themselves. With sudden unexpected death there is no time for preparation and these patients are often subjected to unsuccessful resuscitation attempts and their deaths can be traumatic and lacking in dignity. Wright (1996) asserts that sudden death is one of the most traumatic crisis events that can be experienced. In these situations nurses not only have to deal with the pain, anguish and distress of the suddenly bereaved family, but must also deal with their personal responses to sudden death. These include being reminded of previous losses, experiencing an increased awareness of feared personal losses and being reminded of their own mortality (Saines 1997b). In addition, these situations give rise to feelings of self-doubt and a multitude of concerns related to the care of the patient and the reason for this sudden unexpected event.

The quality of patient care and the patient outcome (morbidity and mortality) is dependent on the technical expertise of the critical care nurse and also on her psychological state (Hay & Oken 1972). To be effective, critical care nurses must successfully cope with stressful situations and so maintain both their physical and psychological integrity (Crickmore 1987). Failure to cope leads to high levels of burnout and attrition amongst this group of highly skilled nurses. The way in which nurses experience grief, if indeed they do grieve for patients, is highly individualized

(Rashotte, Fothergill-Bourbonnais & Chamberlain 1997). The way nurses cope is dependent on a number of issues, including past experience, personality traits, relationship with others and the environment (Wright 1996). Also important is what is considered to be at stake and what coping options are thought to be available at the time (Folkman et al. 1986).

Even nurses who have effective coping skills face serious emotional crisis with repeated exposure to difficult and emotionally draining experiences (Wright 1996). This is especially true if there has been no time for emotional recovery between death events (Saines 1997a). Nurses need to be assisted to deal effectively with their feelings (Rashotte, Fothergill-Bourbonnais & Chamberlain 1997) and emotional support is an essential part of helping them cope with the intensity of emotions that sudden death situations provoke. However, before this can be achieved it is important that the way nurses actually experience sudden unexpected patient death is understood.

1.2 The researcher's personal experiences with sudden death.

I have worked in the critical care setting for over 20 years, and first became interested in the way nurses experience the death of a patient, while working as a transplant co-ordinator. This job entailed, among other things, obtaining consent for organ donation from the suddenly bereaved family, and managing the brainstem-dead organ donor until the organs could be harvested. To cope with these situations I found that I focused on the recipients and distanced myself emotionally from the donor and the "donor family". I also observed that many of the attending nurses (i.e. those nurses responsible for the care of these patients) were distressed and expressed difficulty in coping with these situations. In some instances they displayed aggression and hostility towards the transplant team and myself.

I later perceived a difference in my attitude when nursing brainstem-dead organ donors as compared to nursing "hopelessly ill" patients who had had life support withheld or withdrawn, and I wondered whether my colleagues felt the same. Brainstem-dead organ donors have already been certified dead, but their organs have to be artificially oxygenated and perfused to ensure they are in an optimal condition for transplantation. My nursing care in these instances was mechanical as the focus was purely to manipulate and maintain a dead patient's physiological status. I knew that nothing I did would impact on the outcome for that patient, but that well maintained organs would give life to a large number of transplant recipients.

By contrast I found care of patients who had had life support withheld or withdrawn was emotionally draining. While I understood and supported the decision to withhold or withdraw therapy, I still found it uncomfortable to stand back and wait for someone to die. In these instances I had to actively alter my focus from that of preserving life to one of making death as comfortable as possible for both the patient and her or her family. Because of my interest in this area I undertook a small research project (Turner 1995) to determine nurses' attitudes to the withdrawal of life support from the hopelessly ill patient and to nursing brainstem-dead organ donors. Due to my inexperience as a researcher this study had many flaws; primarily that the research instrument was a poorly developed questionnaire. This study did, however, indicate that, like myself, most critical care nurses (74%) experienced emotional conflict and discomfort as a result of the decision to withdraw therapy.

Until recently I worked as the unit manager of a busy intensive care unit in a private sector hospital, and was aware that each patient death affected me differently. My

personal methods of coping in these situations were dependent on a number of factors, including whether there was time to talk to colleagues after the death, whether I thought that more could have been done for the patient, my prior relationship with the family and the quality of nursing care I had been able to provide. I also found that I repeatedly had to reassure and support nurses who felt that a patient's death or deterioration might have been due to some action or omission on their part. These nurses demonstrated increased insecurity with regard to their professional competence.

I have also personally experienced the sudden unexpected death of a family member, in a critical care unit. The well-meaning, but inappropriate actions of both the attending doctors and the nursing staff worsened the emotional trauma of this event for the family. My family were, for example, not given any privacy while we tried to comprehend what had happened, and were initially discouraged from viewing the body and later not allowed to view the body alone. Both the doctors and nurses were defensive and appeared to be hiding information, as they were reluctant to tell us exactly what had occurred. This served to highlight the distress, which can be caused to relatives when health professionals are themselves unable to deal appropriately with the situation.

I knew how deeply and differently sudden deaths had affected me both as a nurse and a family member and was curious about how other nurses experienced and coped in these situations. In retrospect I think I also undertook this area of research to gain some insight into why I had felt so let down by fellow health professionals following my personal loss. Because of my interest in bereavement I have always made a special effort to ensure that family members are given the care and support they need

following the death of a relative. Indeed this degree of care became the norm within the unit where I worked and I presumed other units offered the same level of support. I was shocked by the realisation that this may not be true and that the inept care delivered to my family and myself was more likely to be the norm.

The next chapter (literature review) will highlight the fact that dealing with death, any death, is an important stressor in the ICU. However, few studies have specifically examined death or sudden death in the ICU. As a result one has had to presume that findings from other areas can be readily applied to the ICU setting. Existing studies have not attempted to differentiate between expected and sudden unexpected death. In trying to understand how nurses experience death, I have selected what is recognized as the worst death scenario (Wright 1996). In sudden unexpected death the nurse and family have no time for preparation; rationalization is difficult and the nurse is often thrown off balance because of concerns regarding her professional competence and emotional state.

1.3. Aim of the study

The aim of this study is primarily to explore the experience of critical care nurses related to the sudden unexpected death of a patient and following this, to describe these experiences. More specifically this study attempts:

- to examine critical care nurses' descriptions of the phenomenon;
- to reveal or uncover meaning in their experiences;
- to articulate the ways in which critical care nurses respond following the sudden unexpected death of a patient.

1.4. Overview of the study.

In Chapter Two a broad overview of the literature surrounding death in the intensive care unit is reviewed in order to provide a framework for this study. Chapter Three provides justification for the choice of research methodology and describes the methodology used in detail. Chapter Four reports the data while Chapter Five provides discussion of how these data relate to the existing literature and concludes with recommendations.

University of Cape Town

CHAPTER TWO

Review of the literature.

Qualitative researchers were initially encouraged to commence their research without reviewing the literature, as it was feared that any prior knowledge would direct their research (Holloway & Wheeler 1996). It is however equally important that researchers have a conceptual framework of the area they wish to study so that they are able to link with other research and ideas about the topic (Holloway & Wheeler 1996). It is for this reason that a literature review was conducted prior to the study and is reported here. A further review of the literature, which was guided by the emerging themes, is reported within the discussion in Chapter Five of this dissertation. In addition a literature review relating to methodology is discussed within Chapter Three. This literature review has been included in the Methodology chapter for clarity, as it provides the rationale and justification for the research paradigm and design used in the study.

Thus the literature, which forms the framework for the study is reviewed in this chapter and includes literature related to stress, coping and death in the critical care unit.

2.1 Stress

Vachon (1987) states that stress is one of the most ill defined concepts in biological and behavioural scientific literature. This is because the word *stress* is used to describe a large number of different factors. Three of these factors are discussed by Bailey and Clarke (1989), and are summarised as follows:

- Stimulus-based model – stress refers to the outside stimulus to which the individual responds.
- Response-based model – stress refers to the individual's physiological response to a threatening situation.
- Transactional model of stress – stress is the result of the interaction between the situation and the person who perceives the situation as threatening. In other words any situation can be considered threatening or stressful if the individual interprets it as such.

The first two models are simplistic and do not account for the various individual responses to different stimuli. The transactional model or the cognitive-phenomenological-transactional (CPT) model (Bailey & Clarke 1989) appears to offer a more realistic view of stress. Lazarus and colleagues developed this model, which takes into account the individual's idiosyncratic and variable response to any situation, in 1966 (Bailey & Clarke 1989). Cognitive appraisal of the situation and the perceived ability to cope are identified as two processes, which determine whether or not a situation will be considered stressful (Folkman et al. 1986a). Folkman et al. (1986a) describe two types of cognitive appraisal, which refers to the individual's evaluation of any encounter. During the primary appraisal the individual decides whether the encounter has any personal relevance and evaluates what is at stake. In the secondary appraisal the individual evaluates what, if anything, can be done to prevent or overcome potential harm or to improve the possibility of personal benefit. The outcome of these two appraisals will determine whether the situation is perceived as threatening (negative) or challenging (positive).

2.2 Stress and Nursing

There are a large number of original studies and review articles in the literature, the majority of which were conducted in the 1980's, including works by Hay and Oken (1972), Bailey, Steffen and Grout (1980), Stehle (1981), Friedman (1982) and Crickmore (1987), which support the notion that the ICU is a stressful area in which to work. Other studies on stress in nursing have failed to confirm that critical care nursing is more stressful than other areas of nursing (Gentry & Parkes 1982, Maloney & Bartz 1983, Keane, Ducette & Adler 1985, Boumans & Landeweerd 1994). Foxall et al. (1990) compared the frequency and sources of stress in intensive care, hospice and medical and surgical ward nursing. They report similar levels of stress in nurses working in each of these areas although the causes of stress differ in each area. Death and dying situations were most stressful for intensive care and hospice nurses who are more frequently exposed to these situations, while work-overload and staffing issues were most stressful for ward nurses.

It has been suggested that critical care nurses are *hardier* and thus more tolerant of stress than nurses working in other areas. Maloney and Bartz (1983) examined this issue and compared the degree of commitment versus alienation and the locus of control (internal vs. external) expressed by 40 ICU and 35 non-ICU nurses, as well as the degree of challenge sought by these two groups. They report that the ICU nurses were more alienated and felt more powerless than the non-ICU nurses; however they were more adventurous and sought more challenges than non-ICU nurses. These mixed results seemed to indicate that some degree of stress tolerance exists in both groups.

2.3 Stress and the Critical care nurse

In their classic, albeit dramatic study of the psychological stresses of intensive care nursing, Hay and Oken (1972, p.114) describe the atmosphere in the ICU as "that of the tension-charged strategic war bunker" where the nurses must daily deal with situations, which would normally be considered "frightening, repulsive and forbidden". Hay and Oken (1972) also suggest that the constant exposure to this environment together with the heavy workload, communication problems, repetitive exposure to death and dying and the resultant feelings of loss and personal failure are all formidable stresses for the critical care nurse. The critical care nurses continuously works under "a cloud of latent anxiety" (Hay & Oken 1972, p.113), where one mistake can lead to the death of her patient. They must also deal with repeated failure as many patients die, despite receiving the best possible nursing care. In addition critical care nurses are more likely than other nurses to experience loss following the death of a patient, because of increased patient attachment and the intimacy, which results from having to help patients with their most basic bodily needs (Hay & Oken 1972).

Dealing with death and dying has been repeatedly identified as a major stressor for critical care nurses yet little is known as to exactly why this is so stressful, or if the different types of death which occurs in the ICU are equally stressful. Stehle (1981) in a review of ICU stress in the nursing literature prior to 1981, points out that while these studies attempt to define the components of stress in the ICU none classify these stressors according to existing theories. In addition none of these studies highlights the personal coping resources nurses use in stressful situations or if any coping strategies were found to be beneficial. The signs and effects of stress on the critical care nurse were also not described (Stehle 1981).

Work stress has been identified as an important factor influencing the high turnover of critical care nurses (Cartledge 2001). The stressors in the ICU have increased since the plethora of studies on the subject in the early 1970's and 1980's. This is as a result of increased workload because of rapidly expanding medical technology, increasing job complexity and the associated ethical dilemmas (Le Blanc et al. 2001). In addition, cost-containment and declining numbers of suitably trained critical care nurses in South Africa (Gillespie 2000) have further added to the workload and stress of those nurses who remain.

Three South African studies, outlined below, explore the issue of stress in critical care nursing. In 1990 the Human Sciences Research Council were commissioned by the Critical Care Society of Southern Africa to explore the working conditions of professional nurses in intensive care and high care areas. Only the management summary and recommendations of this study were published (Cilliers 1990). A total of 1457 nurses responded to the study questionnaire. This, at the time, represented 60.8% of the total number of registered nurses working in intensive care units at 84 private sector and public hospitals. The study aimed to identify problems with regard to conditions of service, nursing administration, working conditions and remuneration, and to make recommendations to solve identified problems. Of interest was that nurses reported satisfaction at being able to deliver total patient care and work within a team. They reported a sense of achievement, which resulted from working with high technology, being able to make independent decisions and have greater responsibility. Lack of support, appreciation and the lack of competence of nursing management were reported to be a major cause of discontent along with troubled interpersonal relationships. Stress was reported to be a reason for nurses leaving the area, but no details were given (Cilliers 1991).

A small quantitative study conducted by the researcher (Pike 1993), explored the causes of discontent amongst critical care nurses working in a number of different intensive care units, at a large South African teaching (public) hospital. This study duplicated a prior study conducted by Nichols, Springford and Searle (1981), and made use of a slightly modified version of their questionnaire. One hundred and sixteen questionnaires were randomly distributed to nurses working in seven different intensive and high care units. Forty eight (41%) of the questionnaires were returned and analysed. It was reported that critical care nurses generally enjoyed high levels of job satisfaction and good unit morale. Those nurses working in units with higher mortality rates experienced more discontent.

A phenomenological study by Pope, Nel and Poggenpoel (1998) explores the experience of working in an adult intensive care unit. The themes, which are only listed in the report include "stressful working environment" (Pope, Nel & Poggenpoel 1998, p.35)

2.4 Coping

Holahan, Moos and Schaefer (1996, p.25) define coping as "a stabilising factor that can help individuals maintain psychosocial adaptation during stressful periods". There are two theories about the phenomenon of coping. These are based on the primary determinants that drive the coping process, known as the dispositional and the contextual approach.

The dispositional approach, also known as the ego or trait-orientated approach (Holahan, Moss & Schaefer 1996 and Reeves, Merriam & Courtenay 1999) focuses on

the unconscious, psychological processes that people use in order to cope. It assumes that coping mechanisms are primarily part of the person, and that changes in the nature of the stressful situation have very little impact on the style of coping (Folkman et al. 1986b). Each individual develops adaptive defences in an attempt to maintain the ego under stressful situations (Reeves, Merriam & Courtenay 1999), i.e. their own unique ways and strategies for coping with the demands that they experience, in order to avoid emotional distress (Ironbar & Hooper 1989). These defences may be mature [humour, suppression], neurotic [repression], immature [acting-out] or psychotic [denial] (Reeves, Merriam & Courtenay 1999). If effective, the coping strategy results in the resolution or reduction of the feeling of stress. Effective strategies also enable the person to feel in control, which enhances self-esteem and allows learning to take place. Ineffective coping strategies increase the feeling of stress and further reduce the person's ability to cope. Ineffective coping also creates feelings of loss of control and of being trapped and helpless (Ironbar & Hooper 1989).

The second approach to coping is the contextual, transactional or process orientated approach (Holahan, Moos & Schaefer 1996 and Reeves, Merriam & Courteney 1999). Although their work was originally reported in the 1980's Lazarus and Folkman remain the chief proponents of this approach that describes coping as having two major functions. These are to regulate stressful emotions (emotion-focused coping), and to alter the relationship between the person and the environment that is causing the distress (problem-focused). Most stressful encounters include both of these functions as demonstrated by Folkman and Lazarus (1985) in a study of how students cope during a college examination. These students coped with stressful encounters in a number of complex ways, and almost always made use of both coping strategies. Folkman and Lazarus (1985) found that coping strategies change as the stressful

encounter unfolds and that during a stressful encounter people often experience contradictory states of mind and emotion. It is unclear whether these results are transferable to those who are repeatedly exposed to extreme stress such as nurses in the intensive care unit. Folkman et al. (1986a) also found that the type of coping used varies according to what is perceived to be at stake (primary appraisal) and what coping options are thought to be available (secondary appraisal).

There is a large body of literature, which relates to coping strategies and the critical care nurse. This literature did not form part of the original literature review, but will be discussed within Chapter 5.

2.5 Burnout.

Maslach (1982, p.3), who could be considered one of the major experts in the area, describes burnout as "a syndrome of emotional exhaustion, depersonalisation, and reduced personal accomplishment". Burnout occurs as a result of chronic emotional strain, which results from dealing extensively with people, especially those who are distressed (Maslach 1982). Burnout leads to the development of negative job attitudes and loss of concern and feeling for patients (Oehler et al. 1991). The causes of burnout are complex, but increased levels of burnout have been found in nurses who work in areas with high levels of work related stress (Stechmiller & Yarandi 1993). In addition those nurses with ineffective coping strategies appear at increased risk of developing burnout (Bailey & Clarke 1989). Foxall et al. (1990) report on a number of studies that indicate that job stress contributes to feelings of inadequacy, self-doubt, lowered self-esteem, depression and burnout in nurses.

Maslach (1982, pp.3-5) describes burnout as having three components namely "emotional exhaustion", "depersonalisation" and "reduced personal accomplishments". When experiencing emotional exhaustion the nurse is apathetic and lacks energy, she displays a loss of trust, empathy and concern for others. The depersonalised nurse is irritable, detached, callous, and has little respect for others and so provides inappropriate care. A sense of personal accomplishment is reduced when the nurse feels distressed and guilty when she reflects on the way she has thought about, and treated others. This in turn results in inappropriate negative appraisal of self and personal achievements (Maslach 1982). Burnout leads to depression, absenteeism, poor job performance and high attrition rates (Oehler et al. 1991).

2.6 Death.

Caring for those who are sick and suffering and also for the dying has always been an important part of nursing. Maeve (1998) reports on a phenomenological study, which explored the process nurses used to come to terms with caring for patients who are suffering and dying. There were nine participants in this study. One participant worked in an emergency unit and the others were involved with oncology and palliative care. Although a grounded theory methodology may have been better suited to the topic, Maeve (1998) reports some interesting findings. She states for example (Maeve 1998, p.1138) that caring for patients who are suffering or dying forms an integral part of the nurse; and that this care seemed to imbue "the nurses with a kind of thoughtfulness and courage towards the dilemmas in their own lives". The core theme in this study was "weaving the fabric of moral meaning" and the three supporting themes were "tempering involvement", "doing the right thing / the good thing" and "cleaning up" (Maeve 1998, pp 1139-1140). Maeve (1998) also describes how the dilemmas of patients' lives are woven into the nurses understanding of her own life,

both professionally and personally. In this way each and every patient death the nurse experiences impacts upon, and adds a new dimension to her own life.

Bereavement, its phases and the coping mechanisms people use when confronted with death have been examined in detail by many authors, including major works by Kubler-Ross (1973) and Parkes (1996). These works tend to focus on the reactions of the dying and their relatives and not on those of the caregiver. As stated earlier the effect of death and dying on nursing staff, particularly those working in ICU, has received limited attention.

2.7 Death in the ICU.

The mortality rate in ICU varies from unit to unit. In one study, which compared the decision to limit life support in two tertiary ICUs, one in South Africa and the other in England, the mortality rate was found to range from 7 – 11% of ICU admissions (Turner et al. 1996). [A tertiary ICU is a regional referral centre with a broad base of medical expertise.] In this study Turner et al. (1996) reported that the majority (87%) of patients who die in ICU, die because therapy has either been withheld (i.e. limited) or withdrawn as further medical therapy is considered futile. The remaining 13% of deaths were found to occur as a result of failed cardio-pulmonary resuscitation (CPR) (Turner et al. 1996). The latter deaths can almost certainly be classed as sudden and unexpected deaths.

McClement and Degner (1995) used a quantitative methodology to identify expert nursing behaviours in the care of dying adults in ICU. One of the aims of this study was to compare the behaviours of critical care nurses with behaviours previously identified in hospital-based palliative care nurses. The authors highlight some

important differences between the caring behaviours of these two groups of nurses. For example in palliative care emphasis is placed on "enhancing the quality of life while dying" (McClement & Degner 1995, p.416), which is not possible in the ICU. In the ICU, when it is realised that life preservation treatments are futile, there is little time between the limitation of life support measures and death, and the patients are usually not in a condition to identify what is important to them. Palliative care nurses also place emphasis on maintaining a sense of calm and family involvement during the death scene, something that is also not possible in ICU where the restorative focus sometimes makes it difficult for the nurse to think of the patient as dying. The critical care nurses in this study emphasised the need to create a dignified and peaceful bedside scene for the family to return to after the patient has died, which is not a focus of palliative nursing. Critical care nurses were concerned about psychological neglect during death. In contrast the palliative care nurses were more concerned about their "poor knowledge base" which resulted in poor management of physical symptoms (McClement & Degner 1995, p.417), something which was not reported to be a problem in the ICU where the dying patient's symptoms are usually managed systematically and efficiently. Both palliative and critical care nurses identified "responding to the family" as an important caring behaviour (McClement & Degner 1995, p.417).

Spencer (1994) examines how nurses deal with their own grief when a patient dies in an ICU, and outlines what help can be given to enable them to effectively overcome their grief. She employed a combination of qualitative and quantitative self-report approaches in her research design. Questionnaires were sent to seventy-two registered nurses working in ICU (convenience sample) of which fifty one (71%) were returned. Ten of the nurses who had completed a questionnaire were subsequently

interviewed using a semi-structured interview technique. The questions were similar to those in the questionnaire but allowed for more depth. Little detail is given of how these data were analysed. Spencer (1994) reports that 78 - 98% of nurses sometimes experience feelings of anger, shock and relief following the death of a patient. She also notes that there were a number of factors which appeared to influence these feelings; including the relationship with the family, the amount of discussion nurses were able to have with the doctors, the circumstances surrounding the death, and whether the nurse was involved with the care of the body after death. Spencer (1994) makes no mention whether the deaths were sudden or expected; however the fact that 98% were reported to have felt relieved by the death could indicate that these were expected deaths. The majority of nurses reported that talking about the incident helped them to cope. Only 25% of nurses said that they had ever received any training to help them deal with their own grief and of these, 84% felt this training was inadequate. Spencer (1994) uses a predominately quantitative approach and attempts to show distribution of responses rather than range, richness or depth of experience, which would have facilitated greater understanding of the subject.

Loftus (1998) reports a phenomenological study, which explores the experiences of sudden death for third year student nurses. The students worked within medical, surgical and elderly care units. This paper gives interesting insights into how a group of five novice nurses view and respond to what was, in most instances their first experiences of death and resuscitation. After the experience some of the participants developed physical and psychological signs of stress, which included developing a rash and being unable to sleep at night. They reported getting most support from their friends and relatives. In some cases they were sent away for tea after the event, which they felt cut them off from their emotions and the other people who were

involved and so left them feeling unsupported. When support was offered the focus was reported to have been on the procedure rather than on feelings. These findings concur with findings by other researchers that novice nurses are particularly vulnerable following the death of a patient (Rashotte, Fothergill-Bourbonnais & Chamberlain 1997).

