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Nurses' Narratives of Unforgettable Patient Care Events

Mary Gunther, Sandra P. Thomas

Purpose: *To explore the experience of registered nurses (RNs) caring for patients in contemporary hospitals.*

Design: *The descriptive phenomenological study was based in the philosophical perspectives of Husserl and Merleau-Ponty.*

Methods: *A purposive sample of 46 RNs employed in acute care hospitals in the southeastern United States (US) were recruited by network sampling. Data from unstructured interviews were analyzed in an interpretive group and themes were identified.*

Findings: *Four themes were identified: (a) extraordinary caregiving events, (b) incomprehensibility, (c) questioning whether anything else could have been done, and (d) "alone or together," indicating the isolation nurses often experience while giving care as well as profound moments of connection, especially with patients.*

Conclusions: *Caregiving experiences resulted in an accumulating residue of moral distress which in turn became ground for future experiences in the everyday work life of RNs. Sometimes years later, participants were still trying to justify and understand the outcomes and perhaps to absolve themselves from blame. Participants were confronted with the limits of science and skill and plunged into the realm of existential questions for which they had no ready answers.*

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[Key words: hospital nursing, phenomenology, moral distress]

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The combined forces of economic reform and organizational restructuring have changed nursing practice in hospitals in many parts of the world. The work of registered nurses (RNs) remains largely invisible and undervalued by society, physicians, and administrators (Duffy & Hoskins, 2003; Lawler, 1993; Liaschenko & Peter, 2004). A survey conducted to measure the quality of nursing worklife in the Midwestern United States (US) showed that 74% of the RN respondents (n=341) "agreed that society does not have an accurate image of nurses," and while 70% believed that physicians respected them, only 37% felt respected by upper management (Brooks & Anderson, 2004, p. 271). Ray et al. (2002) quoted an RN as saying that administrators "don't understand what it takes to be a nurse in this day and age" (p. 10). Such perceptions lead to feelings of loss of trust and disillusionment. Subsequently, many registered nurses (RNs) "love" their work and "hate" their jobs (Berliner & Ginzberg, 2002).

The specific aim of this phenomenological study was to explore the experience of registered nurses (RNs) practicing in contemporary hospitals. Abundant quantitative research has been conducted on variables such as job satisfaction and perceived stress, preselected by the researchers. Few studies have been done on areas of concern from the perspectives of RNs about caring for patients (Chard, 2000; Jennings & McClure, 2004; Van Maanen, 1990). As Chang et al. (2002) noted: "Lack of information about nursing practice patterns may limit the ability of nursing leadership to develop and evaluate innovative approaches to improving the quality of nursing care" (p. 406). In this study we explored the reality of practice as revealed in nurses' own words.

Background

The authors conducted an extensive review of quantitative and qualitative research literature, a complete summary of which is beyond the scope of this article. Because the data in this study were nurses' actual words, the literature review for this article was restricted to qualitative research studies and conceptual literature about hospital nursing from RNs' perspectives. The review included international nursing

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publications primarily from the US, Canada, the United Kingdom (UK), Australia, and Sweden. When nurses were asked to talk about caring, they often began by describing the relationships they have with patients. In Sweden, Astrom, Norberg, Hallberg, and Jasson (1993) asked 45 RNs "What does caring really mean to you?" Participants described interactions as being of three kinds: (a) monitoring from a distance; (b) being available when patients had needs; and (c) being present at the bedside in a deep commitment. When asked when caring makes a difference, they spoke of establishing the RN-patient relationship, performance of medical interventions, and situations requiring practical problem-solving.

Begat and Severinsson (2001) asked nurses to reflect on episodes occurring during the provision of care. Participants defined caring as the ability to create a relationship, the ability to understand a patient's suffering, and taking responsibility for technical aspects of physical care. Lack of time and feeling out of control in chaotic environments were seen as barriers to establishing relationships. The inability to understand the patient's suffering was related to communication problems, inexperience, and lack of resources.

