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Faculty of Environmental and Life Sciences

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Understanding healthcare professionals' lived experiences of death in the Emergency Department and the influence of personal values and norms

by

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Thesis for the degree of Doctor of Philosophy

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Abstract

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Background: The Emergency Department (ED) is traditionally viewed as a place, where staff are trained to save lives and improve the patient's medical condition. Death in the ED is rarely planned, but often a sudden and unexpected event, carrying the potential for emotional and psychological impact on healthcare professionals (HCP). While ED is not considered by HCPs an ideal place for end-of-life care, the culture of emergency medicine is shifting to a more patient goal-centred culture. Despite these efforts, death occurring in the ED still presents a unique challenge for the staff. The purpose of this research study is to explore healthcare professionals' lived experiences of death in the ED, their meaning and the influence of their personal values and norms on this experience, using a phenomenological and interpretative methodology.

Methodology and methods: Interpretative phenomenological analysis (IPA) was applied to explore the lived experiences of seventeen healthcare professionals working in the ED, in different roles and levels of seniority, including doctors, nurses and healthcare assistants, about their experiences with death. Data was collected via semi-structured interviews, using an online video platform and audio recordings, and analysis was guided by the phenomenological, idiographic, and hermeneutic principles of IPA.

Findings: The analytic process resulted in three higher order concepts and nine super-ordinate themes. The higher order concept ***Experiencing death in the ED*** was underpinned by the superordinate themes of 'ED deaths to remember' and 'Objectifying and humanising death'; the higher order concept ***Making sense of death in the ED***, was constructed by 'Meaning of death', 'Values and norms' and 'Faith and spiritual beliefs' as super-ordinate themes; and the final higher order concept, ***Influenced by death in the ED***, had its foundation on 'Changed by death', 'Emotional labour of death', 'Coping with death' and 'Learning from death'.

Conclusion: This study concludes that factors, such as a patient's age, traumatic circumstances, or the unexpected nature of death, are responsible for making HCP's death experiences in the ED memorable. Personal, cultural, social, spiritual, and moral values held by healthcare professionals, influence their attitudes towards death, their coping and grieving mechanisms, their relationship with the dying or deceased patient's family members, how they provide care to other patients and their decision-making processes in their personal and professional life. Provision of training and improvement of support services, are seen by staff as practical tools in better managing the death experience in the ED.

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Research Thesis: Declaration of Authorship

Print name: Laszlo Penzes

Title of thesis: Understanding healthcare professionals' lived experiences of death in the Emergency Department and the influence of personal values and norms

I declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. None of this work has been published before submission

Signature: .... Date: 05th August 2023

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Definitions and Abbreviations

CASP	Critical Appraisal Skills Programme
Covid-19	Coronavirus Disease 2019
CPR	Cardio-Pulmonary Resuscitation
ED	Emergency Department
EOL	End-Of-Life
EOLC	End-Of-Life Care
EPOC	Effective Practice and Organisation of Care
GDPR	General Data Protection Regulation
HCP	Healthcare Professional
IPA	Interpretative Phenomenological Analysis
NHS	National Health Services (UK)
NICE	The National Institute for Health and Care Excellence (UK)
NMC	Nursing and Midwifery Council (UK)
PIO	Population, Exposure or Issue, Outcomes
PRB	Population Reference Bureau
PTSD	Post-Traumatic Stress Disorder
RCN	Royal College of Nursing (UK)
SPIDER	Sample, Phenomenon of Interest, Design, Evaluation, Research type
TRIM	Trauma Risk Assessment
UK	United Kingdom
UoS	University of Southampton
USA	United States of America
WHO	World Health Organization

Chapter 1 Introduction

1.1 Introduction

This PhD thesis explores the lived experiences of healthcare professionals (HCP) in relation to patient deaths in an Emergency Department (ED) of an acute teaching hospital in England. The research study, using Interpretative Phenomenological Analysis (IPA) as its core methodology, seeks to understand and interpret these lived experiences, in conjunction with personal values and norms, including the social, cultural, spiritual, and moral aspects, and the effects on their personal and professional life. The study aims to inform practice and facilitate improvement in preparation of HCPs for managing and responding to such traumatic events.

Human life is unique, irreplaceable, fragile and death is an inevitable stage of this life. While in a clinical environment there might be a tendency to look at the end of someone's life , as a natural, biological process, death may have psychological, emotional, social, and spiritual dimensions (Mierendorf et al., 2014), having an influence on the lives of people who are directly involved, including the HCPs looking after their patients (Iserson, 2000). While death can be planned and dignified, as part of a palliative or end-of-life care pathway, at home, in a hospice or even in a hospital ward, death in the ED is often a sudden and unexpected event (Mierendorf et al., 2014).

Chapter One of the thesis introduces the focus of the thesis defines the research question and objectives and offers a background to my personal motivation for conducting this research study. The chapter will close with a summarized overview of the structure and content of the whole thesis.

1.2 Importance and personal motivation for conducting the study

The NHS Long-Term Plan (NHS England, 2019) aims to reduce the number of avoidable emergency admissions in the last year of a person's life however, recent statistics shows that these present an increasing tendency for the past ten years (Nuffield Trust, 2022). While the proportion of deaths that occur in a hospital setting has decreased from 51% in 2011, to 44% in 2021, with deaths occurring at home during the Covid-19 pandemic being above the previous five-year average (Nuffield Trust, 2020), the proportion of three or more emergency admissions in the last year of a person's life increased from 21% in 2009, to 25% in 2018 (Nuffield Trust, 2022).

Emergency Department (ED) is a ‘front door’ for hospitals, intended for easy access of patients in emergent situations, its culture being defined as ‘rescue-oriented’, death being perceived as mostly preventable (Kongsuwan et al., 2016). Yet, when death still occurs in the ED, it is still mostly associated with traumatic, unexpected, and sudden deaths, while gradually becomes the referral site for patients with long-term and terminal health problems, seeking symptom control, medical advice, and adequate EOLC support (Moller, 2004; Bailey et al., 2011). Marck et al. (2014) argues that ED is designed for the rapid cycle of diagnosis-treatment-referral or discharge, with healthcare professionals (HCPs) trained for resuscitation and prioritizing life-saving treatments. As often there is no relationship established between HCPs and the patient, prior of arriving to the ED, deaths that are likely to be perceived as sudden, and as such, challenging and complex, while HCPs are expected to ‘move on’ and function almost immediately after a death experience in this busy work environment, carrying the potential for emotional distress and psychological trauma (Heiner and Trabulsy, 2011; Jackson et al., 2005). On the contrary, Bailey et al. (2011b) argues that emergency nurses have developed coping mechanisms to manage unexpected deaths, through the ‘objectification’ of the patient, while such mechanism don’t exist with patients dying progressively, posing a greater emotional labour when caring for such patients and their grieving families. Either way, HCP's exposure to the death of their patients can make them conscious of their own mortality, often leading to the development of ‘death anxiety’, described as a feeling of dread or unease, negatively affecting the quality of care provided to dying patients and their families (Braun et al., 2010; Deffner and Bell, 2005).

The emotional and psychological impact and influence on HCPs, of deaths occurring in the ED, are widely researched, together with some of the ethical conflicts these HCPs encounter while looking after the dying patient (Ciofi, 2000; Baird et al., 2014; Sandman and Nordmark, 2006). HCPs working in the ED often find themselves in situations when certain complex decision needs to be made, based not only on medical or nursing considerations, but also accounting for the ethical, moral, legal, anthropological, and philosophical aspects (Petty et al., 2013). Studies also suggest that care for the dying and attitudes toward death are often influenced by cultural, social, and philosophical belief systems, religious faith, or frequency of exposure to death (Beckstrand et al. 2008; Heaston et al., 2006; Chan, 2004; Peters et al. 2013; Yingting et al., 2018). However, the relationship between HCP’s personal values and norms, and the experience of death in the ED is under-researched, as such represents a gap in the knowledge.

Personal values and norms are “broad desirable goals that motivate people’s actions and serve as guiding principles in their lives", some values being more visible than others, expressed through our words, actions, and behaviours (Sagiv et al., 2017). While values define an overall ideal, also shaping the person we are aiming to become in the future, norms are action-oriented ‘rules’ or ‘guides’, specifying what needs to be done to achieve this ideal (Parc-Leduc, 2015). Some values represent a rule of conduct, such as religious beliefs, while others tend to adapt and change depending on what the individual aims to achieve or become, but ultimately values become part of our personality (Ponizovskiy et al., 2019). As such, they become the main drivers for our actions, aid decision-making or help navigate through difficult situations in our personal and professional life (Parc-Leduc, 2015). Values and norms are different for every individual, with some commonalities, and will be usually influenced by a series of factors, such as the cultural and social background, the personal upbringing, shared moral and ethical principles within the social circle, spiritual beliefs or faith, education, career, or self-identity (Gamage et al., 2021). Understanding how personal values and norms of HCPs influence their experience and sense-making of death in the ED, how these influences their professional and personal life, such as provision of care for other patients, their coping mechanisms or career choices, will be the main objective of this study.

While the death experience was not unknown to me, as I have encountered the deaths in my own family, this become a more frequent experience during my student nursing years and later during my clinical nursing practice in the ED. Soon after starting my nursing career in the ED, I quickly understood that death in the ED environment is different from anything else that I have experienced before. My exposure to death events in the ED environment was presumably not only more frequent, but the nature and characteristics of these deaths felt more traumatic and unexpected than any other area I have worked in as a student nurse. Reflecting on my own personal experiences and having countless informal conversations with colleagues, I have noticed that there can be significant differences in how ED staff may manage and cope with these events. This led me to be interested in understanding why and how people have different reactions to the same traumatic event and how they appear to be affected by it, in the short and long-term. I have also become very interested in the coping strategies that people may adopt. Experiences gained from my time working in the ED influenced my choice of research methodology and methods for this study, as I was interested in individual experiences of death, rather than departmental or institutional factors, leading me to select IPA , using semi-structured interviews, as my methodological framework.

In April 2020, whilst working as a member of staff in the ED, I was infected with Covid-19, becoming an inpatient in intensive care and placed on life-supporting equipment, with a high probability of dying. This near-death experience added an additional impetus to explore this important topic. Healthcare professionals’ experiences of death during the height of the pandemic were often described as unprecedented. There were a greater number of deaths in the

ED during this period, and often these deaths were traumatic and sudden. Difficulties were exacerbated by visiting restrictions being in place, in all clinical areas of the hospital, putting an even greater psychological and emotional pressure on HCPs due to the lack of support from families. The direct involvement of HCPs in the diagnosis, treatment, and care of patients with Covid-19, associated with a high mortality rate, has taken a toll on their physical, mental, and emotional wellbeing (Cadogan and Hughes, 2021; Shanafelt et al., 2020; Erdem and Lucy, 2021; Jaiswal et al., 2020). Such studies, suggest that exposure of HCPs to Covid-19 cases is associated with a higher risk of symptoms of depression, post-traumatic stress disorder and other mental health issues.

Death and its influence on HCPs, is an established area of academic enquiry with a growing number of research studies being published each year. New challenges, such as the Covid-19 pandemic, constantly uncovers new areas of interest, to widen our understanding of this complex phenomenon. This research aims to add new knowledge in understanding death experiences in the ED, by exploring HCP's experiences in relation to their norms and values, and their effect in their personal and professional life, including personal priorities, patient care or career progression.

Research question

What are healthcare professionals' lived experiences of death in the Emergency Department?

Research objectives

i. To understand how these lived experiences are influenced by personal, cultural, social, spiritual, and moral values and norms.
ii. To explore healthcare professionals' views on managing, accessing support, coping with, and preparing for experiences of death in the Emergency Department.

1.3 Overview of the thesis

Chapter One has introduced the subject, defined the research questions and objectives, and offered an account of the importance and personal motivation in conducting this research study.

Chapter Two discusses the various definitions and interpretations of death, with a particular interest in death that occurs in the ED. The chapter proposes that death extends beyond the realm of biology and the clinical dimension, having a vast cultural, social, spiritual, and moral aspect, which influence peoples' individual experiences. Models of grieving and the psychological, emotional, and often physiological influences of the death experience are also explored.

Chapter Three presents a narrative review of the literature . Aspects of transparency, quality assessment and synthesizing of themes are also explored. Five major themes relating to death emerged from the literature review, and are discussed individually, and in relation to each other. The chapter concludes by identifying gaps in the current literature and knowledge base.

Chapter Four articulates the chosen methodology for this study, Interpretative Phenomenological Analysis (IPA) and the research design. Foundations of IPA, the underpinning philosophical influences, with a dedicated detail to hermeneutics and ideography are discussed. The chapter presents the decision-making process underpinning this choice and details ethical considerations, data collection method, ensuring quality in the research process.

Chapter Five presents a detailed overview of the data analysis process using the six steps of IPA as applied to the seventeen interviews conducted. The analytic process of developing initial codes, emerging themes and then superordinate-themes is presented using one participant, Zoe, as an exemplar. The chapter describes in detail the process of the cross-case analysis and identification of the nine super-ordinate and related emergent themes, that led to the development of three higher order concepts.

Chapter Six provides findings from the study and a discussion of these. The idiographic perspectives of the participants and the double hermeneutic of the researcher’s interpretation are highlighted with quotes taken from selected interviews. The discussion of the findings of the exploration of lived experiences of staff with death in the ED, focuses on abstraction and my interpretation, with references to the wider literature.

Chapter Seven concludes the thesis by demonstrating the novel contribution this research study makes to the existing knowledge base, with the broader purpose to inform practice and facilitate improvement, in preparing HCPs for managing and responding to death they experience in their professional capacity in the ED. Study strengths and limitations are also discussed, while the chapter concludes with a reflexive account and the plans for dissemination.

Chapter 2 Background

2.1 Introduction

Chapter Two of the thesis explores various definitions and interpretations of death, including the social, cultural, spiritual, and moral dimensions, and the influences and consequences such an event can have on HCPs working in the ED.

As detailed in Chapter One, the aim of this study is to understand how personal values and norms of HCPs working in the ED, influence their experiences and sense-making of death and dying. As presented in the previous chapter, values and norms are at the core of our identity and will define our actions, support us in decision-making or help us navigate through complex situations. As these values are often rooted in our social and cultural backgrounds and are influenced by our spiritual and moral belief systems, discussing how death is perceived and interpreted among these dimensions, will help us better understand HCPs death experiences in relationship with their values and norms. HCPs experiences of death in the ED will often incorporate their interaction, relationship, communication, connection with their patients and their families, including the treatment and care provided for the dying. Understanding certain social, cultural, spiritual, or moral aspects of how patients and families manage the end-of-life and death in the ED, will also support reflecting on HCPs experiences.

Understanding death beyond the biological dimension, will start with exploring the social aspect of death, describing how social death builds certain activities around a patient in a hospital, how institutionalisation of death creates a detachment from social activities, HCPs often treating progressively dying patients as being already dead. The cultural aspect of death will be discussed next, acknowledging how the Western concept of death is different from those in some other cultures, including cultures dominated by the views of different religions, how these cultures developed different ways to cope with death, creating often barriers and discomfort in HCPs, when it comes to providing culturally sensitive EOLC. The spiritual aspect of death, will explore how spirituality means more than simply religious beliefs, defining individual's search for purpose in life and meaning in death, how dying patients often experience an existential suffering, and how HCPs can assist patients nearing death to alleviate death anxiety. The discussion will continue with the role of moral values in HCP's care for their dying patients and how moral reasoning supports HCPs to treat their patients with dignity and respect. Dying in hospital and dying in the ED, alongside the patient and HCP relationship, and the physical, psychological, and emotional influences of experiencing death will be further discussed. The complexity of the bereavement process and various models of grieving will be explored with the purpose of informing my thesis, develop the structure of data collection and help focus my empirical research and analysis.

2.2 Death and dying beyond the biological dimension

2.2.1 The social aspect of death

Birth and death are rites of passage experienced by every human, shared universally, and while describing death may seem simple, its meaning, and understanding as a concept are complex and vary, when taking into account the biological, social, cultural, spiritual or moral aspects, making the examination of this behavioural phenomenon important (Gire, 2014). The complexity of concepts about death and dying originate in the challenge of defining what death means (Neimeyer et al., 2003). Traditional biological approaches describe death as the absence of vital functions, such as respiration or heartbeat. Modern life-sustaining technology has connected death to the cessation of brain functions (Segen, 2006). Death as a medical event is subject to controversy among physicians, as some will claim that death represents the moment of cessation of cellular activity, while others relate it to properties of cellular multiplication (Borgstrom, 2017). Beyond the biological aspect, separation of the physical body from the invisible spirit, or the cessation of social activities and relationships of the dying, are two examples of additional dimensions that highlight a more holistic concept of death. As such, there may be no clear, identifiable point in time where a person can be considered, to be dying (Davey, 2001).

Death from a social perspective, can be understood through the thoughts, concerns, emotions, activities, which relates to that person’s location along the temporal dimension of social structures (Timmermans, 1998). In his seminal work, investigating the social aspect of death and dying in a hospital setting, the American sociologist, David Sudnow claims that dying is not a straightforward term, as we are all in the process of dying from the moment of birth (Sudnow, 1967). According to Sudnow (1967), ‘dying’ builds a frame of social activities around the patient, for example, in the hospital. These social activities could include allowing visitors at any time, termination of certain medical treatments, start of rites and final prayers in case of a religious person, or taking the patient into register for a possible autopsy, while the patient is still alive. Sudnow (1967) suggests that from the moment of ‘social death’ hospital staff will treat the patient as someone who is ‘already dead’. Sudnow also highlights how moral presumptions can influence clinical decision-making. A patient who is drunk causing a car accident or someone who tried committing suicide was less likely to receive the same effort for revival, in case of a trauma, compared to a child or a young, otherwise healthy adult (Sudnow, 1967).

Timmermans (1998) revisited Sudnow's work, to investigate whether the radical changes in healthcare systems, such as the rationalization of medical practices or the wider focus on patient autonomy, made social rationing as described by Sudnow (1967), irrelevant. Timmermans (1998) argued that these changes, on the contrary, have contributed to the development of further inequalities, surrounding death and dying. Discussing resuscitation efforts, Timmermans (1998) suggests that ED staff often needs to balance clinical knowledge, boundaries of the law and professional ethics to allow some to live and others to die a dignified death, while much often resuscitation practice "becomes an attempt to avoid a lawsuit as an endeavour to save lives". As resuscitation became a repetitive and frequent practice in ED, developing into an "empty ritual", Timmermans (1998) noted that staff started displaying detachment from their patients, and only when they regained personhood, was that staff intended to "aggressively try to revive them".

Interested in the social construction of death, Seale (1998) argues that social life involves turning towards life and away from the inevitability of death. According to Seale (1998) social activities are able to provide security and meaning to an existence threatened by the knowledge of mortality. From a sociological perspective, Seale (1998) views death as posing a challenge on two levels, in threatening stability of social structures and in the maintenance of individual meanings. 'Hiding away' represents an attitude of 'death denial' in the modern societies, resulting from the observation that people who biologically die, have usually experienced a social death preceding this (Seale, 1998). This social death, is largely supported by the institutionalisation of death, including disengagement from active social participation of the elderly, and the management or physical segregation of those dying in the healthcare system. This attitude of 'death denial', is often explained by becoming free to concentrate on the issues of the living, without considering the needs of the dead (Seale, 1998).

2.2.2 The cultural aspect of death

The importance of examining cultural variations in attitudes towards death and dying, is related to the significance of how people act in life and how they approach death, allowing healthcare professionals to have a more in-depth understanding about individual concepts of death, experiences of grief, or burial rituals, knowledge that can become integral part of their patient care. Individual experiences of death and dying, loss and behaviours of grieving, after the death of a loved one, and the way these feelings are expressed may differ across cultures (Jensen, 2015). A culture represents a mix of values, beliefs, traditions, behaviours, and rituals shared among members of the same cultural group. (Cacciatore and DeFrain, 2015). Culture specific traditions surrounding death provide a set of directions that help structure people’s roles during this time of death (Jensen, 2015).

As described earlier in this chapter, defining a unified concept of death is almost impossible. The largely Western concept of death, including the medical definition of this concept, is rooted in eight criteria, such as lack of spontaneous respiration or response to various stimuli, lack of motor reflexes, and a flat electroencephalogram (EEG) for at least 10 minutes, all of which needs to be met before death is confirmed (Gire, 2014). In some South Pacific cultures, life is seen as departing the body when someone is ill or asleep, as such a person is ‘dying several times’ prior to their final death (Gire, 2014). In cultures where faith and religion are important aspects of everyday life, societies in which most people share the same religion, these beliefs significantly shape the culture (Lobar et al., 2006). Components of the culture shape the ways of defining, interpreting, and understanding the meaning and purpose of life and what happens after death, which could serve as an indication to HCPs how people in those cultures approach or what their attitude is about death (Lobar et al., 2006). Hinduism, for example, sees life as a cycle, where death is only an opportunity to be reborn with a new identity, even multiple times. In contrast, in Christianity and Islam, death occurs only once, and while a person ceases to exist in their physical body, they continue to exist in a spiritual realm. According to some segments of Buddhism and some Native American tribes, the dead and living coexist, the dead often impacting the life of those living (Gire, 2014). These elements specific to a culture include its own rituals that influence the expression of mourning and grief, which are meant to offer a sense of stability and security, when carried out (Jensen, 2015). While death can create a sense of chaos and confusion, because of the experienced loss, traditions and rituals are meant to provide a sense of routine and steadiness (Cacciatore and DeFrain, 2015).

Death is part of a natural life cycle, as such, all cultures have developed ways to cope with the experience of death, while obstructing or interfering with these practices can disturb people’s ability to cope, during this complex process (Cacciatore and DeFrain, 2015). Grief responses within a culture vary from person to person, as often people, to meet their unique needs, will adapt the beliefs and values of their culture within the current circumstances (Lobar et. al. 2006). In some cultures, relatives wear black or white as a sign of mourning, often for a prolonged period of time, and in some cultures for a lifetime. Some cultures require close relatives to shave their heads or marry the spouse of the deceased. Yet, in other cultures, an alternative expression of mourning, a celebration of the life of the deceased is expressed through dancing, eating, and drinking (Gire, 2014). Despite cultural rituals surrounding death, emotional reactions and human reactions to the experience of death, for example, through crying or anger are considered universal (Gire, 2014). This experience is often shared in a Western society, which is made up of people from various cultural backgrounds, when a person’s experience of grief may be at odds with the widely accepted cultural norms. For example, crying in public might feel uncomfortable for some, while others may have a level of despair that, within the given cultural norms, might feel out of step (Lobar et al., 2006).

HCPs are not expected to know the mourning ceremonies and traditions of every culture, however a basic understanding of how different cultures respond to death is important, as it could shape HCPs experience and attribute meaning to death (Cacciatore and DeFrain, 2015). Acculturation is undoubtably paramount for healthcare professionals in determining the beliefs and values of a family, coping, and mourning the death of a loved one, so that both the preparation for death and post-death arrangements meets their individual needs (Robben, 2017). In general, beliefs about the meaning of death help people make sense of it, and cope with the unknown. For example, people who believe in life after death may find death more bearable, or family members often could be comforted by the belief that their loved one is watching over them (Cacciatore and DeFrain, 2015).

Healthcare professionals could experience a sense of discomfort when it comes to providing culturally sensitive end-of-life or bereavement care, especially if language and cultural barriers add to the challenges of remaining both professionally appropriate and compassionate (Swihart et al., 2021). While families experiencing a loss, could need guidance and compassion from healthcare professionals, often the realities of a busy environment such as the ED could cause people to simply fail, in the moment, to express sufficient warmth and sensitivity. In our Western society a logical linear thinking is natural when critical decisions must be made, yet for many people from different cultures, a direct approach straight after death, for example related to organ donation, may appear as inhumane and harsh (Swihart et al., 2021).

2.2.3 The spiritual aspect of death

Spirituality is a broad concept, looking above the physical aspect of human life and refers to how individuals search for meaning and purpose in life, and connectedness to the self, others and the environment (Beauregard and O'Leary, 2009). Spirituality is a broad concept, which often establishes its importance when someone is experiencing physical illness, emotional stress, or death, and could incorporate elements of religious beliefs (Pulchaski et al., 2009). The importance of spirituality reflects in finding a connection to something greater than ourselves, resulting in a positive state of mind and emotions, such as gratitude, peace or acceptance, crucial when someone is experiencing death (Beauregard and O'Leary, 2009).

Most hospital environments, having an emphasis to cure patients, tend to focus on the physical aspects of illness, while research shows that dying patients are confronted with complex challenges, including their spiritual integrity and wellbeing (Costello, 2006; Balboni et al., 2010). Boston et al. (2011), argues that dying patients often experience a spiritual and existential suffering, which may have a profound impact on the wellbeing of family members, often devastating because it prompts their awareness of loss. This suffering can be described as an anguish, that may include concerns related to hopelessness, remorse, meaninglessness, a disruption of personal identity or a general experience of 'death anxiety' in patients and may trigger grief, depression, and anxiety in family members (Bruce et al., 2011).

Kisvetrova et al. (2013) suggests that alleviating dying patients' death anxiety and distress is possible through spiritual care, which may include religious and other existential aspects. Gire (2014) argues that death anxiety is difficult to define, as it can include the fear of death of oneself or others, having different meanings when is examined at private or public levels. Due to its complexity, death anxiety has also a cultural aspect, some cultures managing the idea of someone dying relatively well, being defined as 'death affirming cultures', while other cultures are referred to as 'death-defying cultures', being described by an avoidant attitude towards death. Western societies, incorporating more material traditions, in general could be described as 'death-defying', as talking about death largely remains an uncomfortable subject, while Eastern cultural beliefs, holding often strong spiritual characteristics, generally view death as a mere transition, accepting death as part of life (Gire, 2014). Creating a compassionate and caring environment that brings hope and help patients to deal with the reality of death, will involve interventions conveying empathy, active listening, assisting patients to accept their own feelings about dying, being present and showing respect, while advocating for patient dignity (Tanyi, 2006).

HCPs often experience that the spiritual and existential suffering of their dying patients, emerge as a complex embodiment of various pains, including the physical, mental, emotional, relational, or spiritual aspect (Norberg et al., 2001). HCPs can assist patients nearing death to alleviate anxiety and achieve reconciliation with themselves, the family or with God, resolve family conflicts, settle unfinished affairs, or eliminate worries (Tornøe et al., 2015; Gijsberts et al., 2019; Mascio et al., 2021). Steinhauser et al. (2006) has found that peacefulness in dying patients was often related to a sense of 'completion' or 'closure'. Nurses sometimes have mixed feelings about providing spiritual care, due to lack of time, the constant risk of being interrupted and the insufficient available resources, although they consider that this aspect of care is important. Hesitation to provide support with the spiritual or existential needs of their patients, often roots in relating this care purely to religion or religious beliefs. Sometimes nurses use this as an excuse to avoid the challenge of talking with patients about their spiritual concerns, especially if they don’t consider themselves to be religious, or feel that believes and faith are very personal matters (Tornøe et al., 2015). Batstone et al. (2020) argues that the qualities allowing nurses to provide spiritual care, are rooted in their life experience, professional experience working with dying patients and their families, advanced communication skills and their perception of reality, that develops from personal spirituality. These qualities of spiritual care, enable healthcare professionals to identify and address spiritual needs of their patients, and encourages patients to disclose and co-process these spiritual needs (Batstone et al., 2020).

Spiritual and existential suffering sometimes will emerge spontaneously, for example during personal care or any other time when nurses are able to focus and take time to actively listen. Nurses’ ability to concentrate on the arising moments, when patients wanted and needed to express their thoughts and feelings is seen as an essential nursing skill, that helps patients to alleviate their spiritual and existential suffering, which can be understood as an alienation or a threat against a person’s connectedness and their sense of identity and integrity (Tornøe et al., 2015; Norberg et al., 2001).

2.2.4 Moral and ethical values in healthcare

Understanding the role of individual moral values and how they are shaped by larger structures of ethical constructs, existing in a profession, an institution or society, will offer a better insight into how individual experiences of death in the ED could be influenced by these values. Morality incorporates personal values and the rules of behaviour regulating social intercourse, having at the centre interpersonal relationships, and striving to treat other human beings with dignity and respect, while promoting welfare, creativity and meaning (Doris, 2010). Individual moral values are action-oriented beliefs, about truth, beauty, and worth, giving direction and purpose to the individual (Carvalho et al., 2011). Moral values are more than an external structure, they are bonded in our identity and understanding of who we are as a person (Lapsley, 2009). As such, it is not something we lightly step in and out of. Without a moral order, the individual finds it difficult to interpret and make sense of the surrounding reality (Joas, 2000). It is argued that personal values are not static, and they form a hierarchy, prioritising some values before others, becoming instruments in making decisions (Solbrekke and Jensen, 2006).

In the process of developing a moral self in which the individual, navigates and internalizes the norms, meanings, and language with which interprets the world, needs to define communities that will constitute a framework for this process, establishing shared values within those communities (Solbrekke and Jensen, 2006). Moral order represents a value system that differentiates right, good, and desirable from bad, improper, and immoral (Doris, 2010). Moral order develops over a lifetime and originate from a variety of sources, being influenced by a series of geographical, anthropological, sociological, psychological, and theological factors (Solbrekke and Jensen, 2006).

Austin (2007) argues that moral reasoning in HCPs is a mental process which is applied to set in motion a decision-making effort, making a distinction between 'right' and 'wrong' in any moral dilemma. While values, in general, are interpreted as motivational preferences or dispositions, moral values for HCPs, represent those preferences that are aligned with this moral reasoning (Austin, 2007). Personal values are defined by commitments to, and identification with the moral orders of the communities to which the individual belongs (Solbrekke and Jensen, 2006). In this sense HCP's personal values are influenced by the moral order of the wider society, the medical or nursing profession's norms, the healthcare institution, and the clinical ward where they work. Personal morality of a HCP will develop through engagement and exchange with others in the communities in which they participate (Carvalho et al., 2011). A literature review of nursing ethical values and definitions, reflecting on observations from studies originating in twelve countries, has found, that the ten most commonly shared values in nursing are: human dignity, altruism, social justice, autonomy in decision making, precision and accuracy in caring, responsibility, human relationship, individual and professional competency, sympathy, and trust (Shahriari et al., 2013).

A hierarchy of values represents a structure, where one value is at the top of the priorities while others have less importance (Pullman, 2004). In the healthcare profession the priority of certain values will never change. This could include the standard of treating people as individuals, which require healthcare professionals not to discriminate in any form, against those in their care (NMC, 2015). Another value that may also never change is the conscientious objection, which relates to issues contrary to a nurse's moral beliefs and values, such as sanctity of life, on which nobody should be expected to compromise (Lloyd and Cooley, 2014). While some values can represent an individual's bedrock value that will never change, whatever the circumstances, other values could be more flexible and adaptable.

A clarification and self-assessment of our own values can help us understand why a particular person (for example a healthcare professional or a patient), or circumstances affect us in a certain way (Carvalho et al., 2011). Nurses, who do not examine and articulate their personal values may not be fully effective in their provision of care for their patients (Carvalho et al., 2011). While there is an expectation towards nurses to be 'non-judgemental', personal values will create a framework upon which they judge others. Yet, these judgements must not be allowed to influence a nurse's professional manner (Kaldjian, 2013).

Personal values and moral standpoints taken, will define the outcome of dealing with problems that arise in healthcare, many of them being related to honesty, doing good, valuing someone's worth or being fair in a situation (Moyo et al., 2016). Healthcare professionals are expected to provide anti-discriminatory patient care, thus issues such as accountability, responsibility, and negligence during this process will have to be explored in the context of professional and personal values (NMC, 2015).

Ashcroft et al. (2007) argues that medicine is an ethically driven practice, as its purpose is to improve the health of their patients. Doctors are often faced by a variety of ethical and moral decision-making situations, which should be guided by principles, such as focusing on the outcomes or consequences of these decisions yet giving priority to the inner values of the decision-maker (Ashcroft et al., 2007). Principles that are expected doctors to be engaged with, when confronting moral dilemmas in medical practice include self-determination, competence, confidentiality, honesty, benefit-seeking, and fairness. An example of self-determination is the ability to refuse any proposed medical intervention, even where the decision may result in death, justified by the anticipated benefits exceeding the potential harms (Ashcroft et al., 2007).

A study conducted among doctors of all specialties found that 62% of them agreed that receiving futile and invasive investigations or treatments, for patients near death is very common, mainly because preserving and lengthening life is the default medical approach (Visser, 2012). Marck et.al. (2014) argues that a moral and ethical dilemma often encountered by doctors, is when they do not provide treatments or medical interventions, which are unlikely to benefit a patient at the end of their life, guided by the intention to preserve their dignity.

Human dignity, as an aspect of morality, can be explained and defined alongside numerous competing concepts, taking their meaning from a political, cosmological, religious, or anthropological aspect. The German philosopher Immanuel Kant (1785) argues that a person during their life, including the end of it, must feel that it lived a dignified life. In his view, the autonomy of the individual represents the central element of dignity, something to which every human being has a right (Kant, 1785).

Despite the many differences in interpretation, human dignity in general relates to the ideas of sanctity, autonomy, personhood, flourishing, and self-respect of the individual (Griffin-Heslin, 2005). Having dignity should be recognised and maintained in every human being, reflecting the individual’s choices, ideals, values, and lifestyles (Formosa, 2014). Dignity is also a social construction that regulates our relationship with others, defined by attributes such as respect, empowerment, autonomy, and communication, alongside feeling comfortable with oneself and having control over one's decisions, choices, and surroundings (Haugen, 2010).

Dignity of a human being is extended also to the process of dying. Dying with dignity represents a priority for patients, their families, and the care providers, also being recognised as an essential objective for palliative and EOLC, although it might be sometimes unintentionally overlooked (Griffin-Heslin, 2005). Chochinov's (2002) model for preserving dignity of a patient has identified several characteristics that can influence the patient's sense of dignity. The model identifies three major areas that defines the subject of dignity in end-of-life care, namely: the patient's ability to satisfy themselves their own needs, within the context of the symptoms suffered; prerequisites and actions to preserve patient dignity; and the social context that influence the patient's dignity (Chochinov, 2004).

The most important focus in the ED context is to provide urgent life-saving medical treatment in the hope of minimising morbidity, prevent death and improve patient's overall clinical condition and wellbeing (Forero, et al., 2012). While this ethos remains the primary goal for the ED, end-of-life care is recognised as a core task for ED healthcare professionals, with dignity as a pivotal element of this care (Quest, et al., 2011). Studies suggest that ED clinicians repeatedly reported dignity of the patient being in danger, due to a conflict arising from the life-saving ethos characteristic to ED and providing EOLC in the same environment (Grudzen, et al., 2012a; Grudzen, et al., 2012b; Murphy, 2008). There is a lack of research about the influence of ED staff's personal and professional values, attitudes and beliefs when dealing with death in the ED, as such, understanding their experience from this perspective, is an important aspect of this research.

2.3 Death and dying in a healthcare setting

2.3.1 Death in the hospital

People dying in an acute hospital is a more frequent occurrence in Western societies compared to other societies, where dying at home is more usual (Gomes and Higginson, 2008). A cross-national, population-level study conducted in fourteen countries, suggests that 45.7% of the terminally ill patients with chronic-degenerative and oncologic diseases, die in hospital, higher than those dying at home, in hospices or other settings such as residential health facilities or an ambulance (Pivodic et al., 2016). A scoping review by Lin et al. (2021) reported that in Western societies, the proportion of people dying at home ranges between 22-57%, compared to mainland China, where the proportion of those transferring home to die from critical care units, can be as high as 82-92%. This difference is attributed to decision made on the basis of cultural, religious, and spiritual meanings of the home as a place of death. NHS England (2020a) reported there were approximately 9.4 million hospital discharges between 2018-2019 across 129 trusts in England, from which 287,000 deaths were recorded, either while in hospital or within 30 days of discharge. In 2016 almost half of all deaths in England (46.9%) occurred in hospital, a percentage significantly higher compared to the deaths occurring in people's own home, in a care home or hospice (Public Health England, 2018). The Royal College of Emergency Medicine (2021) has found that at least 4,519 patients died in EDs in England in 2020-2021, during the first waves of Covid-19, numbers being exacerbated by crowding, queuing, and long waits of up to 12 hours of critically ill patients.

When nurses and doctor witness the death of their patients in a hospital setting, they might appear to be virtual strangers, however as providers of care during the last period of their lives, they may have developed a close relationship with them (Aycock & Boyle, 2009). When patients die, healthcare professionals may experience a sense of grief, provoking strong physiological, psychological, or emotional responses especially if it is unexpected (Newson, et.al. 2011). A patient's death is being considered one of the most common stressors in a clinical environment, evoking feelings of distress, helplessness, or inadequacy in healthcare professionals, however, often these feelings are not expressed or evaluated (Park et.al. 2020). The healthcare professional-patient relationship is discussed in section 2.3.3.

Healthcare professionals' behaviour when a patient dies, may vary according to the social values, cultural backgrounds, or religious beliefs that they hold, interacting with their perceptions about death (Zheng et al., 2018; Becker et al., 2017). Perceptions can be described as an individual structure of thoughts and feelings about a situation, incorporating previous experiences and memories that help 'making sense' of that situation (McDonald, 2012). Perceptions of death can be a powerful driving force, influencing HCP's actions and behaviours, influencing their level of death anxiety and provision of supportive EOLC (Lai et al., 2018). HCPs that acknowledge and confront their own perceptions of death, could potentially offer better provision of EOLC in a hospital setting (Hussin et al., 2018; Park et al., 2020).

2.3.2 Death in the Emergency Department

Access to General Practice, and greater expectation from patients about response time and level of treatment, including those on a palliative trajectory, has increased the number of patient attendances at the ED as the first point of contact (Smulowitz et al., 2014; Bailey et al., 2011b). This increase in ED demand is associated with an increased risk of mortality in the ED, a complex issue encountered daily by clinical staff working in these areas (Pines et al., 2011). Patients presenting with chronic disease, acute rapidly progressing conditions or patients identified as being on a palliative or EOL trajectory, historically were usually transferred to a more appropriate setting for treatment or palliation (Pines et al., 2011). However, as healthcare systems more often experience demand that is in excess of staffing levels, these transfers are less likely to be timely (Sanchez et al., 2006). While ED is not considered an ideal place for palliative care, the culture of emergency medicine is shifting to a more patient goal-centred culture, from only providing stabilization of acute medical urgencies, to improve end of life care and manage death and dying (Clements, et al., 2004; Mierendorf et al., 2014).

Deaths occurring in the ED still present a range of challenges for HCPs. Emergency doctors could experience an emotional impact during resuscitation, as they can be reminded of the death of a close relative, making death becoming more personal (Kutner and Kilbourn, 2009). During death notification, doctors often experience an impersonal atmosphere, characterized by a busy space, with no well-established doctor-patient relationship and limited time to spend with a bereaved family (Iserson, 2000). Similarly, Emergency Nurses may also find it difficult to care for dying patients and their families, due the stressful environment, time pressures, lack of space, and a prioritized focus on treatment rather than comfort measures provided for patients (Gerace et al., 2020). Balancing the competing demands of the high-pressure environment of ED, poses one of the greatest challenges for nurses providing end of life care in the ED. With critical and acute patients presenting continuously in the ED, often unable to wait for intervention, nurses find it hard to give the dying patients and their families the care, comfort, and attention they deserve (Gerace et al., 2020). The influences and consequences of experiencing death in ED are discussed in section 2.4.3

2.3.3 Death and the healthcare professional-patient relationship

A traumatic event can be defined as a powerful, extreme, or severe situation, circumstances, or chain of events, able to overwhelm through its intensity a person’s ability to cope. The inability of a person to cope with such events may result in result in unusually strong emotional, cognitive, or behavioural reactions (Meichenbaum, 1994). Nursing and medical professions roles provide numerous occasions to deal with potentially traumatizing situations, Emergency Services being almost constantly confronted with severe injuries, death, suicide and suffering (O’Connor and Jeavons, 2003; Bennett et al., 2005; McFarlane and Bryant, 2007).

As a systematic review suggests, a large proportion of health professionals working in emergency services, ranging between 82–100%, are frequently exposed to work related traumatic events, often multiple times a week, or in some cases even daily (Donnelly and Siebert, 2009). When traumatizing events are affecting the healthcare professional-patient relationship that will have emotional and psychological consequences on healthcare professionals (Linklater, 2010; Redinbaugh, et al., 2003).

The main priority of the healthcare professional-patient relationship is the patient’s wellbeing and this is based on partnership, intimacy and reciprocity (Riley, 2012). This relationship can be defined as a series of interactions with the patient’s need at the core and communication as a foundation on which this relationship is built (Rosdahl and Kowalski, 2008). These interactions focus on the ideas, feelings, requirements, and priorities of the patient with the purpose of progressively enhancing optimum physical, mental, and emotional wellbeing (Riley, 2012). Patients will often experience inequality and powerlessness in this relationship, and may feel vulnerable, reliant, and dependent on healthcare professionals (Webb and Holland, 2011).

The relationship and communication between nurses and patients' families, will have an impact on both sides’ well-being, but also the quality and outcome of nursing care (Beaudoin and Ouellett, 2018). When family is experiencing sudden death of a loved one, the way they handle the grieving process and communicate, will have emotional consequences on healthcare staff too (Loghmani et al., 2014; Iserson, 2000). Reciprocity is a strong element of the nurse-family relationship, with feedback processes occurring often simultaneously, determining the way parties will think, feel, and behave in this relationship (Gerow et al., 2010).

2.4 Influences and consequences of death and dying on healthcare professionals

2.4.1 The complex process of bereavement

The subject of death in the Western societies, in the first half of the twentieth century was largely an uncomfortable topic, and something not to be discussed. Kübler-Ross (1969) observed at that time, that people at the end of life rarely had the opportunity to share their anxiety, feelings, fears, or emotions, sometimes even with the closest members of the family. Kübler-Ross’s (1969) approach suggests that instead of avoiding, isolating, or ignoring the dying or the bereaved, it is important to allow them to speak honestly and openly about their situation, understanding the individual stages of grief they are personally going through (Morris, 2011; Kaplow et al., 2010). Sudden death represents a form of death that is unexpected in its nature or timing, and the term can be applied when someone that is seemingly fit and well dies unexpectedly, but also includes people on a palliative trajectory, who die sooner than expected (Howarth, 2007).

Bereavement, caused by a death that is unexpected, can be a stressful life experience, associated with the development of psychiatric disorders (Newson et al., 2011). The period of bereavement following a death, can be complicated by circumstances such as unexpected or violent death, suicide, traumatic death, being unprepared for death, or the lack of a support system (Schoenberger et al., 2012).

While uncomplicated grief incorporates multiple responses, including emotional, cognitive, physical, and behavioural, as common reactions after a loss, the COVID-19 pandemic has rapidly changed the experiences of grief (Wallace et al., 2020). People's loss of a loved one during the pandemic, may be complicated by a loss of financial security, loss of social and physical connections, loss of mental and physical health and loss of autonomy, because of lockdown measures (Torrens-Burton et al., 2022). In the context of higher mortality rates during the pandemic, experiences of death may have been more frequent, potentially increasing exposure to, and impact of, deaths in clinical settings (Das et al., 2021; Hannah et al., 2021)

2.4.2 Models of grieving

Elisabeth Kübler-Ross (1969) theorises that grief can be segmented into five stages: denial, anger, bargaining, depression, and acceptance. Denial, as an initial reaction, represents the reflection of a false reality, in which the terminally ill patient prefers to cling, believing that the diagnosis is false or somehow mistaken. Denial was considered predominantly harmful in the past, while more recent research suggests that denial may offer protection from unnecessary pain, but this may become unhealthy if it remains a constant state of mind (Janoff-Bulmann, 1992). Anger is the stage of recognition by the individual that denial cannot continue and marks a return from the 'preferable' into the 'actual' reality. Bargaining revolves around the hope that the reason of grief can be exchanged, usually for a reformed way of life or seeking a compromise. This stage can be interpreted also as a phase of false hope. Depression is a stage of recognition of the individual's mortality, being a feeling of 'living in the present', surrounded often by emptiness, due to an upcoming loss that is inevitable. Acceptance as a final stage represents the embrace of an inevitable future, a stable condition of emotions, a calm retrospective of the individual, where the people dying might precede in this state the survivors (Kubler-Ross, 1969).

The Kübler-Ross model has been criticised for a lack of empirical evidence. Further, the model is a product of a certain time and certain people, which may not be transferable to all contexts. Originally developed to describe what patients go through when dealing with a terminal illness, the model has been only applied later to grieving family members, who seemed to undergo a similar process. Even Kubler-Ross denied that grief would follow a linear pathway through all the five stages (Kubler-Ross et al., 2005). Other studies suggest that experiencing grief is very subjective, sometimes experiencing one or more of the stages, repeating or skipping some of them, other times rushing through all of them or going through stages that were never part of the initial model (Shermer, 2008; Tang and Chow, 2017).

The work of Zisook and Shear (2009) suggest that there could be four major components of grief that manifest in different forms depending on the individual and the unique circumstances of the loss. First, separation distress, represents a group of feelings including sadness, anxiety, pain, helplessness, shame, anger, or loneliness; traumatic distress, a group that includes states of disbelief and shock, intrusions, and efforts to avoid the emotions produced by this intrusion; guilt, remorse, and regrets and finally, social withdrawal. Zisook and Shear (2009) suggest that there is an instinctive path that grief takes that leads to better outcomes, called ‘acute grief’. Those who suffer for longer periods of time may be experiencing a block of that pathway, known as ‘prolonged or complex grief’ (Zisook and Shear, 2009). While many people will experience moderate feelings of sadness even after longer periods of time since the loss of a loved one, ‘acute grief’ will lessen within a few months. ‘Prolonged grief’ may often look like depression, and usually requires counselling or other kind of treatments (Szanto et al., 2006). ‘Prolonged grief’ can also be complicated by substance abuse, to escape some of the pain caused by grief, which can make coping even more complex (Shear and Mulhare, 2008).

Another model of grief developed by Corless (2010) describes three distinctive stages, including: notification and shock, experiencing the loss, and reintegration. During the first stage, the individual acknowledges or first learns about the loss, often isolating themselves from others, as the feeling of shock and numbness overwhelms. In the second stage, the loss is experienced both emotionally and cognitively, inducing feelings of anger, sadness, emptiness, or even physical manifestations such as sleep or eating disorders (Lowey, 2008). The final stage is when the individual returns, reorganizes and reintegrates into their life, accepting the loss, carrying on without them. At this last stage, ideally the healing should take place at the end of grief (Corless, 2010).

Vachon (2001), described nurses as wounded healers. While at the heart of the relationship between nurses and patients, caring and compassion positively affects patient care, ‘caring might have a cost’ (Boyle, 2011; Lally, 2005). Unacknowledged grief, if not recognizing and coping with it, may escalate further, ‘taking its toll’ at a later stage (Wakefield, 2000). Compassion fatigue may be another consequence of caring for suffering patients. Compassion fatigue can be a result of nurses showing compassion while caring for patients who are dying or suffering daily (Austin et al. 2009). The effects of cumulative grief may cause compassion fatigue in nurses, who detach emotionally, or overinvest in patients’ lives (Boyle, 2011). Unresolved cumulative grief and compassion fatigue can have consequences for an organization in terms of increases in absenteeism, interpersonal and performance issues, decreased quality of patient care and increased staff turnover (Aycock and Boyle, 2009; Showalter, 2010).

Understanding the complexity of the bereavement process, and analysing and comparing different grieving models, informed my thesis by influencing my choice of methodology and data collection methods, the construction of a structure of my interviewing process and choosing the individual questions, and helped me better focus my analysis. While grieving is always an individual and very personal experience and the grieving models discussed are largely critiqued by their lack of empirical evidence, these often helped me acknowledging the existence of certain aspects discussed within these models in my empirical data.

2.4.3 The physical, mental, and emotional burden of death on healthcare professionals

Experiencing death is often associated with depression and anxiety symptoms, substance use or other psychiatric disorders (Keyes et al., 2014). According to Brown et al. (2009), doctors demonstrate high stress responses, recording an increase in heart rate and heart-rate variability when breaking bad news in simulated patient encounters. A further survey of 150 emergency doctors, suggests that many experienced physical responses to patient death, including insomnia (37%) and fatigue (14%), while in terms of emotional responses, they experienced sadness (60%) and disappointment (38%) (Strote et al., 2011). A combination of emotional and biological stress responses can make emergency doctors more susceptible to job dissatisfaction and burnout (Kutner and Kilbourn, 2009).

Nurses in the ED can also be affected by death (Alden et al., 2008). A UK study suggests that levels of death anxiety were similar in hospice and emergency nurses, although one quarter of emergency nurses showed more fear and less acceptance of death than hospice nurses (Payne et al., 1998). Adriaenssens et al. (2012) suggests that emergency nurses are almost permanently exposed to severe injuries, death, suicide and suffering in their line of work. This exposure can potentially lead to loss of productivity, due to a change in professional attitude, or can negatively alter the quality of nursing care (Alden et al., 2008). Research has shown that emergency nurses report symptoms of PTSD (Post-Traumatic Stress Disorder) after professional confrontations with traumatic events, including sleeping difficulties, nightmares, flashbacks, recurrent images and thoughts, irritability and depression, lack of interest in daily life, loss of hope in the future and loss of concentration (Gates et al., 2011). A further study reported that the three most distressing events ED nurses are repeatedly confronted with are paediatric death, incidents involving children and dealing with patients’ relatives and family (De Clercq et al., 2011).

Emergency nursing is a complex profession, demanding both physically and emotionally. This demand is arising from dealing with complex patient loads in a fast-paced environment, long shifts, often demanding medical staff, and patient's relatives, causing stress for the ED staff (Healy and Tyrrell, 2011; Hooper et al. 2010; Von Rueden et al., 2010). Emergency Nurses experiencing such levels of stress can develop over time compassion fatigue and burnout, conditions that can become overwhelming burdens and can cause physical, mental, and emotional health difficulties (Potter, 2006). Compassion fatigue is a negative result of working with traumatized patients, described as an emotional, physical, and spiritual exhaustion from witnessing other people suffering (Peery, 2010). Burnout, while very similar to compassion fatigue, is associated with feelings of hopelessness and apathy, which, if not addressed, may develop an inability to fulfil the ED job requirements effectively, also having a negative impact on the provision of care (Hooper et al. 2010).

Both compassion fatigue and burnout display similar traits, causing an emergency nurse to become depressed, ineffective, detached or even apathetic (Boyle, 2011). These psychological and emotional consequences, on the long-term can lead to a radical decrease of morale, work ethic, job satisfaction, absenteeism, and the inability to co-operate as a team with the fellow co-workers (Jones and Gates, 2007; Portnoy, 2011). From a professional perspective, these can have an impact on patient satisfaction, and may impact staff retention in the ED (Vahey et al., 2004). A study conducted by Hooper et al. (2010) analysed and compared variations in the levels of compassion fatigue, compassion satisfaction and burnout among nurses from a great variety of specialities including intensive care unit, oncology, nephrology, and emergency services. While the findings of the study suggest that levels of compassion fatigue are similar among the different specialities, there was a notable difference in compassion satisfaction. ED nurses were reporting lower levels of compassion satisfaction compared to the other type of nurses and the study also revealed a greater risk of burnout in the ED nurses (Whippen and Cannelos, 1991; Hooper et al., 2010).

A study surveying 132, year one foundation doctors, reported that 61% of them witnessed deaths, including death of young patients, death that lacks dignity or death of a patient where a strong personal relationship pre-exists, where death remains emotionally distressing, triggering strong reactions (Linklater, 2010). These emotional reactions could include, but not limited to stress, guilt, feelings of numbness and feeling upset. ED doctors specifically report insomnia, fatigue, sadness, and disappointment after facing unexpected deaths (Redinbaugh et al., 2003; Meier et al., 2001; Jackson et al., 2005).

Factors that influence the intensity level of HCPs' emotional reactions to a death experience include, the age of the patient, cause of death, and presence of the family (Strote et al., 2011). These effects will also be influenced by the level of training and years of experience a doctor has (Jackson et al., 2005). These findings are in line with another study which compared nurses' death anxiety and confirmed that nurses' emotional distress was lower as age, education, and nursing experience increased (Deffner and Bell, 2005). Emotional distress often has personal and professional consequences on doctors. One study, surveying 145 emergency doctors, found that 28% revealed they sometimes considered quitting their jobs, 32% looking for another profession, and 14% looking for various means of counselling (Strote et al., 2011). Death anxiety can be defined as a feeling of apprehension, solicitude, or dread, when one thinks of the process of ceasing to be (Deffner and Bell, 2005). When the contrast in death anxiety between palliative care and ED nurses has been compared, various studies found these levels to be very similar (Payne et al., 1998; Santisteban and Mier, 2006). However, nearly 25% of ED nurses showed both less acceptance of death and more fear in comparison to palliative care nurses (Payne et al., 1998).

2.5 Summary of Chapter Two

While ED remains a place with its main purpose to save lives and improve the clinical condition of critically ill patients, caring for the dying and managing the consequences of witnessing death by HCPs, remains a priority without any doubt. Understanding HCPs experiences with death, examining existing coping mechanisms, while evaluating the influence of their norms and values, in relation to this experience, it is hoped to contribute, to raise awareness about this important issue, articulate the need for further work to inform practice and contribute to the better preparedness for such events.

Chapter Two discussed in detail how exploring the various aspects of death, such as the social, cultural, spiritual, and moral, play an important role in understanding the roots of some of the personal values and norms, that could influence HCPs experiences of death in the ED. This chapter concludes that death experiences in the ED, requires to be analysed beyond the biological dimension only. Social death indicates a state and a set of activities surrounding it, where a person is treated as being already dead, before physical death occurs. Cultural-sensitive rituals of death and grief can complicate the EOLC provided by HCPs, while integrating spiritual care into it can help relieving death anxiety of dying patients and their families. Moral values serve as 'compasses' for HCPs in navigating in difficult situations, aiding decision-making, while death experiences, due to their mostly traumatic and sudden, or quite the opposite, slow and progressive nature, carry the potential to cause emotional and psychological burden for HCPs working in the ED. Understanding the complexity of the EOL patient and HCP relationship, and the diverse nature of individual bereavement processes, will help structuring and focusing the collection and analysis of empirical data in this research study. Chapter Three will describe the process and findings of the literature review, including the gaps identified in the current knowledge.

