UNSUCCESSFUL PATIENT RESUSCITATION: UNDERSTANDING ASPECTS OF THE CRITICAL CARE NURSE'S EXPERIENCE

by

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This study describes aspects of critical care nurses' experience of unsuccessful patient resuscitation. The study was guided by the philosophical perspective of phenomenology in the tradition of Benner (1984, 1994) and Benner and Wrubel (1989) because of the intent to understand the commonalities and differences of the experience. Critical care nurses (CCNs) frequently care for patients who are unsuccessfully resuscitated, however, there is a lack of research concerning this phenomenon. The purpose of this study was to explore and describe the experience of CCNs who participate in unsuccessful patient resuscitation. Data were collected through twenty seven interviews with nine participants who work in an urban tertiary critical care area in one Canadian city. The paradigm case interview focused on the participant's narrative account of an unsuccessful patient resuscitation. The researcher sought to understand the CCN's experience through hearing and analyzing the paradigm case. The interviews were analyzed using constant comparative analysis and substantive coding. The theme of "knowing" was central to the participants' accounts of unsuccessful patient resuscitation. Knowing involved three themes: knowing the case, knowing the patient, and knowing the person. Each of the critical care nurses began to know the individual through "knowing the case". Knowing the case was significant as it allowed the
participants to care competently and confidently for the case as they developed a relationship with the patient. "Knowing the patient" involves a relationship characterized by professional concern and responsibility, between the critical care nurse, the patient, and the patient's significant others. The nurse's understanding of the patient allows her or him to identify and anticipate the patient's instability and the unsuccessful resuscitation. The nurses valued knowing the patient as a mechanism for preparing themselves to be emotionally stable during and after an unsuccessful patient resuscitation. "Knowing the person" involved a strong connection between the patient and nurse that created an emotional attachment to the patient and his or her significant others. The critical care nurses' involvement with the person and his or her significant others was frequently painful as they experienced the loss of a person they had come to know and care for prior to the resuscitation effort.
# TABLE OF CONTENTS

Abstract ii  
Table of Contents iv  
Acknowledgements vii  

**CHAPTER ONE: INTRODUCTION**  
- Background to the Problem 1  
- Purpose 3  
- Research Question 3  
- Definition of Terms 3  
- Assumptions 3  
- Philosophical Perspective 4  
- Summary 6  

**CHAPTER TWO: REVIEW OF THE LITERATURE**  
- Embodied Intelligence 9  
- Background Meaning 10  
- The Situation 13  
- Concern 14  
- Summary 16  

**CHAPTER THREE: METHODS**  
- Research Design 18  
- Sample and Setting 20  
  - Characteristics of the Sample 22  
  - The Setting 23  
- Data Collection 24  
  - Pre-interview 24  
  - Paradigm Case Interview 24  
  - Final Interview 27  
  - Field Notes 28  
- Data Analysis 29  
- Human Rights and Ethical Considerations 32
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CHAPTER ONE
INTRODUCTION

Background to the Problem

Cardiopulmonary arrest and resuscitation are frequent events within critical care settings. Inevitably some resuscitation efforts are unsuccessful and result in the patient's death. The critical care nurse's (CCN's) perception of unsuccessful patient resuscitation and the effect of this event on the nurse have received little attention in the literature. The personal experience of the author in the critical care setting suggests that unsuccessful resuscitation elicits powerful responses in nurses involved in the resuscitation of patients. Research indicates that death and dying are among the top stressors experienced by CCNs (Anderson & Basteyns, 1981; Bailey, Steffen, & Grout, 1980; Huckabay & Jagla, 1979; Norbeck, 1985).

Bailey et al. (1980) contend that health care professionals derive much of their satisfaction from seeing patients recover. The nurse may perceive a loss of investment in time, energy, and emotions when a patient dies (Stickney & Gardner, 1984). According to Tucker (1992), the primary role of the CCN is to save the lives of seriously ill patients by providing interventions, including continuous observations and aggressive treatments. An unsuccessful patient resuscitation may be perceived by the
CCN as a professional failure.

Many authors agree that what is perceived as stressful by an individual depends on a variety of personal and environmental factors (Antonovsky, 1979; French, Rodgers, & Cobb, 1974; Lazarus & Folkman, 1984). Two individuals that experience the same situation may or may not perceive the event as stressful. The complex factors involved in an unsuccessful patient resuscitation may influence the CCN's responses to the situation. According to Lazarus and Folkman (1984), an individual copes with a stressful situation by depending on several resources: positive beliefs, health and energy, problem solving skills, and social support.

Several authors have suggested that reduced morale, absenteeism, increased turnover, and burnout may be related to consistent exposure to stress in the critical care setting (Anderson & Basteyns, 1981; Bailey, 1980; Cronin-Stubbs & Rooks, 1985; Keller, 1990). Unsuccessful patient resuscitation may be one consistent source of stress for CCNs, and thus may contribute to decreased morale, absenteeism, and burnout. Understanding CCNs' experience with unsuccessful patient resuscitation can have implications for nursing practice and education that could ease the problems of increased turnover, absenteeism, and reduced morale. Consequently, it is important to explore the CCN's experience with unsuccessful patient
resuscitation, and to understand how this situation influences nurses.

**Purpose**

The purpose of this study was to explore and describe the experience of critical care nurses who participated in unsuccessful patient resuscitations.

**Research Question**

The following question guided this study:

What are the lived experiences of critical care nurses who participate in unsuccessful patient resuscitation?

**Definition of Terms**

**Critical Care Nurse** - A full- or part-time registered nurse working within a cardiac, cardiac surgical, or intensive care unit (ICU).

**Unsuccessful Patient Resuscitation** - The outcome of the cardiopulmonary arrest and resuscitation results in the patient's death, despite basic and advanced cardiac life support provided by the health care team members.

**Assumptions**

The assumptions that underlie the study are as follows:

1. Unsuccessful patient resuscitation is a critical event for CCNs.

2. Unsuccessful patient resuscitation elicits emotional responses from CCNs.

3. Unsuccessful patient resuscitation has psychological effects on CCNs.
4. Individuals may experience the same event differently (Lazarus & Folkman, 1984).

5. CCNs who participate in unsuccessful patient resuscitation will have strong perceptions of the situation.

6. CCNs participating in the study will be receptive to sharing their experiences of unsuccessful patient resuscitation.

Philosophical Perspective

This study was guided by the philosophical perspective of phenomenology in the tradition of Benner (1984, 1994) and Benner and Wrubel (1989). According to Benner and Wrubel (1989), the researcher's concern in this phenomenological approach to research is to "... illuminate what kind of knowing occurs when one does not stand outside of a situation, but is involved in it" (p. 41). Consequently, research using this approach focuses on understanding the phenomenon and its context from the participant's perspective.

There are different interpretations of phenomenology within the literature. According to Benner (1994), "The interpretive researcher creates a dialogue between practical concerns and lived experience through engaged reasoning and imaginative dwelling in the immediacy of the participants' worlds" (p. 99). "The goal of interpretive phenomenology is to uncover commonalities and differences, not private idiosyncratic events or understandings" (Benner, 1994, p.
Benner and Wrubel (1989) identified and described four sources of commonality explored in this approach to research. These concepts provide a framework to explore the nature of our humanness. The concepts are: embodied intelligence, background meaning, the situation, and concern.

**Embodied Intelligence:** "Embodied intelligence refers to the fact that the body itself is a knower and an interpreter" (Benner & Wrubel, 1989, p. 409). Individuals have the capacity to be in situations in meaningful ways because of embodied intelligence. The body learns to be in the world through cultural meanings, use of tools, and perceptual and emotional responses. Embodied intelligence includes recognition of objects and people, integration of past experiences, and maintaining posture and moving our bodies without conscious thought.

**Background Meaning:** "Background meaning is what culture gives a person from birth. It is that which determines what counts as real for that person" (Benner & Wrubel, 1989, p.46). An individual's perception and understanding of the world are shaped by the culture, subculture, and family to which that individual belongs.

**The Situation:** "Situations have the capacity to engage us and to constitute individuals" (Benner & Wrubel, 1989, p.42). In the real world, contexts change and previously unnoticed background meanings, habitual body understanding,
and concern are seen to no longer allow for smooth functioning. The individual is able to reflect on and bring new meaning to the situation.

*Concern:* A person's concern for people and things moves an individual to be involved in a context (Benner & Wrubel, 1989). Concern constitutes what matters to the person (Benner, 1994).

**Summary**

Background to the study and the research question are provided in this chapter. Additionally, the need and purpose of the study were described. Furthermore, the philosophical perspective of the study was introduced.

The thesis is organized into six chapters. An overview of research related to unsuccessful patient resuscitation and the issues surrounding CCNs' experience with unsuccessful patient resuscitation are presented in Chapter Two. Chapter Three outlines the research design, methods, sample, and ethical considerations pertaining to the research. Chapter Four describes the CCNs' perspectives of unsuccessful patient resuscitation. Chapter Five discusses the implications of the research findings for CCNs and for further study. Chapter Six summarizes the research study.
CHAPTER TWO

REVIEW OF THE LITERATURE

The issue of conducting a review of the literature is controversial within phenomenological research. The proponents of not performing a literature review prior to research postulate that additional information may contribute to researcher bias. For example, Omery (1983) supports approaching subjects with complete naivete. Other phenomenological researchers believe that this position lacks pragmatism and is not realistic in the research world (Benner, 1984; Rather, 1992). Furthermore, these authors recommend providing a review of the literature to ethical review boards and funding agencies to increase understanding of the phenomenon of interest.

Phenomenological researchers who have chosen to conduct reviews of the literature contend that examining others' descriptions of the phenomenon under study assists researchers to identify and bracket, or set aside, their personal biases (Benner, 1984; Rather, 1992). Sandelowski, Davis, and Harris (1989) assert that the researcher does not embark on a project without prior beliefs and knowledge that influence the researcher's view of the subject of inquiry. The literature review assists the researcher to identify and bracket his or her pre-existing beliefs and perceptions. Thus, a review of the literature pertinent to the conceptualization of unsuccessful patient resuscitation is
presented.

As the philosophical framework of phenomenology directs the research process for this study, the review of the literature is organized according to Benner and Wrubel's (1989) approach to phenomenology that explores four sources of commonality: embodied intelligence, background meaning, the situation, and concern. Many of the studies cited in this review are dated in the late 1970s or the early 1980s. Although the research studies related to CCNs' stress and coping were conducted a number of years ago, they are pertinent to the research question. The investigation of the experience of CCNs regarding the deaths of their patients was primarily conducted approximately twenty years ago. There have been few efforts since that time to replicate or extend this classic early research.

Within this literature review, the terms stress and coping are referred to frequently. For the purposes of this literature review, stress is defined as "... disruption of meanings, understanding, and smooth functioning so that harm, loss, or challenge is experienced, and sorrow, interpretation, or new skill acquisition is required" (Benner & Wrubel, 1989, p. 59). Coping is defined as what one does about a disruption (Benner & Wrubel). Coping includes "strategies for engagement and involvement as well as strategies for increased control and distance" (Benner & Wrubel, p. xiii).
Embodied Intelligence

The CCN's body has learned to know and interpret situations through the cultural meanings one attaches to a situation, past experiences, use of specialized tools, skilled behaviours, and perceptual and emotional responses (Benner & Wrubel, 1989). Quint (1966) contends that CCNs have learned specific behaviours and skills that are directed towards saving lives and patient recovery. As a result, CCNs view their role as primarily involved with life saving. When the death of a patient occurs, they "are faced with the reality of professional failure" (Quint, p. 51). A CCN's inability to save a patient's life is often associated with feelings of negligence. Although not specifically addressed in the literature, an unexpected death may carry an exacerbated threat to the nurse's self-confidence because it may imply that the nurse's care was inadequate.

CCNs' proficiency with skills may influence how the body interprets and responds to a situation. In a descriptive study of 46 CCNs, Huckabay and Jagla (1979) concluded that the skills acquired with experience as a CCN are helpful in assisting CCNs to cope with the stressors of caring for critically ill patients. In their study, beginning CCNs reported a higher level of work related stress than did the experienced CCNs in their sample. No other study was located that examined the effect of expertise on a CCN's ability to cope with stress.
Background Meaning

The critical care unit represents a unique culture in nursing; one which shapes the perceptions and understandings of the nurses who work in it. Some research has investigated the experience of health care workers in situations of unsuccessful patient resuscitations (Jimmerson, 1988; Mitchell, 1983, 1988a, 1988b). This body of research has been used to justify the need for stress reduction and critical incident stress debriefing programs among rescue personnel, emergency health care workers, and CCNs. The researchers do not appear to have considered the fundamental differences that may exist in the background meaning of the experience of CCNs vis a vis other health care workers. The CCN has often developed a relationship with the patient and family, prior to unsuccessful resuscitation. A paramedic, however, would rarely know either the patient or the family before a resuscitation was initiated. A prior relationship with the patient and his or her significant others may heighten the meaning of an unsuccessful patient resuscitation for the CCN.

Foxall, Zimmerman, Standley, and Captain (1990) investigated the differences between the frequency and sources of stress experienced by 138 ICU, hospice, and medical-surgical nurses. The authors reported no significant differences among the three groups of nurses on their total job stress scores. However, ICU and hospice
nurses experienced more stress related to death and dying than medical-surgical nurses. The authors suggest that death and dying are more stressful for those who deal with it on a daily basis.

The literature related to stress and CCNs subdivides into three categories concerning the types and severity of stressors (causes of stress), the effects of stressors, and coping with stressors. The types and severity of critical care stressors have been studied over the last three decades. The research in this field has been primarily limited to exploratory and descriptive studies. These studies have attempted to quantify stressors using questionnaires or inventories. Eight of the thirteen quantitative studies related to critical care stressors described the survey tool and reported the reliability and validity of the tools in the research reports (Bartz & Maloney, 1983; Cronin-Stubbs & Rooks, 1985; Dewe, 1987; Foxall et al., 1990; Huckabay & Jagla, 1979; Lewis & Robinson, 1986; Norbeck, 1985; Stone, Jebsen, Walk, & Belsham, 1984). The lack of information in the other studies regarding the nature of the survey tools and their reliability and validity limits the usefulness of their findings (Anderson & Basteysns, 1981; Lewis & Robinson 1992; Schaeffer & Peterson, 1992; Spoth & Konewko, 1987; Vincent & Coleman, 1986).

The sources of stress for CCNs have been the subject of
seven research studies (Anderson & Basteys, 1981; Foxall et al., 1990; Huckabay & Jagla, 1979; Lewis & Robinson, 1992; Spoth & Konewko, 1987; Vachon, 1987; Vincent & Coleman, 1986) summarized in Appendix A. All but one of these studies (Vachon, 1987) identified the death of a patient within the top three stressful events in the experience of CCNs. Vachon's study was unique in that the researcher conducted individual and group interviews with health care workers in both palliative and critical care settings. The caregivers in Vachon's sample reported that the top five occupational stressors consisted of team communication problems, patient/family personality or coping problems, the nature of the unit, role ambiguity, and role conflict. Although the death of a patient was not reported as a specific stressor, the participants discussed their stressors in relation to the anticipated death of their patients.

High levels of stress are associated with a variety of psychological symptoms in CCNs (Norbeck, 1985) and contribute to diminished work performance (Huckabay & Jagla, 1979) and burnout (Bartz & Maloney, 1986; Cronin-Stubbs & Rooks, 1985). Consequently, study of stressors surrounding unsuccessful patient resuscitation and nurses' response to this event is important to those concerned with optimal patient care and the psychological well being of CCNs.
The Situation

The CCN's ability to cope with the stressors associated with the care of critically ill patients is largely determined by the context of the patient care situation and the nurse's coping strategies. Stress is an integral part of critical care units. It stems from the high-tech environment, the acuity of patients' conditions, and the need for crisis decision-making (Lewis & Robinson, 1992). Unsuccessful patient resuscitation may be associated with CCNs' stress in the critical care setting.

The research literature reveals that CCNs use a variety of methods to cope with stressful situations. Several researchers found that CCNs use particular coping strategies frequently. Ehrenfeld and Cheifetz (1990) collected data at a one day workshop related to coping with stress for approximately 260 cardiac nurses. The workshop was designed to encourage nurses to share their experiences and ideas related to stress and was not planned as a research project. Although the cardiac nurses used a variety of coping strategies, the nurses' reported the following primary coping modes in specific situations: 32.6% used active coping skills toward solving a problem, 11.7% diverted the responsibility of problem solving to others, 37% were passive, and 18.6% participated in some activity not directed toward resolution of the situation.

Although the investigation by Ehrenfeld and Cheifetz
(1990) was not intended to be a formal study, their findings are congruent with those of five research projects (Dewe, 1987; Lewis & Robinson, 1986; Oskins, 1979; Schaeffer & Peterson, 1992; Stone et al., 1984), which investigated how CCNs cope with work-related stress. These studies are summarized in Appendix B. The findings from these surveys indicate that CCNs prefer direct, active coping measures, such as talking to coworkers about the situation.

**Concern**

A CCN's concern for a patient affects his/her willingness and ability to be involved in the patient's care. Caughill (1976) addresses the issue of dying in acute care settings, based on findings in the literature and clinical experiences. She emphasizes that nurses working within intensive and coronary care units develop close relationships with their patients. The development of the relationship is influenced by the low patient to staff ratio and the almost continuous demand for nursing care. As the patient's social history unfolds and the patient is seen as a unique person, the nurse's personal involvement grows. According to Caughill, when a close relationship has been formed between the nurse and the patient, a patient's death may constitute a personal loss and a feeling of professional failure.

The CCN's concern for a critically ill patient may precipitate ethical conflicts within the nurse. *Nursing '74*
(1974a, 1974b) reported that nurses involved in patient resuscitation efforts experienced distress associated with prolonging life through artificial means. A survey of 205 nurses conducted by Davis (1981) found that one of the most frequent ethical dilemmas identified by nurses was "prolonging life with heroic measures" resulting in ethical distress (p. 402). Ethical distress is related to the concept of moral distress. Jameton (1984) reports that moral distress occurs when moral choices cannot be translated into moral action. A CCN's concern for a patient may result in both ethical and/or moral distress for the nurse. An individual's responses to moral distress may include feelings of guilt, anger, frustration, and powerlessness (Jameton).

The CCN's concern for a patient may influence his or her ability to participate in ethical decision making. Rodney (1987) explored the experiences of CCNs' ethical decision-making with prolongation of life. She found that moral distress was a component of nurses' experiences. The "... moral distress was associated with some significant feelings for nurses, including resentment, frustration, and sorrow" (Rodney, 1988, p. 10). Moral distress is helpful in understanding the complex dimensions of ethical situations and may relate to CCNs' experiences with unsuccessful patient resuscitation.

The CCN's reaction to a patient's death may vary with
each situation. The following feelings have been identified within the literature: professional failure, negligence, hopelessness, helplessness (Caughill, 1976; Quint, 1966), personal loss (Caughill, 1976), resentment, frustration, and sorrow (Rodney, 1988).