Nurses in the United Kingdom, Canada, and Australia appeared to have similar views. Beeby (2000) asked nine intensive care unit (ICU) nurses in London to tell about "the last time you truly felt you cared for a patient" (p. 152). Although the focus in the ICU was on physical care, the nurses did describe being involved with patients and families on a personal level. Caring also involved sustaining a patient's physical stability and emotionally supporting the family. Meeting a patient's needs through technical interventions and being a patient's advocate within the healthcare team were identified as manifestations of caring. Nurses spoke of being frustrated in their attempts to display caring when they encountered communication problems with a patient, family, or the healthcare team members because of lack of time, feedback, or understanding.

Henderson (2001) explored the concept of emotional labor during individual and focus-group interviews with 49 nurses in Canada. The majority of these nurses viewed emotional engagement as a prerequisite for the provision of excellent nursing care. However, achieving emotional engagement frequently is thwarted by being forced to deal with "hassles" such as the physical layout of units, interruptions, and completing the work of other healthcare providers (Beaudoin & Edgar, 2003). In Australia, Irurita (1996) found that lack of time and resource availability, coupled with increasing patient acuity, inhibited the development of caring nurse-patient relationships. This failure resulted in feelings of guilt, dissatisfaction, and stress (Irurita & Williams, 2001).

In the US, Ebright, Patterson, Chalko, and Render (2003) conducted a micro-ethnographic study with eight medical-surgical RN participants to understand the complexity of acute care work. Similar to the findings of the Canadian study on "hassles," the physical layout, supply problems, and having to wait on organizational processes to complete care left the nurses feeling tired and frustrated. Using emancipatory methodology, researchers in the northeastern US convened groups of nurses to reflect on their practice (Jacobs, Fontana, Kehoe, Matarese, & Chinn, 2005). Loss of control, powerlessness, fragmentation, frustration, and overextension were reported, along with the apt metaphor of "being buried in the sand" and trying to dig their way out (Jacobs et al., p. 10). RNs queried by Turkel (2001) described caring as "being, knowing, and doing all at once" (p. 72). Having to do so in a chaotic environment was "disturbing and distressing" (p. 73).

Methods

This descriptive phenomenological study was based in the philosophical perspectives of Husserl and Merleau-Ponty as interpreted by Pollio, Henley, and Thompson (1997) and Thomas and Pollio (2002). After obtaining university IRB approval, graduate research assistants (GRA) conducted 46 interviews in southeastern Tennessee during an 18-month period. Using network sampling, nurses working in hospitals were approached by the graduate students and invited to participate in the study. The criteria for study participation were: (a) licensed registered nurse; (b) employed in a hospital setting; (c) employed in hospitals for at least 3 years (duration of experience needed to attain competence and knowledge of topic); and (d) willing to talk to the researcher for approximately an hour about their experience. After the study was explained and written informed consent obtained, a 60 to 90-minute interview was scheduled, with the time and setting at the convenience and preference of the participant.

The interview was an individual, in-depth, nondirective interview like those conducted by Thomas and colleagues in previous phenomenological studies (Thomas & Pollio, 2002). The interviewer asked participants to "Tell me about a time that you provided nursing care to a patient." During the narration, the interviewer spoke only to seek clarification or elaboration. Consistent with the tenets of phenomenological methodology, no prespecified agenda or list of questions was used. Interviews were audiotaped and transcribed verbatim. Names of places and people were changed during transcription to maintain confidentiality. The principal investigator and graduate assistants participated in bracketing interviews to identify preconceived ideas regarding possible research findings.

The purposive sample included representation of several clinical specialties: medical-surgical (MS, n=6); emergency department (ED, n=10); intensive care (ICU, n=7); oncology (ONC, n=10); pediatrics (PEDS, n=10); and obstetrics-gynecology (OB-Gyn, n=3). Demographic information was collected from all participants. The nurse participants ranged in age from 23 to 64 years, with an average age of 40. Ninety-six percent of the participants were Caucasian women, consistent with the racial composition of the nursing workforce in the area. Educational levels also reflected

the general nurse population: 17% diploma, 28% associate degree, 45% BSN, and 10% MSN.