Chapter 3 Literature Review of healthcare professionals' experiences of death in the ED

3.1 Introduction

Chapter Three provides an outline of the literature review aim, the approach to undertaking the review and search strategy, before presenting the results of the literature review which explored HCPs' experiences of death in the ED, and how this has been studied within contemporary literature. The purpose of the literature review is an evidence-based, in-depth analysis and critical appraisal of the current collective knowledge on a subject (Winchester and Salji, 2016). Ridley (2012) argues that a literature review should be a personal, but unbiased synopsis and insight to the background information related to the studied phenomenon, rather than an exhaustive list of all that has been published in relation to that topic. The literature review is an important chapter of this thesis as it provides justification for the research undertaken, by consolidating what is already known about HCP's experiences of death in the ED and identifying gaps in the research evidence (Rudestam and Newton, 2007; Machi and McEvoy, 2016; Fink, 2010).

3.2 Methodology of undertaking the literature review

3.2.1 Initial contemplation to aid review method selection

Selecting the most appropriate method in conducting this literature review was a crucial element in gaining insight and identifying gaps in the current knowledge. To aid this method selection process, I undertook an initial contemplation, through which the main purpose, direction and methods of the review were clarified (Grant and Booth, 2009). This initial contemplation focused on answering the following: 'What is the goal of the literature review?' and 'What are the initial expectations?'. As death experiences in the ED was anticipated to be a broad topic, resulting in numerous studies, a further refinement of the search relating to HCPs' values and norms was applied. The questions to define the main direction of the review were 'Should the topic be broad or narrow?' and 'Should the information gained from the sources be simply summarized or should it be synthesized and critiqued?' Focusing on the broad experience of death, yet also on the influences of HCPs' values on this experience, was expected to offer a more in-depth understanding of the topic. Synthesizing and critically appraising the selected papers was important to evaluate the strengths and limitations of the existing knowledge. Finally, answers were sought for three major questions about what the review should be, search strategy and critical appraisal tools. Narrative review, SPIDER and CASP tools (section 3.6), were selected for this purpose as would fit with the goals and the direction initially set for this literature review (Oliver, 2012). The answers to these questions, including their rationale are summarized in Appendix A.

3.2.2 Selecting the literature review method

Based on the answers given to the questions described in the initial contemplation, the approach used to conduct the literature review was a narrative method. Prior to deciding on selecting the narrative review method, other review methods were also considered but rejected including the systematic review, meta-analysis, rapid review, systemized review, scoping review and umbrella review. The main characteristics of these review methods are listed in Appendix B. Systematic reviews are considered the ‘gold standard’ of literature reviews, in specifying a focused research question, being more methodologically explicit and less biased than narrative reviews. However, authors have suggested that the two methods do not compete, but may complement each other (Yuan and Hunt, 2009). A systematic review is a preferred method when the research problem requires quantifiable, measurable, or objective data. However, when clarification, insight and interpretation is needed, a more interpretative and discursive approach in literature review, such as a narrative approach, may be preferred (Ferrari, 2015).

In contrast to systematic reviews, the main goal of a narrative review is to remain authentic when presenting an argument, based on informed knowledge drawn from evidence, and the methods used to combine them, to inform the review’s conclusion (Greenhalgh et al., 2018). One of the legitimate criticisms of narrative reviews, is that they can be very selective in choosing what evidence should be included to make a particular perspective more noticeable (Cronin et al., 2008). This must be weighed against the counter argument, that narrative reviews offer an interpretive overview of a topic that clearly highlights the state of knowledge, explaining how we know what we know, and where the unanswered questions could be found (Bolderston, 2008).

To minimise the risk of selectively choosing evidence, this review used a structured and transparent approach in searching for relevant literature, to avoid being ad hoc or ‘cherry-picking’. As the purpose of the research is to explore personal experiences, feelings, and emotions, which are impossible to quantify, a narrative literature review allowed me to carefully select and build on existing knowledge that provides the best possible fit for purpose (Greenhalgh et al., 2018).

For this thesis I scoped the literature at the start of the study in 2017-18, undertaking a further structured review in May 2022, before updating and searching for new papers prior to submission in March 2023.

3.3 Stages of the literature review

Using a clear strategy and a systematic literature search, I maintained a high level of transparency and accuracy, to add clarity and structure to the review process (Ferrari, 2015). The stages of this narrative review are detailed in Table 3.1 in chronological order.

Table 3.1 Stages of the narrative literature review (adapted from Ferrari, 2015; Cronin et.al. 2008; Bolderston, 2008)

STAGE	DESCRIPTION
Stage 1: Define the review question, aim and objectives	• Define a broad review question to generate a broad range of results • Define the aim and the objectives of the review to find direction, trying to limit the scope and purpose of the research by identifying key concepts to be explored
Stage 2: Define search strategy and identify studies	• Define the sources and databases used for searching • Define keywords and their variations used for searching. Identifying appropriate keywords will happen by: - Identifying key concepts in the review question, aim and objectives - Brainstorming related terms to these key concepts: ○ **Broader terms**: to find more general information ○ **Narrower terms:** to find more specific information ○ **Related terms:** to find information about related topics ○ **Similar terms:** to explore the options of synonyms • Search various sources to be as comprehensive as possible • Define limitations applied for the search and their rationale
Stage 3: Define selection criteria and select studies	• Define inclusion and exclusion criteria and the tool used • Define the quality assessment tool used to evaluate the studies for selection • Obtain a list of full text studies that fit within the set criteria • Visualize the process using a flowchart

Stage 4: Evaluate, analyse and chart studies	• Evaluate the resources to make sure they contain information that is authoritative, reliable, relevant and the most useful in supporting the current research. • Criteria for evaluation: o Significance and contribution to the field o Methodology or approach o Argument and use of evidence o Writing style and text structure • Charting selected studies with the following details: o Author o Publication date o Country of origin o Study title o Setting and sample size o Research method o Research objective o Results and conclusions o Limitations
Stage 5: Synthesize themes from selected studies	Synthesis in comparison to summary has specific characteristics: • Has a well-defined focus • Highlights important points and personal observations to the text • Discussion is supported by various sources • Compare and contrast information from various sources • Makes connection between sources (support argument, refute argument, similar or opposing concepts) • Visual representation of the synthesized themes and their relationship with each other.
Stage 6: Present and discuss findings	The discussion and the presentation of the findings will include the following elements: • A demonstration of a thorough investigation of and acquaintance with sources related to the research topic • A critical discussion, not only a simple listing • Compare and contrast opinions • Identify gaps in research • Focus on the defined research question • Includes a compilation of the primary question and the related subject areas involved

3.4 Stage 1: Define the review question, aim and objectives

The PIO (Population-Issue-Outcome) format was used to support the development of the review question, which guided the development of the narrative review strategy (Bettany-Saltikov 2016) (Table 3.2).

Review question:

What is currently known about the experiences of death of healthcare professionals working in the Emergency Department?

The aim of the literature review was to capture relevant knowledge about the studied phenomenon, by summarizing and synthesizing ideas and arguments from selected and reviewed research papers. The purpose reaches beyond a simple summary of the sources, as the intention is to re-organize, interpret, combine, and critically appraise the relevant literature (Randolph, 2009). The literature review provides a comprehensive knowledge about staff's experience of death in Emergency Department, and reveals the gaps in current knowledge, offering a clear focus in developing a study design, which will address these gaps (Callahan, 2014).

The objectives of the literature review are to:

- Collect and review currently available knowledge about HCP's experiences of death in the ED
- Explore current understanding of the influence of personal, cultural, social, spiritual, or moral values and norms on these experiences of death in the ED
- Identify any strategies used for managing, accessing support, coping with, and preparing for such experiences of death in the ED
- Identify gaps in the current knowledge that should be addressed by the empirical work

Table 3.2 The PIO format used to define the review question

P	**POPULATION**	HCPs (doctors, nurses, healthcare assistants, advanced clinical practitioners) working in the ED
I	**ISSUE**	Experiencing death in the ED and the the influence of personal, cultural, social, spiritual, or moral values and norms
O	**OUTCOME**	Lived experiences of HCPs of death in the ED

3.5 Stage 2: Define search strategy and identify studies

As I was interested in the experiences of death in the ED from a medical, psychological, social, moral, and spiritual aspect I included database sources which potentially contain publications focused on these (see Appendix C for the list of databases searched). A set of keywords were then defined and used to conduct the literature search. The review question and objectives informed the keywords and concepts (Table 3.3).

Table 3.3 Key concepts identified in the review question and objectives

Review question	**Key concepts identified**
What is currently known about the **experiences** of **death** of **HCPs** working in the **ED**?	• Experience • Death • Healthcare professional • Emergency Department
Review objectives	**Key concepts identified**
• Explore current understanding of the **influence of personal, cultural, social, spiritual, or moral values** and **norms** on these experiences of death in the ED • Identify any **strategies** used for **managing, accessing support, coping with, and preparing for** such experiences of death in the ED	• Influence • Personal values/norms • Cultural values/norms • Social values/norms • Spiritual values/norms • Moral values/norms • Measures • Manage death • Access support for death • Cope with death • Prepare for death

Unlike searches initiated with popular search engines (such as Google or Bing), library database searches work best using keywords or ‘search strings’, a combination of multiple keywords, using the method of truncation and Boolean operators: AND, OR and NOT used to expand or reduce search parameters. As keywords represent the main ideas and concepts in my research topic, using different words authors may use, was crucial to produce alternate search options, to widen my scope and overcome potential difficulties finding resources. To achieve this, I consulted the Medical Subject Headings (MeSH) thesaurus, which is a controlled and hierarchically organized vocabulary, used for indexing, cataloguing, and searching of biomedical and health-related information. Table 3.4 includes the different set of keywords used in the search strategy.

Table 3.4 Keywords considered including broad, narrower, related, or similar terms

Broad terms	Narrower terms	Related terms	Similar terms
Experience	• Lived experience	• Understanding • Sense • Reality	• Knowledge • Practice • Involvement
Death	• Death and dying • Sudden death • Unexpected death • Imminent death • Immediate death • Traumatic death	• Decease • Pass/Passing away • Loss/Losing (a life) • Cessation (of life) • Fatal outcome	• Suicide • Homicide • Palliative care • Palliative Supportive Care • Palliative Therapy • Palliative Treatment • End of life • End of life care • EOL • EOLC • Advance Care Planning • Life Support Care • Terminal care • Bereavement • Grieving • Grief • Attitudes to death
Healthcare professional	• Healthcare workers • Healthcare providers	• Clinical staff • Hospital staff	• ACP • Advanced care practitioner • ENP • Emergency nurse practitioner

			• Physician • Nurse • Doctor • Consultant • Healthcare Assistant
Emergency Healthcare	• Emergency Department	• Accident & Emergency • A&E • Emergency Room • ER • Accident and Emergency Department • Emergency Care • Emergency Services • Emergency Health Services • Emergency Medical Services	• Emergency Hospital Service • Emergency Outpatient Unit • Emergency Units • Emergency Ward • Emergency Prehospital Care • Emergency centers/centres
Values	• Personal values • Professional values • Institutional values • Social/Societal values • Cultural values • Spiritual values • Moral values	• Beliefs • Principals • Ethics • Ideals • Morals • Standards • Norms	• Attitude • Code • Conduct • Integrity • Sense of duty
Manage	• Manage experiences of death	• Handle • Control	• Supervise • Care for
Cope	• Cope with experiences of death	• Handle • Endure • Deal with	• Battle with • Carry on • Live with • Suffer with

Support	• Support with experiences of death	• Help • Aid	• Support services • Advice • Guidance • Assistance
Prepare	• Prepare for experiences of death	• Education • Training • Planning • Study • Qualification	• Teaching • Learning • Coaching • Improvement • Course

The next step was to combine these keywords into ‘search strings’ and conduct searches that reflect the review question and objectives. The keywords were combined into broader and narrower ‘search strings’ looking to use different variations of certain words, such as *death, dead and dying* or *loss, losing and lost*, yet also to acknowledge some differences between the British and American spelling, such as *centre and center*. The ‘search strings’ used to conduct the database searches are listed in Appendix D.

In conducting the first literature review in 2018, I searched for literature published between 2008-2018, for two main reasons. Firstly, the UK Government published the ‘End of Life Care Strategy’, in 2008 as a response to an increase demand for standards to be set and trajectories to be offered for those approaching the end of their life, about where they would like to live and die (Department of Health and Social Care, 2008). The second was related to the rapid change of demographics in developed countries including a general ageing of the population (Bone, et.al. 2018), confirmed by reports from around the world, for example, Eurostat (2017), in the US (PRB, 2019), Australia (AIHW, 2018) and Japan (SBJ, 2019). A report published by Marie Curie (2016) suggests that palliative care needs in UK between 2008 and 2014 increased from 63% to 74% and will continue to grow. In the light of these statistics, research published before 2008 might not provide an accurate account of the current realities and challenges in this field, and potentially might not offer a true reflection of clinical staff’s lived experiences with death in healthcare settings, especially in the ED.

While this literature review has included literature published in English from various geographical regions, it is worth to be mentioned that developed societies usually benefit from improved healthcare systems, and emergency services, also investing more into research, as such literature originating in such countries could potentially be ‘over-represented’ in reviews (BMJ, 2017; ONS, 2019; WHO, 2020). The literature was updated in March 2023 to capture more recent publications prior to thesis submission.

3.6 Stage 3: Define selection criteria and select studies

Transparency during the literature selection process is achieved using a clear inclusion and exclusion criteria (Bart et al., 2006). The SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, Research type) tool has been used for this purpose, which incorporates many aspects of the PICO (Population, Intervention, Comparison, Outcome) tool and developed to support effective search strategies of qualitative and mixed-methods research (Cooke et al., 2012). A detailed list of the inclusion and exclusion criteria can be found in Table 3.5.

Table 3.5 Inclusion and exclusion criteria using the SPIDER tool

SPIDER tool	INCLUSION criteria	EXCLUSION criteria
S : Sample	1. ED healthcare professionals including doctors, nurses, healthcare assistants, ACPs (Advance Clinical Practitioners), ENP (Emergency Nurse Practitioners) 2. Healthcare professionals that witnessed death in the ED	1. Non-clinical ED staff including administrative, office clerks or clinical but not dealing with death and dying (eg. physiotherapist). 2. Staff that have not witnessed death in the ED
PI : Phenomenon of interest	Experiences of death in the ED	Experiences of death following a discharge from ED (e.g., to a hospital ward) Experiences of pre-hospital deaths (e.g., in an ambulance)
D : Design	Published literature of any qualitative design, secondary qualitative analysis and mixed method papers with a substantial qualitative component	Quantitative methods, such as randomised control trial, secondary research of quantitative data only, or surveys with quantitative questions only
E : Evaluation	Views and experiences reporting on experiences of healthcare professionals about death in ED	Views and experiences not reporting experiences of healthcare professionals about death in ED
R : Research type	1. Qualitative method 2. Mixed method *Included:* • *Journal articles* • *Primary research* • *In English language* • *Published between 2008-2022* • *Peer reviewed* • *Full text available*	Quantitative method only *Excluded:* • *Patient booklets* • *Information leaflets* • *Trade publications* • *Magazines and News* • *Conference materials* • *Editorials* • *Opinion publications/articles*

Following the removal of duplicates, the combined number of search results for all three searches was 9,572 (Figure 3.1), while after applying the exclusion criteria, the results were reduced to 754. After reviewing the titles and the abstracts of these publications the number of results was reduced to 72. After a full text review, 55 papers were excluded as not being relevant for the current purpose of the research, concluding the total number of included publications to 17. The reasons for exclusion in this last phase of the selection process is detailed in Table 3.6.

The complete search process is illustrated in a PRISMA diagram in Figure 3.1.

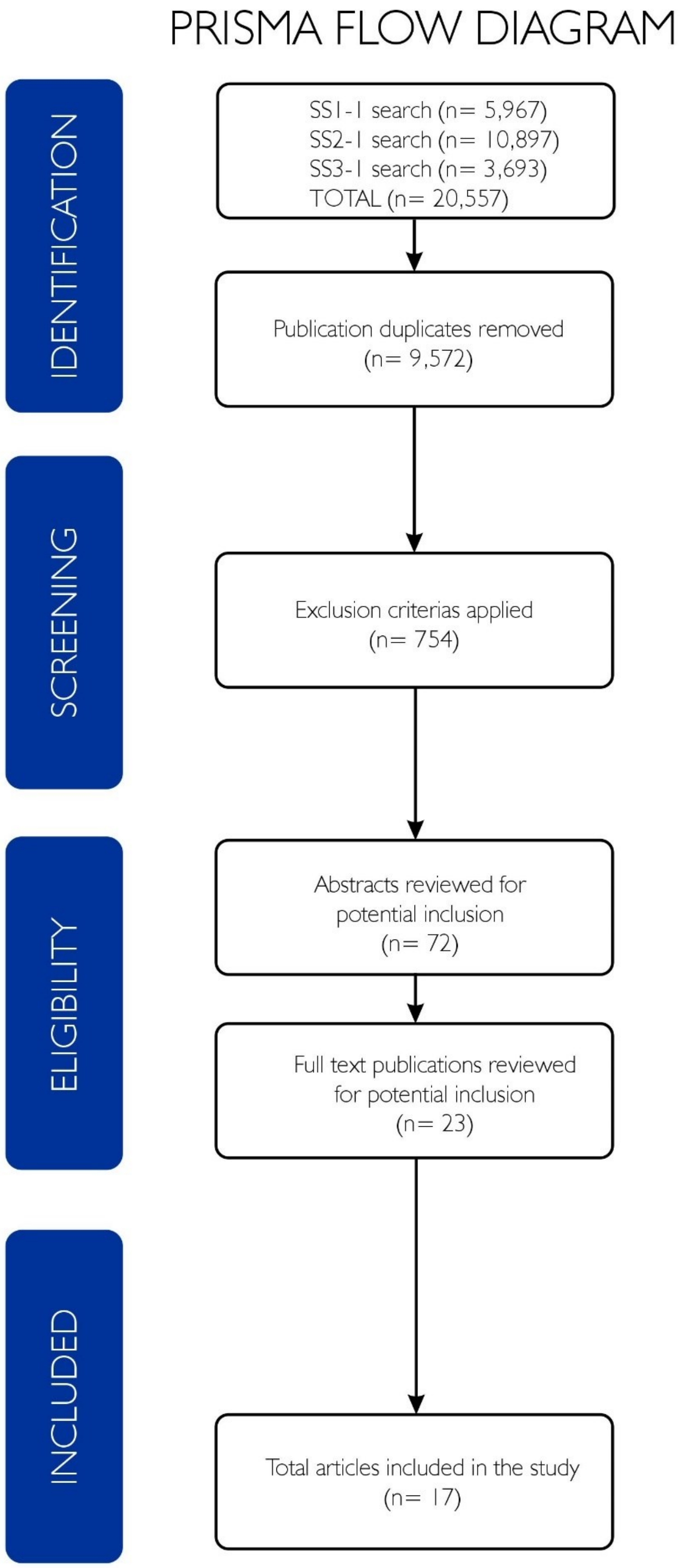


Figure 3.1 Prisma Flow Diagram

Table 3.6 Reasons for exclusion in the last phase of the literature search

Full text reviewed for potential exclusion: 49 *publications excluded (n=23)*
N=23 - study focusing on a specific cause of death in the ED rather than staff experiences N=13 – no full text available N= 11 – surveys/questionnaires used only for quantitative data collection N= 2 – only a protocol, not full study
Final review for the final list of included publications: *6 publications excluded (n=17)*
N=6 - moral/ethical values not discussed in relation to death, but various other interventions in the ED

Trustworthiness of the research is a key element in evaluating the quality and in assessing the result of the literature review (Lincoln and Guba, 1985). The model described by Yardley (2000), incorporates four components by which the quality of a study can be assessed, incorporating: sensitivity to context; commitment and rigour; transparency and coherence; impact and importance. A critical appraisal tool is used for the systematic assessment of the trustworthiness and relevance of the papers, ensuring that the review findings are accurate and balanced (Butler et al., 2016). While there is potentially a high number of appraisal tools available to assess the quality of research, some were rejected as they did not meet the objectives of this review. AMSTAR2 (Shea et al., 2017) was rejected as it examines the effectiveness of interventions, NOS - Newcastle-Ottawa Scale (Wells et al., 2021) was rejected as it assesses the quality of non-randomized studies in meta-analyses, while the Cochrane Risk of Bias Tool (Higgins et al., 2011) because focuses on the risk of bias of randomized control trials (Tod et al., 2021). Two very similar tools were considered, the Critical Appraisal Skills Programme (CASP, 2018), and the JBI Critical Tool (JBI, 2018). Both tools contain a set of ten questions each, presenting many similarities in their approach. I tested both tools on two papers, as a pilot. After evaluating this, I preferred the CASP tool, as it better supported my aim to individually identify and weigh up the strengths and weaknesses of each paper in a shorter amount of time. I have applied the CASP tool both when reading the abstracts only and the full text articles, with the list of questions (Appendix F) next to me, answering the questions to myself and taking notes, as I was progressing through each article, evaluating each paper based on the answers given.

3.7 Stage 4: Evaluate, analyse, and chart studies

Evaluating, analysing, and charting the data from the articles selected for inclusion is a key element in generating a comprehensive literature review (Cronin et al., 2008; Bolderston, 2008). The aim of this stage is to offer a comprehensive overview of the spectrum and areas covered in relation to the review question and objectives, while giving a frame to the development of themes and their later discussion.

3.7.1 Characteristics of papers included

Three of the selected publications originated in the UK, four in Europe, four in Australia, one in the US and the remainder from Asia and the Middle East. Most of the studies focused on a mixture of professions as participants, mostly emergency nurses, and doctors, some also explored the views of patients and other professions, alongside of nurses and doctors, while healthcare assistants or care support workers were almost completely excluded from these studies. Phenomenology was the most popular approach in these studies, whilst others used ethnography or case study. Most studies used semi-structured or in-depth interviews and focus groups, and a smaller number used observations, surveys with open-ended questions or retrospective data analysis. The datasheet created for data extraction can be found in Appendix E, and a summary of the selected papers are presented in Table 3.7.

Table 3.7 Final list of selected papers for literature review

No.	Author Date Country	Article Title	Setting and Sample Size	Research Method	Research Aim or Objective	Results and Conclusions	Limitations
1.	Bailey et. al. *2011 a.* *UK*	**Trajectories of End-of-Life Care in the Emergency Department**	Emergency Department of a large urban hospital in UK. Emergency Nurses (n=11) Emergency Doctors (n=2) Technicians (n=2) Patients with terminal illness (n=7)	Qualitative method using ethnography. Observations and informal interviews. In-depth interviews.	Exploration of end-of-life care in the ED and provision of an understanding of how care is delivered to the dying, deceased, and bereaved in the emergency setting.	Two distinct trajectories of end-of-life care were identified in the ED: (1) *spectacular* (2) *subtacular.* Patients and relatives experiencing different end-of-life care in the ED because of these two trajectories.	Data collected from one hospital only, might not be relevant nationwide. Majority of the data collected from nurses, whereas the doctor's data are from specialist registrars and may not therefore be reflective of the whole medical team.
2.	Bailey et. al. *2011 b.* *UK*	**Dying cases in emergency places: Caring for the dying in emergency departments**	Emergency Department of a large urban hospital in UK. Emergency Nurses (n=11) Emergency Doctors (n=2) Technicians (n=2) Patients with terminal illness (n=7)	Qualitative method using ethnography. Observations and informal interviews. In-depth interviews.	Exploration of the needs of patients as death nears in the ED. The role of critical decisions made in the ED which have a significant impact on the quality of care experienced by patients.	The allocated space of the patient and their place within a priority-driven environment, has a direct impact on the care which they receive in the ED.	Data collected from one hospital only, might not be relevant nationwide. Majority of the data collected from nurses, whereas the doctor's data are from specialist registrars and may not therefore be reflective of the whole medical team.

3.	Bailey et. al. *2011 c.* *UK*	**Professional tears: developing emotional intelligence around death and dying in emergency work**	Emergency Department of a large urban hospital in UK. Emergency Nurses (n=11) Emergency Doctors (n=2) Technicians (n=2) Patients and their relatives (n=13)	Qualitative method using ethnography. Observations and informal interviews In-depth interviews	Exploration of how emergency nurses manage the emotional impact of death and dying in emergency work.	Emergency nurses develop expertise in end-of-life care giving by progressing through three stages (1) *investment of the self in the nurse–patient relationship* (2) *management of emotional labour* (3) *development of emotional intelligence.*	Data collected from one hospital only, might not be relevant nationwide. Majority of the data collected from nurses, whereas the doctor’s data are from specialist registrars and may not therefore be reflective of the whole medical team.
4.	Batley et. al. *2017* *Lebanon*	**The effect of patient death on medical students in the emergency department**	American University of Beirut, Lebanon. Medical students who encountered death in ED (n=16)	Qualitative methods Semi-structured interviews.	Examination of aspects of patient deaths in the ED that most strongly influenced students’ reactions while comparing it to those of an inpatient setting.	Student reaction to patient death is determined by: (1) context of death; including age of patient, expectation of death, first death experience, relating patient death to personal death (2) extent of interaction with patient and family members.	There were at least two interviewers in any given interview which may have increased the number of follow up questions asked, potentially confusing the interviewee. Additionally, since the topic is sensitive, this may have prevented participants from sharing their emotions openly and honestly. Recall bias may have limited the generalization of the results further.

5.	Chan et. al. *2011* *USA*	**Trajectories of approaching death in the Emergency Department: Clinician Narratives of patient transitions to the end-of-life**	Emergency Department of a Level II trauma centre in Northern California, USA. Emergency Nurses (n=5) Emergency Doctors (n=3) Respiratory Therapist (n=3) Observation of patients (n=10)	Qualitative method Interpretive phenomenological approach. Observations and interviews.	Identification of different trajectories of patients approaching death in an effort to describe the end-of-life experience in the ED.	Seven trajectories of approaching death in the ED identified. Findings will help clinicians in their recognition of the clinical situation and react appropriately Will help identify the transitions to the end-of-life phase Will help to explore the possibilities open to the patient, family, and clinicians.	The participants were recruited from a single community ED in northern California and gave local accounts of providers', patients', and families' experiences, thereby limiting generalizability. Other limitations include a small sample size and the risk of selection bias. Only experienced clinicians were included in this study.
6.	DiLeo et. al. *2019* *Italy*	**Palliative care in the emergency department as seen by providers and users: a qualitative study**	Emergency Department of a large urban hospital in Northern Italy Healthcare professionals: (n=21) Patients (n=6) Relatives (n=5)	Qualitative method Focus group interviews with Emergency Department professionals and semi-structured interviews with patients with palliative care needs and their relatives was conducted.	Exploration of issues in delivering palliative care in the Emergency Department from the perspective of both providers and users, as part of a larger project on the development and implementation of a quality improvement program in Italian Emergency Departments.	Five themes were identified: 1) shared priorities in ED among healthcare professionals and patients, 2) information provided by healthcare professionals and that desired by relatives, 3) perception of environment and time, 4) limitations and barriers to the continuity of care, and 5) the contrasting interpretations of giving and receiving palliative care.	Study participants were recruited at a single hospital. This may affect the generalizability of the findings. Focus groups were attended by fewer participants than expected. The study was performed on patients and relatives having moved from ED to another hospital ward. Their feedback could have been different in case of discharge.

7.	Fernandez-Sola et. al. *2017* *Spain*	**Defining dignity in end-of-life care in the emergency department**	Emergency Departments of 2 hospitals in Almeria, Spain. Emergency Nurses (n=16) Emergency Doctors (n=10)	Qualitative method Hermeneutic phenomenological approach. 2 focus groups and 12 in-depth interviews	Definition of the attributes of dignity in end-of-life care in the emergency department, based on the opinions of physicians and nurses	Dignity is defined by: (1) Care Environment (2) Professional actions (3) Socio-family context	Being a qualitative study, the results must be interpreted with caution; they are of value within the context in which the investigation was carried out. Furthermore, interviewing family members and patients could have found different results.
8.	Giles et. al. *2019* *Australia*	**Nurses' perceptions and experiences of caring for patients who die in the emergency department setting**	Emergency Department nurses across Australia. Emergency Nurses (n = 211)	Qualitative method Descriptive online survey with open-ended/free text questions	Exploration of nurses' perceptions and experiences of caring for patients who die suddenly and unexpectedly in the Emergency Department.	Five themes were identified during analysis: 1) Key elements of EOL care 2) Systemic and environmental barriers 3) Educational deficits 4) Role ambiguity, 5) Emotional impact.	The moderate sample size may limit transferability to similar contexts. Additionally, the structure of the survey tool with pre-defined sections may have influenced participant comments to some degree, however, this aspect was desired in the research as the participants were able to elaborate on specific areas of care within the ED.

9.	Jime´nez-Herrera and Axelsson *2017* *Spain*	**Some ethical conflicts in emergency care**	Emergency Department of a University Hospital in Spain Emergency Nurses and Advanced Life Support (ALS) Nurses (n=16)	Qualitative method Interviews and focus groups	The aim of this research was to analyse and describe situations that can generate ethical conflict among nurses working in emergency situations.	Two categories emerged: one in *'ethical issues'* and one in *'emotions and feelings in caring'*. Four ethical subcategories are presented: *Autonomy, Reification of the injured body, Pain, and Death.*	The results of this study can only be regarded as representing the meanings and the experiences of the participants. This research study was carried out only with females, and maybe different findings may be revealed if the study included male nurses and a larger number of participants.
10.	Kongsuwan et.al. *2016* *Thailand*	**Lived experience of caring for dying patients in emergency room**	Three Emergency Rooms of tertiary hospitals in southern Thailand. Emergency Nurses (n=12)	Qualitative method with a phenomenology approach. In-depth interviews	This study aimed to explore the meaning of nurses' lived experience of caring for critical and dying patients in the Emergency Rooms.	Experiences of caring for critical and dying patients revealed four thematic categories: *defying death; no time for palliative care; lacking support for family; and privacy for peaceful deaths.* The meaning of the experiences of caring for critical and dying patients in the ERs, was "to defy death and secure time for palliative care"	Phenomenological research does not aim to offer findings that can be generalized, as such these can be regarded as meanings and experiences of the individuals taking part in the research. Only hospitals in Southern Thailand were explored. Experiences of other professionals, such as doctors were not sought.

11.	Mar Díaz-Cortés et. al. *2018* *Spain*	**Promoting dignified end-of-life care in the emergency department: A qualitative study**	Emergency Departments of 2 hospitals in Almeria, Spain. Emergency Nurses (n=16) Emergency Doctors (n=10)	Qualitative method Hermeneutic phenomenological approach. 2 focus groups and 12 in-depth interviews	Exploration and Interpretation of doctors' and nurses' experiences regarding conservation of dignity in end-of-life care in dying patients in the ED.	Conservation of dignity in the Emergency Department is influenced by two factors: (1) *Dignified care in hostile surroundings* (2) *Design of a system focused on the person's dignity.*	The data were collected over a limited period of time, prolonging the data collection for a longer period could have offered a more complete vision of the phenomenon studied. The study took place in public hospitals but including professionals from the private care sector could have produced different results. Exploring differences in ideas/concepts depending on gender.
12.	Marck et. al. *2014* *Australia*	**Care of the dying cancer patient in the Emergency Department: Findings from a national survey of Australian Emergency Department clinicians**	College of Emergency Nursing Australasia Australian College of Emergency Nursing Austral-Asian College for Emergency Medicine	Mixed methods Online survey with open-ended/free text questions included	Assessing the (1) Barriers and (2) Enablers regarding end-of-life care for cancer patients as perceived by Australian ED clinicians.	(1) Respondents felt it was rewarding caring for the dying, but ED was not the right place to die. (2) Lack of initial patient and family understanding of the situation. (3) Dying patients have treatments in the ED which is unlikely to benefit them	Respondents may represent a cohort within the ED workforce with particular interest in EOLC, which limits the generalisability of the findings. College membership is not mandatory for nurses working in Australian ED, making it impossible to estimate the proportion of nurses that responded to this survey. Very low response rate (13%).

13.	Omoya et.al. *2022* *Australia*	**Death, Dying, and End-of-Life Care Provision by Doctors and Nurses in the Emergency Department**	Emergency Doctors and Nurses across Australia responding to Australasian College for Emergency Medicine and the College of Emergency Nursing Australasia email request. ED Doctors (n=7) ED Nurses (n=9)	Qualitative method. Hermeneutic phenomenological approach. Semi-structured in-depth interviews.	The aim of this research is to understand the lived experiences of emergency department doctors and nurses concerning death, dying, and end-of-life care provision.	From the data obtained, 4 major themes were identified: (1*) providing for respect and dignity,* *(2) ethical dilemmas,* *(3) providing EOLC in the ED and the role of the participants, and (4) experiencing conflict.* The findings showed that maintaining dignity throughout the dying process was a crucial aspect of EOLC provision	Limitations identified include the subjective nature of the research. The findings cannot be generalized; however, they may be transferrable to other ED settings. The small number of participants was sufficient for a qualitative study.
14.	Peters et. al. *2013* *Australia*	**Emergency and palliative care nurses' levels of anxiety about death and coping with death: A questionnaire survey**	Emergency Department and Palliative Care Unit in 2 health services in Melbourne Australia. Emergency and Palliative Care Nurses (n=43)	Mixed method Survey and interviews	Investigation of attitudes of Emergency and Palliative Care Nurses towards death and dying.	Emergency Nurses reported higher death avoidance and lower coping skills than Palliative Care Nurses. Both reported they coped better with a patient who was dying than with, the patient's family.	Attitudes to death are complex human phenomena and it may be that the instrument used may not capture all aspects. Research techniques such as surveys are subject to bias of self-reporting. A small sample of registered nurses recruited by convenience and drawn from two health services may not represent the views of all nurses in the specialty.

15.	Sadler et. al. *2020* *Saudi-Arabia*	**Deaths in the emergency department: An assessment of patient's end-of-life trajectory and quality of care**	Emergency Department of a large tertiary hospital and cancer center in Saudi Arabia. Patients: (n=103)	Qualitative method Retrospective data analysis	(1) Determine the incidence, nature and illness trajectory of deaths in the ED (2) Examine to which extent end of life discussions took place (3) Analyse the aggressiveness of the care (4) Determine if palliative care services were being consulted.	End-of-life care discussions tend to occur late in the disease trajectory; a number of patients are subjected to aggressive treatments, and palliative care services remain underutilized. An early, integrated, and collaborative approach is warranted to address the challenges of end-of-life care.	The study was conducted in a single center in Saudi Arabia and most of the cases were cancer related. Results may not be applicable elsewhere. The study design itself can lead to bias as the results are dependent on the available data. Classification of each patient in an EOL trajectory is not without bias, especially with two competing illness trajectories.
16.	Siddiqui *2016* *Singapore*	**A physician's moral dilemma in the emergency department: going against a patient's perceived wishes**	A large district hospital in Singapore ED doctor (n=1)	Qualitative method Case study	The aim of the study was to explore ethical and moral dilemmas that arise and looking after a dying patient in Emergency Department.	Traditionally, the ED is a place where split-second decisions need to be made. The line between right and wrong is often blurred. Issues of triage, resource allocation, truth telling, confidentiality, and end-of-life care co-mingle with other varied difficult and conflicting scenarios.	The study has several limitations including that focuses on a single case, in a single hospital and reflects on the experience of a single ED doctor. Exploring the lived experiences of multiple staff would have given a greater insight.

17.	Yingting et. al. *2017* *Singapore*	**Spiritual perspectives of Emergency Medicine doctors and nurses in caring for end-of-life patients: A mixed-method study**	Emergency Department of a public tertiary teaching hospital in Singapore. Emergency Nurses (n=15) Emergency Doctors (n=14)	Mixed method. Socio-demographic form and validated Spiritual Care-Giving Scale Focus group discussion	Exploration of the perspectives of ED doctors and nurses in spirituality, spiritual care in end-of-life care. Factors influencing spiritual care provision in the ED.	Positive attitudes and understanding of spirituality and spiritual care, but often limited this to religion. Education regarding spiritual care may help healthcare professionals feel more competent and cope with emotional burden.	The use of Focus group discussion is susceptible to bias as one's opinions may be swayed by the dominant participants, hence limiting exploration of the minority views. Difficulties to establish the representative sample compared to the general healthcare population, making generalizability problematic.

3.8 Stage 5: Synthesize themes from selected studies

Each selected paper was reviewed and findings were treated as qualitative data using an inductive approach to enable the generation of themes. Reviewing the text also used a semantic approach, which involves analysing the explicit content of the data, as this was more appropriate for a literature review (Braun and Clarke, 2013).

The process of developing the themes of this literature review was based on Braun and Clarke's (2013) 'thematic analysis' approach (Table 3.8). As a first step I read and re-read each paper to get familiar with the text, the objectives, the methods used and the key findings of the study. I highlighted interesting sections, sentences, or phrases, labelling them to easily describe their content and these labels became my 'review keywords'. These labels of highlighted content was cross-compared to the same labels or keywords in the rest of the papers. Labels or keywords which displayed similarities were grouped together, a process which yielded the identification of five themes.

Table 3.8 Steps in developing the themes from the studies included in the review (adapted from Braun and Clarke, 2013)

STEP 1	Familiarisation with the text, by reading and re-reading the papers
STEP 2	Highlighting interesting sections and labelling them (keywords)
STEP 3	Comparing the labels (keywords) and its highlighted content in all studies
STEP 4	Grouping the labels(keywords) and creating the literature review themes

The main themes, their description, and the studies in which these themes were identified, are detailed in Table 3.9. A detailed discussion of the findings of the literature review is described in Stage 6 of this review.

Table 3.9 Themes emerging following the full text review of the articles

Main themes	Description	Articles discussing the theme
Managing dignity in the ED	The perception and interpretation of dignity by HCPs in ED may vary, while its importance is captured through recognising the need to improve environment, question futile treatment or focus on its holistic aspects.	Bailey et.al. 2011b DiLeo et.al. 2019 Fernandez-Sola et.al. 2017 Kongsuwan et.al. 2016 Mar Diaz-Cortes et.al. 2018 Omoya et.al. 2022
HCPs relationship with the dying patient and their family	EOL patients in ED and their families will interpret the quality of care through the attention they receive and relationship they build with HCPs. Avoiding distancing, building trust, communicating effectively, allowing patients and families to express their wishes or concerns will support managing these relationships.	Bailey et.al. 2011a Bailey et.al. 2011c Batley et.al. 2017 Chan et.al. 2011 DiLeo et.al. 2019 Giles et.al. 2019 Peters et.al. 2013 Sadler et.al. 2020 Yingting et.al. 2017
HCPs coping strategies and managing the emotional labour of death	ED culture characterized by a fast-paced environment and a focus on patient stabilisation, offer minimal choice for HCPs to cope with the death experience. As a result, avoidance or shielding is often adopted by HCPs as a defence mechanism, while managing the emotional labour and developing emotional intelligence will help in managing the burden of such experiences.	Bailey et.al. 2011a Bailey et.al. 2011b Bailey et.al. 2011c Batley et.al. 2017 DiLeo et.al. 2019 Giles et.al. 2019 Jime´nez-Herrera and Axelsson 2017 Marck et.al. 2014 Peters et.al. 2013 Yingting et.al. 2017
Supporting HCPs in managing the death experience in the ED	HCPs will develop resilience and better manage the death experience when they have a social support network, receive support from their supervisors and colleagues, and when their education incorporate topics about managing the death experience.	Bailey et.al. 2011a Bailey et.al. 2011c Chan et.al. 2011 Giles et.al. 2019 Marck et.al. 2014 Mar Diaz-Cortes et.al. 2018 Peters et.al. 2013
Ethical and moral challenges when experiencing death and dying in the ED	HCPs experiencing death in the ED will often encounter situations which will present ethical dilemmas, causing a moral conflict. Such conflicts could arise for example when family wishes contradict clinical judgement or when only interventional treatment is being considered as a course of actions.	Jime´nez-Herrera and Axelsson 2017 Omoya et.al. 2022 Siddiqui 2016

3.9 Stage 6: Literature review findings

3.9.1 Managing dignity in the ED

The first theme of this literature review draws together findings on how HCPs manage the dignity of EOL patients in the ED. Various perceptions and interpretations of HCPs about dignity in the ED were explored, followed by a socio-cultural reflection on death, how EOLC could be depersonalized by technification, the importance of the physical environment and finally, the impact of family being close for EOL patients to share their feelings, fears and anxiety. Perceptions and interpretations of dignity in the process of a dying person in the ED, from the perspective of HCPs, has a multi-faceted aspect, according to the emergency nurses and doctors interviewed in two Spanish hospitals, as part of a phenomenological study (Fernandez-Sola et al., 2017). HCPs suggested that dignity beyond anything else is recognised by clinical staff, as a human attribute, something that only a human being is aware of possessing, demanding or under certain circumstances, losing. Dignity of a patient is defined by HCPs working in the ED, as a person having a human quality, where treating someone with dignity is a moral duty to which even life itself must submit (Fernandez-Sola et al., 2017). Maintaining the dignity of a dying person in the ED has complex implications for HCPs. ED is not designed and not an ideal place to provide EOLC, as a dying person's dignity implies treating them with respect, recognizing their value as a person, as well as offering them autonomy and self-esteem (Fernandez-Sola et al., 2017). Respecting the dignity of terminally ill patients in the ED also reflects socio-cultural aspects of death. From this perspective, displacing death and simply incorporating it into a hospital environment surrounded by technical equipment, the dying person is institutionalised, and may experience isolation, desertion of choice, and amplification of suffering, taking away dignity from the dying process (Fernandez-Sola et al., 2017). 'Humanising' a patient is crucial in providing EOLC in the ED, as 'technification', the predominant use of technical equipment and methods in patient care, and 'massification', a state where the demand oversized available resources leading to a decline in quality, can depersonalize care, dignity also meaning interaction and respect towards someone encountering situations of extreme vulnerability, such as being at the end of life. Findings of this study also suggests that for HCPs perceived a person's dignity implies the right to honour, to a good reputation, to one's own image, to intimacy and physical, mental, and emotional integrity (Fernandez-Sola et al., 2017). While this study reflects on HCP's interpretation of dignity at the EOL, it is limited to data collected only in two public hospitals, excluding EOL patients or family members, which could have broadened the spectrum of the findings.

Bailey et al. (2011b) interviewed and observed HCPs and EOL patients in a UK ED, and suggests that one of the important factors in promoting dignity for palliative patients in ED is by creating an environment and developing surroundings that reflect decency, respect, decorum, and worthiness. In a Spanish study, ED nurses and doctors suggested that the environment can be improved through softening the lighting, moving palliative patients to a quieter and more private space, or facilitating family members and loved ones to be with patients (Del Mar Diaz-Cortes et al., 2018). Improving the physical environment by redesigning spaces in ED has a direct connection to increased patient and family satisfaction and an increase in staff confidence and satisfaction (Del Mar Diaz-Cortes et al., 2018). The importance of physical spaces is also highlighted by Di Leo et al. (2019) in the ED of an Italian hospital, suggesting that the inadequate spaces in the ED used for communicating bad news to patients and their families was perceived by HCPs as a serious breach to dignity requirements. The privacy provided by a simple curtain is not enough especially when a patient is in extreme pain and distress as noted by a member of staff, this is something “a human being does not deserve” (Di Leo et al., 2019). Nurses and doctors referred to ED as a place lacking the means to offer proper comfort for patients, but also family members are using spaces that provide neither intimacy for receiving bad news, nor have basic commodities such as chairs or a coffee table (Di Leo et al., 2019).

The relationship between dignity of physical space is also highlighted by a phenomenological study that interviewed 12 emergency nurses in a hospital in Thailand (Kongsuwan et al., 2016). Nurses suggested that a peaceful death is possible in the ED where the family, that is typically the main source of spiritual care, is allowed to spend time with their loved one. As one of the participants states: “A peaceful death in ER, I think, can be possible but it needs a period of time and a place. When the doctor says to stop resuscitating, there should be a place or a room available where the patient’s family members or relatives can stay and the dying patients can be with them” (Kongsuwan et al., 2016). While care for the dying in the ED orbits around ‘prescriptive or routine care’, HCPs are unable to provide the appropriate emotional or psychological support for the family, preparing them for their loved one’s death, due primarily because they lack competency and confidence in providing spiritual, emotional, or psychological care (Kongsuwan et al., 2016). Lack of time is also described by the emergency nurses as a crucial factor in missing opportunities to provide palliative care in the ED. As palliative care was considered to take a considerable amount of time, it was never prioritized or integrated into the ED procedures, instead EOL patients were transferred to other wards or discharged to their homes to die (Kongsuwan et al., 2016). This study offers valuable insights into emergency nurses’ views about dignity at the EOL in ED, however, it’s limited by the lack of exploring other HCPs views, such as doctors, and could be potentially influenced by the South-East Asian cultural and social environment.

Mar Diaz-Cortes et al. (2018) suggests that dignity for many dying patients in the ED means offering the opportunity for their loved ones to be close to them, to share their fears, feelings, and their anxiety, to resolve any pending issues or to have the chance to say good-bye. Under such circumstances, dying patients in the ED, sometimes need contact more than ever with the family, closeness, enough time, someone to listen and the comfort and peace that creates the ideal setting for accompaniment (Mar Diaz-Cortes et al., 2018). These findings were similar to an Australian study that interviewed ED doctors and nurses, where dignity in the ED was seen as a way of caring for patients and their families that encompasses emotional, spiritual, and even religious aspects (Omoya et al., 2022). Maintaining dignity, meant maintaining an empathetic attitude, facilitating a dialogue with patients and family members about all topics, including death (Omoya et al., 2022). Offering comfort to dying patients and re-assurance that they are not viewed as a burden is an integral part of sustaining dignity, while respecting the wishes of a dying patient, could become a voice in a situation in which a dying patient could become voiceless (Omoya, et.al. 2022). In contrast, Bailey et al. (2011b) argue that the absence of dignity is captured also in situations when palliative patients are accessing emergency services for symptom control or supportive care as death nears. Often such patients in the ED are labelled as being ‘out of place’, ED being not considered by staff as ‘the right place to die’, which manifests in an urgency of transferring the patient to a ward, even with the risk of dying enroute (Bailey et al., 2011b).

3.9.2 HCPs relationship with the dying patient and their family

The importance of the relationship between HCPs and the dying patient and their families was a returning theme across the papers included in the review. Factors that can undermine this relationship include segregation of the patients into ‘spectacular’ and ‘subtacular’ trajectories, HCPs adopting a distancing attitude or withdrawing completely from it. In contrast, HCPs communicating with EOL patients and their families openly, on an empathetic level, about their prognosis, wishes or preferences, including elements of spiritual care, are more likely to build a relationship characterised by trust. Bailey et al. (2011a), from interviews and observations of HCPs and patients with terminal illness and their families, concluded that a common concept in defining the quality of a healthcare professional-patient relationship, is related to the trajectories a patient can have in the ED. The ‘spectacular’ trajectory suggests a public display of the EOL in the ED, for example a major trauma patient, where efforts to save their life require additional nurses, doctors and often a variety of specialties within the hospital. In contrast, the ‘subtacular’ trajectory, for example a patient diagnosed with terminal illness, refers to a ‘lower status’, care that does not consume the same attention as the ‘spectacular’ and does not evoke the heroic, elaborate reaction of its witnesses (Bailey, et.al. 2011c). One of the most common behaviours displayed by

HCPs towards a ‘subtacular’ patient and their family, was distancing. This behaviour was often expressed by withdrawing from situations and, in some cases, from the nursing profession altogether. These observed behaviours had often a detrimental effect on the patients’ experience, making them feel ‘uncared for’, ‘forgotten about’, and ‘neglected’ (Bailey et al., 2011a). HCPs and the family could have a disagreement upon the trajectory of a terminally ill patient presenting to ED with an imminent possibility of death (Bailey et al., 2011c). This study offers important conclusions, however it is limited by the data collected from a single hospital, and while clinical staff participants included both doctors and nurses, the doctors involved were specialist registrars only, therefore may not be reflective of experiences of other medical groups.

Peters et al. (2013), from a survey and interviews of Australian palliative and emergency nurses, suggests that ED nurses are able to communicate on a warm, empathetic, and emotional level, encourage the discussion of concerns that otherwise might not be revealed openly by their patients and their families, lead to the development of trust and confidence in this relationship (Peters et al., 2013). Nurses reported that an informative and empathetic communication style, adopted towards patients at the EOL, especially when time is given to ask questions, will encourage a greater understanding and acceptance of the inevitable, offering also physical and mental health benefits by reducing blood pressure, anxiety, depression or even pain (Peters et al., 2013). Some emergency nurses are seen as experts in providing quality EOLC that is supportive to patients and their family, while others avoided getting involved altogether, lacking skills and confidence in providing EOLC (Bailey et al., 2011c).

Using retrospective data analysis, Sadler et al. (2020) investigated EOL patients’ quality of care and trajectories in the ED of a hospital in Saudi-Arabia. The study concluded that the relationship between HCPs and a patient at the EOL is influenced by the amount and depth of discussions, exploring what the patient or their family knows about their overall condition and prognosis. Such discussions should occur in a calm setting, with sufficient time allocated for patients and the family, to express concerns, preferences, and deal with the associated emotions, EOL conversations never being one-time discussions, but an ongoing collaborative process (Sadler et al., 2020). This study also suggests that a considerable proportion of invasive treatments in the ED occur due to a lack of EOLC discussions, prior to a patient’s emergency admission, who lives with a terminal illness, and is on an EOL pathway already. When a palliative or EOL patient is taken into ED, the patient or family may not be in a mental state to process complex information and consider care options (Sadler et al., 2020). A palliative patient attending an ED should be considered as an opportunity to review the goals of care, involving not only the primary treating teams but also palliative care services, even if this leads to longer stay (Sadler et al., 2020). This study is limited by its retrospective data analysis method, which could potentially limit its findings quality, while other qualitative methods such as interviews or focus groups with HCPs might have produced different findings. The study is also potentially limited by being influenced by the cultural, social, or spiritual environment where the data was collected.

A qualitative study by Chan (2011), using interviews and observations of HCP's working in a US ED, investigated clinician narratives of patients approaching EOL in the ED. The study argues that the transition to EOL for a patient coming to ED can occur suddenly and without warning. For example, a patient who arrests in the ED, transition to EOL is short, and there might be impossible to apply palliative care principles, so HCPs are constantly trying to understand whether the actual status is going to be the end for a patient or not and integrate this knowledge, into the care given and communication approaches applied (Chan, 2011). HCPs reported that communication with families in the ED can be often confusing, forced or pressured, complicated by an atmosphere of high stress and crisis, especially if family treatment wishes are incongruent to the chances of success of the requested, such as invasive interventions (Chan, 2011). Misunderstanding from the family about the role of hospices and EDs, the signs of impending death, or what death actually looks like, raise challenges for HCPs in managing successfully these relationships (Chan, 2011). Another challenge is raising from the relationship with 'frequent flyers', a term that denotes patients who are heavy users of emergency services, where care could be routinized and given lower priority, increasing the chances to not realize in time if the patient is approaching death (Chan, 2011). While this study provides valuable insight into the HCP relationships with the EOL patients and their families in the ED, it is limited by a potential selection bias, as the included doctor participants were only experienced clinicians, while the views of more junior medical members of staff could have enriched the findings.

An analysis of open-ended responses in an Australian survey of ED considered open and honest communication with dying patients and their families very important (Giles et al., 2019) in establishing accurate prognostic information, managing patient and family expectations, dealing with unrealistic expectations in a timely manner and explanations about the inappropriate nature of particular tests and interventions (Giles et.al., 2019). ED nurses suggested that communication with patients and their families should be in a clear, easily understood language, minimising jargon, and tailoring information to individual levels of understanding (Giles et al., 2019). Avoiding or delaying difficult conversations would undermine early recognition of patient and family needs, while giving consistent information to patients and their families and nominating one family spokesperson wherever possible to streamline conversations, was noted as being paramount (Giles et al., 2019).

Die Leo et al. (2019) however reported on the difficulties ED doctors encounter when family members of a dying patient have unrealistic expectations, Nurses and nursing assistants in the same study complained about doctors, who did not update them on the patient’s situation in time, putting the nursing staff in an uncomfortable position of not knowing what to communicate to the patient’s family, often anxiously waiting in the waiting room (Di Leo et al., 2019). Omoya et al. (2022) also reported that HCPs adopting good communication skills with the family were factors in conflict resolution surrounding EOLC, especially when the family felt they are heard, they can have a voice and their wishes are considered.

A mixed methods study that investigated the spiritual perspectives of ED doctors and nurses in caring for EOL patients in a teaching hospital in Singapore, argues that acknowledging the spiritual needs of EOL patients in ED, will improve the nurse-patient relationship (Yingting et al., 2018). This will help patients to express their physical and emotional needs openly, that being more involved in decisions concerning their EOL pathway, promoted the idea of greater control over their own condition (Yingting et al., 2018). HCPs in this study reported that spirituality for them represents more than religion, being rooted in the meaning of life, becoming more important when one experiences life crisis, such as being diagnosed with terminal illness or nearing end of life (Yingting et al., 2018). Empathy, kindness, appropriately sharing of oneself or offering chaplaincy services, as part of the HCP-EOL patient relationship has been recognised by ED nurses as a fundamental attribute in providing spiritual care (Yingting et al., 2018). HCPs reported conflicting views about supporting patients to observe their religious beliefs as part of the spiritual care. While some perceive this as something very personal to the patient and would avoid bringing the topic up, others argue that education on the differing views of various religions may help to better accept the individual views of patients (Yingting et al., 2018). The study offers a valuable insight into the role of spiritual aspects in the relationship between HCPs and EOL patients. This study was based on focus group discussions as one of the data collection methods. Minority views in this method could be overruled by the dominant participants, while collecting data through interviews could have focused more on individual experiences, or using both methods could have compensated for each-others limitations.

3.9.3 HCPs coping strategies and managing the emotional labour of death

Coping strategies adopted by HCPs after witnessing death and the management of the associated emotional labour was a common theme across the reviewed literature. Avoidance, shielding, or objectification was often reported by HCPs, as an attempt to avoid distress, suffering, or the feelings of helplessness in cases when an emotional relationship was established with the dying patient and their family. Open conversations about death and the development of an emotional intelligence were positive strategies adopted by HCPs, to help them deal with their experiences of death in the ED. Witnessing death in the ED has an emotional impact on HCPs wellbeing as suggested the ethnographic study of Bailey et al. (2011a; 2011b;2011c). In this research, that interviewed 11 emergency nurses, 2 doctors, 2 technicians and 7 palliative patients and their relatives, and observed clinical areas of the ED in a UK hospital, HCPs often developed strategies to protect themselves from the adverse effects of these experiences. Objectification, taking away the personhood of the deceased patient or avoidance were means of HCPs to protect themselves from building a relationship, that could potentially carry harmful effects for them, as one nurse described, “It’s never someone, it’s something in the viewing room. This is the language we use” (Bailey et al., 2011a). HCPs reported that the greatest challenge, when struggling with avoidance, comes from situations when someone is dying slowly (Bailey et al., 2011a).

