THE PERCEPTIONS OF PROFESSIONAL NURSES WITH REGARD TO THE PROCESS OF WITHDRAWING LIFE-SUPPORT TREATMENT IN A PRIVATE INTENSIVE CARE UNIT

by

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TO WHOM IT MAY CONCERN

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ABSTRACT

Life-support treatment is regarded as the support of vital functions of respiration and circulation such as mechanical ventilation and inotropic support, and life-sustaining therapy which incorporate therapies such as artificial hydration, nutrition and haemodialysis. Life-support treatment is rendered to critically ill patients within the intensive care units. However, when treatment options are maximised, and the patient’s condition is unchanged, a decision is often made to withdraw treatment. Professional nurses are usually involved in the process of withdrawal of life-support treatment as they care for this population of patients.

The study followed a qualitative, explorative, descriptive and contextual research paradigm in order to explore and describe the perceptions of professional nurses with regard to the process of withdrawing life-support treatment in a private intensive care unit. Data was collected by means of interviews, which were transcribed according to Tesch’s method of analysis. Field notes were used to supplement the data findings. Based on the data collected, it is clear that professional nurses experience difficulties when performing withdrawal of life-support treatment. There are a number of communication concerns which need to be addressed and suggestions were also made by the interview participants regarding these concerns. The study makes recommendations to assist professional nurses with the process of withdrawing life-support treatment in a private intensive care unit. The findings of the study will be disseminated to the relevant hospital and unit managers. Ethical principles were maintained throughout the study by adhering to the principles of privacy, confidentiality, anonymity and beneficence.

Key words:
Withdrawal, life-support treatment, life-sustaining support, professional nurses, intensive care unit, perceptions.
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CHAPTER ONE
INTRODUCTION AND OVERVIEW OF THE STUDY

1.1 INTRODUCTION

Intensive care units (ICUs), also called critical care units, are specially equipped areas in hospitals that are designated for patients with potential life-threatening conditions. ICUs contain resuscitation and monitoring equipment and are staffed by medical and nursing staff specially trained and skilled to recognise and immediately respond to cardiac and other emergencies (Mosby’s Medical Dictionary, 2009). Critically ill patients, who require treatment modalities to support physiological functions, are admitted to the intensive care units. Although patients are admitted to these units with the goal to heal, restore and preserve life, they might also be subjected to a situation where they have the right to die a peaceful death. Death can occur naturally or treatment can be withdrawn if it appears to be non-beneficial to critically ill patients. The issue of withdrawal of life-sustaining treatment came to the attention of the American public in 1976 when Karen Ann Quinlan’s parents requested that she be removed from the mechanical ventilator and allowed to die (Luce and Alpers, 2001:41). Although the case involved a number of legal and ethical issues regarding the right to die, it also brought about the construct of “withdrawal of life-sustaining treatment” (Luce and Alpers, 2001:40; Truog, Campbell, Curtis, Haas, Luce, Rubenfeld, Rushton and Kaufman, 2008:957). Professional nurses working in intensive care units are often the forerunners in caring for these critically ill patients.

The aim of this research study was to explore and describe the perceptions of professional nurses with regard to the process of withdrawing life-support treatment in a private intensive care unit. However, because of the number of life-support treatment options available, the study will focus only on mechanical ventilation and inotropic therapy as life-support treatment modalities.

1.2 BACKGROUND TO STUDY

The terms most frequently used in ICUs are life-support treatment and life-sustaining treatment, which are used interchangeably and which can, at times, lead to
misunderstandings. Rady and Verheijde (2010:2) describe life-support treatment as the support of vital functions of respiration and circulation such as mechanical ventilation and inotropic support, and life-sustaining therapy as that which incorporates therapies such as artificial hydration, nutrition and haemodialysis. For the purpose of this study the researcher will concentrate on life-support treatment. In the following excerpt, Dunstan (1985:479) explains why the process of withdrawing life-support treatment is such an important aspect of intensive care nursing:

The success of intensive care is not to be measured only by the statistics of survival, as though each death were a medical failure. It is to be measured by the quality of lives preserved or restored; and by the quality of the dying of those in whose interest it is to die.

In a study conducted by Kirchhoff and Kowalkowski (2010:533) it was identified that roughly 70 per cent to 90 per cent of all deaths in the ICU in the United States followed a decision to withdraw life support. Allmark and Tod (2009:37) point out that the decision to withdraw life-support treatment must be driven by the principles of best interest and consent. According to Rubenveld (2004:436), withdrawal of life-support treatments must be understood as the removal of unwanted treatments rather than to hasten death, for example in a patient who experienced an acute ischemic stroke with a poor prognosis. Indeed Smith (2012:941) notes that withdrawal of life-support treatment should be seen as a key component of care rather than as a failure of care in appropriate cases.

Withdrawal of life support is a complex and difficult process that requires continuous planning and management. For instance, clear communication with the patient and the patient’s family can ensure that the process goes smoothly. Furthermore, having an organised approach to withdrawal of life support can ensure that the patient experiences a peaceful death and that staff members caring for such patients experience closure regarding the event (Stacy, 2012:22). However, there is little empirical research that provides information about the process to follow when withdrawing life-support treatment. According to the Oxford Dictionaries (2014) the word “process” refers to “a series of actions or steps taken in order to achieve a particular end”.

2
According to Truog et al. (2008:957), mechanical ventilation is the only life-sustaining treatment that, if discontinued abruptly, can cause discomfort. Therefore, there is no justification to wean treatments such as intravenous fluids and antibiotics. Stacy (2012:20) describes two methods to withdraw mechanical ventilation, but also mentions that pressure support and/or positive end-expiratory pressure should be discontinued and the fraction of inspiratory oxygen should be reduced to 21 per cent before further withdrawal of mechanical ventilation takes place. The first method Stacy (2012:20) describes is terminal weaning or gradual ventilator withdrawal which consists of gradually decreasing the ventilator rate until the rate is zero. The decrease in the ventilator rate may occur over a predetermined period, but the time should be long enough to ensure proper symptom management and short enough to avoid prolonging the dying process (Stacy, 2012:20). The second method Stacy (2012:20) points to is the immediate withdrawal of mechanical ventilation and consists of the immediate removal of ventilator assistance. Apart from these two methods, a decision can also be taken to rather extubate the patient or to leave the endotracheal tube in place for additional respiratory support. Whichever method is chosen, withdrawal of mechanical ventilation as a life-support treatment option is done to allow the patient’s underlying disease process to take its natural course and usually results in the patient’s death (Stacy, 2012:16).

Once the decision is made to withdraw life-support measures like mechanical ventilation, all curative intervention should be discontinued, including dialysis, enteral and parental nutrition, blood transfusions and antibiotics. In addition, all routine monitoring should be stopped including monitoring of vital signs, pulse oximetry and electrocardiogram. However, Rubenveld (2004:442) indicates that there is no justification to wean inotropic support as weaning this treatment might just delay the patient’s death and potential suffering. In many cases patients might even sustain rapid cardiac arrest after inotropic support is discontinued. Furthermore, all tubes and other supporting devices are usually removed, as the goal is to remove treatments that are no longer desired or indicated and that do not provide comfort to the patient (Truog et al., 2008:957). Family care should also be considered during the withdrawal process as the families of these patients need closure and often just want to be at the patient’s bedside during these last moments. Davidson (2009:31) identifies incidents of anxiety, depression and posttraumatic stress disorder in family
members of critically ill patients, and communication is identified as one intervention that can improve these conditions of the family members. Communication includes educating the family members, informing family members of changes in the patient’s condition and case conferences. Wiegand (2006:185) discuss the fact that the healthcare providers’ behaviours, for example postponing discussions about withdrawal of treatment, delaying withdrawal once it is decided and withdrawing from the families, can contribute to the distress of the family members of critically ill patients.

Withdrawal of mechanical ventilation might occur in different stages as indicated above. However, apart from the process of withdrawal from mechanical ventilation, the nurses caring for the patient have to consider how they are going to withdraw and ultimately stop other forms of treatments and remove the tubes and lines that are often inserted for initial treatment in this population of patients. Kompanje, van der Hoven and Bakker (2008:1594) note that during the withdrawal process, the patients might present with various clinical manifestations, for instance pain, dyspnoea, anxiety, delirium, post-extubation stridor and excessive pulmonary secretions.

Thus, the process of withdrawal of life-support treatment not only affects the families of the patients, but also the healthcare team who participates in the experience. Browning (2013:150) notes that nurses experience a higher level of moral distress when they are not participating in the patient care conferences and when they are not educated in the field of end-of-life care. Emotional labour surely accompanies all nurses involved in withdrawal of treatment, therefore Browning (2008:257) suggests that support mechanisms need to be in place for the nurses to discuss their feelings, for example peer debriefing and support.

The researcher attempted to gain a deeper understanding of the perceptions of professional nurses in a private ICU with regard to the process to follow when withdrawing life-support treatment from critically ill patients.
1.3 PROBLEM STATEMENT

In an ICU in Nelson Mandela Bay, mechanical ventilation is a common life-support treatment modality for critically ill patients. Unfortunately there are no statistics kept on the frequency of withdrawing mechanical ventilation, but from interaction with the shift leaders in the unit, the researcher established that withdrawing of mechanical ventilation is more often done in patients that are declared brain dead. The withdrawal of inotropes happens more frequently in this ICU and is the more popular choice by the physicians. Most frequently, the patients will die before the decision can be made to withdraw mechanical ventilation.

The decision to withdraw life-support treatment from a patient is made by a doctor in consultation with the patient (if he/she is able to make decisions) and with the family. The professional nurses in the unit are not regularly asked to be involved in these discussions, although they are responsible for the actual deed of withdrawing life-support treatment. Some professional nurses however do initiate discussions with the doctors and families regarding withdrawal of treatment. The current practice of the withdrawal of life-support process is for the doctor to give the order that treatment be withdrawn from the patient. If the patient is mechanically ventilated, the doctor might, in some situations, order for the patient to be put on continuous positive airway pressure or to decrease the fraction of inspiratory oxygen to 21 per cent. In some situations, however, the doctor will direct the nurses to withdraw mechanical ventilation, but will not specify which process to follow. Some of the professional nurses will not feel confident enough to ask questions about the process and when the doctor leaves the unit, they will ask the shift leader or other colleagues about the process to follow to withdraw mechanical ventilation. If the patient is on inotropic support, the order normally states to wean and stop the inotropes, but there are no guidelines from the doctor regarding which weaning protocol to follow. The weaning of inotropes normally leaves the professional nurse in doubt, because inotropes are usually decreased if the patient’s blood pressure is adequate, which means that if the patient’s blood pressure is within normal limits, the inotropes can be decreased. In the case where patients are weaned off inotropes because treatment is withdrawn, patients’ blood pressure is normally low and the normal weaning process cannot be followed, seeing that the blood pressure is too low to reduce the inotropes, but it will still be reduced as treatment is being withdrawn.
The fact that a protocol or guideline for the process of withdrawing life-support treatment is not available in the intensive care unit where the study was conducted leaves the professional nurses with no choice but to lean on their own experience and that of their colleagues and shift leader in order to decide which process to follow.

Being involved in the process of withdrawing life-support treatment in the critically ill patients might be stressful and professional nurses might have different perceptions and emotions. Therefore it is important that nurses are allowed to express their emotions and opinions about the process. Furthermore, these nurses might require closure regarding the event and the withdrawal process and not only with reference to the death of the patient. The research study aims to explore and describe the perceptions of the professional nurses with regard to the process of withdrawal of life-support treatment. The results from the study will assist professional nurses with the process of withdrawing life-support treatment in the ICU, since there appears to be paucity of guidelines or protocols to guide the nursing staff in the process of withdrawing life-support treatment. Withdrawing life-support treatment can include diverse aspects, but for the scope of this study, it was decided to focus only on mechanical ventilation and inotropic support, therefore the research question is; what are the perceptions of professional nurses with regard to the process of withdrawing life-support treatment in a private ICU?

1.4 OBJECTIVES

The objectives of the study are as follows:

a. To explore and describe the perceptions of professional nurses with regard to the process of withdrawing life-support treatment in a private ICU.

b. To make recommendations to assist professional nurses with the process of withdrawing life-support treatment in a private ICU.

1.5 PURPOSE OF THE STUDY

The purpose of the study is to explore and describe the perceptions of professional nurses with regard to the process to follow when withdrawing life-support treatment
and to make recommendations to assist professional nurses with the process of withdrawing life-support treatment.

1.6 CONCEPT CLARIFICATION

Perceptions: According to the Oxford Dictionaries (2014) it is the way in which something is regarded, understood, or interpreted.

Professional nurse: A professional nurse is a person who is registered with the South African Nursing Council as a nurse or midwife and who is qualified and competent to practise comprehensive nursing care independently (Nursing Act 33 of 2005:34). The study includes professional nurses who care for the critically ill patients who are on life-support treatment. Contextually, these professional nurses include experienced ICU nurses and those who hold an additional qualification in intensive care.

ICU: Urden, Stacy and Lough, (2014:2) describe an ICU as a place for the management of patients who are at high risk for actual or potential life-threatening illness or injury. These patients are admitted to specialised units or departments in the hospital for individualised and more intense monitoring. Furthermore, the multidisciplinary team working in the ICU have in-depth education in the specialty field of critical care.

Withdrawal of life-support treatment: Miller, Truog and Brock (2010:456) state that “when clinicians justifiably withdraw life-support treatment, they allow patients to die but do not cause, intend, or have moral responsibility for the patient’s death”. Rubenfeld (2004:436) adds that the goal of withdrawing life-support treatments is to remove treatments that are no longer desired or do not provide comfort to the patient. Withdrawal of life-support treatment in the ICU where the study will be conducted is done by the professional nurses caring for these patients.

Life-sustaining therapy: Truog et al. (2008:956) name antibiotics, vasoactive drugs, renal dialysis, ventricular assist devices, intravenous fluids, nutrition, and mechanical ventilation as life-sustaining therapies. In this study, life-sustaining or life-support treatment refers to inotropic support and mechanical ventilation as these are the two
treatments most commonly withdrawn once the decision is made to withdraw treatment in the ICU where the study will be conducted.

1.7 RESEARCH DESIGN

The research will follow a qualitative, exploratory, descriptive and contextual design. Denzin and Lincoln (2011:3) define qualitative research as the study of things in their natural settings. Qualitative research focuses on the experiences of individuals and their interpretation and understanding of their experiences. As such, the qualitative researcher believes that there are many different interpretations of reality and these interpretations lie within each individual (Houser, 2012:36). The rationale for using a qualitative research design for this study is to explore and describe the perceptions of professional nurses with regard to the process to follow when withdrawing life-support treatment in a private ICU. The research design will be discussed comprehensively in Chapter Two.

1.8 RESEARCH METHOD

Streubert and Carpenter (2011:33) identify key elements that are necessary to ensure a good quality qualitative study, namely that the research question is clear, that an appropriate study method was selected to answer the research question, and that the data sources and participants that are required are available. The research method includes describing the process of selecting the research population, sampling, data collection and data analysis. The research method will be comprehensively discussed in Chapter Two.

1.9 TRUSTWORTHINESS

This research ensures trustworthiness by using the four key components developed by Guba and Lincoln (1995), namely credibility, dependability, confirmability, and transferability. These components allow the researcher to demonstrate how the interpretations that are presented in the data and the conclusions drawn from it reflect the participants’ experiences (Moule and Goodman, 2009:188). These four concepts and how they will be applied in the study will be discussed in further detail in the next chapter.
1.10 ETHICAL CONSIDERATIONS

According to Ewing (1995) as cited by Pera and Van Tonder (2011:2), ethics is the understanding of the meaning of what is “good” and “bad”, “right” and “wrong”. It is also the understanding that some things are good while others are bad, and that some actions are right while others are wrong. Nurses practise within a unique social world with its own norms, controls, rules and regulations, and under the mandate of caring, it is expected of them to do no harm to patients. Nurse researchers are even further limited by this principle (Boswell and Cannon, 2011:56). In any research the researchers must be aware of what is regarded as acceptable or not acceptable in conducting the research inquiry. The following ethical matters have been considered and applied by the researcher throughout the research process: informed consent, autonomy, confidentiality and beneficence. These concepts and the application of them in the research are discussed.