Analysis of the data included identification of both the contextual ground and the figural (predominant) themes which stood out in participants' perceptions: "Figure and ground co-create each other in human experience" (Thomas & Pollio, 2002, p. 18). An interdisciplinary phenomenology group consisting of faculty and students, co-led by Pollio and the co-principal investigator (Thomas), contributed to the rigor of the analysis, providing critique and consensual validation of the thematic structure delineated by the principal investigator (Gunther). Members of the group signed confidentiality agreements before working with the interview transcripts. Approximately half of the transcripts were read aloud and categorized in themes in group meetings during the 3 years of data analysis.

Findings

An overwhelming majority of the participants had no difficulty in answering the question "Tell me about a time when you provided nursing care to a patient." Their responses were immediate, detailed, and intense. Only two participants seemed unable to focus on specific patients, instead describing a "typical" day or the technical tasks performed. Grounded in the routines of mundane everyday work life, four themes were identified as figural across clinical specialties: (a) extraordinary events disrupted the routine; (b) these events were incomprehensible in nature or led to postevent questioning; (c) participants sought to understand what could have been done differently; and (d) participants described both being alone in the situation and working closely together with either the patient or colleagues.

Extraordinary Events

Many nurses began their stories by relating how ordinary everyday work life is. As one oncology nurse (#4) noted: "There are so many things that happen everyday, it's kind of a grind and then you get in a rut, but one sticks out in my mind." An emergency department nurse (ED #2) said, "You see so many [patients] every day, they all tend to run together, and there are very few things that stick out in your mind." In contrast, as the study participants related narratives of extraordinary events, they used the phrases "most memorable" or "I'll never forget." These stories were told in exquisite detail. Often they resembled change-of-shift report, providing assessment data from the range of systems including vital signs and laboratory results. The first sight of the patient foretold the future: "I was working in the CVICU and would come in to this lady screaming and five people holding her in the bed, trying to get her intubated. I was like, 'Oh, boy. This is going to be a long day'" (ICU nurse #4). Another ICU nurse said, "I mean, he just had impending doom written all over him. He was . . . one of those patients that I knew something wasn't quite right."

These extraordinary events included extreme examples of the unexpected horror of mutilated bodies, burns, and gross, bizarre injuries. One nurse (ED nurse #4) said, "Well, in the emergency room where I work, some of the worst cases always kind of stand out in your mind." An MS nurse (#1) described one patient as: "split from her knee almost up to her pubic area and laid wide open on both legs." An ED nurse (#4) recalls treating a burn victim: "They had to do what's called an escharatomy, bilaterally on both sides of the chest and it was the grossest thing I've ever seen done. It's literally filleting him on both sides." An ICU nurse (#1) recalls a pediatric patient whose father had amputated the child's leg in a lawnmower accident. She will never forget that, "When the family brought in the bag that had the pieces of the leg and foot in it, the foot itself still had the sneaker on it."

Despite heroic effort, many of the narratives concluded with the death of the patient. The losses took a powerful emotional toll, especially when the nurse felt a sense of powerlessness at averting the patient's inevitable demise. But as one oncology nurse (# 9) said: "I'm not always crying." A very few and quite endearing narratives related unexpected humorous situations and at least one of them is worth repeating in its entirety as an example of true caring. An oncology nurse (#5) recalled:

> We heard a scream coming from her room. We ran in there and everyone in the station ran into the room to see what was wrong. And she said, "I'm falling, I'm falling." And she had not been confused to this point. She really thought she had fallen to the floor and we were, you know, trying to comfort her and I noticed that the air hose had come out of the mattress. To her, she really had fallen. The air mattress was completely flat. So I said "Here's our problem." I hooked it back up and it floated her back up in the air and she absolutely loved it. She said, "Oh, this is nice," and laughed. She wanted me to do it again, and so she made me unhook it and plug it back in. So we did this for about 30 minutes to an hour.

Incomprehensibility

Except for a few humorous vignettes such as the foregoing, events described by participants tended to be catastrophic and tragic, catching them unprepared, and leaving them to ponder mystery ("You couldn't get the answer. . . . I've always wondered why"). For example, an ICU nurse (#2) recalled an unexpected death: "She was not a smoker. She was not a drug abuser. She was a healthy young girl who I knew had a lot going for her. Why did this complication happen to her? We still will probably never know." A pediatric nurse (#6) telling of the death of a young boy said:

> We were all very, very, very, very traumatized, like I mean, it was just horrendous because we really felt like we had done everything. You know, we were just kind of desperate to save him. Despite all of our efforts, he still died. We hadn't got to him too late. You know, we had had him the entire course of his illness. And then we still hadn't saved him. That's when it's really hard when you have to look at people and say we don't really know why they died, but they died. And that sounds really lame.