Summary

No research was located that specifically investigated the experience of CCNs with unsuccessful patient resuscitation. The research findings pertaining to stress among CCNs imply that the death of a patient is stressful and, at times, emotionally difficult for nurses to manage. The research is limited by the use of the survey tool as a primary data collection method as this technique may not illuminate the complex nature of a situation and people's responses. The lack of information about the nature of the survey tool used, or the reliability and validity of the tool limits the usefulness of some research findings. The research in this area is also limited because several researchers have investigated stress in relation to a variety of health care workers, not specifically CCNs. It may be postulated that the unique role of CCNs will result in experiences that are not characteristic of other health care workers. For example, the nature of the CCN's relationship with the patient and family may intensify the nurse's responses to a resuscitation effort and the death of a patient.
The actual experience of CCNs in regard to unsuccessful patient resuscitation has not been explored to date. Although some authors (e.g., Quint, 1966) have suggested that an unsuccessful resuscitation is a traumatic and critical event for CCNs, there is lack of empirical data to support that assumption. There is a need for explorative and descriptive study that seeks to understand the meaning of the experience of unsuccessful resuscitation for CCNs.
CHAPTER THREE

METHODS

The research design, sample and setting, data collection, data analysis, and ethical considerations of the study are outlined in this chapter.

Research Design

The research design was guided by the philosophical perspective of phenomenology in the tradition of Benner (1984, 1994) and Benner and Wrubel (1989). According to Benner (1994), the goal of interpretive phenomenology is to uncover commonalities and differences of the phenomenon. "The phenomenon and its context frame the interpretive project of understanding the world of participants or events" (Benner, 1994, p. 99). A phenomenological perspective is appropriate for the investigation of previously unexplored areas because, through this approach, the researcher seeks to understand the essence of a phenomenon. This method was suitable for the purpose of this study because little is known about the CCN's experience with unsuccessful patient resuscitation, and no previous studies were located in which researchers investigated this topic.

The phenomenological approach described by Benner (1984, 1994) and Benner and Wrubel (1989) provided methodological strategies for the data collection and data analysis in this study. Data collection involved paradigm
case interviews that allowed the participant to relive and
describe the experience of unsuccessful patient
resuscitation during the interview process. According to
Benner (1984), paradigm cases are narrative accounts of
clinical situations that open up new areas of practice or
teach the nurse something new about nursing practice. The
researcher creates a dialogue between practical concerns and
lived experience through engaged reasoning and imaginative
dwelling in the immediacy of the participants' world
(Benner, 1994). Diekelmann (1990) contends that, through
paradigm case dialogue, we are fully engaged in the
situation and we seek to get the story 'right'. "Reflecting
and probing, we search for words that disclose and bear
witness to our understanding" (Diekelmann, p. 301). The
opportunity for CCNs to tell their stories of unsuccessful
patient resuscitation allowed these nurses to bring meaning
to this experience.

A phenomenological approach was used in this study to
gain insight into the experiences of CCNs involved with
unsuccessful patient resuscitation. The data generated from
the paradigm case interviews were analyzed using paradigm
analysis. Paradigm analysis is based on narrative inquiry.
The narrative approach is inductive and uses paradigm cases
to explicate issues, concerns, meanings, and understanding
from the informant's perspective (Benner, 1994).
Individuals' experiences can be brought to a level of
awareness by enabling nurses to reflect upon their experiences and to tell their stories (Benner & Wrubel, 1989; Diekelmann, 1990; Krysl, 1991).

The researcher used four strategies congruent with this tradition of phenomenological research to interpret the participants' stories. These strategies are analysis, synthesis, criticism, and understanding. They were used to articulate the meanings of the text and to generate interpretive commentary (Benner, 1994; Taylor, 1985, 1993). These strategies are described in the sections on data collection and analysis.

Sample and Setting

The first step in gathering the interview data was identifying the population from which the informants could be selected. The designated population was CCNs who had experienced caring for patients who were unsuccessfully resuscitated. The sample size was nine CCNs. This sample size was considered adequate as participants' narratives revealed meaningful patterns and the participants' repeated concerns that allowed interpretation of the paradigm interview texts (Benner, 1994).

The sample was selected to meet the following inclusion criteria:
1. Eligible Registered Nurses were currently employed in a full- or part-time capacity in the selected critical care units, specifically cardiac, cardiac surgical, and intensive
care units. The sample was limited to these settings to ensure that the context of the nurse-patient relationship was similar. The nature of the nurse-patient relationship may be different in other critical care settings, such as emergency and post-anaesthetic care units.

2. Eligible nurses participated in at least one unsuccessful resuscitation of a patient for whom they had cared for prior to the resuscitation attempt. The researcher believes that attending resuscitation attempts as part of the cardiac arrest team, in order to resuscitate patients unknown to them, is a different situation with distinct issues for CCNs.

In recruiting the informants, the researcher contacted the Head Nurses of the critical care units to explain the study, answer questions, and arrange to present the study to the staff at a meeting. The purpose of the study and the research design was explained at each staff meeting.

A letter explaining the study and requesting participation was distributed to each CCN who attended an information session or staff meeting (Appendix C). The letter included information regarding how to contact the researcher if the nurse was interested in participating in the study. The nurses interested in participating in the study contacted the researcher.
Characteristics of the Sample

CCNs were recruited from one tertiary level hospital in Vancouver, British Columbia. The participants were employed in cardiac, cardiac surgical, and intensive care units. The nine participants had between eight and nineteen years of experience as a Registered Nurse, and between three and fourteen years of experience as a critical care nurse. The participants included one male and eight females. The anonymity of the one male participant in the study has been protected by referring to all the participants as female. The participants were employed in cardiac care (3), intensive care (4), cardiac and intensive care (1), and cardiac, cardiac surgical and intensive care (1). The educational preparation of the participants included: a Baccalaureate in Nursing (5); a Baccalaureate in Arts (1); and Critical Care Specialty Certificates (5). Two of the participants who held a Baccalaureate in Nursing had also completed a Critical Care Specialty Certificate. The age range was between thirty and forty years.

The paradigm stories that the participants selected to relate to the researcher were from recent (i.e., within the past two years) experience (8) and from past (i.e., fourteen years prior) experience (1). The unsuccessful patient resuscitations described in the narratives occurred both in cardiac and intensive care settings and took place on day (5) and night (4) shifts. In each of these situations, the
nurse had cared for the patient prior to the cardiac and/or respiratory arrest and unsuccessful patient resuscitation.

The Setting

The CCNs who participated in the study worked within tertiary level intensive and cardiac care units. It is significant to the purposes of this study to identify the unique characteristics of each setting. These units are considered busy by the CCNs with a fairly rapid turnover of patients. The nurse-to-patient ratio ranges from one nurse to one to three patients. In the cardiac care unit the patients can communicate verbally to the nurses; however, in the intensive care unit, patients may not be able to communicate verbally for a variety of reasons (e.g., intubation or altered level of consciousness). In both settings, the patient's family members are able to visit the patient at any time with the exception of when patient treatments or emergency situations were occurring. Family members tend to visit frequently for short periods.

The CCNs in the cardiac and intensive care units work with a variety of physicians to provide care for patients. The physicians include house staff (e.g., cardiologists and intensivists) and residents and interns covering the specific areas. These CCNs work with the house staff on an ongoing basis and work with residents and interns for short periods (e.g., one to three months). According to the CCNs, the nurses and physicians are expected to work as a team
during resuscitation situations.

Data Collection

Data were collected from each CCN through a pre-interview, a paradigm case interview, and a final interview.

Pre-interview

The pre-interview was conducted in person or by phone. The interviewer reviewed the purpose of the study, answered the participant's questions related to the research interview, and introduced the interview plan to the CCNs. According to Benner (1994), the participant must be coached that narrative accounts of events, situations, feelings, and actions are needed. Introducing the interview plan to the participants allowed them to select a paradigm case that they chose to share.

Paradigm Case Interview

The researcher sought to understand the CCN's lived experience through the collection and analysis of paradigm case exemplars. A paradigm case exemplar has been described as "a clinical episode that alters one's way of understanding and perceiving future clinical situations" (Benner, 1984, p. 296). Benner (1984) states that exemplars become part of the clinician's "perceptual lens" (p. 297). The clinician's "perceptual lens" influences the nurse's perceptions and ability to make qualitative distinctions in practice. The paradigm method has been used in nursing to study characteristics of novice and expert nurses (Benner,
1984), the role of experience in ethical practice (Benner, 1991), the different clinical worlds of beginning and expert CCNs (Benner, Tanner, & Chesla, 1992), the experience of being a returning registered nurse student (Rather, 1992), and patient perceptions of caring in interactions with nurses (Rieman, 1986).

The paradigm case interview is like the telling of a story. "The role of story telling is central to interpretive phenomenology because when people structure their own narrative accounts, they can tap into their more immediate experiences . . ." (Benner, 1994, p. 108). In this phenomenological approach to data collection, the researcher appreciates that knowledge revealed through stories is contextualized, personal, never replicable, and full of life experience (Bergum, 1989).

The perceptions of the CCNs regarding their experiences of caring for patients who were unsuccessfully resuscitated originated from living through certain situations and experiences. The paradigm case interview involved asking the CCN to share an exemplar that was a significant or memorable experience with unsuccessful patient resuscitation. The researcher strives to understand the world of participants or events through dialogue and listening that allow the voice of the other to be heard or to reveal silence (Benner, 1994). The interview focused on obtaining the individual CCN's perspective, and required the
researcher to ask questions to clarify the CCN's meaning and to understand the experience. The paradigm case interview was based on the method reported by Benner (1984). The participants were given the following instructions:

1. Describe an incident or situation from your experience with unsuccessful patient resuscitation that was significant to you.
2. Describe the context of the situation.
3. Include why the incident was significant to you.
4. Include your concerns at the time.
5. Include what you were feeling during and after the situation.

The interview was audiotaped by the researcher and transcribed by a secretarial transcriber. Demographic information was also requested (Appendix D).

Several of the participants described the experience of telling the story as "a clear memory", "vivid", "a clear picture", and "through the dim lighting of nights". One participant described the situation as "a little moving picture and you, you see the whole thing evolving in your mind." Through the process of story telling, the participants relived the experience of the unsuccessful patient resuscitation.

The researcher asked open ended questions to clarify aspects of the interview and to explore aspects of the unsuccessful patient resuscitation not discussed by the
participant. Many of the participants stated that through telling the story, they were able to recall aspects of the resuscitation that they had not previously remembered. Additionally, many of the participants expressed that the interview process helped them to make sense of the experience.

Final Interview

A final interview was arranged to clarify interpretations of the paradigm interview and to discuss the emerging themes with the critical care nurse. A transcript of the paradigm interview was mailed to the participants prior to the final interview. Instructions regarding the reading of the transcripts and the aim of the final interview accompanied the transcripts (Appendix F). It was assumed that mailing the interview transcripts the week before the final interview provided the CCN time to consider the accuracy of the description of her experience. The participants were asked to review the transcripts prior to the final interview. The CCNs were informed that within the final interview both they and the researcher would have an opportunity to review, clarify, and expand on statements from the paradigm interview. The participants were also given an opportunity to ask the researcher questions regarding the research process.

The transcripts were pre-coded by the researcher. Pre-coding involves identifying general themes and categories
within the transcripts. The researcher shared the emerging interpretations of the data with the participants to validate the researcher's interpretation and to check for errors in interpretations of the paradigm case (Benner, 1994). The CCN was asked to reflect on the researcher's interpretation of the experience. Sharing the emerging themes with the CCN allowed the researcher to clarify interpretations and permitted the CCN to validate the researcher's interpretation of her paradigm case (Benner, 1994). Clarifying and validating the emerging themes enables the researcher to accurately present the voice of the participants (Benner).

Field Notes

The researcher recorded her observations, methodological notes, and personal notes following each interview. May (1989) advises that researchers use field notes to capture important information that is discussed after the formal interview has ended. The field notes assisted the researcher to recall the context of the interviews, to critique her interview techniques, and to discover common meanings and differences. According to Benner (1984), "Common meanings make it possible for persons to communicate directly and understand one another without interpretation or translation" (p. 292). Common meanings are embedded in CCNs' work practices and expectations (Benner, 1984).
Data Analysis

The phenomenological strategies of analysis, criticism, understanding, and synthesis are used to articulate the meanings of the text and generate interpretive commentary (Benner, 1994; Taylor, 1985, 1993).

The nine transcribed interviews were analyzed using the framework developed by Collaizi (1978). Collaizi's framework is congruent with the phenomenological approach described by Benner (1994). The search for themes involves not only the discovery of commonalities, but also the search for differences in the data (Benner, 1994). The steps in Collaizi's framework are as follows:

1. The transcripts of the interview are read as a whole.

2. Statements are extracted from the transcripts that directly relate to the phenomenon under study.

3. Meanings of the extracted statements are determined by indicating the meaning while using the original words and descriptions of the participant.

4. Clusters and themes are formulated from these meanings. The themes are validated by referring to the participant's original description. The outliers and discrepancies between themes are noted.

5. An extensive description of the phenomena under study is produced from integration of the above process.

6. The transcripts of the paradigm interview with the
analysis of emerging themes related to the phenomenon is returned to the participants. The researcher validates that the themes/descriptions capture the true meaning of their statements.

The first step in the data analysis was to read each transcript to envision the situation. Next, the researcher extracted significant statements from each transcript, relating to CCNs' experience with unsuccessful patient resuscitation.

Meanings were attached to the significant statements, which were then organized into clusters of themes. Examples of significant statements and their formulated meanings are provided in Appendix G. The clusters of themes were validated by referring to the original transcript. Outliers and discrepancies between themes were identified.

The process of analysis involved critically reading texts - questioning, comparing, and imaginatively dwelling in the participant's situation (Benner, 1994). To analyze the phenomenon within its context, the researcher critically reflected on the ways the "... methodological strategies, personal knowledge, and social context create a theoretical and perceptual access that influences understanding" (Benner, 1994, p. 99). Studying the participants's reality required the researcher to "... move back and forth between foreground and background, between situations, and between the practical worlds of the participants" (Benner,
p. 100). In addition, the researcher critically reflected on biases and blind spots that may exist and why she thought the questions that she was asking were relevant (Benner, 1994). Critical reflective exercises created openness and the ability to hear questions and challenges (Benner, 1994).

The researcher sought to hear and understand the voice of the participant (Benner, 1994). The final interview provided the researcher with the opportunity to review the tape and text prior to the final interview. According to Benner (1994), this technique allows the researcher and participant a second chance to ensure that understanding has occurred. "Understanding is historical and must be understood historically" (Benner, 1994, p. 101). The researcher tracked changes in thinking and understanding in field notes and a journal. Analyzing the text from different perspectives often changed the researchers' understanding of data. Writing the findings clarified understanding of the commonalities and differences in the phenomenon.

The final strategy of this approach to phenomenological research consists of synthesizing the themes associated with the paradigm cases. The themes should be universal enough to apply to each informant but do not require a total systems account nor a single-factor theory (Benner, 1994). The description of the themes is the focus of chapter four.
Human Rights and Ethical Considerations

Several procedures were used to ensure the protection of human subjects in this study. The study proposal was approved by The University of British Columbia Behavioral Sciences Screening Committee and the Hospital Internal Review Board. To ensure the participants' right to informed consent, all participants were given a letter of information that explained the purpose of the study (Appendix C) and an opportunity was provided to raise questions or concerns with the researcher.

A written consent was obtained at the time of the first meeting (Appendix E). The written consent form contains the following components that Field and Morse (1985) recommend:
1. an explanation of the study, including its purpose, the taping of interviews, and the number and duration of interviews,
2. an assurance of confidentiality and that only anonymous quotes will be used in any publication,
3. a statement indicating that the study will hopefully heighten awareness regarding nurses' experience with unsuccessful patient resuscitation,
4. a statement that the participant is free to refuse to answer any question without consequence,
5. an indication that the participant is free to withdraw from the study at any time or to withdraw some or all provided data without repercussion.
The confidentiality and anonymity of the informants were protected by identifying all participants with a code number on all transcripts and in the final report. The researcher will be the only person that knows the identities of the participants. The list identifying the participants, the audiotapes, and transcripts was stored in a locked drawer.

**Summary**

The lack of research related to nurses' experience with unsuccessful patient resuscitation may have consequences for CCNs in the clinical setting. This research design was based upon the phenomenological approach described by Benner (1984, 1994) and Benner and Wrubel (1989). The characteristics of the sample and setting are outlined. In addition, the data collection and analysis processes are described. Furthermore, the human rights and ethical considerations related to this study are summarized. The critical care nurse's experience with unsuccessful patient resuscitation requires study in order to uncover naturally occurring concerns and meanings associated with such experiences.
CHAPTER FOUR

FINDINGS

The nine participants in this study shared paradigm stories of unsuccessful patient resuscitation from recent or past experiences as CCNs. One participant relayed a paradigm story from fourteen years ago but discussed this situation in contrast to her usual response in similar, current situations. The participants of this study described paradigm situations that were significant to them. Many of these experiences changed the CCN's thinking and practice in critical care nursing.

The central theme of knowing emerged from the accounts of CCNs' experiences with unsuccessful patient resuscitation. The context of knowing was identified by the participants as significant in determining how knowing was enacted in their role in an unsuccessful resuscitation. Knowing entailed three themes: knowing the case; knowing the patient; and knowing the person. The boundaries of these themes were often determined to be overlapping and, at times, indistinct by the CCNs. The participants used the words "knowing the patient" and "knowing the person" frequently in their narrative accounts of unsuccessful patient resuscitation. These themes have been previously identified by Fonteyn and Fisher (1994) in a study of CCNs who cared for unstable post-operative patients. The framework of themes identified in the study conducted by
Fonteyn and Fisher was compared to the clusters of themes related to CCNs' experience of unsuccessful patient resuscitation. In many instances these themes are parallel to those of CCNs who care for patients that were unsuccessfully resuscitated.

This chapter includes the description of the findings as they relate to CCNs' experience with unsuccessful patient resuscitation. The context in which knowing occurred is described, followed by a detailed description of the three theme clusters identified in the data analysis. A discussion of the reliability and validity of the findings of the study concludes the chapter.

The Context of Knowing

The Nature of the Setting

The contextual factors that are unique to critical care nursing (e.g., the role demands and the structure of the unit) were viewed by the participants as affecting the nature of their lived experience in cases of unsuccessful patient resuscitation. The participants stated that the nature of the critical care setting provides unique challenges to CCNs, particularly in cases of unsuccessful resuscitation.

The acuity of the patients, as well as the goals and pace of care, influence CCNs' knowing. The critical care environment is structured to provide care to critically ill patients. The goal of both the nursing and medical staff is
to stabilize critically ill patients. When a patient is or becomes unstable (i.e., a significant change in vital signs, oxygenation and/or level of consciousness occurs), the patient care goal shifts from one of monitoring and restoration to life saving. If the individual is unable to be successfully resuscitated, the life saving goals are thwarted.

She came up (from emergency) and we began. It was just full bore. With the cardiologist calling out orders rapidly and, within a short space of time of her being in the unit - from putting her on the monitor, seeing that she was tachycardiac, hypertensive and then she also went into V tach (ventricular tachycardia), then the crash cart and the beginning of resuscitative efforts.