1.10.1 Informed consent

Moule and Goodman (2009:389) explain that informed consent refers to process where the researcher gains an agreement from an individual to participate in a research study. Informed consent is based on the individual receiving relevant information in a manner and in a language that is relevant for the individual, and on what participation means with particular reference to possible harm and benefits. Burns and Grove (2011:122) consider informed consent to include four elements: (a) disclosure of essential study information to the participant, (b) comprehension of this information by the participant, (c) competence of the participant to give consent and (d) voluntary consent of the participant to participate in the study.

a) Essential study information

Essential information is that which is necessary for the researcher to give to the participant prior to obtaining consent. The initial information that is given to the participants must clearly indicate that a research study is going to be conducted and that they are being asked to participate. It is important for the researcher to state the purpose of the research study including any long-term goals as well as explaining to the participants why they were selected to participate in the study. Participants must receive a description of the process that will be followed as well as any reasonable
foreseeable risks that might result from the study. The researcher must describe any benefits that might come from the study and must explain to the participants the extent to which their responses will be kept confidential and their identities anonymous in the research report and any publication. Before obtaining consent, the researcher must offer to answer any questions and the participants must be informed that they may withdraw from the study at any time without penalty. For the consent form to be complete, it must include a statement saying that participation is voluntary and that refusal to participate will not result in a penalty (Burns and Grove, 2011:122-123).

The researcher met with the professional nurses in the ICU where the study took place on three separate occasions. The inclusion criteria for participants were mentioned and a brief explanation of the process was given to them. The professional nurses were then asked who would like to participate. For those professional nurses agreeing to participate, an information letter was provided, giving the details of the study. The researcher answered the participants’ questions and then handed them the consent form to sign. An example of the information letter can be viewed in Annexure C and the consent form can be viewed in Annexure D of this study.

b) Comprehension of the consent form

Giving informed consent does not only mean that the researcher has adequately explained the research process, goals and possible harms and benefits. It also includes the fact that the participants should completely understand what was explained and what is expected of them. The researcher must make completely sure that the participants do not walk into this research study blindly (Burns and Grove, 2011:123).

After the consent form was given to the participants, the researcher made sure that the participants understood what was expected of them and what to expect throughout the study.

c) Competence to give consent
Burns and Grove (2011:124) state that a competent person who is allowed to sign consent is one who is autonomous and understands the benefits and risks of a proposed research study. People with less autonomy, whether it is due to legal or mental incompetence, terminal illness, or who are confined to an institution, are more often than not deemed competent to sign consent to participate in a research study.

d) Voluntary consent

Voluntary consent means that the prospective participant decided to take part in the research study without any coercion or influence from anybody, but merely by his/her own accord.

The researcher explained to the professional nurses in the initial meetings that participation in the study will be voluntary and that for those who agreed to take part in the study, it is also indicated in the consent form that participation is voluntary.

Consent was granted by Nelson Mandela Metropolitan University’s Departmental Research Committee as well as the Faculty of Postgraduate Studies Committee with the following reference number: H14-HEA-NUR-013. Consent was also given by the private hospital group’s ethics committee. The hospital manager and the nursing manager also approved for the research to be conducted after it was approved by the ethical committee. An example of the consent form used in the study may be found in Annexure D.

1.10.2 Autonomy

Pera and Van Tonder (2011:332) mention that autonomy is the right of self-determination. It is just as much respected in health research as it is in clinical practice. Self-determination indicates that people are capable of controlling their own destiny. Individuals need to be respected and treated as autonomous agents who can conduct their own lives without external control, coercion or exploitation.

It is easy for a researcher to violate a participant’s right to self-determination through the use of coercion, secret data collection and deception. Coercion refers to a situation where the researcher intentionally presents a threat or a reward to the participant in order to gain the participant’s compliance. Secret data collection
occurs when the participants are not aware that data has been collected and deception refers to misinforming participants of the research purpose or any other information (Burns and Grove, 2011:110).

The researcher overcame these violations of autonomy through the use of informed consent as described above in detail. No rewards were offered to the participants who took part in the study and none of the participants was threatened if he/she did not wish to take part. Questions were answered prior to the interviews and following the interviews to make sure the participants understood what the study was about. Examples of the informed consent form and the information letter that was given to participants prior to signing consent may be found in Annexure C and D.

1.10.3 Confidentiality

Green and Thorogood (2009:70-71) cite the World Medical Association (2000) in saying that “every precaution should be taken to respect the privacy of the subject [and] the confidentiality of the patient’s information”. Ethics in social research also emphasises the importance of confidentiality as a key criterion for ethical practice. Confidentiality according to Burns and Grove (2011:117) is the way the researcher manages the private information that is shared by the participants. The researcher is not allowed to share the information without the participants’ consent.

Confidentiality according to Green and Thorogood (2009:71) has two important aspects. The first aspect is not to disclose any of the information that was gathered during the research in other settings, for example in an informal conversation. It is important for the researcher who is doing research close to home – for example in her own work environment – not to disclose any of the information gathered through interviews, in everyday conversation. The second aspect of confidentiality relates to the completed report and publishing of the research. In order for the researcher to maintain confidentiality, names and other identifiers can be changed to protect the privacy of the participants.

The researcher maintained confidentiality by changing the names of the participants and only giving them numbers in the written report of the study. Where quotes were used, the participants were approached to ask if they felt comfortable with use of that
specific quote. Only the researcher had access to the raw material where the participants could be identified. The independent coder and supervisor used the transcriptions, which only contained numbers of the recorded interviews in order to analyse the data. Annexure C is an example of the information letter that was given to all participants, which includes the steps that were followed by the researcher to maintain confidentiality of the participants.

1.10.4 Beneficence

Babbie (2010:65) states that every human being has a right to be protected from harm. This right to protection from harm is based on the ethical principle of beneficence which states that one should always strive to do good to others and avoid harming another person. It is important for the researcher not to reveal any information that could embarrass a participant, or cause a threat to his/her home, relationships or job. Polit and Beck (2012:153) state that harm in research can be physical, emotional, social, financial or any combination of the four.

There are certain strategies according to Polit and Beck (2012:153) that need to be followed by ethical researchers to minimise all kind of harm and discomfort. Firstly, research should only be conducted by qualified people. Researchers that are ethical must be willing to terminate an investigation if they suspect that continuation of the investigation will result in injury, death or severe distress to any of the participants. Researchers should pay close attention to psychological consequences which can be subtle, and they should be very sensitive when dealing with psychological issues. Especially in qualitative research, researchers should be very aware of the consequences of questions that can intrude on the participant’s psyche.

The researcher in this study informed the participants prior to commencing the interviews of the possibility that they might experience some emotional distress due to the sensitive issues of withdrawal of life-support treatment. The researcher was aware of the possibility that some participants might not have adequately dealt with previous situations where life-support treatment was withdrawn and that they might relive the experience and become upset during the interview. Only one of the participants displayed tearful emotion during the interviews.
Once each interview was completed, the researcher spent some time with each participant to make sure whether the participant needed any assistance with emotional feelings. Debriefing by the Independent Counselling and Advisory Services (ICAS) was offered to the participants if required. ICAS is a service that the hospital group collaborates with to use for staff who might, for example, need emotional or psychological support. The employer is not informed of the details of the discussion between the employee and the staff from ICAS. In collaboration with the unit manager, if approval is given by the participant, an appointment is arranged for the participant to see a psychologist at ICAS. If the participant does not wish the unit manager to be aware of the appointment, the participant can contact ICAS for an appointment. In this study, only one of the participants indicated that she might contact ICAS personally for further counselling.

1.11  CHAPTER DIVISION

Table 1.1 provides an outline of the chapter headings of the study which includes an overview of the study, the research design and method, data analysis method, the research findings, and the conclusions, limitations and recommendations for the study.

<table>
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<tr>
<th>Chapter</th>
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<tr>
<td>One</td>
<td>Introduction to the study</td>
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<tr>
<td>Two</td>
<td>Research design and method</td>
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<tr>
<td>Three</td>
<td>Data analysis and research findings</td>
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<tr>
<td>Four</td>
<td>Conclusions, limitations and recommendations</td>
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1.12 DISSEMINATION OF RESULTS

The study will be made available to the Nelson Mandela Metropolitan University and the respective hospital where the study will be conducted. The research findings may be presented in a formal presentation if the opportunity arises and an informal presentation will be conducted in the respective ICU. An article will be prepared for publication in a peer reviewed journal. In addition, the researcher will inform the participants of the research findings by presenting the findings in groups.

1.13 CONCLUSION

The researcher has identified the topic to be researched and has provided an introduction to the topic as well as some background regarding how the topic was identified. In addition, the objectives of the study were presented, namely to explore and describe the perceptions of the professional nurses in the ICU with regard to the process to follow when withdrawing life-support treatment; and to make recommendations to assist professional nurses with the process of withdrawing life-support treatment. An overview of the research design and method to be used in the study was provided as well as the ethical principles to be considered.

In the next chapter the researcher will present an in-depth description of the research design and method used to conduct the study as well as steps taken to ensure the trustworthiness of the study.
CHAPTER TWO

RESEARCH DESIGN AND METHOD

2.1 INTRODUCTION

In Chapter One the researcher introduced the study. The identified problem was described and the objectives of the study were stated. In this chapter, a detailed description of the research design, method and the research process will be given. The objectives of the study are to explore and describe the perceptions of professional nurses with regard to the process of withdrawing life-support treatment in a private ICU, and to make recommendations to assist professional nurses with the process of withdrawing life-support treatment in a private ICU.

2.2 RESEARCH DESIGN

The study as indicated in Chapter One followed a qualitative, exploratory, descriptive and contextual design. Holloway and Wheeler (2010:3) define qualitative research as “a form of social inquiry that focuses on the way people make sense of their experiences and the world in which they live”. The aim of qualitative research is to understand, describe and interpret social phenomena as it is perceived by individuals, groups and cultures. The basis of qualitative research lies in the fact that an interpretive approach is used to social realities and that it describes the lived experiences of human beings who live in these realities (Holloway and Wheeler, 2010:3)

A fundamental belief of qualitative researchers is that there is not only one truth or reality, but that there are multiple truths or realities as experienced by individuals. Because individuals participate in social actions, they come to know and understand phenomena in different ways as they live and interact based on previous experiences. It is therefore important for the qualitative researcher to consider multiple perspectives in order to understand a situation or phenomenon completely (Streubert and Carpenter, 2007:21). Qualitative researchers often use multiple methods of data collection to understand a phenomenon completely. In a qualitative study, the method of data collection can change in order to describe the actual perceptions of an individual (Streubert and Carpenter, 2007:21). The qualitative
researcher is a co-participant in the understanding of the reality or phenomenon that is studied. In the current study the researcher conducted extensive interviews to fully understand the reality being researched; these interviews provide the views that are important to the participants (Streubert and Carpenter, 2007:21). In qualitative research, the findings are reported in a rich literary style and the participants’ experiences are the findings of the study. It is therefore important that these experiences are reported from the perspective of the people who lived them, by including quotations, commentaries and narratives which will add to the richness of the report and the understanding of the experience (Streubert and Carpenter, 2007:21).

A qualitative research design was used in the study in order to gain an understanding of the perceptions that professional nurses in an ICU have with regard to the withdrawal of life-support treatment. The qualitative research design assisted the researcher in obtaining data from a subjective participant view, which in itself indicated that one person does not experience an event in the same way as another. The experiences and perceptions of the participants were explored and described through the participants’ own words, which led to a subjective interpretation of the events experienced.

**Exploratory research** refers to the process in which the researcher becomes familiar with the particular topic. This design is typically used when the researcher examines a new interest, because measures or instruments are not available, variables are unknown, or no guiding framework is utilised (Terry, 2012:109). De Vos, Strydom, Fouché and Delport (2011:95) state that exploratory research is conducted to gain insight into a situation, phenomenon, community or individual. This study made use of an exploratory research design in order to gain insight into the perceptions of professional nurses regarding the process to follow when withdrawing life-support treatment in a private ICU. The researcher’s personal experiences with withdrawal of life-support treatment in the ICU led to a desire for deeper understanding of the most appropriate process of withdrawal of life-support treatment in an ICU.

When a researcher is researching a new topic, exploratory research proves to be valuable, because it more often than not brings new insights into a topic. Exploratory
research is not without its shortfalls, and one of these shortfalls is the fact that it rarely provides a satisfying answer to the research question. It may suggest research methods which can give more definitive answers and therefore exploratory research should go together with descriptive research in order to find clearer answers and to find the deeper meanings to experiences people have of a specific event (Babbie, 2010:93).

The researcher undertook a literature review prior to commencing the study to familiarise herself with previous studies on the specific topic and the guidelines and conclusions that are available from other studies. Journal articles, internet sources and nursing books were consulted to make the researcher more familiar with the topic being investigated. Through the data collection process the researcher explored the professional nurses’ perceptions with regards to the process of withdrawing life-support treatment in a private ICU. This process enabled the researcher to explore the perceptions of professional nurses in the identified ICU with regards to withdrawal of life-support treatment.

Descriptive research has the purpose to paint a picture of situations as they happen in their natural environment. According to Burns and Grove (2009:237), a descriptive design may be used to develop a theory, identify problems with current practice, justify current practice, makes judgements or to determine what other institutions are doing in the same situations. Using a descriptive design, allows the researcher to identify and document the phenomenon as it happens and this design is often used to assess current practice (Schmidt and Brown, 2009:149). In this research study, the perceptions of professional nurses with regard to the process to follow when life-support treatment is withdrawn were explored within the professional nurses’ natural environment and their perceptions will be described as they interpret it.

A unique feature of qualitative research is thick description which is defined by Denzin (1989) in Holloway and Wheeler (2010:7) as

…“deep, dense, detailed accounts of problematic experiences… It presents detail, context, emotion and the webs of social relationship that join persons to one another.”
Thick description allows the reader of a research study to become active in the research, because of the researcher’s sharing of his/her knowledge of the participants’ perspectives with the readers of the study. If the culture, context and process of the research are clearly described, the reader can follow the path of the researcher and reach an understanding of the phenomenon at study. Through thick description readers of the study can see what they would experience if they were in the same situation as the participants (Holloway and Wheeler, 2010:7). Through exploring the perceptions of professional nurses with regard to withdrawal of life-support treatment, the researcher was able to understand the meaning that professional nurses ascribe to these events. A thorough description of the data collection and data analysis process is done in order to assist the reader to understand the process of the research. The findings of the data analysis will be described in Chapter three of the research report.

**Contextual design** refers to a research study that is conducted in the environment where the participants practise and to the use of participants who form part of that specific environment (Holloway and Wheeler, 2010:41). Research that is based on a contextual design involves observing participants’ behaviour as well as probing into the behaviour of the participants in their environment. By conducting contextual research, insight is gained into the experiences of the particular event in a specific environment. LoBiondo-Wood and Haber (2010:88) state that the environment or circumstances of an observation may have an influence on the meaning of this observation in contextual research. According to Holloway and Wheeler (2010:4-5) the researcher needs to be aware of the fact that both personal and social context are important and that the contexts of the participants’ lives and work may affect their behaviour.