One way of coping is trying to understand what happened and why. Retrospective reflections on giving care to these patients appeared to be aimed at making meaning from incomprehensible events. The nurses appeared to be attempting to cope with the mystifying outcomes of care and their own distress by identifying "lessons learned" that in some way changed their practice. An ED nurse (#7) reflected:

> None of our nursing skills could save him. The things I learned from him were the importance of acting quickly, but also the importance of teamwork. Because we were in a situation where we had enough team members to come in and provide the care that he needed. But it still didn't make a difference.

Even seemingly miraculous recoveries stimulate the search for meaning: "You know, he started getting some renal function back which was kind of amazing" (ICU nurse #5).

Questioning

Even when "what and why" are known, nurses frequently wondered if they could have done something else to change the outcome. An oncology nurse (#5) recalled a patient who died unexpectedly while she was at lunch:

> You sort of relive the experience and you think, "What should I have done different?"...Guilty, guilty! I mean what did I do? But I did not do anything. I just went to lunch. He was fine, he was just sitting up in the bed talking, and he just bled out, just in no time.

Nurses frequently wondered about their actions and inaction as one ICU nurse (#4) described:

> You know, if I had called the ER doctor and said, "Look, I'm about to have a code, could you come intubate my patient?" that lady may have made it. Or if I had, you know, not let him give her atropine or if I had made him, after the first time he tried to intubate her with his knee on the bed, if I had made him stay away from her—I don't know.

An ED nurse (#10) recalled a case from her new-graduate days that still haunts her:

> I was frustrated then, a new grad and having somebody go bad, you know, really quickly, downhill really quickly, and even though everybody was trying to be helpful, you know, there wasn't anything I could actually do that was going to make a difference in the ending outcome, and fairly early on I could tell that it wasn't going to be good.

Alone or Together

The isolation of a nurse giving care was prominent in many narratives, as participants related incidents of working alone against the odds. An ED nurse (#9) explained why she transferred out of the ICU: "I felt like we were alone quite often. I think that in the ICU where I worked, a lot of the nurses were burned out and didn't realize it and did not want to get up and help other people, to care for these patients, because they were just tired of it, they were tired of it all." Another ED nurse (#1) had also left the ICU, saying, "The ICU nurses I was working with, they were kind of arrogant, because they knew a lot. And whenever you would ask them things, they kind of thought you were stupid. And that wasn't a real comfortable experience." An MS nurse (#2) described how her colleagues laughed in reaction to her story of the dying patient who believed he had seen Jesus. She was disappointed and "never thought nurses could be like that." For the most part, these nurses believed that, although they worked alongside others, they were not really a team because "We don't really know much about each other" (ED nurse #8).

On the other hand, some nurses, especially those working in oncology, believed that their coworkers shared a camaraderie that made everything worthwhile and kept them from leaving the profession. An ED nurse (#1) describing a chaotic shift praised her coworkers:

> And then at once we all came together. I mean it was like one of those things where as, I think if individually each one of us walked in, we probably couldn't have done it. But to have the whole group there, it kind of helped to pull each other through, the time of the crisis. In order to get things done for that patient.

Nurses who were friends with their coworkers benefited from the support offered to them. As an OB nurse (#1) explained, "One of the other nurses is one of my good friends and we work a lot alike and so she always makes me go with her or I'll go with her if we know it is going to be bad because we work well together at handling bad situations."