Collegial support and critical feedback from colleagues was one of the expert critical care nurse behaviours identified by McClement and Degner (1995) although they report that some nurses found this support to be inadequate. Spencer (1994) also reported this lack of support by colleagues. In her study only 45% of critical care nurses said they received adequate support from their peer group and that this took the form of informal discussions (Spencer 1994).

2.8 Sudden death and the Critical care nurse.

Wright (1996) acknowledges the importance of sudden death and the impact this has on the caregiver, mainly nurses working in the accident and emergency [A&E] unit (sometimes referred to as the Trauma Unit), and gives advice on how the needs of the caregiver can best be met in order to prevent burnout. The situation in the ICU differs from that in the A&E unit because critical care nurses have usually had time to build up a relationship with the patient and the family, which is not usually the case in the A&E unit (Saines 1997b).

Rashotte, Fothergill-Bourbonnais and Chamberlain (1997) used a phenomenological approach to examine the grief experiences of paediatric critical care nurses. The paediatric deaths included expected and sudden deaths, which took place within an ICU. Eight themes emerged from their data. The first theme described the nurse's

reactions to the death, the next two outlined contextual factors that influenced the grief response and the remaining five themes related to how nurses managed their grief. The principle grief reactions these nurses experienced were feelings of hurt, sadness and sorrow. Inexperienced nurses were reported to experience overwhelming sadness while the more experienced nurses were able to balance these feelings with other emotions, like relief that the death for example had been pain free. Nurses also experienced feelings of powerlessness, vulnerability and guilt. These feelings of guilt, which ranged from a sense of remorse to that of culpability, were found to intensify and lengthen the grief experience (Rashotte, Fothergill-Bourbonnais & Chamberlain 1997). The contextual themes, which influenced the intensity and duration of the grief experiences, included the nature of the relationship between the nurse and the family unit, and any feelings of dissonance. Dissonance was reported to be the clashing of the nurse's beliefs with the reality of the death. These beliefs relate to the nurse's ideas on the nature of an ideal death and also her philosophy of critical care nursing and caring (Rashotte, Fothergill-Bourbonnais & Chamberlain 1997).

Saines (1997a, 1997b) used a phenomenological approach to explore registered nurses experiences of sudden death within an A&E unit in the United Kingdom. Six experienced A&E nurses were interviewed. Four themes were identified. These are "encountering", "facing", "dealing with", and "reflecting upon sudden death" (Saines 1997b, p.205). The findings emphasize the sudden and unpredictable nature of these experiences and also the difficulties nurses have in coming to terms with sudden death, especially when young people are involved. Hospice nurses are able to positively contribute to their patients' experience of death by ensuring that they are pain free, peaceful and dignified; A&E nurses seldom have this opportunity, which adds to their distress (Saines 1997b). In the study reported earlier McClement and Degner

(1995) also noted this difference between hospice and critical care nurses. Nurses revealed a strong protective instinct towards the family and also expressed feelings of inadequacy when caring for them. Saines (1997b) concludes with recommendations for practice that include allowing staff time to reflect on each sudden death situation before they have to encounter another, and ensuring effective education and support for vulnerable staff.

Nurses need time to recover emotionally between sudden death experiences or they face the risk of severe distress, burnout or post-traumatic stress disorder (Lally & Pierce 1996 and Clark 1997). While the above studies by Saines (1997b) and Rashotte, Fothergill-Bourbonnais and Chamberlain (1997) use different nursing populations they concur in their descriptions of how nurses cope with sudden death experiences. Nurses report a need for an avenue for emotional expression, which may be either public (papers, presentations) or private (keeping journals). They need a satisfactory and meaningful conclusion to each sudden death situation and termination of the relationship was found to be an important coping mechanism for the paediatric critical care nurse. Closure may take the form of writing a letter, attending the funeral or simply making a follow-up phone call. Saines (1997b) reports that nurses felt past experiences make them better able to cope with these situations and noted the need to closely observe junior staff as they have limited experience on which to draw comfort. Rashotte, Fothergill-Bourbonnais and Chamberlain (1997) also report that self-reflection and being able to do something special for themselves, like exercising; having a hot bubble bath or going shopping helped nurses come to terms with their grief. The experienced paediatric ICU nurses also reported being better able to manage feelings of grief by using established self-control behaviours, which included establishing boundaries, withdrawing or distancing themselves and performing

"personal death rituals" (Rashotte, Fothergill-Bourbonnais & Chamberlain 1997, p.382).

The nature of these death rituals was unfortunately not described.

The majority of these studies recommend the need for the proper counselling of staff; however it is this researcher's experience that counselling is seldom, if ever, provided in practice. The way nurses experience and respond to sudden death scenarios in the adult ICU have not been fully explored, nor have the methods used by the critical care nurse to cope with these deaths been adequately described. If critical care nurses are to be properly trained and supported in this matter, it is vital that the experience of sudden death be fully understood.

This study therefore aims to supply information, which will fill this gap in the literature and provide a description of how the critical care nurse experiences the sudden unexpected death of her patient, as well as to articulate the ways in which she copes following this event.

In the next chapter the research design will be described and a detailed description given of the methodology.

CHAPTER THREE

Methodology

The previous two chapters have supplied the background and framework for this study. This chapter will provide a justification for the choice of research methodology as well as give a detailed description of the methodological choices taken in this research project. This chapter is written in the first person to highlight my intimate involvement with the research process (Wolcott 1990).

The aim of this study is primarily to explore the experience of critical care nurses related to the sudden unexpected death of a patient and following this, to describe these experiences. More specifically this study attempts:

- to examine critical care nurses' descriptions of the phenomenon;
- to reveal or uncover meaning in their experiences;
- to articulate the ways in which critical care nurses respond following the sudden unexpected death of a patient.

3.1. CHOOSING A RESEARCH PARADIGM.

There are currently two major approaches to research in nursing. These are the qualitative and quantitative approaches that are based on different philosophical perspectives or paradigms of viewing the world and knowledge. These paradigms are positivism (also called traditional, experimental or empirical) and naturalism (also referred to as interpretivist, constructivist or interactionist) (Creswell 1994). Positivism and naturalism are fundamentally different when one examines the assumptions of each with regard to their explanations of ontology, epistemology and methodology

(Holloway & Wheeler 1996 and Lincoln 1992). These differences are summarized and tabulated in Table 3.1 below.

Table 3.1 The differences between the positivism and naturalism paradigms.

	Positivism	Naturalism
Ontology [the nature of reality and human behaviour]	Belief in an objective reality, which can be explained, controlled and predicted by means of natural laws. Human behaviour can be explained in causal (cause-effect) ways and so can be manipulated and controlled.	Belief in multiple realities, which are constructed and which can be explained by discovering the meanings that people in specific settings attach to it. Human behaviour is intentional and creative and can be explained but not predicted.
Epistemology [the relationship between the researcher and the subject]	The researcher is detached or separate from the object being studied. The researcher is thus able to be objective and will not influence or be influenced by the study subject.	The researcher is subjective and interacts with the subject or object of investigation. The result is created by the interaction between the researcher and the researched.
Methodology [the principles and ideas on which research is based]	Uses a strategy that is both experimental and manipulative. Hypotheses are stated and then subjected to empirical testing to verify them.	Dialectical and interpretative. During a process of interaction between the researcher and the participant, the participant's world is discovered and interpreted.

(Lincoln 1992)

Quantitative research which is rooted in positivism, looks for relationships between variables in an attempt to explain causality and give accurate predictions; these relationships are deduced from previous knowledge or research and the purpose of the research is to test this deductive theory (Field & Morse 1985). Qualitative research is

concerned with the in-depth study of human phenomena in order to understand the nature and meanings they have for the individuals involved (Hockey 1991). The goal of this type of research is to document and interpret as fully as possible the phenomena being studied (Leininger 1985). Qualitative research is often used to discover and document unknown phenomena and is especially useful when trying to research the attitudes, values and feelings of individuals and groups (Leininger 1985).

The nature of the research question determines the method to be used. This research project is directed towards gaining in-depth knowledge, insight and understanding about a relatively unknown human phenomenon (i.e. how critical care nurses experience the sudden unexpected death of a patient) thus a qualitative methodology was selected.

3.2. QUALITATIVE RESEARCH METHODS.

A methodology refers simply to the way in which data is collected and analysed (Lincoln 1992). There are a number of qualitative research methodologies that have developed out of the various disciplines, which support the naturalistic paradigm. Of these three are commonly used in nursing research, they are:

Grounded theory – developed by Sociologists to generate theoretical constructs that explain a process or answer the question “what is going on here?”;

Phenomenology – has its roots in Philosophy and attempts to uncover the meaning of human experience through analysis of the participant’s detailed descriptions; and

Ethnography – used in Anthropology to provide descriptions of cultural groups within their natural setting, over a prolonged period of time (Habermann-Little 1991).

The initial focus of this research project was to explore how nurses coped in situations in which the patient they were looking after died unexpectedly. This involved trying to understand what the coping *process* was, which enabled nurses to deal with these situations. Grounded theory thus seemed the obvious choice of methodology. It was only after two interviews had been conducted that I realized that the coping process could not be understood before I had a full understanding of how nurses *experienced* these situations. This meant that the focus of this study needed to change, thus instead of focusing on the interactions of critical care nurses following sudden death I focused on understanding the lived experience of having a patient die suddenly and unexpectedly within the ICU. The methodology changed from grounded theory to phenomenology. An explanation of the basic differences between these two qualitative methodologies will be offered in the following sections.

3.2.1 Grounded Theory.

The grounded theory approach was first used in the 1960s by two sociologists, Barney Glaser and Anselm Strauss, while they were researching health professionals' interactions with dying patients. Glaser had been trained in quantitative research while Strauss came from a background of qualitative research (Strauss & Corbin 1990). Together they built a methodology that enabled them to inductively develop theory from data (Benton 1991) while still approaching data collection and analysis in an orderly and systematic way (Holloway & Wheeler 1996).

The theoretical framework for grounded theory is based on a social philosophy called symbolic interactionism. Holloway and Wheeler (1996) cite George Mead (1934) as the main proponent of this philosophy, which views the *self* as a social rather than a

psychological phenomenon. Symbolic interactionism is a theory about human behaviour (Chenitz & Swanson 1986) that focuses on the interaction between people as they explore behaviour and social roles. This theory explains how members of society, by their expectations and influence, affect an individual's social development (Holloway & Wheeler 1996). This is an active process in which the individual interprets the behaviour of others and acts in accordance with these interpretations.

In the same way grounded theory stresses the context in which people function and observation of these interacting roles forms the basis for data collection (Holloway & Wheeler 1996). When using the grounded theory methodology the researcher must enter the world of interacting human beings, in order to understand both the participants and the situation from their perspective.

Grounded theory shares the data gathering strategies of the other qualitative research methodologies. However it is primarily concerned with the inductive development of theory that is grounded in the research data (Bailey 1997). This is achieved through the constant comparison of data with the emerging categories and theoretical sampling of different groups to highlight similarities and differences in the data (Creswell 1994).

3.2.2 Phenomenology.

Phenomenology is both a philosophy and a methodology and it is therefore important that the researcher has an understanding of both the methodology and the philosophy that underpins it. The philosophy is complex and challenging for a researcher to translate because, as Cohen and Omery (1994 p.136) state, "philosophers and phenomenologists are not noted for their clear language".

There are two basic schools of philosophy, the analytic and the continental schools. Analytic philosophy is derived from ancient philosophers such as Socrates and Aristotle and is concerned with analysing and defining abstract concepts (Holloway & Wheeler 1996). Continental philosophy takes these abstract concepts and constructs theories about them. Phenomenology, a form of continental philosophy (Holloway & Wheeler 1996) is often described as a movement to indicate how the philosophy has and continues to change or move over time (Cohen & Omery 1994). The two philosophers who have had the most influence on this movement are Husserl and Heidegger, and the two main schools of phenomenology carry their names.

Edmund Husserl (1859-1938) is credited with being the father of the phenomenological movement. There are three dominant ideas central to Husserlian phenomenology: intentionality, essences and reduction or bracketing (Koch 1995). Intentionality originates from the work of Franz Brentano (1838 – 1917) and is a way of describing how the conscious mind directs thoughts towards an object. One does not just think, one thinks *about* something (Holloway & Wheeler 1996). Husserl believed that in forming knowledge of reality one should start with this conscious awareness; and that in describing a phenomenon, one would by determining the essences, be able to “return things to themselves” (Koch 1995 p.828). Experiences are therefore studied to reveal consciousness, which Husserl believed are always intentional (Cohen & Omery 1994). The final concept of Husserlian phenomenology is that of reduction or bracketing, which can be explained as the self-inspection of the researcher’s assumptions about the experience being studied, so that any preconceptions can be identified (Koch 1995). Researchers must therefore be self-critical, explicit and conscious of their own subjectivity (Holloway & Wheeler 1996). Husserl’s philosophy

was further developed and used to guide the work of researchers such as Giorgi, Colaizzi, Fischer and van Kaam (Cohen & Omery 1994).

Martin Heidegger (1889-1976), an assistant of Husserl, was interested in the ontological aspects of the nature of *being*. He took phenomenology past simple description into interpretative or hermeneutical forms of enquiry (Holloway & Wheeler 1996). Heidegger's philosophy in turn influenced the work of the French philosophers Marcel, Sartre and Merleau Ponty. These philosophers preferred to be called existentialists rather than phenomenologists, as existentialism tries to focus on the fact that something *is* rather than describing the features (Holloway & Wheeler 1996).

The combination of description and interpretation is found in the Dutch school of phenomenology, in which the most commonly cited researcher is van Manen (Holloway & Wheeler 1996). Van Manen, a Dutch educator now resident in Canada, believes that phenomenological research is primarily about wanting to know the world in which we live. Van Manen argues that interpretive phenomenological research and theorizing cannot be separated from the practice of writing; that phenomenology is the "application of language and thoughtfulness to a phenomenon" (van Manen 1990, p.33). Van Manen refers to his approach as the human science approach which is concerned with the study "of persons or beings that have consciousness who act purposefully in and on the world by creating objects of meaning that are expressions of how human beings exist in the world" (van Manen 1990, p.4)

Regardless of the branch of phenomenology the essential task of this research method is to use language to describe an experience as it is lived (van Manen 1990, Oiler 1981) without imposing on it any prior theoretical views held by the researcher (Versey

& Faulkes 1990 cited in Holloway & Wheeler 1996). Indeed Field and Morse (1985, p.28) assert that "a primary requisite of phenomenology is that there are no preconceived notions, expectations or frameworks present" and that "phenomenology does not presuppose the existence of process, although process may be discovered as the research takes place". The researcher thus attempts to uncover and describe the essence of being, as portrayed by the participants during in-depth interviews (Bailey 1997). The fundamental difference between grounded theory and phenomenology relates to the development of theory. In phenomenology research the aim is to present an interpretation of the lived experience under study while in grounded theory the emphasis is the development of theory (Bailey 1997).

3.3. THE RESEARCH PROCEDURES.

The remainder of this chapter contains a description of the procedures followed during the research process together with the rationale for each decision, under the following headings:

- the participants;
- data collection;
- data analysis; and
- ensuring the rigor and trustworthiness of the data.

3.3.1. THE PARTICIPANTS.

The participants in this study were drawn from a group of 26 registered nurses who worked within an ICU in a South African private sector hospital. The majority of patients admitted to private hospitals in South Africa are those able to afford private tariffs and those covered by medical insurance. Patients covered by workmen's compensation insurance are also admitted to private hospitals; and new legislation is

making medical insurance more accessible to those members of society previously excluded (Sonderlund & Hansl 2000 and Gore 2002). The diagnoses of patients admitted to this ICU are varied and include adults and children with acute medical and surgical conditions as well as traumatic injuries. More recently patients with haematological malignancies have also been admitted to the unit. This broad spectrum of acutely ill patients exposes the critical care nurse in this ICU to sudden death situations.

All the nurses working in this ICU are registered nurses. Some of them hold a post-basic qualification (certificate or diploma) in critical care nursing while others simply have gained practical experience in the area.

This specific ICU was selected, as the hospital management is well known to me, and this facilitated access procedures (Field & Morse 1985). As I had previously worked as the unit manager in this unit (1994-1999) I had already established a relationship of trust with the participants. The first interview was conducted 5 months after I left the unit. The participants knew that I understood the unit and the situations they were describing, and because I had once been part of their team they could safely express their thoughts and feelings without having to justify themselves (Field & Morse 1985). I was, however, aware that this familiarity had the potential for misinterpretation as I could easily attach my own meaning to their experiences. My attempts to avoid this problem are outlined in detail throughout this chapter.

There was only one inclusion criterion for this study, which was that the participant, a registered nurse working in the ICU, must have experienced the sudden unexpected death of a patient in her care. There were no exclusion criteria.

3.3.1.1 Sample selection and sampling procedures.

In qualitative research sampling has a profound effect of the quality of the data (Coyne 1997). It is important that participants are good informants, which Morse (1991, p.127) describes as someone who is "articulate, reflective and willing to share" her experiences. The sample in this study was purposefully selected (Coyne 1997) and those nurses most likely to give rich, in-depth data invited to participate (Holloway & Wheeler 1996). Care was taken to ensure that the participants had different levels of experience in an attempt to ensure that all nuances of the phenomenon were fully described and understood, and to avoid elite bias (Sandelowski 1986).

Sandelowski (1995) quotes Morse (1994) as recommending that at least six participants are required in a phenomenological study if the essence of the experience is to be found. In this study a sample number of five was used as the quality of data given by each participant was such that information redundancy or theoretical saturation was achieved and no new data were emerging (Sandelowski 1995).

3.3.1.2 Ethical considerations and Entry Issues.

Permission to perform this study was obtained from the hospital management where the nurses were employed as well as from the University of Cape Town (UCT) Faculty of Health Sciences Research Ethics committee (see Appendix A and B).

3.3.1.2.1 Voluntary participation.

Voluntary participation was required and the participants were contacted telephonically, informed about the study and asked if they were willing to take part. They were asked to phone back later to discuss an interview date and time. One nurse

indicated that she was willing but then failed to make future contact, this was taken as a refusal to take part in the study.

3.3.1.2.2 Informed consent.

Informed consent is difficult to obtain in qualitative research as the course of the research is not predictable, and also because of the inherent flexibility and unexpected ideas that arise during data collection (Holloway & Wheeler 1996). Flinders (1992) suggests that in qualitative research, a deontological ethical framework would enhance the more common utilitarian approach, and suggests the extension of informed consent to include the concept of reciprocity. This means that the research must have benefits for both the researcher and the participants, and that in exchange for information the researcher should be prepared to act as advocate, thus going beyond the act of merely documenting the findings (Flinders 1992). All participants in this study were asked to sign a consent form (Appendix C) and were informed of the benefits they would gain from being part of the study and also the possible harm that could occur. Only two potential harmful effects were envisaged, firstly that the participants may be confronted with, and disturbed by, previously suppressed emotions related to a death and secondly that some disclosures may compromise their professional reputations.

Contingency plans were made for referral of traumatized participants to a grief counsellor should this be necessary. This was fortunately not necessary and most participants indicated that the interviews had enabled them to gain better insight into their feelings surrounding death and were grateful for this improved understanding.

Excerpt: Concluding statements of interview. **[Interviewer in bold]**

Thank you! You have made me see things differently, or more clearly (pause).

You have made yourself see.

Ja, I have made myself see. (Laughs). Ja, because before we have never, like, really discussed it and gone through and, and now I feel “Okay, I can still do this”. [Giggle].

Compromising disclosures were avoided by ensuring confidentiality and anonymity, which is described more fully in the next section. The fact that I no longer worked in the ICU from which the participants were selected, also meant that any disclosure, which may be considered professionally compromising, would not impact negatively on their standing in the unit.

3.3.1.2.3 Confidentiality and anonymity.

Anonymity and confidentiality were guaranteed and the participants were informed that they not only had the right to refuse to take part in the study, but that they could withdraw at any time, without prejudice.

Because of the small sample and the nature of qualitative data, great care was taken to ensure confidentiality, however, as Flinders (1992) points out, the better the qualitative study the more readily others can recognize participants and the more readily participants can recognize themselves. Therefore in addition to the usual utilitarian attempts to ensure confidentiality I also adopted a deontological approach, which calls for fairness to the participant when writing research reports (Flinders 1992). Every attempt has been made to ensure that this report represents the experience described by the participants. In addition, a full transcript of an interview has *not* been included as an example, nor is full identification of the excerpts included. Detailed descriptions of the participants have also not been given as it was felt that

this information could lead to identification of the participants and potentially cause embarrassment or professional compromise.

Participants were allocated numbers [e.g. Participant 1 or PI] so that their names could not be linked to any interview transcripts. All interview transcriptions were stored on my personal computer and hard copies locked in a filing cabinet at my home. All audiotapes will be destroyed at the end of the study. In the two instances where the interviews were transcribed by a third party the transcriber was asked to sign a contract of confidentiality (Appendix D). The typist was debriefed following each transcription to ensure that she was not unduly affected by emotionally sensitive content.

3.3.2. DATA COLLECTION TECHNIQUES AND STRATEGIES.

The data collection technique used in this study was primarily individual free-attitude in-depth interviews (Kvale 1983, Meulenberg-Buskens 1996, Oskowitz & Meulenberg-Buskens 1997). Following the analysis of the transcripts of these interviews a focus group discussion with a different group was conducted to ensure trustworthiness. During the initial stages of this study, while I was still working in the field I kept a diary in which I documented my feelings and observations following the death of a patient. While these data have not been included in this report they did offer valuable insights into my own responses to sudden unexpected death.

3.3.2.1 Free-attitude in-depth interviews

The free attitude interview [FAI], which is also referred to as a non-directive, controlled depth interview, is a form of unstructured interview technique in which the participant is free to talk about anything as long as it falls within the framework of the

starting question. This interview technique apparently arose from research in 1929 (the Hawthorne research study), which found that when interviewees were given the freedom to speak, the information obtained was more relevant than when a structured questionnaire was used (Meulenberg-Buskens 1996). The term Free Attitude Interview is a translation of the Dutch term "Vrije Attitude Gesprek" as developed by Vrolijk, Dijkema and Timmerman in 1980 (Oskowitz & Meulenberg-Buskens 1997, p.86).

The participant is asked one exploratory, starting question at the beginning of the interview. This question is formulated in an open and undefined way (Meulenberg-Buskens 1996). The participants in this study were asked to **describe the experience of having a patient they were caring for die suddenly and unexpectedly**. During the interviews a scenario, providing the participants with context, always preceded the exploratory statement. An example of the exploratory question is given below.

Excerpt from interview **[Interviewer in bold]**.