The context of the research study was a selected ICU in a private hospital in Nelson Mandela Bay where professional nurses experience the withdrawal of life-support treatment from patients. The ICU is a multidisciplinary unit where adult and geriatric patients are being treated. It comprises surgical, medical and trauma patients and provides medical and surgical care for patients who need intensive monitoring and treatment. Withdrawal of life-support treatment may be performed on patients receiving mechanical ventilation, inotropic support, renal dialysis, enteral feeding and
other life-supporting treatment, but for the sake of this study the researcher only focused on withdrawal of mechanical ventilation and inotropic support. The medical team in the context of the ICU comprises physicians, surgeons and professional nurses. The data collection of the research was conducted in the natural setting of the professional nurses which was the selected ICU.

2.3 RESEARCH METHOD

The research method must be the researcher’s exact description of the research that was done and how it was implemented. The research method also determines the reliability of the research in such a way that if the study was replicated, the same results would be achieved (Terry, 2012:41).

2.3.1 Research population

A research population is defined by Moule and Goodman (2009:391) as “a group of people, documents, events or specimens the researcher is interested in collecting information or data from”. In this research study the population was comprised of 25 professional nurses working in the ICU of a private hospital in Nelson Mandela Bay who had been exposed to withdrawing life-support treatment from a patient.

2.3.2 Sampling method

Sampling method refers to the process that is followed to select a group of people, events, behaviours, or other elements that represent the population that is being studied (Burns and Grove, 2009:349). Purposeful sampling is a sampling technique where the researcher selects participants, because they possess certain characteristics that are important for the study and they will be able to give the researcher rich information regarding the research question (Houser, 2012:424). It is important that the sample in qualitative research fits the population of interest, because it is the subjective experiences of the sample that is at the heart of the research study (Rebar, Gersch, Macnee and McCabe, 2011: 109).

Purposive sampling was used and the inclusion criteria were that the participants must work in the intensive care unit where the study took place and that they must have one or more experiences with withdrawal of life-support treatment from a
patient. Purposive sampling assists the researcher to identify the study population and to gain rich data from sources with first-hand experience of withdrawal of life-support treatment in the ICU. The study included permanently employed professional nurses together professional nurses employed via an agency. Both groups of nurses had experienced withdrawing a patient from life-sustaining treatment in the ICU where the study was performed. There were approximately 25 professional nurses working in the ICU, but only eighteen of them have experienced withdrawal of life-support in the ICU. Four of the professional nurses that fit the criteria for the study were not available and three did not wish to take part in the study. The sample size was ten professional nurses after the researcher approached everybody.

The researcher searched for the most contextually rich sources when choosing purposive sampling in order to understand the meaning of the experiences that are of interest. This sampling strategy can be flexible and can be revised based on the data analysis which may suggest new areas of interest that need exploration. The sample size is normally dictated by the data analysis process and therefore once data saturation occurred, the sample size is adequate (Rebar et al. 2011:109-111).

2.3.3 Data Collection Method

A study can be designed to perfection, but if the data that is collected is not accurate and consistent, the results will be suspect (Houser, 2012:227). The qualitative interview is a research method that gives the researcher privileged access to the basic experience of people in their lived world. It also seeks to understand the meanings of central themes of the lived world of the participants. The life world can be defined as the way everyday life it is encountered and expressed in direct and immediate experience, independent and before any explanations (Kvale and Brinkmann, 2009:29). The qualitative interview seeks qualitative knowledge which is expressed in everyday language. Through descriptive qualitative interviews, participants are encouraged to describe exactly what feelings they have and the experiences and actions they relate to the topic being investigated (Kvale and Brinkmann, 2009:30).
After the necessary permission was obtained from the Nelson Mandela Metropolitan University, the hospital, and the hospital group, the researcher invited all professional nurses working in the specific ICU to participate in the study by meeting them in groups and explaining the purpose and methodology of the research study. The nurses thus participated voluntarily and gave their consent. Once the participants agreed to participate, their participation was confirmed formally in writing. Appointments for interviews were then scheduled at times and venues that were most suitable for the participants.

Kvale and Brinkmann (2009:28-32) discuss twelve aspects of qualitative research, but only seven of these were used in this study to gain more insight into how to conduct a qualitative interview. The first aspect is life world and may be defined as the focus of qualitative interviews on the lived experiences of the participants’ world and how they relate to their world. The perceptions of the professional nurses during their experience of withdrawal of life-support treatment was the focus topic.

Meaning is the second aspect that is important when doing a qualitative interview. Kvale and Brinkmann, (2009:29) explain that the qualitative interviewer attempts to identify and interpret the meaning participants give to main topics in the experiences that they live, especially with regard to the topic being studied. The researcher asked the participants to explain their perceptions with regards to withdrawal of life-support treatment and what it means to them when they get the order to withdraw life-support treatment. In order for the researcher to understand and interpret what the participants meant with their experiences, she had to listen to what the participants said, but also how it was said.

The third aspect of a qualitative research interview is qualitative information. Qualitative information is what the researcher is looking for and is expressed in everyday language by the participants (Kvale and Brinkmann, 2009:30). In order for the researcher to ensure that the participants answered the questions in their own words and according to the way they wanted to, open-ended questions were used not to lead the participants in answering. The participants’ versions of their experiences and perceptions with regard to withdrawal of life-support treatment revealed valuable data which led to the quality of the data.
The fourth aspect used in the interviews was **description**. During the interview process, the researcher attempts to obtain descriptions of various aspects in the life world of the participants (Kvale and Brinkmann, 2009:30). The researcher encouraged the participants to describe their experiences and perceptions with regard to withdrawal of life-support treatment from patients in the ICU as well as how these experiences made them feel. The researcher also described the data findings in words as understood and interpreted from the participants.

The fifth aspect to consider is **deliberate naïveté**. Kvale and Brinkmann, (2009:30-31) explain deliberate naïveté as the ability of the researcher to keep an open mind to new ideas and topics, rather than focussing on biased ideas and thoughts. A scoping literature review was done prior to starting the study, and open-ended questions were used to allow the participants to express their own thoughts and ideas to ensure that the researcher achieved deliberate naïveté.

The sixth aspect of the qualitative research interview is **focusing**. The interview according to Kvale and Brinkmann, (2009:31) is focused on specific themes and uses a semi-structured interview approach. A semi-structured interview schedule was used to ensure that the researcher stuck to the original theme, but open-ended questions were used to give the participants freedom to express themselves within the topic. Participants had to be guided by the researcher towards particular themes according to the interview schedule, but they were still given the freedom to express their own perceptions and how they interpret these themes.

The seventh and final aspect that was used by the researcher in this study is **interpersonal interaction**. Kvale and Brinkmann (2009:31) state that the knowledge which the researcher obtains from the interview is produced through interpersonal interaction between the participants and the interviewer. The data that was analysed was produced by means of one-to-one interviews and the interaction that took place between the interviewer and participant.

The study was conducted using semi-structured interviews to obtain a clear idea of the participants’ perceptions with regard to withdrawal of life-support treatment from patients in the ICU. This method gave the researcher more flexibility and particular interesting ideas that come from the interviews can be followed up. De Vos et al.
(2011:351-352) point out that a semi-structured interview has a set of predetermined questions, but instead of being dictated by the predetermined questions, the interview is guided by these questions.

2.3.3.1 Types of interview questions

Various types of interview questions were used by the researcher. The researcher began with a demographical question to determine how long the participant worked in the specific ICU. The demographic question was then followed by an introducing question. Kvale and Brinkmann (2009:135) explain that an introducing question is one where the participant gives spontaneous and rich information from his/her own lived experiences. The introducing question was open-ended and allowed participants to answer the question in their own words.

Follow-up questions were used, which are questions that are led by the responses from the participants to preceding questions. Probing questions were used where the interviewer probed deeper into answers that were given by the participants. These two types of questions were used to gain deeper insight into the comments made by the participants. Interpreting questions are used by an interviewer when he/she needs clarification of an answer or a point that was made by the participant (Kvale and Brinkmann, 2009:136). The researcher in this study used interpreting questions successfully to ensure that she had a clear interpretation of what the participant intended in a statement for example: “If you say you feel guilty, is it feeling guilty about stopping treatment, or feeling guilty about not being able to give the family what you felt they needed?”

Kvale and Brinkmann (2009:136) note that silence or allowance for a pause can be used by an interviewer during the conversation in order to give the participant time to reflect on a statement or question. The researcher used silence during the interviews to allow the participants time to think about their response or what the question entails. In one of the interviews the participant was particularly emotional, the researcher used silence to allow the participant to compose herself and formulate her answers.

The researcher planned to ask three open-ended questions, but after the pilot interview it was clear that more questions were needed to be asked to elicit
adequate and sufficient information regarding the topic. An interview guide was then designed that contained the following questions:

- How long have you been working in ICU?
- Have you ever been involved in withdrawal of life-support treatment at the chosen ICU?
- Can you tell me of your experience or experiences?
- How do you specifically experience the withdrawal of mechanical ventilation and inotropic support in this ICU?
- How did it make you feel?
- How do you feel about the actual process of withdrawal of life-support treatment at this ICU?
- Do you have any recommendations in terms of the process of withdrawal of life-support treatment?

According to Grove, Burns and Gray (2013:272), it is important to consider the environment where the interview will take place. The physical surroundings, for example the chairs, play a role in making the participant feel at ease when being interviewed. A table present in the interview room can be useful especially when the consent needs to be signed. The temperature of the room also needs to be comfortable so that the participants are not distracted when being interviewed. The researcher planned to conduct the interviews in a room in the hospital, but some of the participants preferred that the interview be conducted at the researcher’s home. All the venues where the interviews took place were conducive to recording and no distractions were experienced. The pilot interview was conducted at the end of September, but due to difficulties with scheduling appointments with all the participants, the interviewing was only completed at the end of October.

Gerrish and Lacey (2010:353) emphasise the importance of setting the scene for the participants by explaining to them that there are no correct or incorrect answers, they can withdraw at any time, they can interrupt or ask for explanations at any time and that the interview will be recorded with their permission. At the start of the interviews in the current study, the researcher gave a brief introduction to the research study and asked whether the participants had any questions before the interviews started,
and reinforced the fact that confidentiality would be maintained. It seemed that the participants were satisfied with the information letter that was handed to them when they agreed to participate in the study.

Before the interviews were carried out, the researcher asked the participants whether they would feel comfortable to do the interview in English. Three of the participants however preferred to be interviewed in Afrikaans - and because the researcher is bilingual it was easy to translate the interviews. The participants signed the consent before they were interviewed and the interviews were recorded with a digital recorder.

After ten interviews, data saturation occurred and the interview process was discontinued. Data saturation according to Schmidt and Brown (2009:161) occurs when no new information is obtained from the interviews and when information is consistently repeated. Towards the end of the interviews, the researcher noticed that no more new themes emerged from the interviews and therefore the data collection process was discontinued.

2.3.4 Field notes

Field notes according to Holloway and Wheeler (2010:117) are detailed descriptions of the setting where the interview takes place and of the behaviour of the participant. These field notes are written notes of the observations that the researcher makes during the interview or directly after the interviews. The researcher's own reflections and feelings about the situations can also be documented in the field notes. These field notes can be very important additions during the data analysis process, in that they can validate important points that were made by the participants and they can help to emphasise emerging themes (Streubert and Carpenter, 2011:49).

Hand written field notes were made by the researcher during and after the interviews to document various facial expressions, body language and emotions of the participants. The researcher for example documented when the participant shook her head in disapproval to a particular statement, the fact that one of the participants had a very unsure and closed body language indicating she might be scared and she documented when one participant became tearful or more emotional. These field
notes allowed the researcher to better understand the meaning the participants revealed with regard to events during withdrawal of life-support treatment and could assist with the data transcription. Examples of the field notes that were made for two transcripts may be found in Annexure F and H.

2.3.5 Pilot study

A pilot study which is a smaller version of the actual research study may be conducted prior to commencing the larger study in order to develop and demonstrate the effectiveness of the methods that were chosen to conduct the research study (Rebar et al., 2011:232). Grove et al. (2013:46) define a pilot study as “a smaller version of a proposed study that is conducted to refine the methodology”. The key to a pilot study is that the researcher uses similar participants, the same setting, data collection and data analysis techniques. The pilot study however can also be used to develop and refine a measurement method, data collection tool or the data collection method (Grove et al. (2013:46). A pilot study may be used by the researcher to demonstrate the ability of the researcher to implement the research study and is an important first step in the data collection process (Rebar et al. 2011:232).

The following are some reasons for conducting a pilot study according to Grove et al. (2013:46):

- to determine whether the research study is feasible;
- to develop or refine a research intervention;
- to identify problems with a research design;
- to develop or refine data collection instruments;
- to refine the data collection and analysis plan;
- to give the researcher some experience with the setting, participants, methodology and methods of measurement.

A pilot study was conducted prior to commencing with the actual research study in order to test the research process and to assist the researcher to become familiar with conducting interviews. The same procedure for obtaining consent was followed for the pilot study as for the main study. Questions were identified in the pilot study
by the researcher that could be added to the interview schedule in order to gain more information from the participants. The researcher established a better idea from the pilot study of the time that needs to be allocated to the interviews, in order to inform the participants of the estimated time that the interview was likely to take.

After the pilot study was conducted, the researcher re-visited the interview guide to adapt it in order for the following interviews to provide more information. Only one participant was used for the pilot study and it was initially a short interview, but after more questions have been added to the interview guide, the researcher re-interviewed the participant for the pilot study in order to follow up on some of the responses from the participant. The follow up interview yielded a satisfactory result. The data obtained from the pilot study was used in the main study and formed part of the data analysis.

2.3.6 Data analysis

Data analysis in qualitative research occurs concurrently with data collection and therefore starts as soon as the data collection process starts (Burns and Grove, 2011:92). The purpose of data analysis according to Polit and Beck (2012:556) is to organise the data, to provide structure to data and to bring the true meaning forward from the data. The data analysis process involves continuous reflection, asking analytical questions and writing notes regarding the data throughout the study (Creswell, 2007:160).

Before data collection and analysis can commence, the researcher has to identify and clarify his/her own preconceptions, prejudice and beliefs regarding the topic being investigated. This concept is called bracketing and forms an important part of the data analysis process. It is important to practise bracketing to prevent the researcher’s preconceptions, prejudice and beliefs regarding the topic from interfering with or influencing the researcher’s description and interpretation of the participants’ experience (Parahoo, 2006:465). Bracketing was practised by the researcher in this study when she discussed her own beliefs regarding the topic with her peers, as well as by documenting these ideas and thoughts in a reflective journal.
The researcher analysed the data using the Tesch method of data analysis as described by Creswell (2003:191) as indicated below:

- Get a sense of the whole. Read through all transcripts carefully and perhaps jot down some ideas.
- Pick one transcript, go through it and ask “what is this about?” Write thoughts in the margin.
- When the task is completed with several of the transcripts, make a list of all topics. Cluster similar topics together and then form these topics into columns that might be arrayed as major topics, unique topics and leftovers.
- Take this list and go back to the data. Abbreviate the topics as codes next to the segments of the text. Try this preliminary organising scheme to see if new categories and codes emerge.
- Find the most descriptive wording for the topics and turn them into categories. Look for ways to reduce your total list of categories by grouping topics that relate to each other.
- Make a final decision on the abbreviation for each category and alphabetise these codes.
- Assemble the data material belonging to each category in one place and perform a preliminary analysis.
- If necessary, recode your existing data.

Once the researcher commenced with the interviews, the data analysis process started. On completion of all the interviews, the researcher transcribed the interviews verbatim. (Two of the transcribed interviews can be viewed in Annexures E and G). The researcher read through the transcribed interviews to get a sense of the information that was gathered and to reflect on the meaning of the collective interviews. After obtaining a general idea of the information that was gathered, the researcher went through each transcribed interview separately to understand the meaning the participant ascribed to her experiences. Topics were identified from the transcribed interviews and listed in a column. The researcher abbreviated each topic as a code and used these codes to indicate the segments in the transcribed interviews that represent the specific topic. By organising the topics using the particular strategy, the researcher was able to identify when new topics emerged.
The topics were developed into categories after the most appropriate wording was identified to describe the topics. Topics that were related to each other were grouped together in order to reduce the total number of categories.