The setting of the critical care unit is different than many medical-surgical units in that patients are often able to witness the care that others in the unit receive. A concern expressed by the participants was for patients witnessing an unsuccessful cardiac and/or respiratory resuscitation. The participants stated that the close proximity of patients to one another in a critical care unit makes it difficult to ensure privacy during a cardiopulmonary arrest and caused patients' distress when they were able to recognize that another patient was not successfully resuscitated. Participants described strategies such as pulling the bedside curtains, closing doors, and speaking softly to avoid other patients becoming anxious about the resuscitation.
Lack of Time and Competing Roles

The contextual factors of lack of time and competing roles and responsibilities were identified by the participants as common constraints to CCNs' knowing the patient. All participants perceived that a certain amount of time was required for them to begin to know the case, patient, and person effectively. If this time was not available, the participants reported that they often felt compromised in their ability to provide individualized care for the patient and to recognize significant changes in the patient's condition. When an unfamiliar patient was unsuccessfully resuscitated, the participants stated they felt the individual's care had been compromised because they had not known him/her well enough to provide the individualized care they had required.

I did not really know the man as an individual because he wasn't really with it and I had only nursed him that evening so he had been my patient for five hours.

The whole thing probably took an hour and a half from the time he came in the door until he died and he was pretty well almost coding when he came in.

The goals of care in the critical care unit and the acuity of patients determine the roles enacted by CCNs in a resuscitation effort that was unsuccessful. The CCN may assume multiple roles during and after an unsuccessful resuscitation procedure. Each of these roles requires different skills and abilities of the nurse. Some participants described the levels of stress associated with
Interestingly, doing the CPR (cardiopulmonary resuscitation) is the least stressful job in an arrest procedure. It's pretty simple and basic and you don't have to think beyond the task. Other jobs like giving the drugs and defibrillating are anxiety provoking because they require more thinking and decision making.

The participants stated that their job was one of multiple demands, requiring constant prioritization and juggling of needs. In many instances, the participants felt that they were unable to care for the patient and his/her significant others adequately because of these multiple demands. Other than the technical roles assigned in the resuscitation procedure (e.g., documenting the interventions given, monitoring the cardiac rhythm, and defibrillating the patient), the CCN's roles commonly included caring for the patient, performing skills (e.g., giving intravenous medications, drawing arterial blood gases, inserting a nasogastric tube), decision making, interacting with family members, delegating to others, overseeing other patients, accessing resources, and advocating for the patient. Beyond these traditional aspects of critical care nursing, some participants' roles included: serving as the charge nurse or acting head nurse and orienting a staff nurse. When the resuscitation efforts were unsuccessful, the participants stated that they regretted that their multiple role demands had compromised the quality of care they gave to the individual and his/her significant other prior to the arrest procedures.
Clearly, in my mind, the number one place at this point in a sense, was with the family and, yet, I kept thinking, "Oh. But if you want this woman to survive, you've got to get those gases sent off." And (laughing) you know. And so, it's a crazy position. You are torn and you just don't feel there's enough of you.

Several of the participants commented that an added complexity of the multiple role demands in a critical care unit is that each role requires different approaches, skills, and behaviour. For example, a focused, assertive, unemotional, and efficient manner was required in a resuscitative effort. A calm and compassionate manner was required when interacting with families after the resuscitation had proven to be unsuccessful. Two distinct modes of interaction were described as part of the CCN's experience with unsuccessful resuscitation, one mode of interaction was required to function in the resuscitation effort and another mode to interact with family members.

It's tough. You almost have to be an actress, don't you? Your emotions come up to the surface with the family and then you have to switch and become more clinical and objective to deal with the patient's care (referring to care provided in the patient's resuscitation).

The participants stated that they had learned and grown in their various CCN roles by reflecting on the unsuccessful resuscitation experience, following the arrest procedure. A common feature of the participants' stories was that CCNs conducted a "post mortem" of the resuscitation effort and their role in it. The participants analyzed their performance during the arrest procedure in terms of their
skills, knowledge, and efficiency.

The post mortems go on. Like, how could I have done this better? How come this happened? I should have been more assertive. The old, did I miss something, or could we have anticipated this, that sort of thing.

The post-resuscitation analysis often resulted in new learning and a change in their nursing practice. Often this new learning was based on mistakes or omissions committed by the CCN during the resuscitation effort. One participant described the change that resulted from her post-resuscitation analysis as "a determination to be the patient's advocate." She had learned this because the effects of her not advocating strongly to the cardiologist regarding her concern about the patient's condition prior to the arrest procedure influenced the patient's treatment prior to his cardiac arrest and death.

Cultural Patterns

The participants agreed that, particularly following an unsuccessful resuscitation, the CCN spends a great deal of time "normalizing" the physical environment of the critical care unit in order that the setting appear calm and ordered to onlookers. Normalizing included preparing the patient who had been unsuccessfully resuscitated for the morgue, cleaning up the resuscitation debris, and restocking the supplies in the room. Cleaning up and restocking the area ensured that the room and equipment was ready for subsequent patients. Preparing the patient for the morgue involved
"tidying up" the patient, and shifting from life saving techniques to removing the intravenous lines and tubes that were inserted during the resuscitation effort.

And then you have to change, and there's all those, you know, IV's and that, you know, tubes that took so much time and effort putting in, you just start pulling them out and that part is hard sometimes too, you know.

The participants stated that normalizing the environment also assisted them to deal with the inner turmoil they experienced after an unsuccessful resuscitation. One participant described the time spent preparing the body and normalizing the environment as important for "private debriefing" or processing the emotional aspects of the resuscitation effort.

I think part of it is that you sort of need to put time in between the event and getting onto your next job whether its taking a new patient or helping someone. I'm not saying they, I don't think they do it consciously but I think it's sort of a little private debriefing or something that people do.

Physiological/Psychological Effects

The physiological and psychological effects of participating in an unsuccessful resuscitation were deemed by the participants to significantly influence the CCN's experience. Participating in an unsuccessful resuscitation was viewed by the participants as affecting them physiologically. Each of the participants described a "rush of adrenalin" when they were required to participate in a resuscitation effort; this rush was sustained until the resuscitation team pronounces that the individual is dead.
The participants stated that the initial adrenalin rush allowed them to think clearly and focus on the resuscitation effort.

Your adrenalin goes, kicks in and you're almost switching to a different mind set that you --- at the time, I don't think you see or you're aware just how much you're seeing, but after when you start recalling it, you start to think all the different things at the time. You're so, so focused. You perform those things that you learned, from memory.

When the individual was pronounced as dead, the CCNs described the dissolution of the adrenalin rush, as "a let down". They characterized this period as feeling tired, weak, and exhausted. Several participants commented that their ability "to take anything else in" after an unsuccessful resuscitation was severely compromised. They stated that, if the resuscitation occurred early in a work shift, they generally were exhausted and distracted for the remainder of the shift.

After the event, it was, mind shut down. It was sort of that, a numbness. Just get me to seven thirty.

**Knowing**

Three main theme clusters emerged from the data: knowing the case, knowing the patient, and knowing the person. The presentation of the findings in this chapter is adapted from the thematic inquiry developed by van Manen (1990) to facilitate the data analysis in a phenomenological study. Each of the theme clusters is presented within the thematic organization adapted from van Manen's data analysis framework: aspects of the theme, manifestations of the
theme, isolating what the theme does, describing how the theme does what it does; and the significance of the theme for nursing. The first theme refers to knowing the case.

Knowing the Case

According to the participants of the research study, CCNs must know the case in order to provide competent care to critically ill patients who may become unstable and require resuscitation. Knowing the case refers to nurses utilizing their theoretical knowledge and past experience of the diagnosis, physiology, and typical responses associated with the diagnosis to anticipate the interventions and outcomes associated with resuscitation of the case.

Aspects of Knowing the Case

CCNs' experience with unsuccessful patient resuscitation revealed the following aspects of knowing the case: diagnosis, assessment of physiological responses, recognizing indicators of cardiac and/or respiratory arrest, expected responses to interventions, and interventions associated with cardiopulmonary arrest. The CCN's interventions in a cardiac and/or respiratory arrest are based on theoretical knowledge of specific resuscitation protocols and knowing the case. Resuscitation protocols are learned in basic and advanced cardiac life support certification classes (BCLS and ACLS) and in unit orientation.

As the participants began to tell the story of an
unsuccessful patient resuscitation, each highlighted some basic information about the case. This information included the patient's diagnosis and pertinent physiological responses. Patient diagnoses in the paradigm stories included: an abdominal aortic aneurysm repair, a fractured leg, a thoracic aortic aneurysm, AIDS, chest pain, myocardial infarction, sepsis, cancer of the breast, and cardiogenic shock. Additionally, the CCNs related the degree of stability or instability associated with the case and the relevant physiological responses.

He had been admitted to hospital with myocardial infarction. Now I'm assuming it was an inferior infarction because, uh, he had significant left ventricular failure.

Several participants described the diagnosis, physiological responses, and interventions as "typical" for the case. These cases were considered stable and the CCNs' envisioned routine care.

He'd had a large MI and so, he was in with the monitoring and let's say he was sick, but stable. The CCNs stated that they learned to know the case by comparing it to the routine care provided to other patients with the same diagnosis.

He was HIV positive, had AIDS and he was in severe respiratory distress. And I think he hadn't previously had PCP (pneumocystis carinii pneumonia) because we won't intubate somebody if this is a second bout because all of the data show that they don't make it off the ventilator and stuff.

The nurse draws on her theoretical knowledge, assessment skills, and previous experience with like
situations to determine the patient's stability. For example, in the following situation, the nurse knew that the patient had a fractured leg, however, it was unknown why his condition had deteriorated to critical status.

They (referring to the ward staff) wanted to get him down as quickly as possible. He was on a hundred percent oxygen and one thing I just remembered about him was that he was purple from the nipple line up. He had that mottled, um well, he was pale all the way from his --- his extremities were like cyanotic but he had that mottled embolus look from the nipple line up. They get that funny mottled look and a fair amount of JVD (jugular venous distention) and he was conscious, was talking and seemed quite calm about everything.

In this dramatic case, the patient arrived in the ICU and the nurse assessed his stability and potential for cardiopulmonary arrest rapidly.

(I) could tell when you looked at him that he was an imminent arrest. You could just tell that he wasn't going to do well.

The indicators of this cardiopulmonary arrest were apparent to the CCN almost instantly.

In two of the nine paradigm narratives, the CCN's knowledge of the patient's diagnosis, typical physiological responses, and assessment findings assisted the nurse to determine the patient's stability and to anticipate a cardiac and/or respiratory arrest. It appears that knowing the case assists nurses to anticipate a cardiac and/or respiratory arrest in selected situations. The ability to anticipate an unsuccessful patient resuscitation altered the emotional tone of the experience for the CCN. For example, one participant stated that she "expected the arrest" and
that the unsuccessful resuscitation "was not a surprise". This participant expressed feelings of sadness for the family but little emotion was expressed for the patient. Knowing the patient as a case limited the CCNs emotional response to the patient's death. The participants concurred that knowing the patient is often more helpful in predicting an arrest than knowing only the case.

The concept of routine interventions and predicted responses to interventions in a resuscitation effort contributed to the nurses' knowing the case. The participants stated they were able to predict the outcome of resuscitation efforts because they had learned that the length of time that was required to resuscitate people, the procedures used, and the responses of the patient were predictors of success in a resuscitation effort.

I think time and just the way the arrest went and how he needed to be shocked so many times and, um, you know after using a lot of lines and drugs and nothing was really working, I mean there's not too much you can do about that.

Manifestations

Knowing the case manifests itself in the baseline data that the CCN collects and reports to others; the CCN's perception of the range of patient outcomes; the CCN's recognition of an impending cardiac and/or respiratory arrest; the conventional care provided by the CCN prior to, during, and after the resuscitation effort; and the CCN's confidence in the situation.
CCNs reveal their knowledge of the case by the way in which they are able to detail the facts of the case to others. This is illustrated in one participant's story involving a patient who experienced severe chest pain and was thought to be in the midst of a myocardial infarction when he arrested.

The rhythm changed into VT (referring to ventricular tachycardia) and quickly into V Fib (referring to ventricular fibrillation). Successive shocks were delivered and the patient had a ventricular escape rhythm. Within one minute, the rhythm degenerated back to asystole and the external pacemaker was tried.

Knowing the case is manifested by the range of patient outcomes that the CCN anticipates. Knowledge of the diagnosis, physiological responses, and common responses to therapeutic interventions assist the nurse to anticipate a range of patient outcomes. One participant described a patient with progressive left ventricular failure that was unresponsive to standard interventions.

I knew they couldn't help him out because he had this terminal type of condition with his heart.

Several participants described a sense of the patient's inevitable death during the resuscitation procedure. One participant described the length and the patient's response to resuscitative efforts in connection to "digging" for interventions to save the patient's life and to a sense of desperation.

When you get to that point --- like twenty-five minutes into a full blown arrest where you're digging now and, uh, you know, you're just not getting anything back and, uh, you know, from experience as well.
In three paradigm narrative situations, the CCNs stated they did not want the patient to survive the resuscitation. The nurses viewed some situations as futile, and in other situations there was concern about the patient's quality of life if they survived the resuscitation. One participant described the resuscitation of a patient that was in end stage cardiac failure. The nurse had no desire to resuscitate the patient, but the cardiologist had not written a "do not resuscitate" order. In this situation the CCN described feeling "angry and frustrated" and that it "seemed to take forever for the physicians to make a decision".

No one really could make the decision to stop because they hadn't gotten ahold of the cardiologist, and everyone, everyone knew the futility of this but they kept on anyway.

Another participant described a resuscitation event in which she hoped the patient would not survive. This nurse was concerned with the patient's quality of life following a cardiac and/or respiratory arrest.

The main thing was that the consequences of him surviving this arrest are too devastating or potentially devastating ... which maybe to look at the other side of that coin - maybe critical care nurses tend to be too sceptical sometimes, you know, I do.

Knowing the case manifests itself in the CCN's expectations of the situation and her ability to provide rapid and appropriate nursing care, prior to and during cardiac and/or respiratory arrest. The CCN must plan, implement, and evaluate interventions based on her knowledge
and experience with the case and resuscitation procedures. Several participants described technical proficiency in terms of how quickly care was provided.

You're going as fast as you can. I mean you're over compensating, by doing things as quickly as you can and, um, you know, just trying to be as technically as good as you can be.

Knowing the case is fundamental to the CCN's ability to provide care and to participate in the resuscitation effort with a degree of confidence. Confidence in caring for critically ill patients and participating in resuscitations is built, in part on knowledge of the case, knowledge of resuscitation protocols, and experience with resuscitation efforts. Knowing the case is illustrated in the participants' descriptions of recognizing the cardiac and/or respiratory arrest and in the routine care provided in the resuscitative efforts. Each resuscitation requires the CCN to know the protocols or algorithms for various life threatening heart rhythms and situations. With knowledge and experience, CCNs develop a sense of comfort and confidence with cardiopulmonary resuscitations.

All of a sudden, the algorithms take over and people fall into their roles and, I think people feel more, uh, that know what to do next.

The participants' confidence was reflected in their assessment of data, planning, implementation, and evaluation of interventions.

I thought just by looking at the ECG that they should really take a look at it, and maybe consider something like thrombolytics. Like I thought - There was a major
event happening.

What does Knowing the Case Do?

Knowing the case provided the participants with baseline information about the case that is essential to the determination of stability, the anticipation of responses to interventions, and the anticipation of the range of patient outcomes. Knowing the case enhances CCNs' competence and feelings of being in control in the provision of care.

The participants agreed that knowing the case influenced their decision making and confidence. For instance, one experienced CCN was able to utilize her knowledge of the case and cardiorespiratory arrest to rapidly assess the situation, categorize the crisis, plan and implement care.

He was in respiratory distress - uh... we better get some help. First, I pressed the patient call bell, and then I said, "Oh, no! This is too serious just to press the patient call bell, and get someone to answer one minute later. We better press the staff alert button" - meaning look we need some help right away, could someone come down to this room? And I realized, "Oh, no! He's one more step further than that. I'd better press the cardiac arrest button." That whole procedure probably took 10 seconds.

Knowing the diagnosis and physiological responses of the case assisted the participants to appraise the degree of patient stability. Repeated exposure to patients with specific diagnoses and physiological responses may allow CCNs to identify predictable patterns of physiological responses and to anticipate some cardiac and/or respiratory arrests.
The participants valued knowing the case as a way of preparing themselves for the situation in order that they be "protected" from unexpected occurrences. The CCN's ability to anticipate an unsuccessful patient resuscitation is influenced by her ability to contrast the case with previous experience with similar diagnoses and responses to interventions. The participants agreed that, if a CCN is prepared for the eventuality of an unsuccessful resuscitation, the nurse is better able to protect herself emotionally from the trauma of the patient's death.

And there are different ways of approaching certain diagnoses and patients. It's important that the nursing staff know that, to protect themselves and understand what's going to happen.

Knowing the case assists the nurse to contemplate the range of patient outcomes. The participants described the patient outcomes from a variety of perspectives. For example, several participants stated that "if a patient was stable and progressing normally" the CCN expected recovery. Another participant described listening to report from another nurse where she had a sense of the patient's unsuccessful resuscitation and death. In the case the patient had "repeated set backs" and he was "getting worse".

I was pretty sure that this was all just an ICU admission, a morphine drip and sedation induced kind of stuff.

I assume that his aneurysm burst and that he had lost his volume before he lost his rhythm.

You know the patients that aren't going to make it long before they don't make it.
The participants stated that knowledge of the case, derived from past experience with and learning about resuscitation cases, enables the CCN to be technically proficient during the arrest procedure. Many of the participants described their knowing the case as resulting in comfort and satisfaction with the technical care provided in the resuscitation procedure.

I did CPR for a long time and was giving drugs and I felt comfortable with what I had done.

Technically, it went really well and things were done like right away, you know. He was intubated and you know, lines were put in and drugs were given. And the surgeon came down and did kind of what he could.

Several of the participants described their satisfaction with the technical care in terms of "smoothness", "efficiency", and "control". They emphasized that feeling confident about one's role in the technical aspects of a resuscitation effort enabled them to experience control in the situation. Control was defined as knowing what to do, anticipating interventions, and experiencing a consistent flow in thinking. The perception of "smoothness" and "control" provided the CCNs' with a sense of satisfaction even when they failed to save the patient's life. Several participants expressed that they did not feel "guilty" when they had done everything could for the patient.

Even if it's (resuscitation) unsuccessful, and if it's controlled, you feel like, well, I've done everything. You feel more positive about the experience because it's just like sort of that well-oiled machine. It's working and things are going the way they should. You know, like everything is being done. Things aren't
How does Knowing the Case Do What it Does?

Knowing the case provides the CCN with fundamental information that assists the nurse to make nursing care decisions. The CCN's confidence and expectations are influenced by her theoretical or textbook knowledge of the case and past experience with the case. The nurse compares and contrasts the textbook case and her previous experiences with the current case. This activity reveals the similarities and uniqueness of the case. In some paradigm narratives, the CCN concluded that the case was "routine", consistent with usual patterns of patient response, interventions and nursing care. Such a conclusion enabled the CCN to feel confident that she could predict the outcomes of the case. The CCN's ability to predict the potential outcomes of the case, specifically unsuccessful patient resuscitation was pivotal to her perception of the experience.