What I am looking for is. I am looking at sudden death [Um] and the nurse's experience of sudden death [um], unexpected death [ja]. I don't know if it will help you to think about a scenario [okay]. Some patient who has come in, say with a myocardial infarction. You expect him to do okay [um], you are looking after him [um], and suddenly [um] something happens and he dies [Ja]. How do you, how do you feel? What is that experience for you?

Following the starting or exploratory question the researcher summarizes, reflects, and asks for clarification throughout the interview. Reflective summaries are used to give feedback about the researcher's interpretation of the participant's opinions and feelings on the subject. This helps the participant to structure his or her thoughts and stimulates more information, while also ensuring reliability and validity of the data

(Meulenbergh-Buskens 1996). To illustrate this technique an example of a reflective summary taken from the data, is given below.

Excerpt from interview. [Interviewer in bold]

So ##, what I am hearing you say is that the acute sudden death is traumatic [Yes] because, because there has been lack of preparation [Ja]. And you try and resolve this in a way by trying to prepare the family a little bit, even though it is just a tiny bit and perhaps a few minutes in advance, but at least they do have some preparation [Yes]. But essentially you feel a bit guilty but you can deal with that by talking to people and getting clarity on whether in fact you have a burden to carry or not [Yes]. And by apologizing too, to somebody, perhaps as it is part of our culture to do, but you need to apologize that you couldn't actually save this life [Yes] and perhaps that is what our role is, is to save lives and if you don't then you apologize [Yes]. But you can deal with that because they are in God's hands and we are actually doing God's work and God's will and, and that's okay. But the futile prolonged death where, where, where the problem is perhaps that the doctors are not accepting that they can't save this life, because the family, I'm hearing you say, perhaps don't want to continue, but they are almost being bullied into continuing and that makes you angry and you think it creates negative, it is sort of a drain on everybody. Because what they are doing is futile, because whatever they do the end result is ultimately going to be death.

Absolutely! That is exactly how I feel! I just, I feel, I feel so strongly about this ...

Clarifying questions are also asked throughout the interview. It is important that the clarifying question be directed towards information that has already been given by the participant so that they do not become new exploratory questions (Meulenbergh-Buskens 1996). This technique was especially relevant in this project, as I am very familiar with the subject matter and the temptation to presume meaning was therefore great. An example of an exploratory question follows.

Excerpt from interview. [Interviewer in bold]

When you say you feel helpless and hopeless?

Ag [sighs], because you can't do anything more. You have done your bit and you can't um, from a practical point of view you have defib-ed them, you have given them all the

drugs that have been, that have been created through the knowledge of God and, and that's, and here you have done all this and that person is no longer with you. What can you do now? Nothing! Just stand there and go and commiserate with the family.

The final technique used in the free attitude interview is that of allowing silence, which gives the participant time to think and reflect on what has been said.

3.3.2.2. Focus group discussion.

Focus group discussions, as a method of data collection, are often considered incompatible with phenomenological research, where one is trying to capture the essence of a phenomenon through the experience of individuals (Webb & Kevern 2001). They can however be useful for the further interpretation of qualitative data (Steward & Shamdasani 1990). I wanted to give critical care nurses feedback on the themes that had emerged from my data, and also needed to see if they regarded the themes as a reasonable account of how they experienced sudden unexpected death of a patient (Mays & Pope 1995).

Six critical care nurses who met the inclusion criteria were invited to participate in the focus group discussion. These nurses worked in the ICU of a different private hospital to the original participants. Only six participants were selected to ensure that each participant was comfortable to contribute, while still eliciting a range of responses (Kingry, Tiedje & Friedman 1990). At the beginning of the focus group discussion the participants were introduced to each other, given an explanation of the format of the discussion and asked to sign the consent or leave if they felt uncomfortable. Each theme was described in turn, and the group asked to comment on what they had just heard. The members of the focus group found the themes were applicable to their own experiences of sudden unexpected death. These comments were not included in

the findings, which are presented in the next chapter. In some instances the focus group discussion allowed for a fuller description of the phenomenon and enabled me to gain additional insights into the experience. These insights form part of the discussion chapter.

3.3.2.3. Other strategies.

All the interviews and the focus group discussion were audiotaped. I wrote a memo immediately after each interview and the focus group discussion. These memos related to how I felt about the interview, what if any problems had occurred, and also my first impressions of the data.

Before commencing with the data collection I attended workshops and training on interviewing and focus group techniques. No pilot study was conducted. I did however gain experience in the FAI technique by interviewing fellow students. I was also interviewed twice. Firstly, to gain focus and perspective on the area I wanted to research and later to gain insight into my thoughts and presuppositions on the subject, which would facilitate bracketing (Hycner 1985). As the most important instrument in this project I needed to be prepared and skilled if the data was to be trustworthy (Oskovitz & Meulenberg-Buskens 1996).

3.3.3. DATA ANALYSIS

According to van Manen (1990) the purpose of data analysis or phenomenological reflection is to grasp the essential meaning of a phenomenon. This essentially means reducing an enormous amount of information into categories and themes so that it may be interpreted (Creswell 1994). However data analysis is eclectic (Creswell 1994), which makes it difficult to provide the novice qualitative researcher with specific steps

to follow. The data analysis in this study was informed by a number of texts, including works by van Manen (1990), Ely (1991), Creswell (1994), Morse (1994) and Holloway and Wheeler (1996) but focused specifically on the work of Hycner (1985) and Giorgi (1975) as they were found to be the most explicit.

3.3.3.1. Transcriptions.

It is important that transcriptions accurately represent both what has been said and how it was said (Sandelowski 1994a). An experienced medical typist transcribed the first two interviews. Checking and correcting these transcripts proved to be extremely time consuming as the typist had inadvertently altered the language in many instances and so changed meaning. In addition most of the non-verbal interaction and important nuances were omitted. I transcribed the remaining interviews, within 24 hours of each interview. This allowed for far quicker, accurate and more effective transcriptions that recorded both verbal and non-verbal interactions, and thus ensured all nuances were documented (Hycner 1985). These nuances are important in that they enable the researcher to gain a better sense of the whole interview during later data analysis (Hycner 1985).

3.3.3.2 Interpretation of the data.

By the time all the interviews had been transcribed, carefully checked for errors and considered accurate, I had listened to the recordings a number of times and so had a good sense of the whole.

Each interview was again re-read, this time I observed and noted my reactions, thoughts and emotions while still doing justice to the text. These observations were recorded in a memo. The principal issues that presented themselves at this time were also recorded in a memo. The purpose of this was to gain an understanding of what

the participants were saying, while at the same time highlighting any preconceived ideas held by myself, which may have influenced my interpretation of the data (Hycner 1985).

Excerpt from memo

27 March 2000 – Some thoughts which came to me during my initial analysis of P*.

1. P* speaks of the finality of death and emphasizes the loss – “he’s gone, gone”. I wonder if she is referring to her own loss, i.e. the death of * and what the circumstances were surrounding this death.
2. I also wonder if at times she was testing what I feel about certain religious issues.
3. P* seems to have a “need to do something” which appears quite often throughout the text. The inability to do anything must result in enormous frustration??
4. Why does she not tell anyone that she goes to funerals? Does this embarrass her? If this is the case then why does she do it?
5. I was distracted when she mentioned my personal loss – it seemed to change the tone of the interview.

Each interview was then broken down into natural meaning units (Giorgi 1975) or units of general meaning (Hycner 1985) as expressed by the participant. This was done with maximum openness and without reference to the specific aim of the study. Any personal observations at this time were again documented in a memo. Each natural meaning unit was then re-written into the neutral third person as this enabled me to place some distance between myself and the text, which by now was very familiar. This, in turn, helped to ensure that the text was reflected upon from the perspective of the participant and not from mine.

Excerpt from the analysis of interview.

NATURAL MEANING UNITS	THIRD PERSON
And I walked in and saw the bed space was empty and that feeling of absolute, everything just drains out of you. Just wow he is gone! [P*:20-21]	P* felt shocked when she walked in and saw the bed was empty and realized the patient had died.

And you, you, it takes you a while to actually pick up and start asking the question why and what happened and just, just like blankness all of sudden [P*:21-23]	P* described how she felt blank and empty and that it took a while before she started functioning again.
Um, ja and then of course all the “whys”. Wanting to know, you know, was it. [P*: 23]	P* finds she then has a number of questions in these situations.
A lot of the times that this has happened my first question is did I do something wrong or didn’t I do enough? [Okay] Um, um, what else? [Pause]. [P*: 23-25]	The first questions are usually related to her performance (competence) as a nurse.

The next step was to re-evaluate each natural meaning unit [NMU] in terms of the research question. I asked the following question of each NMU “What does this tell me about the experience of sudden unexpected death?” The answer to this question was recorded. If the NMU was not in anyway related to sudden unexpected death then it was left blank (Hycner 1985).

NATURAL MEANING UNITS	ANSWER TO THE QUESTION “What does this tell me about the experience of having a patient die suddenly and unexpectedly?”
And I walked in and saw the bed space was empty and that feeling of absolute, everything just drains out of you. Just wow he is gone! [P*:20-21]	Unexpected sudden death results in feelings of shock and disbelief.
And you, you, it takes you a while to actually pick up and start asking the question why and what happened and just, just like blankness all of sudden [P*:21-23]	Unexpected sudden death leaves the nurse feeling stunned.
Um, ja and then of course all the “whys”. Wanting to know, you know, was it. [P*: 23]	The nurse needs to understand why the patient died.
A lot of the times that this has happened my first question is did I do something wrong or didn’t I do enough? [Okay] Um, um, what else? [Pause]. [P* 23-25]	Unexpected sudden death makes the nurse question her professional competence.

Once this was done those “answers” which appeared to have similar meaning were clustered together. These clusters, which contained one or more of the “answers”, were then labelled using the participant’s own words and given an explanatory definition. This definition attempted to contextualize and give meaning to each of the clusters. I repeatedly returned to the original interviews to check and validate these clusters. The number of clusters identified in this manner ranged from 18 – 24 per interview and can be seen in Appendix E.

At this point the clusters derived from all 5 interviews were examined together to establish whether there were any clusters that were common to most or all of the interviews, which could be grouped into common categories (Hycner 1985). At this stage I also looked for any individual variations and ensured that clusters, which did not appear to fit with the others were not lost. Eighteen categories were formed in this manner (see Appendix E). These categories were later reduced, by combining categories that related to each other. In this way seven and later five themes were formed.

It should be noted that while there are a number of computer programmes available to assist with the management of data in qualitative analysis, none were used in this study. The data were entered onto the computer word processor where it was stored. The initial stages of analysis were done using the computer simply as a word processor. Later the interviews were printed and manually “cut and pasted” into clusters, categories and later themes.

3.3.4. ENSURING RIGOR OR TRUSTWORTHINESS

The concept of trustworthiness or rigor is used to demonstrate validity in qualitative research. Trustworthiness or rigor exists when the findings of the study represent reality (Holloway & Wheeler 1996) and when these findings are credible, dependable and transferable (Koch 1994). In their book *Naturalist Inquiry* Lincoln and Guba (1985) describe alternative ways of ensuring rigor in qualitative research which incorporate the conventional quantitative assessments of reliability, validity and objectivity while still being relevant to the many approaches of qualitative research. This model, which is based on the identification of four aspects of trustworthiness namely truth-value, applicability, consistency and neutrality, has been successfully used by qualitative researchers for many years (Krefting 1991).

3.3.4.1 Truth-value or credibility.

Truth-value relates to how the researcher has established confidence in the *truth* of the findings. As truth in qualitative research is participant-orientated rather than researcher-defined, the truth-value of a study relates to the credibility or accuracy of the description of the phenomenon or experience being studied (Lincoln & Guba 1985). According to Ely (1991, p.93) a study is trustworthy or credible if the research was conducted fairly and the results "represent as closely as possible the experiences of the people who were studied" and if the people who have had the experience immediately recognize it from the descriptions or interpretations (Sandelowski 1986). This study was shown to be credible when members of the focus group discussion recognised the themes as representing their own experience.

There are a number of common distortions to truth, which Lincoln and Guba (1985) warn against. These distortions arise from the researcher's presence at the site, the

researcher's involvement with the participants, bias on the part of either the researcher or the participants, and the data collection techniques that are used.

As the primary instrument of data collection (Rew, Bechtel & Sapp 1983) it was important that I was familiar with the participants and that adequate time was allowed for the establishment of trust and rapport. Intimate familiarity enhances research findings and leads to the discovery of hidden facts, as this enables participants to volunteer more sensitive information than they would otherwise have done (Krefting 1991). As described earlier, I already had an established relationship of trust with the participants. Krefting (1991) warns that it is equally important that the researcher guard against over involvement with the participants, as this may lead to the researcher finding it difficult to separate her own experience from that of the participants.

Ely (1991) states that biases, which are held by all, are impossible to escape. It is the responsibility of the qualitative researcher to understand this and come to terms with her or his biases, honestly and completely, so as not to distort the data. To be able to understand the minds and hearts of the research participants the researcher must recognize her or his personal prejudices, stereotypes, myths, assumptions and other thoughts or feelings that may cloud or distort the perception of other's experiences (Ely 1991). While it is not possible to lose subjectivity, this greater self-knowledge helps the researcher to separate personal thoughts and feelings from those of the research participants and to be less judgmental and appreciative of experiences, which deviate from her or his own (Ely 1991). I have already described how I made every effort to understand my own personal prejudices and thoughts on the subject by keeping a diary documenting my personal experiences of sudden unexpected death, by

being interviewed on two occasions prior to commencement of data collection and by documenting my initial reactions to the data.

Excerpt from the interview exploring my experience of sudden unexpected death. April 1999.

I often, I dream about things which happen or, or worry and hassle, you know, maybe I could have done something differently, maybe somebody else could have done something different, maybe if we'd handled it differently that person would not have died, if we had noticed something earlier? I'm sure those are all normal, normal concerns and reflections but when one is able to talk about it then those issues are resolved and so it's not a matter of ... so you can lay that to rest and move on. So what I'm saying is I think that by being aware of things I'm probably handling things a lot more effectively than a lot of other people who aren't aware of it. And what concerns me is that if I, who am aware of it, don't think I'm handling it all that well, those that aren't as aware may be handling it even worse. But maybe it's not .. it's not like that.
[Long Silence]

3.3.4.2 Applicability or transferability.

Applicability or transferability refers to the degree to which the findings can be generalized to a larger group if applied to other contexts or settings. Transferability is not relevant to phenomenology where the aim is to describe a particular phenomenon or experience in the natural setting (i.e. without controlling conditions) rather than generalize the results (Krefting 1991). Fittingness is the criterion that is more appropriate to qualitative research (Sandelowski 1986). Fittingness means that a study meets the criterion if the findings are applicable to, or *fit* contexts outside of the current study; or if the findings are meaningful and applicable to the reader in terms of their own experiences (Appleton 1995). Fittingness of this study was demonstrated when critical care nurses from another hospital (i.e. focus group members) found the themes to be applicable to their own experiences. In addition the finding must *fit* the data from which it comes and reflect both the typical and atypical elements of the

experience being studied (Sandelowski 1986). In this study the sample included nurses with different levels of experience, different ages and from different religious backgrounds (Beck 1993). The focus group was drawn from nurses working within a different ICU. A *thick* description of the findings is presented in the next chapter (Krefting 1991). [In qualitative research a thick description refers to the rich and thorough description of the research context (Polit & Hungler 1997).]

3.3.4.3 Consistency or dependability (auditability)

In qualitative research consistency or dependability refers to the ability of the reader to follow the decision trail of the research process (Appleton 1995). I have attempted to ensure dependability or consistency of this research by providing in depth descriptions of the methodology and also by recording a field journal and memos. According to Koch (1994) and Sandelowski (1986) the researcher is able to demonstrate dependability by maintaining an accurate decision trail which enables the reader to audit the events, influences and actions taken by the researcher from the beginning to the end of the study (Koch 1994). Lincoln and Guba (1985) emphasise that the audit may be the single most important technique available to the naturalist researcher. I found it useful to keep a single chronological log or cohesive history as described by Ely (1991), which contained *all* the data gathered during the research process. This included the interview transcripts and field notes, a record of the analysis. It was also the place where I documented all my own insights, feelings, hunches, insights, assumptions, biases and decisions about the methodology.

Excerpts from Memos

7 March 2000

My research seems to change all the time. This I'm told is the nature of qualitative research, i.e. a journey of self-discovery as well as the uncovering of data that may be useful for others. The first two interviews, though very interesting and informative did not really seem to answer what I want to know. I seem to be getting a lot of irrelevant

data. I then realized that perhaps my question was too direct and I needed to re-look at exactly what I want to know!! So ... more self-reflection and onto a third interview and now I have more clarity on the issue. Which is essentially what nurses experience when a patient they are looking after deteriorates and dies suddenly and unexpectedly. For e.g. a young MI who everyone expects will be okay who then suddenly arrests and dies - how does the nurse experience this situation? The ways in which the nurses cope will surely be revealed in their description of the experience?

9 March 2000

... I realise now that the original starting question was too direct and in a way too confrontational especially coming from me, who was, until recently, their unit manager. Nurses, especially ICU nurses will never admit that they are not coping! So, I realised that I needed to change my starting question a bit. In the third interview I gave a scenario and then asked how Participant 3 would feel in this situation. This was the best interview to date and seems to contain the data what I was looking for.

3.3.4.4 Neutrality or confirmability.

Neutrality refers to inter-subjective agreement (Lincoln & Guba 1985), which is the freedom of bias in the research process and is essentially dependent on all of the other criteria for trustworthiness being met (Appleton 1995). Lincoln and Guba (1985) describe two major techniques for ensuring confirmability, these are triangulation of the data and the audit trail.

The audit trail has already been described in detail. Triangulation refers to the use of several methods or data sources in the study of one phenomenon (Holloway & Wheeler 1996). Lincoln and Guba (1985) quote Denzin (1978) as differentiating between four different modes of triangulation, namely triangulation of data, investigators, theories and methods (Holloway & Wheeler 1996). Triangulation is different from mixing methodologies, as in triangulation researchers look at the same phenomenon in different ways or from different angles (Holloway & Wheeler 1996). In this study triangulation was achieved by presenting the final themes to a different

group of critical care nurses in the form of a focus group discussion, which is described earlier. I considered carrying out "member-checking" or revealing previously collected data during the next interview as a means of enhancing credibility (Krefting 1991 p.219), however I rejected this method for two reasons. Firstly, I was concerned that it would influence the responses given by the participants. Secondly, I was concerned about the ethical implications as the participant pool was small and participants could easily have been identified by some of their comments. I therefore enlisted the help of an experienced qualitative researcher who is also a critical care nurse to check *fit* of the themes once they had been written up.

In this chapter the methodology used in this study has been described in detail together with the references, which informed and guided the process. In the next chapter a description of how the critical care nurse experiences the sudden unexpected death of a patient will be presented.

CHAPTER FOUR

Description of the themes.

4.1 Introduction.

In this chapter I present the themes that emerged from the analysis of the data, with the aim of making it possible for the reader to gain understanding and insight into how the critical care nurse experiences the sudden unexpected death of her patient. The participant's voices are incorporated as quotes. Quotes enable the reader to judge how well the results have been derived from the data and so establish credibility for the themes (Sandelowski 1994b). Only the most illustrative quotes have been used (Wolcott 1990).

The sickest patients are admitted to the ICU in order that their failing organ systems be monitored and supported, so that they are given the best opportunity to recover and survive. The nurse who works in this setting must be technically skilled and able to operate complex equipment while performing several other interventions at the same time. In crisis situations, she must also diagnose, respond and treat the critically ill patient by initiating resuscitation and other emergency treatments. Through experience the nurse gets a sense of which patients are more likely to survive and those who will probably die; however there is always an element of hope that her patient will survive.

Because there [in a hospice] you are preparing for a death, in the unit you are preparing for life, you are preparing [that person] to live; you are wanting that person to live!

Even with a patient whose odds are stacked against them there is always that element of expecting them to survive ... your hope for that patient is, that they don't, that they don't die.

4.2 The types of death that occur in the ICU.

The nurses in this study describe three different types of deaths that occur in the ICU. These descriptions have been included to provide context and a deeper understanding of the experience of critical care nurses.

The majority of deaths in the ICU occur because life support is withdrawn or withheld, as further intervention is considered futile (Turner et al. 1986). These deaths are expected and predictable and the nurse has time to prepare both herself and the family for the death. These patients are not resuscitated and the family is usually present when they die. The nurse will have developed a relationship with both the patient and family, but she is able to accept the death, as she understands that there can be no other outcome.

With the expected one, I am already like. I think with adults you sort of think “okay, it is going to happen” and you have time to prepare yourself for it and then it usually happens. ... When you have like say 2 or 3 days to think, okay, you know it will be best and all the things that go with it, ... with the terminal patient you say “okay” you can work this out for yourself because you have got time to do that.

At other times the patient for whom death appears inevitable has the dying process prolonged by seemingly futile medical interventions. In these instances nurses have to continue to provide optimal care to a patient whom they know has minimal chance of survival. Prolonging this person’s life appears pointless and serves only to increase the patient’s suffering, and the pain and financial burden of the family. Nursing these patients causes almost unbearable conflict for the nurses who think what they are doing is morally wrong, yet they feel powerless to intervene.

... because somebody is trying to play God. I can’t take it!! I actually cannot take it!!
... I just think it is wrong!! Who do we think we are?!! I think that, that is far more traumatic. Okay, it is traumatic to nurse a 40 year old who has a coronary and who dies

and that, and you feel what, if only I could have done something else. That is traumatic. But to actually see this whole thing go on and on and on for a month ... everybody knows what the end is going to be. I feel devastated. I feel, that worries me far more...

In these circumstances, not only is the nurse failing the patient, but she is also unable to meet the needs of the family. This is because the nurse finds it difficult to interact with, and support the family when she has to hide information from them. She feels the need to hide information from the family because she believes that the doctor has either given the family false hope, or has not adequately informed them of the poor prognosis. This causes enormous conflict within the nurse, as she feels professionally bound to support the doctor by not telling the family what she really believes to be the truth. She ends up feeling angry and frustrated and sometimes even avoids interaction with the patient and their family. This in turn leaves her feeling guilty and negative about herself, as she knows she is failing in her caring role.

... I can't go to the bed if they don't know. I can't say they don't know that the patient is dying, but they haven't been told that they are actually dying ... When they know then I can go to them and they can ask me the same questions and I can tell them truthfully what is happening. Where if they didn't, they know, but they don't know, it's sort of, you must really think before you answer them. I don't know for me it is sort of like I am less at the bedside then, trying to avoid it, than dealing with it.

Sometimes patients, who are expected to do well or who seem to be improving, die suddenly and unexpectedly. These are the patients admitted with a condition that usually carries a good prognosis, or those who have been assessed by the critical care nurse as stable and unlikely to die. In this situation the nurse has no way of preparing herself or the family, and the patient is usually subjected to a failed resuscitation attempt. It is this experience of sudden unexpected death, which will be described more fully in the themes that follow.

... with the sudden death you don't, you completely don't expect this person to die.