Yingting et al. (2018) similarly argues that ED doctors often expressed concerns about being emotionally attached to their EOL patients. This could have an influence on their decision-making process, describing it as “(If) we are emotionally involved, it becomes hard to think in a clear minded way... I’m not entirely comfortable”. Di Leo et al. (2019) also concludes that a form of avoidance from HCPs towards the dying patient and their family, manifests in concentrating on practical care tasks, sometimes ‘shielding’ and waiting for the patient to be potentially transferred, as being in their close proximity gives staff a sense of discomfort. Avoiding conversations or meetings with relatives was another way from staff to protect themselves from the dead body becoming ‘real’ (Bailey et al., 2011a; 2011c). Finding the ‘right’ balance between staying close or distancing from a dying patient, according to DiLeo et al. (2019) creates a feeling of ‘uneasiness’ in staff when caring for a dying patient. As a member of staff suggested, “Sometimes we shield ourselves behind the fact we’re busy carrying out our work”, avoidance was used as an escape from building an empathetic relationship, to avoid becoming upset when death occurs (DiLeo et al., 2019). While the study of DiLeo et al. (2019) had a mixture of HCPs including doctors, nurses and healthcare assistants, the participants were recruited in a single hospital setting and focus groups were reported to have less participants than expected. Another limitation of the study reflects on the views of EOL patients and their families, who were already transferred from ED to a ward, while still being in ED their views could have been different.

Medical students interviewed in Lebanon by Batley et al. (2017), also reported that HCPs working in the ED were looking to distance themselves and detach from the dying patients, as a way of softening the emotional impact, often labelled as a ‘form of defence mechanism’, while others were seeking follow a task-oriented strategy. Some participants stated that experiencing ‘the worst’ helps in adapting and coping better with future deaths. Emotion focused coping was also seen by staff as a learning experience, which helped them to become less attached, more confident or ‘expecting the worst’ (Batley et al., 2017). Individual reactions and the extent of the emotional effects of witnessing death in the ED is often related to factors including, the patient’s age, the expectation or suddenness of death, the level of relationship with the patient and their families, and the visibility of a family member’s reactions (Batley et al., 2017). Overall emotional reactions of HCPs were also influenced by the coping mechanisms adopted, if the death witnessed was the first ever experienced, and if the death was relatable to personal experiences (Batley et al., 2017). Medical students interviewed described death on wards as impactful, due to the high level of interaction with patients and their families, in comparison the deaths in the ED which were also described as impactful but because of the added trauma, disturbing imagery and emotionally moving family reactions (Batley et al., 2017). The words used to describe the death experience on the ward included grief, sadness, feeling heartbroken and upset, compared with ED which used words such as shock, confusion and surprise (Batley et al., 2017). While this study explores some specific experiences of death in the ED, it is limited to the views of medical students, rather than qualified HCPs working in the ED, reflecting on their relative inexperience and the findings could potentially reflect cultural and social realities of that geographical region.

Jimenez-Herrera and Axelsson (2015), from interviews with Spanish ED nurses, report that they express feelings of helplessness, distress, suffering, and even anger when trying to act as advocates on behalf of the end-of-life patients, often confronting doctors who may treat the patient only based on pathological and clinical aspects. More than 200 emergency nurses surveyed by Giles et al. (2019), and 43 emergency and palliative nurses surveyed and interviewed by Peters et al. (2013) reported that witnessing ’large scale’ trauma events, such as a major accident, compared to repeatedly witnessing ’small scale’ situations, can potentially have the same emotional influence on them, suggesting that repeated exposure to minor traumatizing events can have severe consequences. ED nurses described ‘feeling guilty’ from not spending more time with dying patients and their families, or not meeting their EOL needs (Peters et al., 2013). Some nurses reported that “this feeling stays with you” or expressed their frustration because “not the right care was given” (Giles et al., 2019). When emergency and palliative nurses coping mechanisms were compared, emergency nurses consistently reported significantly lower coping regarding dealing with a dying patient and the family members, due to the nature of sudden and unexpected death (Peters et al., 2013). Dealing with grief and emotional issues surrounding death in the ED environment and during the little time available, was reported by emergency nurses as offering minimal opportunities to cope. ED nurses experiencing unexpected and traumatic patient deaths reported difficulties finding the words to speak with families of dying patients especially when increased workloads and time pressure is present. Interviews and survey of nurses with longer clinical experience showed significantly higher coping skills compared to their less experienced colleagues (Peters et al., 2013). Giles et al. (2019) and Peters et al. (2013) offer valuable insights into HCPs experiences of death in the ED, however they are both limited by entirely or partially relying on open ended text surveys. Other data collection methods could have produced more rich data and potentially reaching to different conclusions.

In a further Australian survey of ED HCPs, Marck et al. (2014) report that, despite the complex emotional effects on HCPs of the death experience, HCPs mostly agreed that “caring for a dying patient in the ED is a reasonable demand on them”. Most of them agreed that “it is rewarding caring for a dying patient”, although many agreed that the ED is “not the right place to die” (Marck et al., 2014). The findings of this study contradict some aspects other papers reviewed, however is limited by the single method of data collection used, the low response rate and the possibility of respondents having a special interest in EOLC in the ED.

Managing emotional labour, is required in coping with the influence of death (Bailey et al., 2011a). Emotional labour that accompanies a critical event in the ED can be described as demanding, an attitude that requires sensitivity when acting and reacting in a traumatic situation (Bailey et al., 2011a). Hochschild (1983) defines emotional labour as “the induction or suppression of feeling to sustain an outward appearance that produces in others a sense of being cared for in a convivial, safe place”. Bailey et al. (2011c) suggests that ED nurses have clearly identified a link between caring for terminally ill patients, patients transitioning from active treatment into palliative care, patients being in pain and emotional labour. ED nurses who are unable to manage this emotional labour will most likely adopt a distancing behaviour to protect themselves from grief, although, this coping mechanism can be more stressful for most nurses in the long term (Bailey et al., 2011a). Nurses reporting an inability to engage in emotional labour, suggested that this was due to personal anxieties over death, being unable to handle their own feelings in a traumatic situation, fears of saying or doing the wrong thing and the feeling of being untrained or unprepared when sudden death of a patient occurred (Bailey et al., 2011c). While Bailey et al. (2011a) suggests that further research is still required for evidence, this study proposes a possible link between not being able to manage emotional labour and leaving emergency nursing as a profession. Experiences with dying patients were described by some nurses as overwhelming events, with heavy emotional impact on their professional role and often on their personal life (Bailey et al., 2011a).

Bailey et al. (2011c) also suggest that it is possible to develop emotional intelligence, a method of self-support that relies on the inner resources, to solve problems, facilitate learning and manage change. Emotional intelligence has four major components such as self-awareness, self-management, social awareness, and relationship management, which allows HCPs working in the

ED to recognise other individuals' emotions and regulate their own. This requires using 'gut feeling' or intuition to guide decisions and actions (Bailey et al., 2011c). Self-awareness allows the HCPs to identify strengths and weaknesses in their practice, reflect on and learn from past experiences while integrating core values into practice. Self-management involves the control of emotions in response to a traumatic event or a highly demanding work environment (Bailey et al., 2011c). Observations in this study also suggest that the ability to demonstrate self-control in potentially emotional situations, is not directly proportional with the number of years spent in the ED by HCPs (Bailey et al., 2011c). Social awareness relates to the ability to understand another person's emotions, interpret, and communicate within social networks, for example when an ED nurse, despite time pressures can prioritise a dying patient and their family's needs and wishes (Bailey et al., 2011c). Relationship management requires skills to manage conflicts as well as to be an inspiration, motivation, and source of development for others. Developing emotional intelligence could potentially help HCPs in providing self-support, especially during traumatizing events (Bailey et al., 2011c).

3.9.4 Supporting HCPs in managing the death experience in the ED

Dignity, relationships with EOL patients and their families, coping mechanisms and emotional labour in relation to the death experience in the ED are better managed by HCPs when they develop resilience through support from their supervisors. This may be provided by staffing adequate skill-mix on shifts, through debriefs, or through receiving tailored training about managing the death experience. Bailey et al. (2011a) reported that HCPs felt that they often feel unprepared for caring for the dying patient. This is partly because of the lack of support from managers in providing adequate professional training to address the issues raised by these experiences (Bailey et al., 2011a). As a results, staff rely on learning from others and from their own experience (Bailey et al., 2011c). Support should not start in ED, but earlier, in undergraduate and postgraduate education, Bailey et al. (2011a) advises. At undergraduate level, the focus should be on the effect of EOLC delivery in critical care areas and building awareness of the psychological and emotional needs of both staff and patients. At postgraduate level, supportive practice for trained staff and acknowledgement of their role and understanding how to manage the emotional impact in the EOLC delivery are the key elements for HCPs working in the ED, to feel prepared in their roles (Bailey et al., 2011a).

A similar solution is recommended from a phenomenological study of Del Mar Diaz-Cortes et al. (2018), involving 16 ED nurses and 10 ED doctors working in Spanish hospitals. Education and professional training are an efficient tool in supporting ED healthcare professionals, not only to cope with the consequences of traumatizing events, but also to facilitate conservations about dignity in the ED. HCPs suggested that specialized training that would equip them with such knowledge would provide additional support in decision-making and managing their own feelings in relation to death and dying (Del Mar Diaz-Cortes et al., 2018). While this study involved participants from multiple hospitals, they were from the same region of Spain, and were all public hospitals. Participants working in the private healthcare sector could have had different views and experiences, compared to those in the public sector, also involvement of patients and their families' views could have also influenced the findings. A similar conclusion was drawn by the study of Peters et al. (2013), in that education promoting professional development of efficient communication skills with the dying patient and their family, were considered valuable elements of providing support for HCPs. Nurses suggested that "[We need] education sessions outlining strategies when dealing with patients and families", rationalizing that training sessions could offer greater confidence to staff to comply with the demanding role of carrying for EOL patients (Peters et al. 2013). Marck et al. (2014) also highlights the importance of education in supporting provision of EOLC in the ED, while Giles et al. (2019) highlights that education concerning counselling, delivering bad news or conducting difficult conversations was considered by participants as an indispensable support in the ED.

Chan (2011) interviewed and observed ED HCPs in a US hospital, and suggests that managers and administrators ensuring appropriate staffing rates and skill mixes during shifts, at any given time, will support the delivery and will positively influence the care provided for the dying patient. Similarly, Giles et al. (2019) suggests that adequate staffing on duty, at any given time, comprising of a good mix of knowledge, skills and expertise is essential. Studies have reported on the importance of debriefs, as means in supporting HCPs with managing their death experiences, as being an efficient way to cope with a failed resuscitation or a traumatic event. However, these are often missed, or postponed due to time pressures (Giles et al., 2019; Peters et al., 2013). Sometimes debriefs were organized several days or weeks after the incident, often led by facilitators with no expertise, perceived by many HCPs working in ED as unhelpful (Giles et al., 2019). However, some emergency nurses argued that debriefs are not required after each death event, a formal debrief should be only conducted in special circumstances, such as the death of a child or in case of a traumatic death (Giles et al., 2019). While many nurses had to organise their own informal debrief with colleagues, it has been recognized that more regular and consistent debriefing would positively impact the provision of EOLC in the ED (Giles et al., 2019). Any form of professional support offered to staff appears to have a very positive impact on job satisfaction (Bailey et al., 2011b; 2011c).

3.9.5 Ethical and moral challenges when experiencing death and dying in the ED

The final theme of this review discusses how certain situations surrounding death and dying in the ED, could be the source of ethical challenges. These may arise from clinical judgements that contradict family wishes, clinical interventions prioritized over holistic care, different interpretations of 'quality of life' or ED resources being focused on life-saving procedures, rather than palliation. Ethical and moral dilemmas are frequently raised in emergency situations, especially when the clinical rationale of a case presentation, from the healthcare professional perspective, contradicts the wishes of the patient, or their close family. A case study of an EOL patient, reported by an emergency doctor in a Singapore hospital, reflects on the moral complexity of a clinical decision, taking into consideration the clinical realities, the perceived wishes of the patient and the conflicting demands of the closest family members (Siddiqui, 2016). The patient in his late 60's presented with shortness of breath and fever at the ED, having a history of nasopharyngeal carcinoma. The patient also had an Advanced Medical Directive (AMD), a legal document that informs a doctor, in the event of becoming terminally ill and unconscious, that life-sustaining treatment should not be used to prolong life. The patient's AMD clearly stated that in case of dying from cancer, he does not wish to have invasive or mechanical ventilation (Siddiqui, 2016).

A moral conflict arose as the patient's family demanded the medical team to do everything in their power to save his life, against the patient's documented wishes. Family wishes were granted, and after two days spent in intensive care, with the family at his bedside and once the irreversibility was established, the treatment was discontinued, and the patient died. The family members were reported being at peace with the decision, offering everyone the possibility to say goodbye and have their closure (Siddiqui, 2016).

The study acknowledges that in similar situations the "line between right and wrong is often blurred" in the ED (Siddiqui, 2016). On one side there were the clinical risks associated with the intervention and the documented wishes of the patient against being intubated. On the other, the distress of the family, not being ready to 'let go' of their son, husband, and father. The case study raises the dilemma, that the unconscious patient potentially would have agreed with the treatment if he would have known, that he spares his family from unnecessary social harm and emotional pain. The study argues that the principles of autonomy and non-maleficence should be applied not only to the patient, but also as relational, contextual principles, to the extended family, taking into consideration, not only the physical aspect, but also other elements of individual wellbeing (Siddiqui, 2016). While this study acknowledges that many of the moral questions remain unanswered and that this case reflects the views of its participants, raising important issues in judging individual ethical and moral challenges, the study is single case, describing the moral dilemmas of a single healthcare professional.. Findings are likely to reflect the cultural context of South-East Asia, which might be different to other cultures. Omoya et al. (2022), also suggests that similar conflicts between staff and family members are often seen by HCPs working in the ED as inevitable, and that communication and conflict resolution skills are required to resolve such situations. Conflicts are often resolved by allowing patients and their family, to have all their questions answered and clarified or by offering them the experience and the feeling of being heard. Transferring a patient from ED to intensive care, for a slow removal of invasive treatment, instead of a sudden and determinant decision to stop all treatment in ED, was also seen as a measure of allowing the family to accept the inevitable death of their loved one (Omoya et al., 2022).

The dilemma of patients in the ED being treated only based on pathological and clinical aspect, with moral or ethical aspects often ignored, is highlighted also by Jimenez-Herrera and Axelsson, (2015). Ethical dilemmas most often occur when an EOL patient is brought to the ED, and the wishes of the patient and their family are unknown. The dilemma is often fuelled by a conflict with the doctors, who consider only medical treatment as a course of actions, while nurses may try to act as advocates on behalf of the patient. Nurses argued that they experience “discomfort with feelings of distress, suffering, anger and helplessness in these situations” (Jimenez-Herrera and Axelsson, 2015).

Similar ethical controversy is expressed in an Australian study exploring experiences of ‘futile treatment’ provided to patients nearing death in the ED and how to define ‘quality life’ and ‘quality death’ (Omoya et al., 2022). The study argues that the decision to consider a treatment futile, it’s not always ‘black and white’ and should be based not only on clinical considerations, but weighed individually, looking into the ethical aspect of each case. While an invasive treatment would prove futile for an 80-year-old, living a ‘low quality’ life, the same treatment prolonging the life of a 34 years old with a month, to see her daughter’s first birthday, would fall under a different moral category. Quality of life or death should be also defined by the dying patient and not accounted as what an ED doctor or nurse would imagine as being for that individual patient (Omoya et al., 2022).

Jimenez-Herrera and Axelsson (2015) argues that when a patient has a cardiac arrest the first decision to be made is to whether to start resuscitation, and if resuscitation is started, what is the likelihood that resuscitation will bring the patient back to a ‘good quality life’ or not? While the decision taken must be immediate, the ethical dilemma will persist up until the outcome and even after. The same dilemma within the context of emergency HCPs being trained to save lives, raises the question of defending life at all costs, potentially leading to not ‘allowing’ people to die and denying their right to do so in a dignified way (Jimenez-Herrera and Axelsson, 2015). While the study of Jimenez-Herrera and Axelsson (2015) interviewed both emergency and advanced life-support nurses, but included only female nurses. The inclusion of male nurses, or participants from various other HCP roles in, potentially could have offered a more diverse perspective of these ethical conflicts experienced in the ED. Omoya et al. (2022) argues that these dilemmas are influenced by HCPs cultural and religious views and beliefs about death and dying. HCPs personal beliefs and values have an influence on the death experience and provision of EOLC in the ED, when those are shared with the dying patient and their family (Omoya et.al., 2022). As one of the nurses participating in the study reported: "I think those situations were easier maybe because I felt like they (the dying patient and families) were behaving the way I would behave" (Omoya et al., 2022).

Lack of emergency nurse's autonomy to exercise their professional role, and of the patients in decision-making about their course of treatment is further source of ethical and moral challenges. These dilemmas are mostly evident when doctors and nurses in ED do not share the same view, doctors being mainly concerned with the biomedical aspect of a dying patient, while nurses' approach is more holistic (Jimenez-Herrera and Axelsson, 2015). On the contrary, Omoya et al. (2022) argues that both ED nurses and doctors consider the role of nurses carrying more responsibilities, doctors believing that "it is very intensive from a nursing point of view to keep the patient comfortable, intensive emotional relationship that is built up and that is required, the intensive kind of communication, so to do (EOLC) well". Doctors who identified themselves as being 'an extension of the nurse's role' when it comes to end-of-life care, contradicted nurses, who often felt that once EOLC was determined in the ED, care was relinquished to them by doctors. Other nurses felt that at this point doctors can't offer more to patients, while nurses will offer emotional support as part of EOLC (Omoya et al., 2022).

Junior doctors interviewed by Omoya et al. (2022) shared their moral concerns over expectation by senior doctors to move on from the care of the dying patients, once they were confirmed of being admitted to a ward, despite being physically still in the ED. As a result, the dying patient was given a lower care priority in ED and was neglected by medical staff, resources being redirected to life-saving procedures and acute emergencies, making doctors feel uncomfortable about not going back to look after their dying patient (Omoya et al., 2022). Nurses also confirmed in the same study, that when a patient presented with the possibility of dying, clinical care came first, while emotional support for the EOL patient only occurred later, as this was "the only way to do the job" (Omoya et al., 2022). The small number of participants and the semi-structured interviews are adequate for a phenomenological study, however inclusion of a more diverse set of data collection methods could have potentially enriched the findings.

3.10 Summary of Chapter Three

Chapter Three sought to answer the question: *What is currently known about the experiences with death of healthcare professionals working in the Emergency Department?*

The literature review revealed that, while HCPs have various interpretations of dignity at the EOL in the ED, they recognise the importance of improving the environment, develop a holistic approach to patient care, instead of advocating futile treatments and the importance of patient and family wishes being respected, as essential elements of this dignity. The review also concludes that the quality of EOLC in the ED is often seen through the lenses of the HCP's relationship with the patient and their family. Allowing patients and families to express their wishes or concerns, instead of shielding or distancing, will allow trusting relationships to be built. The fast-paced environment of ED offer limited opportunities for HCPs to cope with the effects of the death experience and manage their emotional labour. Negative coping strategies adopted by HCPs often are characterized by avoidance of the dying patient, while positive approach include debriefs or developing emotional intelligence. Findings suggest that HCPs would cope better with the death experience in the ED if they receive adequate support from their line managers or through education. Finally, the results of the review suggest that HCPs are constantly exposed to death and dying situations, which pose ethical and moral dilemmas, for example when family expectations contradict clinical judgement or the best interest of a dying patient.

While the current literature provides a broad insight into the lived experiences of HCPs, it doesn't address the question of how HCPs make sense of these experiences or find meaning in them. Interpretation of a phenomenon it's about how individuals make sense of their social world and environment, as discussed in detail later in Chapter 4, when describing IPA as methodology, and hermeneutics and ideography as its key characteristics. As described in Chapter 2, an individual's personality will incorporate its values and norms. The influence of these on people's experiences of death in the ED context has not been well researched in the literature. While current literature identifies certain characteristics of particular death experiences in the ED, such as the death of a child or a sudden death, can have a greater impact on HCPs, the nuanced nature of peoples' experiences nor the potential for sustained impact is not understood. While notions of 'objectification' of patients has been discussed as a mechanism for an HCP to protect themselves emotionally, under what circumstances this could happen, or how the patient may be later 'humanised' again is not explored in detail. Similarly, a lack of understanding on how the death experiences in the ED will impact HCPs' personal and professional decisions, behaviours or priorities are not explored in detail in the literature. Gaps in knowledge identified from this literature review are addressed in this research study and will add to what we know already about the HCPs experience of death in the ED, including an understanding of what are the characteristics that will make a death in the ED memorable for HCPs, and when and how a dying patient, who is not on an EOL trajectory, is objectified and humanised by HCPs. Another aspect refers to how HCPs are making sense of the death experience in the ED, through their personal values and norms and often through their spiritual beliefs, and how this experience, together with HCP's values and norms, influences their personal and professional life, their coping strategies, their emotional labour, the care provided for other patients and their families or the decisions surrounding their career choices. Overall, the selected papers discussed a series of important aspects of the death experience in the ED, collecting data from a variety of healthcare professionals, including doctors and nurses, often also from patients and their families, using a great variety of qualitative methodologies. While phenomenology was the most popular approach in these studies, IPA in particular was under-represented, often healthcare assistant being excluded as participants. This research study used IPA as its methodology and interviewed HCPs working in the ED, including doctors, nurses, healthcare assistants and advanced care practitioners, having a great variety of professional grades and bands.

Chapter Four presents a detailed description of IPA as methodology and interviews as data collection methods used in this study, including the theoretical perspectives and the philosophical background of IPA, an exploration of quality and validity, ethics, and data management.

Chapter 4 Methodology and Methods

4.1 Introduction

Chapter Four presents the methodology and methods used to collect data. Paradigm, ontology, and epistemology are presented first as the basis for methodology and methods, followed by phenomenology being presented as the theoretical perspective of this study. This chapter also explores the philosophical influences underpinning IPA, as the chosen methodology. The chapter details the research design and methods, including the recruitment, sampling, and interviewing of participants. It then discusses the quality and validity principles of the study, ethical considerations, and the data management framework guiding this study.

4.2 Paradigm, ontology, and epistemology as basis for methodology and methods

Brown (2006) suggests that methodology represents “the philosophical framework within which the research is conducted or the foundation upon which the research is based”. Methodology can be also defined as a framework, which is associated with a specific set of paradigmatic assumptions that a researcher will use to conduct its research (Brown, 2006). In the process of deciding on the methodology I should use for my research project, I ensured that the chosen methodology met the following two criteria: firstly, to be the most appropriate to achieve the objectives of the research; secondly, so that it would be possible to replicate the methodology used in other research of the same nature (Allan and Randy, 2005). The main research question is “What are the healthcare professionals’ lived experiences of death in the Emergency Department?” The objectives of the research study are to understand how these lived experiences are influenced by personal, cultural, social, spiritual, and moral values and norms, and to explore healthcare professionals’ views on managing, accessing support, coping with, and preparing for such experiences of death in the ED.

Wong et al. (2011) argues that when determining truth from untruth, right from wrong, and the real from the imaginary, it is impossible to have the same perception and interpretation of reality as another person. Burrell and Morgan (1979) define these questions as being answered and evaluated by self-reflection, without a pre-existing process or method to produce a ‘correct’ answer, as all that the individual can decide at a given place and time, what the ‘best answer’ for a question might be. In human perceptions of the existence, Beck (1992) suggests that there is no dominant and absolute conception of reality, only a guidance through the philosophical branches of epistemology and ontology.

As a researcher, I had to be able to understand and articulate my beliefs about the nature of reality I was willing to study, what can I know about it and how should I collect and structure the knowledge related to it. These represented the cornerstones of my research paradigms. According to Guba (1990), a research paradigm is a set of shared beliefs and agreements about how research problems should be addressed and understood. A paradigm can be also defined as a belief system and a theoretical framework concerned about ontology, epistemology, methodology and the research methods (Patton, 2002). Ontology refers to the nature of our beliefs about reality, and our, often implicit assumptions, if that reality is a singular, verifiable truth or multiple realities that are socially constructed (Richards, 2003). Epistemology refers to "the branch of philosophy that studies the nature of knowledge and the process by which knowledge is acquired and validated" (Gall et al., 2003). Methodology represents a guide to inform decisions about what type of data is needed, an articulated, theoretically informed approach, while the research method relates to the most appropriate data collection tools for the purpose of the study (Ellen, 1984). In Figure 4.1 the relationship between these components is represented.

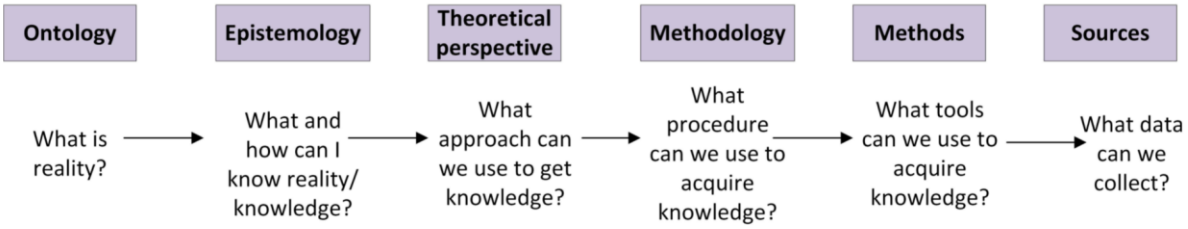


Figure 4.1 Components of a paradigm and their relationship (adapted from Crotty, 1998)

While death can be interpreted as an objective reality that exists independently, from a biological and physical perspective, exploring it from a social, cultural, spiritual, or moral point of view, a subjective approach is the only way for an individual to perceive this reality. From an ontological point of view, to understand individual experiences of participants, a mixture of an objectivist and subjectivist perspective is needed in which, as Habermas (1972) argues, human cognition recognises reality in an effort to make a valid inquiry, interpreting reality through a socio-historical background. Concerning epistemology, a subjectivist approach is chosen, generally rejecting the theory of a neutral observational language (Goffman, 1969). The main differences between an objectivist and subjectivist ontology and epistemology are detailed in Table 4.1.

Table 4.1 Objectivist and subjectivist ontology and epistemology (adapted from Wong et.al. 2011)

OBJECTIVIST	**SUBJECTIVIST**
ONTOLOGY	
• Social and natural reality exists independently	• Reality is derived from the human cognitive process
EPISTEMOLOGY	
• Believes in the theory of neutral observational language • Objectively accessing the external world	• Rejects the theory of neutral observational language • Subjectively accessing the external world • Knowledge is socially and historically constructed

The paradigm of inquiry penetrates the researcher's belief, representing the theoretical principles and faith that shape the way a researcher sees and deciphers the world and acts in it (Tobin and Begley, 2004). In the process of selecting the most appropriate methodology for this research, I have adopted a naturalist paradigm, as views of the reality are being constructed, multiple and value-oriented, in opposition to the positivist paradigm, that interprets the reality being single, tangible, and value-free. I was interested in understanding how HCPs in the ED construct their own reality within their social, value-driven context, and how these HCPs behave when absorbed in genuine life experiences in their natural settings, such as the death experience in the ED. The main differences between the naturalist and positivist paradigm are detailed in Table 4.2.

Table 4.2 Naturalist and positivist paradigm (adapted from Frey et.al. 1999)

NATURALIST (Qualitative)	**POSITIVIST** (Quantitative)
PARADIGM	
• Realities are multiple, constructed and holistic • Knower and known are interactive and inseparable • Only time and context-bound working hypotheses are possible (idiographic statements) • All entities are in a state of mutual simultaneous shaping, making impossible to distinguish causes from effect • Inquiry is value-bound	• Reality is single, tangible and fragmentable • Knower and known are independent, a dualism exists • Time and context-free generalizations are possible (nomothetic statements) • There are real causes, temporally precedent to or simultaneous with their effect • Inquiry is value-free

Chapter 1 of this thesis discussed in detail death as a reality that has multiple interpretations, taking into account beyond the biological, also the cultural, social, moral and spiritual aspects. As such my paradigm is interpretivism, with an ontology in which, me as a researcher and the reality are inseparable (Figure 4.2). In the epistemology knowledge is based on the abstract descriptions of meanings, formed by the individual experiences of HCPs in the ED. To capture these individual experiences phenomenology, hermeneutics and ideography were used as theoretical perspectives and interpretative phenomenological analysis (IPA) as methodology. Semi-structured interviews were chosen as the most appropriate research method to attain and structure knowledge from these experiences with death in the ED of HCPs .

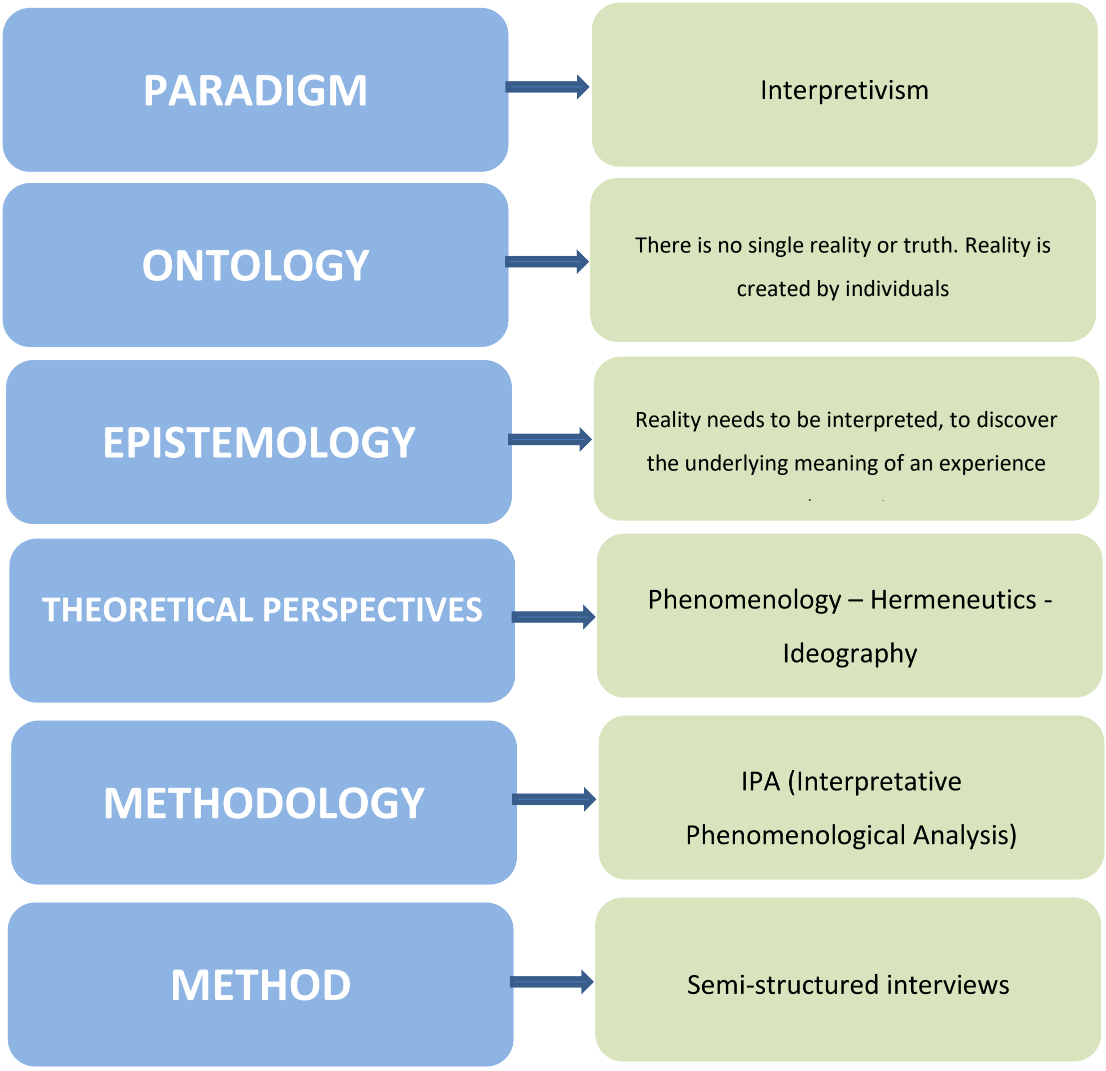


Figure 4.2 Foundations underpinning the elements of my research study

4.3 Interpretative Phenomenological Analysis (IPA)

4.3.1 Phenomenology as the theoretical perspective

As this study sought to examine the views, beliefs, and experiences of people from their own perspective, a qualitative research approach was chosen (Creswell, 2007). Qualitative research is the most appropriate, as it focuses on the meaning of how people make sense of their own lives, experiences, and their structures of the world (Flick, 2010). Qualitative research is interpretative, and I was interested in process, meaning, and understanding gained through words, and inductive, building abstractions, concepts, and hypotheses from details (Creswell, 2007). Benefits of qualitative research include an in-depth, contextually based, and flexible analysis, while the major challenges could include a higher exposure to bias through personal views and interpretations (Pope and Mays, 2006). Initially four qualitative approaches were considered to conduct the research: Ethnography, Case Study, Grounded Theory and Phenomenology. Ethnography focuses on a collective experience, studying the beliefs, behaviours, and culture. However, I was more interested in the personal and individual experiences of the research study participants (Hammersley and Atkinson, 2007). Case study focuses on answering the questions ‘How?’ and ‘Why?’, and is interested in one or multiple cases, situations, events or individuals, while my goals were to answer the ‘What?’ question, exploratory in nature, and understand the experience of many individuals, synthesizing these findings into themes (Yin, 2009; Stake, 1995). Grounded theory sets out to discover or construct theory from data, systematically obtained and analysed using the constant comparative method (Glaser and Strauss, 1967; Strauss and Corbin, 1990). As my intention was to explore and understand individual experiences of participants, discover, and make sense of their thoughts, feelings, and responses to the phenomenon of death in the ED, and finally interpret, how they make sense of this experience, I have decided to adopt a phenomenological approach, as it best aligns with this research goal (Giorgi, 2012). Phenomenology can be viewed as a direct investigation and description of a phenomena as consciously experienced by people living those experiences (Starks and Brown, 2007).

4.3.2 Philosophical influences underpinning IPA

IPA endeavours to reflect upon phenomenology as a singular and pluralist entity existing in a continuum (Finlay, 2011). IPA integrates the works of four major phenomenological philosophers: Husserl, Heidegger, Merleau-Ponty, and Sartre to seeks to understand the lived experience of the individual. Lived experiences in phenomenological research, are collections of the experiences and choices of an individual, and the knowledge that has been gained from it, research willing to understand them not as facts, but to determine the meaning of these experiences (Marshall and Rossman, 2011). The works of these four philosophers complement each other and collectively contribute to a holistic, mature, and comprehensive phenomenology.

The theoretical background of IPA originates from Husserl's attempts to construct a philosophical science of consciousness, with hermeneutics and with symbolic interactionism, which suggest that the meanings an individual associates to an event are crucial, but access to these is only possible through an interpretative process (Husserl, 1970). Husserl (1970), the founder of modern phenomenology, believed that by achieving a transcendental state, a researcher can identify conscious and unconscious beliefs and biases. According to Husserl (1970), phenomenology is a method of philosophical inquiry that rejects the rationalist bias in favour of a method of reflective attentiveness that discloses the individual's lived experience, rooted in intentionality. In his concept, being present in a situation contains both perception and meaning. This concept allows the researcher to establish an inter-subjective relationship with the participants and share their experiences and meanings (Husserl, 1970). Husserl was interested in a detailed and systematic analysis of consciousness, capturing the participants' experiences of a phenomenon. In Husserl's (1970) view this requires bracketing our own foreknowledge. As such, Husserl (1999) encouraged an attitude of consciously setting aside from our previous knowledge, our own history, prior understandings and from our own prejudices, while identifying core structures and features of human experience.

Husserl's thesis on phenomenology has been criticized widely. The idea that setting aside pre-conceived knowledge of a researcher is achievable when human experience is examined has been labelled as simplistic and unattainable (Finlay, 2011). Husserl's approach has been also criticized for being too conceptual, philosophical, and often difficult to decipher. Nevertheless, human experience in its purest form, as advocated by Husserl, is simply inaccessible because the event has already happened when the experience is witnessed (Spinelli, 2005).

Heidegger modified Husserl's concept of phenomenology defining consciousness as peripheral to the primacy of one's existence. This idea suggests that one's state of mind is an effect rather than a determinant of existence, including the unconscious, shifting the centre of gravity from consciousness to existence (Heidegger, 1985). Heidegger argued that investigating and interpreting existence as it is humanly experienced, should represent the primary concern for an existential phenomenologist (Heidegger, 1985). Heidegger, Sartre and Merleau-Ponty suggested the argument that we cannot escape the historical accuracy of all understanding, because we are embedded in the world of language and social relationships (Moran, 2000; Moran and Mooney, 2002). Heidegger requests from a researcher to infiltrate in the lived world of people, language, things and relationships and question knowledge outside interpretation. This should happen as the interpretation of people's meaning-making of their experience, becomes a cornerstone in phenomenological inquiry, by being reflexive in interpretation, in relation to the foreknowledge of the phenomenon being investigated (Heidegger, 1985).

Heidegger and Merleau-Ponty suggest that we can never make Husserl's reduction to the abstract, as our observations already require a viewpoint, and the participant itself is not an 'independent' entity but embodied into the world and its relationship with others (Merleau-Ponty, 1962; Heidegger, 1985). This position is emphasizing that while hermeneutic phenomenology could be descriptive in its inclination, it can only ever be interpretative in its implementation (Polt, 1999).

Merleau-Ponty focused much of his work on our relationship with the world, on subjectivity and embodiment. At the basis of his philosophy stands the concept that perception plays a primary role in understanding and engaging with the world (Merleau-Ponty, 1962). He argues that humans use their holistic sense to engage with the world, being unique and different from everything else. He also suggests that it is essential to acknowledge human existence in shaping the elementary principles of knowing the world, because the mechanisms of perception and judgement cannot be adequately conceptualized by empiricism. Merleau-Ponty's also suggests an emphasis on the role of sensation and physiology in relation to intellectual or rationale as an element of perception that cannot be overlooked (Merleau-Ponty, 1962).

Sartre's philosophy suggests that understanding human existence, human freedom, responsibility, and the physiology of human action, is more essential than understanding the world itself (Henriksson et al., 2012). Sartre argues that human nature is more about becoming than being. As a result, our own actions have both responsibilities and a freedom of choice, with certain human complexities such as the individual's life, social circumstances, and the biographical history to be taken into consideration when making a judgement or interpreting an experience (Catalano, 1980). Sartre's work is exceptional in its nature, as it offers a comprehensive glimpse of what a phenomenological analysis of a human experience should look like, taking into consideration the context of personal and social dimension, but also moral encounters and values of the individual (Busch, 1990). Table 4.3 summarizes the philosophical influences underpinning IPA with a special look to hermeneutics and ideography, discussed later in this chapter.

Table 4.3 Philosophical influences underpinning IPA (adapted from Peat et.al. 2019)

	Descriptive	**Interpretative**	**Hermeneutics**	**Ideography**
Purpose	*Describe the lived experience without assigning meaning.*	*Reveal and interpret the meaning of the lived experience.*	*To guide the interpretation of the text of individual accounts.*	*Identify and value the perspectives of individuals in context.*
Dominant scholars and influences	**Husserl:** put to one side preconceived judgements, known as the epoché or 'bracketing', in order to better appreciate the experienced phenomena.	**Heidegger**: we as researchers are part of the research. **Merleau-Ponty**: interpretation comes from our own perspective/being in the world. **Sartre:** we are always in a state of becoming.	**Schleiermacher**: understanding involves grammatical and psychological interpretation. **Heidegger**: recognises that researchers have preconceived ideas and experiences that they bring to the study. **Gadamer:** meaning making is a fusion of participant and researcher perspectives.	
Application to IPA	1. Ongoing reflecting on the phenomenon itself rather than exploring how experiences can fit with predefined criteria. 2. Bracketing, where each previous case is put to one side before the researcher moves on to read and analyse the next transcript.	1. The interpretation of an individual's meaning making is considered in light of the researcher's perspective, at that time. 2. Researchers observe and empathise but view phenomena from their own perspective or being in the world; the researcher cannot fully share the experiences of others. 3. The narrative is developed through interpretation.	1. Interpretation becomes an art; through detailed and meaningful analysis participants accounts can be appreciated providing insights into their lived worlds. 2. Making sense of what has been shared involves close engagement with the data, but interpretation can only occur in light of our own experiences, therefore a cyclic approach to bracketing is required. 3. The researcher cannot be separated from the researched, engaging with a world transforms the researcher in some way.	1. Case by case, systematic analysis.

4.3.3 Fundamentals of IPA

IPA was developed by Smith et.al. (1995), to allow rigorous exploration of the social cognitions and the idiographic subjective experiences of the individual. Interpretative Phenomenological Analysis (IPA) is an approach to qualitative research with a particularly psychological perspective on how people make sense of their experience (Smith and Osborn, 2008). This experience, in which IPA is interested in and explores in detail, describes the way people make sense of their personal and social world (Larkin and Thomson 2012). An IPA study seeks to understand the meanings of particular experiences, events and states, characteristic for the participants of the study, by collecting detailed, reflective, first-person accounts from research participants (Biggerstaff and Thompson, 2008). The IPA approach is phenomenological as it requires a very detailed examination of the participant’s world, also including the invisible aspects of the self, such as the meaning behind the words (Smith, 2007).

As opposed to attempts to produce an objective statement of an object or event itself, IPA is concerned with the personal experience of the individual and attempts to discover its personal perception or account of that object or event (Harre, 2004). From an IPA perspective, research is a dynamic process, where the researcher has an active role in that process (Madill et al., 2000). As IPA provides a phenomenologically focused approach to the interpretation of these experiences, the outcome of a successful IPA study is interested in ‘giving voice’ and ’making sense’ of a phenomenon (Smith et al., 2009). While ’giving voice’ can be described as capturing and reflecting upon views, emotions and concerns of the participants, ‘making sense’ relates to the interpretation of this experience, often using psychological concepts to extend beyond their direct meaning (Larkin et al., 2006).

The researcher in an IPA study is willing to get close to the participant’s personal world, to take an ‘insider’s perspective’, but access is limited and complicated by the researcher’s own conceptions (Conrad and Conrad, 1987). This interpretative activity is required to facilitate making sense of the participant’s personal world. The researcher's engagement with the participant's experience has an interpretative element, and assumes an epistemological stance whereby, using an explicit interpretative methodology, it becomes possible to access the participant's cognitive inner world (Smith, 2004).

4.3.4 Hermeneutics and IPA

Hermeneutics is the theoretical underpinning of IPA, that could be described as the art and science of interpretation or meaning. In this context, it is something fluid and flexible, continuously changing and remaining open to new interpretation and insight (Smith et al., 2009). Hermeneutic phenomenology in IPA is modelled by influential philosophers such as Heidegger, Schleiermacher, Ricoeur and Gadamer. Concepts of meaning, in Ricoeur's view, is indispensable to experience, and as such he linked hermeneutics and phenomenology by explaining that experience and meaning are closely related (Henriksson et al., 2012). In hermeneutics language is not only used for descriptive purposes, as Ricoeur describes it, it is co-emergent and an expressive force of experience. Experience will reveal its true self only when it is expressed in a language that carries a figurative, even poetic language (Henriksson et al., 2012). As a result, reconstructing original meanings of an experience, during textual interpretation, can happen through utilizing subjective expressions of interactive interpretation and embracing the literary and poetic aspects of language that emanates from the process of research (Moran and Mooney, 2002).

Heidegger believes that our being in the world presents us with an essential nature of interpretation, that triggers us to constantly ask questions about the world we live in and our very own existence. Furthermore, IPA compels that the essence of interpretation is captured thoroughly by Heidegger's concept of appearance (Smith et al., 2009). The main concept is that there is a phenomenon out there ready to be explored, yet prior experience, assumptions, or preconceptions of a researcher, doing a 'detective work', are required to bring it to light and make sense of the experience once it is revealed. Gadamer also believed that all understanding assumes an essential element of presumptions and a proportionate amount of interpretation (Henriksson et al., 2012).

Making sense of a participant's narrative, requires a close engagement with interpretation, however, preconceptions of a researcher might not be necessarily clear and conscious beforehand (Smith et al., 2009). Unpacking the relationship between interpretation and fore-understanding, reveals the need for bracketing or reflexion. The concept of meaning-making is only possible at the level of the person-in-context. Understanding the inner world of the participant is a two-stage interpretation process, also called a double hermeneutic (Smith, 1999). During this process, the participants are trying to make sense of their own world, while at his own level, the researcher is trying to make sense of the participants trying to make sense of their world. This means that the focus first is on the meaning of an experience and then recognize its significance for that participant (Larkin and Thomson 2012).

Approaching data by an IPA researcher, happens with the aim of understanding ‘what it is like’ for the participant, but recognising that access to ‘experience’ is both partial and complex (Smith et al., 1995). In other words, a first-person account in the analytic process can never be achieved. The account is always constructed mutually by researcher and participant, willing to result in a coherent and psychologically informed description, reflecting as genuinely as possible the participant’s view (Smith, 2004). Once this account is produced, an interpretative analysis needs to be developed, which positions the initial experience in relation to a wider social and cultural context. This analysis aims to provide a critical and conceptual commentary upon the participants’ experience of ’making sense’ of the account previously produced (Smith and Osborn, 2008).

An IPA researcher will engage in ‘double hermeneutic’, in that the researcher is making sense of the participants’ sense making, by assuming a central role in the analysis of the participants’ experiences (Smith et al., 2009). Thus, reading ‘between the lines’ is required to probe the surface meanings, to reach a deeper interpretation. The dynamism of interpretation and reflection suggest a familiarity with the dynamic relationship between the ‘part’ and the ‘whole’ of a holistic analytical interpretation. In IPA, this ‘part’ could represent the encounter with the participant in the research project, while the ‘whole’ the finding meaning and developing of knowledge from the participant’s experiences (Finlay, 2011).

4.3.5 Ideography and IPA

Ideography and hermeneutic phenomenology are the key conceptual frameworks for IPA as it is concerned with meaning and processes, rather than with events and their causes (Biggerstaff and Thompson, 2008). IPA is fundamentally ideographic, a term that has been traditionally associated with the study of the individual in psychology (Smith et al., 2009). Ideography also has a wider interpretation as it makes a distinction between the study of specifics and the study of nomothetics, described as the study of ‘things in general’ (Lamiell, 1998; Windelband, 1998). Idiographic studies concentrate on specific individuals as they deal with specific situations or events in their lives (Robson, 2002; Smith, 1999).

On a methodological level, an IPA study typically involves a small number of participants to which an intensive and detailed analysis is associated (Shinebourne and Smith, 2010). These verbatim accounts are generally captured via semi-structured interviews, focus groups, or diaries, with the analysis producing patterns of meaning, synthesized, and reported in a thematic form (Larkin, et al., 2006). Each case is treated individually, before moving to the general cross-case analysis for convergence and divergence between cases, valuing each case by its own value and quality (Shinebourne and Smith, 2009). To achieve a meticulous and detailed examination of the convergence and divergence between the participants’ experiences, the IPA researchers must consciously follow an idiographic approach throughout the analytic process (Smith and Dunworth, 2003). The interpretative analysis allows the researcher to focus on the particular meaning that made the participant, to have made particular claims, expressing particular feelings and concerns, during a particular situation or event (Smith and Osborn, 2003). This focus on the particular, rather than the general, commits to IPA an ideographic level of analysis, while it doesn't aim for transcendent knowledge (Halling, 2008). IPA represents a suitable research methodology for my particular research question, because of the two important features of this approach, ideography and hermeneutics, as my focus was to understand the meaning of the healthcare professionals' individual experiences of death in ED.

4.3.6 A critique of IPA

IPA has been criticized for being ambiguous, lacking standardization for being mostly descriptive and not sufficiently interpretative (Giorgi, 2010). One of the major criticisms of IPA is that the methodology has four major conceptual and practical limitations. Firstly, IPA often does not offer satisfactory recognition to the integral role of language (Brocki and Wearden, 2006). However, it is commonly accepted that meaning making takes place in the context of narratives, analogies or metaphors, and that interpretation is interconnected with language (Hefferon and Gil-Rodriguez, 2011). Secondly, IPA has been critiqued, if it can accurately capture the experiences and their meanings, or maybe only the opinions of it. More precisely the criticism relates to whether both the participants and researchers have the adequate communication tools to successfully identify the nuances of experiences (Willig, 2008). This may be particularly true when interviewing people about sensitive issues such as death. On the other hand, this criticism could be seen as elitist, suggesting only those having access to the right level of fluency are allowed to express their individual experiences (Willig, 2008).

Thirdly, IPA, like other phenomenological methods, seeks to understand the lived experiences but does not always explain why they occur. The representatives of this criticism, suggest that an authentic research approach would both seek to understand the experiences of its participants and understand the conditions that triggered those experiences (Willig, 2008). Often these are rooted in individual past events, but could relate to a wider social, historical, or cultural domain (Willig, 2008). Finally, the criticism that some aspects of phenomenology are not compatible with cognition and the role of cognition in phenomenology is not fully understood (Willig, 2008). Smith et al. (1995) although argues that the IPA is using hermeneutic and ideography to understand the cultural and social context, and its core elements of making sense and finding a meaning, encompassing reflection, resonate with cognitive psychology.

IPA is an approach that interprets and amplifies the lived experience stories of research participants. A profound understanding by the researcher, of these lived experiences are crucial, reached through the interpretation of the essence behind those stories (Alase, 2017). To achieve this understanding of the participant's lived experience, I had to 'put myself in their shoes', using an interpretative paradigm, and explicitly narrate and profoundly interpret how the phenomenon has influenced the individual (Burrell and Morgan, 1979).

4.4 Research procedure

4.4.1 Data collection in the context of the Covid-19 pandemic

Initially data collection was originally designed to use face-to-face semi-structured interviews with a small group of participants. In March 2020, new restrictions and limitations were introduced as a response to the Covid-19 pandemic, in all clinical areas of the ED to protect patients and staff. In April 2020 as an ED nurse at that time, I became infected and critically ill with Covid-19, suspending my research for 6 months. Once the research restarted, data collection was reviewed to be in-line with current hospital protocols and to protect myself, due to a high risk of re-infection. Under these circumstances conducting face-to-face interviews was impossible. As mitigation measures and to adhere to the social distancing and infection prevention measures of the hospital, I decided to conduct semi-structured interviews using a video interview, discussed in detail in section 4.4.6.

4.4.2 Sampling, selection criteria and recruitment

A purposive sampling strategy was utilised to find a closely defined group for whom the research questions were relevant. Smith et al. (2009) suggests that the specificity of a sample is defined in some cases by the topic under investigation, which could itself draw the boundaries of the relevant sample. Exploring experiences of HCPs working in the ED, of death is a well-defined topic, aimed at a specific group of individuals, which guided my sampling approach.

Participants comprised of HCPs recruited from the same ED of a large NHS Foundation Trust Hospital. This is a 57-bed unit, divided into seven sections, including the Major Injuries Unit and Initial Assessment, Ambulatory Majors, Resuscitation Room, Minor Injury Unit, Clinical Decision Unit 1 and 2 and an Enhanced Care Suite. The unit has a rapid turnover of patients over the age of 17 who usually stay for less than 10 hours. The ED has a sub-unit dedicated for paediatric patients. The number of clinical staff working within the department at the time of the study was approximately 150. HCPs were asked to participate in the research study and included both newly qualified and more experienced members of staff. All HCPs, including doctors, nurses, healthcare assistants were considered for inclusion. Table 4.4 contains the inclusion and exclusion criteria used during the sampling and recruiting process.

Table 4.4 Inclusion and exclusion criteria during sampling and recruitment

INCLUSION CRITERIA	**EXCLUSION CRITERIA**
• Clinical role (working in Resus): ○ healthcare assistant ○ nurse ○ charge nurse ○ senior charge nurse ○ junior doctor ○ registrar ○ consultant ○ advanced care practitioner • Time spent in ED: min. 6 months • Gender: no limitations • Age: no limitations • Nationality: no limitations • English speaker	• Clinical role (not working in Resus): ○ nurse specialist ○ radiographer ○ physiotherapist ○ occupational therapist ○ mental health practitioner • Non-clinical role: ○ Receptionist ○ Clerical worker ○ Housekeeper • Time spent in ED: less than 6-month • Non-English speaker

The sampling was informed by job role. It was important that the participant was in a clinical position and working regularly in a patient-facing environment, especially the Resuscitation Room (Resus) where most deaths occur in the ED. While many clinical specialities have patient-facing roles, such as a nurse specialist or physiotherapist, it is less likely that they are exposed to death experiences as part of their daily duties. The minimum length of experience in the ED was set to 6 months, as that represents the end of the preceptorship programme for a newly qualified nurse and it was judged to be a sufficient period of time in which a participant was likely to be exposed to death experiences. Participants were purposively selected to give diversity in terms of profession, gender, age, nationality, and work experience in the ED, to capture different perspectives in understanding the experiences of death. When analysing IPA studies published over the past few years, I found that the sample size ranged frequently from one and fifteen, or higher, with some recent trends to conduct some IPA studies with a very small number of participants. Smith et al. (2009) argues that there is no right answer to the question of the sample size, as it depends on the richness of the individual cases, the degree of commitment to analysis and reporting, but is also be influenced by the level of constraints the researcher encounters.

Considering the richness of the research subject, the multitude of job roles present in the ED, the length of experiences or the various national or cultural backgrounds, I was conscious that by working with a very small sample, I would not be able to explore multiple angles and perspectives of death experiences in the ED. To capture as many different accounts as possible from different viewpoints, 17 healthcare professionals, working in various job roles and having a varied seniority level, were interviewed, a considerably high number of participants for an IPA study. I initially set the upper target to 20, but data collected from 17 participants was rich enough for the purposes of the study, yet also feasible to be analysed under the given time constraints. Responses given by participants to open-ended questions, with only a minimum amount of prompting, producing almost 1000 minutes of recording. The answers given and the stories told by 17 participants, generated sufficient data to answer the research question and achieve this study's objectives. Seven of the participants were nurses, working in Band 5, 6 and 7 roles; five were doctors, of which one was a junior doctor and two were registrars and two were consultants; three were healthcare assistants and the remaining two were advanced clinical practitioners. The number of male and female participants was almost equal, mostly represented by the 20-39 age group, five working for more than ten years in ED, eight between 6-10 years, while four of them between 1-5 years. Characteristics of the participants that took part in the interview are listed in Table 4.5.