An MI being monitored but no invasive monitoring, just on the monitor watching his rhythm, and such and on, you know, a nitro infusion and heparin that sort of thing and, he had been stable all day. Just the usual, a little diaphoretic here and there but no complaints of pain or anything all day and so I thought we were going along pretty good here.

In two paradigm stories, the participants reported that they were familiar with theoretical aspects of the case, but had no personal experience to draw upon. In both cases, the participants were unprepared for the turn of events and
patient outcomes. Both situations caused the participants to experience much angst and grief. One participant described an early experience in critical care nursing when she was caring for a patient with a thoracic aortic aneurysm. It was her first exposure to that diagnosis and to the medical management of an aortic aneurysm. The aneurysm ruptured and the nurse was involved in the resuscitation effort when the surgeon arrived.

The participant stated she had not understood the goals of care in this case and felt uncertain, helpless, and angry. The participant described feeling confused and abandoned in this case when the surgeon did not act in the way she had anticipated. The CCN had anticipated that the surgeon would "rush the patient to surgery and attempt to repair the aneurysm". This situation altered the participant's thinking and practice because it taught her that, in cases...
such as this one, you may not always be able to "save people" and that it is extremely important to understand the medical plan at the onset of a resuscitation in order to anticipate the potential interventions and outcomes.

**Significance of Knowing the Case**

Knowing the case gives meaning to the situation. It allows the nurse to make some assumptions about the patient's physiological responses and to anticipate interventions and patient outcomes associated with the diagnosis and the resuscitation procedure. It also enables the CCN to anticipate her role in the resuscitation. The participants concurred that knowing the case heightens the predictability of the resuscitation experience for the CCN and, thus, her sense of control in the situation.

**Knowing the Patient**

"Knowing the patient" was perceived by all participants in the research study to be significant in meeting the care needs of both the patient and his/her significant others. Knowing the patient entailed knowing details about the patients (e.g., age, gender, past medical history), roles (e.g., father, unemployed) in order to provide nursing care to the patient.

**Aspects of Knowing the Patient**

The CCNs viewed the following aspects of knowing the patient as critical to providing effective nursing care before, during, and following an unsuccessful resuscitation:
the patient's age, gender, past medical history, roles (e.g., father, unemployed), significant others, location of residence, and current physiological status.

Knowing the patient's past medical history often revealed whether the patient was likely to undergo an arrest and how successful a resuscitation might be. In several paradigm narratives, the patient had been healthy prior to admission and the CCN was aware of this prior to the arrest. In situations where the nurse knew aspects of the patient's history and current physiological status and she did not expect the patient's unsuccessful resuscitation it caused her to question why the unsuccessful resuscitation occurred, and at times, it caused the participant to assume blame for not anticipating and preparing herself for the unsuccessful resuscitation.

I think it was something like an inferior infarction. But, prior to his admission to hospital, he'd never been admitted to hospital before. And it was one of his first hospital admissions. He was in extremely good health.

In other narratives, the patient's history was crucial to the outcome of the resuscitation effort but was not known until during or following the arrest procedure.

It turned out that he had broken his leg a month before that. But he was out of the hospital and had come in the night before with complaints of chest pain, and it turned out he had microemboli throughout.

Each of the paradigm stories told by the CCNs included an approximation of the patient's age. In the paradigm
stories, the patient's age ranged from eighteen to eighty years old. The participants agreed that knowing the patient's age created expectations regarding the outcome of the resuscitation effort. The younger the patient, the more CCNs' expected the patient to survive a resuscitation attempt and the more affected they were by the event of an unsuccessful resuscitation. The participants in this research study defined a young patient as eighteen to early sixties in years.

While forty (referring to the patient's age) you're thinking, "Oh, it will be Okay, she'll survive." Initially when you, its crazy how much weight you put on the age before other things. You know, um, had we all taken more time, to just really delve into her history and look at what was happening, um, it wasn't probably that surprising that this had happened (referring to the unsuccessful resuscitation).

A resuscitation of a young patient created a sense of intensity and significance for the participants of the research study. The younger the patient the greater the investment of the nurse in the patient's survival and the stronger the feelings associated with the patient's death. The CCNs' described feeling extreme sorrow and pain when they were unable to successfully resuscitate a young patient.

The fact that she was forty was just, you feel the intensity of the time because she's, uh, young.

Especially when its somebody who is, you know, young. And you think, you know, his time maybe really shouldn't have come yet.

One participant described an eighteen year old male who had
been previously healthy. This CCN cried as she described the unsuccessful resuscitation attempt. The unsuccessful resuscitation of this patient was described as "devastating" by the CCN.

Participants of the research study perceived that the interventions used in the resuscitation procedures of young patients were more aggressive than those with older patients. One paradigm case focused on a patient in his late forties or early fifties who had a myocardial infarction. During the course of the resuscitation effort, the patient received defibrillation, drugs, a thoracotomy, visual inspection of the heart, and open cardiac massage. The resuscitation effort continued for over a hour. The participant described feeling a sense of "desperation" as the traditional interventions were ineffectual.

And everybody, I remember, like no matter what sort of the next suggestion was, you know, to carry on further, you know. Everybody was really, "Yes, let's go ahead." You know, "Let's try this." You sort of try anything.

Knowing the patient also included knowing the gender, location of residence, and roles of the patient. The most significant of these to the participants was the family roles enacted by the patient. Occupational roles, location of residence, and gender were considered identifiers of the patient. For example, several of the participants said that, at the time of the unsuccessful resuscitation, they had been aware of what the patient did for a living but could not recall that information during the interview.
Data concerning where the patient lived (e.g., out of the city; in the city) were generally provided in the research interview in relation to the patient's significant others (e.g., how long it would take the family members to be with the patient once the arrest had occurred).

The participants consistently recalled, and emphasized in the research interview, the patient's role(s) in the family. Family roles of the patients described in the paradigm narratives included mother, father, and son. The patient's age and roles within the family provided the CCN with an indication of the significance of the illness and the unsuccessful resuscitation for the patient and his/her significant others. Knowing the significance of the unsuccessful resuscitation effort created meaning for the CCN. The participants were able to understand the experience from the patient and his or her significant other's perspective and empathize with the anguish the patient's death caused.

A young man probably in his late forties, um, or early fifties, you know, wife and children. He was from out of town and he'd had a large MI.

We were told that her (patient) child was in the waiting room with the dad. Oh, suddenly the whole emotions changed rapidly. You know. So we --- what I did was, I did try. I left the situation because I had to spend --- I kept thinking that each, if we could get her back, if we could get her back so he (child) could, the child could come in and see his mom.

This was more than just an eighteen year old boy. This was somebody's son.

Knowing the patient in an unsuccessful patient
resuscitation frequently included knowing the patient's significant others. The participants stated that information regarding significant others was provided by the patients, from the significant other during visits to the critical care unit, and from one nurse to another during report.

He talked a lot about his children. He talked a lot about his child or children. There might have been two because I noticed him using the word "children". Anyways, he talked a lot about his children and, uh, how loving they were.

The participants agreed that one of their roles was to provide information and support to significant others before, during, and following unsuccessful patient resuscitation. Knowing the significant others of the patient was perceived by the participants to be necessary in order that they be able to fulfil this role effectively.

The participants had met the significant others prior to the resuscitation in only three of the nine paradigm cases. In two of these situations, the significant others had been with the patient just prior to the arrest and were asked to wait in the waiting room during the arrest procedure. In the third situation, the nurse had met the patient's wife the day before the arrest. One participant reported that she found it very "bothersome" that the patient's wife had witnessed the patient seizing, alerted the nurse, and, when the patient subsequently arrested, was asked to wait out of the unit in the hallway. The CCN
explained that this event was "bothersome" because the wife's distress over her husband's seizure and arrest was uppermost in her mind during the resuscitation effort.

Yeah, yeah, that she was there. And of course then knowing that, you (the wife) know what's going on and the arrest is called. I mean it's different than calling somebody at home.

In the other six paradigm cases, the significant others were not known to the CCN prior to the resuscitation attempt. In these situations, the significant others were notified of a deterioration in the patient's condition and were asked to come to the hospital. These participants described the difficulty of supporting significant others whom they had not met prior to the resuscitation effort.

It was hard. First of all, it's a bit hard when you hardly know the family. If you've developed a bit of a relationship with the family, uh, I find it a little easier to, to be supportive. I don't know. It's, it's something that you do a fair bit, trying to be some form of emotional support for the family so - but it's always hard. It's a very sad time.

Some of the participants stated they had personalized the loss of the patient, following an unsuccessful resuscitation, when they knew the patient's gender, roles, and family. One participant discussed the unsuccessful patient resuscitation of an eighteen year old in relation to maternal instinct and the focus of professional nursing.

It stood out for all of us, you know, it was, um, I don't know so much for the physician, he just felt generally bad. I think he saw it quite differently as upsetting. And I'm not sure because we were females and have this maternal instinct. Although I was the only one with kids or, um, whether it's just the difference in our focus professionally.
Knowing the patient also encompassed knowing the details of the patient's recent physiological status. Details of the patient's stability within the past twenty-four to forty-eight hours were provided in the paradigm narratives. Frequently, this information related to the CCN's and significant others' expectations of the outcome of the resuscitation.

I look back now. It had been only in the last twenty-four or forty-eight hours that there had been a real acuteness to her illness. And so, it was like --- okay, well, she'll recover. She's been through other things like this.

**Manifestations**

Knowing the patient is manifested in the CCN's relationship to patients and significant others and in the detachment or distancing they enacted in an unsuccessful resuscitation. Knowing the patient was evident in the physiological and psychological care that the participants of this study provided for their patients and their significant others. This care incorporated what the CCN knew about the patient (i.e., the aspects of knowing the patient).

The CCNs' relationships with their patients were described by many of the participants as a sense of concern for the patient and a perception of responsibility for their care. Frequently, this role was described by the participants as "advocating" for the patient. One participant described a situation in which a patient
developed severe chest pain that was unremitting. The patient's chest pain was unaffected by conventional treatment. The physicians were alerted to this patient's condition but did not assess the patient immediately.

I was a little worried about the patient and I was frustrated that I thought this patient really needed to be looked at. And there were a number of doctors there but the intern was placing, our intern was placing the wire (a pacemaker wire), and the cardiologist was supervising her and didn't feel it was appropriate to leave her, even though there were, you know (other physicians there).

Knowing the patient was revealed in the participants' interactions and relationships with significant others. Because the participants knew that the patient was connected to significant others, the CCNs incorporated the needs of these significant others in the plan of care. The CCNs identified the needs of families by assessing the families coping strategies and resources, anticipating patient outcomes, and drawing on their past experience with families experiencing crisis and grief.

I mean it's not that you don't shift your focus of care but you have, I think you widen the scope of your caring not to just include that patient that probably won't make it but also too the family whose going to be in the aftermath of the whole situation. You have to widen it rather than restrict it, it's so much easier to restrict your focus. Caring for significant others entailed providing information and emotional support, as well as accessing appropriate resources to meet the needs of the significant other. At times, this included preparing the family members for the patient's death.
One participant described a paradigm case that involved her interaction with the partner of a patient with AIDS. The CCN told the partner that the patient would be more comfortable after he was intubated and asked the significant other to wait in the waiting room during the intervention. The patient arrested following the intubation and died. The participant spoke of feeling that she had betrayed the partner because she had not prepared him for the eventuality of the patient's death. The CCN described feeling guilty that she had not anticipated the patient's unsuccessful resuscitation, and that she had deceived or "tricked" the partner into believing that the patient would be more comfortable after his intubation.

The participants stated that, although the patient was their priority in an unsuccessful resuscitation, there were times when it became apparent that the significant others had needs that required a referral to other hospital departments and/or the allocation of resources.

So when I went in I really made an effort of sort of talking with the little boy, talking with the dad just because I thought this isn't going to work. Well, let's build that rapport as fast as you can in a short space of time. And, uh, the boy was a little, he was a talkative fellow and he listened as I talked to the dad but he was very much a part of what was going on. And I thought, oh that was interesting - that obviously the dad didn't feel that he had to shelter him, or say, or say, "Well, I'd like to talk to you alone." There was nothing like that. They were a group the two of them and so, um, I began to let them know what was happening to, uh, their loved one and, uh, they were okay and there was this feeling of yeah, she's been through some tough stuff, it's okay, it
was almost as if one says it's okay, she'll pull through because you know we've been there.

Following this interaction, the CCN asked the unit clerk to call a social worker and she apprised the social worker of the situation.

Knowing the patient was also manifested by the participants' use of professional distancing and detachment when interacting with patients. Professional distancing was defined as concern and care for the patient and family members while maintaining some emotional distance and protecting oneself. Knowing that the patient was likely to die because of his/her poor physiological status and knowing that the death of the patient would be devastating to his/her significant others were the most common reasons given by the participants for detachment to occur in an unsuccessful resuscitation. The participants concurred that detachment is a strategy that reduces the impact of the CCN's loss and grief associated with unsuccessful patient resuscitation.

There was a part of me that also distanced myself from him because I knew he wasn't going to make it. We could see that happening.

(I) try and be empathetic and care for the patient but not allow the emotions to --- to get so much involved. A little, yeah, professional distance.

From the emotional part of it, you know, I mean you certainly --- that's your job to show concern and care but there is a point that you've got to care about yourself too.

Several participants stated that they used detachment so
that they could support the family more effectively. The CCNs' explained that when they were emotionally "controlled" they felt they were more supportive to family members.

If you are a little more detached it makes it a little easier and you're a little more effective with the family.

Telling family members "bad news" about the patient was viewed as one of the most stressful aspects of the CCNs role in an unsuccessful resuscitation. One participant told of how she had to put on a professional mask before she prepared the significant others for the patient's death. Another reported that she had learned "lines" to help her deliver the news in a professional but caring manner in such situations.

I think okay "Nurse", I almost have to mentally because inside I'm just churning. So I really try to be as slow thinking and talking when I see them, you know, because I'm trying to think of them. Their anxiety level's up to here.

I remember going out and telling them that it really wasn't looking very good, you know, that she was really unstable. I always do - those are my lines, when I know that there's the impending doom, just in the old preparation work and making the point when I, when I had this gut feeling that the person's not going to make it.

Two participants stated that past experiences involving the death of a patient precipitated their deliberate use of detachment to protect their emotional integrity.

Earlier in my career I'd gotten really quite involved with a family and a patient and when the patient died, it was like the whole nursing staff was there crying their eyes out. The doctor was there. We were all holding hands and it was just the most emotionally draining thing that ever happened. So I've tried to
put a little bit of professional distance ever since then. I went home a basket case for two days. It was like, oh, I was so depressed.

One participant stated that she chose to be detached because she had seen too many CCNs become "burnt out" as they were "too emotionally involved" with patients who died. Two other participants described becoming "businesslike" during a resuscitation, particularly when the arrest had been expected and the outcome was predicted to be negative.

Then I'm pretty sure I felt business like. Okay, now what is the next task? This man has died.

Emotional detachment was abandoned, however, when the CCNs interacted with significant others following an unsuccessful patient resuscitation. The participants described "looking into" themselves for feelings when they were required to tell a significant other that the patient might not live. This "getting in touch with feelings" was viewed as necessary to support and care for significant others in an empathetic manner.

You see the hope faltering, um, then somehow the old emotions take over and you find it hard and, harder as you find yourself getting more and more closer to them and feeling what they're feeling and, uh, so yeah, toward the end, I found it very difficult.

Several participants stated that it was much easier from an emotional perspective not to have to interact with the family following an unsuccessful patient resuscitation.

It would have been easier if I had not had the family. It would have been very quick and over with.

I guess that made it easier on us in a way, that we didn't have to deal with the family. Because that's
certainly a stressful thing to deal with and sometimes I find it more stressful dealing with the family than, you know, with the patient dying and whatever.

One participant described a situation where she had anticipated that the charge nurse would inform the family of the patient's death. The charge nurse, however, was absent from the unit when the family arrived. Having the charge nurse tell the family of the patient's death was a strategy used within this unit to reduce the CCN's stress and allow the nurse to remain detached from the situation.

Typically, the way it runs in our unit - is the doctor would be the one to inform them or the charge nurse. We have assistant head nurses who are always on duty and they usually perform that function, one of those two people. In fact, in our area, the bedside nurses do not get put in that position. That's sort of rare for me.

Although the CCN began to tell the news of the patient's death to the family in a detached manner, she recognized that she would have to discard her cloak of detachment before she could relate to the family in an empathetic way.

I've had many patients die - I didn't have a lot of feelings like emotions, or I wasn't caught up in my emotions, or I wasn't caught up in my emotions at all about this man having died. But, so it was more, a little, um, difficult for me to remove sort of - I had to sort of force myself to say the first few words - knowing that I was delivering to this family this news.

What does Knowing the Patient Do?

Knowing the patient improves the CCN's ability to plan and implement care that is specific to the patient and family. The nurse is able to use her knowledge of the patient and the case to identify particular patient...
responses. In many of the paradigm narrative situations, the CCNs stated that they had customized their care based on their knowledge of the patient. Knowing the patient's typical responses altered the CCN's assessment and level of concern for the patient.

I asked him to describe the pain, where it was and I saw that he was in, you know, he was in obvious distress. So, I sort of - really limited what I asked him, uh, checked his blood pressure, gave him nitroglycerin, um, called for a stat twelve lead.

Knowing the patient's roles within the family assisted the CCNs to relate to how it would feel to lose a child, father, or mother. This was deemed necessary to be truly empathic with significant others during and following an unsuccessful patient resuscitation.

How was she (significant other) going to manage, and you know, yeah and, "How do you tell the children?" And they're children now and they love their dad.

This was unexpected for the family. They did not expect her to suddenly, um, pass away. I went out to, you know, to see the family. I try to be aware of the fact that it's the longest forty minutes of their life or, however, long it is.

The participants agreed that knowing the patient influenced CCNs' grief responses in unsuccessful patient resuscitations. CCNs experienced an increased sense of loss with unsuccessful patient resuscitation of young patients.

In the end you say, "Oh forget it, it's a woman, she's forty, she's dying". You know, the emotions are there. In a few paradigm narratives, the participants were able to cope with their feelings about an unsuccessful resuscitation of an older patient by referring to the patient's age.
It's a lot easier most of the time if somebody is like very old and has been very sick for a long period of time. I'm not saying that's right, but for me it's, it's not the same, you know, I really think you know this is maybe a good time for that person to die.

Knowing the patient frequently resulted in the CCN experiencing personal emotions that were "draining" when the patient was not successfully resuscitated. The participants concurred that the unsuccessful resuscitation of a patient created a sense of loss for the CCN. Several participants described feeling the "loss of hope" and emotionally "upset" following an unsuccessful resuscitation. One participant described a sense of "defeat" with the unsuccessful resuscitation of a patient that she had grown to know. During the resuscitation procedure, the CCNs often experienced alternating feelings of hope and hopelessness followed by emotional exhaustion.

It's emotionally draining to go, to go through, through the process and those couple of times when there was a rhythm. There's, "Oh, there's a bit of hope." Then there's not. So it, it's very emotionally draining to go through a long, complicated arrest.