4.3 Factors that impact on the experience of a patient's death.

The critical care nurse may have to deal with death more often than the majority of her nursing colleagues, but she never gets used to death. Each time she is involved with death, regardless of the circumstances, she is affected in some intangible way.

I have had people say to me 'Oh, you must be used to death?'. I don't, I can never get used to death, never!

There are a number of factors that influence the way critical care nurses experience death. These factors relate to the nurse herself as well as to her relationship with the patient and their family. As these factors are not specific to the sudden unexpected death they are outlined below to provide additional contextual background.

The way the nurse responds to difficult situations depends on how emotionally strong she is feeling at that particular time. This emotional strength is influenced by a number of factors that include cultural and religious upbringing, emotional equilibrium, professional and personal experiences of loss and grief. Other less tangible factors including hormonal cycles and work related conflict can also leave the nurse particularly vulnerable.

And I mean each time is different. Every single time is different; it depends on how you are on that particular day. Some days you can sail through anything and although it impacts on you, you can deal with it. On other days you will fall apart at the end of the day and perhaps the stresses and the whole scenarios that happened during that day, or you know a death today and a death tomorrow you will deal with them completely differently because it depends where you are at that particular time. ...it could be, it could be just hormonal maybe or it could be you have been bugged by all sorts of other stupid things that day so by the time you have to deal with something like a sudden

death you, your coping mechanisms are strained. It might be a family thing; it might be something with a colleague at work. It might even be that you had a bad lunch (giggle).

One older nurse argued that younger nurses were better equipped to cope with death because the world has recently changed so much and so rapidly that the older nurse may never have been exposed to issues and situations that are now routine to younger people. Younger nurses are also perceived to be more comfortable in expressing their emotions and feelings than their older colleagues, who were often socialised to be stoic and less expressive.

Ja, but whether that is because of the way the training has changed or whether that is just the way the world has changed. Because, I mean the things that our children are dealing with are totally different to what we had to deal with and in some ways they are better equipped to deal with things than we were.

Yet the older, more mature nurse is more likely to have experienced personal loss and so from this perspective may be better equipped to cope with death.

Perhaps I have matured a little bit, or whatever. ... my outlook has changed having experienced the death of my ...

Regardless of age, personal bereavement and life experiences influence how nurses experience these situations. In some instances, especially if the nurse is able to identify strongly with the patient, she is brought face-to-face with her own fears about death and this can cause discomfort.

I think that, that is the most frightening thing and I find that it is a feeling of... we all know that there is a hereafter, or some of us believe in the hereafter others don't. But if you believe that way then that's fine, and that there is a God and there is somewhere where our souls are going. But nobody has ever come back to tell us what, "Hey chaps it's fine, you'll be absolutely okay". So it is that fear of the unknown ...

If able to draw on previous experience, the nurse will have more mature coping skills, greater confidence and a deeper understanding of how best to successfully handle her emotions and the family during this time.

And hopefully you have actually learned something from that experience to carry onto another experience later on. You know: "How did I cope with that [situation] then? Okay, well maybe I must look at it differently this time". [Pause]

You use your past experiences [ja, ja] to guide your coping [ja] with the future ones?

Ja, and I think that I didn't realise that that was how it worked at first. But that is something I have only realised lately. That, that is actually what you are supposed to do, or what I feel I should do with these experiences.

The impact is greater if a number of deaths occur within a short period of time. Another factor that may play a role is the level of expertise the nurse has achieved in the ICU. One nurse describes how her focus within the ICU has changed with experience and how this has altered the impact of patient death. As a novice critical care nurse her focus was on the technology and procedures, but through experience and increased confidence her focus has moved back to the patient and their family.

... maybe before I was more involved with you know, am I doing the right thing, and then now maybe moving beyond that, and saying, hang on, I'm comfortable with what I am doing and being able to sort of look at the patient, and the family, not just the diagnosis. Maybe it is that, I am not sure.

The relationship between the nurse, her patient and their family also plays an important role in how the nurse experiences the death of the patient. The depth of this relationship commonly correlates with the duration of patient stay, and with the degree and intimacy of any interaction that occur. However, in some circumstances the death of a recently admitted patient can affect the nurse far more than that of a patient who has been the ICU for a longer period of time. Nurses describe how they

sometimes develop an immediate rapport and bond with patients whom they have only just met. When these patients die they feel saddened, and have a sense of loss that they will never be able to get to know this person, who touched them so deeply.

It is funny how with patients you can nurse a hundred patients and maybe only one patient out of those will get to you, for whatever reason. There is no logical reason why one particular patient should get to you. ... and the funny thing is that sometimes it is not even as if you have had a long time with that patient, it is just an unexplained thing.

Other deaths leave the nurse unaffected emotionally.

I would say, I actually find that it's maybe almost a bit callous, but it does not really affect me, because I have not had a chance, an opportunity to get to know the family and the patient.

I don't know the patient that well, I don't know the relatives. ... when we get to know them then it is more personal.

Sometimes the loss of the relationship with the family can affect the nurse more than the death of her patient. In the following excerpt a nurse describes the sense of loss and incompleteness she experienced when she returned to work and found that a long-term patient had unexpectedly died while she was off duty.

I'd built quite a good relationship with his wife while he was there. And I never saw her again. And that. It was terrible, you know! I wonder how she is getting on. I know that she was very dependent on him, she was a very sort of meek, mild sort of person and I sort of wondering is she all right. Is she getting through this? He just wasn't one of those people who should have died. He had everything going for him. And everything was going well and then he wasn't there anymore.

The boundaries that exist in the relationship between the nurse, her patient and their family members made it difficult for this nurse to contact the patient's wife after the death had occurred.

The age of the patient does not influence the impact of the sudden unexpected death, although the situation is easier to rationalise and accept if the patient is elderly or when a protracted or painful rehabilitation is expected to follow survival. The death of a child is *always* a difficult experience, especially if the critical care nurse has children of her own. In the following excerpt a nurse explains how, since the birth of her own child, the death of other children affects her profoundly. The loss of a young life that has not yet realised his or her full potential, leaves nurses feeling helpless and vulnerable. Nurses who have children of their own identify very strongly with other children and their parents, and more easily become personally involved with both the child and their family.

Long ago not, but um, I think it is a personal thing where I sort of like seeing my own child lying there. I make it personal and then it is like, ugh, no I can't deal with that.

Long ago, before you had your child?

Ja, long, before I ja, before I had mine, it was um still okay, a bit sad and it was still very ... because it is a child. It's still young it must still live and must go through everything you know and reach adulthood.

Because that child was just the same age as my child and its feet was the same size and so that was very awful for me.

Critically ill and dying children evoke extremely powerful emotional responses. One nurse describes her fear of being involved with the resuscitation (potential death) and death of children. She is especially fearful of her own reaction if confronted with the death of a child in her care, and worries that she will break down and lose control of her emotions. This fear is related to traumatic childhood experiences, previous negative professional experiences of death and the fact that she has children of her own.

I don't know how I would cope; I don't think I would cope. I don't know, I think that I

am going to be one of those nurses that fall apart at the time, when it comes to a child's death, but in the meantime I am not around. And I don't, I haven't given myself that opportunity to, to experience it. I don't ever want to experience it. I fear so much.

I was not there because I just thought "Oh God, I can't, if that child goes I don't want to be there", and I thought "Oh God" you know and being pregnant at the time I'm just thinking, "Oh, no, I don't want to see this, I don't want to see this baby die". And I really couldn't get myself to that bed.

Nurses manage this death anxiety surrounding critically ill children in many different ways. In the previous excerpt a nurse describes how she avoids the situation completely, by physically distancing herself from critically ill children and refusing to be in anyway involved with their care. At the other end of the spectrum another nurse confronts this fear head-on by volunteering to nurse children, despite experiencing extreme emotional distress and finding it difficult to cope if the child dies.

... I would rather look after the child and then I have to face it and then go through all these things. ... I went home every night crying and hugging my child and playing with the poor child late into the night and whatever. And then he [my husband] will say 'so why do you do this to yourself?' and 'you punish yourself' or 'why do you do this?' And I don't know!! I can't answer him. I can't.

Each death which occurs in the ICU is different, thus although the critical care nurse may experience the death of a patient relatively frequently she has no way of predicting her response or protecting herself from the emotional consequences of these patient deaths. The way in which each of the participants in this project experienced the sudden unexpected death of a patient was different, yet it was possible to identify commonalities of experience, which emerged in data analysis. This experience will be described in five themes:

- Theme one: The shock of it;
- Theme two: The burden of guilt;
- Theme three: Dealing with the relatives;
- Theme four: Denial of self; and
- Theme five: Regaining emotional equilibrium.

In this report the critical care nurse's experience of having the patient she is taking care of die suddenly and unexpectedly has been described in a linear fashion. However, in reality this experience is more like a spiral, with many events occurring simultaneously; there are also many layers of feelings and emotions that flow through the entire experience. These themes should therefore not be viewed as independent of each other but rather part of an intricate whole.

From the moment the nurse realises that her patient has arrested (cardio-pulmonary arrest) and requires resuscitation she experiences numerous and conflicting emotions, which continue until after death has been confirmed.

4.4 THEME ONE: THE SHOCK OF IT.

The nurse is initially transfixed by a sense of shock and disbelief when her patient unexpectedly arrests. Although this is only a brief moment, it seems to take a while for her to register what has happened and move into action with the resuscitation.

You kind of, for that, for a moment, for a sometimes it is a very brief moment but sometimes it is for a while there is just this feeling of almost you can't believe it. You kind of, you are kind of shocked, it is a shock, a slap in the face kind of feeling.

... Um, I don't know it takes, for me it takes a little while, it feels long. Like, it depends on where you are standing and where it happens but you think "Oh shit!" or whatever and try to assess the situation. Um, it sometimes seems like, the message

getting to the brain takes a little while... You are thinking where am I, what is happening, why is this happening and it is not supposed to happen ... then normally there is someone else that is a bit quicker than you and then it is fine, you get into the motions. But that initial shock, I think ... for me it is shock.

... feeling of absolute, everything just drains out of you.

Two levels of functioning can be identified during this time, when the nurse must focus on the urgent practicalities of the resuscitation. The first is a "mechanical" level where she is able to "go through the motions" and perform practiced skills without much thought or feeling. The nurse "feels automated" during this time and often can't remember the exact sequence of events afterwards.

... already in something like a resuscitation process or in progress, I already withdraw, I already cut off and become mechanical.

The second "emotional" level must be suppressed, modified or blocked, during the resuscitation so she is able to remain calm and in control. The nurse would find it difficult to perform her duties during this time of crisis, if her thoughts were centred on her own emotions. So she learns to suppress or alter her emotional response and prevent herself from becoming overwhelmed by events or breaking down and crying. One way in which this can be achieved is through the use of black humour and joking.

a bit of interaction amongst the people involved that breaks the tension, releases the tension. Be it in a laughing manner ...

... it is strange how it changes, it was a very light mood, everyone makes jokes, not about the patients, but you make it easier to cope.

The nurse finds the action and drama surrounding the resuscitation both challenging and exciting. During the resuscitation she is able to put all her specialised skills into practice, which can be very exhilarating.

Say there is, whatever happened, and you have this huge adrenaline rush, everything is going fast and ... well you feel like you are more or less on a high ...

... first it's the adrenaline, and doing what you can do, and hoping that they will pull through ...

Throughout the resuscitation the nurse continues to hope that she will be successful and that the patient will survive. When the patient is pronounced dead and resuscitation attempts stopped; she experiences a number of unpredictable and often conflicting emotions. These emotions range from feelings of frustration and anger to a sense of having been cheated; she feels disappointed and "let down" because her best effort has been wasted; she feels remorse as she has been unable to save the patient's life. An unsuccessful resuscitation and subsequent patient death leaves the nurse feeling powerless, helpless and useless because the situation is beyond her control. The nurse has done everything she knows and yet she has still failed. This leaves her with a sense of loss; she has been beaten and the consequence of this defeat is irrevocable and absolute – the patient is dead. She feels incompetent and inadequate. There is nothing she can do.

Absolute total and utter devastation from a point view of um, one feels so helpless and so hopeless, maybe that one has failed. ... you can't do anything more. You have done your bit and you can't um, from a practical point of view you have defibrillated them, you have given them all the drugs that have been, that have been created through the knowledge of God and, and that's, and here you have done all this and that person is no longer with you. What can you do now?! Nothing.! Just stand there - and go and commiserate with the family.

... on the one hand you have failed because that person has been put into our care ...

After it is all over the nurse needs to be alone, to have some privacy and a few moments of quiet where she can gather her thoughts and reflect on events before she

has to go out and deal with the family and the body. This usually means retreating to the sluice room or the staff toilet.

... my first response is, is, I would actually sort of, once we have dealt with maybe the acute sort of needs of everything, I would actually walk away and try and be alone. Umm, and not necessarily cry in front of somebody else, if I feel I need to, maybe even go into the staff loo or something like that, or go into the sluice or something.

... to actually sit down and answer the questions that are going through your head ...

Following the drama of the resuscitation the nurse always has questions. These questions, which invariably revolve around her role in the sudden unexpected death, are described in theme two.

4.5 THEME TWO: THE BURDEN OF GUILT.

During the period following her patient's death the nurse has a sense that she is responsible or to blame for what has happened. Her first thoughts are that this unexpected event has occurred because she either did something wrong or because she failed to do something she should have done.

... you think "what did I do, what did I do, what didn't I do?" ...

She feels guilty and scrutinizes her role in the events by re-playing them in her mind or discussing them with other nurses who were present. This re-examination of the events continues when she gets home and in the days that follow the patient's death. There is almost always concern that she missed some sign that should have alerted her or the doctor, and which in turn could have prevented the death. If only she had acted sooner, been more alert, more knowledgeable or if she had not done or given something then the patient would not have died. A nurse describes how this sense of

guilt leads her to apologize both to the doctor for her perceived inattention, and to the family because she was unable to save the patient's life.

... to the doctor for not phoning him earlier, you know. "I'm sorry I didn't phone you earlier". He can think what he likes; I couldn't care about that, but at least I'm saying sorry to somebody ...

... if we had done so and so or if we had done something else, or if we, maybe if we had phoned somebody, or recognized something earlier ...

... I feel very guilty that I should have picked that up ...

The relationship between the critical care nurse and the doctor is very important during this period. If there is a good rapport between them she feels able to ask questions and gain clarity about what precipitated the arrest and she will also feel comfortable expressing her feelings in front of the doctor. She needs a plausible explanation for why the patient died so she is able to judge her role in the events and place matters into perspective. She needs the doctor, as the most knowledgeable team member, to provide her with this explanation. If the doctor is not well known to the nurse she feels uncomfortable about asking these questions, which then go unanswered and the matter is never laid to rest.

... the doctors stay and they talk you right through it, "you did everything", "this is what you did", "how do you feel"? So that is quite good.

... and that is very hard to deal with. You kind of, it is like unfinished business. It is always at the back of your mind 'Why?' You know there must have been a reason!

Sudden unexpected death sometimes evokes feelings of extreme anger in this nurse; these feelings are directed towards the doctor whom the nurse may feel has not given her sufficient information to enable her to accurately assess the patient's condition.

I just feel so angry at times when there is not enough information. ... he wasn't expected to die and there was really no reason why he should die... but there wasn't enough information that came through to the nursing staff. Information to make us more prepared for when it happened, and when it did there just wasn't enough information...

The senior nurse who is in-charge of the shift when a patient dies carries an extra burden, as she feels accountable and answerable for all deaths that occur during her shift regardless of her direct involvement.

... even if it is not really my sole responsibility, but if I'm the shift leader then it is my responsibility ...

The sense of guilt that the nurse feels following an unexpected death needs to be addressed and resolved if she is to continue to nurse effectively.

... you actually need to deal with that because otherwise every single death that you deal with you are just knocking yourself further and further down ...

The ways in which the nurse tries to deal with her emotional response to her patient's sudden unexpected death are described in theme five. However, before any of these issues can be addressed she must take care of the patient's body and interact with the shocked and grieving relatives.

4.6 THEME THREE: DEALING WITH THE RELATIVES.

The critical care nurse finds that interaction with the family during this time is one of the most difficult and stressful aspects of sudden unexpected death.

I don't think that it is stressful dealing with death, I find it stressful dealing with the relatives who are dealing with death.

During this time she is still trying to come to terms with her own emotional response to the patient's death and finds it difficult to deal with the family whom she knows are feeling even more traumatised. This is especially true when the family are "emotionally expressive" at the time or "fall apart" on hearing the news.

'Cos I still dealing with what I am feeling. I can't handle that as well.

Nurses feel inadequate and uncertain about their role during this time, as they do not know how best to support the family. They do not know how to behave or comfort the family.

Definitely, I am uncomfortable with grieving. I don't know what to say.

They express concern that the training received in this aspect of care was inadequate, so they tend to draw on past experiences to guide their practice.

I don't think that as student nurses and as junior nurses that we actually get any sort of input or any guidance.

Those nurses who are clinically more experienced and those who have experienced personal bereavement are at an advantage as they are able to draw on this experience as they support the family. In the following excerpt a participant demonstrates concern that her lack of experience and insight may cause her to minimize what the family are feeling and so increase their distress.

... what I have not felt, I don't feel that I can share an experience about. I am not going to make something less of what people are feeling, when I don't actually know about it myself... in the meantime I am not going to belittle what they feel when I haven't felt it.

This lack of training, knowledge and experience together with feelings of guilt makes the nurse ill at ease when interacting with the patient's relatives. She is awkward and defensive and thinks the family hold her responsible for her patient's death; and she

has not yet had the time to determine whether or not she is responsible for what happened. Professional experience and personal bereavement gives her more insight into what the family are experiencing during this time.

[Later on you realize that] they are not going to blame you; they are not going to hold you responsible.

There is conflict in knowing whether to share her emotional response, by crying in front of the family. If she cries with the family she is concerned that her colleagues will consider her "unprofessional", and that she will be unable to offer "professional" support to the family. Yet a participant reported how she found that crying with the family provided comfort for both the family and herself.

... once when I was crying with a mother who had just lost her baby, somebody actually made some comment to me in passing, about don't cry you're supposed to be strong...

... and my feelings were that by crying with that mother I was actually showing her how I felt, that ... I mean I wasn't out of control, I wasn't not helping the mother and her seeing my tears was probably helping her more than if I was super efficient and kind of brushing the whole thing aside. And it certainly helps me to have a good cry.

... if I'm crying I'm not really of much use mentally.

One way in which the nurse can help the family is to give them some time to prepare for the impending death, albeit only a few minutes. She does this by ensuring they are kept informed of events during the resuscitation. This communication means the family are more prepared when they are later informed of the death, which makes the situation easier for both the family and the nurse.

I think that it is very important that communication, communication with with the family. The loved ones, must be there and even if they are not there you have got to communicate and tell them to come. If they are outside, somebody must go outside and say "your husband has taken a turn for the worse". I think that, to try and save their, not save but try to and lessen the terrible blow of that finality.

When a patient dies suddenly and unexpectedly both the family and the nurse have questions; many of these questions have no answers. The nurse feels inadequate and frustrated when unable to provide the family with the answers they are seeking. Answers appear to be something that the family really need from her at this stage, and she is powerless to assist the family. In addition their questions make her feel defensive, as they also appear to be questioning her professional competence.

Because if you are asking yourself “why?” “what happened?” they are asking themselves and hundred times more. And they are wanting, they are wanting answers, which you are actually unable to give them. You know, “when is this going to happen”, “why did this happen”, “what is going to happen now”. And you can’t answer those questions, and that is all that people want to know.

The family usually linger in the ICU for a while following a patient’s death, as they try to comprehend what has happened and wait for other family members to arrive and view the body. In the following excerpt one participant describes how she has to fake sadness when comforting the family during this time. This is because she is still feeling exhilarated by the action and drama, which inevitably surrounds a resuscitation attempt. Later, when she could be more genuine, the family have already left, which leaves her feelings that she has let the family down and that she has also lost the opportunity to reach some meaningful closure for herself.

I think it is more when it happens the family are there and you go to them and you say “Sorry, whatever” but you still feel all this adrenaline. And then when everything is done and say the body is fetched ... but then there is no-one there and it’s like “okay, now it is finished” and you think, “Okay, now this is what happened”. And then that is sort of when you start or when I start thinking about what happened and then you can’t go to the family and I think that it is almost cheating on emotions. But when you go to them you don’t feel sad, not sad, you just feel someone has died. And then afterwards when everything is settled and is calm then you sort of realise what [happened] but then you can’t go to them and say “I am really sorry about”...

There are times when the nurse tries to protect her own emotional integrity by ignoring the impact of sudden unexpected death on the family, or by trying to keep her contact with them to a minimum.

... you don't want to see that there is still a family, or that they didn't expect it either.

... not that I particularly want to feel with the family, I don't want to feel everything that goes around! So I withdraw ...

Throughout the period surrounding the resuscitation and death the nurse must constantly suppress or deny her own emotional responses to the events which have just occurred, while she first attends to the needs of the patient and later to those of the family.

4.7 THEME FOUR: DENIAL OF SELF.

When a patient dies suddenly and unexpectedly the nurse has to put her own needs and anxieties aside so she is able to present a professional face to the family. Her immediate personal need is to withdraw and have some private time in order to reflect on what has just happened. Unfortunately this is not usually possible, as she must first attend to the more pressing needs of the family and disposing of the body. She has to set her feelings aside, put on her "professional mask" and support the family as best she can during the acute phase of their grief.

I would actually sort of, once we have dealt with maybe, the acute, sort of needs of everything, I would actually walk away and try and be alone.

And, and then to feel that you can't speak to anyone, because, because you are standing there and you have to deal with the parents and you must be the, the strong one.

When the family has finally left the hospital and the body removed to the mortuary there is inevitably another critically ill patient in need of care waiting to fill the bed. There is thus limited time for self-reflection and the nurse must continue with her work, while denying her own needs, as though nothing has happened.

You don't have time to stop and think about what really happened, where say it happened at four and then you get another patient and you go home at seven and you have your quiet time and you can deal with it. Where then you have to like stop completely thinking, feeling whatever you are doing and then being, pretending to be someone else, and that is quiet difficult for me. I mean you can't really say I'm not dealing with it now, but, you have to adjust but it takes a while for me.

During this time the nurse finds that she must repeatedly "change roles", "switch modes" and pretend to be feeling what she is not. When she informs the family of the patient's death she may still be feeling angry about the events surrounding the death or exhilarated from the excitement of the resuscitation, yet these feelings appear inappropriate during a time when it is more fitting to be sorrowful.

But like you feel on this high, you still feel like "wow" type of feeling, but now you must feel sad. You are supposed to feel sad!! And then I'd don't feel that at the time. I am still (pants) getting all that adrenaline sorted out.

The demands of a busy ICU are such that she may immediately have to take over the care of another patient. Later, when she returns home at the end of her shift, further demands in her personal and social roles, e.g. as wife and mother, await her. There is no time or space to reflect.

I will come home and I will want be withdrawn for a, I just withdraw for a little while, sort of thing but obviously life goes on and you have to get, get into the home situation and whatever.