This coding process was applied to all transcribed interviews and the data that belonged to each category was gathered together in one place where a preliminary analysis was performed. The researcher and the independent coder identified categories separately and then got together to discuss the most appropriate categories to be used. The categories that were identified and data that was collected through the data analysis process by the researcher and independent coder was reviewed by the research supervisor and co-supervisor. The identified themes were verified and are presented in Chapter Three of this research report.

2.3.7 Literature control

The literature review generally provides the researcher with the most up to date theoretical as well as scientific knowledge, making it possible for the researcher to identify what is known and what is not known. A literature review provides a background for the problem that is being studied and includes the description of the current knowledge about a practice problem, identification of gaps in the literature and knowledge base and it also gives the researcher an idea of what contribution the present study will make to building knowledge in this area (Burns and Grove, 2011: 189).

The timing and purpose of the literature review in qualitative research may vary. In some qualitative studies, a scoping literature review takes place at the beginning of the research process. This literature review makes the researcher aware of studies that have been conducted in relation to the topic and does not influence the theory development or direct the data collection of the current study. The literature review assists the researcher to explain, support and extend the theory generated in the current study. The literature review can also be delayed until after the data collection and analysis process, where the literature can then be compared with the findings from the current study in order to determine similarities and differences without any bias from pre-knowledge (Burns and Grove, 2011:192-193).
A scoping literature review was conducted before the researcher commenced the study in order to identify whether any guidelines were available in the literature on the process to follow when withdrawing patients from life-support treatment. After the main themes were identified and described, an in-depth narrative literature review was conducted to validate the identified themes. The literature was used to confirm the accuracy of the data analysis findings and to identify dissimilarities. The literature is explained and relevant quotations are used to support the themes identified.

2.4 TRUSTWORTHINESS

The researcher ensured trustworthiness by following the framework presented by Polit and Beck (2012:584-585). This framework provides guidance for qualitative researchers to proceed with their research studies ensuring trustworthiness and rigour. The four criteria in Polit and Beck (2012:584-585) which were first proposed by Lincoln and Guba in 1985 to develop the trustworthiness of a qualitative study are - credibility, dependability, confirmability and transferability. Streubert and Carpenter (2011:48-49) explain that trustworthiness is very important in qualitative research, because it demonstrates the rigour of the study that is being done and it demonstrates to the readers of the qualitative study that the research study has a respectable approach to science. Moule and Goodman (2009:188) assert that the four key components of trustworthiness namely credibility, dependability, confirmability and transferability allow the researcher to demonstrate how the interpretations that are presented in the data and the conclusions drawn from it reflect the participants’ experiences.

2.4.1 Credibility

Credibility according to Lincoln and Guba (1985) cited in Streubert and Carpenter (2011:49) includes activities that will increase the probability that credible findings will be produced in the study. Rebar et al. (2011:154) refers to credibility as the truth between the data collected and the findings. Gerrish and Lacey (2010:139) refer to credibility as the congruency between the perspective of the participants of the studied event and the interpretation and representation of the researcher of the studied event. Rebar et al. (2011:154) suggest that credibility of qualitative data can
be supported by seeking feedback from the participants (member checking), by prolonged and varied field experiences, and from peer examination.

### 2.4.1.1 Member checking

Rebar et al. (2011:154) explain that member checking refers to data and findings that are taken back to the participants so that they can judge the accuracy and credibility of the interpretation and the representation of the findings. Creswell (2003) cited in Streubert and Carpenter, (2011:49) considers that member checking should also be used to determine the final qualitative findings by showing the final report or specific themes and descriptions to the participants to determine whether they are accurate. Lincoln and Guba (1985) cited in Rebar et al. (2011:154) consider member checking the most critical technique for ensuring the credibility of a study.

In the current study informal unstructured interviews were conducted with six of the participants wherein the researcher described the preliminary themes identified in the data. Five of the participants were approached after the themes were identified and clarified with the independent coder, to discuss the themes that were identified. The participants were given the opportunity to comment on the themes and to state whether the themes that were identified were accurate. Member checking ensured that the themes that were presented in the study were accurately identified and interpreted.

### 2.4.1.2 Prolonged and varied field experience

According to Rebar et al. (2011:155) prolonged and varied field experience has been found to ensure trustworthiness and credibility. Spending time with the participants and observing the environment in which the experienced event occurs, allows the researcher to develop trusting relationships with the participants.

Prolonged and varied field experience was ensured by the researcher, as the researcher was employed in the ICU at the time that the study was conducted. Relationships were developed before the study when the researcher was working with the professional nurses that are now taking part in the study and during the study, because participants discussed certain issues and thoughts with the
researcher that will not be discussed with anybody else. The relationships that were formed with the participants allowed the participants to share freely of their experiences for the purpose of data collection. The professional nurses that were interviewed voluntary had previous experience of withdrawing life-support treatment, although their experience varied.

2.4.1.3 Peer examination

Peer examination is done by an individual who assists the researcher in remaining honest about findings, questions methods and interpretations, and provides the researcher with opportunity for reflection (Creswell, 2007:208).

The research method and design were discussed with the researcher’s supervisor and co-supervisor prior to commencing the data collection process in order to ensure peer examination. The independent coder that was used to assist the researcher with the data analysis process is also an ICU professional nurse. The researcher’s supervisor and co-supervisor further examined the data analysis to verify findings and interpretations of the themes.

2.4.2 Dependability

According to Boswell and Cannon (2011:204) dependability can also be described as auditability. The study is considered dependable if the same conclusions were reached when any other researcher followed the decision-making process of the researcher throughout the study. Documents that can be used for the data trail are field notes, personal notes, transcribed interviews, coding schemes, themes and indicators as well as the complete research report. Dependability guides other researchers who wish to conduct similar research. Even though the research cannot be replicated in exact circumstances with exactly the same participants, it can be repeated (Holloway and Wheeler, 2010:303). Dependability may be ensured by dense description and peer examination.

2.4.2.1 Dense description

Creswell (2007:209) explains that the researcher uses dense description to describe the participants or the setting being studied in detail. This rich description allows the readers to make the decision regarding the dependability of the study. Furthermore
the detailed description allows the readers to transfer information to another setting and to determine whether the study is dependable owing to shared characteristics between participants or settings.

Dense description has been achieved by the researcher providing in-depth descriptions of the research methodology, data collection and data analysis process, together with transcriptions of the interviews. Relevant quotations have also been used from the interviews in order to support themes and findings in the data that was collected. A literature control was done in order to identify other studies that support the findings of the research.

2.4.3 Confirmability

Boswell and Cannon (2011:204) describe confirmability as a measure of the objectivity of the data and it represents freedom from bias. It is important that the researcher keeps his/her own biases, assumptions and perspectives separate from the data being analysed. Gerrish and Lacey (2010:139) define confirmability as establishing that data, findings and interpretation are clearly linked. Moule and Goodman (2009:190) propose that in order for the researcher to confirm the objectivity of the research, it is important for the researcher to present an audit trail of the methods, presentation of data and analytical processes which are recorded over time so that another individual can follow this trail. Confirmability may be ensured by reflexivity and an audit trail.

2.4.3.1 Reflexivity

Burns and Grove (2011:95) define reflexivity as the responsibility of the researcher to examine his/her own influence on all aspects of the qualitative inquiry, thus doing self-reflection. Once researchers are aware of the influence their ideas may have on the interpretation of the findings of the data collected, they can develop a mechanism to enter the field and to collect data.

The researcher ensured confirmability by doing self-reflection on the topic of the research. She practised bracketing as explained by Burns and Grove (2011:96) and cognitively put aside her own beliefs, not making any judgements about participants’ comments and was open to the data provided by the participants. On completion of
the data analysis, some of the participants were given the analysed data to review in order to ensure that their experiences are accurately documented. The data that was collected with the assistance of the independent coder is rich in information and does not reflect the researcher’s personal thoughts and biases.

2.4.3.2 Audit trail

Rebar et al. (2011:153) describe an audit trail as a continuous documentation of decisions made by the researcher regarding the data collection and data analysis process. Documentation may include field notes, theoretical notes as well as notes on various methods used throughout the research process. The audit trail assists the researcher in remaining consistent in data collection and analysis.

All the work that was done was documented by the researcher to ensure that an audit trail was maintained. The data collection and data analysis processes were described in detail in the research report and the researcher's supervisor and co-supervisor ensured that necessary changes were made. All the data, including the interviews and transcriptions were saved on computer as well as external hard drive. The documentation will be kept for five years.

2.4.4 Transferability

Transferability refers to the fact that the research findings in one context can be transferred to similar situations or participants (Holloway and Wheeler, 2010:303). Gerrish and Lacey (2010:139) define transferability as whether the adequacy of the description can be transferred or related to another similar situation. The focus is on confirming that data that was meaningful to a specific setting or group can be found meaningful and accurate in a different setting or for a group in a similar situation (Rebar et al. 2011:154). Transferability can be achieved by providing a “thick or dense description” of the research setting and processes that include a description of the data as well as sampling and design details (Moule and Goodman, 2009:190). The table below summarises the criteria to ensure trustworthiness.

Table 2.1: Criteria to ensure trustworthiness

<table>
<thead>
<tr>
<th>Criteria to ensure</th>
<th>Criteria</th>
<th>Application</th>
</tr>
</thead>
</table>

35
<table>
<thead>
<tr>
<th>trustworthiness</th>
<th>Credibility</th>
<th>Dependability</th>
<th>Confirmability</th>
<th>Transferability</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Member checking</td>
<td>Dense description</td>
<td>Reflexivity</td>
<td>Dense description</td>
</tr>
<tr>
<td></td>
<td>Prolonged and varied field experience</td>
<td>Peer examination</td>
<td>Audit trail</td>
<td>As discussed above</td>
</tr>
<tr>
<td></td>
<td>Peer examination</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Some participants were asked to review the themes that were identified to ensure that the data was interpreted accurately. Researcher is employed in the research field and has already developed relationships with the participants prior to interviews. Independent coder who is also a professional nurse assisted with the data analysis. Supervisor and co-supervisor verified the collected data.

| | Detailed description of the research methodology, data collection and analysis processes. Transcriptions of interviews are provided. Relevant quotations from interviews used. As discussed above. |
| | Bracketing of personal thoughts and feelings. Dense description of data gathered. Documents stored by the researcher. |

| | As discussed above. |

2.5 CONCLUSION

This chapter provided a detailed description of the research design as well as the research method that was used in the study. The measures that were taken to ensure trustworthiness of the study that were followed in the study were discussed. Data analysis and literature control will be discussed in Chapter Three.
CHAPTER THREE
DATA ANALYSIS AND FINDINGS

3.1 INTRODUCTION
In Chapter Two the research design and method were discussed. Trustworthiness and ethical considerations were explored and the researcher also indicated how these concepts would be applied throughout the research study. In this chapter, a discussion will follow on the identified themes which address the research question. The themes that are identified will be discussed separately and an in-depth explanation will follow on the identified sub-themes. Each theme that is discussed will be supported by relevant quotations from the participants who took part in the interviews during the data collection process.

3.2 DATA COLLECTION PROCESS
In-depth semi-structured interviews were conducted with ten voluntary participants. Most of the interviews were conducted in a private consultation room in the hospital and in the researcher’s home, while one of the interviews took place in the participant’s home. Once data saturation was achieved, the interview process was discontinued. All the interviews were voice recorded and then transcribed. Data was analysed using the Tesch method of data analysis (Creswell, 2003:192). An independent coder assisted the researcher with the data analysis and after discussion, it was agreed that data saturation had occurred and no further interviewing was necessary.

3.2.1 Demographics of participants
All the participants who were interviewed in the study were females with experience in the ICU used for this study ranging from one to thirteen years. One of the participants had a total of 45 years’ experience in ICU while another participant was newly qualified and had only worked in ICU for a year. Seven of the participants have a Diploma in nursing and the other three have a Bachelor’s Degree in nursing. Six of the participants were also trained critical care nurses.
The following table indicates the themes that were identified by the researcher and verified by the independent coder. A literature review was done to determine whether professional nurses from previous studies had similar experiences. The literature control was used to verify the identified themes.

### 3.3 PRESENTATION OF RESULTS

The themes and sub-themes that were identified by means of a coding system from the data is presented in Table 3.1.

**Table 3.1: Identified themes and sub-themes**

<table>
<thead>
<tr>
<th>THEME</th>
<th>SUB-THEME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses had mixed emotions and experienced challenges related to withdrawal of life-support treatment.</td>
<td>Nurses encountered the following:</td>
</tr>
<tr>
<td></td>
<td>• Mixed emotions regarding withdrawal of life-support treatment.</td>
</tr>
<tr>
<td></td>
<td>• Difficulty in performing withdrawal of life-support treatment without clear orders.</td>
</tr>
<tr>
<td>Nurses reflected on their experiences related to communication and relationships with families during withdrawal of life-support treatment.</td>
<td>Nurses expressed communication and relational needs regarding withdrawal of life support which included:</td>
</tr>
<tr>
<td></td>
<td>• Family preparation concerning what to expect should be the doctor’s responsibility</td>
</tr>
<tr>
<td></td>
<td>• Teamwork should be implemented to support the family during this time.</td>
</tr>
<tr>
<td>Nurses had suggestions regarding an inclusive process of withdrawing life-support treatment.</td>
<td>Nurses suggested the following needs:</td>
</tr>
<tr>
<td></td>
<td>• The formulation of guidelines for withdrawal of life-support treatment.</td>
</tr>
<tr>
<td></td>
<td>• Introduction of an ethics committee.</td>
</tr>
<tr>
<td></td>
<td>• Comprehensive documentation related to family and staff interactions.</td>
</tr>
<tr>
<td></td>
<td>• Supportive strategies for the staff.</td>
</tr>
</tbody>
</table>
3.4 THEME 1: NURSES HAD MIXED EMOTIONS AND EXPERIENCED CHALLENGES RELATED TO WITHDRAWAL OF LIFE-SUPPORT TREATMENT

The research findings indicate that the nurses had comparable feelings related to withdrawal of treatment. Nurses encountered mixed emotions regarding withdrawal of life-support treatment and difficulty in performing withdrawal of life-support treatment without clear orders.

3.4.1 Nurses encountered mixed emotions regarding withdrawal of life-support treatment

From the data analysis, it was found that the nurses encountered mixed emotions regarding the withdrawal of life-support treatment. The researcher could identify the mixed emotions, when the professional nurses expressed feelings of relief, guilt and fear. They were trying to keep everybody happy and felt that withdrawal of life-support treatment left them open to criticism from colleagues. McMillen (2008:257) describes how nurses experienced frustration and distress when the decision to withdraw life-support treatment was made too quickly or conversely when it was prolonged. Nurses in the study by McMillen (2008:257) also expressed feelings of sadness and being upset as well as experiencing moral and ethical issues which made them feel uneasy. The mixed emotions of the professional nurses were related to questions about how they felt when withdrawing life-support treatment. One participant states that she wants to do her best when caring for a patient undergoing withdrawal of life support. This aspect of the nurse trying to do the right thing or doing her best is supported in the interviews conducted by Vanderspank-Wright, Fothergill-Bourbonnais, Brajtman and Gagnon (2011:33) where one of the participants said that, as a nurse she always tries to do the right thing by the patient, family and the staff.

“I think I felt relieved for the patient’s sake and for the family, because when you know that it’s not gonna get better, everybody, like just waits for the patient to die, so I think you feel relieved.” [Participant 1.]

“For me it was a very emotional and a scary experience, because I’ve never done it before.” [Participant 8.]
“You want to do your best, but you also want to do the doctor’s orders, um… and you also realise that the patient is the one who is suffering. So you want to do it that it is more dignified for the family, for the patients and, you know to get the doctor’s orders done.” [Participant 2.]