Although some nurses related stories of working together with physicians within an atmosphere of mutual respect, others told of how some doctors "just blew me off" (ICU nurse #5) when they reported problems with their patients. One participant told of holding pressure on a young man's lacerated liver until he died: "I was in a very small hospital. We had one surgeon and he would not come." Knowing what ought to be done for a patient, but unable to convince a physician to do it, was very distressful. An ICU nurse (#5) described his desperate action on a patient's behalf when a resident who had been refusing to come see a patient finally arrived on the unit: "The way I dealt with that was I basically just grabbed her shoulders and turned her toward the patient and tried to get her focused on him, but it was obvious she just didn't want to do anything." The most difficult aspect of providing care can be coordinating communication among multiple physicians, especially in ICUs: "You're dealing a lot with the physicians and making sure that everybody is aware of what everybody else is doing, 'cause that's not always the case" (ICU nurse #1). Lack of communication between physicians and families also can complicate a nurse's work. Another ICU nurse (#6) explained:

> Well, I think nurses have always been put in the middle of ... well ... "the doctors had not been around" and you know, "When's the doctor going to come talk to us" and "We haven't seen the doctor

> all day!" and I am trying to say yeah, he's really busy, and yeah, he hasn't been around. You know, we're put in the middle all the time.

An OB nurse (#2) summed it up: "So there's that kind of balancing act, keeping the doctors happy and completing the orders that they give us and being an advocate for the patient."

By far the most important people that nurses work with are patients and families. Several nurses spoke of "fighting" death with the patient, "going through a tough time together" (ICU nurse #5). An oncology nurse (#3) related one of her most memorable patients: "I walked in that night and he looked at me and said, 'You know I'm going to die tonight.' And I said, 'Not on my watch, you're not. We will make it through this night.' I stayed with him in that room most of the night and talked him into living." An ICU nurse (#5) put it simply: "I would not let him die on me." Other nurses experienced losing the fight, but always learning something from the experience.

> So, I get everything ready, and I go into the room, and I tell this lady. I said, 'So, hey, we're going to put you on the ventilator for a few days and let you rest and let you get better. But you're going to be just fine.' That, right there, was my biggest mistake. I learned, and I was still a young nurse, and I learned right then, never, ever, ever, ever tell your patients that they'll be just fine. Because they may not, and this lady wasn't. (ICU nurse #4)

If death cannot be conquered, the nurses made sure the patient was not alone. As one pediatric nurse (#3) said: "I think no one should die alone. I would do someone else's work to put someone with a patient who was dying if they didn't have someone with them because I think that that is very essential."

While they are providing care for their patients, nurses must also care for the families by providing information and comfort. As one ED nurse (#7) related the story of a critically ill young mother, she remembered the family sitting in the waiting room:

> And she was a young person about our age, who had children as we did, and we empathized with what was going on with her. And we empathized for the family, the children, and the elderly father who was here and feeling very helpless and hopeless. We wanted to help them all. In fact, we did arrange for volunteer people to come and stay with the children and entertain them, and provide games and stuff for them.

Many of the nurses became emotionally attached to their patients, especially those hospitalized multiple times, in the hospital for a prolonged period of time, or alone during critical illnesses. As an oncology nurse (#8) said, "Some of the older patients sort of crawl in and curl up around your heart." Nurses rejoice in the recovery of their patients and that rejoicing may take the form of tears: "When she went to the medical floor it was amazing. I literally cried when she went to the floor because I was so emotionally involved with her. To see her actually get up out of our unit bed and get into a wheel chair" (ICU nurse #2).

Nurses knew that their work was appreciated when patients sent cards and letters or visited after discharge. This visible display of appreciation meant the most to them. "For me the appreciation has to come from the patients and their families or it'd be very easy to quit" (ICU nurse #7).

Context Affects Care

Interwoven in nurses' stories of caregiving were many references to contextual factors, such as changes in the healthcare system that affect their ability to provide quality care. ED nurses were concerned about providing care when organizational guidelines limited the time patients could remain in the department. Other RNs worried about the effects of staffing shortages: "That's always in the back in our mind, whether you will be able to take care of this patient good enough because of, you know, we've only got two hands so I think that's been a main worry for us lately, working because of being short staffed" (ED nurse #4).

They were aware that it is not always the sickest patient who receives the most care.

> There is not as much time as you thought there would be to take care of that patient, and the squeaky wheel gets the oil, and most of the time, the squeaky wheel is not the sick patient. It is generally the drug seeker, you know, or the person who is generally the least sick out of your group of patients. And it is disheartening sometimes.