The nurse who has been deeply affected by a particular death is not always able to ignore her emotions in this way, and so has to deal with concerns that she may in someway have failed the next patient as well.

... and if it is busy it is like, it's like switching modes from oh, crying, can't deal with this, not feeling and then going to a healthy patient and go "Hello – how are you?". That is what is difficult for me. I could not do that. I couldn't, stand and smile and shame I didn't know what the patient thought of me and I just couldn't go there and change that, to that other role. That was a bit bad for me.

Because of this lack of time and the superficial nature of her relationship with her colleagues (described later in theme five) the critical care nurse is usually unable to discuss her emotional response or validate her feelings. She feels alone and emotionally out of step with her colleagues and thinks that no one understands what she is experiencing.

... you are just standing there alone ...

... and then I don't really feel that way, the way they are feeling so I can't really relate to them. And when I am feeling like that, then they have already gone through it.

I thought I was abnormal, because I didn't feel these things that people felt ...

In the following excerpt a nurse describes the unexpected comfort she experienced when a doctor validated her feelings of sadness following the death of a child.

I felt like, I, I looked at him and he looked, he was just standing there and he actually started crying and I thought, um. So some people feel this way as well. And that was quite a like thing for me. ... I don't know, how do I say that, not a shock, but like you are not alone in this. You know there is like, some other, the parents are sad but there are other people also who are involved and who feel the same as what you did. ... so that made it a bit, not feeling so alone

Following the shock of the sudden unexpected death, the nurse has to find a way of coping with her emotions and feelings of guilt and regaining her equilibrium.

4.8 THEME FIVE: REGAINING EMOTIONAL EQUILIBRIUM.

The nurse needs to find some way of dealing with her anxieties and emotional response in these situations. This is achieved either by discussion at work or at home, or simply by working through events alone.

4.8.1 Support at work.

The nurse needs to establish whether she is responsible for the death of her patient, as this sudden unexpected event challenges her competence as a critical care nurse and makes her question her belief in herself.

... it makes me feel incompetent and unworthy of being an ICU nurse ...

This reassurance with regard her professional competence can only be gained at work by talking over events with those who knew the patient or those who were directly involved with the resuscitation. Those colleagues not involved cannot provide this reassurance, as they are unable to judge her performance, nor can her family who have no understanding of the nature of her work nor any experience of death.

... you only get the support that you need if it's from work.

A discussion of the events and the nurse's role in the period surrounding the patient's death, should ideally take place as soon as possible after the incident, while the memory is still fresh. Talking about what happened enables the nurse to view the event from the eyes of others and so paint a clearer picture of what actually happened. This allows her to put her role into perspective and remove some of the guilt she

experiences. These discussions are usually technically orientated and emotionally very superficial, as the parties focus on the actual events and not on the feelings of those involved.

Ja, if they go through it with me. I can actually stand still and think 'this is what I did' and they can say 'but you did that as well'. Or you know where you forget because you just sometimes just say, think about what you did and forget there are 10 other people around the bed and miss things that they have done as well. And it is quite helpful if they go through the whole thing with you. Not the emotional thing, but the say 'okay we did what we could and you can ask like 'what if we did whatever' and they can explain the reasons.

... go through the whole thing but you never really discuss your feelings. You can say: 'I'm not agreeing with it' or, but you would never say 'I am angry because the doctor didn't do this' or 'I'm disappointed that' you might say disappointed but you never really. You discuss what happened, but you never say 'I can't cope now with this' or 'It is too much for me' or 'I don't know why we do this [work]'.

The nurse usually finds these sessions extremely helpful and reassuring. She feels uncomfortable about expressing her emotions and deeper thoughts to the group because the members of the team are not always well known to herself.

... but we never really do it then, I think because everyone has so much emotion, and so much things to deal with that it is so difficult. Because work is work ...

If it goes deeper I would feel a bit uncomfortable. Because then you would have to open up more than what you would want to. But not always ...

... do I express my feelings in front of these people, they don't really know me and I don't really know them ...

Nursing units and teams that are stable, where staff have worked together for a long time and understand each other, can offer the nurse a great deal of support. In a stable team the nurse is comfortable to discuss events in a safe and non-judgmental

environment. The nurses in the team are aware of each other's strengths and weaknesses, which makes it easier for them to support each other.

... we were actually a super, super close team. And everybody fitted in and everybody could say or tell their feelings to the other person. There wasn't any, nobody was trying to be better than the other or whatever. It was a kind of a, it was a really good, good team and the doctors were involved with that and the personal relationships between everybody was very good. And that was an ideal situation. It didn't last very long because when the dynamics, people left and other people came and it didn't work out the same way, but it was almost like the ideal situation.

The nurse also does not want to burden her already overburdened colleagues with her emotional needs. She knows that she would not cope if one of her colleagues broke down emotionally and so is reluctant to place them in this difficult situation. The nurses have more than enough to deal with at this time without also having to support each other emotionally, and risk altering long-term working relationships. In the following excerpt a nurse describes how, when she was unable to deal with a particularly difficult death, she broke down and revealed her emotions to her colleagues. Her emotional distress was worsened because her outburst made her colleagues uncomfortable; no one knew how to support her.

... when that child died I couldn't deal, I couldn't deal with the whole, whole thing. And it is so difficult for us because um, no-one knows what to do. No-one really knows what to do. Cos, if this happens to one of my colleagues I wouldn't know what to do, I would not know what to say to her. You would say "okay" or whatever and give the support that you can, but you really don't know what to say to her.

... [colleagues] standing there and going, crying! I wouldn't know how to cope...I think if they all did this the whole time I wouldn't know what to do with them. That would just be another person that we have to ... Oh No!! No!

The services of a professional counsellor are also not readily accepted, as she primarily needs reassurance with regard her competence. She is also afraid that her colleagues

may interpret her seeking counselling as a weakness and an indication of her inability to cope. An outside counsellor is perceived not able to fully appreciate the subtleties of the situation and therefore unable to help provide the support she requires. One participant described how she does not really know what "counselling" involves and would not know what to say; another was afraid of other issues which may surface and need to be managed.

They were thinking of getting someone in, but I would not know what to tell, what to say...

... they got someone in to talk to us. But no-one, we know that it's there, but no-one is using it. I'm not sure if people think that, that they will think you won't be able to cope or (pause) you can't deal with this ...

... said, "I think you need therapy for that", I said, "no life with teach me, just give me time". I will deal with it [emotions] when I am ready to deal with it, no blooming therapist is going to force me to deal with it until I am ready to deal with it!

4.8.2 Friends and family.

Friends and family are a source of emotional comfort, although because they have no real understanding of the nature of her work or experience of death, they are unable to allay her feelings of guilt.

Because most of the time I can't, I can't go home and tell [husband]. I can tell him okay we had a death today and he will say "okay". He just sees death on TV or wherever and he doesn't really know what it feels like to go through all these high rushes of adrenaline and then suddenly (sound and hands indicated falling) 'what now' type of thing, and then go home and be normal.

Even if her family did understand, the nurse is reluctant to discuss details of the events that occurred at work as she is concerned about issues of confidentiality and also feels the need to protect her family from the harsh realities of her work. In this excerpt a

nurse describes how she usually tries to alert her husband to the fact that she has had a tiring day, but will not burden him with the details.

... [I will tell him that] I'm feeling really tired and it's been an emotionally draining day and I wouldn't elaborate on the scenario because as I said number one confidentiality and number two I have, the more I have come to know him I think he doesn't really cope well with sensitive things like that. Especially having had a loss himself. I think he still really doesn't want to know about suffering and such ...

Family and friends are often able to provide comfort on a purely emotional level through their readiness to listen and allow the nurse to work through her feelings. One nurse found that the only person she is able to reveal her emotional distress to was her mother with whom she was exceptionally close. Another found she is able to gain a completely different perspective if she broadly discussed disturbing events with friends who have no knowledge of nursing or medicine.

... if something like really bothers me, that happened or whatever. I will never tell them exactly what happened I will just say ... and they will give me a complete different view of what I am seeing and that also helps. ...they would go 'Oh, yes I saw that on Oprah [TV Chat-show] and whatever and we will have this huge discussion, and in a way this helps.

4.8.3 Doing it alone.

The nurse cannot rely on receiving adequate emotional support at work or at home and so develops ways of dealing with her memories and self doubts on her own and in her own way.

I've got my own little scheme of how I work things out and that influences how I deal with any traumatic emotions or feeling .

... we all have our little thing that we do, how we cope ...

Religious beliefs can provide great solace. One participant described how she finds comfort and reassurance in prayer. She uses her faith to create meaning and this enables her to come to terms with traumatic events.

... after a day where it's been trauma and drama the whole day ... I actually pray about it. ... put it in Gods hands. ... I just go home and say "God it is your will" and "May they rest in peace".

Keeping a diary helps the nurse release stress and gain perspective by documenting the events. A nurse found that recording events and her reactions in a diary allowed her to acknowledge and validate her emotional response.

... and expressing thoughts and through that I also find other things become clear to me like, you know we still have our health and you know, just to focus on the moment, life is short and just to live it to its fullest...

Time alone in the bath or on a long solitary walk also provides space for the solitary reflection of events.

... then I just go and have a bath and I just lie there and I think it is just 'cut off time' and 'relax time' and I kind of think about the whole thing and go through it and. But I am doing it on my own.

... being able to just go for walks on the beach, ... I do find I would need to be alone, I would not ask somebody to come with me, just so that I could almost recharge, I find that I am able to do that, especially if I go into nature as such.

Sometimes it is easier to simply suppress her emotions and feelings and continue as though nothing has happened. She tries to push the memory of the event and her emotional response out of her mind, pretend it never happened, or that she is completely unmoved by the events.

I will either cut off totally at work. The incident has happened, the person has died, I have to cope with it so then I cut off totally, and that's finished.

... just box it off for a while, until I can deal with it and do something about it. Feelings can get you into so much trouble by (pause). They can make you incapable of doing anything or continuing on. So I think I box them up until I can deal with them. I know for a time being I probably don't want to deal with the situation ...

She also uses distraction to prevent herself from thinking about the situation. However the memory remains close to the surface and continues to cause physical signs of anxiety.

I feel very fidgety for a while, for a long time afterwards, but, I tend to put things out of my mind that I can't do anything about. ... I carry on for the rest of the day, and do my work. I might come back and think about that later on in a quiet moment but then it's a little bit, you know, gives you a little bit of palpitations... it makes me feel that, it drives me into overdrive and then I start you know (laughter) doing 10 000 things at a time, and that is probably my way of coping, it is like I do other things so that I don't think about it.

These suppressed memories resurface unexpectedly during a conversation or while watching television and the nurse is then able to cry and express emotions she has denied for a long time.

...say it all happened today and I will cry and I won't worry and I will sort of block it away. And the next death will happen and it will, and then just one day something will happen. I will just maybe sit and watch a movie or something silly and I will just cry. I think that is the way I just cope with it. I don't really talk about it, then it builds up and then it just one day reaches – I don't know it all comes down!

In the following excerpts a nurse describes how she copes with traumatic events by initially blocking the memory. Later when she is feeling stronger she is able to reflect on and reach an understanding of what happened.

I often deal with things I don't like or which have been very traumatic, [by pretending] it doesn't exist for a period of time. Nothing of that thing exists for a period of time,

and afterwards I get it out of my memory, later on and in little bits as I'm able to deal with it. ... I retrieve it from memory and I might go through a muted version of despair at that time, but it is nothing like I, you know, as bad, because I just feel you, if you despair so, you don't carry on with life, you don't get beyond a point, you're just, you're not able to cope with normal things. ... I have learnt that in any case time heals things, you think that you will never get over something, but you do, and you're so surprised at the end of the day that it no longer hurts. ... if it's so painful, well let's cut it off there and then. It will come out of the box some time, much later.

Sometimes the nurse tries to protect herself emotionally from the effects of repeated exposure to death by becoming "hardened". She achieves this by creating distance between herself and her patient, and by not engaging with them. She feels pitiless, uncompassionate, unsympathetic and scornful of reality; she is unwilling to form any attachment with the patient for fear of exposing herself to further emotional trauma.

In the way that you kind of laugh at the reality. Agh, I don't know. You just go to your patient and think what am I doing here. Um, they are going to die anyway, type of attitude. You still care and you still do what you can. You sort of get hard. I think it is trying to protect yourself,

... girls who are hard, who have hardened themselves and are using that kind of protective mechanism.

Closure or ending the relationship with the patient and their family is another important part of coming to terms with the death. Some nurses achieve closure by attending the funeral and telephoning or writing a note to the family. Closure is sometimes not possible, and the knowledge that she has in some way helped the family to come to terms with their loss has to suffice.

Oh and another way that I deal with, with a patient's death is that I quite often go to their funerals. I find that, that is, you know it is very important so that you can and it is one way of closing that chapter on that life. Really. I often go to patient's funerals. I don't tell anybody but I just go. ... If I possibly could have gone to that girl's, that

person's funeral I would have, but I couldn't, I was working. But, I had said goodbye to her.

Knowledge is one way in which the critical care nurse is able to empower herself and cope more effectively. Knowledge allows her to function safely and with confidence. Knowledge about the patient and their condition; knowledge about her work and how to use various pieces of equipment; knowledge of other members of the team and how they work as well as knowledge of herself all enhance her ability to cope.

... the way I have done that and the way I think most people probably do that is to equip yourself better to deal with whatever situation you are in. Like for instance studying further and getting more knowledge and talking to people and finding out how other people deal with things ...

And also just knowing within your team who you can rely on, who can support you ...

I mean that [information] is your most empowering tool and it is the most easily available...

In the five themes above I have presented a linear description of how the critical care nurse experiences the sudden unexpected death of her patient, so that the reader more easily understand this experience. However, this is a complex, non-linear event which gives rise to many emotions and feelings that flow through the entire experience. Sudden unexpected death challenges the very core of the critical care nurse and leaves her vulnerable and doubting her professional competence. In the next chapter I will reflect upon these themes and relate them to the existing literature. I have also included comments from the focus group discussion where they deviate from or add to the experience as described in this chapter.

CHAPTER FIVE

Reflections on the themes.

5.1 Introduction.

In the previous chapter I used the participant's own words to describe how the critical care nurse experiences having the patient she is caring for die suddenly and unexpectedly. This experience was described in five themes, namely:

- Theme one: The shock of it;
- Theme two: The burden of guilt;
- Theme three: Dealing with the relatives;
- Theme four: Denial of self; and
- Theme five: Regaining emotional equilibrium

In this chapter I reflect on these themes and how they relate to the literature. As Ely (1991, p.179) points out: "doing qualitative research is by nature a reflective and recursive process" and thus this chapter becomes a reflection on reflections. Data obtained from the focus group discussion served to confirm the data already described in the previous chapter, and is included in this chapter only where it differs from, or adds to the data presented earlier. I conclude the chapter by highlighting the limitations of this study and making recommendations for the application of this study to critical care nursing and for future research.

In order to provide structure for this chapter I have singled out the overriding issues and paradoxes within the five themes that emerged from the data and related them to the four essential life world themes as described by van Manen (1990). Van Manen

(1990) points out that all phenomenological research explores the structure of the human life world, or the lived world as it is experienced in every day situations. He describes four fundamental existential themes that pervade the life worlds of all human beings. These four existential themes or existentials are lived space (spatiality); lived time (temporality); lived body (corporeality) and lived human relation (relationality or communality).

A description of each of the existentials that guide my reflection of the themes is given at the beginning of every sub-section. While these four existentials are described under different headings, they are not separate, as together they form the intricate unity that is the life world (van Manen 1990) of the critical care nurse. In some instances a single theme has been re-conceptualised and included in more than one of these existentials. Issues relating to power, powerlessness and the need for control permeate the narrative in all the themes, and appear to be central to critical care nursing in general and in particular to the experience of the sudden unexpected death of a patient.

5.2 LIVED SPACE (SPATIALITY).

Lived space is felt space and refers not only to the physical space in which the person functions, but also to the way this space is perceived and how the person responds to the space or environment (van Manen 1990). In the life world of the critical care nurse the physical space is the intensive care unit, a technological space in which she must provide care and comfort to her patient. This technological space and the impact of this space on the critical care nurse's experience of the sudden unexpected death of

her patient relates to theme one (the shock of it) and theme two (the burden of guilt) and is described in the following paragraphs.

5.2.1 Technological space in the ICU.

Highly technical equipment and extremely ill patients dominate the lived workspace of the critical care nurse. The sensory (sight, sound and smell) impact of entering an ICU can be overwhelming. Hay and Oken (1972, p.110) state that the greatest impact comes from the technology "with flashing lights, buzzing and beeping monitors, gurgling suction pumps and whooshing respirators". Attached to this technology are desperately ill and injured human beings, who often appear more dead than alive (Hay & Oken 1972). For the nurse to function effectively within this environment she has to gain understanding of, and control over, the technology and medical interventions. This control is gained through the attainment of knowledge, or to quote one of the participants in this study "knowledge is empowering". Foucault (1978) cited by Kuokkanen and Leino-Kilpi (2000) suggests that power and knowledge are closely related as power increases through knowledge; where there is power there is also knowledge and power generates knowledge. Many nurses who work in the ICU have extensive specialist training and relative autonomy in their work, which is predominantly medical and technical in orientation (Walby & Greenwell 1994 as cited by Seymour 2001). This technical expertise, coupled with her medical knowledge, enables the critical care nurse to control her environment and provides her with status and respect from her medical colleagues that is unparalleled in nursing (Seymour 2001).

5.2.2 Caring space in the ICU.

Although the critical care nurse works within a highly technical environment and has expert techno-medical knowledge she remains a nurse, and the essence of nursing is providing comfort (Morse 2000) and care (Henderson 1980). The Collins Paperback English Dictionary defines "comfort" (1990, p.166) as "a state of physical ease or well being; relief from suffering or grief". Morse, Bottorff and Hutchinson (1994) in a phenomenological study on the nature of comfort argue that while the goal of nursing is to enhance comfort and ease and relieve distress, it is not possible to provide total comfort. This is because the process of achieving comfort is dependent on patients needs to live with illness or injury without being dominated by their bodies.

The Collins Paperback English Dictionary defines "care" (1990, p.121) as "to be worried or concerned; to have regard or consideration for; to look after or provide for". Beeby (2000) considers the concept of caring and how it relates to critical care nursing; she cites Watson (1979) as describing caring as not just "an emotion, concern, attitude or benevolent desire", but also the "moral ideal of nursing to protect, enhance and preserve human dignity" (Beeby 2000, p.78). Seymour (2001) asserts that achieving a balance between the technological and caring components of her work is central to critical care nursing. Bush and Barr (1997) in their study of critical care nurses experiences of caring, describe caring as a complex, multidimensional process, which is in part influenced by knowledge and competence. Walters (1995a), who reviewed the literature surrounding the philosophy of technology and how this relates to the practice of critical care nursing, cites a number of authors who argue that technology and caring are polarised opposites, and that the ICU environment is dehumanising for the critically ill patient. This dehumanisation occurs as technology destroys human dignity

and reduces people to objects. Indeed, one of the challenges facing the critical care nurse is to be able to “tame” this technical environment and make it less hostile for the patient (Benner, Hooper-Kyriakidis & Stannard 2001, p.271), and so ensure her patient’s comfort. Walters (1995b), in a qualitative study of the practice of critical care nursing, describes how experienced critical care nurses are able to incorporate technology into caring and so enhance caring. It is my personal experience and observation that novice critical care nurses are initially so overwhelmed by the ICU environment that this becomes the primary focus of their attention, and they find it difficult to function effectively within their caring role. It is only once she has mastered the technology and equipment that the nurse is able return to her true function of providing comfort to her patient. This reflection is supported by a comment by one of the participants, in the following excerpt.

... maybe before I was more involved with you know, “Am I doing the right thing”, and now I’m maybe moving beyond that, and saying, “Hang on, I’m comfortable with what I am doing” and being able to sort of look at the patient, and the family, not just the diagnosis [and equipment].

5.2.3 Sudden unexpected death and the ICU environment.

The focus of care within the ICU is the preservation of life, through the use of advanced technology and medical knowledge, and death is often perceived as a failure (O’Gorman 1998). Within this environment, there can be no greater challenge for the critical care nurse than cardio-pulmonary resuscitation (CPR), when she attempts to defy death itself. It is during the resuscitation that the nurse is able to determine her control over the technological environment and put her knowledge and skills to the test. Participants described the exhilaration of the resuscitation; how they became

"mechanical" or at one with the technology. Later when the resuscitation attempt was declared unsuccessful the participants felt disappointed, angry, frustrated and guilty. Folkman (1984) explains that when a situation is initially appraised as a challenge (i.e. an opportunity for growth, mastery or gain) it is characterised by emotions like excitement and eagerness. In contrast, situations that are appraised as threatening (i.e. there is a potential for harm or loss) are characterised by negative emotions like fear and anger. Field (1989) suggests that successful resuscitation can be very rewarding and satisfying for the nurse, as she is able to prevent death through the application of her specialised training. The participants in this study reported feelings of powerlessness, hopelessness and frustration following an unsuccessful resuscitation. Members of the focus group added that, if unsuccessful, the experience left them feeling exhausted and emotionally drained.

5.2.3.1 A double knock?

Resuscitation creates one of the paradoxes of critical care nursing and highlights the tension between the nurse's techno-medical and caring roles. During resuscitation, the critical care nurse uses technology together with her expert knowledge in an attempt to preserve life; yet if she fails and the patient dies, she also fails in her caring role and denies her patient a good death. It is only in this situation of sudden unexpected death that the critical care nurse is unable to achieve a positive outcome by emphasizing one of her two roles. When a patient has life support limited or withdrawn because further treatment is considered futile, the nurse is able to change her focus from life preservation to providing comfort or palliative care to the dying patient and supporting the family (Simpson 1997). Thus, while the techno-medical aspects of critical care nursing may have been unsuccessful, she is still able to

positively impact on the experience of dying for the patient and his or her family, through the provision of nursing care. Buyssens (1986, p.106) identifies "positive interpretation" or emphasizing the positive aspects of a situation as one way to cope with traumatic events; this is, however not possible in sudden unexpected death as the nurse has no preparation and no way of predicting, at the onset of CPR, which patients will survive or which will die. When the patient's condition changes unexpectedly, the critical care nurse immediately assumes her techno-medical role and implements life-preserving techniques. During the resuscitation it is difficult for her to even think of the patient as dying (McClement & Degner 1995).

The participants in this study felt that patients who died suddenly and unexpectedly were denied a "dignified death". Steinhauser et al. (2000) describe a bad death as one that does not allow the patient the opportunity to plan ahead, arrange personal affairs, decrease family burden or say good-bye. They also report that people "fear bad dying more than death" (Steinhauser et al. 2000, p.829). Field (1989) states that nurses are more easily able to accept death if it was perceived as a good death. This inability to have a positive influence on the patient's experience of death is shared with the accident and emergency unit (A&E) nurse, which Saines (1997b) claims significantly affects the distress experienced by this group of nurses. It is worth noting that in ICU, unlike the situation in the A&E unit, the critical care nurse has usually established a relationship with the patient and the family at the time of death, thus increasing the impact. In addition, the knowledge that she has failed in both her roles must make it especially difficult for the nurse to come to terms with sudden unexpected death.