“I think it leaves you open to criticism from colleagues if you going too fast, or all colleagues might not feel the same and… it’s, it’s actually very ambivalent, because people have ambivalent feelings.” [Participant 4.]

Some of the participants commented that they would never get used to doing it, that their religious beliefs also have an impact on their emotions and that they feel they are actually practising a form of euthanasia. McMillen (2008:257) mentions that this morally or ethically uneasy feeling is a common finding in her study as well as other studies where junior nurses in particular are worried about the closeness of their actions to euthanasia. According to Langley and Schmollgruber (2006:63) these mixed emotions and intense environment could cause conflict for the professional nurses which may lead to undue stress, dissent and frustration which impacts negatively on the clinical staff and lead to burnout. A good example of the conflict a professional nurse experiences is Participant 8’s comment in the quotations below. This quotation explains that a critical care nurse you work to save lives and when withdrawing life-support treatment, assists a patient to die. Religion is also mentioned by one of the participants as an aspect that can cause possible conflict. It is possible that the religion or culture of a patient dictates that the family perform certain rituals with the patient before death, which for the nursing staff might be unacceptable or not in the best interest of the patient. The aspect of religion or culture is also mentioned in a study by Brysiewcz and Bhengu (2010:46), in which one participant mentioned that religious tolerance is necessary and another spoke of how families sometimes bring people to come and perform rituals which she as a nurse does not feel is in the patient’s best interest, but she also does not want to step on anybody’s toes.

“So you go home and you do feel bad for the family, because basically you took a life and we are actually here to save lives.” [Participant 8.]
“It is just not, even if the patient is very sick, even if he suffers, you know your patient will be more comfortable, you wish it upon him, but to physically do it and to see it is not nice for me and is not something that I can get used to.” [Participant 5.]

“I think though that there would always be something about your religious belief. That is one thing that is always there, and I have to say that is something that is always in the back of my mind. Who are we?” [Participant 5.]

“Yes, that’s how I see it, that we’re actually practising euthanasia unofficially.” [Participant 6.]

The research findings in this study were supported by a study done by Van Rooyen et al. (2005:49) where nurses experienced conflicts and questions within themselves regarding the influence of religion on their experience of the withdrawal of treatment. The study also indicates the moral dilemma that the nurses experience with preservation of life versus withdrawal of treatment. Kirchhoff and Kowalkowski (2010:535) found in their study that more than half of the respondents experienced difficulties with the actual process of withdrawal of life-support treatment and that emotional difficulties with this process were the most frequently cited problems. This is consistent with the research study where the participants revealed mixed emotions during the withdrawal of life-support treatment.

3.4.2 Nurses encountered difficulty in performing withdrawal of life-support treatment without clear orders

While conducting the interviews the researcher found that nurses encountered difficulty in performing withdrawal of life-support treatment without clear orders. For the participants, “clear orders” mean complete understandable written orders by the physician. The researcher could identify these difficulties when two of the participants expressed a belief that they were practising withdrawal of life-support treatment illegally or unofficially. They perceive it in this way because, according to the participants, it happens often that there are no written orders to withdraw life-support treatment. These comments were made after the researcher asked whether the participants had anything else to add. It is a clear indication that they feel very
strongly about the fact that they struggle with the idea of practising withdrawal of life-support treatment without clear orders or guidelines.

“It’s a subject that I know a lot of registered nurses in ICU talk amongst each other, but it’s not a topic that you actually want to talk outside the ICU about, because we all know in our hearts that we’re actually not guided by policy and regulations properly… we’re actually practising euthanasia unofficially.” [Participant 6.]

“I think this whole thing just feels better if it can be legal, if it can be done in a more legal way. [Participant 5.]

According to the South African Law Commission Project 86 (1998), it is legal for a medical practitioner to withdraw life-support treatment from a patient who is, in the doctor’s opinion in a state of terminal illness. The law also states that the medical practitioner must give written authorisation for the withdrawal of life-support treatment. Although the study done by Birchley (2012:360) does not refer to the experiences and perceptions of nurses, it explains that nurses who are participating in withdrawal of life-support treatment do not have similar judicial subjectivity to that of the doctors. Birchley (2012:355) also contends that the fact that nursing regulatory bodies fight for autonomy of nurses, place the nurses under significant professional risk due to the practicalities of teamwork and the idealisation of nurses becoming autonomous practitioners. It is thus clear that the professional nurses have a valid reason to feel insecure during the withdrawal of treatment.

The participant in the current study who was a newly registered nurse, expressed feelings of incompetence and confusion with the orders that were given to her to withdraw life-support treatment from the patient. In the interview, the researcher noted the emotional distress the participant experienced with the confusing orders and the fact that she had no written guidance.

“He wrote down on the ICU chart to stop the Adrenalin, but verbally he said just to keep the blood pressure on a stable level, like 90 systolic. It is difficult to maintain a blood pressure if the patient is dependent on Adrenalin.” [Participant 7.]
“I also think that as sisters we are left to our own grace when there are no orders.” [Participant 7.]

“I felt incompetent and felt that I put my burden on the shift leader as well, further, I know nothing.” [Participant 7.]

“There’s also not anything written, most of the doctors will write TLC, but what does it mean?... So you don’t know if TLC means you don’t do anything anymore and if the blood pressure drops you don’t call him, or must I still call him if anything happens to the patient? [Participant 10.]

This confusion from the nurses as a result of unclear orders is a valid problem. In a literature review by Rubenfeld (2004:445), it is also mentioned that physicians need to write specific withdrawal of intervention orders which will not cause confusion, rather than, for example saying “no heroic measures” or “comfort care only”. Kirchhoff and Kowalkowski (2010:538-539) also indicate in their study that if institutional policies and practice guidelines are implemented in the units, this will assist the nursing staff to provide competent care to patients and families experiencing withdrawal of life-support treatment.

It should be noted that the participant in the study who stated that she felt incompetent was a newly registered nurse. As Kirchhoff & Kowalkowski (2010:535) indicate in their study, nurses became more confident in their ability to care for patients during withdrawal of life-support treatment the longer they have worked in ICU.

3.5 THEME 2: NURSES REFLECTED ON THEIR EXPERIENCES RELATED TO COMMUNICATION AND RELATIONSHIPS WITH FAMILIES DURING WITHDRAWAL OF LIFE-SUPPORT TREATMENT

In the study, nurses expressed communication and relational needs with regard to withdrawal of life-support. They expressed the need for the doctor to prepare the family concerning what to expect and for teamwork to be implemented to support the family during this time. They also desired good communication between nurses, doctors and family members.
3.5.1 Family preparation concerning what to expect should be the doctor’s responsibility

From the data that was analysed in the study it was clear that the nurses are adamant that the physician must explain the process of withdrawal to the family. One of the participants also expressed the wish that the physician would inform the family to how long it may take for the patient to die once life-support treatment has been withdrawn. Another participant expressed her dismay that the doctor was not there for the family to explain the patient’s condition and the process that needs to be followed to withdraw life-support treatment.

“If they know that the patient’s condition is critical or that anything can happen to the patient, they must inform the family, so it’s not our responsibility at the end of the day to tell the family that doctor said we’re not going further with treatment.” [Participant 10.]

“I think there should be more support for the staff in situations like that, because often it’s left to the nurses and we are the ones supporting the family, we are the ones there with the patients, and the doctors are nowhere to be seen. Often we’re the ones explaining to the family what’s going on, you know?” [Participant 9.]

“Sometimes the doctor can come over as hard and cold, even by the family, but when the family discuss the situation with the nursing staff, they realise that there is not really another way out for them. I think we as nurses have a gift to speak to the families, where the doctors don’t, because they just say switch off and walk away.” [Participant 8.]

“Secondly, the doctors must be there, like in my first case, the doctor was not there the whole day. We had to “comfort” the family by saying the doctor is on the way, he’s just busy with something. It is one of those cases where they have to be there, not just for the patient, but also for the patient’s family. It is still the doctor’s responsibility, it doesn’t mean if the patient is brain dead that you can just leave the patient or family. He must still be there emotionally and support the family, even if you just come to inform the family of the patient’s condition and what to expect further on. Just help the family through that process.” [Participant 7.]
“...what the plan is, for example if ventilation is going to be stopped it will be over more or less one or two days. He needs to be more specific. Many people will think if you stop inotropes it's not going to happen immediately, so they will just say, 'Okay, stop.' Many people expect the patient to still be alive for a couple of days more and when you call them after two or three hours to say that the patient's condition is deteriorating rapidly, it is a huge shock for them. They will say, 'How do you mean rapidly?, I was there just now.' So they have to inform the families more or less how long it will take, but that it can take a shorter or longer time, just so they know.” [Participant 10.]

“I was very upset with the way he handled the family, like I said, it's a very sensitive topic, especially if a family member is taken in such a way.” [Participant 7.]

Caring for family members in the ICU is seen by Truog et al. (2008:955) as a very important part of caring for the critically ill patient. Family-centred care is based on values, goals and needs of the patient and family, which includes their understanding of the illness, prognosis and treatment options as well as communication. Langley and Schmollgruber (2006:63) find in their study that in the South African context, medical specialists who were schooled in a hierarchical model rather than a collegial model will make decisions on their own and leave the actions to the nurses as well as explaining the decisions to the family.

In support of the nurses in the current study, it was found by Hansen, Goodell, DeHaven and Smith (2009:268) that nurses expressed the need for better communication and the presence of the physician in patient conferences in order for the family to communicate with the physician and thus understand the patient’s condition and the treatment options, including withdrawal of life-support. The same frustration that was experienced by the nurses in this study was also experienced by the families of patients in a study by Wiegand (2006:182:183). The families stated that they would have liked the primary physician to help them with the life-and-death decisions that they were faced with. They had seen the primary physician on the floor, but noted that he did not come to see the patient.

In a South African study by Van Rooyen et al. (2005:48), the nurses indicated that they experienced the doctor as uninvolved, distant and not open to discussion with
staff and the families regarding the decision and process of withdrawal of life-support treatment. The nurses on the other hand, indicate how they patiently listen to the families’ questions, fears, uncertainties and frustrations. The findings of the study by Van Rooyen et al. (2005:48) endorse the frustrations of the nurses in the study with regards to the physician not communicating adequately with the families.

3.5.2 Teamwork should be implemented to support the family during this time

The study identified the nurses’ need for teamwork to support the family and during the process of withdrawal of life-support. Two of the participants suggested having a committee where nurses could be present as well as the family to discuss the patient’s condition and progress and to support the family. It was also proposed to involve all physicians in this committee as they are required to stand in for each other over weekends. Some participants spoke of assisting each other as a nursing team to support each other and the family, since teamwork does not only involve doctors and nurses. One of the participants also mentioned how not being involved in the discussion made her feel excluded. Participants found it important for nurses to feel that they are part of the team helping to make decisions and supporting the patients and families.

“I think we actually need to have some form of a committee where these decisions, ‘cause again we look at doctors, they are all involved with our longer-term patients, because they’re on call and they do call… There must be, because we’re the ones who carry out the orders, so there must be representation for registered nurses.” [Participant 4.]

“I think to have a decent support team around you, um, would be… It, it’s a lonely feeling, and I don’t think one, it’s not good for one to carry the can on their own so to speak. Even if you are, you do have a very, you know that it is for the better, and you feel, you don’t feel bad about it, but it is better to have, almost a decision taken by a group and to have probably the doctors behind you, more so, and we do have them here in that aspect. Also that you can bounce things off each other and you can, you feel like you’re going in as a team into a situation like that, and making, two
heads are always better than one, three heads are always better than two.” [Participant 3.]

“They always say we work as a team, but it should be like a group, it should involve everybody. We should all give our opinions and be able to ask our questions and give our input and together decide what’s best for the patient. How we’re going to handle, what we’re going to do, why we’re doing it and then how the family will cope with it.” [Participant 1.]

“I think I felt left out, because he didn’t explain anything, and I didn’t know what was going on until I saw what he was doing.” [Participant 1.]

Langley, Schmollgruber, Fulbrook, Albarran and Latour, (2013:14) find in their study that although nurses were directly involved in the end-of-life care of patients, they were to a large extent not involved in the decision-making process. Most of the nurses in the study by Latour, Fulbrook and Albarran (2009:114) indicated that they were not involved in the decision-making process, but that involvement in decision-making positively influenced their job satisfaction.

The New South Wales End-of-Life Care and Decision-making Guidelines (2005) specify clearly that nurses play a significant role in providing clinical and social information about or to the patient and family when discussions are initiated with regards to treatment and as managers of the dying patient. It is therefore important to include the nurses in the collaborative process where the team develops a management plan with the patient and/or the families. According to Carlet et al. (2004) as cited in Latour et al. (2009:117) European guidelines state that the ultimate goal of end-of-life discussions should be in the patient’s best interest; these guidelines advocate nurses playing an active role in the clinical team.

Ultimately nurses’ involvement in end-of-life decisions is of paramount importance for effective communication between the physicians and the families. The role of the nurses in end-of-life care which includes withdrawal of life-support treatment is to guide the patient and the family through emotionally and physically difficult times Latour et al. (2009:117). Physicians are also encouraged, in a study by Kirchhoff and Kowalkowski (2010:539), to be present at the patient’s bedside during the
process of withdrawal of life-support treatment to provide more explicit direction and coordination of the withdrawal process.

3.6 THEME 3: NURSES HAD SUGGESTIONS REGARDING AN INCLUSIVE PROCESS OF WITHDRAWING LIFE SUPPORT TREATMENT

The nurses in the study made four recommendations with regards to the process of withdrawal of life-support treatment namely to formulate guidelines that can guide the nursing staff, introduction of an ethical committee in order to improve communication, comprehensive documentation related to family and staff interactions and having supportive strategies in place for the staff. These recommendations were offered by participants throughout the interviews in response to the researcher’s question regarding possible recommendations in order to improve the process of withdrawal of life-support treatment.

3.6.1 The formulation of guidelines for withdrawal of life-support treatment

All participants, except one, recommended the development of guidelines in order to guide the staff, especially newer and inexperienced staff, through the process of withdrawal of treatment. Two participants also mentioned that having the orders in writing and complete, would make the process more legal, since doctors’ orders were frequently incomplete or even absent. Participants explained that nurses currently practise withdrawal of life-support treatment based mostly on verbal orders. Even though verbal orders were recorded in writing by the nurses, they would feel more comfortable performing withdrawal of life-support treatment when orders were initially received in writing. One of the participants suggested this process would also give the doctors a guide to follow when withdrawing life-support treatment from patients.

“Yes, for the newer sisters I believe they need a guideline if there’s not someone experienced enough to assist them. They do definitely do need a guideline in what to do, because the majority of them have gotten attached to the patients and it’s quite emotional for them to just switch off. So yes, they definitely need a guide.” [Participant 2.]
“Secondly, I think policies should almost be in place, where there’s a, there’s a guideline. There’s something to follow. It’s not just scrambling certain aspects, that you feel that you followed a procedure that had structure, whereas you, it’s not that you don’t have structure in the sense, but written in black and white, the institution that you’re working for has structure and guidelines that you feel that you are working within parameters, which will guide you to do the right thing.” [Participant 3.]

“And also then something the doctors then will have to follow, the way it is supposed to be done, because they are sometimes very vague in the orders they are doing. Yes, so a guideline will even help to guide the doctor in the correct way of putting their orders down.” [Participant 6.]

“I normally decrease it [inotropes] to 2ml/hour, um, until it’s stopped and switched off. Depending on how, I mean like for a brain dead patient, when there’s been a brain dead patient where he’s failed the brain death test and they aren’t going to use him as an organ donor, in a situation when I nursed that patient, I weaned very quickly. I weaned 5ml/hour at the start… Well, there’s no proper guideline, it’s my own, it comes to my own discretion, you know?” [Participant 9.]