Table 4.5 Characteristics of the participants selected

<table>
<tr><th colspan="5">PROFESSION/ROLE</th></tr>
<tr><th>Healthcare Assistant</th><th>Nurse</th><th>Advanced Clinical Practitioner</th><th>Doctor</th><th>TOTAL</th></tr>
<tr><td>3</td><td>7</td><td>2</td><td>5</td><td>17</td></tr>
<tr><th colspan="5">GENDER</th></tr>
<tr><th>Female</th><th colspan="2">Male</th><th colspan="2">TOTAL</th></tr>
<tr><td>8</td><td colspan="2">9</td><td colspan="2">17</td></tr>
<tr><th colspan="5">AGE</th></tr>
<tr><th>20-29</th><th>30-39</th><th>40-49</th><th colspan="2">TOTAL</th></tr>
<tr><td>6</td><td>7</td><td>4</td><td colspan="2">17</td></tr>
<tr><th colspan="5">EXPERIENCE IN ED</th></tr>
<tr><th>1-5 years</th><th>6-10 years</th><th>10+ years</th><th colspan="2">TOTAL</th></tr>
<tr><td>4</td><td>8</td><td>5</td><td colspan="2">17</td></tr>
<tr><th colspan="5">LEADERSHIP</th></tr>
<tr><th>Leadership role</th><th colspan="2">Non-Leadership role</th><th colspan="2">TOTAL</th></tr>
<tr><td>12</td><td colspan="2">5</td><td colspan="2">17</td></tr>
<tr><th colspan="5">NURSES professional band</th></tr>
<tr><th>Band 5</th><th>Band 6</th><th>Band 7</th><th colspan="2">TOTAL</th></tr>
<tr><td>1</td><td>3</td><td>3</td><td colspan="2">7</td></tr>
<tr><th colspan="5">DOCTORS professional grade</th></tr>
<tr><th>Junior</th><th>Registrar</th><th>Consultant</th><th colspan="2">TOTAL</th></tr>
<tr><td>1</td><td>2</td><td>2</td><td colspan="2">5</td></tr>
<tr><th colspan="5">HEALTHCARE ASSISTANT professional band</th></tr>
<tr><th>Band 2</th><th colspan="2">Band 3</th><th colspan="2">TOTAL</th></tr>
<tr><td>2</td><td colspan="2">1</td><td colspan="2">3</td></tr>
</table>

Prior to the start of the study, senior ward staff was informed of the aim of the study and the data collection method, was part of a regular staff meeting. With the permission of senior staff, recruitments posters (Appendix J) were displayed across the department in non-clinical locations where staff gathered, such as the staff room, sister's office, doctor's office, or on the education board. A recruitment e-mail (Appendix K) was sent out to all members of staff in the department, by one of the senior nursing members of staff. A folder was created with hard copies of Participant Information Sheets (PIS) (Appendix H) and Consent Forms (Appendix I) and left in the sister's office for those who were interested to take a copy. The study was advertised through the weekly 'Top Tips' of the department, a regular newsletter containing useful information for staff. Potential participants were also notified about the study during the morning handovers for a period of time. Potential participants could register their interest in participating in the study by sending an email or by texting or calling. Dates and times for interviews were individually agreed with each participant. Some participants, after reading the PIS, required further clarification information or asked additional questions, mostly during a phone conversation.

Participants who agreed to take part in the study signed two copies of the consent form, one of which they could keep for their record. The participant then either scanned the hard copy and emailed the form to me or left a hard copy in the folder provided and kept in the sister's office. These hard copies were collected once a week, when visiting the department. Participants who agreed to take part in the study, also received an interview appointment email, detailing the process and preparation for the interview (Appendix L). As a requirement to comply with the Covid-19 regulations of the hospital and minimize non-essential visits to the department, the preferred method of collecting the signed consent forms was in a digital, scanned format.

4.4.3 Semi-structured interviews – description of the method

Interviews are a common data collection method in qualitative research, focusing on how individuals perceiving the situations they are facing, and how they are making sense of it (Polit and Beck, 2010). Research questions in IPA studies are usually framed broadly, being concerned with complexity, process or novelty (Smith et al., 2009). This research study did not attempt to test a predetermined hypothesis, instead the aim was to explore, flexibly and in detail, an area of concern: experiences of death of HCPs working in the ED. Understanding how participants make sense of their experiences, requires a flexible data collection instrument (Smith et al., 2009). The method chosen was semi-structured interviews. This form of interviewing allowed me to engage the participants in a dialogue, whereby initial questions could be modified in the light of the participants' responses. These interviews were grounded in open-ended questions, allowing the participant to elaborate and answer in more detail, describing freely, without any constraint, the events and associated emotions (Rosdahl and Kowalski, 2008). Interviews on average 60 minutes in duration, and covered the participant's broad experience of death in the ED. The interviews were conducted over a three-month period, between January and March 2021.

4.4.4 Piloting the interview and creating an interview schedule

After crafting an initial schedule for the interview, and being an inexperienced researcher, I piloted it with one of my peers, a fellow PhD student. The purpose of this pilot interview was to test the feasibility of this initial schedule and make appropriate adjustments to it if needed. As an additional benefit, I also wanted to ensure that the technology (both hardware and software) used to conduct the virtual interviews, were fit for purpose and that the chosen environment and background facilitated a conducive environment for the participants during the interview. Data from this pilot interview were not analysed or included as findings of the main study, as the participant was not a member of staff of the ED, from where participants were recruited. However, the same ethical and data management considerations were applied as for the rest of the participants of this study. The observations made during the pilot interview and the changes implemented in the interview schedule or technique, are detailed in Table 4.6.

Table 4.6 Observations and adjustments to the interview schedule, following the pilot interview

OBSERVATIONS	**ADJUSTMENTS**
1. *Starting immediately into the first question, caused the respondent to take longer to relax.*	**Solution:** Adding a warming up section to the schedule, which was not recorded. **Rationale:** Establishing proper rapport and better assess, any particular needs of the participant straight at the beginning.
2. *Strict order of questions, often gave me too much control and less freedom for the participant.*	**Solution:** Flexibility with the order of the questions **Rationale:** Exploring areas where the participant was leading me, with their interests or concerns.
3. *I became often inpatient, prompting the participant too early, when it took them too long to answer a question.*	**Solution:** Use of silence, not allowing to feel uncomfortable by it, but allowing enough time for the participant to put their thoughts and feelings into words. Reminding participants at the beginning of the interview that they can take as much time as needed to answer a question.

	Rationale: Penetrating more the participant's psychological world
4. *Conversation often took interesting, unexpected turns*	**Solution:** Developing additional questions, grouping them in sets. **Rationale:** Greater variety of options at hand, even if not all questions were asked at each participant.
5. *Questions often seemed to lack clarity for the participant or required additional explanation of the meaning*	**Solution:** Some questions were re-formulated or additional prompts were added as a reminder what areas to possibly explore in more detail. **Rationale:** Additional support for participants to answer a question focusing on the research aim.
6. *Sometimes the order of the questions related to a specific area first, then to a broader area*	**Solution:** Funnelling was used during the interview to adjust the order of questions. **Rationale:** More logical and natural development of the conversation, rather than, asking the questions randomly.
7. *Casual distortions or interruptions in the connection*	**Solution:** During some of the distortions or short interruptions of the connections, I couldn't recall what was said exactly. Asking the participant to repeat what was said. **Rationale:** Avoiding possible false interpretations.
8. *Interview took more than 90 minutes (50% longer than expected) and included several major 'derails' from the topic.*	**Solution:** While the 60 minutes average duration of an interview was a flexible target, incorporating techniques to guide the participant back to the topic, in case they 'derail' completely, were implemented. **Rationale:** A complete detour from the topic could cause unnecessary data to transcribe and analyse, while increasing significantly the time allocated for the interview.

The rationale for producing an interview schedule was to think explicitly prior to the start of the interviews, about what I planned to cover, considering the difficulties and challenges that I might encounter, thinking about sensitive areas in the conversation that would require considerate wording and strategies on how to handle these. Having such strategies developed beforehand, allowed me to concentrate during the interview more fully and confidently on what the participants were saying. Table 4.7 illustrates the four steps suggested by Smith et al. (2009) that were followed to develop this schedule.

Table 4.7 Sequence to produce an interview schedule (Smith et al., 2009)

Step	**Considerations in planning of the interview schedule**
1.	Defining the broad range of issues, the interviews will cover
2.	Defining an appropriate sequence based on logical order and sensitivity of the questions
3.	Defining appropriate questions for each area
4.	Defining possible prompts that can follow the questions

A strategy recommended by Smith et al. (2009) implemented in my interviewing style was to encourage the person to speak about the topic with as little prompting as possible. This happens in an attempt, to get as close as possible to what the participant thinks about the topic, with a minimum intervention from the interviewer. However, semi-structured interviewing often involves a gentle ‘push’ or ‘guidance’ from the interviewer rather than being too direct. When I reflected on the pilot interview, I realised that many of my questions were too explicit, which after redrafting, became gentler and less direct. For example, one of the initial questions, *“What does death mean to you, including any biological, social, cultural, spiritual, or moral aspects?”* has been replaced with, *“What does death mean to you personally?”*, using the details as possible prompts in some cases. My observation with the initial draft was that, when a participant seemed unable to answer a question, it was either because the issue was too complex, or because the question was too vague or general. However, not all general questions, had a more specific question or a prompt attached.

A method adopted in creating my interview schedule was the technique of funnelling (Smith et al., 2009). The first questions in my schedule were more general questions, hoping that this would be enough for the participant to talk about the subject. If the participant found a question difficult to answer, a more specific prompt, was intended to help them respond r. Most of the interviews were conducted using more general and sometimes specific questions moving between the two, reasonably seamlessly. The danger of conducting an interview only with very specific and explicit questions is that the engagement of the participant becomes questionable (Smith et al., 2009). The question that I had to ask myself under such circumstances, especially later during the analysis, was

"Am I really entering the inner world of the participant, or I am forcing them to enter mine? By asking questions in this sequence, I allowed the participants to give voice to their own views first resulting in it being less likely to produce data that reflected my own views and experiences Table 4.8 contains an extract from the interview schedule produced for this research study. The full schedule with questions, prompts and a list of good practice guidance was included in Appendix G.

Table 4.8 Extract from the interview schedule

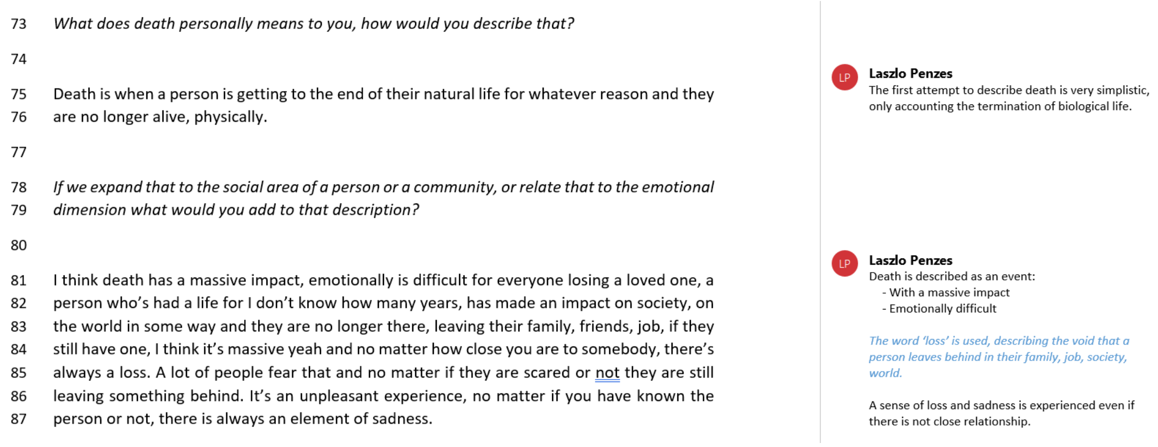
Area	General Question	Specific Question	Prompts
Identity & values	Tell me about yourself?	How do you see yourself and how others would describe you?	eg. personality is optimistic, cheerful, introverted, family, parents, siblings, education, cultural and social background, etc.
Experiencing death	How would you define death?	What does death mean to you personally?	eg. separation, sadness, mourning, deep feelings, thinking about how fragile life could be, thinking about what's important in life, etc.
Effects of experiencing death	Had this experience any effect on you?	How would you describe this effect?	eg. mood, behaviour, health, habits or relationships
Support in experiencing death	Is there anything you would have wanted to know prior to this experience?	Is there any training about death, you would have wanted to attend?	eg. breaking bad news, last offices, coping with death, emotional intelligence, CBT, etc.

To support my preparation for each interview apart, I created a list of good interviewing practices based on my own experience with the pilot interview, and also informed by the principles suggested by Smith et al. (2009). Prior to the start of each interview, I took time to read through these and remind myself how to make the most of each encounter. Table 4.9 includes a few examples of good interviewing practices I adopted.

Table 4.9 Extract from my list of good practices for interviewing (Smith et.al. 2009)

No.	**Good practices of interviewing**
1.	The ordering of questions is less important
2.	Prompts and questions are intended to be only suggestive, not prescriptive
3.	Questions should be neutral rather than leading
4.	Avoid jargon or assumptions of technical proficiency

In Figure 4.3, an example of prompting was taken from the interview transcript of Margaret, a pseudonym used to maintain participant confidentiality, as detailed in the ethical principles guiding this study, under sub-heading 4.7. When asked, what does death means to her personally, initially she gives a very short and simplistic answer, focusing only on the biological component, defining it as the termination of life. When prompted towards the social and emotional aspects, she elaborated on her answer in much more detail about what death means to.



What does death personally means to you, how would you describe that?

Death is when a person is getting to the end of their natural life for whatever reason and they are no longer alive, physically.

If we expand that to the social area of a person or a community, or relate that to the emotional dimension what would you add to that description?

I think death has a massive impact, emotionally is difficult for everyone losing a loved one, a person who's had a life for I don't know how many years, has made an impact on society, on the world in some way and they are no longer there, leaving their family, friends, job, if they still have one, I think it's massive yeah and no matter how close you are to somebody, there's always a loss. A lot of people fear that and no matter if they are scared or not they are still leaving something behind. It's an unpleasant experience, no matter if you have known the person or not, there is always an element of sadness.

Laszlo Penzes
The first attempt to describe death is very simplistic, only accounting the termination of biological life.

Laszlo Penzes
Death is described as an event:
- With a massive impact
- Emotionally difficult

The word 'loss' is used, describing the void that a person leaves behind in their family, job, society, world.

A sense of loss and sadness is experienced even if there is not close relationship.

Figure 4.3 Example of prompting while interviewing Margaret

4.4.5 Conducting the participant interviews

During the interviews I was able to probe interesting and important areas as they arose. A set of questions, as part of an interview schedule were developed which guided but not dictated the interview (Smith et al., 2009). As I had an initial idea about the questions to pursue to reach areas of interest, during the interview my aim was to enter the psychological and social world of the participant, as far as possible. The aim was to encourage the participant to talk freely about their experiences, and this often led to them introducing an issue I had not considered. Smith et al. (2009) suggests that the participant should be allowed an unconditional opportunity to tell their 'own story', and that the participant can be perceived as the 'experiential expert on the subject'. The advantages of semi-structured interviews include the ability to build a better rapport and empathy between researcher and participant, be flexible enough to explore novel areas during the conversation, with the aim of producing rich data. The disadvantages of this method relate to the reduced control of the interviewer, the length of the interview, potentially taking longer, and the data analysis which could require more effort (Smith et al., 2009).

During the planning process other data collection methods were also considered. Focus groups, for example, might have helped to uncover ideas and issues, that initially may not have been considered, but could have proved important to staff. Focus groups with a mixture of job roles and seniority, could potentially have generated conversations and themes that individual interviews might never uncover. This data collection method was rejected, beyond social distancing measures being still in place at that time, also due to my aim of recording individual experiences and giving voice to each participant. Focus groups carried the potential to reflect only the experiences of those participants, who are brave enough to speak in front of others, about such a difficult subject. On the other hand, the use of a questionnaire or survey with a set structure of questions, especially if published online, could have increased the number of responses, and increase the sample size, potentially offering a wider perspective of the subject. This method was excluded due to the lack of time and resources available in processing the amount of data produced, beyond the semi-structured interviews, its inclusion being considered unrealistic in reaching the objectives of this study.

During the interview non-verbal communication techniques were used to support interpreting the participant's body language but also mirroring what the participant says or does, to facilitate establishing a rapport, a more comfortable, friendly, and safe environment (Jack and Miller, 2008). During the conversation I aimed to maintain eye contact and avoid gestures that could be interpreted as judgemental or threatening (Webb and Holland, 2011). I used silence as a valuable communication tool as it can offer enough time for the participant to answer an open-ended question, especially on such a delicate subject as death. Clarifications was important when the answers provided were not clear enough or additional information was required (Goble, 2009). I also used reflection to echo the participants' answers, allowing them to reflect on what it has been said, judging if the answer truly reflects what it was meant. Paraphrasing helped me rephrase a message in other words in order to help interpret its true meaning, whilst summarizing, when required, supported the participant to add more to their statement (Rosdahl and Kowalski, 2008).

Interviews were anticipated to take approximately 60 minutes, but were flexible depending on the individual circumstances, availability, and willingness of the participant to share their personal experience. Interviews were audio-recorded with the permission of the participants and no video recordings were made. During the interviews I took some field notes, however I minimized these to provide my full attention to the participant through the whole duration of the interview. Participants were offered the possibility to pause, take a break or even to finish an interview if the conversation would trigger memories that would make them feel uncomfortable or cause distress. Although interviews took place via a video meeting, interviews were digitally audio-recorded (not video recorded), with the participant's permission and participant's various preferences were considered. This allowed participants to relax and express themselves more freely, but also to minimized distraction, while they often re-lived a painful memory in sharing their stories.

4.4.6 Using a virtual method to conduct the interviews

While online tools and methods are becoming increasingly common methods to conduct research and collect data, including online ethnographies (Beneito-Montagut, 2011); blogs analysis (Hookway, 2008); Facebook as a research tool and source of data (Baker, 2013), and particularly since the COVID-19 pandemic where , virtual methods have gained traction (Roberts et al., 2021; Lobe et al., 2020; Tremblay et al., 2021) research into the use of digital technologies as data collection tools is still at an early stage. VoIP (Voice over Internet Protocol) mediated technologies, along of their growing importance in everyday life, recorded an increasing use in terms of academic research, especially as a tool for conducting qualitative interviews (Lo Iacono et al., 2016; Archibald et al., 2019). VoIP is a system which offers a way to send voice and video across the internet, with the option to also use written text, via a real-time connection, characteristics which are not shared by emails and messenger protocols (Archibald et al., 2019). While VoIP is a much more advanced technology, it is often grouped together with other data collection methods, such as email and instant messenger services, under the umbrella of 'internet research methods' (Hesse-Biber, 2012).

As there are several applications and platforms offering VoIP communication, Microsoft Teams© has become a highly regarded and widely used platform, offering the ability to communicate in real time with geographically dispersed individuals via computer, tablet, or smartphone, possessing numerous additional advantages, that enhance its potential research utility. This platform has become the standard approved application both for University of Southampton, and the hospital where the research took place. The advantages offered by Microsoft Teams© include free access to students and hospital staff, user-specific authentication, real-time encryption of meetings and the flexibility to be easily installed on different operating systems with no or minimum experience (Microsoft, 2021). Other benefits of conducting interviews, using a virtual method included, flexibility, conducting the interviews from home, cost, and time effectiveness, as there was no need to commute, or the ability to share files and screen if needed. The disadvantages included the potential to be interrupted or a poor-quality recording, due to technical issues, adding potentially stress or discomfort for the participants. Table 4.10 highlights the advantages and disadvantages of using Microsoft Teams to conduct virtual interviews.

Table 4.10 Advantages and disadvantages of using Microsoft Teams for interviews

ADVANTAGES	**DISADVANTAGES**
Rapport • Better than non-visual methods such as telephone or email • Ability to respond to non-verbal signs • Ability to build an interpersonal relation • File and screen sharing option	***Difficulties when connecting*** • Internet bandwidth issues • Hardware and software issues • Microphone or camera issues
Convenience • Access to geographically remote participants • Time effectiveness • Cost-effectiveness • No need to organize logistics	***Call reliability and quality issues*** • Video quality - causing difficulties in reading and interpreting facial expressions or gestures • Audio quality – causing difficulties in clearly understanding the answers • Interruptions – causing discomfort in the participant or the loss of a certain idea during an answer
Simplicity and user-friendliness • Easy installation • Intuitive functionality • Robust security and privacy options • No need for an account when connecting as a guest (participant)	

When organising the interviews, I’ve sent a connection link via email to each participant. For those unfamiliar with the use of the platform, further instructions or links to training videos were provided, prior to start the interview. Testing the quality of connection, audio and video features was also part of the warming up phase of the interview. If for any technical reason, the interview could be interrupted, prior to the start, a strategy was be agreed with the participants, on how to reconnect or if the interruption would have been longer than convenient, on an alternative date to continue the interview. The quality of the audio recordings was also tested and adjusted prior to the start of the interviews.

4.5 Defining quality and validity

Irrespective of the specific theoretical orientation of a qualitative study, assessing quality and validity is crucial, for which the guidelines produced by Yardley (2000) or those of Elliott et al. (1999) present a rich and broad criterion. I followed Yardley's (2000) model, who suggests four primary aspects by which the quality of a research study using qualitative methods can be assessed: sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance. While in quantitative research, validity refers to whether the researcher measures what they are supposed to measure, or the consistency of the measures, in qualitative research, quality refers to being thorough and honest, addressing the most common threats of the researcher bias, reactivity and respondent bias (Robson, 2002; Lincoln and Guba, 1985).

In Yardley's (2000) view, establishing sensitivity to context can happen in numerous ways, such as sensitivity to the relevant theoretical knowledge by reviewing the relevant literature, understanding the socio-cultural context of the research study and by engagement with participants involved in the research study. Figure 4.4 represents the four criteria for quality and validity of a qualitative research, as described by Yardley (2000).

Figure 4.4 Quality and validity in qualitative research (adapted from Yardley, 2000)

In this study, choosing IPA as the research methodology, implied a commitment to idiographic and hermeneutic principles and a focus on recruiting participants from a particular context, HCPs from ED, with a specific lived experience, exposure to death in the ED. Sensitivity to context can be also demonstrated from the initial literature review and the themes that were generated, as a result of this process. Semi-structured interviews as a choice of data collection method and the rationale for its adoption, but also engagement with research participants with sensitivity to their individual experiences and understanding of their predicaments, contributed to achieve sensitivity to context. However, sensitivity to context, did not stop at this stage, reflecting in all further steps of the analytic process, particularly in the dedication to care and attention to detail in analysing and interpreting data or disseminating findings. In line with Smith et al. (2009), this study also demonstrated a sensitivity to the context by giving participants an individual voice in the study and allowed the reader to check the interpretations being made, by having participants' accounts included, as representations of the grounds for the analytic claims being made. Sensitivity was also demonstrated, by making sure to offer interpretations as possible readings grounded in the data, but also to widen interpretations and contextualize the findings of this research in relevant existing literature.

Yardley's (2000) second criteria, commitment and rigour, was demonstrated through immersion in the data of the research using a prolonged engagement with the topic. Rigour in this case referred to the thoroughness and completeness demonstrated during data collection and data analysis. Rigour also describes the thoroughness of this study, including appropriateness of the sample selected, the quality of the interview structure and questions, but also refers to the comprehensive nature of the analysis (Smith et al., 2009). Similarly, commitment was demonstrated throughout each element of the research process. This included the selection of the sample which required perseverance in accessing potential participants. It was also manifested through commitment to engaging with participants during data collection with sensitivity and respect, while engaging with commitment to a meticulous analysis (Yardley, 2000).

The third criteria, transparency, was achieved through precise description of the stages in the research process. This transparency was achieved through providing specific details of the process of selecting participants, constructing the interview structure, and then conducting the interviews, followed by the process of data analysis (Yardley, 2000). Coherence, was achieved by building a coherent argument yet finding opportunities to include ambiguities and contradicting experiences in the data in a coherent way. Yardley (2000) argues that coherence also bridges the gap between the research question and the philosophical perspective adopted, and the method of data collection and analysis.

Yardley’s fourth criteria resonates with Elliot et al. (1999), who suggests that the real validity of a study, lies in the reader finding something important, interesting, and useful in the study. Yardley (2000) also argues that a study should be judged by its impact and importance, as the ultimate criteria. Nevertheless, importance should be always judged through the lens of the objective of the study, and its impact in conjunction with the community for whom the findings were deemed relevant. The importance and impact of this study is detailed in the discussion of the findings in Chapter 6.

Following Smith’s et al. (2009) suggestion that an independent audit is a powerful way of approaching validity, this was considered in a form of ongoing mini audits at different stages of the project. Sharing information, at every stage of the research project, through regular research supervisions with my supervisory team, formed the most important part of checking the validity of interpretation that was subsequently reported in this study. Another form of active audit was through regular conversations with a clinical advisor in the ED, that helped shape the transparency, quality and effectiveness of the investigating and analysis methods. The overall aim and objectives of the research, with early findings were shared at various local conferences, through oral or poster presentations. Conversations during these events with other researchers and healthcare and medical professionals also shaped and guided the research process. Informal conversations also took place with fellow postgraduate students and early career researchers, exchanging experiences, however aligning with ethical approval requirements, maintaining confidentiality and anonymity and ethical research practice, data were never shared outside of the supervisory team.

Other audit trails in this research study consist of initial notes on the research question, the research proposal, the interview schedule, my reflexive diary, supervisory meeting notes, recorded transcripts which were annotated to trace the process of generating themes through the IPA analysis, and finally the writing up (Smith et al., 2009). This audit trail was regularly checked and discussed with my research supervisors. This thesis, provides a consistent and detailed record of the development of both the study and my skills and abilities as a researcher, throughout the process. Such level of transparency throughout each stage of this IPA research, will enable others to assess the overall quality, validity, importance, and impact of the study conclusions (Smith et al., 2009; Shinebourne, 2011).

4.6 Researcher's relationship with the participants

The relation between researcher and the participants of a research, is a recurrent concern in the methodology literature, notably the privileged position of the researcher compared to the participant is often emphasized (Finley, 2002). Reflexivity in qualitative methodology concerns with analytic self-awareness of researchers' reasoning, experiences, pre-understanding, construction of knowledge, integrity, openness, or the opposite, closeness, and their overall impact throughout the research process (Kvale and Brinkmann, 2009). Reflexivity is discussed in more details in section 7.6.

As a Clinical Doctoral Researcher during the period of this research I had a double role. In addition to being a researcher, I was also working as a healthcare professional at the same hospital where the research was conducted, for a certain period, as a staff nurse in the ED. This role however, ceased nearly a year prior of the start of data collection. As a clinician-researcher, I could not adopt a completely non-clinical research identity, the possible positive and negative ethical implications had to be considered prior to commence data collection (Hay-Smith et al., 2016). Potential participants could have felt obligated to participate in the study because they are former colleagues or perhaps because they feel a moral responsibility. To minimise any coercive effect, I made sure that every participant was clear that they do not need to take part and that they have the right to withdraw at any time, without giving an explanation. My position as a researcher, was emphasised during the interviews by not wearing a uniform. I strove to work in accordance with the participant's wishes and best interests, ensuring that the research was clearly discussed, to facilitate engagement around the topic. As a researcher, putting the wellbeing of the participants above the interests of the research was a goal clearly expressed and constantly assessed during the process. These principles were incorporated in detail into the Participant Information Sheet (Appendix H) and discussed individually with participants, prior to the start of interviews. This dual role required an additional effort to reflect on my own views and feelings, not being biased by my previous experience of working in the same environment as the participants. To support this effort, data collection proceeded at a pace which allowed time for thoughtful and in-depth reflexive evaluation. Writing a reflexive diary, where my views, experiences, ethical, moral, and spiritual values were clearly defined, helped me to proceed with the analysis and interpretation, minimizing bias. Reflecting on my own feelings, emotions, and thoughts after each interview, made me often discover and observe fine details, that might have skipped my attention during or after the interview.

4.7 Ethics and data management

4.7.1 Ethical approval process and ethical considerations

University of Southampton was the sponsor of the research project, and the University of Southampton Ethics and Research Governance Committee granted approval for the study in December 2019 (ERGO II ID: 52903). Due to restrictions that were put in place as a response to the Covid-19 pandemic at the hospital where the research was taking place, the research protocol was updated with the implemented changes and submitted to the Ethics Committee again in November 2020. Approval was granted in January 2021 (ERGO II ID: 52903.A1). Simultaneously approval was granted by the NHS Health Research Authority in January 2021 (IRAS ID: 292601) and by the R&D department of the hospital where the research took place, also in January 2021 (ID: RHM MED1670).

Protecting participants from harm is an important aspect of any study. During the research process six ethical principles have been considered, that can be applied regardless of conditions and format of research or type of participants. Beneficence suggests that the research offers a benefit to the participant and the society in general. Non-maleficence offers the security for each participant of being protected of any harm (Cottone and Vilia, 2006). Fidelity represents the ability to build trust with the participants and the obligation of safeguarding them. Justice will treat each participant equally and fairly, not giving preferential treatment to some. Veracity is the responsibility of telling the truth, even if the participant decides to withdraw from the research (Cottone and Vilia, 2006). Confidentiality is the ultimate ingredient as shows respect towards the individual and the information collected (RCN, 2009). Figure 4.5 is an illustration of the six principles guiding the ethical considerations of this research study.

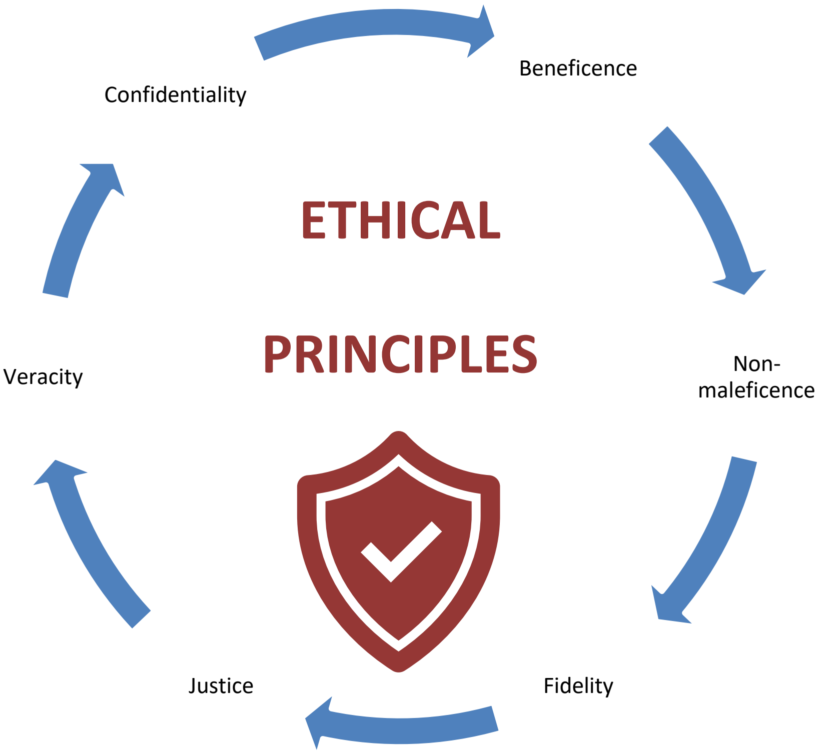


Figure 4.5 The principles guiding ethical considerations of the research study

Another guidance in the ethical considerations was taken from the GDPR - General Data Protection Regulation (2018), which states that all collected data must be accurate and relevant, not to be used for any other purpose than the research and be always kept secure.

4.7.2 Benefits and risks of participation

Participants were informed through the Participant Information Sheet (PIS) about the benefits and risks of taking part in this research study. While there was no direct benefit for participants, research suggests that participants can experience feelings of relief and consolation during conversations where they can express their thoughts and feelings freely (Hammersley and Traianou, 2012). Participants involved in interview studies also often report positive feelings such as empowerment, from helping to contribute to the improvement of the future care of others, with a similar condition or facing a similar situation (Wiles, 2013). Participants were made aware, prior to the interviews, that the findings of this study could form a basis for better education and preparation of healthcare professionals for death events, improvement in coping strategies and interpersonal relationships. Risks for the participants consisted in feeling distressed, tired, anxious, or overwhelmed, however the design and data collection method of the study allowed me to spend unhurried time and listen unconditionally, and often this had visible positive effect on participants (Hammersley and Traianou, 2012).

As the researcher, I was also exposed to the risk of experiencing emotional upset, while talking about emotionally challenging experiences (Wiles, 2013). Regular debriefs and peer support was available, to attempt to offset these potential negative emotional impacts. Sources of debrief made available included regular supervision meetings each month as well as access to the student health and wellbeing drop-in service of University of Southampton. Support from senior members of staff and specialist services at the hospital were made also available.

During the interviews, to minimize the above risks and achieve the best possible outcome, my approach incorporated self-awareness, empathy, and trust. As individuals we are unable to understand others, until we come to know ourselves (Hammond et al., 2002). Empathy allowed me to understand how the other person experiences a situation, by relating directly to them. Trust was the ultimate ingredient as without trust, sharing sensitive information might have been painful, if not impossible (Hammond et al., 2002).

4.7.3 Confidentiality and anonymity

During this research study I have applied the Caldicott Principles, which states that all identifiable information should be transferred for justifiable purposes only (NHS Wales, 2012), respecting people's right to privacy and confidentiality, as part of the NMC (2015) code of conduct. The device used for audio recordings was a digital recorder with encryption features, to which no one else had access. All audio recorded data was downloaded onto a password protected university computer straight after an interview finished and was then deleted from the handheld device. Audio files were also backed-up on the University of Southampton's servers. Pseudonyms were used to identify participants, and the file containing the list of pseudonyms in relation to participant's names was saved in a password protected file, on the password protected university computer. Beyond myself, only the research supervisors had access to this data. The use of audio files means that a participant could be recognised even though no identifiable personal data would be attached to the audio file. These audio files were kept until transcription and analysis of the interviews was finished, as re-listening to some of the original elements of the conversation, proved crucial in the interpretation process. Once the analysis was completed, audio files were deleted. Transcription of the audio recordings was handled personally by me, while during anonymization of data, all details that could identify the participant were removed, being referred to by their pseudonym.

In accordance with the GDPR - General Data Protection Regulation (2018), any information identifying participants, individuals or the organisation were removed from transcriptions, the interview recordings, reports, and publications. The hospital where the research study was conducted was referred to as an 'acute teaching hospital in England'. Paper documents, due to Covid-19 restrictions, such as signed consent forms were digitalized and stored electronically on the same university computer. All original paper documents after this digitalization, were destroyed as confidential waste at the site of the hospital where the research took place.

4.7.4 Consent and rights to withdraw

Seeking consent is fundamental in any research study involving people. Consent of participants is legally valid and professionally acceptable only if they have been properly informed and have agreed to participate without pressure or coercion (Manti and Licari, 2018). The principle that guided and underpinned this research was the respect towards HCPs participating in this study, as they had to deal with the distress of the death experience which affected them differently. Consent was negotiated at individual level as all potential participants were invited to consider whether they wish to take part in the interviews, offering them a minimum of 24 hours to ask questions. All participants were invited to complete a consent form prior to participating, a copy of which they could keep (Appendix I). Signed consent forms could be left either in the ED sister's office in a dedicated folder or sent by email in electronic format directly to my university email address. I was prepared to follow an established protocol, in case any of the research participant becomes concerned or distressed when talking about their death experiences. This protocol would have included pausing or suspending the interview, however there were no interviews which needed to be interrupted, postponed, or cancelled. All participants had the right to withdraw from the study at any stage. The participant that decides to withdraw from the study may or may not give a reason for withdrawing, however by signing the consent form agreed that the data collected up to that point can be used for the purpose of the research. Instructions were also provided in the Participant Information Sheet about who to contact if there are any questions or concerns that arise after completing the study.

4.7.5 Safeguarding and protection from harm

A researcher's responsibility is to ensure that those taking part in a research study, will not experience distress, and are protected from physical, mental, and emotional harm. This means that the risk of harm must be no greater than or additional to those encountered in their normal lifestyles, participants being protected from embarrassment, fear, or offence (Hammersley and

Traianou, 2012). Considering the delicate nature of the subject, talking about a death experience, the research posed the risk of bringing to the surface painful memories. If the interview became uncomfortable, participants had the option to take a break, to stop or withdraw if required. I aimed to create an environment and conduct the interviews in a manner that had the participant's feelings, emotions, beliefs, views, and requests at the centre. If recalling memories of an incident could have caused any distress to the participant, an organisational response was made available at the hospital where the research took place, called TRIM (Trauma Risk Management). TRiM is a service of assessing the psychological impact upon staff of exposure to distressing situations. TRiM is a service that is open to everyone affected by an incident and is aimed to help exploring how someone is coping after a traumatic event, and thinking about what support, if any, might be helpful. Details of TRIM contacts were provided in the Participant Information Sheet.

4.7.6 Data management

Managing research data represents the effective handling of information, created in the course of a research study, and is an integral part of the research process. The methods used to manage data usually depends on the type of data involved, but also how this data is collected and then used. Data management is required from the point of creation through to dissemination, publication, and archiving, covering the entire lifecycle of the data, often continuing even after the research project has ended (Pryor, 2012).

Management, storage, and retention of all data generated from this study were in accordance with the University of Southampton Research Management Policy which is reviewed annually. The study generated a large volume of data – audio recordings, transcripts, and reflective diaries, following the collation, analysis, and interpretation of the collected data. Records of the study will be archived by the Faculty of Health Sciences Archivist and kept for 10 years, in accordance with university policy. Only the research team will have access to the data will have access to the data during this period. After 10 years that data will be destroyed in accordance with the University of Southampton's recommended practises for the destruction of data. Figure 4.6 highlights the three major areas of data management in this research study.

Figure 4.6 Main areas of data management

4.8 Summary of Chapter Four

Chapter Four has identified the paradigm of inquiry, epistemology, ontology, and methodology used for this research study. IPA has been discussed in detail as the chosen methodology, with a notable reflection on the theoretical perspectives and philosophical influences, yet also the criticism of this methodology. This study sought to examine the views, beliefs, and experiences of people from their own perspective, focusing on the meaning and their structures of the world, of how they make sense of their experiences. Phenomenology, hermeneutics, and ideography were supporting my aim in finding meaning, and the understanding gained through words, abstractions, and concepts described by participants about their experiences with death in the ED. Sampling, selection, recruitment, and interviews using an online video platform, as the data collection method, has been also explored, alongside quality and validity, ethics, and data management principles.

The research question, *"What are the healthcare professionals' lived experiences of death in the Emergency Department?"* was answered through data collected, using semi-structured interviews with 17 HCPs in the ED, including doctors, nurses, and healthcare assistants. Chapter Five will describe how the collected data has been transcribed and analysed, to generate the emergent themes, superordinate themes and the higher order concepts, based on Smith's et al. (2009) 6-step IPA analysis method.

Chapter 5 Data Analysis

5.1 Introduction

Chapter Five describes the process of data analysis following the IPA analysis approach and steps recommended by Smith et al. (2009). The chapter will also elaborate on the principles guiding the process of transcribing the interviews, defining the codes, emerging themes, super-ordinate themes and finally the method used to cluster them into higher order concepts.

5.2 Characteristics of analysis in IPA

5.2.1 The purpose of IPA analysis

The purpose of IPA is to return ‘to the things themselves’, aiming to uncover what a lived experience means to the individual, through a process of in-depth reflective inquiry, drawn from phenomenological thinking (Husserl, 2001). While IPA is defined as an interpretative process between the researcher and researched, it also acknowledges that we are each influenced by the worlds in which we live in and the experiences we encounter (Peat et al., 2019). In this context, the researcher is positioned as an integral part of the research process, influenced predominantly by Heidegger’s interpretive phenomenology, hermeneutics, and ideography (Tuffour, 2017).

During the IPA analysis, I was interested in learning about the study participant’s beliefs, moral constructs being evident or suggested by their talk, or their stories, that itself can represent a piece of their identity, while exploring their experiences of death in the ED (Smith and Osborn, 2008). In this analysis, meaning was a central element, and my aim was to try to understand the content and complexity of these death experiences, rather than count the occurrence of those meanings (Smith, 2007). A sustained engagement with the transcript and a process of interpretation was required, in the attempt to capture the psychological, emotional, and social world of the participants, and obtain the meanings, which were not immediately transparently available (Smith et al., 2009).

Being committed to a detailed IPA analysis, my approach required a fundamentally ideographic focus, beginning with a particular case, valuing it for its own merits, analysing it in nuance and detail, and only then moving slowly to the next case (Tuffour, 2017). This ideographic focus of meticulous examination was maintained during the whole analytic process, as I was working up to more general categorization, to cross-case analysis, in an aim to identify convergence and divergence between cases (Smith and Osborn, 2008). As an IPA researcher, in my view the participant was an ‘expert of their own experience’, yet I acknowledged that revealing this experience requires a process of rich engagement and interpretation involving both parties. This engagement is referred to as the double hermeneutic (Peat et al., 2019). My aim in this process was to seek to make sense of the participants making sense of their own experience of death in the ED. This meaning-making process in IPA is assisted by the hermeneutic circle, which ensures that the lived experiences of participants are given a substantial voice, together with my interpretation of their narratives (Peat et al., 2019). Heidegger (1985) developed the concept of the hermeneutic circle, placing the reality as a ‘whole’, being situated in the ‘detailed’ experience of the individual, representing the parts of this whole. In this context the interpretation of a text, its content, intent, and context, is possible through the understanding of the individual parts, while the understanding of each individual part is only possible through the whole (Peat et al., 2019). The circle is a metaphor for the procedure of questioning prior knowledge through iterative recontextualization, reaching to multiple interpretations of text and dialogue, moving between the parts and the whole of the investigated lived experience or phenomena, or the smaller units of meaning and the larger units of meaning (Figure 5.1) (Smith et al., 2009).

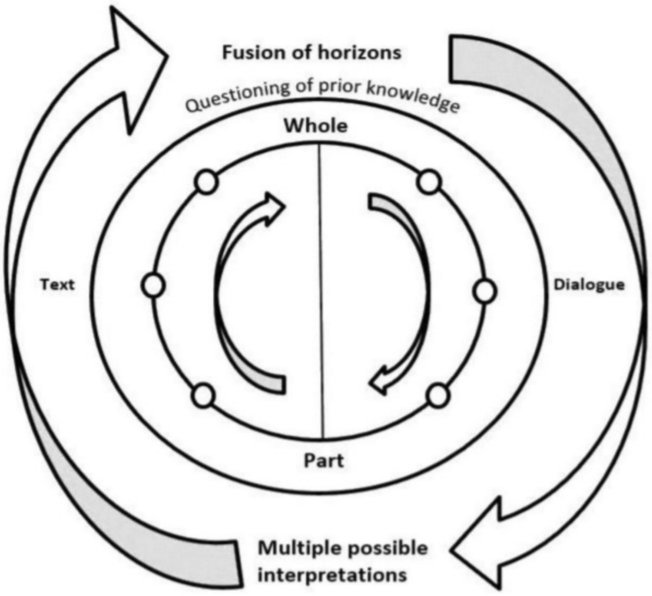


Figure 5.1 The Hermeneutic circle in IPA analysis (adapted from Peat et al., 2019)

The analysis was aimed to answer the following questions:

- What are the clinical staff’s experiences of death in the Emergency Department?
- How are these experiences influenced by personal, cultural, social, professional, or institutional values and norms?
- What are the clinical staff’s views on managing, accessing support, coping with, and preparing for such experiences of death in the Emergency Department?

5.2.2 Defining ground rules as preparing for data analysis

As part of the preparation stage for data analysis, it is important to define a set of ground rules to guide me during the process. These ground rules were meant to offer transparency of the analysis and supporting my efforts on reflecting on any possibility of being biased in my interpretation. These ground rules included the following principles:

- To pay attention to the beliefs and constructs that are made manifest or suggested by the research participant's talk and the stories told by them, that can itself represent a piece of their identity. This allowed me to learn something about the respondent's psychological world (Smith and Osborn, 2008).
- When looking to create a list of codes and emerging themes, try to understand the content and complexity of the meanings rather than simply measure or count their frequency (Smith, 2007).
- As these meanings are often not transparently available, I must obtain them through a sustained engagement with the text, by reading and re-reading it, taking proper time to reflect and put certain details in the context of the whole conversation (Smith and Osborn, 2008).
- Due to the sensitive nature of the research topic, each interview, and their analysis, carries a large amount of emotional 'burden'. Allowing proper time for this emotional effect to settle, rather than rushing through the analysis process, will allow me to draw more accurate conclusions and interpretations.
- As a former ED nurse, I will constantly have to distance myself from my own experience and allow to get closer to the participant's experience and persona, not allowing to be biased, when engaging in interpretation. However, using reflection and reflexivity enables acknowledgement and recognition of my own influences and subjectivities and making explicit researcher's pre-conceptions, values and beliefs rather than eradicating them.
- As an important part of the analysis, I will focus on the influence of the participant's norms and values on these experiences. As such, defining and listing my own values related to death were inevitable, to avoid being biased.
- As the number of participants was higher than of those in a typical IPA method-based research, the amount of data to be analysed was substantially greater. In conclusion, I decided that during the transcribing process, I will not take note of laughs, sobbing, pauses or other non-verbalised characteristics of the conversation. Instead, prior of starting the analysis of each transcript, I have consulted my own recorded reflections, to

better recall the overarching ‘atmosphere’ of the conversation and recall my own thoughts and feelings.

5.2.3 Glossary of terms

In preparation for data analysis, I prepared a glossary of terms and definitions to ensure consistency in their application along the analysis process of each transcript. These terms included the following elements:

Code: A word or phrase that is assigned to a portion of the data to label, analyse and describe it’s meaning and support later interpretation (Saldaña, 2016).

Emergent Theme: A basic building block of inductive approach, a phrase that derives from interpretation through the process of coding. Emergent themes must be grounded both empirically (in the data) and conceptually (linked to the wider analytic context) (Smith et al., 2009).

Super-ordinate theme: Represents the next level of themes developed from the emergent themes across the whole dataset (Smith et al., 2009).

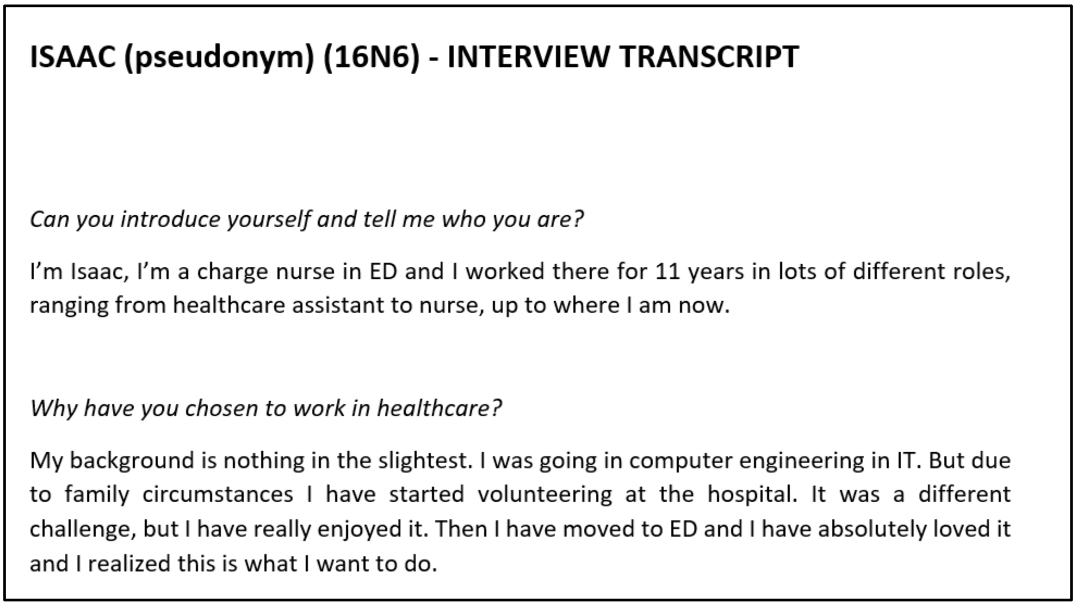
Higher order concept: Describes super-ordinate themes that various cases will share across the whole dataset (Smith et al., 2009).

5.2.4 Transcribing the interviews

All interviews were transcribed verbatim, and each participant had a pseudonym and an internal code allocated. The pseudonym served the purpose of protecting the participant’s identity and maintain confidentiality, while the internal code was used to code the participant’s job role, professional seniority and order occupied in the list of interviews (Figure 5.2). According to Smith et al. (2009) the normal convention is to transcribe the whole interview, including the interviewer’s questions.

The level of transcription in IPA is usually at the semantic level: all the words spoken needs to be seen, including false starts, significant pauses, laughs and other similar features (Smith and Osborn, 2008). However, Smith et al. (2009) suggests that the researcher does not necessarily need the more detailed transcription of prosodic features. The process of transcription enabled me to build familiarity with the data, and an opportunity to reconnect with the study participants and their experiences. Reflexivity played a crucial role during analysis, for which purpose I started a reflexive diary, recording my thoughts and feelings about my own judgements, belief, or value system, examining, and identifying potential incidental biases (see also section 7.6).

Interview questions were formatted in italic, while the participant's answers were left with normal font, to allow a visual distinction when reading the transcript. Although, Smith et al. (2009) suggests leaving a margin wide enough on both sides of the transcript to make analytic comments, this wasn't necessary, as transcripts were not printed out, but all comments were made and stored electronically in the created document. Figure 5.2 includes an example of an interview transcript for the participant Isaac (pseudonym).



ISAAC (pseudonym) (16N6) - INTERVIEW TRANSCRIPT

Can you introduce yourself and tell me who you are?

I'm Isaac, I'm a charge nurse in ED and I worked there for 11 years in lots of different roles, ranging from healthcare assistant to nurse, up to where I am now.

Why have you chosen to work in healthcare?

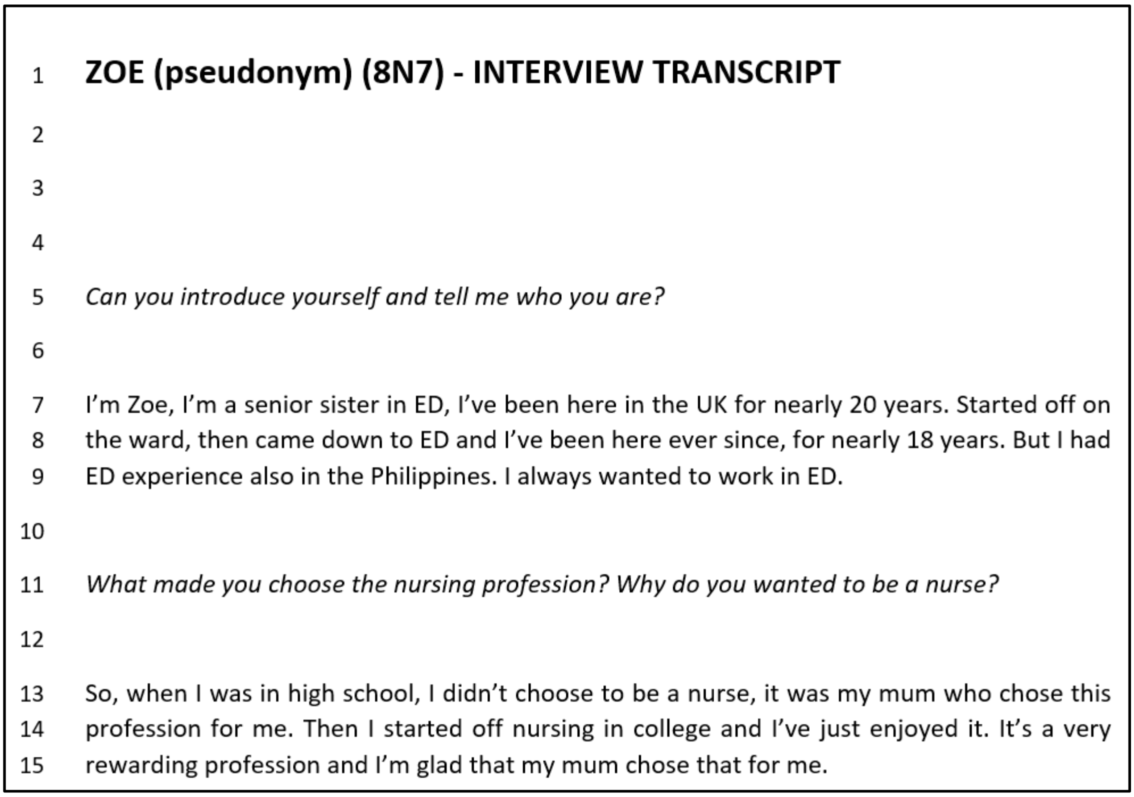
My background is nothing in the slightest. I was going in computer engineering in IT. But due to family circumstances I have started volunteering at the hospital. It was a different challenge, but I have really enjoyed it. Then I have moved to ED and I have absolutely loved it and I realized this is what I want to do.

Figure 5.2 Transcript example with pseudonym and internal code

Transcription of a recording can take a long time, as a rough guide between five and eight hours of transcription time per hour of recorded interview (Smith and Osborn, 2008). As the clarity of the recordings was not always ideal, due to poor internet quality during the virtual interviews, and being a novice typist, transcribing of an interview, took in average between ten to fourteen hours. This often difficult process, proved to be the starting point of my analysis, as I was building a closer, often intimate relationship with the data, allowing me to be better prepared for the next steps of the analysis (Smith et al., 2009).

5.2.5 Preparing the document for analysis

The document generated in Microsoft Word as the transcript of the interview, had each of its lines numbered, to enable attribution of text to participant (Figure 5.3). When quoting a participant, by taking an excerpt from the participant's interview, the identification happens using the participant's pseudonym followed by the line numbers of the transcript. For example, Zoe's quote from line 14, "I started off nursing in college and I've just enjoyed it" was recorded as Zoe:14.