How does Knowing the Patient Do What it Does?

Knowing the patient creates a relationship between the CCN and the patient. The patient is no longer a "case". The transition from case to patient is marked by the creation of a relationship between CCN and patient. The nature of this relationship and the value that the CCN placed on the patient's ability to live influenced the nurse's grief response in unsuccessful patient resuscitation. Knowing
patients who are unsuccessfully resuscitated aroused a variety of feelings including loss, hope and hopelessness, ambivalence, and pessimism. In an effort to protect themselves from the loss they would experience when the patient died following an unsuccessful resuscitation, the participants practised emotional detachment or distancing.

Knowing the patient created a connection between the patient and the CCN. The implications of this connection became apparent in the participants desire to protect their patient from "poor" outcomes. These nurses defined poor outcomes in a contextual way. In some situations, the CCN wanted to protect their patients from death. For example, the CCN who cared for the previously healthy middle age man that suffered a myocardial infarction had a strong desire for the patient to live because she felt he had the potential to fully recover. In other paradigm cases, a peaceful or "good" death was desired. For instance, the participant that cared for the patient in his 70's or 80's who had suffered a myocardial infarction and then developed worsening cardiogenic shock felt that the patient had lived a "full" life and desired a peaceful death. In the event of long and complex resuscitation efforts, the CCNs did not want the patient to live if his or her quality of life would be diminished.

Because they knew the patient, the CCNs were able to recognize the importance of including significant others in
their plan of care. The relationship between the CCN and the patient and significant others involved caring, concern, and a sense of responsibility for the patient and significant others. At times, this responsibility and concern generated both moral and ethical concerns for the CCN. The moral and ethical concerns of knowing the patient are illustrated in two paradigm cases. In one situation, the CCN appreciated the way the situation was managed by the physician, family, and health care team. The patient in this situation had an underlying history of cancer of the breast and was septic upon admission to the ICU. During the resuscitation effort, the internist telephoned the patient's oncologist, after consultation with the oncologist, family, and nursing staff, the decision was made to discontinue the resuscitative efforts. The participant described a moral and ethical fit to the situation because the interests of the patient were considered paramount.

Another thing I was really impressed with was the physician, the internist who decided, who took a minute, who took the time to just stop and think about what was doing. What was happening? What was best for the patient? Talking, taking time to phone the oncologist - to say tell me a little bit more about this woman, I don't know her, what do you think? And being assured immediately that whether we do, the aggressive efforts were probably not the wisest.

In the second situation, the CCN's concerns for a patient experiencing severe chest pain were disregarded by the cardiologist. The patient subsequently arrested and died. The nurse felt that she had not advocated strongly
enough for the patient, and she believed that she had a moral obligation to the patient. This participant felt significant responsibility for the patient's death and personal distress.

The most significant thing for me was that sense of frustration and almost helplessness that we didn't do everything that could have been done. So I was, that, that was going through my and I felt abandoned.

This paradigm case influenced both the CCN's thinking and practice. The participant learned through her moral concern for this patient to trust her own judgement and she renewed her commitment to patient advocacy.

Significance of Knowing the Patient

Knowing the patient gives meaning to CCNs' experience of unsuccessful patient resuscitation. The nurse's knowledge of the patient's age, past medical history, and current physiological status created expectations surrounding the potential for the patient to be unsuccessfully resuscitated. In situations, where the CCN predicted the patient's instability and unsuccessful resuscitation, she frequently used detachment or professional distancing to protect herself emotionally from the loss of a patient. The participants valued knowing the patient as a mechanism for preparing themselves to be competent, as well as emotionally stable, during and after an unsuccessful patient resuscitation. This predictability, also enabled the nurse to prepare the patient and his/her significant others for the anticipated outcome of the
The CCN's relationship with the patient created a sense of professional responsibility for the patient's care and for the consequences of the resuscitation effort. The participants felt a sense of responsibility to protect their patients from "poor" outcomes. The CCN's desire for the patient was contextual in nature based on her knowledge of the patient and his or her circumstances. The CCNs described feeling sadness, pain, upset, hopeless, defeated, and emotionally drained during and following unsuccessful resuscitation of a patient they knew.

Knowing the Person

The participants of this research study shared paradigm narratives that entailed caring for patients whom they perceived they did not know well as a person. Knowing the patient as a person, and not simply as a case or a patient, was deemed crucial to providing individualized, compassionate care to patients and to significant others in unsuccessful resuscitation efforts. The participants defined knowing the person as knowing the unique personality, responses, and needs of the individual. Although the contextual factors associated with a resuscitation in the critical care unit (e.g., lack of time to know the patient as a person and the unresponsiveness of many patients) constrained the participants' ability to know the person to the extent they desired, many of the CCNs
related distinct and unique characteristics of the patients they described in their paradigm interviews.

Aspects of Knowing the Person

The participants stated that knowing the person entailed the following aspects of the individual patient: his or her character, specific and individual responses (i.e., physiological and behavioral) to his/her critical status and/or interventions, and primary need(s).

The participants of the study frequently described the character of the person in their interactions with the person prior to the resuscitation. Descriptions of the nature of the person included "nice", "cooperative", "loving", "pleasant", and "a bit of a fighter". In several of the paradigm situations, the patient was unable to verbally communicate due to intubation or diminished level of consciousness. In these situations, the participants amassed an understanding of the person through interaction with significant others during the resuscitation effort and following the patient's death.

I began to get to know her, just from her husband and her son, what they said about her. What her health - she had her fight through her breast cancer, and I thought, "Well, this woman's a fighter." ---- There's certain things, you know, you begin to admire about her.

The CCNs gained further insight into the person's character through understanding the person's unique responses to his or her situation. The CCN's knowledge of the person includes recognizing and understanding the
person's usual and atypical physiological and behavioral responses. Recognizing the unique physiological and/or behavioral responses of the person alerted the participants to the person's instability and the imminence of cardiac and/or respiratory arrest. In several paradigm cases, the CCN noted a significant change in the person's normal pattern of responses prior to the patient's arrest.

The first incident happened that morning, and it probably happened around nine thirty or ten. Where, because he was getting progressively confused, even though the side rails were up on the bed, he fell out of bed.

I called some of the docs over and I said, "Yeah, this is something new. His limbs are all mottled and this hasn't happened before."

The participants defined knowing the person as recognizing patients' individual responses to interventions, both prior to and during unsuccessful patient resuscitation. The CCNs frequently described the person's unique responses to interventions as a short term improvement or a rapid deterioration in the person's condition.

He was getting more distressed and more distressed, as soon as you put him into trendelenburg. ---- And, through this we had to put the star wars (referring to a specialized oxygen mask) on because he wasn't doing well and more oxygen. He was becoming more distressed and restless, and he wasn't complying.

In some paradigm cases, knowing the person entailed identifying the person's primary need(s). The CCN required an understanding of the person's distinctive behaviour, character, fears, and goals to recognize the person's need(s). In one paradigm case, the participant related the
story of an eighteen year old male in severe respiratory distress who repeatedly asked for his mother. It was clear to the CCN, because of the unusual intensity in the patient's voice, that seeing his mother was this person's primary need. This nurse was to later regret that she had not acted on this knowledge because other members of the resuscitation team had believed that lifesaving efforts should be the priority. The patient died without seeing his mother.

She (referring to his mother) went over and started talking to him and telling him (after his death) how much she loved him and kissing him on the forehead and just sort of rubbing his head. And telling him probably everything she would have told him had she had the opportunity to come in and see him and I think that really hit me hard. Because I knew that she'd missed this opportunity to tell him. And what kinds of thoughts went through his mind waiting for his mother? It's so unfair that they (mother and son) should be separated at that time. I mean it just shows a little bit of how technical we've become and we're going to save despite everything and yet what he needed --- he wasn't going to be saved, you could almost tell that right from the very beginning. What he needed was his family. He didn't get that contact.

Manifestations

Knowing the person is manifested in the CCN's caring connection to patients and significant others, as well as the CCN's emotional response to the person's suffering and death. Knowing the person was apparent in the CCN's respect for and admiration of the person as an individual, as well as the desire to protect the person from suffering and to maintain the person's dignity.

The CCN's connection with the person included a
dimension of caring that was not evident in the paradigm narratives of participants who only knew the person as a patient. The nurse's sense of connection and her respect and compassion for the person was evident in the empathetic dialogue between the CCN and the person.

A very, very nice man, very warm. He happened to have a name that was the same as one of our former prime ministers, so he found that quite amusing that he'd been in politics indirectly.

I had him for a couple of days and, uh, and he'd really been through a lot and uh, I think anybody that can survive the shock study is amazing (laughs), most of them are pretty sick, most of them are pretty sick, most of them die.

Frequently, connection involved respecting the character of the person. In several situations, the participants stated that they had learned to admire the qualities of the patient as they "got to know" the person.

He was just the most pleasant man, very talkative, um, very warm. He'd lived. He kept talking about his full life that he'd lived.

Not everybody's wonderful but he, he was just truly a wonderful son too. And it was just devastating for his father and his father just couldn't even comprehend it.

Knowing the person was revealed in the CCN's desire to protect the person from suffering. The participants used their knowledge of the person's characteristic behaviour to gauge the person's degree of distress. Because they felt connected to the patient, the CCNs stated that they experienced feelings of helplessness, anxiety, and emotional distress when the person suffered.
I mean helplessness. I think no matter what had happened, there would have been some sense of helplessness because there's nothing much you can offer these people. But it was intensified by pain which isn't always that evident in cardiac arrest and in his pre-arrest.

Several participants described paradigm cases in which the CCN was unable to relieve the person's emotional and/or physical distress. These situations aroused feelings of powerlessness in the CCN. In one paradigm case, the CCN admitted that she was relieved when the person became unconscious and she did not have to watch his suffering any longer.

It was written all over his face. Yes, so that was upsetting and you don't ever like to see that and to not be able to do anything, you know. (There were) Sort of standard, you know, standard things I might do to try to reassure and to calm someone, to help him, (like) touching them and talking to them. You know, I think we had enough of a relationship that he should have connected with me and we would have made eye contact and we would have been okay but nothing worked. He, he couldn't communicate, I mean he looked at me and stuff but he was just shaking his head and writhing. So I was almost glad when he became unconscious.

When the participants knew the person who was unsuccessfully resuscitated, they experienced loss and grief. Frequently, the participant's loss and grief was expressed in tears and sadness. In some of the narrative accounts the CCNs' used laughter to ease the tragic nature of the patient's death. One participant described the undignified way the patient had died as "upsetting", she further explained, that she "didn't like to see anyone die this way".
And so, when they stopped it and said, "Okay, let's finish now. We've had it", I immediately burst into tears and ran out of the room. And it was interesting because one of the cardiologists said, "Is she upset because we stopped the arrest (laughs)?" And I thought, "No - I'm just upset that he had to die this way".

In one paradigm case interview, the CCN stated she had gained her knowledge of the person through his mother. In this situation, the participant's grief was shared with the mother.

I remember her (referring to his mother) just saying, "I don't know how I'm going to do this. I can't walk out of here and leave him." --- and, I was crying and hugging her (laughs). I don't know who was comforting who by the end and but, uh, I remember saying, "I'm sorry, so sorry this happened."

Several of the participants expressed difficulty "letting go" following the death of a person they knew. This letting go included both the person and the significant others. The idea of letting go often involved a paradox in that the CCN did not want the patient to suffer; however, she did not want to let go of the person.

It was hard to say goodbye to him too. It would have been nice if he had survived (chuckles) you know, at least for a little while longer but that would have been unrealistic.

Knowing the person was manifested in the ways in which the CCNs maintained the dignity of the person throughout the resuscitation experience. Respect for the dignity of the person was maintained even after the patient had died. Respect was evident in the nurse's care of the patient following death.
I often find that I --- I think the body is still that person and that I still want to have a certain amount of respect or consideration for that person, even though they're not alive.

The participants consistently described "tidying up" the person following the unsuccessful resuscitation. "Tidying up" included cleaning and normalizing the deceased patient. This action was seen as being respectful to the person and to protect the significant others from viewing the ravages of the resuscitation efforts.

There was blood everywhere. There was, you know, we tried to get as much of it done as quickly as possible before the family came in. We certainly spent some time just tidying him, the patient, up and trying to get some of the worst blood off him, but we had to leave all of the lines in unfortunately.

The participants identified a number of active and passive strategies for dealing with the loss of a patient to whom they had become connected, the most pervasive of which was to cry initially and then to put the incident "behind you". Most of the participants described the need for private tears to manage their grief.

I had a moment (referring to tears) out by the hopper. It's funny how you can choose these little places (laughter). They're such lovely spots. --- I felt myself losing it just a little bit so I went to the bathroom, pulled myself together because it wasn't quite over and I knew I had to get through this.

I grab a book or a hot bath, go and have a good, good, hard cry and that's it. I mean, I leave it after that and usually go to bed, early to bed and get up. I'm drained for the next day. But I leave it after that. I just don't want to talk to anybody. I don't want to live it again.

One participant stated that she was "uncomfortable crying in
the unit because tears are often considered a weakness" by her colleagues. Some participants stated that the memory of specific person's unsuccessful resuscitation can be triggered unexpectedly by a sight, sound, or smell. At these times, the CCN's sorrow and loss remain strong.

Some participants described a transition that occurs in the CCN's thinking about the person, following an unsuccessful resuscitation, in which the deceased patient becomes a shell of the person he/she once was.

I often think, you know, just a few minutes ago this was a person here but now it's sort of not any more, you know. Like whatever that person was isn't there any more and that's really --- sometimes you know, you are just awed by that.

The participants acknowledged that they also experienced feelings of loss when they observed significant others leave the hospital after the death of the patient.

It felt so awkward seeing them leave. You know, you sort of thought (makes sighing sound) ---- then they left the hospital sort of that's it. --- That was very difficult. To sort of say goodbye as well, yeah, I remember that.

What does Knowing the Person Do?

Knowing the person enhances the CCN's ability to assess the person by providing data, which are not evident in knowing the case and knowing the patient, regarding the unique characteristics and responses of the person. In some paradigm cases the CCNs were able to identify the person's instability and impending cardiac and/or respiratory arrest based on the person's unique physiological and behavioral
responses. This knowledge of the person's unique responses assisted the CCN to judge the severity of the situation and to predict the outcome of the resuscitation effort. Knowing the person's unique behaviour and responses often alerted the participants to a deterioration in the patient's status, although the cardinal signs of deterioration were not present. The participants admitted that often they knew that something was wrong with the patient before they knew what was wrong.

I think that scared me (referring to the patient's confusion and distress immediately before an arrest) because it set up all kinds of alarms about what was happening to him. See, logically, you know even though I maybe didn't pinpoint it or articulate it at the time. I mean his blood pressure was dropping because his aortic aneurysm was worsening.

In many paradigm cases, the CCN's sensitivity to, and understanding of the person's usual and atypical responses assisted the nurse to assess the person's level of anxiety, fear, and their resilience. Knowing the person facilitated the CCN to recognize and understand the meaning of the experience to the individual.

I mean at one point he, it was, it was sort of, things just didn't, because he was trying to sort of bargain. Well, he was doing I, "I want to have this shortness of breath taken away but I don't want to be on a ventilator. Can't we just do this instead?"

He had a VT (ventricular tachycardia) arrest in ICU and survived that. And then he came to us and, the day I had him he had, he went into VT and, he was just defibrillated out of it and survived that and then I believe he had another small arrest and went into VT and then he came out of that again. And then, the next night I had him, well, actually I didn't really have him but I was helping out and, then he went into a full
arrest and didn't survive that one.

Knowing what the person had been through and what they were going through (i.e., anxiety, fear) produced feelings of anxiety, helpless, suffering, and distress for CCNs when they were unable to alleviate the cause of the behaviour (e.g., pain).

The participants used their knowledge of the person's unique characteristics and responses to determine the specific needs of the person for care and intervention. Because the CCN knew the person, and not just the patient or the case, she was often able to identify that the patient's primary need was other than what was typical in these situations. For example, one participant recognized that a patient had a greater need to see his significant other than to have pain relief. Another participant described her interaction with a man in his eighties who had a large myocardial infarction, two days prior to her caring for him. The nurse's knowledge of him as a person assisted her to understand that this person had lived a full and complete life and that he would not want heroic measures to sustain his life. Because of this, the nurse advocated after he arrested that no heroic measures be used in resuscitation.

Knowing the person established a connection between the CCN and the person. The CCNs were able to empathize with the person's distress, suffering, and responses more closely because they knew the patient as a unique individual. The
participants concurred that being connected to the person influences the CCN's grief response in unsuccessful patient resuscitations. Although the loss of a patient, to whom the CCN had become connected, was painful, the connection of the CCN to the patient as a person enabled the nurse to advocate for the person's needs and wishes, as well as to enhance the meaning of the experience for the nurse.

The CCNs' knowledge of the person's desires and needs often resulted in moral and ethical conflicts for the CCN. In one paradigm case, the CCN believed that, if the person had been apprised of the severity of his condition, he would not have wanted resuscitative efforts. The participant involved in caring for this man expressed moral distress over what she perceived as the "violation" of the person.

It would have still been upsetting if he had died and to follow him through that death would have been upsetting - but the fact that he was "violated" like that, by all these people coming in and, you know, doing the compressions and sticking him with these needles and trying to get a blood gas off and all those kinds of things. It was so unnecessary because the outcome was not going to be any different.

How does Knowing the Person Do What it Does?

Knowing the person gives a different meaning to the CCNs' experience of unsuccessful patient resuscitation. In knowing the person, the patient becomes not someone who receives care but someone who is cared for. Such a distinction entails the involvement of the CCN in the world of the person. Knowing the person results in the CCN experiencing concern for the patient. Concern for the
person creates an involvement of the CCN in which she must engage with the person in such a way as to acknowledge his/her individual needs, desires, and characteristics.

Knowing the person creates a relationship between the CCN and the person. The person is no longer a "patient" or a "case". The transition from patient to person is distinct in that there exists a strong connection, characterized by compassion and empathy, experienced by the CCN for the individual. The nature of this connection and the participants' identification with the person in an unsuccessful resuscitation influences the nurse's personal loss and grief. Detachment is not possible when the CCN knows the person; therefore, the CCN is unable to protect herself from the loss and grief she experiences when the patient is unsuccessfully resuscitated. Because the grief response is so painful, the CCNs attempted in a variety of ways to negate or minimize the impact of the person's death.

Knowing the person creates a strong connection and identification with the person. The CCN identifies with the anxiety, fear, and suffering experienced by the patient. The implications of this relationship become apparent in the participants' desire to protect the person from suffering and indignity.

Significance of Knowing the Person

Suffering is a significant dimension of the experience of CCNs when they know the person who is unsuccessfully
resuscitated. Because the CCN knows the patient as a person, the nurse is vulnerable to the issues, concerns, and emotions associated with observing the suffering of the patient and his/her significant others. Knowing the person intensified the sense of the CCN's loss when the patient died, thus resulting in the nurse's suffering.