5.3 LIVED TIME (TEMPORALITY).

Lived time refers to subjective time as opposed to objective or clock time. Lived time includes the past, the present and the future, which are all dimensions of our temporal way of being in the world (van Manen 1990). Sandelowski (1999, p.80) describes lived time as "in-here time" which she says is fundamental to "all human beings regardless of, although shaped by, biographical and historical time". Sandelowski (1999) asserts that our understanding of human conditions is dependent on the recognition of the temporal flow that shapes events. Saines (1997b) cites Worden (1991) as saying that death awakens memories of past losses, while heightening our awareness of both our own mortality and feared future losses. This existential provides a useful basis for the explication of theme two (the burden of guilt), as well as themes one (the shock of it) and three (dealing with the relatives).

5.3.1 Past experiences and losses.

In this report lived past time relates to the critical care nurse's prior experience, both personal and professional, of death and dying. The participants described how past experiences with death and dying impacts on the way they cope with death and also influences how comfortable they are when interacting with the patient's family during this time. Those nurses who have experienced personal loss felt more comfortable about supporting the relatives, while nurses with no personal experience of bereavement reported feeling inadequate and often distanced themselves from the patient's family. More experienced nurses are also able to draw on past professional experience in these difficult situations; novice nurses who have limited experience must feel particularly vulnerable at this time. Wright (1991) explains that people [and

nurses are also people (Taylor 1992)], draw on past experience when confronted with a crisis situation, as an early means of finding a solution and resolving the situation.

The participants and members of the focus group reported that their training in grief management and bereavement was insufficient and inadequate, which placed greater emphasis on their own professional and personal experiences during this time. The literature indicates that most critical care nurses feel that they receive inadequate training in supporting and caring for the newly bereft (Kelly & Cross 1985, Vachon 1987, Wright 1996).

5.3.2. The present.

Expecting and being prepared for the unexpected is central to critical care nursing (Benner, Hooper-Kyriakidis & Stannard 2001). When a patient dies suddenly and unexpectedly the nurse is rapidly brought back to the present and experiences a sense of shock and disbelief. A participant described how time seemed to stand still while she tried to comprehend, how despite her vigilance, she had been unable to anticipate this crisis event. It was only once her colleagues had moved into action that she returned to the present and was able to assist with the resuscitation. Despite this initial sense of inertia, time appears to move very fast during the resuscitation and the participants reported feeling energised and exhilarated. As described earlier, these emotions occur because the nurse views the resuscitation, as a challenge and believes that the patient will survive.

The participants described how the impact, and thus the experience of sudden unexpected death, is dependent on how they were feeling on that specific day, at that

specific time. Sandelowski (1999) explains that there are no objective life events, and that the impact of any event will vary for every person.

During the resuscitation the nurse tries to ensure that the family are kept informed about what is happening. This communication, which ensures that the family are continuously up-to-date with the present situation, aids the nurse when she must later notify the family of the patient's death. Members of the focus group described how they felt disturbed by having to inform family members, who were not at the hospital when their relative died. In this situation the nurse conceals the fact that the patient has already died, and telephonically requests that the family immediately come to the hospital, stating only that the patient's condition has "deteriorated". The family are only informed of the death once they arrive at the bedside. This deceit is justified by the nurse as an attempt to protect the family from receiving the shocking information while alone and unsupported, but still leaves her feeling guilty. McClement & Degner (1995) support this finding in their study on expert nursing behaviours in the care of the dying adult in the ICU, and report that many nurses believe it important to let the family know immediately when a patient's condition deteriorates resulting in a poor prognosis. This early reporting facilitates the transition from curative to palliative thinking for both the family and the nurse.

5.3.3 The future.

An expert critical care nurse usually has the knowledge and the ability to foresee events and so prevent complications before they occur. Brenner, Hooper-Kyriakidis and Stannard (1999, p.2) call this "clinical forethought", which they define as "the ability to anticipate and prevent potential problems". This ability, which is based on

the nurse's scientific understanding and experiential learning of the clinical course, becomes intuitive and enables her to recognise early changes in the patient, predict what is likely to happen by projecting possible clinical eventualities, and to act early (Benner, Hooper-Kyriakidis & Stannard 1999). Clinical foresight enables the nurse to prepare the environment and the patient for all eventualities and possible future crises (Benner, Hooper-Kyriakidis & Stannard 1999). In sudden unexpected death clinical forethought has failed to warn the nurse of the imminent crisis, and she feels guilty that she may have missed some sign which in turn leads her to question her competence as a critical care nurse. Her ability to anticipate similar crises in the future is also placed in doubt. The participants reported feeling remorse at being unable to prevent the patient's death; and guilty as they are initially unsure whether they are responsible. Participants also reported feeling angry when the doctors do not divulge all the available information on the patient's condition, as insufficient information may result in their failure to anticipate the patient's death. Members of the focus group discussed this point at length and concur that if doctors were more forthcoming with *all* the relevant patient information, nurses would be better able to anticipate and prepare for death.

5.4 LIVED HUMAN RELATION (RELATIONALITY or COMMUNALITY).

Lived relation refers to the relationship we maintain with others within the interpersonal space we share with them (van Manen 1990). This existential has been explored in each of the relationships that the nurse has during her interactions with patients, relatives, other nurses, doctors, and others following the sudden unexpected death of her patient. Themes three (dealing with the relatives) and five (regaining

emotional equilibrium) are elucidated in the exploration of this existential. The nurse's interactions with herself during this time are discussed under the *lived body* existential.

The issues of power and control are entwined throughout this existential, as many of the nurse's relationships are based on an unequal distribution of power. This is also a particularly pertinent issue in South Africa, where female nurses (all categories) outnumber men by 15:1 (SANC 2002) and where the majority of practicing doctors are men. In the past many nurses were marginalized and oppressed on the grounds of race, and today strong cultural beliefs still result in the oppression of woman (van der Merwe 1999). These feelings of powerlessness are brought to the fore when a patient dies suddenly and unexpectedly and impact on all her relationships as outlined in the following paragraphs.

5.4.1 Nurse-patient relationship.

Participants described how they developed an instant rapport with some patients and as a result were saddened by their deaths. This was despite the fact that they may not spend much time with that patient. Members of the focus group added that they felt a sense of loss when a patient they had "connected with" died, and that this sadness was related to "what might have been" as they would never have the opportunity to get to know this person. Those participants who have children of their own identified very strongly with sick children and their parents and reported feeling devastated by the sudden unexpected death of children. Members of the focus group who did not have children of their own stated that they could not identify with these feelings, as the death of children and adults affected them equally.

Vachon (1987) explains that as a result of various personal factors nurses identify with particular patients. This "counter-transference" as Vachon (1987, p.104) calls it, may be conscious or unconscious, positive or negative. Nurses are more likely to identify with patients who are similar to themselves in personality, age or lifestyle or who remind them of significant people in their lives. In addition certain patient groups such as children, young people and those with young families are more likely to evoke this response (Vachon 1987). Saines (1997b) cites McCord (1990) when stating that nurses have a great deal of difficulty in coming to terms with sudden death, especially if young people are involved. Wright (1996) comments that the death of a child is a complex and painful event that does not fit into the natural order of things.

Yet, according to Reynolds and Scott (2000) there is now a large body of evidence that supports the notion that nurses (and other health care workers) have a limited ability to empathise with their patients. Empathy, which Reynolds and Scott (2000, p.226) define as "the ability to perceive and reason, as well as the ability to communicate understanding of the other persons feelings and their attached meanings" is a core component of a helping relationship. Rushton (1992) describes the suffering of critical care nurses and their struggle to balance their obligations to others with their obligations to themselves. Is it possible that nurses fail to empathise with their patients because this would cause them too much pain? Nurses who are also mothers, clearly empathise with the parents and later suffer from this *over* involvement.

5.4.2. Nurse-relative relationships.

Care of the critically ill patient includes care of the family and significant others (Bush & Barr 1997). There are a number of reports in the nursing literature exploring how to

care for the family when a patient dies suddenly in both ICU and the emergency unit (Cooke, Cooke & Glucksman 1992, Adamowski et al. 1993, Edwards & Shaw 1998, Jackson 1998, Andrew 1998), which acknowledge the important role nurses play in this difficult time. Andrew (1998) highlights that nurses are very aware that the time surrounding a patient's death is vividly remembered by family members for years after the event, and so attempt to make the experience as positive as possible.

Following admission to ICU, both the patient and his or her family are extremely vulnerable and as a result find it easy to open up to the nurse. This enables the critical care nurse to establish intense relationships with patients and their families, in a relatively short period of time (Meyer 1992). If the nurse identifies strongly with either the patient or their family, this relationship is even more intense.

The participants in this study indicated that interaction with the family was one of the most difficult and stressful aspects of sudden unexpected death. This was largely because they were not sure how best to support the family during this time. Saines (1997b p.206) describes the grief reactions of relatives in sudden death situations to be "individual, intense, diverse and wide ranging". Cooke, Cooke and Glucksman (1992) in their study on the management of sudden bereavement in the accident and emergency unit concluded that most staff felt inadequate when dealing with death, grief and bereavement. McClement and Degner (1995) reported that critical care nurses found dealing with upset or bereaved relatives to be extremely stressful, especially if they themselves had not learned to manage emotions, like anger. Wright (1996) comments on how quickly the nurse can feel disempowered, when dealing with the suddenly bereaved. Nurses are left feeling helpless and overwhelmed during the

interaction of breaking bad news and the raw feelings of hurt and the stark reality of pain expressed by the suddenly bereft can be distressing for the nurse (Wright 1996). Edwards and Shaw (1998) noted in their review of the literature on the care of the suddenly bereaved, that nurses are generally not skilled at breaking bad news, and that they find this aspect particularly stressful.

One of the participants described her relationship with a family member and the distress she experienced at not knowing how the wife, of a patient who had died, was coping. This intense and intimate relationship between the nurse, the patient and their family appears to be governed by convention, making it difficult for the nurse to contact the family outside of the ICU. Within my own practice I often resisted making contact with family members following a patient's death, as I was apprehensive as to how this communication would be received.

In some instances the participants appeared to displace their need to provide a *good death* for the patient on to the relatives, and tried to lessen the impact by providing the family with some prior warning, even if only a few moments. McClement and Degner (1995) report that critical care nurses, in contrast to palliative care nurses, place a great deal of importance on creating a dignified and peaceful bedside scene for the survivors to return to after the patient had died. One participant commented that she felt uncomfortable about letting the family see the body of patients who "look awful" in death, as she did not want "the relatives to be more distressed". This peaceful bedside scene is achieved by modifying the patient's appearance, by removing invasive equipment and providing subdued lighting, and moderating the noise level when the grieving family are present. In palliative care the family would

already be at the bedside, and the environment is unlikely to be in a state of disarray when the patient dies.

5.4.3. Nurse-nurse relationships.

The study participants indicated that they needed to speak about what had happened with their colleagues, specifically those who had been present during the resuscitation, or who had knowledge of the patient. Jones and FitzGerald (1998) support this finding in their study on the lived experience of critical care nurses caring for a patient during withdrawal of life support. One of the themes in their study was "being able to talk" and related to how nurses felt the need to talk to someone after the event. Jones and FitzGerald (1998) report that paradoxically while nurses identified this need to talk and were able to recount events long after they had happened, they were in practice hesitant to speak about these events.

Participants in this study also described a reluctance to express themselves emotionally in front of their colleagues for fear of being seen as the "one who can't cope". They also stated that they needed the support of their colleagues more than support from any other group, yet commented that any support they got from their colleagues was superficial. One participant described how on one occasion she had broken down and was even more distressed when her colleagues did not know how to respond. It is paradoxical that nurses, whose primary function it is to care, appear incapable of caring for each other.

One reason for this may be related to a phenomenon known as horizontal violence. Horizontal violence occurs when oppressed groups direct their frustrations and

dissatisfactions inwards and towards each other, instead of towards the people and systems that have rendered them powerless (Leap 1997 as cited by Freshwater 2000). This could explain why when nurses are feeling especially powerless, following a sudden unexpected death they are also unsupportive. Nurses are described as an oppressed group (Farrell 1999 & 2001 and Freshwater 2000). This horizontal violence is not always covert, but more commonly takes the form of lack of support, snide remarks, hostile undercurrents, and withholding of information (Freshwater 2000 and Farrell 2001). Nurses report finding inter-staff aggression more upsetting and more difficult to deal with than aggression from other disciplines (Farrell 2001). This links with the nurse's reluctance to share her emotional response with her colleagues, as the nurse who is feeling vulnerable and guilty following the sudden unexpected death of her patient is unlikely to further expose herself to hostile colleagues.

Another reason why nurses are unable to confide in and support each other could be that this is seen as a threat to professional competence. The nurse may be aware of the therapeutic benefits of emotional expression, but be concerned that by revealing her emotions she is indicating that she is unable to cope and is thus incompetent. Saines (1997b) cites Hockey (1993) as having stated that loss of emotional control in a professional and public setting can be problematic, because once lost, control cannot be easily retrieved.

5.4.3.1. The Nursing Team

The participants also describe the importance of being part of a stable team, where everyone knows everyone else, and where they feel comfortable to express themselves without the risk of being judged by others. Vachon (1987) reports that poor team

communication is the greatest environmental stressor in ICU. These problems arise because either the members do not know one another well enough, and therefore do not acknowledge and recognise each other's areas of expertise, or because the members are too close. Other factors that impact on team communication are team stability and group conflict (Vachon 1987). One of the participants commented that team stability seldom occurs in nursing because of shift work and the high staff turnover. This is especially true in this country where the profile of the critical care nurse has changed since this research was conducted. Today a large proportion of critical care nurses in Cape Town are hired via nursing agencies. These critical care nurses are not only transient and isolated from the team, but many of the permanent members of nursing and medical staff are openly hostile towards them.

5.4.4. Nurse-Doctor relationships.

Doctors have always been in a position of dominance over nurses. This dominance is said to be because of their gender, social position and monopoly on knowledge (Svensson 1996). In the South African private sector this inequality is particularly noticeable as hospital management, at the expense of the nurse, elevates the status of the doctor. Svensson (1996) cites McMahan et al. (1994) as describing the relationship between doctors and nurses as one in which nurses are essentially powerless and only able to exert influence through indirect, manipulative strategies that only serve to reinforce the prevailing power relations. A number of recent studies have examined the interplay between the two professions (Svensson 1996, Bowler & Mallik 1998 and Snelgrove & Hughes 2000). Snelgrove and Hughes (2000, p.666) interviewed 39 nurses and 20 doctors and concluded that both professions perceive a clear dichotomy between their roles, along the lines of 'cure' and 'care'. However a blurring of these

traditional roles occurs in specialist clinical areas, including ICU where nurses willingly expand their roles to encompass medical-technical tasks (Snelgrove & Hughes 2000). Svensson (1996), in a study of 45 registered nurses describes how nurses are now negotiating a new order between themselves and doctors. Relationships between the two groups are changing and now portrayed as collegial, and discussion between doctors and nurses is now more common. This is especially true within the ICU, where doctors and nurses work side by side, both giving directions and sharing opinions, but as Seymour (2001) describes, their roles are differently constituted. The doctors are responsible for initiating changes in treatment, ordering investigations and making diagnoses about any complications the patient may develop. By contrast, the critical care nurse is responsible for ensuring that these treatments are carried out safely and accurately and that physiological data is accurately recorded and reported. In addition, she is responsible for providing all her patient's care needs as well as for providing support, comfort and information to the family and visitors (Seymour 2001).

In the South African private sector from where the study participants were recruited the doctor is seldom physically in the ICU and the role of the nurse overlaps that of the doctor. When a patient collapses, it is typically the nurse who must respond, diagnose and treat the patient by instituting resuscitative measures and emergency therapies, before the doctor is summoned (Benner, Hooper-Kyriakidis & Stannard 1999). It is these techno-medical skills which critical care nurses usually perceive as having greater value than their caring skills. An explanation for this phenomenon can be found in the writings of Freire (2000) who describes how the oppressed (in this case nurses) feel an irresistible attraction towards the oppressors (in this instance doctors) and their way of life. Nurses therefore try to resemble and imitate doctors at the expense of their own

areas of expertise. Self-depreciation is another characteristic of the oppressed, which comes from their internalisation of the opinion their oppressors hold of them (Freire 2000). As medical knowledge is perceived by society to be the most valuable, both doctors and nurses undervalue the importance of the nurse's expertise and care.

The participants repeatedly described their need for recognition and approval from doctors when their patient died suddenly and unexpectedly. This approval related to their performance prior to and during the resuscitation. The doctor is clearly perceived by this group of critical care nurses to be the authority figure, and participants indicated the need to apologise for any lack of vigilance, which may have lead to the patient's death. One participant described how she felt less isolated and was able to acknowledge her own grief when she saw a doctor demonstrating similar emotions. Expressions of emotional distress from her nursing colleagues did not carry the same weight.

The relationship between nurses and doctors is complex and despite her expert knowledge and status the South African critical care nurse remains the subordinate in this relationship. In a book review Jordan (1995) describes how critical care nurses on both sides of the Atlantic are gaining power and status as they moves into areas that were until recently the domain of the doctor. Increased education, assertiveness and technical knowledge have resulted in the increasing demand by nurses for professional autonomy. The modern critical care nurse sees herself as the equal of the doctor and is unwilling to play the doctor-nurse game (Jordan 1995). These changes, while apparent in the literature, have yet to gain much momentum in this country, where

gender and cultural issues still result in oppression and non-assertiveness amongst nurses.

5.4.5. Others (family and friends).

Nurses in this study described how they were reluctant to burden their families and friends with work related issues because of reasons related confidentiality and the need to protect others from the harsh realities of their work. Participants report that while friends and family were able to provide emotional support, this did not help them come to terms with their feelings of guilt or offer them reassurance about their professional competence. Norbeck (1985), in a study exploring the types and sources of social support for managing job stress in critical care nursing, reports that married women get most of their support from their spouses. Interestingly while unmarried nurses are reported to get most of their support from friends, it is only the support they receive from relatives which is really effective.

5.5 LIVED BODY (CORPOREALITY).

Lived body refers to the fact that one is always physically and bodily in the world. The way in which we perceive our body reflects on the way in which experiences are interpreted (van Manen 1990). I have extended this understanding of the lived body to include all aspects of the nurse as a person. Rogers (1961, p.21) perceived the person as the whole of the feelings, attitudes and beliefs, which make up "a real and vital part of him". I will therefore, within this existential, reflect on both the physical and emotional body that comprises the critical care nurse, and how these relate to themes four (denial of self) and five (regaining emotional equilibrium) and thus to the critical care nurse's experience of sudden unexpected death.

This existential is especially salient when describing the life world of the critical care nurse, where at times the environment in which she works leads to a lack of harmony between the two aspects of her person, namely her emotional and physical aspects. In this section I reflect upon the nurse's denial of her emotional needs (theme four), her need to moderate her emotional response (theme four), and how she goes about reconnecting with herself following the experience of sudden unexpected death (theme five).

5.5.1 Denial of self.

The participants in this study described how they struggled to come to terms with having constantly to deny and or suppress their emotional needs and feelings. They describe a split between their professional, techno-medical functioning and their emotional side as they are often not able to acknowledge the emotional impact of the death, or validate these feelings. Two of the participants used terms usually reserved for the technological equipment to describe themselves. An especially strong metaphor used by one of the participants was that of "changing modes". This is a term usually used to describe alterations in mechanical ventilation. Taking over the patient's respiratory function with mechanical ventilation, represents a common and very important aspect of her role in the ICU and during CPR. This metaphor likens the nurse to a machine, a piece of equipment without emotions and with modes that can be changed with the flip of a switch. Hudak, Gallo and Benz (1990) describe how critical care nurses are socialised to be selfless and not feel grief, fear, disgust or love when working intimately with patients.

5.5.2 Moderation of emotional response.

Participants described how they suppress their emotions during this time so as to remain calm and in control of the present situation; this is often achieved through the use of humour. Benner, Hooper-Kyriakidis and Stannard (1999) describe how in a crisis situation the expert critical care nurse is able to modulate her emotional responses in order to assist others to function well. The nurse knows that a calm demeanour will help calm others, enable them to function better, and so ensure a better outcome for her patient (Benner, Hooper-Kyriakidis & Stannard 1999). Hudak, Gallo and Benz (1990) explain that this ability to detach oneself emotionally during stressful situations is a coping mechanism utilised by critical care nurses to come to terms with the grim reality of their work. They caution that it is difficult for the nurse to suppress her response to negative emotional experiences without also suppressing her emotional response to pleasure and joy (Hudak, Gallo & Benz 1990).

Many authors recognise the value of humour as a defence against overwhelming stress (Hay & Oken 1972, Vachon 1987 and Knight 1996). In a study exploring the use of humour in an ICU Thornton and White (1999) describe how critical care nurses find humour to be an essential stress-reliever and coping mechanism, and that this humour was usually *black* or *sick* humour which is directed at the situation rather than the patient. Participants emphasised that humour was not directed towards or in anyway disrespectful to the patient. Within my own practice I am often amazed how, when managing an extremely stressful situation or at the end of a prolonged resuscitation, I am able to appear outwardly calm and see the humour in the situation, while inwardly I feel devastated.

5.5.3 Physical symptoms of stress.

Some of the participants described how they developed physical signs of stress e.g. palpitations. Members of the focus group described how the “intense excitement” they felt during the resuscitation left them feeling emotionally drained and exhausted afterwards. Lewis and Robinson (1986) used questionnaires to gather information on coping strategies used by ICU nurses in response to stress. The physical manifestations of stress they reported are fatigue, headaches and emotional changes (frustration, irritability, anger, quietness and restlessness). Maslach (1982) supports these findings and states that exhaustion and frustration are some of the ways in which nurses manifest stress.

5.5.4 Burnout.

There are many factors that make the critical care nurse vulnerable to burnout. These may be categorised as personal, occupational or a combination of these factors. The personal factors, which place someone at high-risk for burnout are non-assertive behaviours, health difficulties, family demands, defective coping skills and inadequate social support (Stechmiller & Yarandi 1993), while those related to work include workload, lack of control, inadequate peer support, lack of or negative feedback from supervisors (Maslach 1992). In this study the participants indicated that the experience of sudden unexpected death left them feeling angry, frustrated and powerless. Maslach (1982) warns that the nurse who feels powerless is at greatest risk of burnout and comments that many of the strategies recommended for the prevention of burnout are directed at increasing personal power. One of the hallmarks of the burnout syndrome is the individual's shift from positive caring to negative uncaring (Maslach 1982). Maslach (1982, p.17) goes on to describe how the nurse

who is burnt-out views her patients in more “cynical and derogatory terms”, and may even begin to have a “low opinion of their capabilities and worth”. These negative views help the nurse to create exaggerated distance between herself and the patient, which in turn makes it easier for her to maintain a distance between herself and the patient. Vachon (1987) describes how nurses also sometimes distance themselves from patients and their relatives through technology, to prevent themselves from identifying with them and experiencing their pain. One of the participants said “I don’t want to feel everything that is going around”. The nurse experiencing burnout spends less time with the patient, demonstrates callous and insensitive behaviour and there is a deterioration in the overall care provided (Maslach 1982).