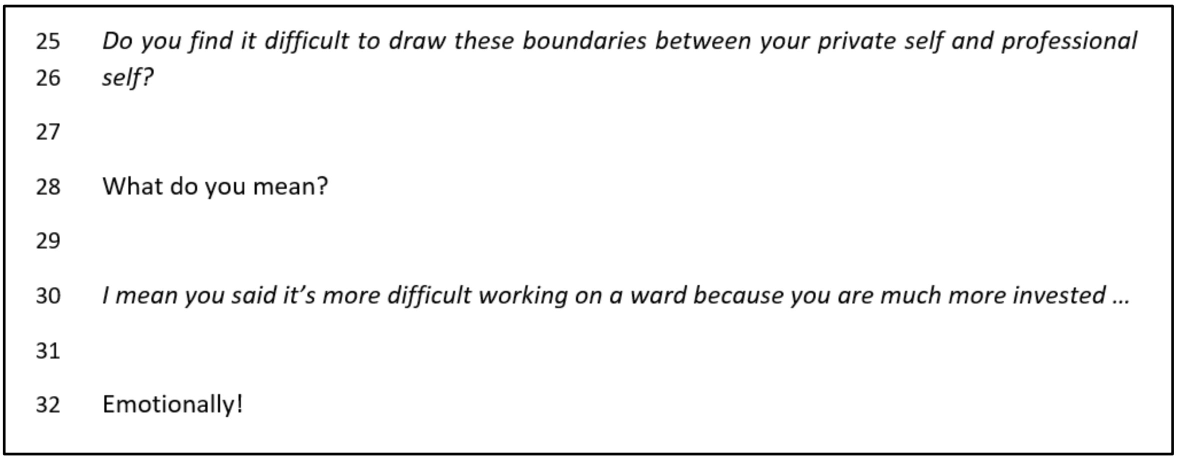


1 **ZOE (pseudonym) (8N7) - INTERVIEW TRANSCRIPT**
2
3
4
5 *Can you introduce yourself and tell me who you are?*
6
7 I'm Zoe, I'm a senior sister in ED, I've been here in the UK for nearly 20 years. Started off on
8 the ward, then came down to ED and I've been here ever since, for nearly 18 years. But I had
9 ED experience also in the Philippines. I always wanted to work in ED.
10
11 *What made you choose the nursing profession? Why do you wanted to be a nurse?*
12
13 So, when I was in high school, I didn't choose to be a nurse, it was my mum who chose this
14 profession for me. Then I started off nursing in college and I've just enjoyed it. It's a very
15 rewarding profession and I'm glad that my mum chose that for me.

Figure 5.3 Transcript example converted into a lined document

The lines left blank such as, Zoe:6 (Figure 5.3) provided visual differentiation between interviewer questions and participant's responses, to allow a better overview of the transcript as a whole. Participant quotes from across the whole dataset were used as proof in the process of the development of super-ordinate themes.

Any unfinished sentence was marked with […] at the end of the sentence. For example, Zoe:30 (Figure 5.4) contains an unfinished sentence, as the participant finished the interviewer's question.



25 *Do you find it difficult to draw these boundaries between your private self and professional*
26 *self?*
27
28 What do you mean?
29
30 *I mean you said it's more difficult working on a ward because you are much more invested …*
31
32 Emotionally!

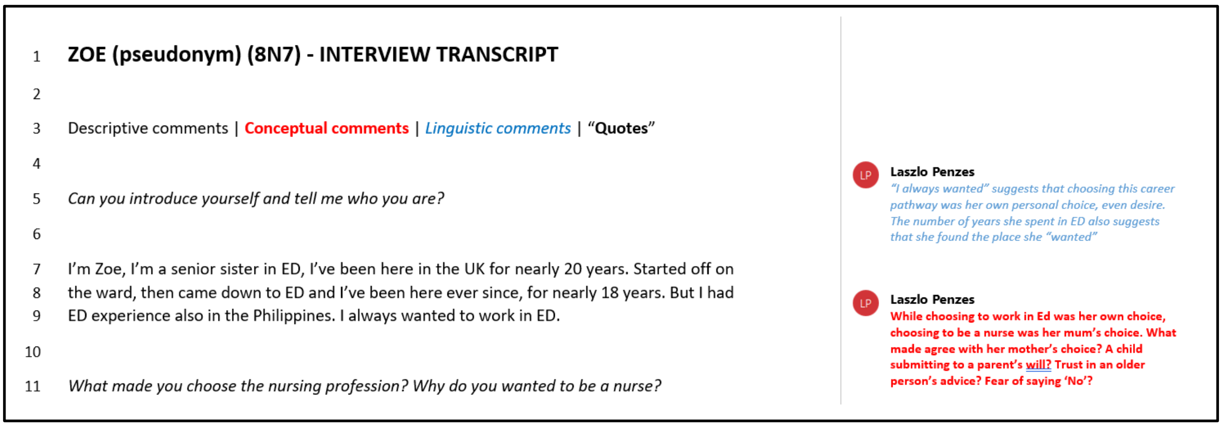
Figure 5.4 Example of an unfinished sentence in the transcript

5.3 Analysis of the collected data

5.3.1 Step one and two: Reading and re-reading/transcript annotations

According to Smith and Osborn (2008), during the first two steps of the six-step analysis method, the transcript is read and re-read several times, while the margins are used to make annotations of what appears to be interesting or significant about what the participant said. During this stage of the analysis, a close connection is formed between the researcher and the transcript, to become as familiar as possible with the account. Every time the transcript is read, it carries the potential to reveal new insights. Smith et al. (2009) suggests that at this stage there are no rules about what is commented upon. This activity can be interpreted as a free textual analysis. There is no strict requirement to comment on each portion or unit of the transcript either, as some parts of the transcript will provide a richer content than others.

Some of my initial comments were loose attempts at summarizing or paraphrasing, sometimes simply quoting the participant. When reading for the first time some associations and connections come to mind, which later become the foundations for a more in-depth interpretation. Initial annotations included four type of comments (Figure 5.5): Descriptive comments (normal black font), "**Quotes**" (bold black font), **Conceptual comments** (bold red font), and *Linguistic comments* (italic blue font).



ZOE (pseudonym) (8N7) - INTERVIEW TRANSCRIPT

Descriptive comments | **Conceptual comments** | *Linguistic comments* | "**Quotes**"

Can you introduce yourself and tell me who you are?

I'm Zoe, I'm a senior sister in ED, I've been here in the UK for nearly 20 years. Started off on the ward, then came down to ED and I've been here ever since, for nearly 18 years. But I had ED experience also in the Philippines. I always wanted to work in ED.

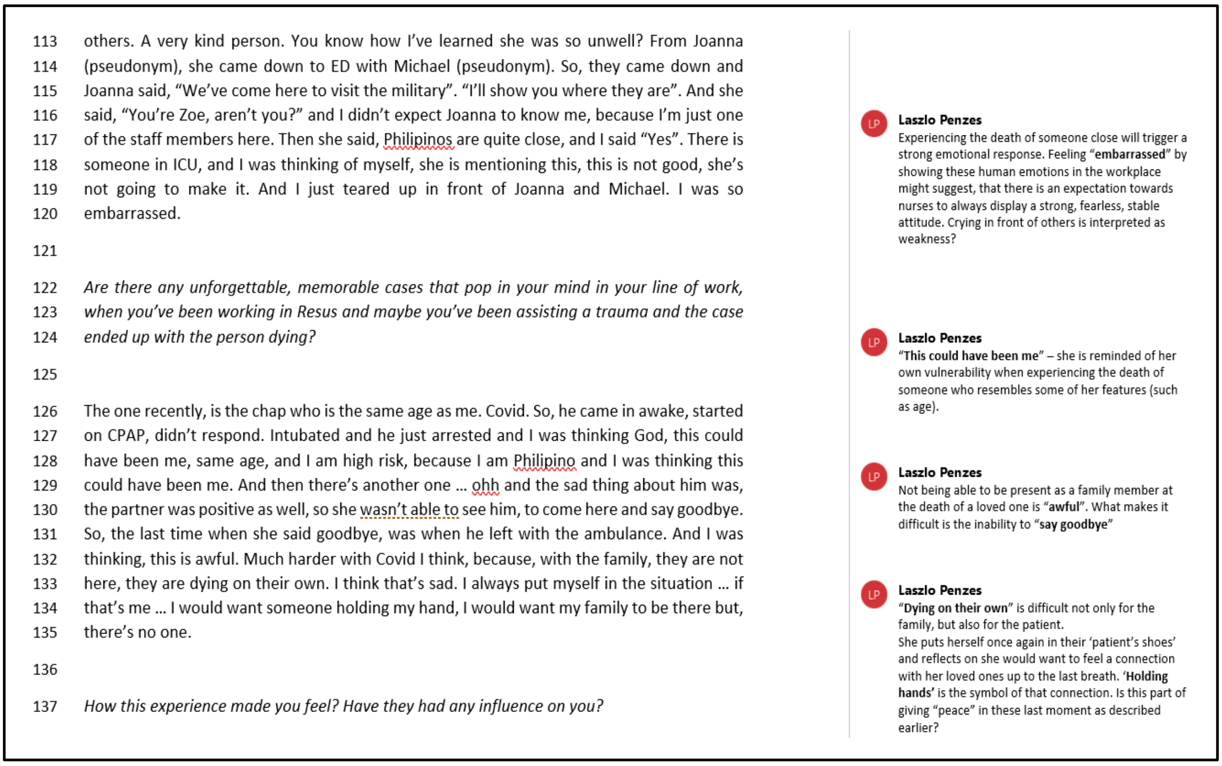
What made you choose the nursing profession? Why do you wanted to be a nurse?

Laszlo Penzes
"I always wanted" suggests that choosing this career pathway was her own personal choice, even desire. The number of years she spent in ED also suggests that she found the place she "wanted"

Laszlo Penzes
While choosing to work in Ed was her own choice, choosing to be a nurse was her mum's choice. What made agree with her mother's choice? A child submitting to a parent's will? Trust in an older person's advice? Fear of saying 'No'?

Figure 5.5 Type of comments used in step one and two of data analysis

When reading the transcript for the first time, 'descriptive comments' and direct 'quotes' were used in the annotation process, to describe each participant's experience, often referred to by using the participant's own words (Figure 5.6).



others. A very kind person. You know how I've learned she was so unwell? From Joanna (pseudonym), she came down to ED with Michael (pseudonym). So, they came down and Joanna said, "We've come here to visit the military". "I'll show you where they are". And she said, "You're Zoe, aren't you?" and I didn't expect Joanna to know me, because I'm just one of the staff members here. Then she said, Philipinos are quite close, and I said "Yes". There is someone in ICU, and I was thinking of myself, she is mentioning this, this is not good, she's not going to make it. And I just teared up in front of Joanna and Michael. I was so embarrassed.

Are there any unforgettable, memorable cases that pop in your mind in your line of work, when you've been working in Resus and maybe you've been assisting a trauma and the case ended up with the person dying?

The one recently, is the chap who is the same age as me. Covid. So, he came in awake, started on CPAP, didn't respond. Intubated and he just arrested and I was thinking God, this could have been me, same age, and I am high risk, because I am Philipino and I was thinking this could have been me. And then there's another one … ohh and the sad thing about him was, the partner was positive as well, so she wasn't able to see him, to come here and say goodbye. So, the last time when she said goodbye, was when he left with the ambulance. And I was thinking, this is awful. Much harder with Covid I think, because, with the family, they are not here, they are dying on their own. I think that's sad. I always put myself in the situation … if that's me … I would want someone holding my hand, I would want my family to be there but, there's no one.

How this experience made you feel? Have they had any influence on you?

Laszlo Penzes
Experiencing the death of someone close will trigger a strong emotional response. Feeling "**embarrassed**" by showing these human emotions in the workplace might suggest, that there is an expectation towards nurses to always display a strong, fearless, stable attitude. Crying in front of others is interpreted as weakness?

Laszlo Penzes
"**This could have been me**" – she is reminded of her own vulnerability when experiencing the death of someone who resembles some of her features (such as age).

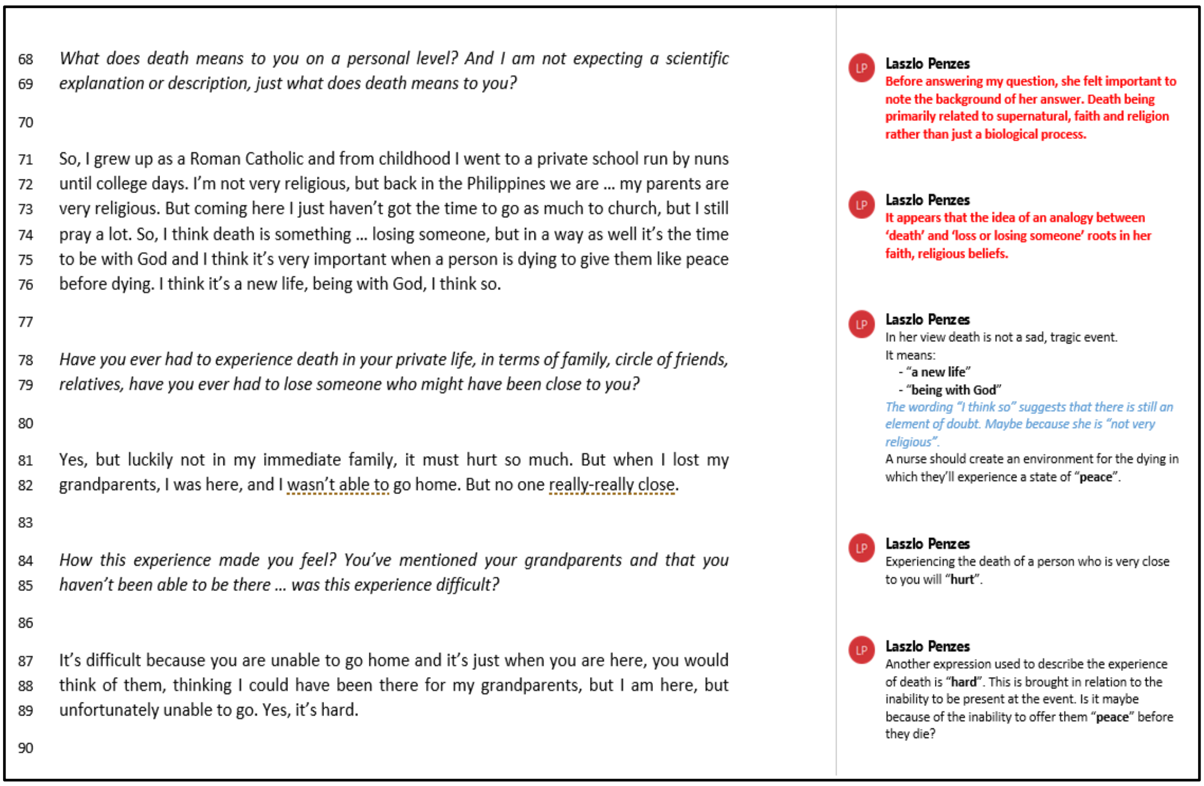
Laszlo Penzes
Not being able to be present as a family member at the death of a loved one is "**awful**". What makes it difficult is the inability to "**say goodbye**"

Laszlo Penzes
"**Dying on their own**" is difficult not only for the family, but also for the patient.
She puts herself once again in their 'patient's shoes' and reflects on she would want to feel a connection with her loved ones up to the last breath. '**Holding hands'** is the symbol of that connection. Is this part of giving "peace" in these last moment as described earlier?

Figure 5.6 Example of 'Descriptive comments' and 'Quotes' in annotations

'Conceptual comments' were developed while re-reading the transcript multiple times, often making a "comment on similarities and differences, echoes, amplifications and contradictions in what a person is saying" (Smith and Osborn, 2008). I have used a reflexive method of repetitive 'interrogation of the data' through analytic questions recorded in these conceptual comments. The aim of questioning was to achieve the purpose of double hermeneutics, in making sense of how the participant is making sense of its own experience. This intention of a profound understanding of the meaning of the participant's overall experience, led to a more in-depth interpretative phenomenological analysis.

'Linguistic comments' were used to identify signposts in participant's language that identify a certain attitude towards their own experience described by certain repetitive or significant wording, metaphors or analogies used. Often the sense of the persons themselves are coming across through the language used by the participant (Smith et al., 2009).



What does death means to you on a personal level? And I am not expecting a scientific explanation or description, just what does death means to you?

So, I grew up as a Roman Catholic and from childhood I went to a private school run by nuns until college days. I'm not very religious, but back in the Philippines we are … my parents are very religious. But coming here I just haven't got the time to go as much to church, but I still pray a lot. So, I think death is something … losing someone, but in a way as well it's the time to be with God and I think it's very important when a person is dying to give them like peace before dying. I think it's a new life, being with God, I think so.

Have you ever had to experience death in your private life, in terms of family, circle of friends, relatives, have you ever had to lose someone who might have been close to you?

Yes, but luckily not in my immediate family, it must hurt so much. But when I lost my grandparents, I was here, and I wasn't able to go home. But no one really-really close.

How this experience made you feel? You've mentioned your grandparents and that you haven't been able to be there … was this experience difficult?

It's difficult because you are unable to go home and it's just when you are here, you would think of them, thinking I could have been there for my grandparents, but I am here, but unfortunately unable to go. Yes, it's hard.

Laszlo Penzes
Before answering my question, she felt important to note the background of her answer. Death being primarily related to supernatural, faith and religion rather than just a biological process.

Laszlo Penzes
It appears that the idea of an analogy between 'death' and 'loss or losing someone' roots in her faith, religious beliefs.

Laszlo Penzes
In her view death is not a sad, tragic event.
It means:
- "**a new life**"
- "**being with God**"

The wording "I think so" suggests that there is still an element of doubt. Maybe because she is "not very religious".
A nurse should create an environment for the dying in which they'll experience a state of "**peace**".

Laszlo Penzes
Experiencing the death of a person who is very close to you will "**hurt**".

Laszlo Penzes
Another expression used to describe the experience of death is "**hard**". This is brought in relation to the inability to be present at the event. Is it maybe because of the inability to offer them "**peace**" before they die?

Figure 5.7 Descriptive, conceptual, linguistic comments and quotes in the annotations

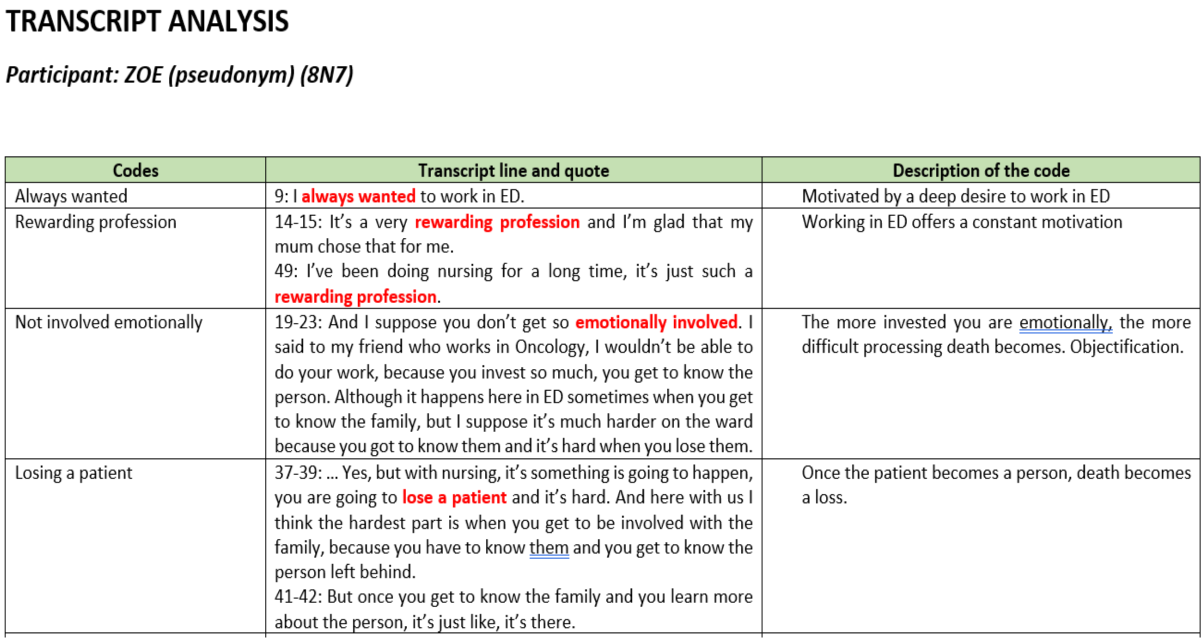
The next step of the process will focus on the development of the emergent themes from these initial annotations.

5.3.2 Step three: Development of emergent themes

The third step of the analysis method focuses on the development of emerging themes. Smith and Osborn (2008) recommend that the initial notes are transformed straight into concise phrases, aiming to capture the essential quality of what was found in the text, serving to become emerging themes. Saldaña (2016) suggests that coding is a two-cycle process, where in the first cycle the initial coding of data occurs, while in the second cycle, more analytic skills are required, such as classifying, integrating, conceptualizing, abstracting, and synthesizing. Saldaña (2016) argues that a code in qualitative analysis is most often a short phrase or even just a word, that symbolically assigns a summative and essence-capturing attribute for a portion of data. The portion of data coded can range in magnitude from a single word to even an entire page of text (Saldaña, 2016). During this analytic process, codes served for me as links between the first interpretation captured by annotations and their explanation of meaning, when later these codes developed into emergent themes (Charmaz, 2013).

Codes in this process should not be confused with the interpretation of symbols in their specific social and cultural contexts. Some of the codes I have chosen may appear metaphoric, however in this data analysis, these codes are constructs that ‘translate’ the data (Saldaña, 2016). “Just as a title represents and captures a book, film, or poem’s primary content and essence, so does a code represent and capture a datum’s primary content and essence” (Saldaña, 2016).

The example below (Figure 5.8) shows the structure of creating codes from a transcript and the annotations associated in the previous steps.



TRANSCRIPT ANALYSIS

Participant: ZOE (pseudonym) (8N7)

Codes	Transcript line and quote	Description of the code
Always wanted	9: I **always wanted** to work in ED.	Motivated by a deep desire to work in ED
Rewarding profession	14-15: It’s a very **rewarding profession** and I’m glad that my mum chose that for me. 49: I’ve been doing nursing for a long time, it’s just such a **rewarding profession**.	Working in ED offers a constant motivation
Not involved emotionally	19-23: And I suppose you don’t get so **emotionally involved**. I said to my friend who works in Oncology, I wouldn’t be able to do your work, because you invest so much, you get to know the person. Although it happens here in ED sometimes when you get to know the family, but I suppose it’s much harder on the ward because you got to know them and it’s hard when you lose them.	The more invested you are emotionally, the more difficult processing death becomes. Objectification.
Losing a patient	37-39: … Yes, but with nursing, it’s something is going to happen, you are going to **lose a patient** and it’s hard. And here with us I think the hardest part is when you get to be involved with the family, because you have to know them and you get to know the person left behind. 41-42: But once you get to know the family and you learn more about the person, it’s just like, it’s there.	Once the patient becomes a person, death becomes a loss.

Figure 5.8 Generating codes from the transcript and annotations data

The other example below (Table 5.1) illustrates an element of in-vivo coding (red bold text) using Zoe’s language and the associated definition linked to Zoe's commentary around her experience with death in ED.

Table 5.1 Example of in-vivo coding

Code	**Transcript line and quote**	**Description of the code**
Appreciates	140-143: So, I look at it more positively I suppose. I’ve learnt to **appreciate more my family**. I phone my parent’s every day … like before it’s probably like once every week. But now, almost like every day. You just learn to **appreciate what you’ve got**. And my kids, I’m just grateful that they are here. For my husband. You learn to **appreciate things** I think.	Death experiences caused her to be more thankful

The table collecting the codes has three distinctive columns. The first column indicates the code that has been generated. The second column indicates the direct text in the transcript and the line numbers from where the code was generated. While the third contains a brief explanation, description of the code.

In this example, Zoe was asked, how does she feel about witnessing death in ED and if these experiences have had any influence on her? In her reply she is emphasising the positive aspect of the experience, saying “So, I look at it more positively, I suppose” (Zoe:140). In her elaborated response she is using three times the term ‘appreciate’ and the term ‘learn’, suggesting that seeing the positive aspect of these experiences, doesn’t happen in an instant, it takes a while, through a learning process (Zoe:140-143). Appreciation firstly is directed to certain people, especially family members, including her parents, her husband, and children. Secondly is oriented to ‘things’, which doesn’t translate into ‘objects’, yet relating to a collection of ‘possessions or things owned in life’, as she also mentions: “You just learn to appreciate what you’ve got” (Zoe:142). This resulted in the code ‘**Appreciates**’ being generated, described as ‘Death experiences caused her to be more thankful’.

This idea links into what she says later, about changing priorities in life, due to these experiences: “I think you just have to live your life to the fullest. There are a lot of things that doesn’t matter anymore” (Zoe: 147-148).

The initial code list, made by salient, essence-capturing, and evocative attributes, was generated for Zoe's transcript (Table 5.2). Moving between the parts and the whole is an important element in the hermeneutic circle, the transcript becoming a set of multiple parts with the intention to be re-arranged in a whole again, yet in a new structure, in the final research write up (Smith et al., 2009).

Table 5.2 Initial code list for Zoe

INITIAL CODE LIST FOR ZOE			
1	Always wanted	16	Walking and running
2	Rewarding profession	17	Talking
3	Not involved emotionally	18	Still the same
4	Losing a patient	19	Being human
5	Auto-pilot mode	20	Praying
6	Grateful to feel	21	Know the patient
7	Being with God	22	Die like that
8	Being there	23	Important for me
9	Doesn’t sit right	24	Closure
10	Embarrassed	25	Much harder
11	Could be me	26	Learning from experience
12	If that’s me	27	Holistic way
13	**Appreciates**	28	Unnoticed
14	Doesn’t matter	29	Humbling experience
15	Being strong	30	Role model

At this stage of the analysis, the themes move the response to a slightly higher level of abstraction, move further away from the participant, focusing on the researcher’s interpretation, and may invoke the use of more psychological terminology (Smith et al., 2009). Development of emerging themes requires a balancing between the researcher’s own interpretation and the researcher remaining immersed in the participant’s lived experience. The researcher’s interpretation should thread back to what the participant said, and that should be apparent in the themes generated (Smith and Osborn, 2008). The skill required at this stage is finding expressions which are grounded in the particularity of the words and specifics said by the participant, and yet are high level enough to develop theoretical connections. These theoretical connections will be made within and at a later stage, across cases (Smith et al., 2009).

At the start of this step, the entire transcript was treated as data, and no attempt was made to select particular passages for special attention or to omit part of the transcript. The transformation of initial codes into emerging themes is continued through the whole transcript, with the possibility that similar codes will turn into a single theme, as such, the number of emerging themes could be lower than those of initial codes. The number of emerging themes however could reflect on the richness of data in a particular passage or the whole transcript (Smith et al., 2009).

The initial code '**Appreciates**', a verb, following an in-depth exploration of the transcript, has been converted into the emerging theme '**Thankful**', an adjective. This change captured overall much better, not only particular acts of being grateful for various things in life, but also denoted her attitude, values and norms towards life in general, as an influence on her persona, of her experience with death in ED (Zoe: 140-143). Below, Table 5.3 lists all the initial codes for Zoe and the emerging themes generated from them.

The next step in the analysis process will be searching for connections across the emergent themes and developing super-ordinate themes, which reflect on Zoe's lived experience.

Table 5.3 Initial codes and emerging themes for Zoe

INITIAL CODES		EMERGING THEMES	
1	Always wanted	1	Desired profession
2	Rewarding profession	2	Rewarding profession
3	Not involved emotionally	3	Emotional numbness
4	Losing a patient	4	Death as loss
5	Auto-pilot mode	5	Auto-pilot mode
6	Grateful to feel	6	Emotional involvement
7	Being with God	7	Comfort in faith
8	Being there	8	Connecting with the dying
9	Doesn’t sit right	9	Moral judgement
10	Embarrassed	10	Embarrassment
11	Could be me	11	Resemblance
12	If that’s me	12	Empathetic
13	**Appreciates**	13	Thankful
14	Doesn’t matter	14	Values and priorities
15	Being strong	15	Being strong
16	Walking and running	16	Walking and running
17	Talking	17	Talking
18	Still the same	18	Unchanged values
19	Being human	19	Being human
20	Praying	20	Praying
21	Know the patient	21	Emotional investment
22	Die like that	22	Good death
23	Important for me	23	Dignified death
24	Closure	24	Closure
25	Much harder	25	Memorable death
26	Learning from experience	26	Learning from experience
27	Holistic way	27	Holistic approach
28	Unnoticed	28	Unnoticed influence
29	Humbling experience	29	Humbling experience
30	Role model	30	Role model

5.3.3 Step four: Searching for connections across emergent themes

The starting point for the fourth step, are the emergent themes generated for Zoe, listed in a chronological order, based on the sequence with which they came up in the transcript. As I was analysing this list of emergent themes, my intention was to find connections between them. This stage involved a more analytical or theoretical ordering (Smith et al., 2009). Finding connections was not purely based on the words and expressions used, but re-reading the relevant passages of the transcript, to find more profound connections among the emergent themes. Some of the themes were clustering together, giving already a sense of what the superordinate concept might be. Smith and Osborn (2008) describe this process in a very pragmatic way: “Imagine a magnet with some of the themes pulling others in and helping to make sense of them.”

The example below (Table 5.4) shows how emerging themes with links and connections to each other, were grouped together, to form a super-ordinate theme. The initial code ‘**Appreciates**’, and the emerging theme ‘**Thankful**’ (marked with bold red in the table below) generated from it, has become part of a cluster that incorporates other emerging themes, describing various aspects of managing the experience of death in ED, from an emotional perspective. As a result, the super-ordinate theme was named ‘**Emotional Labour of Death**’.

Table 5.4 Example of clustering of emergent themes for Zoe

Super-ordinate theme	**Emerging theme**
EMOTIONAL LABOUR OF DEATH	Emotional numbness
	Emotional involvement
	Emotional investment
	Connecting with the dying
	Embarrassment
	Being human
	Resemblance
	Empathetic
	Thankful
	Closure

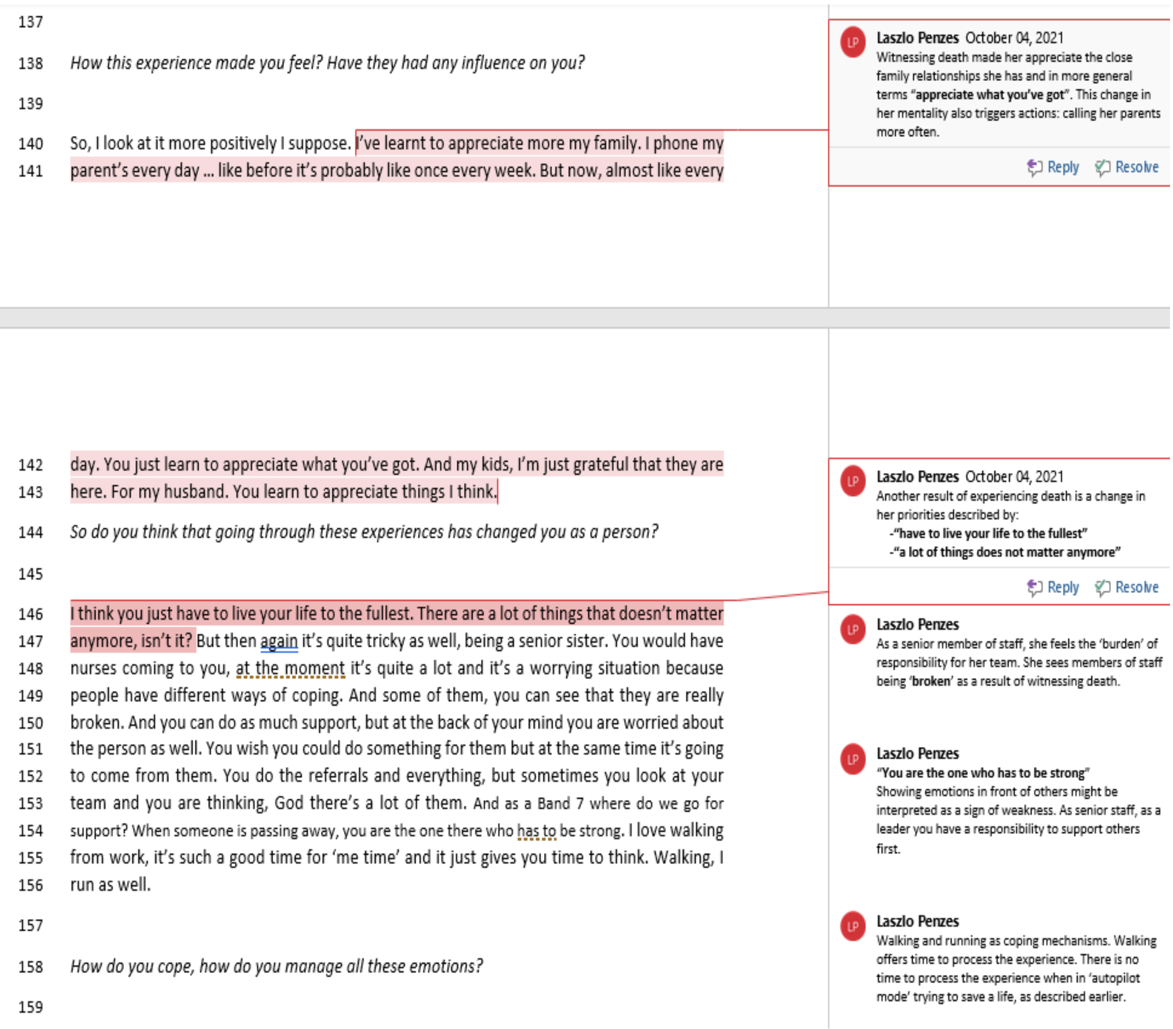
As the clustering of emergent themes was progressing, checking in the transcript the actual words of the participant became standard practice, to make sure the connections are reasonable and form a collective meaning. This form of analysis is iterative and involved me constantly checking my own sense-making against what the participant said (Smith and Osborn, 2008). Once all clusters of themes which capture most strongly the participant's thoughts on a particular area were formed, these clusters being given a name, the final list of superordinate themes was generated.

In Zoe's case the final list of super-ordinate themes and their relating emergent themes are shown in Table 5.5. Five super-ordinate themes were created in total, reflecting on the richness of the transcript and relating closely to the research questions, set as a starting point at the beginning of the analysis. The super-ordinate theme '**Working in the ED**' represents a collection of thoughts and feelings about motivations, inspirations, and aspirations of someone working in a healthcare environment where death is prominent, "it's something is going to happen" (Zoe:37). '**Defining death**' represents more than just a description, it's a standpoint, a view of the participant's world, captured through case examples and personal values. '**Spiritual dimension of death'** denotes Zoe's understanding and interpretation beyond the physical and biological dimension. The '**Emotional labour of death**' focuses on the emotional element of making sense and coping with death, as Zoe describes it, "I'm quite grateful that I could feel" (Zoe:43). Finally, '**Coping with death'** represents all the influence death has had on Zoe's coping mechanisms or the influence on her professional practice.

Table 5.5 List of super-ordinate themes and emergent themes for Zoe

Super-ordinate theme	**Emerging theme**
WORKING IN THE ED	Desired profession
	Rewarding profession
	Role model
DEFINING DEATH	Death as loss
	Good death
	Dignified death
	Memorable death
	Auto-pilot mode
SPIRITUAL DIMENSION OF DEATH	Comfort in faith
	Moral judgement
	Unchanged values
	Praying
	Values and priorities
	Humbling experience
EMOTIONAL LABOUR OF DEATH	Emotional numbness
	Emotional involvement
	Emotional investment
	Connecting with the dying
	Embarrassment
	Being human
	Resemblance
	Empathetic
	Thankful
	Closure
COPING WITH DEATH	Walking and running
	Talking
	Learning from experience
	Holistic approach
	Being strong
	Unnoticed influence

The idiographic focus of the relationship between the super-ordinate theme ‘**Emotional labour of death**’, the emergent theme ‘**Thankful**’, and the transcript itself are shown in Figure 5.9. This example illustrates how the language used remains closely linked to and is representative of Zoe's lived experience. Copying passages from the transcript, into the table where the list of initial codes and their description were noted, aided with the organization of the analysis and facilitation, finding the original source subsequently, using the line numbers as identifiers.



137

138 *How this experience made you feel? Have they had any influence on you?*

139

140 So, I look at it more positively I suppose. I’ve learnt to appreciate more my family. I phone my
141 parent’s every day … like before it’s probably like once every week. But now, almost like every
142 day. You just learn to appreciate what you’ve got. And my kids, I’m just grateful that they are
143 here. For my husband. You learn to appreciate things I think.

144 *So do you think that going through these experiences has changed you as a person?*

145

146 I think you just have to live your life to the fullest. There are a lot of things that doesn’t matter
147 anymore, isn’t it? But then again it’s quite tricky as well, being a senior sister. You would have
148 nurses coming to you, at the moment it’s quite a lot and it’s a worrying situation because
149 people have different ways of coping. And some of them, you can see that they are really
150 broken. And you can do as much support, but at the back of your mind you are worried about
151 the person as well. You wish you could do something for them but at the same time it’s going
152 to come from them. You do the referrals and everything, but sometimes you look at your
153 team and you are thinking, God there’s a lot of them. And as a Band 7 where do we go for
154 support? When someone is passing away, you are the one there who has to be strong. I love walking
155 from work, it’s such a good time for ‘me time’ and it just gives you time to think. Walking, I
156 run as well.

157

158 *How do you cope, how do you manage all these emotions?*

159

Laszlo Penzes October 04, 2021
Witnessing death made her appreciate the close family relationships she has and in more general terms **“appreciate what you’ve got”**. This change in her mentality also triggers actions: calling her parents more often.

Laszlo Penzes October 04, 2021
Another result of experiencing death is a change in her priorities described by:
-**“have to live your life to the fullest”**
-**“a lot of things does not matter anymore”**

Laszlo Penzes
As a senior member of staff, she feels the ‘burden’ of responsibility for her team. She sees members of staff being ‘**broken**’ as a result of witnessing death.

Laszlo Penzes
“You are the one who has to be strong”
Showing emotions in front of others might be interpreted as a sign of weakness. As senior staff, as a leader you have a responsibility to support others first.

Laszlo Penzes
Walking and running as coping mechanisms. Walking offers time to process the experience. There is no time to process the experience when in ‘autopilot mode’ trying to save a life, as described earlier.

Figure 5.9 Example of the ideographic link in the transcript for a super-ordinate theme

Once all the connections across emergent themes were identified, clusters were formed and super-ordinate themes were defined, analysis moved on to repeating the first four steps of the analytic process, across the remaining sixteen individual transcripts, using the same principles as previously described.

5.3.4 Step five: Moving onto the next case

As the study involved interviews with seventeen participants, at this stage of the analysis I had to make a crucial decision about the strategy used to move onto the analysis of the remaining cases. One option suggested by Smith et al. (2009) is to use the themes from the first case to help orient the subsequent analysis. While the second option is to put the table of themes for the first participant aside and start working on the next transcript from scratch. Whichever approach I would choose, I knew that I have to remain disciplined to discern repeating patterns, yet acknowledge new issues arising, as analysing the remaining transcripts (Smith and Osborn, 2008). While Smith et al. (2009) recommends, to use the 'starting from scratch each transcript' strategy, when the number of participants is low, I've decided to follow this approach in my analysis. As I am aiming to respect convergences and divergences in the data, I felt that recognizing ways in which accounts from participants are similar but also different, could occur more naturally in this way. This approach in cross-case analysis and the development of themes, supported my efforts of making sure the data will fit the emergent and super-ordinate themes, rather than the other way around.

To optimize the efficiency and outcome of this method, I've decided to follow a set of rules, that I set myself:

- **Leaving gaps between two analytic processes.** As the topic was very sensitive, it required from me both an intellectual and emotional investment during the analytic process. As such, to start from scratch with a new transcript, it required from me to wait a few days, as a 'cooling off' period, prior of starting. In this way my memories and feelings slightly faded, allowing me to be less influenced by data from the previous case.
- **Moving on to a participant with a different role or seniority.** Starting from scratch was supported also by the fact, that I have chosen to analyse next, a participant with a different role or level of seniority within the organization. If my previous case was a nurse, I have chosen to analyse next a doctor, then a healthcare assistant for example. Another time, I have chosen to analyse a Band 7 nurse, after a Band 5 nurse, or analyse the case of a consultant, after that of a junior doctor. This allowed me to change my focus and reset my attention, allowing any common features in the participant's experiences to occur more naturally
- **Consulting my reflective diary.** During the interviewing process, I have started recording my own thoughts and feelings for each interview in a reflective diary. This diary also collected my own thoughts and feelings about the experience of death, in my personal life

> and as a former ED nurse, beside my own values and morals related to this subject. Revisiting often this diary helped me to acknowledge and step back from my own thoughts and feelings, while immersing in the participant's experience.

Moustakas (1994) argues that, supporting this internal effort of distancing the self from the participant's experience, a technique known as 'bracketing' should be used. This technique requires a temporary suspension of critical judgement and critical engagement, which would bring in my own assumptions and experience, achieved by describing first my own personal experience with the studied phenomenon (Spinelli, 2005). While a researcher cannot escape completely their own preconceptions, using a reflective journal is essential in recognising their potential impact on the interpretation of the data (Spinelli, 2005). Smith (2007) acknowledges that researchers will be influenced in a way or another by the previous cases, however following rigorously the first four steps of the analytic process for each case, facilitates the ideographic commitment to IPA and the individual theme development.

To illustrate the similarities and differences among the transcripts analysed, Table 5.6 contains the super-ordinate and emergent themes for John, a junior doctor, in contrast with the first case analysed, Zoe, who is a nurse working in the same department.

Following the completion of the first four steps of the analytic process, in the next step I was looking to identify patterns across the cases.

Table 5.6 List of super-ordinate themes and emergent themes for John

Super-ordinate theme	**Emerging theme**
WORKING IN THE ED	Detective work
	Pure medicine
	Comradery
	Objectification
SOCIAL DEATH	Social death
	Different person
	Meaningless death
HUMANISED DEATH	One chance
	Special care
	Good death
	Emotional attachment
	Quality of life
DEATH INFLUENCE	Memorable deaths
	Emotional influence
	Greater grief
	Relationship with family
	Not a robot
	Influence on practice
	Professional identity
	Something missed
LEARNING FROM DEATH	Experiential learning
	Validation and education
	Pseudo-experience
	Right people
	Debrief
	Therapeutic chat
	Small gestures

5.3.5 Step six: Searching for patterns across cases

Once I analysed each transcript by the interpretative process, the last step of the method was to construct a table of higher order concepts, called superordinate themes (Smith et al., 2009). According to Smith and Osborn (2008) deciding upon which themes to focus upon, requires the researcher to create a priority list of the analysed data and begin to reduce them, which can be often challenging. I found this decision-making exercise probably one of the hardest, during the analytic process, as seventeen interviews provided very rich data and as such, a high number of emergent and super-ordinate themes. However, it was obvious that this rich data was not yet coherent, and not always in line with my initial intention of focusing on the original research questions. My strategy in cross analysis, was to not base the theme selection process, purely on their prevalence within the data. I've considered several other factors, such as the richness of a particular passage that highlights the themes and how a particular theme helps answering the research questions and illuminate other aspects of the account.

At first, I was somewhat anxious to find convergences between the individual tables of themes, that would be concise yet reflect on the overarching essence of the transcripts. As this selection process was progressing, in accordance Smith and Osborn (2008) suggestion I started seeing it as an intellectual opportunity rather than a difficulty. The table of higher order concepts and their related super-ordinate and emergent themes that resulted, respects both theoretical convergence but also, as part of this, the individual ideosyncrasy in how that convergence can manifest (Smith and Osborn, 2008).

The process of developing higher order concepts will be presented through 'Zoe's' case, as the previous steps in the analytic process were described, also through her example. A strong emphasis in Zoe's case, was in seeing the positives in a death experience, generating the initial code '**Appreciates**', which was later transformed into the emergent theme '**Thankful**'. This theme was incorporated under the super-ordinate theme '**Emotional labour of death'** for Zoe, alongside other emotional aspects, both positive and negative, describing the lived experience.

When moving onto cross analysing all the other cases, some of them featured the same super-ordinate theme '**Emotional labour of death**' while many other emergent themes, under different super-ordinate themes, featured a similar emotional aspect, worth being considered for inclusion. These emergent themes were re-visited again in conjunction with the initial code and the context they were generated from. This back-and-forth analytic process excluded many themes that appeared to be synonyms to each other, or the context was not providing a sufficiently relevant connection to the other emergent themes in the same cluster. The final list of emergent themes across cases for the super-ordinate theme '**Emotional labour of death**' can be found in Table 5.7.

Table 5.7 Emergent themes across cases for the super-ordinate theme 'Emotional labour of death'

Super-ordinate theme	**Cross-case emergent themes**
EMOTIONAL LABOUR OF DEATH	• Professional grief • Internalizing emotions • Shared emotions • Emotional investment • Emotional awareness • Emotional numbness • Being thankful • Seeking closure

Consonant with the iterative process of IPA, as the analysis continued, original super-ordinate themes were reviewed in the light of the new cross-case emergent themes clusters formed. This led to the reconfiguring and relabelling of themes, while both convergence and divergence were sought. During this process, as often happens in qualitative research, I found contrasting views, negative cases, contradictory or odd with the rest of the study participants, that could be a source of ideas to enrich data analysis (Smith et al., 1995). For example, most of the participants highlighted having meaningful conversations, debriefs at the workplace or doing physical activity, such as running, as a way of coping with the death experience. One participant however mentioned to play FPS (first person shooting) video games as a coping mechanism, to relieve the accumulated stress. The emergent theme '**Coping virtually**', describing this experience, was added to the cluster that forms the super-ordinate theme '**Coping with death**'.

As a result, three higher order concepts, nine super-ordinate themes and fifty-eight emergent themes were generated, detailed in Table 5.8. Emergent themes from seven participants were represented in all three higher order concepts, from nine participants in two of the higher order concepts and from one participant in only one higher order concept. This also shows how the richness of data and their relevance to the research questions varied across cases. An example of how and why themes were excluded from the final list can be found in Appendix M, while the original list of emergent themes, super-ordinate themes and higher order concepts can be found in Appendix N and Appendix O.

Table 5.8 Higher order concepts, super-ordinate and emergent themes across all cases

Higher Order Concept	**Super-Ordinate Themes**	**Emergent Themes**
EXPERIENCING DEATH IN THE ED	**ED DEATHS TO REMEMBER**	• Unexpected and unplanned death • Shocking and traumatic death • Child and young adult death • Early career death • Evocative death • Feeling helpless
	OBJECTIFYING AND HUMANISING DEATH	• Auto-pilot mode • Family involvement • Social death • Cultural characteristics of death • Death becomes personal • Positive outcomes
MAKING SENSE OF DEATH IN THE ED	**MEANING OF DEATH**	• Mystified death • Cessation of life • Separation • Loss • Regret • Part of the job • Pragmatism
	VALUES AND NORMS	• Death becomes out of norm • Unfair death • Good death • Ethical dilemmas • Decision to stop • Decision to carry-on • Priorities driven by values
	FAITH AND SPIRITUAL BELIEFS	• Comforting faith • Praying • Better place • Spiritual coping
INFLUENCED BY DEATH IN THE ED	**CHANGED BY DEATH**	• Changed behaviours • Changed priorities • Changed relationships • Empathy • Cynicism
	EMOTIONAL LABOUR OF DEATH	• Professional grief • Internalizing emotions • Shared emotions • Emotional investment • Emotional awareness • Emotional numbness • Being thankful

		• Seeking closure
	COPING WITH DEATH	• Talking and walking • Debriefs • Armour • Avoidance • Blame • Pause • Weird sense of humour • Coping virtually
	LEARNING FROM DEATH	• Pursuing a good death • Providing dignity • Improving patient care • Supporting colleagues • Learning from experience • Training development • Career plans

The six steps of the data analysis process described in this chapter have been visually represented in Fig. 5.10

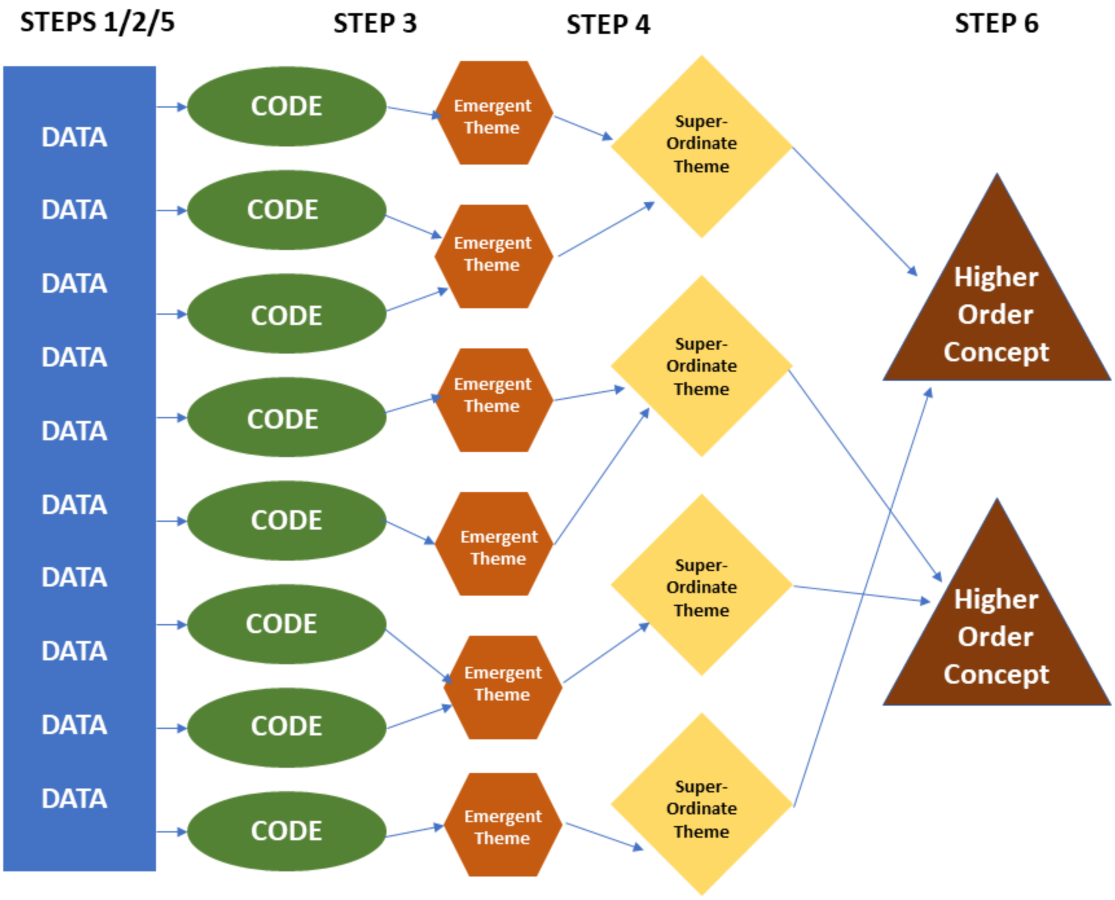


Figure 5.10 Visual representation of the six-step analytic process

5.4 Summary of Chapter Five

This chapter has detailed data analysis using the six steps suggested by Smith et al. (2009) for IPA, focusing on the hermeneutic and ideographic characteristics of data analysis. The whole process, starting with transcribing the interviews and generating the original codes, up to the development of the three higher order concepts, was illustrated through Zoe's case and the superordinate theme '**Emotional Labour of Death**'. The findings drawn from this in-depth analysis are presented and discussed in Chapter Six.

Chapter 6 Findings and discussion

6.1 Introduction

The previous chapter described the process of analysing the data, collected through semi-structured interviews, using Smith and Osborn's (2008) six-step process. The three higher order concepts developed were the result of learning from participants as 'the experts of their own experience', about the content and complexity of their inner world, their beliefs and moral construct, suggested or often made evident through their talk and stories (Smith et al., 2009). Hermeneutics and ideography were used to make sense of the participant's own sense-making, of their own experiences of death in the ED.

This chapter aims to address the objectives of this research study by i.) understanding how the lived experiences of healthcare professionals in ED about death are influenced by personal, cultural, social, moral, or spiritual values and norms, and ii.) to explore what are the healthcare professionals' views on managing, accessing support, coping with, and preparing for such experiences of death in the ED. This chapter seeks to answer the research question: *What are the healthcare professionals' lived experiences of death in the Emergency Department?*

The higher order concepts of '**Experiencing death in the ED**', '**Making sense of death in the ED'** and '**Influenced by death in the ED'** demonstrate the interplay between ED staff's experiences of death. The higher order concepts are presented individually, with their related superordinate themes (Table 5.8), using quotes from participants, to highlight specific aspects or relevant details of the interpretation. This is followed, for each higher order concept, with a discussion placing the findings and reflecting on them within the wider literature. Interpretation of the findings and discussion start with the higher order concept '**Experiencing death in the ED'**, exploring how death in ED is viewed by staff, what are the characteristics that make some deaths memorable and when, and under what circumstances the death of a patient is objectified and/or humanised. This is followed by '**Making sense of death in the ED'**, where the individual meanings of death will be examined, alongside aspects of ethical and moral dilemmas encountered during the provision of care, and how personal faith and spiritual beliefs reflect in these experiences. Finally, '**Influenced by death in the ED'** is examined to understand how the death experience triggers personal and professional changes, what successful coping mechanisms are adopted by staff, what preparation and support would staff require, to face the effects of these experiences, and how emotional labour is expressed in these experiences of death.

6.2 Higher Order Concept: Experiencing death in the ED

The higher order concept **Experiencing death in the ED** incorporates two super-ordinate themes, '**ED deaths to remember'** and '**Objectifying and humanising death'** which are presented individually, then followed by a discussion of the concept in relation to the wider literature. A key element of this study was seeking to understand participant's lived experiences of death in ED. One of the important observations drawn from the individual conversations with participants, in line with IPA, resulting from analysis across cases, was that everyone is 'carrying' certain experiences, as 'lasting memories' of death cases in ED. The super-ordinate theme '**ED deaths to remember'** seeks to explore the characteristics of these cases, trying to find the answer to the question, why some deaths become unforgettable, what makes them so unique, that they leave a lasting impression on HCPs.

'Objectifying and humanising death' endeavours to understand, when and how the objectification of patients who require a life-saving intervention could happen, and how this influences healthcare professionals' death experiences. The influence of cultural and social background of the patient, together with the impact that the grieving family members can have on staff, making the experience more complex and complicated, is presented.

6.2.1 Super-ordinate theme: ED deaths to remember

Participants talked about witnessing death in the ED on a regular basis, on average at least once over a week period, depending on their shift pattern and time spent in the Resuscitation Room (Resus), where most deaths occur. Although this constant exposure to death caused most of the participants to 'get used' to this experience, all participants could recall cases that were 'memorable' for them. Some of the participants, expressed during the interviews that they did not have to think which one to choose, as particular deaths 'stuck with' them. When asked about what specific features makes a death memorable, the most common characteristics described were a child or young adult death; traumatic, sudden, unexpected, or shocking death; death that occurred during the early career or those that resembles a similarity with the death of a family member.