Meaning is another central aspect of the experience of CCNs when they know the person who is unsuccessfully resuscitated. Because the CCN knows the person, the experience of caring for the patient before, during, and after the resuscitation is meaningful, causing the CCN to reflect, rethink, and to create new options (i.e., new ways to think, feel, and relate) in his or her nursing practice. Although knowing the person who is unsuccessfully resuscitated is connected with both stress and loss, it is the meaning of these experiences which caused the participants to characterize them as paradigmatic in their critical care career.

Reliability and Validity

In qualitative research, the issues of reliability and validity pose specific problems. Benner (1994) proposes two criteria for judging the reliability and validity of qualitative research: ensuring that the researcher has heard the voice of the participant; and accurately presented the voice of the participant.
Hearing the Voice of the Participant

A phenomenological approach to research "requires dialogue and listening that allow the voice of the other to be heard" (Benner, 1994, p. 100). Hearing the voice of the participant is enhanced by several mechanisms. According to Benner "the researcher's own background practical knowledge is considered as part of the perceptual lens, enabling skills and limits for conducting the study" (p. 103).

The researcher attempted to identify her perceptions and biases in a variety of ways. The literature related to unsuccessful patient resuscitation was reviewed prior to initiating data collection. This provided the researcher with an understanding of other descriptions and empirical findings associated with the phenomenon. As a critical care nurse with eight years of clinical experience, the researcher reflected on her own experiences with unsuccessful patient resuscitation to identify pre-existing biases and blind spots. The researcher has acknowledged and recorded her assumptions regarding the influence of unsuccessful patient resuscitation on the CCN (see Assumptions).

The interview process is central to hearing and understanding the voice of the participant. Open listening, or allowing the interviewee to shape the narrative account and focus on the key aspects of the situation, is essential to hearing the voice of the participant (Benner, 1994). The
researcher endeavoured to actively listen and reflect on the narrative accounts without interrupting the participant. Benner (1994) recommends that the researcher use open ended questions to clarify and probe unclear areas. In an effort to obtain the best description of the paradigm case situation, the researcher asked open ended questions to clarify the meaning of participant's statements and to explore areas in greater detail.

The researcher's understanding of critical care nursing and unsuccessful patient resuscitation may have hindered her ability to recognize some aspects of the participants' experience as common or different. Consequently, the researcher may not have clarified or questioned some aspects of CCNs' experience with unsuccessful patient resuscitation that seemed obvious to the researcher. For example, although the participants stated that unsuccessful resuscitations caused them a great deal of emotional stress, it is striking that their accounts of unsuccessful resuscitations are characterized by an objective, unemotional, recounting. Because of the investigator's experience as a CCN, she did not find this to be unusual. The researcher knew from personal experience that a CCN learns to distance oneself from such emotionally-laden situations in order to cope with the assault of such experiences. The researcher did not question it. When a member of the thesis committee asked why such a disparity
existed in the participants' accounts of unsuccessful resuscitation, the investigator considered two possible explanations: (1) the participants practised emotional distancing as a protective mechanism and, therefore, recounted their narratives in a decidedly unemotional manner; and (2) the researcher is an inexperienced interviewer who may have lacked the skill to encourage the participants to move beyond an objective stance to a more personal and emotional one.

The researcher maintained a reflective journal of the data collection and analysis process. Benner (1994) suggests that researchers remain critically reflective about what their biases and blind spots might be and why they think the questions that they are asking are pertinent. The researcher carefully maintained self-reflexivity in the research process by using the Reactivity Analysis framework (Paterson, 1994) during data analysis.

The Reactivity Analysis framework assists the researcher to analyze data for reactive effects in a reflexive manner (Paterson, 1994). In qualitative research, reactivity consists of the participant's response to the presence of the researcher, and the researcher's reaction to the research process (Polit & Hungler, 1991). The Reactivity Analysis framework employs five themes to assist the researcher in self-reflection. The five themes of the framework are the common sources of reactivity: emotional
valence, distribution of power, importance of the interaction, goal of the interaction, and the effect of normative or cultural criteria. "The framework is particularly effective in assisting the researcher to identify how the participants affected the way in which the researcher constructed and reported the data" (Paterson, p. 12).

Following the initial identification of clusters and themes within the transcripts, the researcher listened to a research presentation by Fonteyn and Fisher (1994) on the phenomenon of "knowing" in critical care practice. The researcher is uncertain how much hearing this presentation influenced the identification of the unifying themes of this study. The participants repeatedly expressed the themes of "knowing the patient" and "knowing the person" in their narrative accounts, however, the investigator may have clustered these themes differently if she had not been exposed to the research findings of Fisher and Fonteyn.

The investigator attempted to reduce researcher bias by sharing and validating emerging themes with the participants of the study, and by critiquing and reviewing the interpretation of the data analysis with members of the thesis committee. Both the participants and members of the thesis committee validated the themes and theme clusters.

Accurately Presenting the Participant's Voice

Accurately presenting the participant's voice is a
rigorous and challenging component of phenomenological research. There are a number of strategies that promote accurate presentation of the participant's voice. Benner (1994) contends that "the guiding ethos is to be true to the text" (p. 101). The researcher attempted to be faithful to the text by staying as close to the participant's words as possible. Additionally, a third interview was conducted to clarify and validate interpretations to ensure that the researcher understood the participant's meaning. The investigator attempted to validate interpretations in a tentative manner, facilitating the participant's ability to disagree (Benner, 1994).

Accurately presenting the voice of the participant is enhanced by examining the text from a variety of perspectives (Benner, 1994). The researcher used both the framework developed by Collaizzi (1978) and an adaptation of the method of thematic inquiry developed by van Manen (1990). Each of these methods assisted the researcher to reflect on the text from different perspectives. This analysis and reflection increased the investigator's understanding of the participant's voice. The researcher tracked changes in perspective and understanding in field notes and a researcher's journal. The process of writing and rewriting the findings assisted the investigator to refine her understanding and accurately portray the voice of the participant.
The rigor of research that uses a phenomenological approach lies in the ability to apply the criteria described by Benner (1994). In examining the research findings the reader must take into account that the method and the researcher's lack of experience influenced the findings of the study. The study offers a beginning understanding of aspects of the CCN's experience of unsuccessful patient resuscitation. The criteria of ensuring that the researcher has heard the voice of the participant, and accurately presented the voice of the participant provided the investigator with a guide to ensure rigor in the research process.

**Summary**

The CCNs who participated in this research study recounted paradigm case stories of unsuccessful patient resuscitation. The analysis of the findings revealed that the experience of CCNs must account for the context of their experience of unsuccessful patient resuscitation. The central theme of "knowing" was identified from the research data. Knowing involves three themes: knowing the case, knowing the patient, and knowing the person. The participants' accounts of unsuccessful resuscitation illustrate that these themes are often indistinct and overlapping.

The way in which the CCN is engaged in the patient care situation (i.e., how much she knows and is connected with
the person) was found to create different possibilities in regard to the nurse's emotional involvement with and commitment to the patient. The degree of involvement was discovered to affect different management issues for the CCN. The CCN's ability to use detachment as a means of protecting herself from the emotional assault of watching the person suffer and die was decreased as the CCN became increasingly involved with the personhood of the patient.
CHAPTER FIVE

DISCUSSION

The findings of the investigation are analyzed and discussed within this chapter. The discussion of the findings begins with an exhaustive description of CCNs' knowing as it relates to unsuccessful patient resuscitation. The themes of knowing the case, patient, and person are discussed in the context of unsuccessful patient resuscitation. Implications of the findings for nursing practice, education, and research conclude this chapter.

Exhaustive Description of Knowing as it Relates to Unsuccessful Patient Resuscitation

A CCN comes to "know" the individual who eventually is unsuccessfully resuscitated through the dynamic process of uncovering the layers of an individual. This process occurs as the CCN becomes increasingly connected to the individual. Knowing the case, patient, and person influences CCNs' expectations regarding the outcome of the resuscitation efforts and their ability to manage the emotional aftermath of unsuccessful patient resuscitation.

Prior to establishing a connection with the individual, the CCN utilizes her/his knowledge of the case to direct the nursing care of the individual. CCNs gain an understanding of the case by applying theoretical knowledge and experience with the patient population in critical care settings to the situation. CCNs' knowledge and experience of critical care
cases assists them to provide competent and confident care to the individual, as well as to anticipate a cardiac and/or respiratory arrest. Anticipating the resuscitation enables the CCN to provide competent technical care prior to and during the resuscitation effort, and to fortify her/himself for the emotional consequences of unsuccessful patient resuscitation.

As CCNs care for individuals over time, and develop a relationship with the individuals and their significant others, they begin to uncover unique facets of the patient and the person. Understanding the patient and the person is heightened by the instability of the individual's status and the degree of distress and suffering experienced by the individual prior to the unsuccessful resuscitation. The patient's responses to pain and suffering illuminate aspects of the person that facilitate the CCN's understanding of the person.

Knowing the patient involves a relationship, characterized by a sense of professional obligation and responsibility, between the CCN, the patient and the patient's significant others. This relationship is manifested in the physiological, psychological, and relational care that the CCN gives to both the patient and his/her significant others. The nurse's understanding of the patient's responses allows her to identify and predict, with greater accuracy than knowing the case, the patient's
instability and the unsuccessful resuscitation.

At times, CCNs use emotional detachment or professional distancing to manage the emotions associated with the potential death of a patient by cardiopulmonary arrest. Despite the use of professional distancing, CCNs are forced to shed their emotional detachment, reaching inside themselves to locate their emotional response, in order to be able to tell the details of the resuscitation effort and support the significant others following unsuccessful patient resuscitation. Knowing the patient who is unsuccessfully resuscitated results in feelings of hope and hopelessness, pessimism, loss and grief.

Knowing the person that is unsuccessfully resuscitated is both rewarding and painful for CCNs. The rewards come from a strong connection between the patient and nurse that is translated into an intimate knowledge of the person and an emotional attachment to the patient and significant others. The benefits of knowing the person are evident in the CCN's ability to provide individualized care to the person and their significant others. Additionally, knowing the person results in the CCN being able to judge the severity of a situation and predict a cardiac and/or respiratory arrest based on very subtle physiological and behavioral cues.

The CCN's involvement with the person and his or her significant others is frequently painful because nurses
experience the threat of loss of the person whom they have
come to know and care for at the onset of the cardiac and/or
respiratory arrest. Knowing the person who is
unsuccessfully resuscitated frequently precipitates the
CCN's feelings of hopelessness, powerlessness, moral
distress, loss, and grief.

**Knowing the Case**

The participants commenced knowing the layers of the
person through "knowing the case". The participants used
their knowledge of the case, in combination with both
theoretical knowledge and previous experience with similar
patient populations, to provide competent patient care.
Knowing the case provided an important foundation that
assisted the CCN to make competent clinical decisions based
on their knowledge and experience. Using their knowledge of
the case as a template, CCNs were able to assess patients
and judge what was 'normal' or 'typical' in the case to make
clinical decisions based on this knowledge. The CCNs were
also able to plan, implement, and evaluate care based on
their knowledge of similar cases.

The CCN's knowledge of the case incorporates scientific
knowledge of the diagnosis, physiology, physiological
responses, and the interventions associated with the
cardiopulmonary arrest and nurses' personal experience with
similar patient populations. Carper (1978) describes four
patterns of knowing in nursing practice: empirics,
esthetics, personal, and moral knowing. Knowing the case encompasses both the empirical pattern of knowing and the nurse's personal knowledge of similar cases. According to Carper (1978), empirics is "knowledge that is systematically organized into general laws and theories for the purpose of describing, explaining, and predicting phenomena of special concern to the discipline of nursing" (p. 13). Personal knowledge has been described as "subjective, concrete and existential" (Carper, p. 17). Empirical knowledge allows the CCN to predict basic physiological responses and behaviours associated with specific events, whereas, personal knowledge allows the nurse to understand how the individual patient is different from similar cases.

Knowing the case was significant as it allowed CCNs to care competently and confidently for the patient as they developed a relationship with the patient/person. The CCN's knowledge of the case is key to caring for patients confidently, despite a limited knowledge of the patient. This knowledge heightens predictability of concerns, interventions, and patient outcomes by uncovering the differences between this case and other cases. Additionally, the CCN is able to draw on her previous experience with cardiac and/or respiratory arrests to judge a patient's instability and predict a cardiopulmonary arrest. The ability to predict instability and a potential unsuccessful patient resuscitation allows the CCN to prepare
herself mentally for the resuscitation effort. The nurses in this study described a personal sense of "control" when they could anticipate the resuscitation effort and employ previously learned theory and skills associated with a resuscitation effort. Anticipation of an impending resuscitation enabled the CCNs to plan and implement strategies that reduced the stress associated with the resuscitation event. In contrast, experience with similar cases decreases the CCN's potential for emotional distress as it influences her ability to anticipate a resuscitation effort.

"Knowing the case" was useful to the participants of this research study because CCNs were able to care for unstable patients both prior to and during a resuscitation effort in a competent and confident manner, despite limited understanding of the patient's unique responses. Recently, researchers determined that knowing the case was essential to CCNs for meeting the primary goal of caring for unstable post-operative patients (Fonteyn & Fisher, 1994). In both this study and that conducted by Fonteyn and Fisher, CCNs who cared for unstable patients valued knowing the case as a mechanism for providing care despite limited information.

There are limitations to knowing the case without knowing the patient and/or the person. Knowing the case forces the nurse to make assumptions about what is 'normal' or 'typical' for the average patient. When one is forced to
make assumptions about 'normal' responses of unique human beings in the context of critical illness, there is a great deal of potential for error in clinical decision-making. Jenny and Logan (1992) studied "knowing the patient" in the context of expert nursing practice during ventilator weaning of adult patients. These researchers found that "without the particularistic patient knowledge, the nurses were aware that they were operating only on generalized knowledge, and often felt that this was insufficient" (p. 257). Knowing the case may limit the CCN's ability to make appropriate clinical decisions and predict a range of patient outcomes. Additionally, knowing only the case limits the CCN's focus to the physiological concerns associated with the case and does not incorporate the patient's or the patient's significant others' behavioral concerns into the plan of care.

**Knowing the Patient**

"Knowing the patient" was the CCNs' second layer of knowing. The participants of this study developed knowledge of the patient by building on their understanding of the case. The CCNs gained knowledge of the patient through the patient's record, assessment, interacting with the patient and his or her significant others, and providing nursing care. The CCNs accumulated additional knowledge of the patient's roles and his or her typical patterns or responses through the process of developing a relationship with the
patient and the significant others.

The CCN's involvement in the relationship with the patient and his or her significant others was central to knowing the patient. The nurse-patient relationship at this level of knowing is characterized by a level of involvement and concern for the patient and the significant others. The level of involvement was dependent on the quality of the relationship and the ability of the nurse to connect with the patient.

The nurse-patient relationship was integral to knowing the patient. The CCN's knowledge of the patient encompassed both the empirical knowledge of the case and the nurse's personal knowledge of the patient. Personal knowledge has been depicted as an interpersonal process between the nurse and patient that assists the nurse to understand the patient's meaning of health in terms of individual well-being (Carper, 1978, p. 16). The CCN uses personal knowledge of the patient to recognize typical and atypical responses or patterns to predict instability and unsuccessful patient resuscitation.

The phenomenon of "knowing the patient" has been described in four recent studies of nurses in practice (Benner, 1991; Fonteyn, & Fisher, 1994; Jenks, 1993; Tanner, Benner, Chesla, & Gordon, 1993). Each of these studies describes knowing the patient in a manner similar to the descriptions of knowing the patient in this study. All of
these studies underscore the knowledge gained from a personal relationship with the patient and the influence of that knowledge on clinical decision-making.

Knowing the patient was important to clinical decision-making as it allowed the participants to perceive the patient's typical and atypical responses or patterns. The participants recognized patterns of responses and responses to interventions and care through constant observation, repeated assessments, and the provision of nursing care. The CCNs were able to anticipate and provide physiological and psychological care to the patient in a skilled manner, based on particular knowledge of the patient's needs. This particularized knowledge assisted CCNs to arrive at appropriate conclusions and to make accurate clinical judgements in the provision of nursing care.

Because they knew the patient, the CCNs were able to predict instability and unsuccessful patient resuscitation with greater accuracy because of their ability to perceive and differentiate salient physiological and behavioral changes in the patient's status. When they were able to predict an unsuccessful patient resuscitation, the participants were able to emotionally prepare both the patient's significant others and themselves for the patient's death. The CCN helped to prepare the patient's significant others for the patient's death by providing information, emotional support, and by accessing resources.
The CCN prepared herself for the patient's death by professionally distancing or detaching herself emotionally from the patient.

In a study of nurses verbal and nonverbal behaviors with cancer patients, Bottorff and Morse (1994) found four types of attending: doing more, doing with, doing for, and doing tasks. 'Doing for' and 'doing tasks' were similar to the way the CCNs described caring for patients they knew who were eventually unsuccessfully resuscitated. 'Doing for' was characterized by a personalized approach to patient requests and needs involving working and connecting touch, and in some instances, comforting and orienting touch (Bottorff & Morse, p. 57). Connecting touch involved two types of touch: "... one involved stationary contact of the palmer surface of a nurse's fingers and hand and the other type involved light carressing of the palmer surface of the nurse's fingers" (p. 55). Bottorff and Morse described 'doing tasks' as: "... at times a focus on tasks was critical, it seemed to distance the nurse from the patient; consequently, nurses were less sensitive to patient's concerns or distress" (Bottorff & Morse, 1994). These patterns of attending were evidenced in the nurse's paradigm cases of knowing the patient who was unsuccessfully resuscitated. 'Doing for' was manifested in the CCN's personalized and focused approach to providing care to unstable patients who were in distress; whereas, 'doing
tasks' was apparent when the nurse blocked out the patient's responses and focused on completing tasks both prior to and during the resuscitation effort. The complex care provided to unstable critically ill patients required the CCN to be able to shift her focus of attention between the patient's needs and the tasks that are required to stabilize the patient.

The nature of the interpersonal relationship between the CCN and the patient and his or her significant others created a sense of concern and responsibility for the nursing care of the patient. The CCN's involvement with the patient established the nurse's sense of relational care and professional responsibility. In this study, CCNs' relational care included moral concern for the patient and his or her significant others. Knowing the patient created an opportunity for the CCN to be able to advocate for the patient, based on her understanding of the patient situation. The nurse's role as patient advocate ranged from attempting to obtain adequate care for the patient to discontinuing the resuscitation attempt. The nurse's role as a patient advocate has the potential to be satisfying and distressing. The findings revealed that CCNs who perceived a fit between the situation and her moral values were satisfied with the care experience. In contrast, CCNs who perceived a lack of moral agency, experienced feelings associated with moral distress (i.e., resentment,
frustration, abandonment, sorrow).

Relational care entailed the CCN's desire to protect the patient and his or her significant others from 'poor outcomes'. This moral concern was contextually determined. Protecting the patient from poor outcomes varied from rigorous attempts to save the patient's life to not wanting the patient to live, based on the anticipated quality of life for the patient. According to Parker (1990), "Experiences of intense pain, abandonment, and fear of living and dying are shared in an effort to coconstruct the meaning of seemingly meaningless experiences" (p.38). Parker defines the coconstruction of meaning as "... a dynamic process that necessitates engaged listening, authentic responsiveness, mutual disclosure, and negotiation" (p. 38). The coconstruction of meaning enhances the nurse's sensitivity to subtle changes in the nature of the situation that "may necessitate a reevaluation of moral options" (Parker, p. 38). The CCNs' involvement and concern for the patient and the significant others influenced how the participants perceived the situation. The participants' compassion and moral concern for the patient within the context of their situation has been described as an ethic of care (Fry, 1989; Parker, 1990).