Rubenfeld (2004:445) proposes ways in which physicians should document the meetings leading up to the decision to withdraw life-support treatment, the specific plans for withdrawal and the pharmacological plan for sedation. This author also suggests that there need to be guidelines, pathways, pre-printed orders and nursing standards developed in institutions for the withdrawal of life-support treatment. In recommendations presented by Truog et al. (2008:955-961) each step is clearly discussed, from the decision-making to the support of the family. These recommendations include steps to follow by the physician as well as by other members of the multidisciplinary team, which includes nurses. Although steps to follow are provided, the physician would still need to document orders and discussions clearly.

From the data analysis of the current study, it is clear that nurses have no way of knowing exactly which steps to follow in the withdrawal of life-support treatment. The participants indicate that physicians are frequently issuing verbal orders, many of which are confusing, and that the physicians do not provide steps to follow, for
example to wean ventilation. It is evident that guidelines are a necessity in the institution, so that nurses will feel competent in their own practice and that they will feel legally protected.

3.6.2 Introduction of an ethics committee

Two of the participants recommended that an ethics committee be formed where patients’ conditions, prognosis and treatment plans could be discussed with the patients, if possible, and with their families. Both of these participants believed that a nurse should be part of this committee, since nurses spend most of their time with the patients concerned.

“I think we actually need to have some form of a committee where these decisions, ‘cause again we look at doctors, they are all involved with our longer term patients, because they’re on call and they do call, so they all know all the patients, most of them. So I actually think that they need to have a weekly progress thing and say, ‘We’re doing this’… There must be nurses, because we’re the ones who carry out the orders, so there must be representation for registered nurses.” [Participant 4.]

“Some form of a consultation meeting.” The participant mentioned the presence of “maybe the physician, unit manager, some of the senior professional nurses.” [Participant 1.]

Langley and Schmollgruber (2006:64) support the idea of forming an ethics committee. They indicate that this committee could assist the physician in addressing ethical dilemmas and reinforce sound values within the unit. This committee could identify and discuss personal and group beliefs, values and aims and through discussion, contribute to interpersonal respect, collaboration and multidisciplinary cohesion. The difficult task of the physician is communicating and negotiating with the patient and family to arrive at a plan of care, which could also be assisted by the committee.

The New South Wales End-of-Life Care and Decision-making Guidelines (2005) discuss a “treating team” and rather than an “ethics committee”, but their roles are similar in terms of what would be expected from such a team or committee. The guidelines stress the importance of having nurses on the team as well as medical
specialists, surgeons, general practitioners, allied workers such as social workers, patient advocates, chaplains or pastoral care workers. Each member of the team may bring valuable perspectives and information to the withdrawal of life-support treatment process and that is why it is important to pursue their involvement.

In a study by Wiegand (2006:183), meetings were held with the families to discuss end-of-life issues. Although it was not an official committee that met, it also consisted of key family members, a physician, nurse and an ethicist. Families in this study found it very beneficial to be able to sit down and talk with physicians, nurses and other members of the healthcare team. The families valued the fact that they could discuss and share each person’s understanding of the patient’s condition and expected course.

By developing an ethics committee which can discuss patients' prognosis and treatment plan, communication among all the members of the healthcare team and the patients' families can improve. This improvement in communication can ultimately lead to confidence in practice by nurses and thus better outcomes for the dying patients.

3.6.3 Comprehensive documentation related to family and staff interactions

One of the participants in the current study suggested that the physician should document what he/she discussed and agreed upon with the family, and that family members should sign their agreement with this decision, whatever it may be. By documenting these interactions with the families and other healthcare team members, the nursing staff would feel more assured of their role and everybody would know what is expected of them and what the patients' treatment plan is.

“What will make it easier is when the doctor speaks to the family that he writes it down and that the next-of-kin signs with the doctor, so you know that the next-of-kin is aware of everything and that doctor discussed everything, so if anything happens to the patient there is proof that the family is aware of the condition and that the doctor discussed the situation thoroughly with the next-of-kin. And what the plan is, for example, if ventilation is going to be stopped it will be over more or less one or two days. He needs to be more specific… With weaning, they must say to wean to
maintain a specific blood pressure for example a systolic blood pressure of 120. If the blood pressure drops, increase the inotrope until the doctor comes to re-assess the patient. That will help more.” [Participant 10.]

It is important for the primary physician to document all meetings that were held with the families of patients and the healthcare team, including the specific plans for withdrawal of life-support treatment and the pharmacological plan for sedation in the patients’ file. Complete documentation will ensure that all nurses and physicians who are covering for the primary physician, who have not been involved in the original discussions, know exactly the plan that was discussed and agreed upon by the family and primary physician (Rubenfeld, 2004:445-446).

Stacy (2012:18) explains in detail how a patient conference should be planned, how the patient conference should be conducted and which aspects are important to address in such a conference. She also explains how the conference should be closed and that documentation should include the outcome of the meeting, the participants, issues that were discussed, goals that were identified and future plans.

The New South Wales End-of-Life Care and Decision-making Guidelines (2005) clearly stipulate that the primary physician is responsible for documenting a summarised version of the discussions held with the patient, family and treating team. These guidelines include the following aspects to be included in the notes:

- Medical facts that led to decision, including the patient’s prognosis.
- Persons who were involved in the discussion.
- A statement of the patient’s wishes, if they were known.
- Goals of the patient’s treatment plan.
- Details about medical treatment to be provided or treatments to be withheld or withdrawn.

There is a clear standard in the literature that is expected of primary physicians with regard to documentation of patient conferences in connection with withdrawal of life-support treatment. These standards are unfortunately not practiced in the ICU where the study is conducted, which leads to much confusion and emotional distress of the nursing staff. The implementation of this recommendation would greatly
improve the confidence of the nursing staff when dealing with the families and patients as well as the level of care provided to the patients.

3.6.4 Supportive strategies for the staff

Most of the participants expressed the need for more supportive strategies specifically for the nursing staff. One participant mentioned that newer staff in particular should be allowed to attend patient conferences and mortality and morbidity meetings, while another suggested a debriefing session with a psychologist, the unit manager or shift leader, in order to handle strong emotions. Two other participants stated that nurses should be there for one another and assist each other, which is part of support.

“As a newly qualified sister, it was my first patient, so I got guidance from my shift leader. She took me through the whole process. She definitely guided me. Was it not for her, I don’t think I would have managed with the patient.” [Participant 7]

“…and also maybe to have a session with a psychologist, the unit manager, or the shift leader to debrief about the situation, so that you can talk about it and it doesn’t stay inside you as emotional feelings.” [Participant 8]

“It [debriefing sessions] is definitely something we lack, and it should not only be for withdrawal of treatment, but we go through a lot of psychological things and then we take it home and tell the people at home what happened on the day. But they don’t necessarily understand what you’re going through, because many of the spouses are not in the medical field. You’re lucky if you do have someone to stand by you.” [Participant 8]

Nurses in a study by Van Rooyen et al. (2005:47) indicated that one of the coping mechanisms they used in dealing with withdrawal of life-support treatment from a patient, was to turn to a comforting person. This support person in many cases was a nursing colleague who had been through a similar experience. One of the guidelines identified in this study by Van Rooyen et al. (2005:49) was the provision of access to proper counselling services for nurses working in ICU.
It was indicated in a study by Hansen et al. (2009:269) that sufficient education, an safe practice environment, or emotional and instrumental support could influence critical care nurses’ perceptions of providing end-of-life care. These identified factors could also explain why nurses in the current study struggled to deal with withdrawing patients from life-support treatment. Nurses in a study by Kirchhoff and Kowalkowski (2010:539) confirmed that emotional support was important to them, especially support from their unit managers and physicians. They did reveal however, that support from these two sources was lacking and that the support from other nursing colleagues was more frequent.

Nurses are normally the ones who must perform the actual withdrawal of life-support treatment, which can lead to several emotional and religious conflicts for the nurse him/herself as well as with other colleagues. There is clearly a need for nurses to be supported, as is indicated in the literature. and thus, for the sake of the study as indicated by the participants debriefing sessions are one of the most needed interventions to emotionally support the nurses.

3.7 CONCLUSION

Throughout this study the researcher has explored and described the perceptions of professional nurses with regards to withdrawal of life-support treatment. The data analysis process has revealed a number of themes and sub-themes which have been supported by previous studies. In the following chapter the researcher will present recommendations related to education, practice and research with regards to withdrawal of life-support treatment. These recommendations will assist in improving the care of the patient and their family during withdrawal of life-support treatment as well as assisting nurses with the practice of withdrawal of life-support treatment. The limitations of the study and recommendations for future nursing research, practice and education will be discussed in Chapter Four.
CHAPTER FOUR

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

In Chapter Three the researcher discussed the data that was analysed and verified the data by means of a literature control. In this chapter, the conclusions based on the data findings are made and recommendations for professional nurses dealing with the withdrawal of life-support treatment are formulated from the data analysis. Recommendations are presented with regard to nursing practice, nursing research and nursing education. The limitations of the research study are presented.

The first objective of the study which was to explore and describe the perceptions of professional nurses with regards to the process of withdrawing life-support treatment in a private ICU, is discussed in this chapter. The second objective was to make recommendations to assist professional nurses with the process of withdrawing life-support treatment in a private ICU. In this chapter, recommendations for nursing practice, education and research are made as well as general recommendations based on the data findings.

4.2 CONCLUSIONS OF STUDY FINDINGS

At the beginning of the research study, the researcher focussed only on including withdrawal of mechanical ventilation and inotropic support as life-support treatment in the study. In the course of the study however, it was found in the data collection and analysis process that withdrawal of mechanical ventilation is rarely practised in the ICU where the study was conducted. Many of the participants only experienced withdrawal of inotropic support in this ICU.

During the data analysis process the researcher established that professional nurses working in the ICU feel uncomfortable with the process of withdrawing life-support treatment from patients. It can be inferred from the data analysed, that the professional nurses who have worked longer in an ICU setup, have fewer difficulties when life-support treatment has to be withdrawn, and that newer professional nurses still have a great deal to learn and experience in that regard. It can, however, be
said that professional nurses never experience withdrawal of life-support as a comfortable task to perform.

Professional nurses encounter many mixed emotions and difficulties with having to withdraw life-support treatment from patients. It is clear from the discussions with the participants that nurses are getting involved with the patients and their families and want what is best for the patients, but that they also take the feelings of the patients’ families into consideration when they deal with their patients. Most of the time nurses express a feeling of relief when the decision is finally made to withdraw treatment, because it means that the patients’ suffering will end and the families’ grief at having to watch their family member suffer will also come to an end. There is, however, an aspect of withdrawal of life-support treatment that nurses always have in the back of their minds and that is the legality of the process. Professional nurses are, after all, the members of staff who actually perform the task of withdrawing life-support from the patient. However, as pointed out by the professional nurses in the study, most of the time this task is performed based on verbal orders or orders which are unclear. Practicing withdrawal of life-support treatment without clear and written orders does create feelings of unease and discomfort for the professional nurses.

Data analysis of the study also indicated that the nurses are obliged to do much of the communication with the families and that the physician is not giving enough support and information to the families. The participants mentioned that the physicians on many occasions visit the patient to give orders and a brief explanation to families, but that they use terms which are not always understood by the families, and that families do not always have the opportunity to ask questions. The fact that families may not understand the terms that physicians use, leads to these families approaching the professional nurses and that they, in turn, have to explain the patients’ conditions and the plan of action. Once again, professional nurses with less experience find it difficult to communicate with the families in this way, and they expressed a strong need for the physicians to be more involved in discussions with the families as well as to support the families during the actual process of withdrawal of life-support treatment.
Some of the participants expressed the need for a committee to be formed where physicians, families and nurses could sit together to discuss the patient’s prognosis and plan of care. It was even suggested having a psychologist involved in this committee to assist the families, and also the nursing staff. By having discussions with everybody involved, all parties would be up to date with plans for the patients’ care. Everybody would have time to ask questions and to give their input into the plan of care for the patients. There was also a recommendation made by the participants to document the discussions between the physicians and the families as well as the nursing staff, so that all parties are aware of what has been discussed and decided, even if they were not present during these discussions. The professional nurses regarded not only the physicians as part of the team, but also their colleagues as significant team members for assistance and support.

Participants made some suggestions regarding what they considered to be very important aspects to be implemented to improve the care of patients experiencing withdrawal of life-support treatment as well as taking care of the professional nurses looking after patients during this process. The first recommendation that was mentioned by every participant was for guidelines on the withdrawal of life-support treatment. These guidelines as mentioned by the participants would assist all nurses during the process of withdrawal of life-support in knowing which processes to follow and to serve as a guide to give them structure. These guidelines would also assist in making the process legal, with clear hand-written orders that need to be followed. It was also mentioned by one of the participants that these guidelines would assist the physicians in clarifying the process. This recommendation was made the most frequently in the interviews with the study participants and is thus clearly an indication of a great need by the professional nurses in the ICU.

An additional identified need was for better support, especially emotional support for the professional nurses in the ICU, specifically with regard to withdrawal of life-support treatment. The participants mentioned that they get support from their colleagues, but expressed the need for debriefing sessions with a psychologist, unit manager or shift leader during difficult situations such as when life-support treatment is withdrawn from a patient. A participant suggested that the newer staff should attend ethics committee meetings once this committee is established and possibly
even mortality and morbidity meetings where certain patient case studies are discussed, to evaluate the care and treatment which patients were given.

4.3 RECOMMENDATIONS TO ASSIST PROFESSIONAL NURSES WITH THE PROCESS OF WITHDRAWING LIFE-SUPPORT TREATMENT

The following recommendations for data findings have been identified and described based on the data presented in Chapter Three. These recommendations are completing the second objective of the research study. The recommendations include recommendations for the complete process of withdrawal of life-support treatment, from discussing the decision with the staff involved and the family, to the physician documenting the orders, professional nurses applying the orders and support for families and nursing staff.

4.3.1 Dealing with the mixed emotions related to withdrawal of life-support treatment

The following recommendations can be made with regards to the mixed emotions the professional nurses experienced during withdrawal of life-support treatment.

Feelings of relief, guilt, fear, pressure of trying to keep everybody happy and worry of being open to criticism from colleagues were emotions that were experienced by participants during the process of withdrawal of life-support treatment. It is recommended that debriefing sessions be held, and with managerial support, that nurses may become more aware of their emotions and the feelings they experience during the withdrawal of life-support treatment. It is acknowledged by Ranse, Yates and Coyer (2010:9) that withdrawal of treatment from a critically ill patient can be emotionally challenging and they therefore recommend emotional awareness and emotional support be offered to nurses through informal and formal methods such as, debriefing sessions, counselling, nursing colleagues and organisational policies and procedures.
4.3.2 Communication with the families of the patients.

The participants of the research study expressed the need for better communication and teamwork with the families of the patients that undergo withdrawal of life-support treatment.

The participants expressed the need for the physician to prepare the family adequately about what to expect during the withdrawal of life-support process, so that it was not purely left to the nurse to do all the explaining and support. The nurses also expressed the need for the physician to be part of the team when the actual process of withdrawal of life-support treatment takes place to support the family as well as the nursing staff. It is recommended that a committee is formed that include physicians, nurses, the family of the patient, and a psychologist who can discuss the patient’s prognosis and plan of care. Hansen et al. (2009:268) indicated that nurses expressed the need for better communication and the presence of the physician in patient conferences. The presence of the physician in the patient conferences will ensure that the family and the physician communicates, which will lead to a better understanding by the family of the patient’s condition and the treatment options, which may include withdrawal of life-support.

4.4 RECOMMENDATIONS FOR NURSING EDUCATION, PRACTICE AND RESEARCH

The researcher suggests ways in which to improve the study design for future studies as a recommendation for further study (Burns and Grove, 2011:546). Recommendations may address the limitations that are identified and suggest further studies that may be required to increase the body of knowledge (Rebar et al. 2011:26). The recommendations from the research study can be applied to nursing education, practice and research.