"Probably one of the daunting ones is one that I have broken down after. It was an auntie who was walking her nephew and niece home from school and the nephew was in a pushchair and the niece was on a scooter. They've reached a zebra crossing where a car stopped and the little girl went forward, but they haven't seen that there was a motorbike coming and hit her headfirst. She came in as a traumatic cardiac arrest and I was looking to this little girl while they were doing CPR, cannulate, taking bloods, who has done nothing wrong in her life and is just hanging to life. She passed away and it was horrific because the parents weren't there, only her auntie." (Julie: 118-125)

"There are a couple that stick with me. Quite a lot of paediatric ones that I always think about, quite frequently ... I think we had a 5 month old that drowned in a swimming pool and it was under the supervision of his brother who was 17 or 18 and he found him after 20 minutes in the swimming pool face down in the evening … in a couple of minutes we had another call which was a 6 month old, who was septic and arrested, and we had those both in the bays side by side due to logistics really ... That is something that stuck with me." (Robert: 131-139)

"Every child case will be emotional, but this was the only one where the child was alive at arrival. A child arrives alive they shouldn't die, as it should be something we could do. I guess the emotional toll of this is harder … you still feel that you should have done something." (Andrew: 149-153)

A death that features traumatic characteristics, accompanied by powerful visual elements, often involving the loss of a high volume of blood or other bodily fluids, a severe deformity of parts of the body, a rapid and sudden deterioration, sometimes followed by the patient's verbal and non-verbal reactions, has been accounted by participants as particular cases to remember. A sense of helplessness in such cases, not being able to fulfil their life-saving aim, was very frequent among participants.

"There is another one which is awful, it was a guy with oesophageal cancer, it ruptured some oesophageal varices, and he was bleeding out, so coughing up blood, swallowing blood, vomiting blood and conscious at the same time. And he had metastases everywhere. I remember seeing him in ED and just knowing, that there is nothing we could actually do for him. That was just the most awful visual experience." (Robert:153-158)

Erica, one of the members of staff, who had less than a year of experience in the ED at the time of the interviews, and had started there as a newly qualified nurse, said that she had never lost anyone close to her, in her family or circle of friends. She witnessed her first death in the ED, this lack of previous exposure making this death a shocking experience.

"There was a lot of blood, and I was in some kind of shock as I have never seen anything like that before, I have never seen anyone dead, so it was like … I have never seen a case as a nurse where they don't survive. So, it was really bizarre that we are just leaving it and walking away." (Erica: 113-116)

Death experienced during the early career period, especially if the case resembles traumatic or visually disturbing features, can contribute to being described as 'awful' and 'horrible'. Aaron describes one of his memorable deaths from his early years in practice, as a traumatic death of a patient who was 'making eye contact' with him while actively dying.

"There is definitely one that I had which sticks with me since I was F1 or F2, a very junior doctor … There was this patient that we never met before, didn't knew anything about him and was having faecal vomit … In essence, this guy, unfortunately was vomiting so much, that he chocked, on his own vomit … We've tried very hard to keep him alive and it took him 20-30 minutes to die in his own vomit, which at that time, being an F1, was a horrible experience as he was making eye contact with me while he was going and going, and he had glassier eye. It was pretty awful ". (Nicholas: 77-88)

Most participants gave accounts about experiencing death in their personal life, prior of start working in ED, and how that affected them. While some suggested that they were not reminded by these deaths while working, others often spotted a similarity with a deceased relative or even themselves. A similar age, physical features, or the medical condition of the patient, could make these cases feel connected to a personal experience, tapping into personal fears for self and for loved ones.

"Since my mum died, I notice more similarities. Especially when cases are similar. When there is a patient of similar age or similar diagnosis. She was a terminal cancer case that was diagnosed very late." (Isaac: 60-62)

"For example, we had a cardiac arrest in Resus. Young, 47 and I was thinking, this could be me." (Zoe:97-99)

Participants often expressed their feelings of being more empathetic towards dying patients and their families, when there is a similarity that reminds them of someone close to them, such as a parent or a sibling, or a particular case when someone close to them died.

"If the patient is your personal age, like the other day there was a patient, very similar age to me, so you make the connection that that's me. Then if it's my parents age I connect them with my parents. For example, we had a patient passing away, her sister came in saying 'Please don't let her die, we are best friends.' You see, I've got a twin sister, you empathize in that respect." (Margaret: 120-124)

Participants talked about a substantial difference between a death that can be anticipated, in comparison to the one that occurs without any warning. These sudden and unexpected deaths become memorable because often staff establishes a relationship with the patient, they build a rapport, determine a course of action or treatments before they die. These outcomes, that suddenly deviates from the original plan and the purpose of their role, are seen as shocking and are interpreted as impacting significantly on participants.

“He had quite a few comorbidities and he had full-time carers. I had a bit of a rapport with him. Unfortunately, he suddenly arrested, which although he was unwell, he wasn’t looking that unwell. It was quite a shock, I guess and obviously we’ve tried everything we could to bring him back, but unfortunately, he died.” (Rachel: 116-120)

“I think the ones that made the most significant impact for me were those who, I wouldn’t say were clinically well at the time, but I had an interaction, a bit of rapport and they suddenly deteriorated, I think those are the ones that stick with me the most … when it’s really unexpected and out-of-the-blue and that’s when it’s difficult.” (Charlie: 113-118)

Some participants often described deaths becoming shocking to them, due to their randomness, and inability to find a meaning or a sense in them. As participants considered that some of these deaths could have been probably avoided, this made these deaths hard to understand or ‘resonate’ with them.

“*It was this lady in her seventies, she was an antique’s dealer, she was just shopping on a Saturday morning, was driving home and for whatever reason she was on the wrong side of the road and hit another car head on, but they think she might have had a stroke at the wheel … There was a man in his early seventies, but had advanced dementia, and he choked to death on a sausage … Then young people coming in with brain haemorrhages, they are fine, then they have a headache, you just see such a wide range … there are these ones that resonate with you.*” (Margaret: 195-213)

Some deaths experienced by the HCP combined several memorable features, including young age, severe trauma and being unexpected, often referred to by participants as being ‘horrific’ or ‘horrible’.

“But then you also see definitely the horrific, the horrible deaths that don’t make you feel warm inside, but upset and sad. So earlier this year there was an 18-year-old girl who was in a boat crush and she came in very poorly and despite everything we did, we couldn’t save her … so that is one that will definitely stay with me forever. It was really sad.” (Margaret: 174-191)

6.2.2 Super-ordinate theme: Objectifying and humanising death

Death can be a complex experience in the ED, where patients sometimes could be objectified and later humanised again. This experience is often characterized by providing care and life-saving treatment in an ‘auto-pilot mode’ or when death ‘becomes personal’ by discovering the person behind the patient, through communication with the family or through learning about their social and cultural background.

Many participants described their ‘natural’ way of dealing with a patient being in a life-threatening condition, as an ‘auto-pilot mode’. This describes a highly alerted and very focused state of the mind when all effort is put into saving the patient’s life. Technical skills are prioritized, such as resuscitation techniques and often an ‘objectification’ of the individual happens, to increase efficiency. This state is usually maintained until either the patient resuscitation is successful, fails or a decision is made to stop. Participants described following a ‘script’ or a ‘protocol’ during resuscitation, as making them feel being less exposed emotionally to the situation.

“Because when they come in arrested, you just automatically focus on the patient and there are no emotions there, you just automatically have to save their life.” (Zoe: 39-41)

“I think we just have to save this patient’s life, and sometimes we just go like in action, like an auto-pilot because this is what you are trained to do.” (Zoe:215-216)

“You know we have some people who are extremely clinical, we come together as the patient is almost an object, let’s do this, let’s do that, everything is structured but when it comes to the holistic side of things, it all goes out of the window.” (Charlie: 312-315)

“I remember once I was doing chest compressions on a 4-year-old and the family was there, and obviously the family was very emotional and screaming. And I was thinking, all I am concentrating was to make sure I am doing the depths of the chest compressions right … I knew my job was to do this, I was very focused on doing that. In those situations, I am fine, I am very good in focusing on the actual practical things rather than the emotional part of it.” (David: 128-132)

Once resuscitation stops and the patient is declared dead, with family members being present or often arriving later, participants described this state as a quick, sudden transition from seeing the individual as a ‘patient’, into seeing them as a ‘person’. The catalysts for this transition are often the family members, who through the after-death conversations will humanise the deceased. This transition was often described by participants as being difficult.

“I knew that that’s going to be difficult when they arrive and it was because suddenly you go from a professional, not lack of emotions, but a professional ‘we are going to tick these boxes, we are going to make sure to address everything we can’. And suddenly this person arrives who is a human being, with feelings and I remember that being incredibly difficult.” (Robert: 143-151)

“The only time I get upset probably is when I see the reactions of the family because that’s when it really hits home about … ahh this is a family member and then I can put myself in their position. That is the only time when I can feel a bit of emotion.” (Christine: 323-326)

Witnessing intense emotional reactions from family members while delivering the bad news to them, could further develop the complexity of the death experience for HCP's. Some of these experiences were described by participants as being the most difficult parts of the bereavement process, contributing for that death to become memorable.

"We and the consultant who was running, went in to meet mum and dad, and we break the bad news, and the scream that came out from that mum's mouth, will stay with me forever. I've never heard a mum make that noise about her child. It's just awful to think about. It was probably the most shocking one that makes you feel sick … It was about 2 years ago now, but it stays with me." (Christine: 361-371)

Beyond a combination of features that will make a death a difficult experience, according to participants of this study, intense reactions of the family and relatives will add to the depths of that experience. At this stage the patient appears as part of a larger social structure, reflecting in the relationships presented or the stories told by relatives, where their death leaves a void, an emptiness.

"The worst part for me is the relatives when they are crying and mourning and shouting, all this expression of pain they have, this is the worst part for me." (Annabelle: 67-68)

"So, I was just watching the chest compressions … Then eventually, the consultant came in and kind of said that we need to stop. The parents were just sat there, and it was horrific as they were screaming" (Erica:109-112)

"Dealing with the family is probably the hardest bit. When a person is dying and telling that to the family is probably the toughest bit." (William: 251-252)

Some participants described death not only as a biological process, but suggested that death occurs earlier, before the physical death, when the patient stops interacting or the person they used to be disappears. This description of 'social death' suggests that the individual is considered dead or non-existent, and experiences a loss of identity and connectiveness, and even the act of grieving can start before the actual biological death occurs.

"I have been criticized before saying this, but for me, people die as a person before they physically die, when they stop interacting with you and stop being the character you know. For me there is an emotional disconnect at that point, for me that person is gone, it become someone else or something else at that point. The mourning can start even before they die." (John: 44-52)

Participants have acknowledged that dealing with death, mourning, and grieving can vary depending on the cultural background of the patient and their close family. Cultural awareness is important, as many aspects of grieving, displayed by family members, could feel alien, something that HCP's, especially born and raised in a Western society, does not feel used to or comfortable with. Reactions of the family members, depending on their cultural background can range from loud screaming or the gathering of a larger crowd in the clinical area to mourn their loved one.

"I had people who got very hysterical even they knew this is going to happen. Some are very cultural. One patient's relative, who passed away, just absolutely freaked out, hitting themselves, shouting at me, stuff like this. Or I had someone who grabbed me and put their hand over my mouth saying: "Don't say it, don't say it." Just a total hysterical reaction. Me and the senior sister were in there and we understand that in different cultures, certain generations do respond like this, for example hitting themselves as a sign of their grief, something that I have never actually seen before. It's been really bizarre." (Nicholas: 161-170)

"You had quite large families turning up of 20-30 people, it's difficult isn't it, for us in healthcare, in England specifically, culturally, we are a bit like, that is too much, that does not feel comfortable to us. We haven't worked in other countries, and we haven't experienced death there. In some places the whole village will turn up in a hospital if someone dies." (Robert: 112-116)

Some deaths were memorable to participants because of being perceived as having a 'good death'. These deaths were perceived as dignified, because they conformed to societal and cultural definitions of a dignified death from their perspective , patient and family wishes were respected, family had the opportunity to say their goodbyes, pain and symptoms were kept under control, and all unnecessary treatment was avoided. Some participants even suggested that we always seem to look to death 'as a negative', while such positive way a death was managed should be role modelled, when achieved in the ED.

"There was a lady … we knew she's going to pass away quite soon. So, putting her on a hospital bed, making her comfortable, getting her pillows, keeping her warm, brushing her hair, making sure she's clean, giving her a freshen-up, these are the things we can do for her. Making sure she's not in pain, giving her a small amount of pain relief making sure, she's not suffering in any way. Turn the lights down, put her in a side room, making it quiet, maybe put on some music on, of that era, something that suits her, because obviously she can still hear you. Talk to her, hold her hands. Getting the relatives in, find out who their relatives are, inform them, get them in as soon as we can, make sure they can sit with her. Offer them a cup of tea, give them all the information they need. Answer any question that they have, give them the written information they need. Make sure they are not alone and that they are comfortable, offer a spiritual or religious leader, should

she need one. So, I think even in ED we can make end-of-life care really-really good, and I have seen that myself and I have enjoyed it, maybe that's not the right word, but just being part of it." (Margaret:149-172)

6.2.3 Discussion: Experiencing death in the ED

The higher order concept **Experiencing death in the ED** is characterized by two super-ordinate themes, '**ED deaths to remember'** and '**Objectifying and humanizing death'.**

The findings of this study were that death often leaves memories which can't be erased, sometimes for years. Some characteristics, such as being the death of a child, being traumatic or unexpected, so that the experience often becomes a death to remember**.** Greater exposure to death has been found elsewhere to be directly associated with greater levels of stress, for example, in a study of oncology care-providers (Whippen and Cannelos, 1991). Results of a further study has shown that the three most distressing events ED Nurses are repeatedly confronted with, are cot death, incidents involving children and dealing with patients' relatives and family (De Clercq et al., 2011). Deaths that are shocking and unexpected by their nature, are known to generate more distress and result in a deeper psychological trauma than natural, planned or expected deaths (Jackson et al., 2005). A study reported that 61% of doctors who witnessed 'memorable deaths', including death of young patients, death that lacks dignity or death of a patient where a strong personal relationship pre-exists, that death remains emotionally distressing, triggering strong reactions, including, but not limited to stress, guilt, feelings of numbness and feeling upset (Linklater, 2010; Redinbaugh et al., 2003). ED doctors specifically report insomnia, fatigue, sadness and disappointment after facing unexpected deaths (Redinbaugh et al., 2003; Meier et al., 2001).

Consistent with these findings, another study reported that 49% of the interviewed doctors, as a consequence of patient death, expressed distress or fear, while almost 12% reported symptoms of Post-Traumatic Stress Disorder, with 30% experiencing symptoms of either re-experiencing, avoidance, and arousal in relation to death (Mills and Mills, 2005). Factors that influence the intensity level of these emotional reactions include, the age of the patient, cause of death, and presence of the family (Strote et al., 2011). These effects are also be influenced by the level of training and years of experience a doctor has (Jackson et al., 2005). These findings are in line with another study which compared registered nurses' death anxiety and concluded that nurses' emotional distress was lower as age, education, and nursing experience increased (Deffner and Bell, 2005). Beckstrand et al. (2008) argues that one of the reasons a death in the ED has a significant influence on HCPs, is when that occurs unexpectedly, is traumatic or have a rapid course, HCPs often not having the opportunity to prepare themselves emotionally for such events (Beckstrand et al., 2008). My empirical study similarly reports that the death of a child or young adult, a traumatic and unexpected death, a death that is witnessed by HCPs at the beginning of their career, or a death that displays a similarity between the deceased and themselves or a family member or friend had a considerable emotional and psychological influence on participants. The novelty of the findings is related to these specific experiences leaving a lasting impression, becoming memorable for HCPs, often described as being ‘stuck with them’.

My empirical study reported that death in the ED can become a complex experience, requiring staff to suddenly transition from an ‘auto pilot’ life-saving mode, into recognizing the person behind the patient, particularly when interactions with the family are difficult or when death is accompanied by culture specific reactions. Batley et al. (2017), similarly described their clinical work as ‘auto-pilot mode’, before meeting the family. Medical students referred to their emotional investment being less accentuated when performing CPR, or clinical interventions on dying patients, compared to when they’ll meet the family of the deceased, and get to know the ‘person’, behind the ‘patient’. This task-oriented approach often served as a defence strategy, against the feelings associated with death (Batley et al., 2017). Di Leo et.al (2019) similarly argues, that whenever staff is concentrating on practical tasks, that involves a protection, a shielding from acknowledging the challenging emotions surrounding death. The same shielding from painful emotions, was observed by Bailey et al. (2011a; 2011b;2011c) in the ED nurses, in the form of using a language that avoids acknowledging the deceased patient as a ‘person’, referring to it only as a ‘body’, and also an avoidance of meeting family members in an attempt to stop the ‘body’ becoming ‘real’. My study argues that the objectification of a patient does not only happen to protect HCPs from the emotional challenges surrounding death, yet often is a sub-conscious or even conscious decision during the resuscitation process, putting the emotional connectedness with the patient or the family aside, in order to follow an algorithm, aimed to save the patient’s life. My research reaches to a similar conclusion, that often meeting family members, is the point when the ‘objectified’ patient is ‘humanised’ again.

Participants of my empirical study often talked about the cultural aspect of death, how for an HCP raised in a Western society, certain mourning rituals of family members, made them feel uncomfortable, or sometimes these even appear to be ‘bizarre’ expressions of grief. Participants interviewed often argued that learning about cultural-specific grieving rituals would help them better support families, especially when breaking the bad news. Naik (2013) suggests that family members can respond to the death notification of their loved one, in various ways, depending on a series of aspects, such as the patient’s age, existing comorbidities, reason for commencing CPR, overall emotional state, spiritual norms and cultural values, that impacts their attitudes towards death and dying. The cultural identity of an individual incorporates a series of elements, including self-identity, language, beliefs, traditions, religion, and their wider value system (Naik 2013). Breaking the bad news to the family, holds a higher risk of increased stress level and strong emotional reactions, according to McClement et al. (2009), when death is a result of a suicide, a criminal event, traffic accident, or when it is the death of a child. Roe (2012) makes a similar observation connecting adverse family reactions with the age of the patient, the opinion that the patient died prematurely, or the suddenness of death. Application of end-of-life strategy and bereavement care in ED, is often limited by anger or agitation displayed by family members (Heaston et al., 2006).

A study of 11 Iranian nurses and doctors, from six hospitals, working in emergency or critical care, were interviewed about their experience with death notifications (Hassankhani et al., 2018). The study found that beyond, the cause of resuscitation, the age of the patient, and the current emotional state of the family, ethnicity and cultural background plays an important role, in what their reactions will be. The study acknowledges that Iran has a rich ethnic and cultural diversity, and each of them has their own individual death rituals and their unique attitudes towards the process of dying (Hassankhani et al., 2018). According to HCPs, the death of an older patient, who’s death was expected, is accepted usually in a calm and quiet manner by family members, and communication is more efficient with those who have a ‘non-aggressive’ personality and higher education level. On the contrary, with certain cultural backgrounds, it is common to experience from family members, verbal or physical aggression towards hospital staff, and often severe emotional reactions such as screaming or self-harm (Hassankhani et al., 2018). Strategies adopted by staff to notify the family about the death of their loved one, included talking softly and gently, using physical contact when appropriate, informing only the male members of the family, or talking with the wider circle of family only, allowing them to break the bad news with close family members, such as a parent or a spouse (Hassankhani et al., 2018). Participants of my empirical study often noted that Britain is a multi-cultural nation, and staff can be exposed to unusual, unexpected or extreme reactions from family members, during the death notification. Understanding the relationship between the grieving process and cultural characteristics, is crucial in better preparing staff for the death and dying experience.

Participants in my study sometimes referred to death, as something that happens even before the biological cessation of life, when the patient stops interacting, when they stop being the person they were before and when an emotional disconnect surfaces. Sudnow (1967) described the term ‘social death’ as the moment from which the dying patient is considered by clinical staff as being ‘already dead’, surrounding him with a ‘special treatment’, which could include termination of active treatment or commencing of religious rites. Králová (2015) argues that social death can be described by three significant characteristics, which already compromised the individual's wellbeing: loss of social identity; loss of social connectedness; and losses associated with deformity or disintegration of the body. Lock (2002) suggests that experiencing social death, involves someone undergoing a loss of moral entitlement. Another frequent example can be found in cases of cardiopulmonary resuscitation, when the perceived social value of a patient, regardless of the chances of survivability, influences a doctor's decisions to resuscitate (Timmermans, 1998). My study reflects on HCPs experiences who often consider a patient, being 'already dead' when they cease to be the person they were before, or when they stop interacting. Decisions to continue resuscitation, being influenced by the social value of an individual, such as a child or young adult was also confirmed by my study.

A crucial aspect related to the death and dying experience, both for the staff, also the death notifier, and the family of the deceased, also the recipient of the death notification, is related to what were the circumstances of death and how the information is shared with the family (Adamowski et al., 1993; Stewart, 1999). Deaths that have sudden, traumatic, or even violent causes, including murder, suicide, road accidents, accidental overdose or work-related severe injuries potentially have long-term effects of stress and discomfort on staff (Marco and Wetzel, 2012; Hobgood et al., 2013). Similarly, family members who cannot find meaning in their traumatic experience, could be more exposed to experience long-term psychological distress, post-traumatic stress and psychosomatic disorders (Neimeyer et al., 2002; Armour, 2003). Participants of my study, describing some of their death experiences as 'shocking' or 'horrifying', often triggered by the visual aspect of the dying process, described various physiological and psychological effects of these experiences, from difficulties sleeping, up to severe emotional distress.

Studies highlight the importance of death notification, especially if death had an unexpected, traumatic aspect, which if not done adequately, can have a significant influence on the bereavement process (Mitchell, 2008; Parris, 2011; Baumann and Stark, 2015). Tuffrey-Wijne and Rose (2017) argues that the psychological, physical, and social characteristics of the individuals who are going to be notified, should be taken into consideration to evaluate potential health risks, for example individuals with cognitive disabilities are often not notified of a death, being over-protected. The notification process is perceived by staff as a difficult and stressful event, especially in the light of shortage of educational material on how to deal with sudden death and how to handle painful communications in a sensitive, empathetic, respectful, and compassionate way (Smith et al., 1999; Ombres et al., 2017). Lack of training to facilitate preparation for the death and dying experience, has been mentioned regularly by the participants of my study, discussed in more detail as part of the final higher order concept, '**Influenced by death in the ED'**.

My study contributes to the knowledge by reporting on the experiences of death in the ED of HCPs, discussing those characteristics that make a death experience memorable, with a lasting impression even for decades, including the death of a child or young adult, a traumatic or sudden death, an early career death or a death of a patient that draws similarities to HCPs, with themselves or someone close to them. Objectification of a patient, as a measure of 'isolating emotionally' to better perform during the resuscitation of a patient, avoiding potential 'distractions' from a life-saving procedure, have been also discussed, alongside humanising the same individual, when meeting family members.

6.3 Higher Order Concept: Making sense of death in the ED

The higher order concept '**Making sense of death in the ED'** endeavours to explore three super-ordinate themes, as supporting pillars for this second concept, '**Meaning of death'**, **Values and norms'** and **'Faith and spiritual beliefs'**. One of the objectives of this study was to understand the influence of personal, social, cultural, spiritual and moral values and norms, reflected in the experiences of death of HCPs in ED.

'Meaning of death' seeks to explore ED staff's interpretation of death, beyond the biological or clinical description. Views of participants in this study ranged from a 'mystifying death', seeing death as a loss or separation, through to being pragmatic, perhaps considering death as being 'part of job'. **'Values and norms'** describe which personal values are reflected in the death experience, such as seeing death as being 'unfair', 'good', or 'out of norm'. This section also explores the ethical and moral challenges and dilemmas staff face when dealing with death, and how clinical priorities can be shaped by personal values. Finally, '**Faith and spiritual beliefs'** discusses how personal beliefs, religious views or spirituality can affect the way HCPs cope with the experience of death in ED. It examines how these views can provide comfort and protection against the negative impact of these experiences and in what way are able to shape the provision of care.

6.3.1 Super-ordinate theme: Meaning of death

Understanding participants values started by exploring what death itself meant to them, and how they defined it. Some talked about death as a complex phenomenon and being difficult to describe. Erica, for example, had no personal experience with death in the family, prior of starting to work in ED, described her sense making of death, as being mystified by it.

"I thought of my two experiences in ED, I had no previous experience with death, no family members, no friends, touch wood, I had no real concept of it, it was just black and white, you die, that's it, I could imagine it must be horrific, but I didn't really knew what it be like. That was something, even as a student, I was always very worried happening, while I was a nurse, as I have no experience of what is like for someone to die." (Erica: 72-76)

More experienced members of staff, in a senior role, also referred to death as something which has no clear description. Christine, reflected on death suggesting that the more she learned about it, the less she knows about it. Giving death a generalised definition is almost impossible as it is an individual experience.

"The obvious description of death is a human passing away and departing to heaven or whatever, depending, if they have a religion or not. There are different ways in which people die, different environments in which people die, some people react differently to death, family, friends, colleagues. So, I don't really think there's a clear description in my opinion but people could have a different understanding of it." (Christine: 116-121)

For some participants death represented nothing more than a pragmatic reality, simply ceasing to exist. Participants sharing this approach, viewed death as a cessation of biological processes, activity of the body, a natural, scientific state. Often participants when expressing their views on death, expressed their spiritual 'standpoint' at the same time. Those defining death purely as a biological process, referred often to themselves as 'atheists' or as someone who doesn't share any religious views.

"So, death for me means not existing anymore. So that means to me that your heart is not beating, you are not breathing, and you have no brain activity. That's what death means to me, it's an endpoint. I don't have religious beliefs, I don't believe in an afterlife, I'm an atheist, so when you die that's it." (Robert: 66-69)

"But death for me is quite a scientific thing, something happened, and this person is not alive anymore. As I said I don't have religious beliefs, so I don't believe in afterlife." (Isaac: 35-36)

"I think death is a natural part of life. For me it's just a natural thing that will happen to all of us. It's a natural end to a life." (William: 60-63)

Similarly, those seeing death as more than a natural process, part of something greater than the end of biological existence, identified themselves predominantly as holding Christian beliefs.

Death in their view is described as a ‘separation’, or ‘being with God’. Death for some participants even meant the beginning of a new life.

“Death for me is when a person is no longer alive in a physical sense. Yet from my perspective as a Christian, it is more to us than just a physical body. So, death is a separation I guess between the physical body and the essence of a person, that being which is no longer present in a physical body. And you can tell, you know, when somebody dies that they are no longer there and there is something that is gone and no longer there.” (Adam: 48-52)

“I think death is … losing someone, but in a way as well … I think it’s a new life, being with God, I think so.” (Zoe: 74-76)

Other participants, who did not identify themselves as being religious or upholding a faith, still associated death with spirituality, referring to it as a departure to a ‘better place’, where pain ceased to exist. Charlie, for example highlights that experiencing death regularly developed the need to find a meaning for this phenomenon.

“Interviewer: What does death mean to you personally?

Participant: This is a very good question, it’s one that I often ask myself a lot of the time. Especially when we deal with it so frequently. The whole honest answer, I wouldn’t say I’m religious, I appreciate religious values and I would say I am spiritual in a sense, I’d like to think it’s someone going to a better place without suffering, without pain and they are going to be with their loved ones.” (Charlie: 66-69)

One of the frequent interpretations of death given by many participants, was that is a component of their everyday job in the ED. This suggests that death, in this line of work, is perceived as something not ‘out of the ordinary’, something to be expected, even if the circumstances of the death are unexpected.

“From a work point of view, I see it as part of the job, something that we expect to see and I realize when we have people coming through our department and haven’t experienced that and can have a very different emotional response to it. But I see it as a fundamental part of what we do.” (Andrew: 52-55)

“I often see horrific things, but I say that’s the job.” (Julie: 72)

“It has become so, normal for me as a nurse and probably as an ED nurse, that it’s part of the job” (Christine: 322-323)

Participants, sometimes following prompting for a more diverse description in the interview, often described death as an event that has wider implications psychologically, emotionally, and socially. The euphemism ‘loss’, used for death, suggests a void that a person leaves behind in their family, job, society, and the world. Death was often viewed as being very difficult for the grieving family with complex ramifications in all areas of life.

“I think death has a massive impact, emotionally is difficult for everyone losing a loved one, a person who’s had a life for I don’t know how many years, has made an impact on society, on the world in some way and they are no longer there, leaving their family, friends, job …” (Margaret: 81-83)

“Death to me is something that is exceptionally sad and it’s life-changing for the people that are left behind.” (David: 88-90)

6.3.2 Super-ordinate theme: Values and norms

Whenever participants referred to death using an adjective, such as ‘normal’, ‘good’, ‘common’ or ‘natural’ they associated their own values and norms with that definition. Most participants associated the death of an elderly person as ‘normal’, while the death of a child was described differently. When death occurred due to ‘natural’ causes that was labelled as ‘good’ or ‘normal’. Conversely, when death occurred unexpectedly, at a young age for example, not allowing for that person to mature, death was seen as out of the norm.

“So, death at old age is a normal thing, that’s a normal life thing. It’s a common thing, we all die at the end of our life, depending on what life path we’ve had. When older people die just of natural things, that is a good place to be you know, I think. It’s not always necessarily a bad thing. I think when death is sudden, unexpected, it’s a shock, I would describe it because, when a child dies. Suddenly and unexpectedly, I would say that is a big shock because that is not a natural life path, like a young person it should grow old, if that make sense.” (Mary: 71-76)

One of the frequent classifications that reflects personal values and norms associated with death, were the notions of ‘good’ and ‘bad’ deaths. A ‘good death’ is associated with dignity, comfort, not being exposed to pain and suffering, not having ongoing futile and unnecessary treatments, and preferably dying with the family members present, whenever possible, in a familiar environment.

“I want people to have a good death. I think for me that means hopefully pain-free, hopefully free of unnecessary interventions, I prefer it if they could die at home. And I think recently we have managed to do that a few times recently which is being good I guess.” (Robert: 215-217)

Stopping active treatment of a patient, was an aspect described by some participants as the most challenging part of the death and dying experience. Described often as a ‘difficult balance’ between clinical judgement, family wishes and patient’s interest, these decisions were infused by the professional, institutional, and personal values of the individual. Often families will require from ED staff to initiate treatments that will not change the outcome, only will prolong the dying process, potentially undermining the possibility of a dignified death. Families however, may use these opportunities to cling to any final hopes of recovery and delay saying goodbye to their loved ones.

“So, it wasn’t unexpected just a really challenging process to bring them to the same page where we were. I wouldn’t say we ED doctors are blunt, but we are very honest about a patient’s condition, but the family was not on the same page at all. There was a lot of talking about what we can and can’t do and, actually to come in say goodbye to him. He was with us for 12 hours in Resus, and we didn’t felt that there is anything else we could do to alter the course.” (Andrew: 108-113)

Experiencing death in the family, and being influenced by personal values, can have an impact on how someone defines death, and how that reflects in their clinical practice. Zoe moved to UK from the Southeast Asian region, and she was working in the ED when her grandparents died. She was unable to travel home and see them while they were still alive. She talked about, how she would have wanted to hold their hands, and offer them peace in their last moments, as that felt ‘the right thing to do’. This event influenced her definition of a dignified and ‘good death’. Therefore, in her practice, whenever she deals with dying patients, she endeavours to offer them opportunities to spend time with their family, even at the expense of delaying the transfer of the patient to the operating theatre.

“If the family is here, I try to make sure, they see them before they go to the theatre, as you don’t know if they are going to make it, so that is really important for me. I would argue even with the doctor if they don’t want to, just even a minute on the corridor, just to hold their hand. It’s important to see them, because you can never know if they are going to make it in the theatre.” (Zoe: 247-251)

Nicholas describes his experience with the family of a patient who died a very traumatic death, in relation to a complex moral dilemma. As the family was asking about the circumstances of death, Nicholas knew he didn’t want to lie, however he also does not want to expose the family to unnecessary suffering either. His immediate reaction to this complex situation was wanting to avoid it.

"I remember how I had a conversation with the family afterwards as well. I have been asked really hard questions by the family about what happened, and I had to go to the post-mortem. I remember they've asked me a really hard question: "Was it quick?" … Wow … Ahhh … You didn't want to lie to them but how to say the whole truth about this guy chocking on his own vomit. I certainly wanted to run from that situation." (Nicholas: 88-93)

Trying to find a meaning to 'justify' the death of a child is sometimes part of the acceptance process of that death. Sometimes this meaning is found in the physical characteristics of a child, being more vulnerable and fragile compared to an adult. Another factor that makes the death of a child difficult, is the thought of how parents are going to cope with this event, as it goes against the social norm of parents dying before their children.

"I think if an adult would have been hit by a motorcycle, they would have survived, and I think I wouldn't felt so bad, because the outcome would have been different. They would have probably gone for a surgery, but they would have survived." (Julie: 148-150)

"With the kids it's always the thought of the impact on the parents and just knowing that two hours just changes everything forever for them. I think before being a parent I was cognisant of that." (Robert:162-164)

A child's death was often linked by participants to a moral duty and an ethical responsibility, that somehow, something needs to be done to save that life. Other times the death of a child left a feeling of void and emptiness in participants, often avoiding facing their own feelings after the event.

"I found it really hard, I have never been involved in a case that took so long for a child to end up dying. What I found really hard, is what to do next, once the case is finished. Everyone steps down, the team disperses, the parents are there with the child and what do you do now? I've been doing this all morning and what I did was, I had a drink, and I went to see another patient. Which I think it was the worst thing I could have done …" (Andrew: 83-87)

A sudden death was often connected by participants to the age of the deceased patient, and the societal expectation that comes with it. Someone of a younger age, fit, socially and physically active was not expected by participants to die in the ED. Assumptions of the participants, that align with societal expectations about death, were often reflected in these accounts, referring to some of these deaths as being 'acceptable' or 'exactly the opposite'.

"These ones are less predictable to end in a death, they are much more unexpected … Young people, being more active, not being at the end of their natural life, I guess makes it more

memorable, compared to the ninety years old coming from a nursing home with a cardiac arrest, it's even more acceptable, isn't it?" (Isaac: 124-130)

Conversations with patients and family members, surrounding the very fact that they are dying, could raise several ethical and moral dilemmas. Telling a patient that they are actively dying or telling the family the truth about the real details of a traumatic death, often put participants in an uncomfortable position, where their decision how to pursue that situation was guided by their ethical and moral standards.

"I find it actually quite hard telling someone that they are dying because it goes against everything you want to do as a doctor or nurse, trying to make them better, and part of me feels like, do you want them to know that, but then it's not your right to deprive them that information, because they need to know that really, but I find that quite hard to have that conversation." (Adam: 227-231)

Life-saving interventions in the ED are often continued, despite knowing it's futile, for the sake of the family being present, or in some cases for the sake of staff. When the condition of a patient reaches a point, where every further treatment or intervention proves to be unsuccessful, the decision to continue a resuscitation is not based on clinical judgement, but moral principles, especially when family members are also present. As one of the participants described it, at that point the focus of the care shifts from the patient to the family. The decision to carry-on with a procedure or treatment is to offer comfort and peace of mind for family members, knowing that the clinical team has done everything in their power to save the patient's life.

"And the hardest part is when you bring that family in and resuscitate that child even though you know it's futile and just doing compressions for the mum to see and then stop. That is probably the hardest thing." (Mary: 374-375)

"Everyone came to realize that this child is too sick to move, but you continue resuscitation as the parents were there. Yet this case turned into a focusing our care on to them. He was probably four hours with us before we've stopped resuscitation." (Andrew: 80-84)

Ethical dilemmas surrounding death and dying can arise in various forms in the ED. William, one of the doctors interviewed, describes two different experiences with two different outcomes. In the first he describes a case where, despite all efforts of the team, the decision was to stop all active treatments for a patient and let him slowly die. He was expected to see other patients and walking away from that dying patient, made him feel guilty. In the other similar case, he argues that while it is sad that he as a doctor, can't spend more time with a dying patient, yet in the reality of ED it's 'unfair' towards the other patients, to delay their treatment.

"Looking back, I feel guilty about this, when I look back to that situation. Because I walked away, I almost feel that my actions were almost inhumane, because I walked away from this man who was taking his last breath and I carried on with my life." (William: 128-129)

"I know it's a very difficult ethical situation, but it wouldn't be right for me when a patient needs that loving support, yet it wouldn't be fair if I am one of the 2 registrars on a night shift to stay with this patient for the next hour. It is not feasible in reality. It is not possible, so I can't do that basically." (William: 155-158)

6.3.3 Super-ordinate theme: Faith and spiritual beliefs

Participants often expressed their views about death, as being portrayed in the Western culture as being an event surrounded by sadness. Some participants talked about the need to concentrate on the positives of a human life and re-focus from the sadness of the moment. For many participants, the belief that the deceased patient is going to a 'better place', a place without pain, suggests that this offers them mechanisms for coping with death. A protection against experiencing a range of negative emotions associated with grieving and a comfort that helps with coping.

"I would say I am more and more open to perspectives of how people are seeing death. I am fascinated how historically we used to celebrate people dying, you know going to a better place. Especially in other cultures it's a celebration of life … we should look at the positives and I think to have that you've got to believe that wherever they are going it's a better place, where they are not in pain." (Charlie: 257-260)

Participants who defined themselves as having faith or religious beliefs, often talked about the influence of their spirituality on their experience with death. Julie, who works mostly with children, defined her faith as a support in maintaining a positive, optimistic view and remaining empathetic. Her spirituality played an important role in not developing avoidance as a coping mechanism. However, her values influenced her views on accepting some deaths as being 'normal', while others were seen as out of norm.

"Interviewer: Do you think without this faith your experience would be very much different?

Participant: Yes. Probably I would be either more pessimistic or I couldn't be bothered, saying that it's just a life there are many more in the world. When an elderly comes in who dies my 'work me' *says that they had a good life, it's normal that they died at that age. But when a 20-year-old comes in and dies, the Catholic me says, that's not fair, that's not God's plan."* (Julie: 65-69)

Often faith and personal values were put to test and their validity questioned, when a death apparently was meaningless for participants. Yet, the same values contributed to them finding comfort and meaning.

"I didn't understand how a beautiful girl who didn't do anything wrong in her life could lost her life so tragically … And as a Catholic you go against your religion, asking 'Why are you doing this?' Like adults, old people fair enough take them, but children? And you do question your faith sometimes, saying this isn't fair. But it's all in His hand." (Julie: 128-133)

Praying as an act of faith was often used by some participants, as a method of coping and processing difficult, traumatic situations, when experiencing the death of their patients. Prayer was not only defined as an act to restore personal confidence, but it was used also as part of the holistic care provided to the grieving family.

"And sometimes I do crossover and I am standing next to a bed, and I am praying quietly, because that's my belief, to ask for help and strength for myself because I see horrific things." (Julie: 56-58)

"When they come here, the viewing room, I pray for them, silently … I just stay there and pray for them. I do. I don't know what religion they are, but I pray for them." (Zoe: 205-208)

6.3.4 Discussion: Making sense of death in the ED

The three super-ordinate themes '**Meaning of death**', '**Values and norms'** and **'Faith and spiritual beliefs'** were ways in which people are **'Making sense of death in the ED**'.

In my empirical study HCPs described their personal views and understanding of the meaning of death in multiple ways. Some described it as something difficult to comprehend, or purely as the end of biological processes in the human body, while others have associated death with fundamental changes in the psychological, emotional, social, and spiritual dimension of all those involved in the process. Understanding death is deeply rooted into the philosophical investigation of two questions. The first question is conceptual or ontological, 'What is human death?' and the second questions is epistemological, 'How can someone determine that it has occurred?' (Green and Wikler, 1980; Halevy and Brody, 1993; Veatch, 2019). However, philosophical debate about death is not limited to these two questions, as a deeper understanding requires an exploration of how the death of a human being is related or connected to other living beings, and if death reaches beyond biology, along what wider basis should be defined? (Bagheri, 2007). Historically a patient who suffered a severe injury of the brain and brainstem, resulted in a respiratory failure leading to cardiac arrest, which in return if it was prolonged, led to an irreversible loss of brain function (Veatch, 1976).

In the *traditional approach* death was the irreversible cessation of cardiopulmonary function, and as such an irreversible cessation of functioning of the organism as a whole, others also conceptualizing death, in more spiritual terms, as loss of the soul (Becker 1975). The *whole-brain approach* defines human death as being an irreversible cessation of functioning of the entire brain, and this also includes the brainstem (Becker, 1975; Bernat et al., 1981). On the old view of definition of death, a 'brain-dead' patient was considered *alive,* as long as respiration (even assisted) occurred, yet the whole-brain approach, accounts such a patient as being *dead* (Cranford, 1995). A progressive alternative offered is the *higher-brain approach*, which defines human death as being an irreversible cessation of the capacity for consciousness (Olson, 1997; McMahan 2002). The term 'consciousness' refers to a state, in which patients are able to sustain a functioning neurological system, including those in a reversible coma, being considered to be alive (Baker, 2000). This idea is rooted in the interpretation that a person has an 'essence', a capacity for 'consciousness', without which we wouldn't exist (DeGrazia, 1999). This approach is also linked to the idea of loss of personal identity and the idea that death is also a moral question, in a sense that certain behaviours are appropriate, while others are not, such as grieving, organ donation or burial (DeGrazia 2005; Green and Wikler, 1980). Some modern alternatives define death as a process, not as a determinate event, arguing that organisms can't fully belong to either sets of existence, life, or death, because the boundary between them is not perfectly sharp (Halevy and Brody, 1993; Youngner et al., 1999). Traditional interpretation of death focused on the physical aspects, while often overlooking the spiritual dimension. Yet, at the EOL patients often wish to re-examine their beliefs, to reiterate spiritual values, to have closure and die peacefully, so the implications of death in the spiritual realm requires recognition (Choudry et al., 2018). Participants of my study have also given various interpretations to death, most of them acknowledging that a generalised definition is almost impossible to be given, death being an individual experience, sometimes even difficult to conceptualize. The novel finding of my study is related to the relationship between HCPs personal values and norms, and their attempt to make sense of death itself.

The study of Cevik and Kav (2013) surveyed 300 Turkish nurses about their attitudes and experiences toward death and caring for the dying patients. 45% of the nurses reflected on their religious views greatly affecting their attitude toward death and the dying patient. Less fear and avoidance of death was noted in the nurses who defined themselves as having strong religious beliefs, in comparison to the nurses who didn't (Cevik and Kav, 2013). Although, the findings of a

Korean study, that surveyed 230 nurses, concluded that a better performance in EOLC is mostly dependant on the positive perceptions of death and attitude towards end-of-life care. These findings are consistent with the results of my study, placing the positive attitude towards death ahead of religious beliefs, when personal views impact the care provided for the dying patient and their families. The role of faith and religious beliefs in making sense, coping with death, or offering holistic support for families was also supported by my study.

Situations surrounding the death and dying, that were challenging the moral integrity of the participants of my study, were frequently reported. Ethical and moral dilemmas surrounding death were primary elements of the death experiences in my study, including labelling death, such as ‘good’, ‘normal’ or ‘unfair’, taking moral decisions to stop active treatment or to prolong resuscitation, or quite the opposite, carrying-on with a life-saving procedure. Other studies also suggest that ED clinicians repeatedly reported a conflict arising from the life-saving ethos characteristic to ED and providing end-of-life care in the same environment (Grudzen et al., 2012a; 2012b; Murphy, 2008). A Dutch study conducted among physicians of all specialties found that 62% of them agreed that receiving futile and invasive investigations or treatments, for patients near death is very common, mainly because preserving and lengthening life is the default medical approach (Visser, 2012). These findings are consistent with an Australian study, in which 65% of the surveyed physicians believed that many patients nearing their end-of-life, receive medical treatment when presenting to ED, which is unlikely to benefit them and as such, represents a barrier in providing adequate care (Marck et al., 2014). Participants of my study agreed that stopping active treatments, that proved to be futile is a difficult balance between clinical judgement and family wishes, clinicians trying to offer a dignified death to their patients, while families cling to their final hopes in saving their relative.

Omoya et al. (2022), conducted a study in Australia, interviewing 7 emergency doctors and 9 emergency nurses, reached to the conclusion that determining if a treatment should be considered futile, not only clinical considerations, but in each individual case, ethical aspects should be also weighed. Another study, interviewing 16 Spanish Emergency Nurses, concluded that ethical dilemmas in the ED, surrounding palliative patients, arise from a conflict between doctors, who will sometimes consider only the medical aspect to pursue a solution, and nurses who will make an effort to be advocates for their patient’s best interest, feeling often helpless (Jimenez-Herrera and Axelsson, 2015).

My empirical study described certain ethical dilemmas when providing resuscitation for a child, with the parents and carers allowed to be present during a resuscitation attempt in the hospital. However, often there is a controversy surrounding this question. Those arguing for parents to be present during their child's resuscitation, say that parents can have a better insight into reality and have a chance to say goodbye, in case the attempt is unsuccessful, helping them in the grieving process. Opposing to this idea, some parents, who lost their child under such circumstances, say that they wish not to remember seeing their child dying (Tsiligiri et al., 2010; Shaw et al., 2011). Those arguing for parents not to be present, claim that they could interfere with clinical procedures, can affect staff's technical performance and stress level, and potentially undermine medical decision-making (Curley et al., 2012; Tripon et al., 2014). Decision to carry-on with the resuscitation of a child when parents were present, even knowing that it's futile, was driven by the personal and professional values of HCPs interviewed in my study.

Participants of my study often expressed their affiliation to a particular faith, and how these spiritual values shaped their view about death and guided their clinical work. For almost all of the interviewed HCPs, the spiritual dimension of death had a great significance, even for those that didn't consider themselves as being religious. Miner-Williams (2006) argues that spirituality is an "integrative energy and the transcendent quest for meaning and happiness", which leads to health and the relief of sufferings. Spirituality represents more than religion, being rooted in the meaning of life, becoming more important when one experiences life crisis, such as being diagnosed with terminal illness or nearing end of life (Vermandere et al., 2012). The same idea is shared by Sulmasy (2009), who claims that spirituality is a broader concept, in which is compatible with all forms of religious beliefs, moreover even with the absence or rejection of faith. The relationship between HCP's working in ED and patients at the end of their life should include spiritual care, based on the assessment of the patient's individual spiritual needs (Seccareccia and Brown, 2009). Many of the participants of my study explicitly expressed the absence of religious beliefs, yet still referred to spirituality as a 'guiding compass' in making sense of the death experience.

Some studies suggest that nurses have significantly more positive attitudes than doctors towards the importance of spiritual care, as historically, nursing has always incorporated this type of care, such as Florence Nightingale's initiative to introduce music in the environment to facilitate the healing process (Balboni et al., 2013; Phelps et al., 2012; Nightingale, 1860). As obstacles in providing spiritual care, ED staff highlights time pressures and the inability to discover and understand dying patient and their family's spiritual background (Balboni et al., 2014). There are conflicting views about supporting patients to observe their religious beliefs as part of the spiritual care. Staff participating in some studies argue that religion is something very personal to them and they would avoid bringing it up (Keall et al., 2014), while others argue that education on the differing views of various religions may help to accept patients' views better (Yingting et al., 2018). Involvement of chaplaincy service is viewed as useful in addressing patients and family members' needs of spiritual care (Puchalski et al., 2006). The need and significance to involve chaplaincy services in dealing with and supporting the grieving family, was often mentioned by the participants of this study as well. Spirituality and faith played an important role in dealing with death for many of the participants of my study, shaping the way they interpret the meaning of death, while for others manifested in practices that supported them in coping with the death experience, but also aided the spiritual support they provided for the bereaved family.

Experiences in my study are supported by the findings of Wu et al. (2009), who argues that nurses who consider religious beliefs important building blocks of their personhood, tend to deal with traumatic events, such as the sudden or unexpected death of their patient, by adopting a more purposeful and positive approach. Ho et al. (2022) also suggests that the death and dying experiences, could strengthen the faith and spirituality of those nurses who hold religious beliefs. Ntantana et al. (2017) surveyed 149 intensive care doctors and 320 intensive care nurses in Greece, to explore the impact of healthcare professionals' personality and religious beliefs on the decisions to forego life sustaining treatments. The study found that the more religious a healthcare professional was, the more reluctant it appeared to withdraw life-sustaining mechanical ventilation, considered by many a 'passive euthanasia'. A link between religious views and negative attitudes towards withdrawal of active therapy, was also found by another study among Iranian students of Muslim faith (Aghababaei and Wasserman, 2013). On the contrary religious faith had predominantly positive influence on the participants of my study, sometimes being 'tested' by certain death experiences, but predominantly offering support in having a positive attitude, coping and provide holistic care.

Establishing a relationship between personal values and norms of HCPs, including the social, cultural, spiritual, and moral aspects, and how death is interpreted and labelled such as 'good', 'fair' or 'acceptable', how these influence clinical decisions, ethical dilemmas or the care provided for the dying patient and the support for their family, are novel findings of my study.

6.4 Higher Order Concept: Influenced by death in the ED

After describing what makes some death experiences in ED memorable and how their values and norms influence this experience, participants described how these experiences influence their own personal and professional life. The final higher order concept '**Influenced by death in the ED'** is underpinned by four super-ordinate themes, '**Changed by death'**, '**Emotional labour of death', 'Coping with death'** and '**Learning from death'**.

'Changed by death' describes how perspectives, behaviours, priorities and personality of participants were affected by the death experience. '**Emotional labour of death'** describes the wide range of emotions triggered by these experiences and the investment it requires to 'handle death and the dying', while '**Coping with death'** explores the various ways participants choose to cope with them. Finally, '**Learning from death'** describes what would be required to be better prepared for and how patient care or career perspectives are shaped by these death experiences.

6.4.1 Super-ordinate theme: Changed by death

Witnessing death in the ED is an experience, that changed peoples' views about themselves and the world surrounding them, both professionally and personally. The death experience caused staff to review their own behaviours, perspectives, priorities, and interactions, yet also to acknowledge the emotions associated with this experience. This is often described as a gradual process, that happens over the years and being changed by the experience of death in the ED was often perceived as almost inevitable.

"After [several] years working in ED, I have no feelings at all anymore seeing a dead person. There is nothing." (Christine: 320-325)

"So, by the end of my foundation year I have seen a tremendous amount of death and you learn to get used to it. I think it has impacted me in terms of my approach to death when it happens in the Emergency Department and certainly helped to build a pile of experiences, for example with breaking the bad news, select the right answers to people." (Nicholas: 104-108)

Experiencing death regularly, according to participants influenced their approach to end-of-life care, clinical practice, patient care and improved their relationship with families. Changes were evident in the improvement of therapeutic communication skills, techniques in breaking the bad news to family members, spending more time with them instead of rushing to the next patient and offering them a compassionate, empathetic support.

"Every case chip a little bit and steer your practice. Meeting relatives and breaking bad news on the whole is getting better. Finding the right phrases that convey the severity of the instance and the gravity of the news you are delivering in a compassionate manner is something that I am learning." (John: 205-208)

"I think it made me empathize more with patients who are dying or family members of patients who are dying because I know exactly what it's like." (Christine: 149-150)

Erica described her experience of witnessing death, as something that changed her understanding about life and death.

"It sounds awful but it kind of makes you become more harsh and harder out to shout. Once I was finally over after the first one, I was proud of myself because I think I went through a low point of my life, finally being able to process something so horrific, felt better and I've enjoyed my job again, and actually I felt quite good afterwards, around 6 months down the line. It definitely changed me as a person and made me aware of what life and death is." (Erica: 223-227)

Clinical practice and patient support, was also changed in case of most participants, often being rooted not only in the influence of the death experience, but also in their own values. Adam, a doctor, expressed his beliefs and Christian faith and how these affected his views on involving chaplaincy services in better supporting families during a time of grief.

"But in terms of how death has affected me, I am always keen to have the family involved as soon as possible … One of the things that I always thought about and I had no chance to use it is things like the chaplaincy service, because I know they are available, they are there to support people … This is something that I would try to incorporate more into my practice." (Adam: 206-213)

Reviewing medical or clinical practices as a response to regularly being exposed to death, was another significant element of the changes experienced by staff. Doctors talked about reviewing futile and unnecessary treatment, while focusing more on palliative medication and treatment to preserve dignity at the end of life. The changes in practice, in the fast-paced environment of an ED, are also fuelled by the understanding that often there is only 'one chance' to provide the most appropriate care.

"You have to know when to stop sometime, especially if they are an elderly patient and spending more time thinking about how to give them a dignified death. I think I have a more insight of that now than I had at the start of my career." (Adam: 254-256)

"I think the change comes from myself. Probably in terms of using palliative care medications and to allow the loved ones in even if it's 2 o'clock in the morning. I would let people come in and say goodbye, because as I said before, you can't take it back, you can't do it again." (John: 143-145)

Witnessing death affected participants both professionally and personally, changing their perspective, and views about the world and mortality. This experience allowed them often to reflect upon and acknowledge their own emotions, in contrast with carrying on, moving to the next case or patient.

"It certainly changes your perspective, your view of the world, it changes your view on mortality and death." (William: 333-335)

"I am much more aware of the impact the cases will have on me. Whether it's being upset, frustration, anger, no matter emotion is, it's important to have that." (Andrew: 165-166)

A change of priorities was also observed in participant's reflections on their death experiences, such as valuing time spent with their family and friends, valuing relationships, or taking every opportunity to express their gratitude. Some participants also expressed how these experiences made them realize how length of life can be relative and made them more inclined to prioritise, for example, travels and holidays.

"I think if you have a case where, or if you have a time when something bad happens at work, it makes you think, I just want to ring my Dad. I just want to ring my Mum and have a chat. Or you know, whatever it is and I think it highlights how important family and friends are." (Rachel: 152-155)

"You just learn to appreciate what you've got. And my kids, I'm just grateful that they are here. For my husband. You learn to appreciate things I think." (Zoe: 142-143)

While putting on an 'armour' was perceived by HCPs as a detachment for their own wellbeing, allowing to 'maintain a distance', some staff consciously decided to become 'softer', to remove this protective barrier, and embrace the feelings associated with the death experience, making them more empathetic towards bereaved families.

"For some time I was putting a shield on because you don't want to see what is it like to die … But I think since moving into paediatrics I have become a lot more softer. I don't put that wall up anymore because I don't have to. The more you do nursing, the more you feel you don't have to put that front up, you can be that person. When you speak with a bereaved family and you start crying you know that the family will appreciate it." (Julie: 186-192)

6.4.2 Super-ordinate theme: Emotional labour of death

Participants reflecting on their own feelings and emotional reactions to the death experience, describe these feelings as ranging from sadness to fear. Participants often found this emotional state difficult to verbalise. Many suggested that these emotions evolved over time, being impacted by it more often at the beginning of their career, whilst later in their careers the experience became less distressing.