Participants of this research study commonly used detachment or professional distancing when they anticipated an unsuccessful resuscitation of a patient they knew.
Tanner, et al. (1993) describe knowing the patient as "... an involved, rather than detached understanding of the patient's situation and the patient's responses ..." (p. 275). Detachment seems a paradox to the CCNs' involvement in the nurse-patient relationship. This finding was not mentioned in other studies associated with knowing the patient. This finding may be related to the context of unsuccessful patient resuscitation. The emotional consequences of knowing patients who are unsuccessfully resuscitated may have taught CCNs to distance themselves from patients whom they know are medically unstable and have the potential to be unsuccessfully resuscitated to protect the nurses' emotional well-being.

What are the costs of detachment? According to Kadner (1994), "Perceptions gathered through verbal and non-verbal communication in a trusting relationship should be more accurate than those obtained when the participants are distanced from each other" (p. 217). This comment suggests that assessment data may be more complete and accurate when the nurse and patient are not distanced from one another. Consequently, a CCN's clinical decision-making may be hindered when she employs detachment. The participants in this research study used detachment predominately to protect themselves from the possibility of loss of a patient, however, the use of this protective mechanism may have influenced CCNs' ability to respond to moral issues. Parker
(1990) contends that "the strength of nursing is linked to nurses' refusal to adopt an impartial, detached posture in response to moral conflict" (p. 39). Detachment may negatively affect the CCN's commitment to respond to moral concerns and to advocate for the patient. Furthermore, Benner and Wrubel (1988) contend that emotional distance does not assist nurses to manage stressful nursing situations, but emotionally numbs the nurse and separates her from the humanity of both the client and the nurse. These findings raise the question: how much detachment is constructive and healthy in situations of unsuccessful patient resuscitation?

Although detachment may have significant implications for patient care, it is important to remember that this process was used to protect nurses' emotional well-being. In unsuccessful patient resuscitation, detachment may assist the nurse to focus on getting the job done. CCNs must be cautious not to be judgemental of colleagues who use detachment, but to recognize the reason for its use.

Knowing the patient was described by the participants as a means of involvement. In a study of nurses in acute medical and surgical wards in Scotland, May (1991) identified three central features of nurses' involvement with patients: "knowledge, reciprocity, and investment" (p. 552). The context in which the participants of May's research described 'involvement' ranges across three moral
imperatives. Two of these three imperatives are very similar to CCNs' involvement with their patients. May described these imperatives as: involvement as a general quality of nursing work, characterized by a nonproblematic interest, and a familiarity with the patient, and as an investment of nursing skills characterized by 'professional distance'. Although May's description of involvement and professional distance parallels the CCNs' experience, the participants of this study did not describe their involvement with patients and significant others as nonproblematic. CCNs were often unable to maintain their professional distance in supporting family members after an unsuccessful patient resuscitation. The nurses' concern for the patient's significant others compelled them to reach inside themselves and to "get in touch" with their emotions in order to tell the news of unsuccessful resuscitation and to support the significant others in an empathetic and compassionate manner. The participants described the experience of telling and supporting the patient's significant others of the unsuccessful resuscitation as stressful and emotionally draining.

The participants of this study described mechanisms that allowed CCNs to maintain their affective neutrality following unsuccessful resuscitation. One practice, imbedded in the critical care unit's structure, included having the assistant head/charge nurse and physician tell
the significant others the news of the patient's unsuccessful resuscitation. This practice allowed CCNs to maintain their emotional detachment and protected them from the emotional aftermath of having to get in touch with their feelings to interact with the patient's significant others. Another method of maintaining affective neutrality involved the CCN transforming a significant unsuccessful resuscitation into a routine event that was viewed as a routine element of the nurse's role.

**Knowing the Person**

The final and most intimate level of knowing was knowing the person. The nurse's involvement in the relationship went beyond the professional and ethical commitment evident in knowing the patient. Knowing the person involved a connection between the nurse and patient. This knowledge was associated with an indepth understanding of the person's character, unique responses, and primary needs. The nurses' interaction with the person prior to and during the resuscitation attempt, and their interaction with significant others during and following the unsuccessful resuscitation provided an opportunity for this knowing to develop.

Jacono's (1993) description of caring as loving is very similar to the CCN's experience of knowing the person. Caring is loving is defined as "the willingness to provide support for others in times of need" (Jacono, p. 193). The
CCNs' identified the person by observing and trying to understand the patient's instability and suffering and by engaging with the patient and/or the significant others in meaningful dialogue.

The only study located that explicates knowing the person was the study by Fonteyn and Fisher (1994). Although this study describes specific components of knowing the person, it does not discuss how the nurse comes to know the person. The study by Tanner, et al. (1993) identifies knowing the person as a subcategory of knowing the patient. These authors discuss nurses coming to know the person through putting away of preconceptions and through engagement with the person and their family.

Knowing the patient as a person established a connection that went beyond rational understanding. In many situations, the CCN who knows the person is able to intuitively sense that there is a problem with few or no definite clues as to the nature of the problem. The term intuitively is defined within the context of this study as "immediate awareness of past, present, or future events without the conscious use of linear reasoning" (Miller & Rew, 1989, p. 85). The CCN's openness to the vulnerability, suffering, and needs of the person and/or the significant others provided the foundation for knowing the person.

Knowing the person is very similar to the concept of therapeutic intimacy as described by Kadner (1994). Kadner
defines therapeutic intimacy as an openness to the exchange of shared meaningful information between client and nurse. This author describes the constructs of attachment, empathy, compassion, trust, and transference in relation to the concept of intimacy. "Intimacy would include each of these feeling states, the degree dependent on the psychosocial history and readiness of each individual involved in the interaction" (p. 216). The rewards and pain associated with the CCN's experience of knowing the person who was unsuccessfully resuscitated will be explored within each of these constructs.

The construct of attachment is similar to how the participants described connection in this study. Attachment may be defined as "the feeling that binds one to a person" (Kadner, 1994, p. 216). The intensity of the situation and the openness of the CCN, allowed a deeper level of involvement, a connection. Knowing the person in an attached or connected way allowed the CCN to recognize subtle changes in the person's responses, anticipate the person's responses to interventions, and perceive the primary need of the person. This knowledge allowed the CCN to provide individualized care to the person, judge the severity of the situation for the individual, and to predict the outcome of a resuscitation attempt with even greater accuracy than merely knowing the patient. Despite early knowledge of the person's instability and the severity of
the situation, the CCN's feelings of hopelessness, powerlessness, and loss were significantly increased when clinical interventions could not provide the desired outcome of successful resuscitation.

The constructs of empathy and compassion are closely related and will be discussed together. Empathy is defined as, "identification with the experiences of another. Compassion is sorrow for someone accompanied by a desire to alleviate the suffering" (Kadner, 1994, p.216). In each of the paradigm cases in which the nurse knew the patient, the CCN was able to empathize with how it would feel to be in the situation of either or both the patient or significant others. The CCN's identification with the experiences of the person and/or significant others produced feelings of hope and hopelessness, and sorrow.

Compassion was evident in the CCN's desire to connect with the person to alleviate their suffering. The CCN's powerlessness to reduce the person's suffering often created feelings of anxiety and distress for the nurse. The nurse suffered emotional distress in watching the person suffer and by being unable to meet the person's primary need. Bottorff and Morse (1994), found a parallel pattern of attending they called 'doing more' in a study of nurses' caring for patients with cancer. 'Doing more' is a type of attending in which the nurse is making contact or trying to 'reach out' to the patient in a manner that is beyond what
is required to complete care (p. 55). An example of doing more is when the CCNs attempted to prepare the person's significant others for the person's unsuccessful resuscitation in an effort to reduce their anguish.

The CCN's compassion encompassed respecting the humanity of the person prior to, during, and following the unsuccessful resuscitation. The desire to respect the dignity of the person generated unique challenges and tensions in the context of unsuccessful resuscitation. The nurses portrayed respect for the person in the way that they communicated with the person and through their provision of intimate and private care. The person's dignity was maintained during the resuscitation procedure and in "tidying up" the person following the resuscitation effort. In a study of how Australian nurses' manage the patient's body, Lawler (1991) found that nurses treated the body 'with respect' when they prepared the body for the morgue, and handled it carefully. Furthermore, Lawler found that one of the critical elements in how nurses treated the body was whether or not they had an existing relationship with the person who died.

At times, the CCNs perceived the person's boundaries had been violated during the resuscitation attempt. Though the CCNs felt the person's dignity had been violated, they had difficulty advocating for the person during the resuscitation effort. The participants expressed moral
distress when they reflected on these experiences.

Trust is a hallmark of a therapeutic relationship and is essential to the notion of attachment. Trust is defined by Kadner as, "reliance on the integrity of another" (p. 216). Trust was implicit in the connection that was established between the CCN and the person and/or significant others in these paradigm cases.

Transference is the final construct of therapeutic intimacy (Kadner, 1994). "Transference is a shift of emotions from earlier relationships to a present relationship" (p. 216). The participants frequently personalized the experience when they knew the person (e.g., the CCNs reflected on what it would feel like to lose their mother).

The concept of therapeutic intimacy lends understanding to CCNs experience of knowing the person that is unsuccessfully resuscitated. The intimate nature of the relationship between the CCN and the person, and the nurse's investment in this relationship places the nurse in a vulnerable position. The stronger the connection between the CCN and the person, the more intense the feelings of pain and loss when the person is unsuccessfully resuscitated. May (1991) described this type of involvement as "a specific attachment to particular patients, characterized by intense stresses on the nurse" (p. 550).

CCNs must manage the threat of and actual loss when
they know the person who is unsuccessfully resuscitated. The CCNs attempted to manage the loss of a person through several practices. The participants focused on the actions associated with the resuscitation effort, rather than the feelings associated the loss of a person. The ability to do for the person was valued by the participants of this study. The CCNs consistently described their satisfaction with the provision of technically competent care to the person during the resuscitation. Following the resuscitation effort, the CCNs concentrated on ordering and normalizing the environment. These actions appeared to assist the CCN to achieve affective neutrality and manage the loss of the person without dealing with the emotions associated with the loss of a person that was connected to the nurse.

**Future Imperatives**

The findings of this study have implications for nursing in the areas of practice, education, and research.

**Nursing Practice**

The findings of this study lead to a number of implications for nursing practice. These are important, not only for critical care nurses who provide care to the unsuccessfully resuscitated patient, but also to nursing and hospital administrators.

Caring for critically ill patients and their significant others poses unique challenges for the CCN. The acuity of the patients and the uncertain or tenuous nature
of their outcomes create tension for the patients, significant others, and the CCN. The potential for unsuccessful patient resuscitation is a constant reality in the critical care setting. According to Beaudoin (1990), "Working with dying patients may make death more familiar, but this does not take away death's sting for caregivers" (p. 19).

The need to care for the CCN is evident in the findings of this study. CCNs must recognize that knowing the patient or person that is unsuccessfully resuscitated places the CCN in an emotionally vulnerable position. The need for CCNs to explore and express feelings associated with unsuccessful patient resuscitation is an important finding of this study. Expressing feelings of personal loss and moral distress requires compassionate listeners and a safe environment. Sharing stories of unsuccessful patient resuscitations would provide CCNs with an opportunity to alleviate the emotional burden of unsuccessful resuscitations. Participating in telling and listening to stories of unsuccessful patient resuscitation would give CCNs an opportunity to understand their colleagues and their own lived experiences. Furthermore, CCNs would realize that they are not experiencing these feelings in isolation.

CCNs need to be involved in the development of practices that support nurses during and following unsuccessful patient resuscitations. For instance,
assistance during the resuscitation procedure from colleagues may provide a sense of support in the chaotic environment of a resuscitation. Colleagues and/or administrators could take direction from the CCN involved in the unsuccessful patient resuscitation about the nature of support that she requires. For example, the CCN may require help with the physical care of the patient, assistance with supporting the patient's significant others, the opportunity to mourn the loss of a patient and/or person, choice of workload following the resuscitation, and the opportunity and time to talk about the situation and feelings the unsuccessful patient resuscitation evoked.

CCNs who experience emotional turmoil associated with knowing the individual who is unsuccessfully resuscitated require adequate resources to deal with these experiences. Examples of resources may include peer support groups, clinical nurse specialists, expert counsellors, and critical incident debriefing teams. Unsuccessful patient resuscitation occurs twenty-four hours a day; therefore, support must be consistently available to CCNs. The individuals involved in providing support would require an understanding of CCNs' experience of knowing the case, patient and/or person, loss and grief, and communication and counselling skills. The CCN's work demands must allow an opportunity and time to analyze and reflect on the unsuccessful resuscitation, and to express the feelings
associated with unsuccessful patient resuscitation. Formal programs that address death, loss, and caregiver suffering may assist CCNs to support and care for one another.

A systematic process to mourn in situations of unsuccessful patient resuscitations may give CCNs permission to grieve. Neonatal and pediatric CCNs have developed bereavement strategies such as follow-up with bereaved families in the months following death, and unit based memorials to assist nurses with the loss of a patient (Sheard, 1990; Small, Engler, & Rushton, 1991). These strategies could be adopted in adult critical care settings if CCNs determined that these strategies would be helpful.

Several participants of this study discussed the need to know the cause of death. Although post mortems are frequently performed on patients who are unsuccessfully resuscitated, CCNs are rarely informed of the results. Communicating the cause of death to the CCNs directly involved in unsuccessful patient resuscitation may diminish feelings of negligence and guilt.

Another implication of the study's findings is the need to reduce CCNs' moral and ethical distress. Interdisciplinary forums that provide dialogue surrounding ethical issues associated with cardiac and/or respiratory arrest may help to challenge standards of care during and following unsuccessful patient resuscitation. Workshops directed at assisting CCNs to express their moral and
ethical concerns in the context of tense situations may assist staff nurses to advocate for patients and their significant others. The moral and ethical issues surrounding cardiac and/or respiratory arrest (e.g., prolonging life, quality of life) are ethical minefields for CCNs. Acute care hospitals should include CCNs on their ethical committees to increase the understanding of committee members regarding the implications of these issues in critical care practice.

Nursing administrators and inservice educators should be aware that CCNs' experience anxiety and turmoil when they are confronted with death. They should encourage all CCNs to participate in seminars that are focused on issues related to death and dying (e.g., biomedical, ethical, religious), counselling, and supporting bereaved family members.

Nursing Education

The unique demands of the critical care nursing challenge beginning CCNs' abilities in situations such as unsuccessful patient resuscitation. Critical care specialty education draws on and develops nurses' theoretical knowledge in basic nursing education and their experience as practicing nurses. The study's findings indicate that CCNs experienced discomfort with death and some turmoil surrounding the conceptualization of death and the body care associated with the dead. Consequently, an implication of
the findings is the identification of the need for educational preparation in the meaning and significances of death for nurses. Nursing students may benefit from examining various perspectives of death (i.e., philosophical, religious, ethical, biomedical) and exploring their own beliefs surrounding death. Educating nurses in theory associated with death and dying, loss and grief, as well as care of the body following death will help nurses understand their personal beliefs surrounding death. Furthermore, increased understanding of the issues involved in death and dying, and loss and grief will assist nurses to support patients' significant others.

The relationship between the CCN and the patient is central to CCNs' knowing. Beginning CCNs need to know the various dimensions of knowing and both the rewards and challenges of this knowing. The significant challenges for CCNs include performing complex skills during the resuscitation despite a relationship with the patient and/or person, potential moral and ethical conflicts, and the emotional implications of unsuccessful patient resuscitation. Each of these challenges have implications for education in the critical care specialty.

Critical care specialty education should include ensuring that beginning CCNs are able to function safely and competently in a cardiopulmonary resuscitation. Critical care educators need to teach beginning CCNs that the
"adrenalin rush" associated with participation in a cardiac and/or respiratory arrest assists CCNs to focus on the resuscitation procedure. Additionally, compartmentalizing segments of the cardiac and/or respiratory arrest decreases the stress associated with arrest procedure and allows the CCN to focus on her role and tasks during the resuscitation.

The CCN's moral and ethical distress is an important finding of this study. Building on students' understanding of ethical issues in nursing, the specialty curricula should focus on the moral dilemmas associated with unsuccessful patient resuscitation. The nature of unsuccessful patient resuscitation creates conflict with the goals of the critical care setting (i.e., patient stability, saving lives). Students must be aware that the goals of the critical care setting are not always achievable. CCNs often felt unable to advocate for their patients before or during the resuscitation procedure. Beginning CCNs need to practice and develop the skill of advocacy in simulated situations that are realistic in nature.

The emotional implications of "knowing" the case, patient, or person who is unsuccessfully resuscitated is a central finding within this study. CCNs must be prepared for feelings of hope and hopelessness, powerlessness, pessimism, sorrow, suffering, grief and loss both during and following unsuccessful resuscitation of patients who they know as a patient and/or person. Although CCNs commonly use
detachment to manage the emotions associated with unsuccessful patient resuscitation, they must understand the limitations and concerns identified with this means of management. Critical care educators must teach alternative strategies to manage the emotions related to unsuccessful patient resuscitation. Critical care educators need to use teaching techniques (e.g., narratives or story telling) that will help beginning CCNs understand the meanings of unsuccessful patient resuscitation to nurses. This type of teaching technique will underscore the reality of this experience and prepare beginning CCNs for practice situations.

Hospital orientation and critical care inservice education program coordinators need to examine issues surrounding unsuccessful patient resuscitation. These programs need to encompass issues related to death and dying, ethical issues of patient resuscitation, loss and grief, emotional responses associated with "knowing" the unsuccessfully resuscitated patient, and strategies to support and care for CCNs. Encouraging experienced CCNs to share their stories of unsuccessful patient resuscitation may assist both experienced and beginning nurses to understand the issues associated with unsuccessful patient resuscitation.
Several implications for nursing research originate from the limitations of this study. CCNs who participated in this research were experienced in critical care nursing. It would be useful to conduct this type of research with beginning CCNs to compare the lived experience of beginning and experienced CCNs.

CCNs often participate in a cardiac arrest team in a medical or surgical ward resuscitation. They seldom have a prior relationship with a patient that is unsuccessfully resuscitated on a ward. It may be useful to study the experiences of CCNs in unsuccessful resuscitations on hospital wards, comparing the findings to that of this study.

The context of nursing may influence the nurses' experience of unsuccessful patient resuscitation. Further research on nurses in other specialty contexts (e.g., obstetrics, emergency) may illuminate the unique aspects of patients' deaths and nurses' resuscitation experiences within the subculture of the specialty. Additionally, nurses who "know" and care for patients on wards but are unable to participate in the arrest procedure of a patient may have a completely different experience of unsuccessful patient resuscitation.