4.4.1 Recommendations for nursing education

In order to improve the practice of withdrawal of life-support treatment in the ICU, nurses should receive formal training on the withdrawal of life-support treatment, especially in basic training. It is recommended by Kirschhoff and Kowalkowski (2010:540) that institutions develop best practice guidelines that will support nurses
in providing the highest quality of care for patients undergoing withdrawal of life-support treatment. These guidelines can be implemented in different hospitals as well as different nursing schools. It is however very important to ensure that the accompaniment of the junior nurse or student nurse in the ICU with regard to withdrawal of life-support treatment is practised.

In-service training and short courses regarding the management of patients undergoing withdrawal of life-support treatment may be implemented in the ICU with the assistance of the training department. Debriefing sessions, attending mortality and morbidity meetings and attendance at ethics committee meetings may also prove to be important sources of education, allowing nurses to learn from previous experience and from the multidisciplinary team.

It is important that the management of a patient undergoing withdrawal of treatment forms part of the orientation programme of the unit. Accompanying the professional nurse who experiences managing a patient where life-support treatment is being withdrawn, can form a valuable part of a professional nurse’s experience of the process for the future.

4.4.2 Recommendations for nursing practice

The development of a best practice guideline that will guide professional nurses through the entire process of withdrawal of life-support treatment is the most important recommendation which was expressed by the participants. This guideline will give structure to the process of withdrawal of life-support treatment structure and will legalise the process by having official written orders from the physicians.

The formulation of an ethical committee consisting of physicians, nurses, the patient’s family and a psychologist is a recommendation that will improve the communication between healthcare workers as well as between the healthcare workers and the families. The families may experience more support by introducing a psychologist and the nurses may benefit from the psychologist as well, by attending debriefing sessions.
4.4.3 Recommendations for nursing research.

The research study can be used as the basis for further research regarding the perceptions of professional nurses with regard to withdrawal of life-support treatment. This research study has identified the perceptions of professional nurses with regards to the withdrawal of life-support treatment as well as making suggestions to improve the care of patients undergoing withdrawal of life-support treatment. Future research may be done to establish whether any guidelines have been developed with regard to the process of withdrawing life-support treatment from patients. The study may also be extended to physicians to determine their point of view and perceptions.

Further research may also help to identify the barriers to effective multidisciplinary communication in the situation where life-support is withdrawn from a patient as well as the communication between healthcare workers and family members of the patients. It is recommended to conduct research regarding the implications of implementation of debriefing sessions after withdrawal of life-support treatment for the professional nurses. The researcher recommends conducting a duplicate of the study in the public sector.

4.5 LIMITATIONS TO THE STUDY

Boswell and Cannon (2011:133) state that the limitations of a study describe the aspects of a study that may have complicated the results. Burns and Grove (2011:48) define limitations as elements of the study that may negatively influence the credibility and generalizability of a study. Generalisation on the other hand can be defined as the extension of the research findings from a small study to a larger, but similar study (Burns and Grove, 2011:48).

The following limitations were identified by the researcher. Difficulty was experienced following a set interview schedule due to the work schedules of the interviewer and the participants. Some of the staff worked on opposite shifts to the interviewer, while others worked night duty. This meant that some of the interviews needed to be conducted during working hours, which were not always feasible because of the activities in the unit. This delay in interviews meant that the period in
which the interviews were conducted was much longer than the researcher planned for, which delayed the data analysis process.

A small sample from one ICU was used to conduct the study. The aim of the research was to gain insight into this specific ICU and how the withdrawal of life-support treatment was perceived by professional nurses in this ICU. The study may, however, be limited in the extent to which the findings can be applied to another ICU context. Findings can thus not be generalised.

4.6 CONCLUSION

Withdrawal of life-support treatment is a reality in ICU which professional nurses are faced with on a regular basis. This study has highlighted the perceptions of the professional nurses working in an ICU with regards to the process of withdrawal of life-support treatment.

The researcher has aimed to gain insight into the perceptions of professional nurses with regard to withdrawal of life-support treatment and to make recommendations to improve nursing care of the patient undergoing withdrawal of life-support treatment as well as to support professional nurses who are experiencing the process. Through the data collection process, it became clear that most professional nurses experience difficulties and emotional challenges during the withdrawal of life-support treatment. The researcher recommends formal and informal methods such as debriefing sessions, counselling, nursing colleagues and organisational policies and procedures in order to support the professional nurses experiencing these difficulties and emotional challenges. Communication between the families of patients and physicians was identified as a shortcoming; therefore the researcher recommends the formulation of an ethics committee consisting of the physician, a professional nurse, psychologist and the family of the patient. In order to improve the practice of withdrawal of life-support treatment, in-service training and short courses are identified as important methods to improve the knowledge of professional nurses with regard to withdrawal of life-support treatment. Development of a best practice guideline for the withdrawal of life-support treatment is highly recommended to provide structure to the process and guide the professional nurses through the process.
It is the intention of the researcher to assist the professional nurses when dealing with a patient undergoing withdrawal of life-support treatment, as well as getting management and the training department involved to apply the recommendations in order to improve the practice when withdrawing life-support treatment.
REFERENCE LIST


Davidson, J.E. 2009. Family-centered care: meeting the needs of patients’ families and helping families adapt to critical illness. Critical Care Nurse, 29(3), 28-34.


Annexure A: Faculty post graduate studies committee approval letter

Copies to:
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22 September 2014

MS E PHEIFFER
16 ROBINVALE
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RE: OUTCOME OF PROPOSAL SUBMISSION

QUALIFICATION: MCur Advanced General Nursing Science

FINAL RESEARCH/PROJECT PROPOSAL:

THE PERCEPTIONS OF PROFESSIONAL NURSES WITH REGARD TO THE PROCESS OF WITHDRAWING LIFE-SUPPORT TREATMENT IN A PRIVATE INTENSIVE CARE UNIT

Please be advised that your final research project was approved by the Faculty Postgraduate Studies Committee (FPGSC) subject to amendments/recommendations being made to the satisfaction of your Supervisor/s
Faculty Postgraduate Studies Committee (FPGSC) reference number: is H14-HEA-NUR-013

We wish you well with the project.

Kind regards

Ms M Afrikaner

FPGSC Secretariat

Faculty of Health Sciences
ATTENTION: E PHEIFFER

APPROVAL FOR RESEARCH STUDY

TITLE: Exploration and description of the perceptions of professional nurses with regard to the process of withdrawing life-support treatment in a private intensive care unit.

Our previous correspondence refers.

The Research Committee has granted permission for your study to be conducted within the company's facilities. Please present this letter to the Hospital and Nursing Manager of each institution when seeking to obtain permission to use their facilities.

We look forward to seeing the results of your research once it is completed.

Yours sincerely

Anne Roodt
Education Specialist
Dear Participant

You are being asked to participate in a research study. I will provide you with the necessary information to assist you to understand the study and explain what would be expected of you (participant). These guidelines would include the risks, benefits, and your rights as a study subject. Please feel free to ask the researcher to clarify anything that is not clear to you.

Problem statement:

In an ICU in Nelson Mandela Bay, the decision to withdraw life-support treatment from a patient is made by the doctor in consultation with the patient if he/she is able to make decisions and the family. The practice currently of the withdrawal of life-support process is for the doctor to give the order that treatment will be withdrawn from the patient. In some situations however the doctor will just write to withdraw mechanical ventilation, but will not specify which process to follow. If the patient is on inotropic support the order normally states to wean and stop the inotrope, but there are no guidelines from the doctor of which weaning protocol to follow.
In the literature there is no clear guideline that describes the process to follow when withdrawing life-support treatment from a patient, but there are suggestions of processes that can be followed. The fact that a protocol or guideline for the process of withdrawing life-support treatment is not available in the intensive care unit where the study will be conducted, will leave the professional nurses with no choice but to lean on their own experience and that of their colleagues and shift leader in order to decide on a process to follow.

**Objectives of the study**

a. To explore and describe the perceptions of professional nurses with regard to the process of withdrawing life-support treatment in a private ICU.

b. To make recommendations to assist professional nurses with the process of withdrawing life-support treatment in a private ICU.

**Proposed methodology:**

The proposed study will follow a qualitative, exploratory, descriptive and contextual design. Purposive sampling would be utilised which means that only certain people will be asked to participate in the study. Interviews would be conducted with participants in order to collect information regarding perceptions of professional nurses of the process to follow when withdrawing life-support treatment. The interviews will be recorded and transcribed and kept safe for a period of five years. The data will be kept strictly confidential at all times.

To participate, it will be required of participants to provide a written consent that will include your signature, date and initials to verify that you understand and agree to the conditions.

Participants have the right to query concerns regarding the study at any time. Immediately report any new problems during the study, to the researcher. Telephone numbers of the researcher are provided. Please feel free to call these numbers.

Participation in research is completely voluntary. You are not obliged to take part in any research. If you do partake, you have the right to withdraw at any given time,
during the study without penalty or loss of benefits. However, if you do withdraw from the study, you should return for a final discussion or examination in order to terminate the research in an orderly manner.

If you fail to follow instructions, or if your medical condition changes in such a way that the researcher believes that it is not in your best interest to continue in this study, or for administrative reasons, your participation maybe discontinued.

Although your identity will at all times remain confidential, the results of the research study may be presented at scientific conferences or in peer reviewed journals.

This informed consent statement has been prepared in compliance with current statutory guidelines.

Yours sincerely

Ms E. Pheiffer

Student number: 212414658
Annexure D: Information and informed consent form

NELSON MANDELA METROPOLITAN UNIVERSITY

INFORMATION AND INFORMED CONSENT FORM

<table>
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<th>RESEARCHER’S DETAILS</th>
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<tr>
<td><strong>Title of the research project</strong></td>
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A. DECLARATION BY OR ON BEHALF OF PARTICIPANT

I, the participant and the undersigned (full names)

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OR

I, in my capacity as (parent or guardian)

| of the participant (full names) |
| ID number |

| Address (of participant) |

A.1 HEREBY CONFIRM AS FOLLOWS:

I, the participant, was invited to participate in the above-mentioned research project that is being undertaken by Evette Pheiffer from Nursing Science Department of the Nelson Mandela Metropolitan University.
THE FOLLOWING ASPECTS HAVE BEEN EXPLAINED TO ME, THE PARTICIPANT:

| 2.1 | Aim: | The investigator is studying the perceptions of professional nurses in an ICU with regards to the process to follow during withdrawing life-support treatment.  
The information will be used to make recommendations to assist professional nurses with the process of withdrawing life-support treatment in a private ICU. | Initial |
| 2.2 | Procedures: | I understand that I will be interviewed and that the interview will be recorded with the use of a tape recorder. | |
| 2.3 | Risks: | None | |
| 2.4 | Possible benefits: | As a result of my participation in this study the researcher will be able to use the information to make recommendations to assist professional nurses with the process of withdrawing life-support treatment in a private ICU. | |
| 2.5 | Confidentiality: | My identity will not be revealed in any discussion, description or scientific publications by the investigators. | |
| 2.6 | Access to findings: | Any new information or benefit that develops during the course of the study will be shared as follows: | |
| 2.6 | Voluntary participation / refusal / discontinuation: | My participation is voluntary | YES | NO |
| 3. | THE INFORMATION ABOVE WAS EXPLAINED TO ME/THE PARTICIPANT BY: | Initial |
| (name of relevant person) | in | Afrikaans | English | Xhosa | Other |
| and I am in command of this language, or it was satisfactorily translated to me by | |
| (name of translator) | I was given the opportunity to ask questions and all these questions were answered satisfactorily. |
4. No pressure was exerted on me to consent to participation and I understand that I may withdraw at any stage without penalisation.

5. Participation in this study will not result in any additional cost to myself.

### A.2 I HEREBY VOLUNTARILY CONSENT TO PARTICIPATE IN THE ABOVE-MENTIONED PROJECT:

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### B. STATEMENT BY OR ON BEHALF OF INVESTIGATOR(S)

1. I, (name of interviewer) declare that:

1. I have explained the information given in this document to (name of patient/participant) and / or his / her representative (name of representative)

2. He / she was encouraged and given ample time to ask me any questions;

3. This conversation was conducted in Afrikaans English Xhosa Other

And no translator was used OR this conversation was translated into (language) by (name of translator)

4. I have detached Section D and handed it to the

### C. IMPORTANT MESSAGE TO PATIENT/REPRESENTATIVE OF PARTICIPANT

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Dear participant/representative of the participant

Thank you for your/the participant’s participation in this study. Should, at any time during the study:

- an emergency arise as a result of the research, or
- you require any further information with regard to the study, or
- the following occur

(Indicate any circumstances which should be reported to the investigator)

<table>
<thead>
<tr>
<th>Kindly contact</th>
<th>Evette Pheiffer</th>
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<tr>
<td>at telephone number</td>
<td>041-3794546</td>
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Annexure E: Interview 1

**R:** Researcher

**P:** Participant

*Italic script:* softer voice

CAPITAL LETTER SCRIPT: louder voice

**Bold script:** emphasis on word

**R:** Date of interview is the 2nd of October 2014

The place is Port Elizabeth

Interviewer is Evette Pheiffer

(The participant sitting on a chair opposite interviewer)

**R:** Thank you for taking part. Um, I’m gonna ask you as few questions and I just want to first start with how long have you been working in ICU in general and then, particularly in the ICU that we, we are talking about now?

**P:** *O my gosh,* I grew up in ICU, *[laughter]*, about 1968, 69 I think. And here when I stopped working, I retired, that was just about seven years now, I suppose. On and off, first a bit at Green Acres, but most, some of, some of it here.

**R:** Okay, and specifically have you had any experience with withdrawing patients from treatment, you nursing the patient… or helping with other staff?

**P:** We don’t do it that often here, um… that’s a bit of a problem. I think sometimes just like with pulling off Dobutrex or um… Adrenaline and *then* really um, to wean ventilation down, but sometimes occasionally it would be a bit of Adrenaline or taking off the inotropes, but nothing as drastic as pulling off the
ventilator, unless there’s been a brain death or, but we don’t often go down to air and pull out ventilation.

R: Can you maybe try to remember specific incidences of cases where, not necessarily the detail of what happened to the patient, but details of the process, when you’ve withdrawn, coming from doctors’ orders to doctors’ involvement with family and with you as the registered nurse?

P: Um, I was thinking of a patient recently that had said and was with the full consent of the doctor that we gave a trial ventilation and trache and then weaning off trache and then if that didn’t work it would be, um… left to God’s good air to keep it going, um. That was with the doctor and her having a very frank discussion. I think it was initiated by the patient, um, and I think that was done except that the doctor wasn’t there over the weekend and so it was a little bit prolonged, um, but I think that was a very nice case that I remember. Most times we tend to just hang on here, and very seldom withdraw. We might maintain, maintain status quo and not escalate, but withdrawal is a very, it doesn’t happen very often here that I can think of.

R: And for the odd cases, say for instance with the inotropes that had been withdrawn, um, do you, do you find that you get specific orders from the doctor, how to go about withdrawing the inotropes or in some cases ventilation? Or is it just, how, how do they do it? How do you know how to go about?

P: I think we quite often, they would just say you know, maybe withdraw the Adrenalin or slow down with the Adrenalin, but there’s very seldom, um, withdraw to 2 ml/hour or a specific rate or, it’s never just switch off the Adrenaline, unless there’s been a resus, a futile resus. Um, it’s, I can’t think of an occasion that I’ve actually been involved here, there’s been…

R: So, um…

P: It might, as I said what we normally do is don’t escalate, but I haven’t really had, that I can think of pulling, or pull out the Adrenaline and if there has been an order that I’m aware, that I can think of, it was just withdraw… slow.
R: Ja, um, do you think that’s a healthy thing for us as nurses?