"There are so many emotions that you go through, like sadness, like the fear for that family. Like they are going to cope, it's quite indescribable actually." (Mary: 58-59)

"That was the first time I've seen a dead body and I was very upset." (Christine: 319)

Sadness and fear, often associated with grieving, could be mixed with feelings of failure, a specific emotional state, many participants described as part of their death experience. The inability to save a life, to change the course of events, despite all efforts, resources, and skills available, could potentially instigate self-blame in staff, questioning if all options were explored in the process.

“You grieve differently in your private life compared to someone you’ve never met. You still grieve but in a different way. I don’t know if you can call it a professional grieve … You grieve for the family because you couldn’t do all that you could do. We want to preserve and save life that’s why we do our job. We want to make people better and fix them so they can walk out of the department. I guess it’s a sense of grief and failure that we couldn’t do that.” (Mary: 96-101)

Participants expressed that their emotions are not always visible, and even though some prefer to internalize these death-associated emotions, the intensity and the complexity remains the same. Staff suggested that the absence of these visible signs of grieving, could be misinterpreted as someone being cold, distant, or less empathetic.

“Crying is the external representation of that emotion, but that does not mean if you are not crying you are not feeling sad. Or anger can be an external representation, but if you are quiet does not mean that you are not angry inside.” (William: 173-177)

While ED is a fast-paced environment, with complex pressures on staff in dealing with a large number of patients over a certain period of time, participants described their time spent with a critically ill patient, as requiring an emotional investment. If that patient dies and clinical staff is required to pick the next case, they’ve found it difficult to make this sudden shift, as could jeopardize the quality of care and attention provided to that patient.

”Just ask yourself the question: Am I the right person to do a procedure or give advice after I had such a difficult case? As a consultant you want people to look up to you and say, that they are calm and confident, they know what they are doing. But it’s fine sometimes to take 5 minutes, have a drink and think.” (Andrew: 176-179)

Emotional awareness is an integral part of dealing with the death experience, recognising, and acknowledging these emotions instead of bottling them up, or pretending that none of these experiences affect the individual. While emotional reactions can differ among staff, working as a team with the same patient, building a similar rapport, getting to know the family, will help sharing the emotional burden with the rest of the team as a measure of coping.

"Some people might feel different emotions, but in general if you are part of that core team, you make decisions as a team, so at the end the emotions you are feeling, would be similar. The core emotions would be similar." (William: 184-185)

Participants have expressed that embracing their own emotions, helped them to have a more holistic approach in care and avoid an objectification of the patient. Participants associated having emotions as an essential component or requirement for this profession.

"I think if I don't get affected anymore, I would leave my profession. I don't think it's the right job for you if you don't get affected anymore. It's part of being human, it's part of being a nurse to be able to empathize. If you wouldn't be able to empathize with the family or the patient than you are in the wrong profession." (Zoe: 193-196)

"Be aware that we are not robots, we are human beings, and we have emotions ... We all need kindness, and we need to look after each other. I think when that's missing, people get too much focused on the patient and the outcomes." (Adam:269-274)

6.4.3 Super-ordinate theme: Coping with death

Participants described various ways of coping with the death experience and while these were different in each individual case, there were many similarities too. Some participants acknowledged that the way they cope with death is not healthy or beneficial to their wellbeing. One mechanism, some participants viewed, as being a least efficient way to cope, was by internalizing emotions and not talking about these experiences, dealing with all associated emotions by themselves.

"I handle them in the worst way you could do it. I have insight that the way I handle them is not a healthy way and the way I handle them is lock them away and don't think about it." (William: 166-169)

"I think it's important to be able to talk about things and not bottle up emotions." (Rachel: 156)

As methods of coping that proved to be unhealthy, participants mentioned alcohol consumption, smoking or physical exercise taken to extremes. Some of the participants reported that they were aware that these do not offer a resolution, only a temporary numbing or distraction from these feelings.

"I think when I was younger, I drank a lot. I didn't had responsibility so kind of can do that, obviously that is not helpful. I went through a period a couple years ago, intense exercise, where I ran almost every day for two years, that doesn't work." (Robert: 240-244)

Wearing the uniform as an ‘armour’ or a ‘shield’, was described by many participants as a way of protecting themselves from being deeply affected by the death experience. The same analogy re-surfaces in some participants, during the conversation about how they cope with these experiences. Coping from many participants means distancing from the experience, imposing preventive measures from the negative influence of grief.

“So, when you wear that uniform, that is an armour, it’s really weird. You have this armour that protects you slightly and how do you manage your grief.” (Mary: 110-111)

Mary also described her way of coping as holding all the memories in an imaginary cupboard, with many drawers inside her mind. Sorting these memories suggests that she does not want to lose them, they’ve become part of her.

“I’ve got a lots of cupboards in my brain, for my thoughts and feelings, different doors. One for example have a door for death, where it might sound very strange, but this is how I cope. So, all the deaths I have experienced at work will go into this cupboard. When I have a new death, there’s a box for every child or adult, there is a box. … This is how I manage traumatic events at work, this is my way of handling it.” (Mary: 133-143)

One of the most common methods of coping described by almost all of the participants was talking about the experience, by verbalizing, expressing their thoughts and emotions. Many of them preferred to speak about these intimate feelings with someone very close to them, their spouse, partner, parent, or a very close friend. In the same time others preferred to talk about these experiences at work, with a colleague, protecting their professional persona.

“So, how I manage things. I tend to ring my Mum if there’s been a death and I cry a lot. That’s how I overcome sadness I just cry. I talk a lot, I need to talk about it.” (Mary: 205-206)

“I think my personal coping mechanism is to go home and see my family and then I get upset or unload, but I can’t really see doing that at work.” (Margaret: 227-228)

In addition, to talking to family or friends, participants discussed various professional methods that they use to access support. Some used TRIM (Trauma Risk Management), a service provided by the hospital to assess the psychological impact on staff of exposure to distressing situations. This service is open to everyone affected by an incident and will help exploring how the individual is coping after a traumatic event, potentially offering additional support. Other participants mentioned talking to a psychologist, a service offered during the pandemic by the hospital. While some welcomed this service, many participants did not feel comfortable discussing their emotions with a ‘stranger’ over the phone. The most common professional support accessed by staff were hot and cold debriefs. A hot debrief is a gathering with the team involved in the death of a patient, including all specialities, whom in some form cared for that patient. Acold debrief is a similar meeting, but it happens a few weeks after the event. Participants were divided in which might be a better method for offering support. Most participants agreed that the advantage of these meetings is that they bring everyone involved together, but a disadvantage could be that not everyone might have a voice, or that the meeting could be dominated by the opinions of a few people, particularly if it is not led by an experienced person.

"We do debrief so once the patient passed away, we would if we can, do a hot debrief if we can one that is pretty much soon after the event. Unfortunately, with ED we have patients coming through the door all the time, so we normally do a cold debrief. But if I am honest, we are not very good in doing debriefs in our department." (Christine: 256-260)

"We have a debrief after we have a particularly traumatic case. But sometimes I'm not sure if that's enough." (David: 293-294)

"I think personally stirring up emotions in cold debrief is not useful but discussing things in a hot debrief is very helpful." (John: 260-261)

Some participants also reported other forms of dealing with such traumatic events, such as the use of humour or playing video games, helping them manage the associated anxiety and stress.

"I think working in Emergency Department … means that you have a slightly weird sense of humour and sometimes you can say things that are inappropriate for some people but not for you." (Rachel: 150-152)

"Sometimes when it comes to dealing with stress, I am into games, sometimes just shooting some people. I don't think I need large amount of coping as I've seen enough death and I know how to pause, stop when it becomes horrible, and I need to move on." (Nicholas: 113-116)

Another form of coping with the death experience, was noted in the language used by the HCPs interviewed, who were often using euphemisms when referring to death. Discussing euphemisms for death was important in establishing analysis on a more conceptual level. Euphemisms are metaphors or analogies, often used to convey something considered too direct, without saying a specific word. The word 'death', and their different variations, are terms that in certain situations could be interpreted to be too 'painful', and as such are often cushioned in more indirect or protective language (Kessler, 2019).

There could be several reasons why people choose to use euphemisms. Often euphemisms for death and dying are used to protect the person speaking the words or those hearing them.

Avoiding using these direct terms, could provide comfort, despite the grief of the situation (Naik, 2013). Avoiding being rude and offensive, could be another reason, with the objective of not increasing the hurt and pain of someone by being too direct or blunt. While death and dying are a natural part of life, they could make some people feel uncomfortable or anxious. Using a milder language may feel easier and less traumatic under some circumstances (Krawczyk and Gallagher, 2016). Sometimes using euphemisms, reflects our own grief feelings, as death is final, and saying it out loud can be difficult, especially if we experience a struggle to cope with this experience (Collins et al., 2018).

As presented in the introduction of this research study, according to some grieving models, denial represents a step in this complex process (Kubler-Ross, 1969). Using euphemisms could be a manifestation of a partial denial, as when using the word ‘dead’ makes it difficult to deny the reality. Indirect language, as a short-term coping mechanism, can sometimes be a helpful way to deal with the death experience mentally and emotionally (Collins et al., 2018). When spirituality represents an important aspect of someone’s life and a faith or belief is central, the emphasis in death is the afterlife (Kessler, 2019). As observed in the answers given by certain participants in this study, this was not an avoidance tactic at all, but rather a shared reminder of the comfort found in their faith.

Healthcare professionals may still find it challenging to speak about death and dying directly, despite working in an area where exposure to death is not unusual. Sometimes this happens when bad news is delivered in a gentle and tactful way, being driven by compassion and a desire to soften the blow. Other times, healthcare professionals have little training on how to cope with the emotional impact of caring for patients who die, as such euphemisms are used as coping strategies (Krawczyk and Gallagher, 2016).

Analysing participant’s answers in my study it was obvious that interviewees in their answers predominantly used the terms ‘death’, ‘dead’, ‘die’, ‘died’, and ‘dying’. In case of three of the participants, these were the only terms used, avoiding any form of indirect language. However, in certain situations most of the participants used euphemism. The alternative terms to describe death and dying, in most of the cases were ‘passing away’ or ‘passed away’ and ‘losing someone’, ‘lost someone’ or simply ‘loss’. On some very rare occasions, describing death as a spiritual event, or a transition to another form of (eternal) life, some participants used expressions to describe death and dying, such as ‘being with God’ (Zoe:76).

When listening to the recorded interviews and during the transcribing process it became obvious, what went unnoticed during the interviews, that often involuntarily I’ve used the same euphemisms in the conversation or when asking a question, as the participant. This unusual choice of words was noticed even by my supervisors, when reporting about these interviews I often still used this indirect language. When I reflected on this phenomenon in my journal, I noted the followings: *"Using the same words for 'death' in the interview as my participant, such as 'passing away' surprised me completely, as I wasn't aware of it, until I've listened to the recording. I was so immersed in the conversation, feeling what the participant felt, displaying compassion towards an experience that visibly still affected her, that I simply mirrored her choice of words. Clearly, this detailed description of her experience made an emotional and psychological impact on me as well."*

One of the typical occasions when participants used euphemisms, was when they've described a death experience in the family or of someone in a very close relationship with them. Often these experiences served as reminders when exposed to a death in ED that featured similar characteristics. Christine, when describing her motivation of becoming a nurse, mentions her grandmother's death, using a euphemism: *"My grandma was a nurse and she* ***passed away*** *in January of the last year of my studies, so she didn't see me qualifying, which was really upsetting at the time obviously. I hope I made her proud."* (Christine: 20-22)

Another moment of switching to indirect language is when the deceased patient, 'suddenly becomes a person' for staff. Zoe, when describing her experience of meeting a deceased patient's family, she's also cushioning the word 'death': *"… with nursing, it's something that is going to happen, you are going to* ***lose a patient*** *and it's hard. And here with us, I think the hardest part is when you get to be involved with the family, because you have to know them, and you get to know the person left behind."* (Zoe: 37-39)

The stories told by the participants, related to their death experiences, carried certain features that made them memorable and unforgettable. One of these features was the patient's age. This was another prominent example of euphemisms being used: *"So earlier this year there was an 18-year-old girl, who was in a boat crush, and she came in very poorly and despite everything we did, we couldn't save her … so sadly she* ***passed away****."* (Margaret: 176-180). The death of a child, especially if the circumstances were traumatic, very often triggered the same effect of softening the account, with the choice of words used to describe it. Julie is using three different euphemisms in the same story, when describing her experience: *"She came in as a traumatic cardiac arrest and I was looking to this little girl while they were doing CPR, cannulate, taking bloods, who has done nothing wrong in her life and is just hanging to life. She* ***passed away*** *and it was horrific because the parents weren't there only her auntie. … I didn't understand how a beautiful girl who didn't do anything wrong in her life could* ***lost her life*** *so tragically. She had a brilliant life ahead of her, but because of a silly mistake that somebody made,* ***took her life*** *and I said it's not fair."* (Julie: 122-131)

Lastly, another typical example of avoiding the word ‘death’ was when participants were willing to express their empathy in a situation. Charlie describes a very emotional episode from his practice using the same euphemism as his colleagues: *“I remember, not this Christmas, but the Christmas before, someone was brought in, who was palliative, end-of-life, and the family didn’t want to come in on Christmas Day. And this poor patient ended up **passing away** with staff around him, but you know, alone, in a Resus Room.”* (Charlie: 102-106)

6.4.4 Super-ordinate theme: Learning from death

An observation made by many participants was the motivation to pursue a ‘good death’, a dignified death by implementing changes in their clinical practice. Participants clearly expressed that the way they view patient care is different as a result of these experiences, for example, often not willing to preserve life at all costs but to act in the best interests of their patients.

“Thinking now as a [senior member of staff], seeing a lot of death has impacted me in pursuing a good, dignified death where it’s appropriate, things like DNACPR, treatment escalation plans, that sort of things.” (Nicholas: 218-219)

“In terms of how I changed my practice, hasn’t really because, care is care, nursing is nursing, but with these experiences I think it gave me more inside knowledge on how my brain works and possibly how are we optimizing the care for our patients.” (David: 194-197)

Another element observed by participants in how their attitude to patient care has changed, is related to improving communication and building a relationship both with patients and families. Family relations, for many HCPs, become a priority alongside clinical interventions, as EOLC provided in ED will be remembered by families.

“I would say you get different patients in A&E and some of them will pass away, you just make sure you always treat your patients with good care, making sure they are not in any pain, always speak with them and make a rapport with them. I think supporting the families is a big thing and from a personal experience you remember that situation.” (Margaret: 308-311)

When asked about what training they have received to help them cope with the death experience, healthcare assistants and nurses confirmed that they either have not received any education or something very basic. Doctors confirmed that it is part of their training to learn how to break bad news or conduct difficult conversations. When asked if they would prefer to have training sessions that would better prepare them for the psychological and emotional impact of the experience or other aspects of looking after the dying patient, participants had mixed views.

Some suggested that exposure to death experiences is the only way to gain understanding and that should happen in a safe environment with support that helps processing these traumatic events. Others however expressed that they would prefer a better preparation, discussion on certain aspects of death and dying, so that they can follow evidence-based practice, instead of department tradition.

"I guess that comes from experience and I don't know if anybody telling me about it would have changed what it was like, because for me I am quite a visual person, even if someone would have told me about it." (Rachel: 331-333)

"I don't think you can prepare yourself prior to death. Because every family is different, every death is different." (Mary: 322-325)

"Through your career you will see horrific things especially if you are in A&E, so why can't we do a half a day on bereavement care? … Why people are not taught how to properly look after the dead?" (Julie: 255-259)

Many of the participants were in leadership roles, for example, as sisters or charge nurses, consultants, or managing a team. In the event of a patient death, most senior staff described that they would make their teams' needs a priority, when dealing with this experience, sometimes delaying, or postponing coping with their own feelings. Almost all members of staff in a leadership position expressed a sense of responsibility for their team, often finding that focusing on other peoples' needs helped them better cope with their own emotions.

"I think you clocked up experience, and you have an understanding of what their concerns are about. I think you can offer useful advice at that time. And I think that is part of what a leader is. Looking after people that he works with." (Robert: 337-339)

"As it affected me, it put things into perspective to see how much it affected someone else. For me it's actually quite a positive thing, to go and sit down and explain what we did and why we did it. So, it's very positive to help someone else." (Andrew: 203-205)

Almost all participants expressed that they would like to continue their professional career in ED, or they would like to embrace these experiences, and expand their professional role or learning. Some talked about how dealing with death helped them to pursue a career in clinical education, while others wanted to become more involved in supporting and training fellow nurses, or pursuing a role in palliative, end-of-life, or bereavement care and services.

"Helping and teaching our staff drove me towards education, which I am doing part-time. So, this was something I think might have influenced me." (Isaac: 221-222)

"I think because my experience was so dramatic for me, in the future I'd like to do something to help other people that have similar experiences, other nurses or members of staff." (Erica: 251-253)

"Later in life I can see myself continuing in bereavement services or maybe end-of-life care." (Julie: 210)

6.4.5 Discussion: Influenced by death in the ED

'Influenced by death in the ED', described participants' views on how the death experience influenced their personal and professional behaviour, priorities, their coping mechanisms, and emotional journey through these experiences. The four super-ordinate themes defining the pillars of this higher order concept were, '**Changed by death**', '**Emotional labour of death', 'Coping with death'** and '**Learning from death'**.

Participants of my empirical study experienced various changes personally and professionally as a response to their experiences of death in the ED. This included changes to how they view life itself and interpret the world surrounding them, or changes in clinical practices, attitudes and their relationship with the dying patient and their family. Kuek et al. (2020) argues that individual experiences that are poorly processed, including those with death and dying, which are immersed in professional, emotional, ethical, and psychological challenges for those working in healthcare, can have a major influence on how healthcare professionals deal with their choices and decisions. Studies also suggest that professional identity, individual personhood, and even patient care is impacted by how well healthcare professionals are able to manage the death and dying experiences (White and Meeker, 2019; Terakado and Matsushima, 2015; Diehl et al., 2021; Zheng et al., 2022). My study confirms that HCPs priorities, behaviours and relationships have been impacted in numerous ways by their death experience in the ED.

Ho et al. (2022) interviewed senior palliative care and oncology nurses in Singapore and aimed to understand the impact of death and dying on the nurses' personhood, principles, values, beliefs, and professional identities, in correlation with the Ring Theory of Personhood. Inspired by Confucian ethics, the Ring Theory of Personhood, describes personhood as having an 'Innate', 'Individual', 'Relational' and 'Societal' domain, each containing specific values, beliefs, morals and norms (Krishna and Alsuwaigh, 2015). The 'Innate' domain deals with gender, religious, moral, ethical, and cultural values, the 'Individual' domain holds the personality and the personal values, whilst the 'Relational' and 'Societal' domains incorporate any family or wider society related expectations and values (Krishna and Alsuwaigh, 2015).

Ho et al. (2022) describes the impact of death and dying on nurses, using three themes: ‘Identity formation’, ‘Identity conflict and it’s influences’ and ‘Identity refinement’ in relation to the Ring Theory of Personhood. ‘Identity formation’ identified significant changes experienced by nurses at the beginning of their career or when they’ve entered the field of palliative care or oncology. These changes were ranging from the development of empathy and a dignity focused care for the dying, to the alleviation of the fear of death, strengthening religious beliefs or weighing life choices differently. ‘Identity conflict and its influences’ described how the death and dying experience created some conflicts among values, beliefs, and principles, and influenced nurses’ professional and personal identity. Finally, ‘Identity refinement’ discussed how these conflicts are addressed, to maintain a stable, balanced identity. These included principles of coping and changes in family relations, work-life balance, or parenting methods, but also a change in how nurses were defining a ‘good life’ and a ‘good death’ (Ho et al., 2022). Participants of my study also reflect on how the death experience had a gradual influence, on their views about life and death, changed their family priorities, the way they express gratitude in their everyday life or how they allow themselves to express their own emotions in front of others.

Participants of my empirical study talked about how an emotional investment is required when dealing with dying patients and how this experience triggers a series of feelings from sadness to failure, requiring from them an emotional labour. Emotional labour that accompanies a crisis in the ED can be described as demanding, an attitude that requires sensitivity when acting and reacting in a traumatic situation (Bennett et al., 2005). Hochschild (1983) defines emotional labour as “the induction or suppression of feeling to sustain an outward appearance that produces in others a sense of being cared for in a convivial, safe place”. A link between caring for terminally ill patients, patients transitioning from active treatment into palliative care or patients in pain and experiencing loss, and emotional labour in nursing, was clearly identified (James, 1992; Smith, 1992; Kelly, 2000), alongside the need for an emotional connectedness and related regulations strategies, between HCPs and their patients (Bender et al., 2021; Kimbell et al., 2020). Bailey et al. (2011c) argues that a distancing behaviour in ED nurses, is often the result of an inability to manage this emotional labour, however this coping mechanism can be more stressful on the long term.

Hunsaker et al. (2015) in his qualitative survey study, conducted with the involvement of approximately 700 Emergency Nurses in the US, argues that compassion fatigue in ED Nurses can be defined as the negative consequences of having a strong, personal, empathic orientation while working with a significant number of traumatized individuals. On the contrary, compassion satisfaction occurs when the Emergency Nurse feels a sense of connection with their patients and also a sense of achievement in the care provided for these patients (Hunsaker et al., 2015).

Another qualitative survey study, aimed on American ED nurses, investigating the prevalence of secondary traumatic stress (STS), suggests that exposure to human suffering by nurses in the ED has a potentially negative consequence with a profound effect on nurses' health (Dominguez-Gomez and Rutledge, 2009). STS refer to exposure to a person who is traumatized or suffering rather than exposure to a traumatic event itself, resulting in an emotional disequilibrium (Dominguez-Gomez and Rutledge, 2008). Symptoms such as irritability, intrusive thoughts, emotional numbing, sleeping disorders, diminished activity level and avoidance of patients were the most reported by the participating ED Nurses (Dominguez-Gomez and Rutledge, 2008). Similarly to the findings of these studies, participants interviewed in my research were reporting on a wide range of emotions, ranging from sadness, feeling upset, to fear, for some of them causing disturbances in sleeping or eating habits.

HCPs interviewed in my empirical study talked about experiencing individual emotions and the importance of acknowledging them, yet as a team, often sharing these feelings. The study of Kostka et al. (2021) surveyed 160 Polish nurses in a municipal hospital and reached to the conclusion that there are several emotions shared among them, when dealing with death. The most common shared emotions were helplessness (62.5% of the respondents), compassion (54.17%), sadness (54.17%) and depression (41.67%). Feeling helpless was a common shared emotion reported by my study, which often occurred in case of a sudden and unexpected, or traumatic death event.

Coping with death was described by the participants of my empirical study in various forms, from numbing or internalizing feelings, and using an 'armour' for protection, up to talking about their experiences with family members or accessing professional support services. A traumatic event can be defined as a powerful, extreme, or severe situation, circumstances, or chain of events, able to overwhelm through its intensity a person's ability to cope, which may result in unusually strong emotional, cognitive, or behavioural reactions (Meichenbaum,1994). ED is almost constantly confronted with severe injuries, death, suicide, and suffering (Bennett et al., 2005; McFarlane and Bryant, 2007). During confrontation with a traumatic event, ED nurses often adopt avoidance as a coping strategy (Crabbe et al., 2004). Avoidance, which can manifest in distraction for example, in short terms can have the benefit for an emergency worker to be able to go on functioning. Nevertheless, in longer terms this may hinder the recovery process and can therefore lead to the development of severe psychosomatic symptoms (Clohessy and Ehlers, 1999). Wearing a uniform was often seen by the participants of my study as wearing an 'armour' that protects them from the effects of the death experience. While some suggested to use 'shielding' as an avoidant coping mechanism, others reflected on allowing themselves to become vulnerable in front of others as seeing kindness, empathy, and compassion of a high importance, because of their death experiences. Yet, other participants in my study reported developing an emotional numbness over the years and almost not ‘feeling anything’ when encountering death. Similarly, Bailey et al. (2011a) reached to the conclusion that avoidance is used by HCPs as a ‘shield’ to protect themselves from the negative influences and upsetting feelings associated with witnessing death, especially if dying has a slow trajectory.

The study of Adriaenssens et al. (2012) surveyed more than 300 nurses in 15 Belgian hospitals, and indicates that during the emergency care interventions, ED nurses can adopt three major types of coping mechanism: emotion-oriented, task-oriented and avoidant. Emotion-oriented coping strategies are self-oriented emotional reactions to reduce stress, usually not successful in nurses. These reactions range from blaming oneself for being too emotional, angry, tense, self-preoccupied to simply fantasizing (Adriaenssens et al., 2012). Task-oriented coping mechanism are often seen as successful because they require an attitude of control, influence, commitment, and resilience (Adriaenssens et al., 2012). Avoidant coping strategies, such as denial, wishful thinking, emotional suppression of intrusion and mental disengagement are experienced as unhelpful by ED staff, as proved to have long-term negative effect on wellbeing (Adriaenssens et al., 2012). Some of the participants of my study reported some unhealthy coping mechanisms, excessive alcohol consumption or physical exercise, which didn’t help managing these experiences. One participant described her avoidant coping strategy, as using an imaginary cupboard, where she stores her memories, while another was using FPS (first-person shooter) videogames to cope.

Peters et al. (2013) argues that ED offers little or no time to cope and that nurses with a longer experience will adopt more efficient coping strategies, compared to their less experienced colleagues. Participants of my empirical study, often expressed their frustration about their inability to take break after a death experience, being required to take the next patient, which jeopardized their own wellbeing and the quality of care provided. Kostka et al. (2021) found that the level of coping with death among HCPs, was directly dependant with the level of seniority.

Giles et al. (2019), surveyed 211 Australian ED nurses, and concluded that debriefs are an efficient support for coping with death, however due to time pressures they are often missed, organized several weeks after the event, or they are not led by an expert, as such they often prove not to be helpful. Gerace et al. (2020) conducted an online survey among 211 Australian ED nurses, and reaches to the same conclusion, that the inability to debrief, is one of the factors that lead to an EOLC in the ED, that is not satisfying for HCPs, patient, and their family. Debriefs were reported in my empirical study, as being very efficient tools in supporting HCPs, however timing and the skills of those leading these debriefs, were seen by participants as crucial.

The need to talk about death more openly, the willingness to pursue a ‘good death’, to improve communication with the deceased patient’s family, the provision of training and preparation for facing death, and the career perspectives influenced by death, for participants in my study represented the milestones to learn from their death experiences. Kübler-Ross (1969) argues that the subject of death historically was an uncomfortable topic, yet, individuals are often eager to talk honestly about death, especially when that involves unresolved family issues, or it simply means expressing their own sadness. One of the reasons, to keep the topic of death as a taboo, according to Chen et al. (2019) is related to death anxiety, described as the fear or panic, that someone’s experiencing when they are faced with their own mortality. A qualitative study conducted by Üzar-Özçetin et al. (2021) among 28 final-year, Turkish nursing student, about their experiences of talking about death with terminally ill patients, concluded that participants typically adopt three attitudes in such situations. They will either question their own competency and refrain from initiating the conversation, a similar avoidance because of the assumption and prejudice of causing harm to patients, or they are willing to discuss the topic but would benefit from experiential learning opportunities to develop the required skills. My study also reports that some HCPs find it difficult to openly talk about death expectation with their patients, as it goes against the core ethos of saving lives and improving patient’s wellbeing.

The study of Bergenholtz et al. (2020) interviewing patients and their relatives in a Danish hospital, found that patients would be willing for healthcare professionals to discuss death and end-of-life with them if that is done in a dignified environment, with a family member present and in an empathetic, compassionate manner. Participants of my study acknowledged as well that death is a topic, they often feel uncomfortable talking about, however they see, being open about it, for them as HCPs, is a way of better dealing with such experiences.

Providing a ‘good death’ has a similar importance as maintaining a quality of life in terminally ill patients (Smith, 2000). According to Steinhauser et al. (2000) a ‘good death’ in a hospital setting is determined by the following factors: control of symptoms, preparation for death, a sense of ‘closure’ or ‘completion’ in life and a good relationship with the healthcare professionals, with an emphasis for patients on retaining control over their own destiny. Participants interviewed in my empirical study, reported that one form of offering a ‘good death’ is by knowing when to stop any active treatment that proves to be futile. There is great debate about determining what constitutes, a futile treatment, a beneficent outcome and who should make this decision, yet there is a consensus that the question reaches beyond physiological measures, and psychological, social, economic, religious, familial, and legal aspects are also important (Schneiderman, 1994; Brody, 1994; Veatch, 1994). A futile treatment should be balanced in the view of the individual’s goals to be achieved and the possible success rate of the treatment which in their view is acceptable (Faber-Langendoen, 1991).

HCPs interviewed in my study, expressed the importance of improving communication with family members, because of their experience with death. Peters et al. (2013) suggests that a therapeutic communication style, will help the patient and its family to express with more ease their wishes, but also to accept the inevitable and find comfort, and a sense of closure at the end of their life (Peters et al. 2013). Giles et al. (2019) argues that difficult and sensitive conversations should not be delayed with patient and their family, as that can become an obstacle for an early understanding of the dying patient and their family needs. Participants of my study often reported how the death experiences, helped them to improve their communication style and be more attentive to the family needs.

Senior HCPs in a leadership role, interviewed in my study, both consultants and senior sisters or charge nurses, expressed the importance of offering support to their team, when they go through witnessing a traumatic event. Adriaenssens et al. (2011) argues that social support from the supervisor, in the view of Emergency Nurses, had close links to reduced psychological distress and somatic complaints, while adequate support from colleagues was associated with less fatigue. Hunsaker et al. (2015) suggests that support from managers, shared decision-making processes and recognizing nurses' contributions to practice are directly related to increased nurse retention, increased job satisfaction and reduced staff turnover.

The importance of preparation, trainings, and exposure to death experiences, for the purpose of practical learning, was regularly argued by the participants of my study. Whitehead et al. (2010) argues that training programs focusing on preparing staff for the death experience and the development of skills in providing spiritual care, have a positive effect in nurses' attitudes towards death. Bailey et al. (2011a) suggests that one of the important supports ED staff should receive, is professional training in EOLC and dealing with the psychological and emotional aspect of care for the dying patient. In Bailey's et al. (2011a) view, this professional preparation for the death experiences should start at university, rather than ED, both at undergraduate and postgraduate level. The study conducted by Mar Díaz-Cortés et al. (2018), among ED nurses and doctors, found that professional trainings surrounding the death experience, will not only improve HCP's capability in coping with traumatizing events, but will also support their decision-making processes and the management of their own emotions. Participants of my study had mixed feelings about an education programme focusing on the death experience. While some argued that it would be beneficial not only to understand processes surrounding death but also to learn how to cope and access support services. Yet, others suggested that a training can't prepare someone for the death experience, as such they recommended regular, safe exposure to death as a way of practical learning.

Majority of the participants asked about their career plans during the interviews of my study, reflected on staying in the ED, despite their experiences with death, some even pursuing career goals in palliative care or bereavement services. Tavakoli et al. (2018) surveyed 709 Emergency Nurses in 10 hospitals in Iran and concluded that 76.1% of them are experiencing moderate levels of burnout. Several studies discovered a link between the burnout of healthcare professionals, a work-related stress syndrome resulting from chronic exposure to job stress and career choice regret (Dyrbye et al., 2018; Chen, 2014; Shanafelt et al. 2009). The study of Wu et.al. (2009), interviewed 14 Taiwanese hospice nurses, from 6 different hospices, about their experiences with death and dying, and found that many nurses, because of constantly being exposed to death and grief, started questioning their career choice and making plans about staying or leaving their field of work. My study contradicts these findings, as none of the interviewed participants experienced career choice regret, on the contrary many of them were willing to pursue a career or be more involved in bereavement or EOLC.

My empirical study concludes that the death experience in the ED is the catalyst for a series of changes in HCPs, both personally and professionally, including their priorities, behaviours, or relationships. Managing death in the ED requires an emotional labour from HCPs, some experiencing professional grief, often a sense of failure, but valuing kindness and empathy, while sharing many emotions with the rest of the team. Coping with the death experience can range from shielding to the use of humour, talking about the experience, and using professional support services, such as debriefs being among the most common forms. Aiming for a ‘good death’, improving communication with families, theoretical and practical preparation for the death experience and pursuing certain careers, were all part of the learning process from the death experience in the ED.

6.5 Summary of Chapter Six

This study sought to answer the research question: *What are the healthcare professionals’ lived experiences of death in the Emergency Department?* HCP’s lived experiences were explored and discussed in detail using three higher order concepts, ‘***Experiencing death in the ED’***, ‘***Making sense of death in the ED’***, and ‘***Influenced by death in the ED’*****,** together with their nine related superordinate themes. The participants had a great variety of job roles, level of seniority, experience in ED and responsibilities with managing the dying patient, and as a result, experiences were very diverse. However, among the complexity of these individual experiences, many aspects were shared, as one of the participants noted: *"Some people might feel different emotions, but in general if you are part of that core team … the core emotions would be similar."* (William: 184-185).

The first objective of this study was to understand how these lived experiences are being influenced by personal, cultural, social, spiritual, or moral values and norms. Personal values of participants in these death experiences were reflected by how they interpreted the meaning of death, what ethical and moral challenges they encountered, and how faith and spiritual beliefs influenced this experience. As discussed in Chapter 2, death and dying can be experienced and interpreted beyond the biological dimension, taking into consideration the social, cultural, spiritual, and moral aspects of this phenomenon. These particular aspects of death were evident in my empirical study, when exploring the link between personal values and norms of HCPs, and the various aspects of their professional conduct in the ED. Some participants expressed how their attitude changed towards a patient at the EOL, how social death occurs when the person who they knew before 'was gone', and for them that person is 'already dead'. While the concept of 'social death' is widely discussed in the literature (Sudnow, 1967; Timmermans, 1998; Seale, 1998), my empirical study explores the link between HCPs' social values and its influence on the care provided for their patients. Some participants reported unusual, often 'bizarre' culturally specific grieving rituals of family members, highlighting the need to develop culturally inclusive EOLC practices, as often HCPs can't fulfil their duty of care in such situations. Bereavement rituals expressed by family members that are considered radically different, compared to the ones considered by HCPs as being 'the norm' in a Western society, as such becoming part of their own cultural values, will often serve as an obstacle in providing holistic care to dying patients and their families. Other participants reported how their sense-making process, their coping mechanisms, or even the care provided for the dying patients and their families are influenced by their spiritual values or religious faith, praying being a common manifestation of these values, becoming a component in the holistic care provided to patients. Finally, moral values influencing clinical decision-making was obvious in situations when a futile or invasive treatment was stopped to focus on holistic care, or when a resuscitation of a child was continued in the presence of the parents, even after the child died, the focus of the care shifting onto the parents from that point onwards. The second objective of the study was to explore what are the HCPs views on managing, accessing support, coping with, and preparing for such experiences of death in the ED. Participants reflected on how their professional and personal perspective, priorities and behaviours were changed by death, what emotional labour is required, how they cope with death and how this experience changed their views on preparation, patient care or career perspectives, or simply put, what they have learnt from death.

The study has demonstrated that both the individual and the death experience interact with each other. HCPs will shape the death experience through their social, cultural, spiritual and moral values and norms, while the death experience will influence staff's preferences, priorities, choices or behaviours. This dual interaction is illustrated in Fig. 6.1.

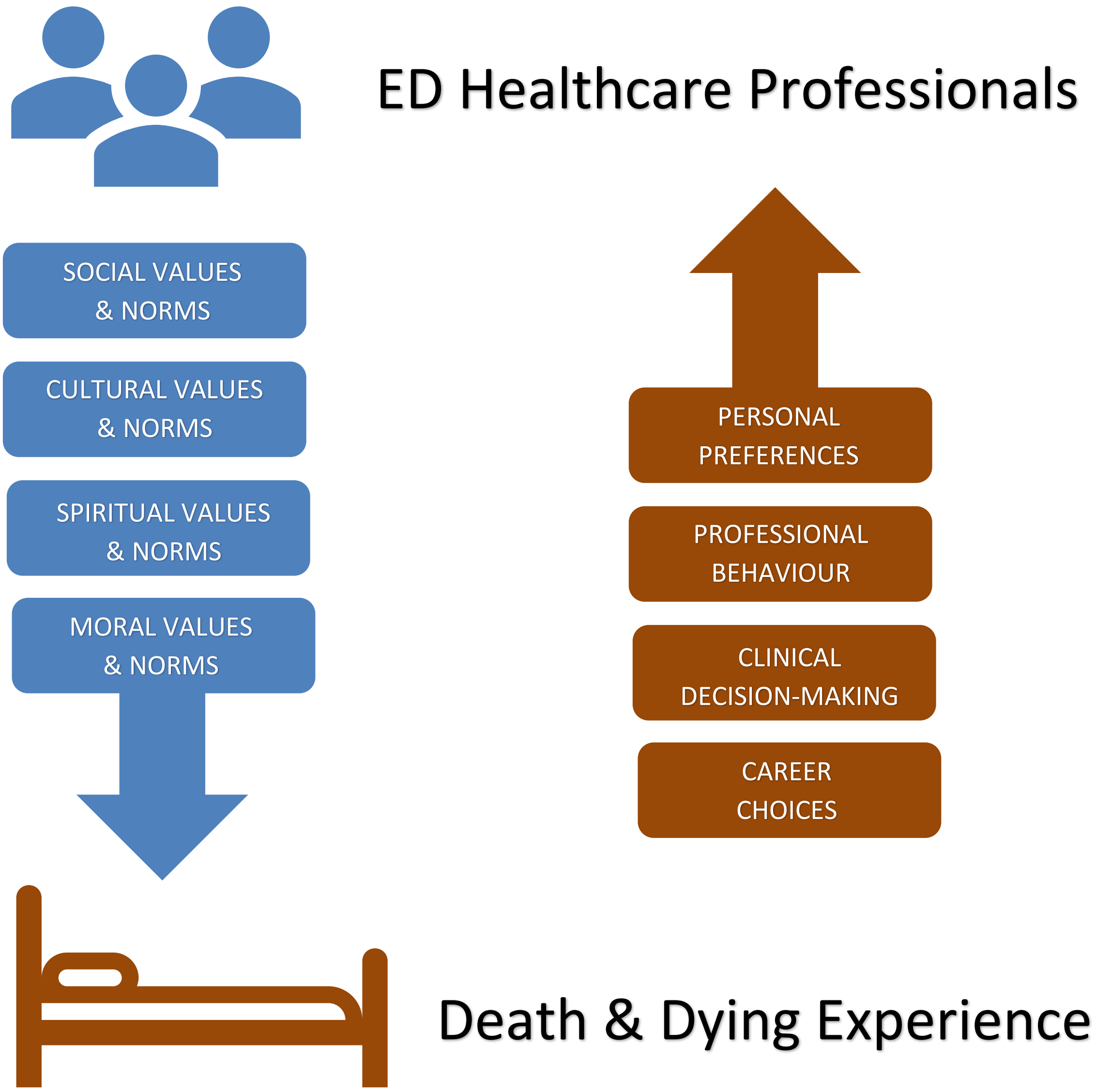


Figure 6.1 The dual interaction between HCPs and the death experience

Chapter Seven, the final chapter, will conclude this study by presenting the implications of the findings and the recommendations to practice, together with the role, these findings play in providing new knowledge, to what we already know about this complex phenomenon. Strengths and limitation of the study will be also discussed, alongside reflexivity, recommendations for future research and the dissemination of the results.

Chapter 7 Conclusions

7.1 Introduction

The three higher order concepts and nine super-ordinate themes presented in Chapter Five have answered the research question '*What are healthcare professionals' lived experiences of death in the Emergency Department?*' and met the objectives of this study.

Chapter Six concludes the thesis by assessing the original contribution of the study to the knowledge, its implications on practice, and the recommendations for future research. Strengths and limitations of the study are further explored, examining how reflexivity played a crucial role in data collection and analysis, and how the dissemination of the findings of this research study will happen. The chapter concludes with an overall summary of the thesis.

7.2 Original contribution to knowledge

Death and end-of-life care are subjects that have been widely researched. Death occurring in a hospital, particularly in the Emergency Department, are events that have been commonly analysed from the perspective of healthcare professionals. There has been a particular focus on caring for the dying patient and exploring the physiological, psychological, and emotional impact and consequences of these experiences on health service providers. To my knowledge, this is the first study to use IPA as a methodological approach, and in doing so, giving a voice to healthcare professionals working in ED. Further it has explicitly aimed to understand their experiences with a focus on their personal values and norms.

7.2.1 The role of HCPs values and norms in experiencing death in the ED

One of the contributions this research study makes to the wider knowledge base is understanding how the death experiences of HCPs working in the ED are influenced by personal norms and values (including moral, ethical, cultural, social, and spiritual values). Relationships between personal values and the way death is experienced in the ED by HCPs have been identified. Our values develop over time, and are directly influenced by various factors of our background, such as gender, ethnicity, cultural and social circumstances, but also shaped by our experiences and interactions with others, and will pinpoint moral standards and milestones as reference points to guide us through our decisions (Taylor, 1989; Solbrekke and Jensen, 2006). Our values are not static or passive, they reflect in our actions, as gradually become part of our identity, creating a hierarchy that will help us understand ourselves and the reality surrounding us (Carvalho et al., 2011; Lapsley, 2009). While current literature discusses moral and ethical dilemmas arising, for example, from resuscitation or futile treatments (Grudzen, et al., 2012b; Murphy, 2008; Visser, 2012; Siddiqui, 2016), the social aspect of death (Králová, 2015; Lock, 2002), the definitions of a ‘good death’ (Steinhauser et al., 2000; Ho et al., 2022) or the role of spiritual and religious beliefs in care for the patients at the end of life (Seccareccia and Brown, 2009; Balboni et al., 2014; Keall et al., 2014; Wu et al., 2009), the original contribution of this study lies in highlighting how HCPs’ personal values influence how death itself is perceived and interpreted.

7.2.2 The role of HCP’s values and norms in making sense of death in the ED

This study concludes that deaths in the ED that occur unexpectedly, deaths of children and young adults and deaths that are traumatic, even ‘horrifying’ in their nature, are more likely to have an emotional, psychological, sometimes physiological influence on staff, that often could have lasting effects for years or even decades, as reported by the participants of this study. Current literature addresses the emotional and psychological effects of traumatizing events on ED staff (Giles et al., 2019; Peters et al., 2013) and how the extent of emotional impact of witnessing death in ED is often related to factors such as the patient’s age or suddenness of death (Batley et al., 2017; Adriaenssens et al., 2012; Hunsaker et al., 2015). This study however, represents novelty in defining those characteristics of death in the ED, that makes them stand-out, become memorable for HCPs in the light of their own values and norms. Values define what staff view as being a ‘normal or not normal’ death, a ‘fair or unfair’ death or an ‘acceptable or unacceptable’ loss, or how they will act and behave when caring for the dying. Participants of this study reported that their own social, cultural, spiritual, or moral values and norms influenced, how they have perceived and interpreted the death of certain patients in the ED, and how these cases had a lasting impact on them as individuals and professionals. These characteristics include death of a child or young adult; traumatic, unexpected, or meaningless deaths; death that occurred during the early career or those that reminds staff of the death of a family member. This study also concludes those crucial processes and moments during resuscitation, dying and death, when the transition from objectifying to humanising a patient occurs. Making sense of death in the ED includes the language and euphemisms used by HCP’s to describe death, often referring to it as a ‘loss’ or as the person ‘passing away’.

7.2.3 The role of HCP’s values and norms in being influenced, personally and professionally by the death experience in the ED

The study concluded that personal values influence HCP’s chosen coping mechanisms, their relationship with the family and the care provided for them or other patients. While personal values shape staff experiences of death, these experiences on the other hand influence certain aspects of changes, interactions, perspectives, behaviours, or decisions made in their personal and professional life.

The original contribution of this study to the knowledge base will help understand better the complex phenomenon of death and dying, the influence that has on HCPs exposed to it in the ED almost daily, and how practice could benefit from these findings by making service improvements.

7.3 Implications for practice

7.3.1 Education and practice development

Education and training for staff, was not only a recurring theme in the existing literature, but was also described by the participants of this study, to prepare for death experiences in the ED. While both medical and nursing higher education programmes, provide a framework of teaching palliative and end-of-life related subjects and skills, including patient assessment, symptom control or communication skills, participants of this study argued that often this does not address some of the specific challenges of the death experience in the ED. Exposure to death experience of students during their training programme will depend on the practice placement allocations. Erica, an example of a newly qualified nurse, with no personal or professional experience of death, reported witnessing her first death as having a considerable influence on her physiological and psychological wellbeing, as she felt unprepared for this experience.

Health Education England in partnership with the Leadership Alliance for the Care of Dying People, in its publication ‘*One Chance to Get it Right’* (Leadership Alliance for the Care of Dying People, 2014) describes views and recommendations for improving people’s experience of care in the last few days and hours of their life. One of the important statements the document makes, is that “some staff caring for dying people do not have the skills and knowledge required to deliver care to high standards”. Further, it suggests that there is a responsibility in “ensuring staff have the experience and competence they need to do their jobs well. This includes making time and other resources available for staff to undergo professional development.” The document recognises the importance of “communication skills, including empathy and recognising emotional response to stress and distress”, and encourages integrating into learning modules that cover social care, bereavement, and spirituality, with an emphasis of consolidating and applying knowledge in different situations. While this document was published almost nine years ago, nurse or healthcare assistant participants reported that they have not received any formal training that would have prepared them for the complex task of caring for the dying patient, their families, and managing their own wellbeing as a result of this experience. Some initiatives are taking place to improve EOLC through education programmes, such as the education improvement across the local health and care sector in Shropshire (NICE, 2018). However, these target mainly the hospice sector, rather than the acute or emergency care in NHS hospitals. Another innovative educational initiative is the ‘Global Classroom’, launched as a joint online training course, aimed on UK and US nursing students with the purpose of discussing various aspects of EOLC, including cultural differences of advance care planning and the role of healthcare professionals in EOLC (Bailey et al., 2017). Such initiatives can widen future HCP’s understanding of the complex phenomenon of dying, encouraging them to ask questions, raise concerns, respond effectively in difficult situations, from the start of their professional career.

Beyond the traditional subjects of palliative and EOL care, the training provided for healthcare professionals, as part of their first 6-12 months of induction and preceptorship in the ED, should include **learning about self-awareness and acknowledgement of their own values and norms**, including social, cultural, spiritual, and moral values, and the influence these can have on their individual perception and experience of death. A similar topic could be potentially also added to the curriculum of undergraduate nursing university courses. According to Webb and Holland (2011), the foundation of every therapeutic relationship, including the healthcare professional-patient relationship, has three basic elements, namely self-awareness, empathy, and trust. As individuals are unable to understand others until they come to know themselves, self-awareness is a key element towards compassionate communication and emotional intelligence. Both are frequently mentioned by the articles selected in the literature review, as essential qualities in EOLC provision. Jack and Miller (2008) developed a self-development awareness tool for nurses by which, they are capable of recognizing their strengths and limitations in the care they provide, clearly reflecting on their own acts and omissions.

My empirical findings of learning about self-awareness and discovering the role and importance of personal values and norms, in providing care for the dying patient and their families in the ED, has some alignment with the three-stage model developed by Bailey et al. (2011c), which illustrated how nurses learn to develop expertise in EOLC in the ED. Learning how to manage the potentially harmful influences of regular exposure to death experiences in the ED, happens through multiple encounters with dying patients and their families, allowing HCPs to progress through these three stages. The first stage of the model is the ‘Investment of the therapeutic self in the nurse–patient relationship’, which can have a positive impact on the patient experience, by getting to know the patient better and by understanding their individual and holistic needs (Bailey et al., 2011c). At this stage, the development of this relationship, could include a discovery of the patient’s personal values and norms, expressed through their words, actions and behaviours, and finding areas of ‘shared values’. Focusing on the individual values, could contribute to a more tailored holistic care provided to the patient. The second stage is ‘Managing emotional labour in emergency work’, which represents the progress from investing the self into the HCP-patient relationship, into handling the burden that comes with the grief and bereavement experienced through the death of that patient, the greatest obstacle at this stage being the distancing behaviour adopted as a measure of self-protection (Bailey et al., 2011c). At this stage, HCP’s could incorporate in their practice those coping measures, discussed by my empirical study, such as formal debriefs or informal conversations with colleagues or family members, that would contribute to successfully manage the burden of the death experience. These internal support services and adopted coping mechanism, may have an even greater importance in successfully managing the emotional labour of the death experiences, in the light of the decreasing number of charities offering counselling services. The final stage ‘Developing emotional intelligence’, makes HCPs capable of solving problems, facilitate learning and manage change, having four principal components, such as self-awareness, self-management, social awareness, and relationship management (Bailey et al., 2011c). Development of training programmes that supports preparation of HCPs for the various aspects of the death experience in the ED, and offering practical support, mentoring, and coaching for new starters or for the less experienced colleagues, would allow a continuum in managing the death and dying experiences in the ED.

Another important element of education should incorporate **cultural and social awareness surrounding death and bereavement**. Similar to self-awareness, cultural and social awareness of death could be incorporated into the ED preceptorship programme, but also could form part of the undergraduate nursing studies. The British society, characterized by multiculturalism, could provide numerous opportunities to encounter acts of bereavement that are ‘out of the ordinary’ for someone raised in a Western society. Learning about and understanding the different cultural, ethnic, or social approaches to death and grief, could help overcoming several barriers faced by staff currently in the ED.

Finally, training alone does not prepare staff for the realities of death and dying, only repeated exposure to this experience does. **Developing EOL ‘coaches’ or ‘mentors’ in ED**, through an appropriate training course, would allow dedicated staff to provide support and assistance to those unexperienced with death, similar, to the support and guidance provided to students and newly qualified nurses. These roles would be similar to the ‘nurse link roles’ for various clinical conditions in ED, or being an ‘education link’, a ‘dementia champion’, a ‘practice supervisor’ or ‘practice assessor’ in the department. ‘Coaches’ or ‘mentors’ could not only prepare new staff for this experience but could chaperone during shifts and have an active involvement in the ‘after-event’ support.

7.3.2 Development and improvement of support services

Support services for staff already exist in the ED, and participants in this study suggested they were effective, particularly the ‘hot’ and ‘cold’ debriefs, the TRIM support service, the informal conversations among colleagues or the access to professional psychologists during the Covid-19 pandemic. However, many of these support services are self-directed and their usefulness greatly depends on the individual going through this experience (or the skills of those providing them, e.g. in leading a debrief session for example). ‘Coaches’ or ‘mentors’, as described earlier, could play a crucial role in overcoming these challenges, supporting HCPs in accessing these support services. Kolbe et al. (2021) suggests that debriefing should be distinguished based on their purpose, into ‘debriefing-to learn’, also labelled as an after-event debriefing, and ‘debriefing-to-treat’, also labelled as critical incident stress debriefing. The WHO (2012) recommends that psychological debriefs, such as the ‘debriefing-to-treat’ should not be used as an intervention method for people exposed recently to a traumatic event, as it will not prevent PTSD, anxiety, or depressive symptoms. However, when a team may require coming together to promote a sense of control, understand recent events and support one another, an alternative method, the ‘debrief-to-manage’ is recommended, with the purpose to normalise reactions, without exploring in detail what happened (WHO, 2012; Van Overmeire, 2020; Rick and Briner, 2004).

Line managers could implement measures of understanding healthcare professionals’ individual values and norms, and the importance of these in relation to the care provided for patients, by incorporating these aspects in their formal and informal communication. Line managers during the induction, evaluation, and appraisal conversations, at the three-, six- and twelve-month interval, could expand their appraisal and evaluation questionnaires to incorporate questions, and initiate conversation about each individual’s personal values, yet also to investigate how these values shape staff’s professional behaviour. Training those members of staff that line manage others in advanced communication skills, should be part of the senior team’s development plan in the ED. Similar questions or areas of investigations relating to personal values could be included in debrief protocols, evaluating the impact of each death case discussed on these forums. This individual evaluation of personal values will help managers offering better training and preparation for staff, will help with a more balanced shift allocation and skill mix, yet will also support the change and improvement of ED culture, becoming socially, culturally, and spiritually more inclusive.

Talking about the death experience was identified as the most preferred way of coping, therefore the **development of a structured framework to conduct debriefs and a development of internal and external staff support network** would be highly valuable. This could be developed, as a research-practice collaboration to be undertaken through co-production with national organisations, such as NIHR ARCs (Applied Research Collaborations), Academic Health Science Networks and local organisations, such as SoAR (Southampton Academy of Research). These organisations could offer valuable resources and infrastructure to support this initiative. One of the aspects of standardizing debriefs would relate to one of the findings of this study, the characteristics of cases which poses a higher threat to induce a negative impact on staff, such as sudden, unexpected, highly traumatic or child and young adult deaths. Initiating a debrief after every such death in the ED for all participating staff, including a follow-up with the 'mentors' or 'coaches' and potentially some specialist services, could potentially minimise impact on staff. The acknowledgment of personal values, under these circumstances, would mean that the support provided for HCPs is not a 'one-size-fits-all', but it is tailored to individual needs and expectations.

7.3.3 Considerations for policy makers and organizations

Findings of this study provide important considerations for policy makers and organizations such as the NHS, Department of Health and Social Care or Health Education England related to development of strategies, policies, and regulations to improve future provision of care. Current NICE guidelines focus on the provision of care for EOL patients and their families, such as the *End-of-life care for adults* - QS13 (NICE, 2011), *End-of-life care for infants, children and young people* – QS160 (NICE, 2017a) or *Care of dying adults in the last days of life* – QS144 (NICE, 2017b), and exclude provisions of wellbeing measures for healthcare professionals exposed to the experience of death. As described in detail in this study, exposure to death can have multiple influences on staff both on the professional and the personal dimension. Incorporating the findings of this study in developing new guidelines and policies would support the efforts of health service providers, not only to maintain and improve quality of care, but also to improve staff's job satisfaction, overall wellbeing, retention, and career progression.

Setting realistic goals and objectives to change the culture of the ED, including policies, processes and systems can be challenging, time-consuming, those actively involved encounter numerous obstacles along the way, including overall pressures on the system generated by staff shortages, high number of patients entering the primary and secondary health services, ongoing impact of Covid-19, lack of funding or more recently HCPs strikes. While change can happen from the top, moving downwards, it is not impossible to generate change from the individual level, role modelling new behaviours and attitudes, encouraging others by showing a good example. Changing the culture in the ED will require in my opinion three well-established steps:

1. **Defining the vision and benchmarks**: Implementation of an evidence-based practice, requires well established and clear benchmarks or measuring outcomes, measuring positive results, both in terms of patient care and safety, but also HCPs confidence and job satisfaction.
2. **Communicating objectives, celebrating successes:** Objectives, benchmarks and outcomes needs to be clearly and regularly communicated. Taking individuals onboard is only possible if goals are shared and tools are offered to accomplish these objectives. The positive impact these changes will have, needs also to be communicated by line managers, ward managers, matrons and care group managers and celebrated regularly on a department, a division or trust level. Communication can happen during meetings, handovers, huddles, using newsletters, social media, or any other internal electronic communication methods. Communication needs to be a two-way process, allowing HCPs to give feedback or raise concerns.
3. **Transparency and accountability:** Transparency of objectives, processes, and benchmarks is needed to build trust. HCPs are more likely to accept and enact change they have had a role in bringing about changes, as opposed to change they feel has been forced on them. This is in turn more likely to be a factor in sustaining changes to practice along with someone being holding others accountable to the change, if there is a move to 'old habits and practice' returning.