The cumulative effect on CCNs of caring for patients who are unsuccessfully resuscitated is unknown. Research
related to the repeated exposure to unsuccessful patient resuscitation and the long term effects of this phenomenon on nurses may provide insight into the experiences of burnout and attrition among nurses.

This study described CCNs knowing in the context of unsuccessful patient resuscitation. The study did not prescribe the length of time a nurse had to care for the patient prior to the resuscitation. It was surprising to the investigator that the length of time that the nurse cared for the patient did not always affect the depth of the nurses knowledge of the patient. Further research should investigate how length of association affects the dimensions of nurses knowing and the care provided to patients.

CCNs frequently employed professional distancing and detachment to manage the emotions associated with unsuccessful patient resuscitation. The findings of this study suggest that detachment influences CCNs' relationships and involvement with patients and their significant others. Further research is required to understand the implications of detachment on CCNs' decision making and provision of patient care.

Finally, the need to implement strategies to support and care for CCNs who experience unsuccessful patient resuscitation is evident. As strategies to support CCNs are implemented it is imperative that evaluative research be conducted to ascertain the effectiveness of these
strategies.

This research study was useful in understanding the experiences of a specific sample of CCNs who experienced unsuccessful patient resuscitation. As the research on nurses' experience with unsuccessful patient resuscitation is in its infancy, it is essential that other studies be conducted to increase our understanding of this phenomenon.
CHAPTER SIX

SUMMARY AND CONCLUSIONS

This chapter includes a summary of the study and conclusions based on the findings and future imperatives.

Summary

Although there have been numerous studies that investigated stress in critical care nursing, there were no studies located that related to CCNs' experience of unsuccessful patient resuscitation. The research related to stress in critical care nursing focused on determining stressors for CCNs and understanding their coping strategies. These researchers determined that the death of a patient was consistently ranked by CCNs among the top three stressors. Despite this finding, there were no studies located that focused on CCNs' experience with the death of patients. The purpose of this study was to explore and describe the experience of CCNs who participate in unsuccessful patient resuscitation.

The study was guided by the philosophical perspective of phenomenology in the tradition of Benner (1984, 1994) and Benner and Wrubel (1989). The goal of this approach to interpretive phenomenology is to illuminate the commonalities and differences of the phenomenon when one is involved in the situation (Benner, 1994). The investigator used paradigm case interviews to explicate issues, concerns, meanings, and understandings from the participant's
perspective. Paradigm cases are narrative accounts of significant clinical situations which reveal the practice of nursing (Benner, 1984; Benner & Wrubel, 1989).

Data were collected from each of the nine participants by means of a pre-interview, paradigm case interview, and a final interview. In the pre-interview, the researcher described the study, answered questions related to the research interview and introduced the interview plan to the participant. During the paradigm case interview, the researcher sought to understand the CCN's experience by the method of paradigm case interview described extensively by Benner (1984). The final interview was used to clarify aspects of the paradigm case interview, to provide an opportunity for participants to ask the researcher questions, and for participants to respond to initial themes and theme clusters identified in the paradigm interview.

The participants had between 8 and 19 years of experience as a Registered Nurse, and between 3 and 14 years of experience as a CCN. The participants included one male and eight females. The majority of the paradigm case stories were from the participants' recent experience. One story occurred early in the nurse's critical care nursing experience and was contrasted with her current response to similar situations.

The central theme of "knowing" emerged from the narrative accounts of CCNs' experiences with unsuccessful
patient resuscitation. The context of knowing was identified by the participants as influencing how knowing was enacted in their role in unsuccessful patient resuscitation. Knowing involved three themes: knowing the case; knowing the patient; and knowing the person.

The contextual factors which are unique to critical care were perceived by the participants as affecting the nature of their experience in situations of unsuccessful patient resuscitation. The goals of both the medical and nursing staff of critical care units is to stabilize and care for critically ill patients. The events prior to and during cardiopulmonary arrest are directed toward life saving. Consequently, CCNs' knowing was influenced by the acuity of the patients, the pace and goals of care. The lack of time and competing roles and responsibilities were identified as common constraints to CCNs' knowing. The relationship between the CCN and the other health care workers involved in the resuscitation effort influenced the CCN's satisfaction with the resuscitation procedure. The "adrenalin rush" associated with participating in an arrest situation was seen as helpful to CCNs as it allowed them to think clearly and focus on their tasks and role within the resuscitation team. Additionally, the participants' perceived that "tidying up" the patient and normalizing the environment following the unsuccessful patient resuscitation assisted them to manage the inner turmoil they experienced.
The CCNs experienced knowing through the process of uncovering aspects of the case, patient, and person. The participants commenced knowing the individual through "knowing the case". The CCN's knowledge of the case incorporated scientific knowledge of the diagnosis, physiology, physiological responses, and the interventions associated with cardiopulmonary arrest and the nurse's experiences with similar patient populations. Knowing the case was significant as it allowed the participants to care competently and confidently for the patient as they developed a relationship with the patient. In addition, the CCN's knowledge of the case increased the predictability of the concerns, interventions, and the range of patient outcomes by uncovering the differences between this case and other cases. The CCN's ability to anticipate an impending arrest allowed the nurse to plan and implement strategies that decreased the stress associated with the resuscitation effort. Participants that lacked experience with the case were unprepared for the turn of events and the patient's death. Whenever a CCN was not able to accurately predict the unsuccessful patient resuscitation, she experienced anxiety and grief.

As the CCNs developed a relationship with the patient and/or significant others, they began to know the patient. Knowing the patient involved understanding the patient's age, gender, roles, past medical history, current
physiological status, and significant others. The CCN's relationship with the patient was characterized by a sense of professional obligation and responsibility. The participants who knew the patient provided care that focused on the patient and the significant others.

The CCN's understanding of the patient's responses allowed her to identify and predict, with greater accuracy than knowing the case, the patient's instability and eventuality of the unsuccessful resuscitation. The ability to anticipate an arrest assisted the CCN to better perform her role in the resuscitation effort.

The CCNs valued knowing the patient as a mechanism for preparing themselves to be competent, and emotionally stable during and after an unsuccessful patient resuscitation. The participants described the use of emotional detachment or professional distancing to manage the emotions associated with unsuccessful patient resuscitation. The CCNs were unable to maintain a detached stance when interacting and supporting the patient's significant others. The inability to maintain their detached stance precipitated feelings of hope and hopelessness, pessimism, moral distress, loss and grief.

Aspects of knowing the person included knowing the individual's character, unique responses to the situation, and their primary need. Knowing the person was a double edged sword for the CCN. Knowing the person established a
connection between the CCN and person. The strong connection between the CCN and the person resulted in the nurse's investment in the person's well-being. The participant's connection with the person provided intimate knowledge of the person and emotional attachment to the person and their significant others. The rewards of this connection between the CCN and person were evidenced in the individualized care provided to the person and their significant others. Additionally, the CCN was able to predict a cardiac and/or respiratory arrest based on very subtle physiologic and behavioral cues. A disadvantage to knowing the person was that the connection between patient and nurse caused the CCN to be vulnerable to feelings of loss and grief when the patient was unsuccessfully resuscitated.

The CCN's involvement with the person and their significant others was painful because nurses experienced the threat of loss of the person who they have come to know and care for. Knowing the person who was unsuccessfully resuscitated was associated with feelings of hope and hopelessness, powerlessness, moral distress, sorrow, suffering, loss and grief for the CCN.

The dimensions of CCNs' "knowing" influence the nurse's role within the resuscitation effort and their sense of satisfaction with the resuscitation procedure. The CCN's relationship with the patient and significant others is
central to the feelings that are generated from the loss of a patient and/or person who is unsuccessfully resuscitated.

Conclusion

The analysis of nine CCNs' paradigm case experiences with unsuccessful patient resuscitation has been presented in this report. The paradigm stories revealed the complex and dynamic nature of CCNs' experience with unsuccessful patient resuscitation. The study uncovered aspects of critical care nursing practice that have not been previously described. For example, the process of detachment as a self-protective measure has not previously been illuminated in critical care nursing. As a result, the study will contribute to the understanding of critical care nursing practice.

This study has contributed to the paucity of research in the area of CCNs' lived experience of unsuccessful patient resuscitation. Further research in the area of unsuccessful patient resuscitation will contribute to a broader understanding of nurses' experience with unsuccessful patient resuscitation.
References


## Appendix A

### Research Pertaining to Causes of CCNs' Stress

<table>
<thead>
<tr>
<th>RESEARCHERS</th>
<th>SAMPLE</th>
<th>METHODOLOGY</th>
<th>KEY FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Huckabay &amp; Jagla (1979)</td>
<td>46 CCNs</td>
<td>Survey: questionnaire</td>
<td>Five most stressful situations:</td>
</tr>
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<td></td>
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<td>• workload</td>
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<td>• death of a patient</td>
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<td>• communication (staff &amp; nursing office)</td>
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<td>• communication (staff &amp; physicians)</td>
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<td>• needs of family</td>
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<tr>
<td>Anderson &amp; Basteyns</td>
<td>182 CCNs</td>
<td>Survey: questionnaire</td>
<td>Five most stressful situations:</td>
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<td>(1981)</td>
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<td>• death of a young adult</td>
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<td>• medication errors</td>
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<td>• inadequate help to properly care for patients</td>
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<tr>
<td>Study</td>
<td>Sample Size</td>
<td>Methodology</td>
<td>Primary Stressors</td>
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<tr>
<td>Spoth &amp; Konewko (1987)</td>
<td>241 CCNs</td>
<td>ICU Stressor Survey</td>
<td>Three primary stressors:</td>
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<tr>
<td></td>
<td></td>
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<td>• work overload</td>
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<td>• issues of death &amp; dying</td>
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<td>• physical &amp; environment stressors</td>
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<tr>
<td>Vincent &amp; Coleman (1986)</td>
<td>•22 ICU nurses •19 non-ICU nurses</td>
<td>Survey: Professional profile tool Stressors for nurses form</td>
<td>Three top ranking stressors (not signif. different):</td>
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<td>• unit management</td>
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<td>• interpersonal conflicts</td>
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<td>• nature of direct pt. care (inc. death of a patient)</td>
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<td>600 health care workers in critical &amp; palliative care</td>
<td>Phenomenological interviews</td>
<td>Five top occupational stressors:</td>
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<td></td>
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<td>• pt/family coping problems</td>
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<td>• role conflict</td>
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<td>Authors</td>
<td>Sample Size</td>
<td>Measures and Survey</td>
<td>Findings</td>
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<tr>
<td>Foxall, Zimmerman, Standley, &amp; Captain (1990)</td>
<td>• 35 ICU nurses • 30 hospice nurses • 73 medical-surgical nurses</td>
<td>Survey: Nursing Stress Scale</td>
<td>• No significant differences in frequency and sources of stress in the 3 groups of nurses • ICU &amp; hospice nurses experienced more stress related to death &amp; dying</td>
</tr>
<tr>
<td>Lewis &amp; Robinson (1992)</td>
<td>• 577 CCNs</td>
<td>Survey: Work Related Stressor Questionnaire • Response to Stressor Questionnaire • Coping Measures Questionnaire</td>
<td>Five main work-related stressors: • interpersonal relations • environment • pt. care (inc. death of a patient) • professionalism • knowledge</td>
</tr>
</tbody>
</table>
## Appendix B
Research Related to CCNs' Coping Strategies

<table>
<thead>
<tr>
<th>RESEARCHERS</th>
<th>SAMPLE</th>
<th>METHODOLOGY</th>
<th>KEY FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oskins (1979)</td>
<td>79 CCNs</td>
<td>Survey:</td>
<td>Four coping methods used over 50% of the time:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Narrative methods used</td>
<td>• talking it out with others</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• questionnaire</td>
<td>• taking definitive action</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Coping scale</td>
<td>• drawing on past experiences</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• anxiety</td>
</tr>
<tr>
<td>Stone, Jebsen, Walk, &amp; Belsham</td>
<td>76 CCNs</td>
<td>Survey:</td>
<td>• Nurses with burnout were</td>
</tr>
<tr>
<td>(1984)</td>
<td></td>
<td>• Maslach Burnout Inventory</td>
<td>• dissatisfied and viewed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Coping Methods Survey</td>
<td>• stressful events as threatening</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Work Environment Scale</td>
<td>• Using a number of coping skills</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Life Experience Survey</td>
<td>• increased CCNs' sense of personal accomplishment</td>
</tr>
</tbody>
</table>
| Lewis & Robinson (1986) | 30 CCNs | Survey: Questionnaire developed by researchers | Five most frequently use coping strategies:  
- discussing problems with coworkers  
- problem-solving  
- watching TV/reading  
- caffeine  
- taking a vacation |
|------------------------|---------|-----------------------------------------------|--------------------------------------------------|
| Dewe (1987)            | 1801 nurses | • Stage 1: content analysis of  
  312 interviews  
• Stage 2: questionnaire developed  
  from data in Stage 1 | Identified six coping strategies used by nurses in stressful situations:  
- problem-oriented behaviour  
- try to unwind & gain perspective  
- express feelings  
- keep the problem to yourself  
- accept the job as it is and try not to let it get to you |
<table>
<thead>
<tr>
<th>Schaeffer &amp; Peterson (1992)</th>
<th>209 CCNs &amp; non-CCNs</th>
<th>Survey: Jaloweic Coping Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>• No difference between the 2 groups in coping strategies used or effectiveness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Most effective coping strategies were:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- confrontational</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- optimistic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- self-reliant</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Least effective strategies were:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- evasive</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- palliative</td>
</tr>
</tbody>
</table>
Appendix C

Participant Information Letter

UBC Department Letterhead

Letter of Information for Research Study:

Unsuccessful Patient Resuscitation:
The Lived Experiences of Critical Care Nurses

I am a registered nurse working towards a Master's degree in nursing at the University of British Columbia. For my thesis, I am conducting a study to gain an understanding of the experience of critical care nurses who participate in unsuccessful patient resuscitation. I hope the findings of the study will be valuable for nursing by increasing awareness of nurses' experiences with unsuccessful patient resuscitation.

This letter is to invite you to participate in my study. The criteria for participation in the study are that you are a registered nurse employed in the cardiac, cardiac surgical, or intensive care unit and that you participated in an unsuccessful resuscitation of a patient you cared for prior to the resuscitation attempt.

The study will involve a telephone or personal pre-interview to discuss your interest and answer questions related to volunteering for this study. If you agree to participate, the study will consist of a two hour interview in which you will be asked to share a situation from your experience with unsuccessful patient resuscitation, and a final interview of approximately two hours to review content and clarify statements from the first interview. If you agree to participate I will be asking you for some demographic information (years of clinical experience, years of critical care experience, educational background, and age).

The interviews will be scheduled at a mutually convenient time and place. The interviews will be audiotaped to ensure accuracy in data collection. However, complete confidentiality will be ensured throughout the study by the use of a code number on audiotapes and transcripts. A secretarial transcriber will transcribe the audiotape, however, this person will not have access to the identity of the participants. The list identifying the participants with the assigned code numbers will be kept in a locked drawer available only to the researcher. The persons mentioned in the interviews will be referred to by a code number or letter.
Appendix D
Demographic Data

YEARS OF EXPERIENCE AS AN R.N. ___

YEARS OF EXPERIENCE AS A CRITICAL CARE NURSE ___

CURRENT AREA OF EMPLOYMENT: Cardiac Care ___
Cardiac Surgical Care ___
Intensive Care ___

EDUCATIONAL LEVEL: (check all that apply)
Diploma in Nursing ___
Specialty Certificate ___
B.S.N. ___
Other (please specify) ___

GENDER: Male ___
Female ___

AGE IN YEARS: ___
My confidentiality will be maintained in this study by the following procedures:

1. I will be identified by a code number on the tape, transcripts, thesis, and presentation or publication of the study.

2. The sole person to know my identity is the researcher, Cheryl Isaak. The list identifying participants in the study will be kept in a locked drawer, available only to the researcher.

3. The identity of myself, patients, and family members will not be revealed in the transcriptions of the research interviews, thesis, or presentation or publication of the research findings. The participants and persons mentioned in the interview will be referred to by a code number or letter.

4. The secretarial transcriber will have access to the audiotape but my anonymity will be maintained by a code number identifying the audiotape. The audiotapes and transcripts will be destroyed after seven years.

5. Transcripts of interviews which indicate only my code number, will be shared only with the researcher's thesis committee members. The thesis committee members will not be informed of my identity.

The risks of participating in this study could involve psychological discomfort that may arise from relating my story. I am free to withdraw from the study at any time. I also have the right to refuse to answer any question. My employment will not be affected by taking part or not taking part in the study. There may be no direct benefits to myself in taking part in this study. However, increased awareness of nurse's experience with unsuccessful patient resuscitation may be valuable.

My questions have been answered. I understand the nature of the study and consent to participate. I also acknowledge receiving a copy of this consent form.

Signature of Participant: ___________________
Signature of Witness: ___________________
Date Signed: ___________________

Please indicate if you would like a summary of the research findings prior to presentation or publication. ______
Appendix F

Participant Letter to Accompany Transcripts

Date

Dear Participant:

Thank you for volunteering your time to be interviewed for my thesis, "Unsuccessful Patient Resuscitation: The Lived Experience of Critical Care Nurses." Please find a copy of the transcript of our interview enclosed. Please keep in mind that the way we talk may not make for good reading, so do not let that concern you. Your ideas are the important aspect of this interview. I am sending you the transcript to allow you to review it prior to our final interview together.

The purposes of this interview are to:
1. give you an opportunity to clarify any aspect of the transcript;
2. give me an opportunity to clarify any aspect of the transcript;
3. give you an opportunity to respond to my beginning interpretations of the interview.

I will call you to set up an appointment for our final interview within the next week. If you have any questions or concerns that you would like addressed prior to our next meeting, please feel free to contact me at XXX-XXXX.

Sincerely,

Cheryl Isaak
Appendix G

Examples of Significant Statements and Their Formulated Meanings

<table>
<thead>
<tr>
<th>Significant Statements</th>
<th>Formulated Meanings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. You have some ... really well run arrests. And even if the person doesn't make it, you still feel good about it; that everything was done and everything was done properly. (8)*</td>
<td>1. Smoothness and efficiency of resuscitation procedures influence satisfaction with resuscitation.</td>
</tr>
<tr>
<td>2. I think you have to turn yourself off during the resuscitation as to who they are just to get through it because you're thinking and you're going through your next algorithms. (8)*</td>
<td>2. The CCN must detach herself during the resuscitation to focus on the procedure.</td>
</tr>
<tr>
<td>3. I had a cry for awhile and then, I might have had a break I just remember taking him down to the morgue, I don't remember that much afterwards. (5)*</td>
<td>3. The CCN experienced sadness and a sense of loss following an unsuccessful patient resuscitation.</td>
</tr>
<tr>
<td>4. I began to get to know her just from her husband and her son — what they said about her, what health she had, her fight through her breast cancer. (12)*</td>
<td>4. Knowing the person can occur through significant others.</td>
</tr>
<tr>
<td>5. I find myself practising that more professional distance and trying to not be emotional. (16)*</td>
<td>5. Detachment protects the CCN.</td>
</tr>
</tbody>
</table>

* Numbers signify the number of similar significant statements from which formulated meanings were derived.