Participants in this study displayed signs of burnout and described how they felt the need to “harden” themselves against their patients; they spoke of colleagues who had worked in ICU for many years and who were now hardened. Severe distress and burnout can occur if the nurse is not given time for emotional recovery between various patient death situations, but especially sudden unexpected death (Saines 1997b). Saines (1997b) cites Bolton & Roberts when she states that support is needed to enable staff to face rather than evade difficult issues.

5.5.5 Reconnecting with self.

The steps that the nurse takes to ensure effective coping are also those that will prevent burnout. Folkman and Lazarus (1988) describe how any stressful event usually has more than one implication for the person’s well being and more than one option for coping. As described in Chapter Two there are many ways of analysing coping strategies, however Folkman and Lazarus (1988) maintain that these are

usually incomplete. This is because the complexity of the emotion and coping processes are often underestimated, and because emotion is treated as a uni-directional instead of bi-directional drive (i.e. coping and emotion each affect the other).

Folkman and Lazarus (1988, p.473) describe four types of coping associated with changes in the ongoing emotions: "planful problem-solving, confrontive coping, positive reappraisal and distancing". Planful problem-solving is not relevant in sudden unexpected death as there is no time for proactive planning. The participants and members of the focus group stated that they often felt angry following the sudden unexpected death and that this anger was usually directed towards the doctor. The unequal power between the doctor and the nurse, which was described earlier, makes it unlikely that confrontive coping would be used, which is beneficial as the expression of anger in these situations invariably worsens the situation (Folkman & Lazarus 1988).

Positive reappraisal occurs when the person feels that the stressful experience has enabled them to change or grow as a person and this helps to reduce distress (Folkman & Lazarus 1988). The participant who described how she uses knowledge gained in stressful experiences, to inform her handling of future incidents, gave an example of positive reappraisal. The final way of coping is through distancing, which was described by a number of the participants and members of the focus group. The nurse copes by "going on as if nothing has happened", or "tries not to let things get to her", or "boxes it away". However, according to Folkman and Lazarus (1988) distancing is a form of maladaptive coping and is not very effective, as intrusive thoughts and other cues keep bringing the experience back into her mind.

Dewe (1987) undertook a large study to investigate and describe the strategies nurses use to cope with work stress. They used the structured interviews of 312 nurses to develop a questionnaire which was mailed to 2500 New Zealand nurses from all areas of nursing. One thousand eight hundred and one questionnaires (72%) were analysed and six coping strategies identified. These are problem-orientated behaviour, trying to unwind and put things into perspective, expressing feelings or frustrations, keeping the problem to oneself, trying not to let things get to you and passive strategies like smoking, overeating and drinking. While these findings are not related to death or critical care nursing they do allow for an interesting comparison of coping strategies. The problem-orientated behaviour was not applicable in the experience being studied. The participants indicated that they only three of the other strategies, which are similar to positive reappraisal (i.e. trying to unwind and put things into perspective) and distancing (keeping the problem to oneself and trying not to let things get to you) as described by Folkman and Lazarus (1988). One participant indicated that she used a passive strategy (i.e. over eating) to handle the situation, while the focus group members described how they sometimes found comfort in alcohol at the end of a difficult day.

Buyssen (1996) cites van den Bout and Kleber (1994) when he states that the main aims of the coping process are the search for meaning and regaining control. He goes on to describe four strategies, which nurses use to cope. These strategies, which are 1) searching for an explanation, 2) re-telling the story 3) comparing with others and 4) positive interpretation, are very similar to those used by the participants in their

struggle to regain equilibrium and come to terms with the sudden unexpected death of their patient and will be discussed in detail.

5.5.5.1. Searching for an explanation.

Participants reported feeling guilty and blaming themselves after a sudden unexpected death, and also the need to establish a reason for the death. Buyssen (1996, p.102) states that during this time the participants ask "why" and "what happened" and then "why me"? People continue to worry and search for a plausible explanation. According to Buyssen (1996) most people begin by blaming themselves, as this helps them to feel in control and also means that they have the power to either avoid similar events in the future, or react differently or more effectively if faced with a similar situation.

5.5.5.2. Talking about it.

The next important step according to Buyssen (1996) is to talk about what happened. At first the tale is not coherent, but in the re-telling she is able to give order and structure to the chaos of her thoughts and remember details, which may have eluded her earlier. Through this process the nurse is able to gain some control over events. The participants described how they felt the need to talk about events with their colleagues but that these de-briefings, when they occurred, avoided any highly charged emotional issues. Buyssen (1996, p.119) suggests that the most important reason why nurses are reluctant to talk about their emotions is that they are "shocked by their own emotions". They need to come to terms with these emotions on their own, before they expose their vulnerability to others.

5.5.5.3. Comparing with others.

The participants indicated that the need to talk about events with those who had been there, who had been part of the resuscitation. Buyssens (1996) maintains that people normally compare themselves with others who have apparently performed better than themselves, which makes them feel ashamed and jealous. Later they compare themselves with people who have had worse experiences and which enables them to regain their self esteem. This strategy was not apparent in the participants, except that they did seek approval for the doctor whom they placed at the head of the team.

5.5.5.4. Positive interpretation.

People who cope best with crisis are those who turn events into a positive experience (Buyssens 1996). As described earlier, in the sudden unexpected death situation the nurse has to accept that she has failed in both her roles. Yet, if she is able to cope she needs to gain something positive from the experience. Participants indicated that they found it easier to cope if they could rationalise that because of the nature of the patient's condition, or the extent of the injuries, the patient was better off dead. Nurse managers can easily and effectively utilise this strategy positively to enhance coping and training, by seeking out and highlighting positive learning opportunities in these situations.

5.6 LIMITATIONS OF THE STUDY.

There are several limitations to this study. Firstly, because of the nature of qualitative research and the sample selection, the findings are not generalizable to all critical care nurses. Fittingness of these data was demonstrated when critical care nurses from another hospital (i.e. the focus group members) were able to identify with the themes and found them applicable to their own experiences of sudden unexpected death.

Secondly, the sample was drawn from a group of registered nurses working within a single private health care sector ICU. Soon before commencement of data collection the ICU had begun admitting patients with sepsis following bone marrow transplantation. The majority of these patients died after a prolonged stay in ICU and were a source of intense frustration and moral conflict for this specific group of nurses. This frequent exposure to death may have negatively influenced the data, however it may also have enriched the data. Because of frequent exposure to death this group of nurses were more aware of their responses to death, and their prior reflection on the subject would have enabled them to verbalise data which otherwise may not have been revealed.

The advantage of using this sample was primarily that a relationship of trust already existed between the participants and me as the researcher. My intimate familiarity with the group and the clinical setting had the potential to enhance the research findings by enabling the participants to reveal more sensitive information than would have been given by another group of nurses. In retrospect it is thought that that selecting the sample from different ICUs in both the public and private health care sectors may have provided a different and broader perspective on the experience of sudden unexpected death.

5.7 RECOMMENDATIONS FOR CRITICAL CARE NURSING PRACTICE.

There is little doubt that sudden unexpected death is a significant stressor for critical care nurses. In this study, the participants described a number of actions that they took to enable them to deal with their experiences. There are a number of possible

actions that have been identified from the study, which may facilitate coping in these situations. These recommendations, which have been subdivided for clarity into recommendations for nursing practice, nursing education and nursing research, are listed below.

5.7.1 Recommendations for nursing practice.

- Following a sudden unexpected death nurses need to be given time on their own to reflect on what has happened.
- Members of the nursing team who were present at the resuscitation need to be given time and encouraged to discuss what happened.
- Nurses need to be encouraged, and supported while they express the emotional turmoil that follows unexpected events like this. This can be done either within the group situation or with a trusted colleague.
- The positive aspects of the situation, which may not always be evident, need to be highlighted where appropriate.

5.7.2 Recommendations for nursing education.

- Nurses need to be skilled in how best to interact with and support the family during this initial period of intense emotional turmoil.
- Nurses should be taught and encouraged to accept that while they perform a different role to the doctor, theirs is of equal importance and value. It is in this manner that critical care nurses can be empowered and develop confidence in their role.

5.7.3 Recommendations for future research.

This study gave rise to a number of questions that need to be addressed before the nature of critical care nursing and the critical care nurses responses to death can be fully understood.

1. Participants in this study repeatedly referred to their professional masks and the need to be professional and behave professionally. It would seem that further understanding needs to be obtained of the term "professionalism" and its meanings for registered nurses and how this perception impacts on the way in which they function.
2. It has been stated that nurses are more likely to identify or connect with patients who come from similar social groups and backgrounds to themselves. It is however unclear whether one can deduce from this that nurses working with patients who are drawn from their own communities are more likely to identify with their patients and are thus at greater risk of burnout.
3. The profile of the critical care nursing team has changed in recent years. Most units now employ a large contingency of transient agency staff. It is important that nurse managers understand how agency nurses manage their job stress so appropriate supports may be put in place to enable quality nursing care to be delivered.
4. It would appear that support from other nurses has the greatest value in these circumstances, yet nurses are not able to effectively support each other emotionally. It is important that we understand why critical care nurses do not feel comfortable to share their feelings or express their vulnerability to each other.

5. How can the learning process of critical care nurses best be adjusted to ensure that they are better equipped to support each other and the recently bereaved family?

5.8 CONCLUSIONS.

In this dissertation I have used a qualitative, phenomenological methodology to explore the critical care nurses lived experience of the sudden unexpected death of her patient. Five main themes were identified which are: the shock of it; the burden of guilt, dealing with the relatives; denial of self and regaining emotional equilibrium. These themes were further explicated and related to the existing literature and to the life world existentials as described by van Manen (1990).

The critical care nurse works in a highly technological environment and presumes to be able to provide her patient and their relatives with both expert techno-medical care and also provide comfort and expert nursing care. There can be little doubt that the experience of sudden unexpected death is a highly stressful and emotive event for the critical care nurse. This event not only exposes her essential powerlessness but also challenges her competence to nurse this group of highly compromised, critically ill patient.

Due to the nature of the experience, coping with the sudden, unexpected death of a patient who is in her care will remain be a significant stressor for the critical care nurse. Symptoms of burnout were evident in some of the participants. This appeared to be due to ineffective coping strategies and limited support from colleagues.

This study has attempted to understand the experience of sudden unexpected death. Further research is, however, required to increase the understanding of this phenomenon, to identify interventions that may assist the nurse in supporting the family, and to develop appropriate strategies for effective support of the critical care nurse.

University of Cape Town

CHAPTER SIX***References.***

Adamowski, K., Dickinson, G., Weitzman, B., Roessler, C. & Carter-Snell, C. 1993.

Sudden unexpected death in the emergency department: caring for the survivors. Canadian Medical Association Journal, vol.149, no.10, pp.1445-1451.

Andrew, C.M. 1998. *Optimizing the human experience: nursing the families of people who die in intensive care.* Intensive and Critical care Nursing, vol.3, pp.59-65.

Appleton, J.V. 1995. *Analyzing qualitative interview data: addressing issues of validity and reliability.* Journal of Advanced Nursing, vol.22, pp.993-997.

Bailey, J.T., Steffen, S.M. & Grout, J.W. 1980. *The Stress Audit: Identifying the Stressors of ICU nursing.* Journal of Nursing Education, vol.19, no. 6, pp.15-25.

Bailey, P.H. 1997. *Finding your way around qualitative research.* Journal of Advanced Nursing, vol.25, pp.18-22.

Bailey, R. & Clarke, M. 1989. *Stress and coping in nursing.* Chapman and Hall, London.

Baker, C., Wuest, J. & Stern, P.N. 1992. *Method slurring: the grounded theory/phenomenology example.* Journal of Advanced Nursing, vol.17, pp.1355-1360.

Barr, W.J. & Bush, H.A. 1998. *Four Factors of Nurse caring in the ICU.* Dimensions of Critical Care Nursing, vol.17, no.4, pp.214-223.

Beck, C.T. 1993. *Qualitative research: the evaluation of its credibility, fittingness, and auditability.* Western Journal of Nursing Research, vol.15, no.2, pp. 263-266.

Beeby, J.P. 2000. *Intensive care nurses' experiences of caring.* Intensive and Critical Care Nursing, vol.16, pp.76-83.

Benner, P., Hooper-Kyriakidis, P. & Stannard, D. 1999. *Clinical wisdom and interventions in Critical Care: A thinking-in-action approach.* W.B. Saunders Company, Philadelphia.

- Benton, D.C. 1991. Grounded Theory, in *The Research Process in Nursing*, Ed. D.F.S. Cormack. Blackwell Science, Oxford.
- Biley, F.C. & Maggs, C. (eds.). 1996. *Contemporary issues in Nursing I*. Churchill Livingstone, London, pp.3-30.
- Boumans, N.P.G. & Landeweerd, J.A. 1994. *Working in an intensive care or non-intensive care unit: Does it make any difference?* Heart & Lung, vol.23, pp.71-79.
- Bowes, B. & Pennington, S. (eds.). 2002. *South Africa – The Good News*. South Africa – The Good News (Pty) Ltd, Hyde Park.
- Bowler, S. & Mallik, M. 1998. *Role extension or expansion: a qualitative investigation of the perceptions of senior medical staff in an adult intensive care unit*. Intensive and Critical Care Nursing, vol.14, pp. 11-20.
- Bush, H.A. & Barr, W.J. 1997. *Critical Care Nurses' lived experience of caring*. Heart & Lung, vol.26, no.5, pp.387-398.
- Buyssen, H. 1996. *Traumatic experiences of nurses: when your profession becomes a nightmare*. Jessica Kingsley Publishers, London.
- Carr, L.T. 1994. *The strengths and weaknesses of quantitative and qualitative research: what method for nursing?* Journal of Advanced Nursing, vol.20, pp.716-721.
- Cartledge, S. 2001. *Factors influencing the turnover of intensive care nurses*. Intensive and Critical care Nursing, vol.17, no.6, pp.348-355.
- Chenitz, W.C. & Swanson, J.M. 1986. *From practice to grounded theory: qualitative research in nursing*. Addison-Wesley Publishing Company, California.
- Cilliers, G.J. 1991. *The working conditions of professional nurses in intensive and high care areas in the RSA*. The Southern African Journal of Critical Care, vol.7, no.1, pp.4-6.

- Clark, C.C. 1997. *Posttraumatic stress disorder: How to support healing*. American Journal of Nursing, vol.97, no.8, pp.27-32.
- Cohen, M.Z. & Omery, A. 1994. *Schools of phenomenology: implications for research*, in Critical Issues in qualitative research methods, Ed. J.M. Morse. Sage Publications, London. pp.136-156.
- Collins Paperback English Dictionary, 2nd Ed.* 1990. Harper Collins Publishers, Glasgow.
- Cooke, M.W., Cooke, H.M. & Glucksman, E.E. 1992. *Management of sudden bereavement in the accident and emergency department*. British Medical Journal, vol.304, May, pp.1207-1209.
- Cormack, D.F.S. (ed). 1991. *The Research Process in Nursing, 2nd Ed.* Blackwell Science, Oxford.
- Coyne, I.T. 1997. *Sampling in qualitative research. Purposeful and theoretical sampling; merging or clear boundaries?* Journal of Advanced Nursing, vol.26, pp.623-630.
- Creswell, J.W. 1994. *Research Design. Qualitative and Quantitative approaches*. Sage Publications, London.
- Crickmore, R. 1987. *A review of stress in the intensive care unit*. Intensive Care Nursing, vol.3, pp.19-27.
- Cutler, L. 1998. *Do intensive care nurses grieve for their patients?* Nursing in Critical Care, vol.3, no.4, pp.190-196.
- Dewe, P.J. 1987. *Identifying strategies nurses use to cope with work stress*. Journal of Advanced Nursing, vol.12, pp.489-497.
- Duffy, M.E. 1985. *Designing nursing research: the qualitative – quantitative debate*. Journal of Advanced Nursing, vol.10, pp.225-232.

- Edwards, L. & Shaw, D.G. 1998. *Care of the suddenly bereaved in cardiac care units: a review of the literature*. Intensive and Critical Care Nursing, vol.14, no.3, pp.144-152.
- Eisendrath, S.J. & Dunkel, J. 1979. *Psychological issues in intensive care unit staff*. Heart & Lung, vol.8, no.4, pp.751-758.
- Ely, M. 1991. *Doing Qualitative Research: Circles within circles*. The Falmer Press, London.
- Farrell, G.A. 2001. *From tall poppies to squashed weeds: why don't nurses pull together more?* Journal of Advanced Nursing, vol.35, no.1, pp.26-33.
- Farrell, G.A. 1999. *Aggression in clinical settings: nurses' views – a follow-up study*. Journal of Advanced Nursing, vol.29, no.3, pp.532-541.
- Field, D. 1989. *Emotional involvement with the dying in a coronary care unit*. Nursing Times, vol.85, no.13, pp.46-48.
- Field, P.A. & Morse, J.M. 1985. *Nursing Research. The application of qualitative approaches*. Chapman & Hall, London.
- Flinders, D.J. 1992. *In search of ethical guidance: constructing a basis for dialogue*. Qualitative Studies in Education, vol.5, no.2, pp.101-115.
- Folkman, S. 1984. *Personal Control and Stress and Coping Processes: a theoretical analysis*. Journal of Personality and Social Psychology, vol.46, no.4, pp.839-852.
- Folkman, S. & Lazarus, R.S. 1985. *If it changes it must be a process: Study of Emotion and Coping during Three Stages of a College Examination*. Journal of Personality and Social Psychology, vol.48, no.1, pp.150-170.
- Folkman, S. & Lazarus, R.S. 1988. *Coping as Mediator of Emotion*. Journal of Personality and Social Psychology, vol.54, no.3, pp.466-475.

- Folkman, S., Lazarus, R.S., Dunkel-Schetter, C., DeLongis, A. & Gruen, R.J. 1986b. *Dynamics of a Stressful Encounter: Cognitive Appraisal, Coping, and Encounter Outcomes*. Journal of Personality and Social Psychology, vol.50, no.5, pp.992-1003.
- Folkman, S., Lazarus, R.S., Gruen, R.J. & DeLongis, A. 1986a. *Appraisal, Coping, Health Status, and Psychological Symptoms*. Journal of Personality and Social Psychology, vol.50, no.3, pp.571-579.
- Folkman, S., Lazarus, R.S., Gruen, R.J. & DeLongis, A. 1986b. *Appraisal, Coping, Health Status, and Psychological Symptoms*. Journal of Personality and Social Psychology, vol.50, no.3, pp.571-579.
- Foxall, M.J., Zimmerman, L., Standley, R. & Captain, B.B. 1990. *A comparison of frequency and sources of nursing job stress perceived by intensive care, hospice and medical-surgical nurses*. Journal of Advanced Nursing, vol.15, pp.577-584.
- Freire, P. 2000. *Pedagogy of the oppressed. (30th anniversary edition)* Continuum, New York.
- Freshwater, D. 2000. *Crosscurrents: against cultural narration in nursing*. Journal of Advanced Nursing, vol.32, no.2, pp.473-480.
- Friedman, E.H. 1982. *Stress and intensive care nursing: A ten-year reappraisal*. Heart & Lung, vol.11, no.1, pp.26-28.
- Gentry, W.D. & Parkes, K.R. 1982. *Psychologic stress in intensive care unit and non-intensive care unit nursing: A review of the past decade*. Heart & Lung, vol.11, no.1, pp.43-47.
- Gillespie, R.S. 2000. *Crisis in training critical care nurses*. The Southern African Journal of Critical Care, vol.16, no.1, p4.

- Giorgi, A. 1975. *An application for phenomenological method in Psychology*, in Duquesne studies in phenomenological psychology. Vol II. Eds. A. Giorgi, C. Fischer & E. Murray. Duquesne University Press, Pittsburgh.
- Giorgi, A., Fischer, C. & Murray E. (eds.). 1975. *Duquesne studies in phenomenological psychology* (Vol II). Duquesne University Press, Pittsburgh.
- Gore A. 2002. *Medical Facilities – Terminal, Curable or on the Mend?* In South Africa – The Good News. Eds. B. Bowes & S. Pennington. South Africa – The Good News (Pty) Ltd, Hyde Park.
- Guba, E.G. & Lincoln, Y.S. 1989. *Fourth generation evaluation*. Sage Publications, Newbury Park.
- Habermann-Little, B. 1991. *Qualitative Research Methodologies: An Overview*. Journal of Neuroscience Nursing, vol.23, no.3, pp.188-190.
- Hay, D. & Oken, D. 1972. *The Psychological Stresses on Intensive Care Nursing*. Psychosomatic Medicine, vol.34, no.2, pp.109-118.
- Henderson, V.A. 1980. *Preserving the essence of nursing in a technological age*. Journal of Advanced Nursing, vol. 5, pp.245-260.
- Hockey, L. 1991. *The nature and purpose of research*, in *The Research Process in Nursing*, Ed. D.F.S. Cormack. Blackwell Science, Oxford.
- Holahan, C.J., Moos, R.H. & Schaefer, J.A. 1996. *Coping, Stress Resistance, and Growth: Conceptualizing Adaptive Functioning*, in *Handbook of Coping: Theory, Research, Applications*, Eds. M. Zeidner & N.S. Endler. John Wiley & Sons Inc, New York, pp. 24-43.
- Holloway, I. & Wheeler, S. 1996. *Qualitative Research for Nurses*. Blackwell Science, Oxford.
- Hudak, C.M., Gallo, B.M. & Benz, J.B. 1990. *Critical care nursing. A Holistic approach (Fifth edition)*. J.B. Lippincott Company, Philadelphia.

- Hycner, R.H. 1985. *Some guidelines for the phenomenological analysis of interview data*. Human Studies, vol.8, pp.279-303.
- Ironbar, N.O. & Hooper, A. 1989. *Self-Instruction in Mental Health Nursing (Second Edition)*. Bailliere Tindall, London.
- Jackson, I. 1996. *Critical care nurses' perception of a bereavement follow-up service*. Intensive and Critical Care Nursing, vol.12, no.1, pp.2-11.
- Jones, T. & FitzGerald, M. 1998. *Withdrawal of life-support treatment: the experience of critical care nurses*. Australian Critical Care, vol.11, no.4, pp.117-121.
- Jordan, S. 1995. *Medicine and books. Caring in crisis. An oral history of critical care nursing*. British Medical Journal, vol. 311, p.399.
- Kvale, S. 1983. *The Qualitative Research Interview: A Phenomenological and Hermeneutical Mode of Understanding*. Journal of Phenomenological Psychology, vol.14, no.2, pp.171-196.
- Keane, A., Ducette, J. & Adler, D.C. 1985. *Stress in ICU and Non-ICU nurses*. Nursing Research, vol.34, no.4, pp.231-236.
- Kelly, J.G. & Cross, D.G. 1985. *Stress, coping behaviors and recommendations for Intensive care and Medical-Surgical ward registered nurses*. Research in Nursing & Health, vol.8, pp.321-328.
- Kingry, M.J., Tiedje, L.B. & Friedman, L.L. 1990. *Focus groups: A research technique for nursing*. Nursing Research, vol.39, no.2, pp.124-125.
- Kitzinger, J. 1995. *Introducing focus groups*. British Medical Journal, vol.311, pp.299-302.
- Knight, C. 1996. *Laughing at death: the ultimate paradox*, in Contemporary issues in Nursing I, Eds. F.C. Bailey and C Maggs, Churchill Livingstone, London, pp.3-30.
- Koch, T. 1994. *Establishing rigor in qualitative research: the decision trail*. Journal of Advanced Nursing, vol.19, pp.976-986.