P: No, um, I think it leaves you open to criticism from colleagues if you going too fast, or all colleagues might not feel the same and... it’s, it’s actually very ambivalent, because people have ambivalent feelings, so I think we actually need to have some form of a... a committee where these decisions, ‘cause again we look at the doctors, they are all involved with our longer-term patients, because they’re on call and they do call, so they all know all the patients, most of them. Um, so I actually think that they need to have a weekly progress thing and say, we’re doing this and... I actually think, I wasn’t involved personally, but I think with um, the patient where the, a patient with aortic incompetence, um, and I think that, not valve, the whole aorta was occluded and I think with that patient there was a, quite a good, the decision was made, the dialysis was stopped and again the, um Adrenalin was, as far as I could understand was just withdrawn gradually, but I am not sure about rate or... We do escalate on maybe a little bit of sedation to keep the patient comfortable.

R: So is that something that you feel you see at least that we do give some form of sedation or pain medication.

P: We definitely, that is a, a stepping up of sedation and pain medication to make the patient comfortable, um, despite the fact that it might drop blood pressure a little or, thing, so I think we do escalate on the comfort side, but we don’t do much active withdrawal.

R: And, um, this escalation of sedation and pain medication, is it normally initiated by the physician, or is it, do you feel it comes a lot from the nursing side, asking doctors if you can escalate?

P: Because we’re there most of the time they rely on our input as to the patients’ needs, so I think it is escalate, it is initiated most times by the staff, by the nursing staff.
R: And, so one of the suggestions you made was maybe to have some form of a committee, um, almost like an ethical committee. Do you think there’s place for a registered nurse in that ethical committee?

P: There must, there **must** be, because we’re the ones who carry out the orders, so there **must** be representation for the registered nurses.

R: And with the ethical committee, do you think there’s some other recommendations you can make for, especially for our newer staff, our younger staff that’s just finished, that will probably still stand in these positions? Do you think there’s other recommendations that **you** can think of that we can maybe bring into place in the unit?

P: I, I’ve read a, it was, it was a really old article now, but at the time, and I still think that was a very good article. *Now I can’t remember who the author was,* but it was, they had resuscitation codes… and their codes would be like an “A”. Code “A” is full resus, which would mean full fluids, inotropes, massage, defibbing, a full, full blown resus. Then a code “B” is everything, if you need like, if you need fluids, if you need gasses and that, we would give that, **but**, if there was a cardiac arrest, respiratory arrest it would not be escalated further than that. You would not go to cardiac massage, defibbing, intubation, ventilation. You would give everything up until that point and if they faded out on that, that’s fine. And then the next code would be, um, we would… just keep give fluids and that, but **don’t** give the next blood transfusion, don’t order the platelets, inotropes, don’t go that way. And then the final one is TLC only and, do **not** initiate any inotropes, anything um, no blood, if the patient bleeds it’s a bleed, if the patient drops their blood pressure, that’s a dropped blood pressure, you **just give comfort.** And I think those codes would, if they’re very clearly defined, um, it’s, it’s an easier way for the doctors to make decisions, um… because you’ve got steps you can take, but at the moment we’re guideless and we’re rudderless. Everybody hums and hahs, and says, I should talk to the family, maybe we need to, but, um, unless it’s family driven and the family is stepping in, but again then you would get one person in the family, which becomes a little bit difficult.
R: Do you that feel our nursing staff get involved enough with the family to maybe initiate some kind of discussion?

P: Um, no, because quite often you get, you’re there with the patient for two days and you get quite close to them and then you’re off for two days and you come back and you’re on the opposite end of the unit and you sort of distance yourself, you’ve got another problem. You distance yourself from that patient. You greet them as you walk pass, but you’re no longer involved in the patient’s personal care, so you step aside and worry about the next one. So there’s no, we miss out on continuation. The staff need a break sometimes, but I think quite often if you do have a very good recall with the family, you need to, and I think quite often we do, we do say to the doctor, look, I think we need to go this way, and the family are leaning to this way. So you give them a guide of what way they’re going. But we need steps, we need a, a structure about how to do it.

R: Because we’re flapping around at the moment. [Laughter]

P: Verdwaalde Jode (Lost Jews) [Laughter]

R: Um, anything else, anything else you want to suggest or you’ve got to say on this?

P: You’re talking about the younger staff. I actually think they need to be initiated into the thing that, you have to look at long-term outcome, long term results as well, um, just… [sigh] just keeping the patient alive is, life is not the absolute value. If it was an absolute value, there would be no suicides, but, life is not an absolute value, so… And quality of life is different for everybody else. One guy will fight for his every breath, and the next one, so you have to have a lead from what the patient’s wishes are and the family’s wishes.

R: In which way do you think can we get the younger staff into, into this whole thing of withdrawal, not as a much accepting it, but… coping with it.
P: I think they all need to (a) attend some of the um, committees, if there is a committee. Um, I'm not sure if this hospital has a, we used to call it a, M and M meeting.

R: No, we actually don’t.

P: Um, and I think those were very good, because you were exposed to what was good with, with some disasters, what wasn’t good, where we could improve, where we could handle things maybe a little differently… um, and I also think sometimes there’s a difference in opinion between the different doctors dealing with the patient. They also need to talk to each other, so that they come out with a cohesive plan. You know one will look at the, and said the PTT in that one is not going to make any difference; meanwhile this guy is dealing with a bleed in the lung and a clot, um, so his worried about clotting factors, the other one is saying it’s not going to make any difference, um, why do you want to do those? Why don’t you use the FFP, that’s, that would be better? So I think maybe they need to when we, especially when we have a critically ill patient, talk to each other as well.

R: Ja, and get some advice from the others as well. Okay, thank you very much. I’ll take all of this into consideration. [Laughter]

P: Pleasure.
Annexure F: Field notes

Interviewer: Sr. E. Pheiffer

Interview date: 02/10/2014

Methodology

The interview was conducted in the counselling room in the hospital during the day. Adequate lighting and ventilation was ensured through an air conditioner and electrical lights. The participant was on duty on the day of the interview, but the interviewer made sure that someone was looking after her patient while the interview was conducted. Cellular phones were switched to silent in order to limit interruptions. The interviewer and participant sat on opposite chairs from each other. Construction sounds could be heard, but the participant’s responses were clearly audible.

The participant appeared relaxed and employed an open body posture during the interview. The participant responded openly and honestly to questions throughout the interview and was even making jokes at times. The participant did not need prompting in giving more detail for questions asked.

Personal reflections

The researcher was becoming a little more accustomed to the process of interviewing as it was her fourth interview and the relaxed demeanour of the participant made it even easier conducting the interview. Eye contact was maintained throughout the interview.

Contributing factors

The participant showed a lot of interest in the topic and had some good suggestions to assist the researcher. The participant was also excited about the outcome of the research and what it can imply for nursing practice in the ICU.
Annexure G: Interview 2

R: Researcher

P: Participant

*Italic script:* softer voice

CAPITAL LETTER SCRIPT: louder voice

**Bold script:** emphasis on word

R:   Date of interview is the 3rd of October 2014

The place is Port Elizabeth

Interviewer is Evette Pheiffer

(The participant sitting on a chair opposite interviewer)

R:   Thank you so much for taking part in the research study today. I know it is sensitive issues, but if there is anything, please ask. I would just like to know from you, how long have you been working in this specific ICU?

P:   I started last year 2013 late August until now, so I’m still in the ICU.

R:   And you recently qualified as a registered nurse?

P:   Yes, as a registered nurse.

R:   Now, tell me. Have you, in the time that you’ve been working here nursed a patient where they withdrew treatment?

P:   Yes, I had a patient… it’s about a month ago, yes, September, early September I had the patient in ICU. My patient was declared brain dead by one of the doctors. The doctor just came in, I took handover on the Monday for that patient. The doctor came in and tested the patient neurologically to
see if there was any eye movement and the patient was on a ventilator, so he also disconnected the patient from the ventilator to see if there was any spontaneous breathing, if the patient breathed spontaneously, but there was nothing. Um... but the patient coned with the night staff and they informed him, so he knew about it. He came the next morning like I said and did the tests, and just wrote down that the patient is brain dead and that we need to inform the family, and he left. I then went to our shift leader and told her what doctor said. She just told me that we just need to contact the family and also contact the doctor to ask that he speaks to the family to inform them of the patient’s condition. We contacted the doctor, but he was not available as he was busy operating in another hospital. He did say that he will come and see the family later in the day, um, but he couldn’t make it due to an emergency operation that he needed to perform. He contacted one of the physicians later that night to come and speak to the family, because he couldn’t make. The brain dead test was then done to confirm brain death and the family was informed by the physician late that evening.

R: So the next day you worked with the patient again?

P: Yes, the Tuesday I worked with the patient again. The night sister handed over to me that the doctor came out and spoke to the family. I was an emotional time for them and um... [emotionally upset]. The family said they want to come the next day, because they’re a Xhosa family and in their culture they must go with the elders to discuss the decision. The wife is not that involved in the decision. So they went home the night to discuss the decision and would come back the next day, (that’s now Tuesday) to inform us of their decision. So, late the Tuesday they came back with the decision whether they’re going to switch off the machines. They eventually came and their decision was for us to switch off the machines. So we put the patient on a t-piece, no, we adjusted the ventilator settings.

R: Can you remember which ventilator settings did you adjust?
P: We adjusted the PEEP (positive end-expiratory pressure) and pressure support as well as the oxygen settings and the rate we switched off. The patient just slowly…

R: How did you know what to do?

P: As a newly qualified sister, it was my first patient, so I got guidance from my shift leader. She took me through the whole process. She definitely guided me, was it not for her, I don’t think I would’ve managed with the patient.

R: Yes, it’s a very difficult situation, especially the first time and I can tell you it doesn’t get easier. It stays a difficult thing to do, but… you understand why? Do you understand why it was done? [Visibly emotional]. It’s fine, you understand. Tell me, it’s difficult to talk about it, if you want to we can fist stop.

P: It’s fine.

R: Are you okay? Another case where you were involved with? I’m not sure which one was more emotional.

P: Oh, my second case was also a patient in ICU. Because I nursed her before… [very emotional]

R: Are you sure you don’t just want to stop for a while?

P: No, I’m fine. Okay, my second patient was a female patient that I nursed. One of the doctors came in, and he has spoken to her husband the previous day regarding withdrawing treatment. She was on Adrenalin and doctor wanted us to stop it, but she was also ventilated. The doctor came that morning that I worked with her. Let me start with the previous day they wanted to start withdrawing treatment, but they first had to discuss it with the husband and family. So doctor discussed it with the husband and he understood the condition of his wife. It was just quite difficult for the family to accept. So that day doctor stopped the Adrenalin. We continued with the other medications and she was still ventilated. The Adrenalin was still on 5
and after I stopped it, more or less a half an hour after that, the blood pressure started to drop. We informed the family, especially the husband to tell them they must come in. Her husband and daughters came and we explained to them that her condition is deteriorating and… not to say their last good byes, but… to be with her.

R: Now we look again at stopping the Adrenalin. Did doctor write the order down on the ICU chart, and if he did, what did he write?

P: He wrote on the ICU chart to stop the Adrenalin, but verbally he said just to keep the blood pressure on a stable level, like 90 systolic, because when the family comes the first thing they look at is the blood pressure and that the saturation is 100 percent. That was basically all order he gave us.

R: So on the one hand he wrote to stop the Adrenalin and on the other hand he said to keep the blood pressure above 90. How did you go about with that order?

P: It’s difficult to maintain a blood pressure if the patient is dependent on Adrenalin. In a half an hour’s time from stopping the Adrenalin the blood pressure dropped from 101 to 95. I told the shift leader on the day, she was with when doctor gave the orders and she told me that there is nothing we can do if the blood pressure drops and if the family arrives at that time, that we cannot say much more to them than it was doctor’s orders and if they have any questions that they must discuss it with doctor. Her blood pressure fluctuated during the day. The other order was also to stop dialysis, so she didn’t receive dialysis that day. So, yes, it was difficult to maintain the blood pressure if the Adrenalin was stopped and you cannot do or give the patient anything else.

R: So that actually confused you a little bit when doctor tells you to stop Adrenalin but to maintain the blood pressure?

P: Yes.
R: I can think that was a bit difficult. [Laughter]. Okay, as a newly qualified sister, you had two of these difficult experiences, what do you think we can do in the unit to make it easier to know what to do in these circumstances, although it’s always going to be difficult?

P: Firstly, in cases like these doctors need to give clearer orders. Like in the case I had, you cannot say stop Adrenalin, but keep the blood pressure stable. So if he can then rather say try to wean the Adrenalin, that is a clearer order. Secondly, the doctors must be there, like in my first case, the doctor was not there the whole day. We had to “comfort” the family by saying the doctor is on the way, he’s just busy with something. It is one of those cases where they have to be there, not just for the patient, but also for the patient’s family. It is still the doctor’s responsibility, it doesn’t mean if the patient is brain dead that you can just leave the patient or family. He must still be there emotionally and support the family, even if you just come to inform the family of the patient’s condition and what to expect further on. Just help the family through that process. I also think that, as sisters, we are left to our own grace when there are no orders. So we are left, especially the shift leaders to call the doctor every time to ask where must we go from here. So yes, just clearer orders from the doctors and support to the family. As a doctor you can’t say that I have a next case, because from your side there is nothing you can do for the patient anymore.

R: Do you think it will help if we have a guideline that the doctor can sign that we can work from?

P: Yes, definitely. Like I say, we are left to our own grace if there are no orders.

R: How did it make you feel when you had to do these things and you didn’t have any guidelines?

P: It felt to me I had to go to the shift leader all the time because she is more experienced than me, but even for her it was difficult, because there are just no orders. I felt incompetent and felt that I put my burden on the shift leader as well, further, I know nothing. So I know, as shift leader she has many other
duties and on top of that she has me and my patient and we have a family that we need to support and handle. It’s really difficult.

R: It was really interesting to hear your side and your story. Is there anything else you would like to add?

P: I would like to say that I think that we… In my case it was the doctor. I am very upset with the way he handled the family, like I said, it’s a very sensitive topic, especially if a family member is taken in such a way. I think more involvement from the doctor, especially to speak to the family and stay involved. Don’t just think you did your duty by speaking to the family and leave the rest to the nurses. I think more involvement from the doctors and proper guidelines will really help.

R: Thank you very much,

P: Thank you.
Annexure H: Field notes

Interviewer: Sr. E. Pheiffer

Interview date: 03/10/2014

Methodology

The participant was interviewed in the counselling room in the hospital during the day. Adequate lighting and ventilation was ensured through an air conditioner and electrical lights. The participant was on duty on the day of the interview, but the interviewer made sure that someone is looking after her patient while the interview is conducted. The door was closed and a notice was placed on the outside of the door in order to limit interruptions. Cellular phones were switched to silent in order to limit interruptions. The interviewer and participant sat on opposite chairs from each other. Construction sounds could be heard, but the participant’s responses were clearly audible.

The participant appeared nervous but still employed an open body posture during the interview. The participant responded openly and honestly to questions throughout the interview. The participant did not need prompting in giving more detail for questions asked. A few times the participant became very tearful and overwhelmed by the memories and needed some time to compose herself. The interviewer did ask her if she wanted to stop the interview, but she willingly continued.

Personal reflections

The researcher was becoming increasingly more accustomed to the process of interviewing as it was her seventh interview. It was a new challenge though to interview a participant that is so emotional, but although the participant was emotional, she was still comfortable in the interviewer’s presence. Eye contact was maintained throughout the interview, except during times when the participant was thinking about a question. During times when the participant was tearful the researcher refrained from providing advice or counselling.
Contributing factors

The participant showed a lot of interest in the topic, especially being a newly registered nurse. The participant was also excited about the outcome of the research and what it can imply for nursing practice in the ICU.