Discussion

Although the aim of this phenomenological study was to understand the everyday experience of caring for patients in contemporary hospitals, what dominated participant narratives were unusual caregiving episodes accompanied by strong emotional arousal. Nurses' described extreme patient care situations that stood out from the "daily grind." Many of the stories began with the equivalent of the statement, "I came in already tired." These unusual circumstances required a transcendence of lassitude and extraordinary responses. These nurses' stories are comparable in their drama and vividness to the "atrocity stories" described years ago by Webb and Stimson (1976), in which patients sought to make sense of medical encounters. Nurses are "thrown in" to the crisis situation, and they must deal with it without time for reflection (Heidegger, 1927/1962). Although many of the stories ended with the death of the patient, some spoke of miraculous recoveries that were equally mystifying. The retrospective descriptions included questions such as "Could I have done anything else?" and statements like "We may never know what happened." Sometimes years later, participants were still trying to justify and understand the outcome, and perhaps absolve themselves from blame. They faced the limits of science and skill and plunged into the realm of existential questions for which there are no ready answers. How do you do your best and it not work? The theme of Alone or Together encompasses both the isolation or feeling of distress often perceived by participants and their

connectedness (or lack thereof) with patients, physicians, and coworkers during the extraordinary incidents.

Participants spoke of the lessons that they learned from a traumatic incident and how it changed their practice. Even more spoke movingly of the moral issues they encountered in everyday practice. This residue of moral distress can undermine a nurse's ability to care. Participants were still trying to make sense of distressing aspects of their world that diminished their efficacy, such as lack of resources and collegial support.

Findings of this study are similar to those of Nathaniel's (2006) grounded theory study designed to elicit RN experiences of moral distress. Her informants told "heart-wrenching stories filled with vivid sensual descriptions" (p. 427) describing "situational binds" and "powerlessness in the decision-making process" (p. 428). They too told of "lessons learned" and subsequent changes in practice. Resolution of their moral distress was achieved either through "taking a stand" or "giving up" (p.431) by leaving the job or the profession. The stage of reflection includes "remembering, telling the story, examining conflicts, and living with the consequences" (p. 432). Nurses attempt to make sense of situations through reflection which "may last a lifetime" (p. 432). Nathaniel (2006) concluded that "Moral distress is a narrow concept that fails to explain the long-term, ongoing process that nurses experience" (p. 420).

Our participants were not asked explicitly about moral distress, but rather to tell about a time that they provided care for a patient. The fact that the findings of the two studies are so similar might indicate that moral distress is inherent in the ongoing worklife of nurses and is not necessarily tied to end-of-life decisions or informed consent issues that receive attention of many researchers.

Nursing is founded on the moral obligation to care for others (Summer & Townsend-Rocchiccoli, 2003; Woodward, 1999). As Neville (2004) said: "Being a nurse is, in itself, a moral endeavor. Almost every decision a nurse makes has a moral dimension. This applies not just to life or death situations, but also to the mundane issues encountered on a daily basis (p. 128)."

To do one's best and not achieve the primary goal of nursing—accomplishing what is best for a patient—is just not enough (Alavi & Cattoni, 1995; Erlen, 2001; Gastmans, de Casterle, & Schotsmans, 1998). Failure to meet this obligation results in moral distress, and every incident of moral distress leaves a residue (Hardingham, 2004). A build-up of moral residue can result in anguish, compassion fatigue (Hanna, 2004), anger, and frustration (Van der Arend & Remmers-Van den Hurk, 1999) and eventually burnout (Canadian Nurses Association, 2003). This "psychological disequilibrium" (Hanna, 2004) comprises a large part of why nurses leave the profession. Emancipatory group work, such as that described by Jacobs et al. (2005), has had therapeutic benefits: "The participants perceived themselves as . . . capable of transforming a rather dismal situation of nursing practice into one that was critical, creative, and freer from constraints" (p. 6).

Conclusions

Unforgettable caregiving episodes, burned into memory by unanswered questions, were described by this sample of American RNs. Moral distress appeared to be inherent in the work life of RNs. This concept should be clarified and expanded. Nurses have a need to tell their stories because "stories express our concerns and anxieties, they deliver moral judgments" (Rashotte, 2005). Nurses expressed their values in the context of work, and embedded in that work and in their subsequent stories lay the practical wisdom of the profession.

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