- Koch, T. 1995. *Interpretive approaches in nursing research: the influence of Husserl and Heidegger*. Journal of Advanced Nursing, vol.21, pp.827-836.
- Krefting, L. 1991. *Rigor in Qualitative Research: The Assessment of Trustworthiness*. The American Journal of Occupational Therapy, vol.45, no.3, pp.214-222.
- Kubler-Ross, E. 1973. *On death and dying*. Tavistock Routledge, London.
- Kuokkanen, L. & Leino-Kilpi, H. 2000. Power and empowerment in nursing: three theoretical approaches. Journal of Advanced Nursing, vol.31, no.1, pp.235-241.
- Lally, L. & Pearce, J. 1996. *Intensive care nurses' perceptions of stress*. Nursing in Critical Care, vol.1, no.1, pp.17-25.
- Le Blanc, P.M., de Jonge, J., de Rijk, A.E. & Schaufeli, W.B. 2001. *Well-being of intensive care nurses (WEBIC): a job analytic approach*. Journal of Advanced Nursing, vol.36, no.3, pp.460-470.
- Leininger, M.M. 1985. *Nature, rationale, and importance of qualitative research methods in nursing*, in Qualitative research methods in nursing, Ed. M.M. Leininger. Grune and Stratton Inc., New York. pp.1-25.
- Leininger, M.M. 1985. *Qualitative research methods in nursing*. Grune and Stratton Inc., New York.
- Lewis, D.J. & Robinson, J.A. 1986. *Assessment of coping strategies of ICU nurses in response to stress*. Critical care nurse, Vol. 6, no.6, pp.38-43.
- Lincoln, Y.S. 1992. *Sympathetic connection between qualitative methods and health research*. Qualitative Health Research, vol.2, no.4, pp.375-391.
- Lincoln, Y.S. & Guba, E.G. 1985. *Naturalistic Inquiry*. Sage Publications, London.
- Loftus, L.A. 1998. *Student nurses' lived experience of the sudden death of their patients*. Journal of Advanced Nursing, vol.27, pp.641-648.
- Macun, I. & Posel, D. 1998. *Focus groups: A South African experience and methodological reflection*. African Sociological Review, vol.2, no.1, pp.114-135.

- Maeve, M.K. 1998. *Weaving the fabric of moral meaning: how nurses live with suffering and death*. Journal of Advanced Nursing, vol.27, pp.1136-1142.
- Maloney, J.P. 1982. *Job stress and its consequences on a group of intensive care and non-intensive care nurses*. Advances in Nursing Science, vol.1, pp.31-41.
- Maloney, J.P. & Bartz, C. 1983. *Stress-tolerant people: Intensive care nurses compared with non-intensive care nurses*. Heart & Lung, vol.12, no.4, pp.389-394.
- Maslach, C. 1982. *Burnout – the cost of caring*. Prentice-Hall, New Jersey.
- Mays, N. & Pope, C. 1995. *Rigor and qualitative research*. British Medical Journal, vol.311, pp.109-112.
- McClement, S.E. & Degner, L.F. 1995. *Expert nursing behaviours in care of the dying adult in the intensive care unit*. Heart & Lung, vol.24, pp.408-419.
- Meulenberg-Buskens, I. 1996. Unpublished Manual for the Free Attitude Interview Technique – developed for the “Research for Intervention in Action Research”, Summer School, Cape Town, January.
- Meyer, C. 1992. *Making a critical difference*. American Journal of Nursing, July, pp.61-68.
- Morse, J.M. 1991. *Strategies for sampling*. In J.M. Morse (ed) Qualitative Nursing Research: A contemporary dialogue. Sage Publications, London, pp.127-145.
- Morse, J.M. (ed.). 1991. *Qualitative Nursing Research: A contemporary dialogue*. Sage Publications, London.
- Morse, J.M. (ed.). 1994. *Critical Issues in Qualitative Research Methods*. Sage Publications, London.
- Morse, J.M. 2000. *On comfort and comforting*. American Journal of Nursing, vol.100, no.9, pp. 34-37.

- Morse, J.M., Botorff, J.L. & Hutchinson, S. 1994. *The phenomenology of comfort*. Journal of Advanced Nursing, vol.20, pp.189-195.
- Nichols, K.A., Springford, V. & Searle, J. 1981. *An investigation of distress and discontent in various types of nursing*. Journal of Advanced Nursing, vol. 6, pp.311-318.
- Norbeck J.S. 1985. *Types and sources of social support for managing job stress in critical care nursing*. Nursing Research, vol.34, no.4, pp.225-230.
- Nyamathi, N.A. & Shuler, P. 1990. *Focus group interview: a research technique for informed nursing practice*. Journal of Advanced Nursing, vol.15, pp.1281-1288.
- O’Gorman, S.M. 1998. *Death and dying in contemporary society: an evaluation of current attitudes and the rituals associated with death and dying and their relevance to recent understandings of health and healing*. Journal of Advanced Nursing, vol.27, pp.1127-1135.
- Oehler, J.M., Davidson, M.G., Starr, L.E. & Lee, D.A. 1991. *Burnout, job stress, anxiety, and perceived social support in neonatal nurses*. Heart & Lung vol.20, pp.500-505.
- Oiler, C. 1981. *The phenomenological approach in nursing research*. Nursing Research, vol.31, no.3, pp.178-181.
- Oskins, S.L. 1979. *Identification of situational stressors and coping methods by intensive care nurses*. Heart & Lung, vol.8, no.5, pp.953-960.
- Oskowitz, B. & Meulenbergh-Buskens, I. 1997. *Preparing researchers for a qualitative investigation of a particularly sensitive nature: reflections from the field*. South African Journal of Psychology, vol.27, no.2, pp.83-88.
- Paley, J. 1997. *Husserl, Phenomenology and Nursing*. Journal of Advanced Nursing, vol.26, pp.187-193.

- Parkes, C.M. 1996. *Bereavement: Studies of grief in adult life (Third Edition)*.
Routledge, London.
- Pike, R.E. 1993. *Discontent among Intensive Care nurses*. Nursing RSA, vol.8, no.2,
pp.22-25.
- Polit, D.F. & Hungler, B. 1997. *Essentials of Nursing Research (Fourth Edition)*.
Lippincott, Philadelphia.
- Pope, E., Nel, E. & Poggenpoel, M. 1998. *The experience of registered nurses in the
general adult intensive care unit*. Curationis, June, pp.32-38.
- Rashotte, J., Fothergill-Bourbonnais, F. & Chamberlain, M. 1997. *Paediatric intensive
care nurses and their grief experiences: A phenomenological study*. Heart &
Lung, vol.26, pp.372-386.
- Reeves, P.M., Merriam, S.B. & Courtenay, B.C. 1999. *Adaptation to HIV Infection:
The Development of Coping Strategies over Time*. Qualitative Health Research,
vol.9, no.3, pp.344-361.
- Rew, L., Bechtel, D. & Sapp, A. 1983. *Self-as-instrument in Qualitative Research*.
Nursing Research, vol.42, no.5, pp.300-301.
- Reynolds, W.J. & Scott, B. 2000. *Do nurses and other professional helpers normally
display much empathy?* Journal of Advanced Nursing, vol.31, no.1, pp.226-234.
- Rodgers, B.L. & Cowles, K.V. 1993. *The Qualitative Research Audit Trail: A complex
collection of documentation*. Research in Nursing & Health, vol.16, pp. 219-226.
- Rogers, C. 1961. *On becoming a person*. Houghton Mifflin Company, Boston.
- Rushton, C.H. 1992. *Care-giver suffering in critical care nursing*. Heart & Lung,
vol.21, no.3, 303-306.
- Saines, J.C. 1997a. *Phenomenon of sudden death: Part 1*. Accident and Emergency
Nursing, vol.5, no.3, pp.164-171.

- Saines, J.C. 1997b. *Phenomenon of sudden death: Part 2. Accident and Emergency Nursing*, vol.5, no.4, pp.205-209.
- Sandelowski, M. 1986. *The problem of rigor in qualitative research*. *Advances in Nursing Science*, vol.8, pp.27-37.
- Sandelowski, M. 1994a. *Notes on Transcription*. *Research in Nursing & Health*, vol.17, pp.311-314.
- Sandelowski, M. 1994b. *The use of quotes in qualitative research*. *Research in Nursing & Health*, vol.17, pp.479-482.
- Sandelowski, M. 1995. *Sample size in qualitative research*. *Research in Nursing & Health*, vol.18, pp.179-183.
- Sandelowski, M. 1999. *Time and qualitative research*. *Research in Nursing & Health*, vol.22, pp.79-87.
- Sawatsky, J.V. 1996. *Stress in critical care nurses: actual and perceived*. *Heart & Lung*, vol.25, pp.409-417.
- Seymour, J.E. 2001. *Critical moments – death and dying in intensive care*. Open University Press, Buckingham.
- Simpson, S.H. 1997. *Reconnecting: the experiences of nurses caring for hopelessly ill patients in intensive care*. *Intensive and Critical Care Nursing*, vol.13, pp.189-197.
- Snelgrove, S. & Hughes, D. 2000. *Interprofessional relations between doctors and nurses: perspectives from South Wales*. *Journal of Advanced Nursing*, vol. 31, no. 3, pp.661-667.
- Sonderlund, N. & Hansl, B. 2000. *Health insurance in South Africa: an empirical analysis of trends in risk-pooling and efficiency following deregulation*. *Health Policy and Planning*, vol.15, no.4, 378-385.

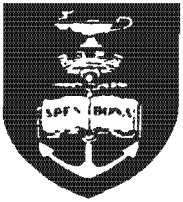
- South African Nursing Council (SANC). 2002. *Geographical distribution of the Population of South Africa versus Nursing Manpower*. SANC, Pretoria.
- Spencer, L. 1994. *How do nurses deal with their own grief when a patient dies in an intensive care unit, and what help can be given to enable them to overcome their grief effectively?* Journal of Advanced Nursing, vol.9, pp.1141-1150.
- Stechmiller, J.K. & Yarandi, H.N. 1993. *Predictors of burnout in critical care nurses*. Heart & Lung, vol.13, pp.534-541.
- Stehle, J.L. 1981. *Critical care nursing stress: The findings revisited*. Nursing Research, vol.30, pp.182-186.
- Steinhauser, K.E., Clipp, E.C., McNeilly, M, Christakis, N.A., McIntyre, L.M. & Tulksky, J.A. 2000. *In search of a Good Death: Observations of Patients, Families, and Providers*. Annals of Internal Medicine, vol.132, no.10, pp.825-832.
- Stewart, D.W. & Shamdasani, P.N. 1990. *Focus group: Theory and Practice*. Sage Publications, London.
- Strauss, A. & Corbin, J. 1990. *Basics of Qualitative Research - Grounded theory procedures and techniques*. Sage Publications, London.
- Svensson, R. 1996. *The interplay between doctors and nurses – a negotiated order perspective*. Sociology of Health & Illness, vol. 18, no.3, pp. 379-398.
- Taylor, B.J. 1992. *From helper to human: a reconceptualization of the nurse as person*. Journal of Advanced Nursing, vol.17, pp.1042-1049.
- Thelan, L.A., Davie, J.K., Urden, L.D. & Lough, M.E. 1994. *Critical care Nursing: Diagnosis and Management*. Mosby, St Louis.
- Thornton, J & White, A. 1999. *A heideggerian investigation into the lived experience of humour by nurses in an intensive care unit*. Intensive and Critical Care Nursing, vol.15, pp.226-278.

- Turner, J.S., Michell, W.L., Morgan, C.J. & Benatar, S.R. 1996. *Limitation of life support: frequency and practice in a London and a Cape Town intensive care unit*. Intensive Care Medicine, vol.22, pp.1020-1025.
- Turner, R.E. 1996. *Attitudes of critical care nurses to the withdrawal of life support (Congress Presentation Abstract)*. Chest, vol.110, no.4, pp.149S.
- Vachon, M.S. 1987. *Occupational stress in the care of the critically ill, the dying and the bereaved*. Hemisphere Publishing Corporation, Washington.
- Van der Merwe, A.S. 1999. *The power of women as nurses*. Journal of Advanced Nursing, vol.30, no.6, pp.1272-1279.
- Van Manen, M. 1990. *Researching lived experience: Human science for an action sensitive pedagogy*. State University of New York Press, New York.
- Wainwright, S.P. 1994. *Analyzing data using grounded theory*. Nurse Researcher, vol.11, no.3, pp.43-49.
- Walters, A.J. 1995a. *Technology and the lifeworld of critical care nursing*. Journal of Advanced Nursing, vol.22, pp.338-346.
- Walters, A.J. 1995b. *A Heideggerian hermeneutic study of the practice of critical care nursing*. Journal of Advanced Nursing, vol.21, pp.492-497.
- Webb, C. & Kevern, J. 2001. *Focus groups as a research method: a critique of some aspects of their use in nursing research*. Journal of Advanced Nursing, vol.33, no.6, pp.798-805.
- Wilson, H.S. & Hutchinson, S.A. 1991. *Triangulation of Qualitative Methods: Heideggerian Hermeneutics and Grounded Theory*. Qualitative Health Research, vol.1, no.2, pp. 263-276.
- Wolcott, H.F. 1990. *Writing up qualitative research*. Sage Publications, California.
- Wright, B. 1996. *Sudden death: A research base for practice (Second Edition)*. Churchill Livingstone, London.

Zeidner, M. & Endler, N.S. (eds.). 1996. *Handbook of Coping: Theory, Research, Applications*. John Wiley & Sons Inc, New York, pp. 24-43

University of Cape Town

UNIVERSITY OF CAPE TOWN



Research Ethics Committee

Faculty of Medicine

Anzio Road, Observatory, 7925

Queries : Martha Jacobs

Tel : (021) 406-6492 Fax: (021) 406-6390

E-mail : Martha@medicine.uct.ac.za

26 January 1999

REC REF NO: 268/98

Ms R Turner
Nursing

Dear Ms Turner

AN EXPLORATION OF HOW CRITICAL CARE NURSES COPE FOLLOWING THE SUDDEN OR UNEXPECTED DEATH OF A PATIENT

I have pleasure in informing you that the above study has been **formally approved** by the Research Ethics Committee on 24 January 1999.

Included is a list of Research Ethics Committee Members who have formally approved your protocol.

Please quote the above Reference number in all correspondence.

Yours sincerely,

V. J. Folb

PROFESSOR FOLB

29.01.1999

CHAIR: RESEARCH ETHICS COMMITTEE

Queries: Martha Jacobs
Research Ethics Committee
Room 212 Werner and Beit
UCT Medical School
Anzio Road, Observatory, 7925
Tel: (021) 406-6492 Fax: (021) 406-6390
E-Mail: martha@medicine.uct.ac.za



CONSTANTLABERG MEDI-CLINIC

MEDI-CLINIC LIMITED / MEDI-CLINIC BEPERK - Reg. No. 69/09218/06
BURNHAM ROAD/WEG, PLUMSTEAD 7800. PO BOX/POSBUS 179, PLUMSTEAD 7800
TEL (021) 799 2911 TELEFAX/TELEFAKS (021) 797 1107
www.mediclinic.co.za

June 17, 1999

Roseanne E Turner
20 Rathfelder Avenue
CONSTANTIA
7806

Dear Roseanne

I hereby acknowledge receipt of your letter dated 3 June 1999, wherein you requested permission to interview staff working in the Intensive Care Unit for your research project, in order to explore the way intensive care nurses deal with their emotions following the sudden death of a patient.

Roseanne, it would be a pleasure, and especially worthwhile if we at Medi-Clinic can learn new methods to reduce the stress in ICU. Please keep us up to date.

You are welcome to come and discuss your progress.

Kind regards.

Yours sincerely

R.E. PELLISSIER (MISS)
NURSING SERVICES MANAGER

rp691/99

PARTICIPANT INFORMATION SHEET AND CONSENT FORM

TITLE OF THE STUDY:

How critical care nurses experience the sudden, unexpected death of a patient.

INTRODUCTION:

I am a post-graduate student at the University of Cape Town where I am registered for a Masters degree. I am currently undertaking a research project, which will form the basis of my dissertation. This sheet has been designed to give you information about the study and what would be expected of you if you agree to participate.

WHAT THE STUDY IS ALL ABOUT:

Critical care nurses are exposed to death more than nurses working in any other areas. While every death affects the nurse in some way, the sudden unexpected death of a patient who is expected to survive is potentially the most devastating. It is important to understand how these traumatic situations are experienced so that efforts can be made to ensure that nurses are better equipped to cope effectively in the future.

WHAT IF THE QUESTIONS CAUSE ME TO HAVE EMOTIONAL PROBLEMS?

Should you find that the interview causes you emotional distress or that you are unable to manage any emotions, which are evoked by the interview you will be referred to a bereavement counselor who will assist you.

WHAT I WOULD LIKE YOU TO DO:

If you agree to take part in this study I would like to interview you about your experiences. This interview will either take the form of a group discussion or one-to-one interviews with myself. The interview will be tape-recorded and will take place in your off duty time in a place and time convenient to yourself. The interview will be very informal.

HOW LONG WILL YOU BE INVOLVED?

It is anticipated that the interview will take between 1-2 hours. It may be necessary to interview you more than once.

CONFIDENTIALITY.

Any information which you give me will be treated with complete confidentiality at all times; the tapes will be stored in a locked cupboard and will be erased at the end of the study. Your name will not appear on any transcript, nor will you be able to be identified in the final report.

REFUSAL TO TAKE PART / WITHDRAWAL FROM THE STUDY

You are under no obligation to take part in this study. If you wish to withdraw from the study at any time, or if you do not wish any part of your interview to be included in the data, for whatever reason, you may do so without providing a reason.

CONSENT FORM

This is to show that I (name) _____
agree to participate in the study entitled "*How critical care nurses experience the sudden, unexpected death of a patient*". The nature, purposes and possible consequences been explained to me by the researcher, Roseanne Turner and are acceptable to me.

I understand that I am entering this project of my own free will and that I am free to withdraw at any time, without necessarily giving a reason. In addition, my participation on non-participation in this project will in no way affect me professionally.

Signature of participant: _____

Signature of researcher: _____

Date: _____

University of Cape Town

PERSONNEL CONTRACT FOR RESEARCH STUDY

TITLE OF STUDY: HOW CRITICAL CARE NURSES EXPERIENCE THE SUDDEN OR UNEXPECTED DEATH.

I agree to keep all information concerning the participants and contents of this study confidential.

Personnel Member:

Signature: Date:

Researcher:

Signature: Date:

Themes, categories and clusters, which emerged from the data.

Themes	Categories	Clusters
1. The shock of it	Deal with the acute things first	• Dealing with the acute things first • It's a bit like bungee jumping • Becoming mechanical
	It happens so quickly it takes your breath away	• Feelings of shock • It takes your breath away • It all happened so quickly • You are not prepared • Unable to do anything
	Knowledge is empowering	• Not enough information • Support from the doctors • Value of guidance and experience • Wanting to know
	Emotions	• Wasted effort • Deserve reward for care given. • Feelings of failure • Feeling helpless • Feeling hopeless • Feeling powerless • Feeling uncertain • Feelings of disbelief

		• All deaths are disappointments • The finality of death
	Defeated by a more powerful force	• Feelings of loss • Feelings of failure • Finality of death • It's God's will
2. The burden of guilt	Did I miss something?	• Why did this happen • Was it something I missed • Attributing blame or responsibility • Re-living the event • Wanting to know • Questioning her role • Feeling guilty • Feeling responsible • Feels accountable for the death
3. Dealing with the relatives	Helping the family Concern for the family	• Concern for the family • Helping herself by helping the family • Unsure about how to help the family • Relatives dealing with death • Uncomfortable with the relatives • Empathy with the family • Hiding information from the family

		• Grieving with the family • Answering the families questions • Regaining some control • Preparedness of the family • Protecting the family
4. Denial of self	A machine changing modes	• An actor changing roles • Switching modes • Controlling her own emotions
	Traumatic for everyone	• Emotional impact on doctor and nurse • Feelings of grief • Feeling sad • How do the doctors feel?
5. Regaining emotional equilibrium	The struggle for emotional equilibrium	• Writing to gain perspective • Distancing herself from the situation • Regaining emotional equilibrium • Returning later to reflect on what happened • Need for emotional space to reflect
	Spirituality as a means of regaining equilibrium	• Using religion to explain • Using religion for acceptance
	Closure	• Achieving closure • The need for closure • Closing the relationship

	Regaining some control	• Preparing patient (expected death) • Preparing family
	Creating distance	• Putting the experience aside • Feeling peripheral • Becoming hard • Distancing when powerless
	Relieving the tension	• Releasing the tension • The mood is light • Laughing about it
	Doing it alone	• Doing it on my own • Feeling alone
	Support away from work	• Bringing it home • Seeking support at home • Talking about it to friends
	The nursing team	• Talking about it at work • Talking about it in safety • Validation by the team • Being part of the team
	Support from the doctors	• Support from the doctors
	Unable to really talk about what happened	• Talking about events not feelings • Unable to really speak to anyone • The stiff upper lip

		• Obstacles to debriefing • The more you talk the deeper you go • Expression of feelings
	Moving on	• Moving on • Carrying it with you
	Becoming hard	• Becoming hardened • Becoming hard
	The value of guidance and experience	• Learning from past experienced • Personal experiences of death • Lack of training and guidance • Carrying it with you • Drawing on past experience
	Improved status of the nurse	• Improved status of the nurse
Issues of context	Some deaths make a greater impact	• Each death is completely different • Death itself is no problem • Depends on the prognosis • Feeling unable to cope • Conflict with terminal patients • Multiple deaths are difficult • Relationship with the patient • It is easier if the patient is ready for death • Allowed to die with dignity

		• It is easier if you don't know the patient well • It is difficult to deal with multiple deaths • Some patients make a greater impact • You did all you could
	Children are difficult / Age	• Children • Children are difficult • Unable to cope with the death of a child • Frightened of dying children • Confronting own fears • Children are quite difficult • It is easier when an adult dies • Patient age makes no difference
	In ICU you are preparing for life	• All death is a disappointment • The nurse is never prepared for death
	The nurse as an individual	• Previous personal experience • Personal circumstances • Being a mother changes the experience • The influence of religious background • Cultural influences • Confronting own fears