7.4 Recommendations for future research

This research study has identified issues and challenges arising from HCPs experiences of death and dying in the ED, offering recommendations to influence and improve clinical practice. However, there is a need for further investigation and research, to explore other aspects of the topic, and to widen the spectrum investigation for a more profound understanding of this phenomenon.

One of the areas recommended for further investigation, are the views of bereaved families who lost their loved ones in the ED, including the exploration of their experiences in relation to their socio-economic and ethnic background, or considering their unique value system. Studies suggest that families will often experience a lack of information, communication barriers, psychosocial emotions, and a busy and undignified environment as part of their experience of death and dying in the ED (Ito et al., 2021; Fernandez-Sola et al., 2017; Bailey et al., 2011a; Mar Diaz-Cortes et al., 2018). The findings of this research suggest that HCPs experiences, attitudes towards death and care for patients at the end of their lives, are influenced by their social, cultural, spiritual, and moral values, including the interactions with family members (Chapter 6). Understanding how personal values and norms of families, influence their death experience, could potentially contribute to the improvement of direct care, organizational design, governance, and local or national policymaking.

Another perspective of the death experience in ED recommended to be explored in more detail relates to paediatric deaths. When discussing the higher order concept of **'Experiencing death in the ED'** in Chapter 6, one of the aspects of death in the ED that was holding the potential to become a memorable event for HCPs, was related to the age of the patient. Child and infant deaths were almost always accounted by participants of this study as leaving a lasting influence. While most of the participants were healthcare professionals caring for adult patients and seeing only occasionally paediatric patients, investigating the views of paediatric nurses and doctors, working in Children's ED could bring to surface other valuable findings.

As part of the warming-up phase of the interviews, participants of this study shared their thoughts and feelings about why they have chosen the nursing profession and in particular ED as their workplace. While this wasn't the primary objective of this study, this initial part of the interviews offered an interesting insight into nurses, healthcare assistants and doctors' primary motivation for choosing their profession, with a particular focus on what they like the most and less about their workplace. Further research into understanding the complex reasons behind people's choices, drives, motivations, inclinations, and influences in choosing certain areas, such as ED, could potentially support the workforce recruitment and retention efforts.

7.5 Strengths and limitations of the study

The nature of qualitative approach used within this study allowed me to collect and analyse data full of richness and depth of meaning, to gain a profound understanding of staff's experiences of death in the ED. The methodology, methods of data collection and the data itself did not seek generalizability or transferability of the findings, but rather reveal an in-depth understanding within a single setting. The strength of the study lies first in IPA as the methodological approach, using semi-structured interviews as the method of data collection used, and a systematic analysis which allowed me to explore the topic in depth, giving a voice to participants' individual experiences . In comparison to other studies that have used IPA, 17 participants is a relatively large sample for an IPA study. Smith et al. (2009) used almost half of the number of participants in their original IPA study and argues that some studies could be built even on a single participant. A further strength of the study lies in recruiting a diverse range of participants, based on job role, age, gender, nationality and professional band or grade perspective, to facilitate a wide spectrum of views within this single setting. The topic itself also represents a considerable strength of the study, as understanding the relationship between HCPs death experiences in the ED, and their personal values and norms, is a subject under-investigated.

While the focus of this study was on HCPs experiences, a limitation of this study was the exclusion of patients and their families, when seeking to understand the influence of the death experience in the ED. Current literature suggests that bereaved families' experiences of death in the ED are characterized by lack of information, often due to poor communication between healthcare professionals and families, or because of ED being perceived as a 'chaotic environment', in which families refrain to ask anything, as staff appears to be constantly busy (Gloss, 2017; Punches et al., 2019). Additionally, studies suggest that families experience various emotions, such as abandonment, agitation, disbelief, sense of guilt, helplessness, loneliness, and sadness (Li et al., 2019; Berbis-Morello et al., 2019; Merlevede et al., 2004). Interviewing family members would have offered a valuable angle in understanding the other side of this complex phenomenon, but this wasn't pursued due to multiple reasons. These included Covid-19 restrictions of family member and researcher access in some clinical areas in the ED. Yet, the main reason was related to potentially missing the same level of detail in focusing on HCPs experiences, if family and relatives experiences were explored as well.

Whilst the use a single method (qualitative interviews) is consistent with IPA approaches, use of additional methods, such as observations of clinical areas, particularly the Resuscitation Room, might have offered additional insight into the phenomenon. Observations could have supplemented interviews, by capturing how people interact in a clinical context. For example, I could have observed the physical environment, including observing the surroundings of the setting, the description of the participants (doctors, nurses, HCA's, clinical staff from other wards), the activities and interactions that occur in the setting and the frequency and duration of these activities and interactions. During these observations, I may have seen things that routinely escape awareness of the participant, while providing me the chance to learn things that people may be unwilling to discuss in an interview (Patton, 2002). Due to the visiting and research activity restrictions in ED clinical areas, during the Covid-19 pandemic, observations as a data collection method, was not possible.

While data was collected from a relatively large sample of participants, the study setting was a single ED, located in a major trauma hospital. It may not reflect the views of emergency staff working in other regions of the UK, in particular healthcare institutions that are smaller in size, that may have an active palliative care team working within the ED, or if the healthcare institution belongs to the private sector. The data and findings generated by this qualitative study, cannot be generalised to an entire population regardless of context, and indeed it is not the aim. However, it may be possible to transfer the concepts and themes from the study to other similar contexts.

Another limitation relates to my relationship to the setting and the participants, as I worked as an emergency nurse for three years in this environment. While I stopped working in ED, almost one year prior of starting the recruitment and the data collection process, some of the participants knew me personally, as their former colleague. During recruitment and interviews, I have observed mainly the benefits of this relationship, staff responding to recruitment in a relatively large number and in a short period of time, potentially because a relationship of trust and credibility was already established with some of them. However, conducting the study in a hospital where I am not known to some of the staff, could have potentially generated different data. This is discussed further in the next section.

7.6 Reflexivity

Reflexivity played a crucial role throughout the planning, data collection, coding, analysis, and interpretation process, in examining my own practices, judgements and belief or value system, so that I could identify potential biases that may have affected the research process and the findings.

During the process of reflexivity, my focus shifted from the main objectives of the study, onto myself, accepting that as a researcher in an IPA research study, I am an integral and dynamic part of it, actively examining myself, as the person who makes judgments while interpreting the data (Dowling, 2006). This process helped me understand and accept that I am actively influencing the outcome of the project and as such, I need to question my own assumptions. In this context reflexivity became a set of continuous and collaborative practice, offering me an opportunity to self-consciously evaluate, appraise, but also critique how my own subjectivity could influence the research process and the findings (Finlay, 2002b). Ways in which data can be affected by the researcher's bias could include the data collection and analysis methods used, or how data and findings are reported (Barrett et al., 2020). As such, I have incorporated reflexivity into my analysis process focusing on the issue or data at hand. I have described how interactions between myself, and the research study could generate unwanted results, instead of describing a judgement call at every step of the process.

The practical method of incorporating reflexivity into my analytical process was by writing a reflexive journal. This journal included a collection of identifiers about myself, such as who I am, what is my background and upbringing; my relationship with the participants; personal values and beliefs that I hold; anything causing confusion or anxiety for me; a record of the decisions I've made and how I feel about them; how I made meaning of the data and certain procedural notes on what I did and why (Finlay, 2002b). I am a white European middle-class male, middle-aged healthcare professional, married with two children, I am heterosexual, born and raised in an urban environment. As I used to work for three years in the same ED, where the research study was conducted, I personally knew some of the participants. However, I stopped working in the department almost a year prior to the start of data collection. This aspect is discussed in more detail in Chapter 4. I consider myself holding conservative values and I identify myself as Christian, sharing the spiritual and moral standards of this belief system. The rigour and rationale of the decision-making process of selecting the research methodology, data collection and data analysis methods, are detailed in Chapter 4 and 5.

During this reflexive exercise, I've used the etic and emic approaches to understand bias in my study of human behaviour, etic looking at behaviour from the outside, while emic is aiming to identify similarities in behaviours from the inside (Berry, 1969). As part of the emic, I've noted that I am sharing attitudes, approaches, language, and experience with HCP's working in ED, while as part of my etic, my values and norms were different from the participants.

In my reflexive journal, I focused on the following four major areas:

Personal reflexivity

In this section I have asked the question: *"How my unique features, background, perspectives, and values are influencing the research study?"*

Personal reflexivity required me to acknowledge that my participation is a significant aspect of the research process, and this participation must be interpreted, that I must clarify my assumptions and my conscious and unconscious reactions to the said and unsaid data (Walsh, 2003; Gentles et al., 2014). This engagement required me to go beyond my background and professional career; including descriptions of how my motivations and experiences could influence the interpretation of the data, and if that influence was positive, negative, or neutral (Finlay, 2002a). One of the challenges that I have encountered during interpretation was to acknowledge my views about 'the afterlife', my own belief system about giving a spiritual content to death and how to interpret views that contradicts mine. At some stage I've reflected about this aspect in my journal: *"I believe death is more than just a natural, biological event. I believe we humans have an eternal spirit, that lives even after our body stops functioning. Yet, I accept that some people don't see it that way. I respect their opinion. As such I don't consider their participation, views, interpretation about death being less important, unequal, or not relevant, compared to those participants that share my beliefs."*

Part of the personal reflexivity should be the impact of the research study has also on the researcher (Finefter-Rosenbluh, 2017). This research study helped me to reshape my practice and widen my view and understanding of certain phenomenon, while the sensitive nature of the subject triggered some intense emotions, as I shared the loss and grief the participants expressed (Koopman et al., 2020). In my journal I have noted the followings at the end of one of the interviews: *"I was surprised that even a consultant, working for nearly two decades in ED, whom almost everyone might consider a 'macho figure' can become so emotional while recalling some of the upsetting memories. I couldn't help it. I feel that it affected me as well. I couldn't not feel what he felt, as he described in detail some of his death experiences. I need to stop, and process and let settle my own emotions first, before making any interpretation of what I just heard … The more I listen to what people are sharing, the more I change as a person. I think I've become more mature along the process."*

One of the events that impacted my journey during this research study, was a complete change of the supervisory team, shortly after my first progression review. A brief note that I have made in my journal highlighted the followings: *"At the beginning of my second year in my PhD studies, I was really scared how this sudden change of the supervisory team, will impact my performance … Looking back, I noticed that after a period of transition, our relationship matured quickly with my supervisors, and while their expectations pushed me often out of my comfort zone, this created the environment for a significant improvement and continuous progress in my study."*

As a summary in my reflexive journal, I have described the journey I have made throughout my research study and the influence it had on my professional and personal life alike: "*Over the past five years, since the start of my research I have developed as a researcher, in my methods, in my understanding and resilience. Both myself and my supervisors noted the quality improvement of my writing as I was progressing in my study, being more sophisticated, using a more diverse vocabulary and referencing more appropriate sources in my work. As a healthcare professional, I* *was able to apply many of the research principles studied, and use them as a source of assessing, understanding, and interpreting a clinical issue, planning using potential solutions, implementing, then re-assessing the results. As an individual I have grown and matured through the challenges and barriers that I had to overcome along this journey, including the recovery from a life-threatening infection with Covid-19."*

Interpersonal reflexivity

In this section I have asked the question: *"Are there any personal relationships with participants and how they are influencing the research study?"*

Interpersonal reflexivity refers to how the relationships with participants, their knowledge, perspective, the possible power position the researcher might play, or their interpretation of the questions could influence the study (Walsh, 2003). Another aspect of interpersonal reflexivity included the interplay between me and the supervisory team's expectations, motivations, and assumptions (Russell and Kelly, 2002). The pre-existing relationship with some participants, often appeared to serve to build a fast rapport with participants, and they appeared often to communicate openly and honestly. For other participants, it took slightly longer to build a relationship of trust where they can share sensitive memories from their practice.

Methodological reflexivity was also considered as part of the process, reflecting on how I have made the decision, in agreement with the supervisory team, to use IPA as my methodology and why in-depth interviews proved to be the most appropriate methodological approach to collect data (Varpio and MacLeod 2020). Details of the arguments, reflecting on the different methodologies considered to be used, and the rationale for choosing IPA and semi-structured interviews were discussed in Chapter 4.

Contextual reflexivity concerns consideration of the potential of social, historical, and cultural contexts that could have influenced the research study (Naidu and Sliep, 2011). As data collection happened during Covid-19, I have reflected on how the pandemic influenced staff's experiences, some of the stories told by staff. In my journal I have noted the following at the end of one of the interviews: *"When talking about memorable deaths during her practice in ED, I couldn't not note, how one of the particular sudden deaths of a male patient, in his thirties, diagnosed with Covid-19, affected her (the participant). There was a sense of anxiety in her voice as she told the story. A feeling of uncertainty. That it can happen to anyone. Not only the old or those suffering with comorbidities. A feeling of helplessness also reflected in her tone. The inability to predict the outcome, despite the vast clinical experience. The speed at which someone with Covid-19 can become acutely unwell and die, almost shocked her."*

Reflexivity, helped me to reinforce my accountability, supporting the reader to better understand the research process, but also being essential in publishing valuable findings (Barrett et al., 2020). Trustworthiness, helps me to gain public trust and better connect with the reader, validating my study in the public eye. Clarity and precision help me to communicate with my readers, explaining how I reached to certain conclusions. Finally, reflexivity helped me to achieve a personal growth, engage in genuine introspection and affected positively my overall work and clinical practice.

7.7 Dissemination of the results

The findings of this project will likely present an interest to policy makers, executives, and managers in healthcare institutions, healthcare practitioners in various roles, academics, researchers, service users, and the wider public, with a dedicated focus on palliative, end-of-life, emergency, and critical care. Details of objectives, importance and partial results of this research study have been disseminated with the wider healthcare and research community on various live and virtual events, competitions, and conferences, including:

- Second International Postgraduate Conference (University of Southampton) 2018 – oral presentation
- 3MT – Three Minute Thesis 2018 (Faculty Runner Up) – oral presentation
- Researcher’s Image Competition 2018 (Judges and People’s Choice Runner Up) – poster presentation
- ‘Proud to care’ Symposium (University Hospital Southampton) 2018 – oral presentation
- Clinical Academic Conference (University of Southampton) 2019 – oral presentation
- Medical and Health Research Conference (University Hospital Southampton) 2019 – poster presentation
- 3MT – Three Minute Thesis 2022 (Faculty Champion) – oral presentation
- 3MT – Three Minute Thesis 2022 (Grand Final – People’s Choice Winner) – oral presentation

Over the past five years I have also used various professional social media platforms to promote and talk about my research, which stirred interest in the research community, resulting in some collaborations with other researchers. These collaborations supported similar studies, being in an earlier stage to gain an insight into my objectives, methods, and partial results, acting as a role model for future research.

Dissemination to the wider academic community will occur through publication of academic papers utilising a publication strategy that will involve aiming to publish in high impact factor peer-reviewed academic journals. This will ensure findings are disseminated to a wide audience including those outside of health care. My plan would include to publish approximately three journal articles from the findings of this study, due to the richness of the collected data, focusing on the findings of the literature review, while the second and third journal article would be drawn from some of the specific aspects of this study, such as the unique elements and aspects of the death experience in ED or the influence of personal values on this experience. I intend to submit to a peer-reviewed journal with a specific focus on palliative, emergency, critical care, or nursing ethics. for example: International Emergency Nursing, Journal of Emergency Nursing, Annals of Emergency Medicine, Social Science and Medicine, Journal of Clinical Nursing, Nursing Ethics, Palliative and Supportive Care and Resuscitation. My expectation is to start developing the first paper following submission of my final thesis in March 2023.

7.8 Overall conclusions

This PhD thesis explored and interpreted the lived experiences of HCPs in relation to death in the ED of a large and acute, teaching and research hospital in England. The interest in this research topic was generated by existing evidence that suggests death in the ED is considered a different experience compared to an environment where death can be planned and expected, and by a lack of knowledge about the influence of HCP's values and norms on these experiences. HCP experiences were explored in relation with their individual norms and values and how these have an implication on their personal and professional life. The core methodology that informed data collection and analysis was IPA, as it offered a unique opportunity, not only for an exploration of individual experiences, but also to understand and make sense of the meanings behind them, through hermeneutics and ideography. This PhD study investigated and answered the research questions:

What are the healthcare professionals' lived experiences of death in the Emergency Department?

Within the higher order concept '***Experiencing death in the ED'*,** characteristics of memorable deaths, and the objectification and humanising of patients by HCPs were explored. The higher order concept '***Making sense of death in the ED'*** had the overall objective of understanding the role of HCP's personal values and norms, upon the experiences with death in the ED. This was followed by participants describing these experiences as influencing their personal and professional life, summarized in the final higher order concept '***Influenced by death in the ED'*.**

As death remains part of the clinical experience in the ED, a better understanding of this phenomenon which will inform practice development and policy, will enable HCPs to have improved confidence and skills to ensure they are better prepared when encountering the death of a patient. Acknowledgement at the individual, organisational and system level, that personal values and norms influence HCP's experience of death, provision of patient care, bereavement and their own self-care, can support the development of better services, to enhance aspects of staff wellbeing, job satisfaction, life-long learning, development, and improvement at the workplace. Implications of the findings from this study should be addressed both locally and nationally, through comprehensive education, training, and support services development, as well as influencing policy and lawmakers. Recommendations for future research could potentially enable the research community to investigate further areas, aspects or subjects of interest, in relation to the death experience in the ED, seeking for solutions in managing this complex phenomenon.

This study presented the experience of death, not as an objective reality, but within the context of the complexity of individual experience, which cannot be detached from the professional practice. This study argues that exposure to death, with adequate preparation and comprehensive support, can be an experience, that will enable healthcare assistants, nurses, and doctors to become even more empathetic and compassionate towards their patients and their families, improve the provision of EOLC in ED, and as such, fulfil the deeper meaning of their professional call, finding satisfaction and perspective in their roles and careers.

This study concludes that personal values and norms, including the social, cultural, spiritual, and moral aspects, are bonded in our identity, and play a crucial role when HCPs are experiencing and making sense of death and dying in the ED. Personal values and norms will influence HCP's attitudes towards death, their coping mechanisms and learning from these experiences, shaping their attitude to patient care or career development, impacting their decisions, priorities and behaviours in their personal and professional life. These experiences were explored by giving voice individually to HCP's working in the ED, through consideration of their stories and interpretation of their meanings.

Appendix A Initial contemplation process to support choosing the literature review method

CLARIFICATION QUESTIONS	ANSWER & RATIONALE
PURPOSE	
What is the principal aim of the literature review?	**A:** Create a knowledge foundation of the topic from the existing literature and identify the gaps in current knowledge. **R:** Current knowledge can be used as 'building blocks', while gaps help in defining the final research question.
What are the initial expectations?	**A:** Possibly numerous resources on death experiences in hospital, possibly also in the ED, while possibly a limited number of research with correlation to HCPs' values and norms and their influence. **R:** Death experiences in the ED is a topic with an emerging importance, while in relation with HCPs' values and norms it appears to be less researched
DIRECTION	
Broad or narrow topic?	**A:** Broad for death experiences in ED, while narrow for HCPs values and norms in relation to this experience **R:** A broad focus on death experience in ED will allow for more depth and breath, while a narrowed focus on HCPs' values and norms will allow identifying gaps
Summarize only or synthesize and critique sources?	**A:** Synthesize and critique **R:** Summarizing only will provide a superficial analysis, while searching for themes and understanding limitations will offer a better insight

METHODS	
What should be the review method?	**A:** Narrative Review with a systematic approach **R:** Narrative reviews provide interpretation and critique, their key contribution being a deepening understanding, while following a systematic protocol will allow transparency of the review process
What should be the tool for defining the search strategy and inclusion and exclusion criteria?	**A:** SPIDER tool **R:** The tool created to develop effective search strategies of qualitative and mixed-methods research.
What should be the critical appraisal method?	**A:** CASP tool **R:** The method is focusing on 3 major areas: 'Is the study valid?'; 'What are the results?'; 'Are the results useful?'

Appendix B Literature review methods considered

TYPE OF LITERATURE REVIEW	MAIN FEATURES
Systematic review	• Seeks to systematically search for appraise and synthesis research evidence, often adhering to the guidelines • It is transparent in the reporting of its methods to facilitate others to replicate the process.
Meta-analysis	• Statistically combines the results of quantitative studies to provide a more precise effect of the results • To be valid requires all included studies to be sufficiently similar (population, intervention, comparison, etc.) • Requires that the same measure or outcome be measured in the same way at the same time intervals.
Rapid review	• Also known as 'Rapid Evidence Assessments' • Proposed as a means of providing an assessment of what is already known about a topic and critically appraise existing research.
Systematized review	• Attempt to include elements of the systematic review process • Are typically conducted as a postgraduate student assignment, in recognition that they are not able replicate a full systematic review.
Scoping review	• Provides a preliminary assessment of the potential size and scope of available research literature. • Aims to identify the nature and extent of research evidence.
Umbrella review	• Refers to a review compiling evidence from multiple Cochrane reviews into one accessible and usable document • Focuses on a broad condition or problem for which there are two or more potential interventions • Highlights reviews that address these potential interventions and their results.

Appendix C Databases used in the searching process

CONTENT PROVIDERS/SOURCES	Brief description
MEDLINE/PubMED	MEDLINE is the American National Library of Medicine bibliographic database that contains references to journal articles in life sciences, with a concentration on biomedicine. MEDLINE is indexed with the Medical Subject Headings (MeSH) and is the primary component of PubMed
AMED	AMED is a bibliographic database produced by the Health Care Information Service of the British Library. AMED covers a selection of journals in complementary medicine, palliative care, and several professions allied to medicine.
PsycINFO	PsycINFO is a database produced by the American Psychological Association. PsycINFO is a large resource of peer-reviewed literature in behavioural science and mental health.
CINAHL	CINAHL is a database providing access to nursing and allied health literature. The literature covered in this database includes a wide range of topics such as nursing, biomedicine, alternative medicine, consumer health and various allied health disciplines.
Cochrane Database of Systematic Reviews	The Cochrane Library is a collection of databases that contain different types of high-quality independent evidence.
SciELO	SciELO is a bibliographic database and a cooperative electronic publishing model of open access journals.
SCOPUS	SCOPUS is a large abstract and citation database of peer-reviewed literature.
HeinONLINE	HeinONLINE is a database containing historical and government documents, including a vast collection of academic journals.
Directory of Open Access Journals	Directory of Open Access Journals (DOAJ) is a community-curated online directory that indexes and provides access to high quality, open access, peer-reviewed journals.

Appendix D Search strings developed from keywords

Search string SS1: Broad version	**Search string SS1-1: Narrowed version**
Death OR Dead OR Died OR Dying AND Emergency Department OR ED OR Accident & Emergency OR A&E OR Accident and Emergency OR Emergency Room OR ER OR Emergency Care OR Emergency Services OR Emergency Health Services OR Emergency Medical Services OR Emergency Ward OR Emergency Unit OR Emergency Centre OR Emergency Center	*In addition to SS1* AND Experience OR Lived experience OR Understand* OR Knowledge OR Sense OR Practice AND Staff OR Clinical staff OR Hospital staff OR Healthcare professional OR Healthcare worker OR Healthcare provider OR Healthcare assistant OR Nurse OR Doctor OR Physician OR Consultant OR Emergency nurse practitioner OR ENP OR Advanced care practitioner OR ACP OR HCA
Search string SS2: Broad version	**Search string SS2-1: Narrowed version**
In addition to SS1 AND Value OR Belief OR Principal OR Ethic OR Ideal OR Moral OR Standard OR Norm OR Code OR Conduct	*In addition to SS2* AND Personal OR Professional OR Institutional OR Social OR Societal OR Cultural OR Moral OR Attitude OR Sense of duty OR Spiritual
Search string SS3: Broad version	**Search string SS3-1: Narrowed version**
In addition to SS1-1 AND Manag* OR Control OR Supervise OR Cop* OR Handle OR Endure OR Deal OR Battle OR Live OR Suffer OR Support OR Help OR Aid OR Advice OR Guid* OR Assist*	*In addition to SS3* AND Prepar* OR Educat* OR Train* OR Plan* OR Qualif* OR Teach* OR Learn* OR Coach* OR Course

Appendix E Data collection form

NARRATIVE LITERATURE REVIEW

Review title or ID

Study ID *(surname of first author and year first full report of study was published)*

Report IDs of other reports of this study *(e.g. duplicate publications, follow-up studies)*
Notes:

GENERAL INFORMATION

1. **Date form completed** ***(dd/mm/yyyy)***	
2. **Name/ID of person extracting data**	
3. **Report title** *(title of paper/ abstract/ report that data are extracted from)*	
4. **Report ID** *(if there are multiple reports of this study)*	
5. **Reference details**	
6. **Report author contact details**	
7. **Publication type** *(e.g. full report, abstract, letter)*	

8. **Study funding source** *(including role of funders)*	
Possible conflicts of interest *(for study authors)*	
9. **Notes:**	

ELIGIBILITY

Study Characteristics	**Review Inclusion Criteria** *(Insert inclusion criteria for each characteristic as defined in the Protocol)*	**Yes/ No / Unclear**	**Location in text** *(pg & ¶/fig/table)*
Type of study			
10. **Participants**			
11. **Research method**			
12. **Notes:**			

DO NOT PROCEED IF STUDY EXCLUDED FROM REVIEW

POPULATION AND SETTING

	Description *Include comparative information for each group (i.e. intervention and controls) if available*	**Location in text** *(pg & ¶/fig/table)*
13. **Population description** *(from which study participants are drawn)*		
14. **Setting** *(including location and social context)*		
15. **Inclusion criteria**		
16. **Exclusion criteria**		
17. **Method/s of recruitment of participants**		
18. **Notes:**		

METHODS

	Descriptions as stated in report/paper	**Location in text** *(pg & ¶/fig/table)*
19. **Aim of study**		
20. **Design**		
21. **Data collection**		
22. **Data analysis**		
23. **Start date**		
24. **End date**		

25. **Duration of participation** *(from recruitment to last follow-up)*		
26. **Notes:**		

PARTICIPANTS

Provide overall data and, if available, comparative data for each intervention or comparison group.

	Description as stated in report/paper	**Location in text** (pg & ¶/fig/table)
27. **Age**		
28. **Sex**		
29. **Race/Ethnicity**		
30. **Other relevant socio-demographics**		
31. **Subgroups measured**		
32. **Notes:**		

RESULTS

	Description as stated in report/paper	**Location in text** *(pg & ¶/fig/table)*
33. **Outcome**		
34. **Discussion**		

APPLICABILITY

35. **Have important populations been excluded from the study?**	*Yes/No/Unclear*	

(consider disadvantaged populations, and possible differences in the intervention effect)		
36. **Does the study directly address the review question?** *(any issues of partial or indirect applicability)*	*Yes/No/Unclear*	
37. **Notes:**		

OTHER INFORMATION

	Description as stated in report/paper	**Location in text** *(pg & ¶/fig/table)*
38. **Key conclusions of study authors**		
39. **References to other relevant studies**		
40. **Notes:**		

Appendix F Critical Appraisal Skills Programme (CASP) questions

The 10 questions used for critical appraisal include:

Question 1: Was there a clear statement of the aims of the research?

Question 2: Is a qualitative methodology appropriate?

Question 3: Was the research design appropriate to address the aims of the research?

Question 4: Was the recruitment strategy appropriate to the aims of the research?

Question 5: Was the data collected in a way that addressed the research issue?

Question 6: Has the relationship between the researcher and participants been adequately considered?

Question 7: Have ethical issues been taken into consideration?

Question 8: Was the data analysis sufficiently rigorous?

Question 9: Is there a clear statement of the findings?

Question 10: How valuable is the research?

Appendix G Interview questions, prompts and guide

Study title: ***Understanding healthcare professionals' lived experiences of death in the Emergency Department and the influence of personal values and norms***

Researcher name: **Laszlo Penzes**

ERGO number: 52903

IRAS number: 292601

TRUST R&D reference RHM MED1670 Version: 6.0 Date: 05.12.2019

The questions and prompts below are for reference purposes only. Conversation will occur in a natural form, following the "warming up phase", where questions will be asked taking in consideration the context of the answers and stories told by the participant.

Warming up phase (not recorded)

Introductions, confirmation of identity and signed consent form, brief everyday conversation

Making sure the participant is comfortable and has enough, uninterrupted time, has a drink available

Making sure the participant understands the relevance and benefits of the study

Making sure the participant is feeling safe, knows that we can pause or interrupt if needed, or he/she can withdraw if needed.

Main phase (recording starts)

IDENTITY AND VALUES

Tell me about yourself?

How do you see yourself and how others would describe you? (Prompt for interviewer: eg. personality is optimistic, cheerful, introverted, family, parents, siblings, education, cultural and social background, etc.)

What are the things that matter/are important for you in life? (Prompt for interviewer: eg. family, health, career, social esteem, money, relationships, faith, volunteering, charity, travel, entertainment, ...)

For how long have you been working in the Emergency Department?

Why have you chosen this profession/this particular area? (Prompt for interviewer: eg. dedication, purpose, career, family tradition, job security, ...)

Can you describe your job role? (Prompt for interviewer: eg. duties, daily tasks, responsibilities, reporting, ...)

What are the things you like the most/least in your job?

EXPERIENCING DEATH

How would you define death?

What does death mean to you personally? (Prompt for interviewer: eg. separation, sadness, mourning, deep feelings, thinking about how fragile life could be, thinking about what's important in life ...)

Have you had any previous experience of witnessing death, prior to working in the Emergency Department?

How this experience made you feel?

Please tell me about the time(s) you experienced the death of a patient while working in the Emergency Department?

How this experience made you feel?

What were your thoughts after this experience?

How this work related death experince compared to a death experience in your private life?

Is there a case or are there cases, that are particularly memorable?

What make these cases unique, memorable?

Would your experience be any different if certain features would have been different? (Prompt for interviewer: eg. age of the patient, gender of the patient, patient was already on a palliative pathway, patient already dead on arrival, etc.)

What were your exact duties during this death experience? (Prompt for interviewer: eg. assisting the doctor, prepare the body for last offices, inform relatives, discuss further steps with relatives, ...)

EFFECTS OF EXPERIENCING DEATH

Had this experience any effect on you?

How would you describe this effect? (Prompt for interviewer: eg. mood, behaviour, health, habits or relationships)

What do you do to cope with these?

Did this experience changed you as a person? In what way?

Do you see patients and relatives differently since this experience? In what way?

Did this experience changed anything in how you see and do your job?

Did this experience changed the things that matter/are important for you in life?

Did this experience had any influence on your career goals and prospects?

SUPPORT IN EXPERIENCING DEATH

Is there anything you would have wanted to know prior to this experience?

Is there any training about death, you would have wanted to attend? (Prompts for interviewer: eg. Breaking bad news, last offices, coping with death, emotional intelligence, CBT, …)

What do you think would have helped to have a different experience?

What do yo think would help to better cope?

What do you think would help to be better prepared for such situations?

Is there anything in particular that you think could help to offer better care for dying patients in ED?

Are there any obstacles that prevents you from offering a better care for dying patients in ED?

Is there anything you would change in current practice? What?

Closing phase (recording ends after these questions)

Is there anything else that you would like to tell me?

Is there anything about this research that you would like to know?

Have you got any final questions?

Good practice – things to keep in mind during interviewing

- There is an attempt to establish rapport with the respondent.
- The ordering of questions is less important.
- The interviewer is freer to probe interesting areas that arise.
- The interview can follow the respondent’s interests or concerns.
- Prompts forces us to think explicitly about what we think/hope the interview might cover.
- Having thought in advance about the different ways the interview may proceed allows us, when it comes to the interview itself, to concentrate more thoroughly and more confidently on what the respondent is actually saying
- Prompts and questions are intended to be only suggestive, not prescriptive.
- Encourage the person to speak about the topic with as little prompting from the interviewer as possible.
- Good interview technique often involves a gentle nudge from the interviewer rather than being too explicit.
- Sometimes an initial question will be insufficient to elicit a satisfactory response. This may be for various reasons – the issue is a complex one or the question is too general or vague for this particular participant. Prompts can help.

- Thus, the interviewer starts with the most general possible question and hopes that this will be sufficient to enable the respondent to talk about the subject. If respondents have difficulty, say they do not understand, or give a short or tangential reply, the interviewer can move to the prompt, which is more specific.
- If an interview is taken up with material entirely derived from very specific follow-up questions, you may need to ask yourself how engaged the respondent is. Are you really entering the personal/social life world of the participants, or are you forcing them, perhaps reluctantly and unsuccessfully, to enter yours?
- Questions should be neutral rather than value-laden or leading.
- Avoid jargon or assumptions of technical proficiency. Try to think of the perspective and language of the participants.
- Use open, not closed, questions.
- Try not to rush in too quickly.
- Ask one question at a time.
- Monitor the effect of the interview on the respondent.
- It is sensible to concentrate at the beginning of the interview on putting respondents at ease, to enable them to feel comfortable talking to you before any of the substantive areas of the schedule are introduced.
- The interviewer’s role here is to facilitate and guide, rather than dictate exactly what will happen during the encounter.
- If the interviewer has learnt the schedule in advance, he or she can concentrate during the interview on what the respondent is saying, and occasionally monitor the coverage of the scheduled topics.
- The interview may well move away from the questions on the schedule, and the interviewer must decide how much movement is acceptable. It is quite possible that the interview may enter an area that had not been predicted by the investigator, but which is extremely pertinent to, and enlightening of, the project’s overall question. Indeed, these novel avenues are often the most valuable, precisely because they have come unprompted from respondents and, therefore, are likely to be of especial importance for them.

Appendix H Participant information sheet

Study title: ***Understanding healthcare professionals' lived experiences of death in the Emergency Department and the influence of personal values and norms***

Researcher name: **Laszlo Penzes**

ERGO number: 52903

IRAS number: 292601

TRUST R&D reference RHM MED1670 Version: 7.0 Date: 09.11.2020

You are being invited to take part in the above research study. To help you decide whether you would like to take part or not, it is important that you understand why the research is being done and what it will involve. Please read the information below carefully and ask questions if anything is not clear or you would like more information before you decide to take part in this research. You may like to discuss it with others, but it is up to you to decide, whether or not to take part. If you are happy to participate you will be asked to sign a consent form.

What is the research about?

I am Laszlo Penzes, and I am undertaking a PhD study to understand staff experiences of sudden death in the Emergency Department. The findings of this study will help us better understand the impact of such events on staff.

Why have I been asked to participate?

As a member of the clinical staff in the Emergency Department, who potentially witnessed death in ED, you are potentially an ideal candidate to help me understand this experience from a staff's perspective. Members of staff with various clinical role, background and experience are welcome to participate.

Do I have to take part?

No, it is entirely up to you to decide, whether or not to take part. If you decide you want to take part, you will need to sign a consent form to show you have agreed to take part.

Are there any benefits in my taking part?

The information collected during these interviews will help us understand the real impact witnessing sudden death in the Emergency Department has on staff, and how that reflects in the future provision of care. These findings can provide a basis for a better education and preparation of staff for such events, improvement in coping strategies and interpersonal relationships.

Are there any risks involved?

Due to the delicate nature of the subject, talking about somebody's death, can bring to surface painful memories. In case the conversation, the interview will become uncomfortable, there will be always a possibility to take a break, to stop or even to withdraw if required. The research team will create an environment and will conduct the interviews in a manner that will have your feelings, emotions, beliefs, views, and requests at the centre.

If recalling memories of an incident could cause distress to you, an organisational response is available at UHS, called TRIM (Trauma Risk Management). TRiM is a way of assessing the psychological impact on staff of exposure to distressing situations. TRiM assessment is a service that is open to everyone affected by an incident and will help exploring how you are coping after a traumatic event, and thinking about what support, if any, might be helpful. In case you would like to benefit from this service please use below contacts:

Lorna Brown -*TRiM Manager, the Emergency Department*

Extension XXXX | lorna.brown@XXX.nhs.uk

Karen MacKinnon - *TRiM lead*

Jude Reay - *TRiM medical lead*

(contact details on trust's StaffNet TRIM page)

What will happen to me if I take part?

During this study, I will conduct one-to-one narrative interviews with members of clinical staff, including consultants, doctors, SHOs, ACPs, ENPs, Nurses (all bands) and HCAs. If you decide to take part in this study, the interview will take place at a time convenient to you. The interview itself will be conversational in nature, where you will be offered the opportunity to freely express your thoughts and feelings. The conversations will be audio-recorded with your permission. The length of the interview will aim to be up to 60 minutes for narrative interviews, but will depend on you and the amount and detail of information you wish to share during these interviews. Prior to the interview, a consent form will be required to be signed.

What data will be collected?

The purpose of the narrative interviews is to reflect on the general experience with death in ED. During the interviews an account of personal experiences will have sought which will include feelings, emotions, thoughts, memories and reflections. These personal experiences will be audio-recorded with your permission, transcribed, analysed and compared to other similar experiences. Direct quotes might be also used from the interviews, but personal identity will be protected, as a pseudonym will be used instead of your name in the reports and final study.

As the interview will happen with a commercial application called Microsoft Teams, over an online platform, detailed information about data and information handling of the application provider, including instructions on how to enable or disable different features can be found in the 'Privacy, security, and compliance in Microsoft Teams' section of the provider's website: https://www.microsoft.com/en-gb/microsoft-365/microsoft-teams/security

Interviews will not be video recorded using the application.

What happens if I change my mind?

You have the right to change your mind and withdraw at any time without giving a reason and without your participant rights being affected. If you withdraw from the study, we will keep the information about you that we have already obtained for the purposes of achieving the objectives of the study only. In case you would like to withdraw please get in touch with the researcher on the contact details provided below.

Will my participation be confidential?

Your participation and the information we collect about you during the course of the research will be kept strictly confidential. Only members of the research team (the researcher and the supervisors) may be given access to data about you for monitoring purposes and/or to carry out an audit of the study to ensure that the research is complying with applicable regulations. Individuals from regulatory authorities (people who check that we are carrying out the study correctly) may require access to your data. All of these people have a duty to keep your information, as a research participant, strictly confidential.

Any information identifying the participants, for instance signed consent sheets, field notes and pseudonyms that are linked to the identity of the participants will be kept in locked storage separately from the anonymised data. In line with the Faculty of Health Science's storage policy, paper data will be kept in locked strictly controlled storage for 10 years and then disposed of securely. The electronic data files will also be held on the University's servers and deleted after 10 years. All audio recordings will be transcribed and handled as above, while the recordings will be deleted/destroyed. Anything you say in the interview will be confidential and not communicated to the senior clinical team, unless you say something which indicates that you may be at risk of harm. In this case, this information will be passed on to the direct supervisor, in a sensitive and confidential manner. This is part of our duty of care and a key responsibility for healthcare professionals' overall wellbeing.

What will happen to the results of the research?

Your personal details will remain strictly confidential. Research findings made available in any reports or publications will not include information that can directly identify you without your specific consent.

The findings of this project will be of interest to policy makers, practitioners, academics, and users and carers in the field of palliative, emergency and critical care. The anonymised findings will be disseminated to individuals participating if they have expressed a wish to be informed during data collection, and clinical work colleagues. Dissemination to the wider academic community will occur through publication of academic papers in high impact factor peer-reviewed academic journals. The researcher will aim to deliver poster or oral presentations at various conferences as well as at the NHS trust where the research takes place and local public engagement events.

Where can I get more information?

If you have any questions about the study, please contact the researcher or his supervisors, using the contact details provided below:

Researcher:

Laszlo Penzes: lp13g14@soton.ac.uk

Supervisory team:

Dr Michelle Myall (Senior Research Fellow – University of Southampton): m.myall@soton.ac.uk

Dr Joanne Turnbull (Lecturer - University of Southampton): j.c.turnbull@soton.ac.uk

What happens if there is a problem?

If you have a concern about any aspect of this study, you should speak to the researchers who will do their best to answer your questions. Getting in touch with the research team is via the contact details provided above.

If you remain unhappy or have a complaint about any aspect of this study, please contact the University of Southampton Research Integrity and Governance Manager (023 8059 5058, rgoinfo@soton.ac.uk).

Data Protection Privacy Notice

The University of Southampton conducts research to the highest standards of research integrity. As a publicly funded organisation, the University has to ensure that it is in the public interest when we use personally identifiable information about people who have agreed to take part in research. This means that when you agree to take part in a research study, we will use information about you in the ways needed, and for the purposes specified, to conduct and complete the research project. Under data protection law, ‘Personal data’ means any information that relates to and is capable of identifying a living individual. The University’s data protection policy governing the use of personal data by the University can be found on its website (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page).

This Participant Information Sheet tells you what data will be collected for this project and whether this includes any personal data. Please ask the research team if you have any questions or are unclear what data is being collected about you.

Our privacy notice for research participants provides more information on how the University of Southampton collects and uses your personal data when you take part in one of our research projects and can be found at the following web address:

http://www.southampton.ac.uk/assets/sharepoint/intranet/ls/Public/Research%20and%20Integrity%20Privacy%20Notice/Privacy%20Notice%20for%20Research%20Participants.pdf

Any personal data we collect in this study will be used only for the purposes of carrying out our research and will be handled according to the University’s policies in line with data protection law. If any personal data is used from which you can be identified directly, it will not be disclosed to anyone else without your consent unless the University of Southampton is required by law to disclose it.

Data protection law requires us to have a valid legal reason (‘lawful basis’) to process and use your Personal data. The lawful basis for processing personal information in this research study is for the performance of a task carried out in the public interest. Personal data collected for research will not be used for any other purpose.

For the purposes of data protection law, the University of Southampton is the ‘Data Controller’ for this study, which means that we are responsible for looking after your information and using it properly. The University of Southampton will keep identifiable information about you for 10 years after the study has finished after which time any link between you and your information will be removed.

To safeguard your rights, we will use the minimum personal data necessary to achieve our research study objectives. Your data protection rights – such as to access, change, or transfer such information - may be limited, however, in order for the research output to be reliable and accurate. The University will not do anything with your personal data that you would not reasonably expect.

If you have any questions about how your personal data is used, or wish to exercise any of your rights, please consult the University’s data protection webpage (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page) where you can make a request using our online form. If you need further assistance, please contact the University’s Data Protection Officer (data.protection@soton.ac.uk).

Thank you if you decide to take part in this research!

Appendix I Interview consent form

Study title: ***Understanding healthcare professionals' lived experiences of death in the Emergency Department and the influence of personal values and norms***

Researcher name: **Laszlo Penzes**

ERGO number: 52903

IRAS number: 292601

TRUST R&D reference RHM MED1670 Version: 6.0 Date: 09.11.2020

Please initial the box(es) if you agree with the statement(s):

I have read and understood the information sheet Version No.7 Date: 09.11.2020 and have had the opportunity to ask questions about the study.	
I agree to take part in this research project and agree for my data to be used for the purpose of this study.	
I understand my participation is voluntary and I may withdraw at any time, for any reason without my participation rights being affected.	
I understand that I may be quoted directly in reports of the research but that I will not be directly identified (e.g. that my name will not be used).	
I understand that taking part in the study involves audio recording which will be transcribed and then destroyed for the purposes set out in the participation information sheet.	
I understand that should I withdraw from the study then the information collected about me up to this point, may still be used for the purposes of achieving the objectives of the study only.	

Name of participant (print name)……………………………………………………………………………

Signature of participant……………………………………………………………………………… Date……………………………………

Name of researcher (print name): **Laszlo Penzes**

Signature of researcher……………………………………………………………………………… Date……………………………………

Appendix J Recruitment poster

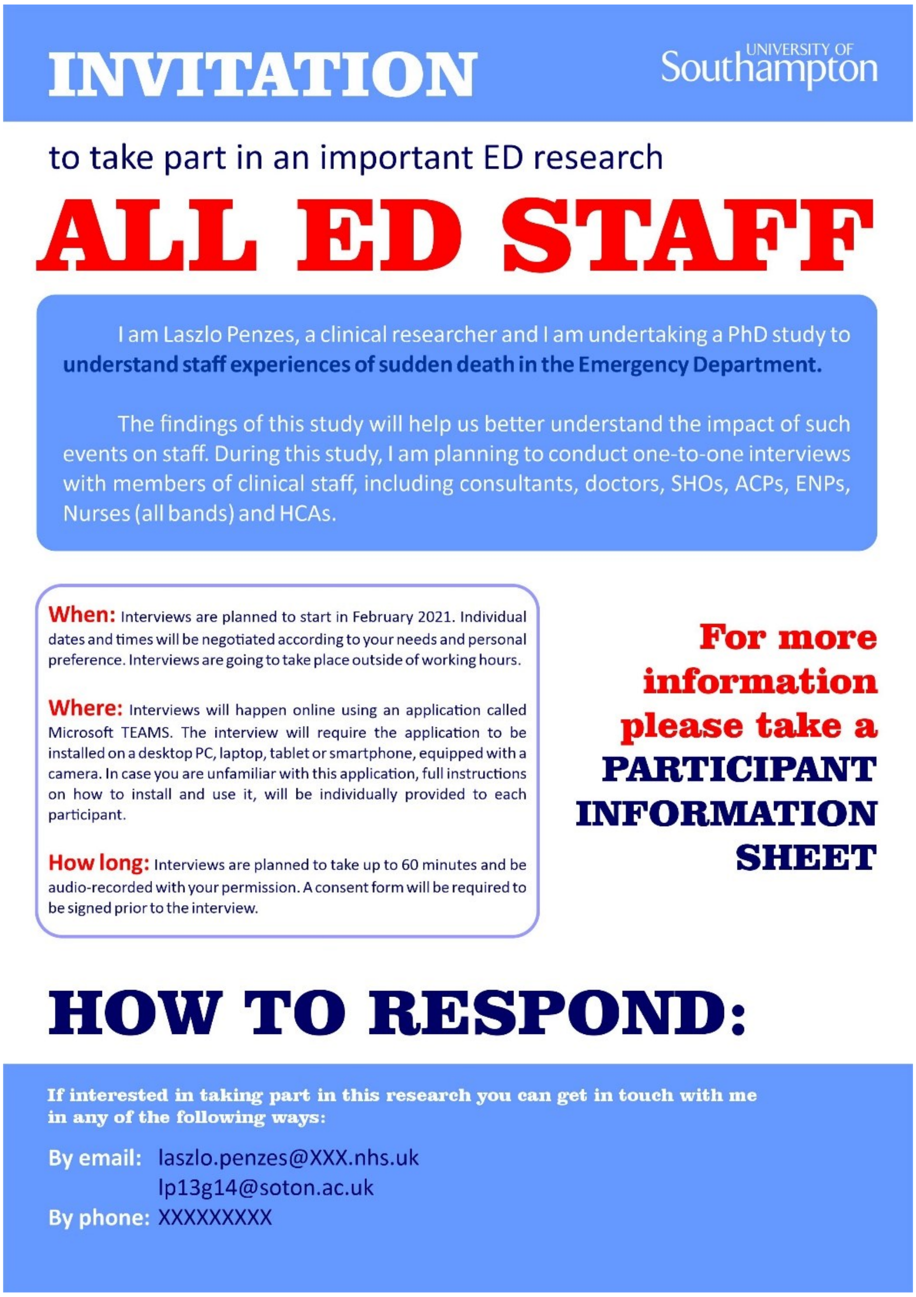
Study title: ***Understanding healthcare professionals' lived experiences of death in the Emergency Department and the influence of personal values and norms***

Researcher name: **Laszlo Penzes**

ERGO number: **52903**

IRAS number: **292601** **Poster size: A4 with portrait orientation**

TRUST R&D reference **RHM MED1670** **Version: 7.0** **Date: 09.11.2020**



INVITATION

UNIVERSITY OF Southampton

to take part in an important ED research

ALL ED STAFF

I am Laszlo Penzes, a clinical researcher and I am undertaking a PhD study to **understand staff experiences of sudden death in the Emergency Department.**

The findings of this study will help us better understand the impact of such events on staff. During this study, I am planning to conduct one-to-one interviews with members of clinical staff, including consultants, doctors, SHOs, ACPs, ENPs, Nurses (all bands) and HCAs.

When: Interviews are planned to start in February 2021. Individual dates and times will be negotiated according to your needs and personal preference. Interviews are going to take place outside of working hours.

Where: Interviews will happen online using an application called Microsoft TEAMS. The interview will require the application to be installed on a desktop PC, laptop, tablet or smartphone, equipped with a camera. In case you are unfamiliar with this application, full instructions on how to install and use it, will be individually provided to each participant.

How long: Interviews are planned to take up to 60 minutes and be audio-recorded with your permission. A consent form will be required to be signed prior to the interview.

For more information please take a PARTICIPANT INFORMATION SHEET

HOW TO RESPOND:

If interested in taking part in this research you can get in touch with me in any of the following ways:

By email: laszlo.penzes@XXX.nhs.uk
lp13g14@soton.ac.uk
By phone: XXXXXXXXX

Appendix K Recruitment email

Study title: ***Understanding healthcare professionals' lived experiences of death in the Emergency Department and the influence of personal values and norms***

Researcher name: **Laszlo Penzes**

ERGO number: 52903

IRAS number: 292601

TRUST R&D reference RHM MED1670 Version: 6.0 Date: 09.11.2020

Date:

Recipient: ED Doctors; ED Consultants; ED Matrons; ED NurseBand7; ED NurseBand6; ED NurseBand5; ED HCA

Subject: Your voice matters: *Invitation to take part in an ED research*

Dear ED staff,

I am writing this email on behalf of Laszlo Penzes, clinical researcher, who is undertaking a PhD study to understand staff experience of sudden death in the Emergency Department. During this study, he is planning to conduct one-to-one interviews with members of clinical staff, including consultants, doctors, SHOs, ACPs, ENPs, Nurses (all bands) and HCAs. The findings of this study will help him better understand the impact of such events on staff.

When: Interviews are planned to start in February 2021. Individual dates and times will be negotiated according to your needs and personal preference. Interviews are going to take place outside of working hours.

Where: Interviews will happen online using an application called Microsoft TEAMS. The interview will require the application to be installed on a desktop PC, laptop, tablet or smartphone, equipped with a camera. In case you are unfamiliar with this application, full instructions on how to install and use it, will be individually provided to each participant.

How long: Interviews are planned to take up to 60 minutes and be audio-recorded with your permission. A consent form will be required to be signed prior to the interview.

How to respond: If interested in taking part in this research you can get in touch with him in any of the following ways:

By email: laszlo.penzes@XXX.nhs.uk or lp13g14@soton.ac.uk

By phone: XXXXXXX

In case you'd like to know more about any aspect of the research, before making your decision, please ask for a Participant Information Sheet, available in print at the sister's office and at the message board in the staff room, or in electronic format by email.

Best regards,

………………

Matron or other senior clinical member of staff

Appendix L Interview appointment email

Study title: ***Understanding healthcare professionals' lived experiences of death in the Emergency Department and the influence of personal values and norms***

Researcher name: **Laszlo Penzes**

ERGO number: 52903

IRAS number: 292601

TRUST R&D reference RHM MED1670 Version: 1.0 Date: 12.02.2021

Date:

Recipient: Participant

Subject: Your interview for the ED research study

Dear Participant,

Thank you for agreeing to take part in my research study.

Death is often sudden and unexpected in ED. As such, can have emotional, psychological or even physiological consequences. This study will help better understand the **individual impact**, such events can have on healthcare professionals working in ED, in different roles.

This **new knowledge** could aid the development of future trainings and improvement of services that will **better prepare** us and **offer support**, whenever we go through similar experiences.

As we prepare for our interview let me ask and recommend a few things:

- **Please share with me your mobile number.** This will remain confidential. This is purely to be able to communicate prior or during the interview (in case we might be interrupted)
- **Please suggest some dates and times** for the last week of January and first half of February when you are not working and would have the time to chat with me remotely. These can be even weekends and evenings. I will try to be as flexible as possible.
- **Please sign the consent form** and leave it in the ED sister's office (or send me by email a scanned copy). You can either print 2 copies and sign the attached document or there

might be some printed blank copies in the red folder. Leave one in the folder and keep one for your records.

- **Interview** is planned to take about an hour. It will depend on you, how much detail you would like to share, we can finish quicker, but we can stretch it longer. The interview itself will be a friendly conversation, where I will simply guide this conversation, but I will let you talk in as much detail as you want about your experience.
- **Microsoft Teams** is an online chat application similar to Zoom. It is the preferred platform by the Trust and University of Southampton. You do not need an account. You will receive an invitation by email with a connection link for the date and time we agreed. In case you've never used Teams, this short video tutorial will explain how you can join a meeting. If still unsure, please do not hesitate to ask. https://www.youtube.com/watch?v=6pauAUOl8v4

Tips for an uninterrupted conversation

- Allow yourself 90 min. in your schedule, so that we can warm up the conversation, test the equipment and connection, but also we can slow down towards the end, especially considering the sensitive nature of the topic.
- Find a quiet room, warm, well illuminated, wear something comfortable and prepare yourself a hot drink or have some water. (there will be no video recording)
- If you don't live alone, let the others know that you need not to be interrupted, if needed, even display a 'Do not disturb' note on the door. (if for any reason we need to interrupt the interview, please don't worry)
- If possible, please put your phone on mute (unless you are expecting an important call)

Please feel free to ask me any questions you might have prior to the interview.

I am very excited to have you as a participant in this study. Looking forward to chat with you.

Best regards,

Laszlo Penzes

Appendix M Example of themes exclusion and reason

HIGHER ORDER CONCEPT	ORIGINAL SUPER-ORDINATE THEMES	FINAL SUPER-ORDINATE THEMES
EXPERIENCING DEATH IN THE ED	**MANY FACES OF DEATH**	***Reason for exclusion:*** Incorporated into the **'ED DEATHS to REMEMBER'** super-ordinate theme as more relevant to that category.
	COMPLICATED DEATH	***Reason for exclusion:*** Incorporated into the **'OBJECTIFYING AND HUMANISING DEATH'** super-ordinate theme as more relevant to that category.
	MEMORABLE DEATH	**ED DEATHS TO REMEMBER** ***Reason for change of name:*** After revisiting the emergent themes and original transcripts, this name seemed to better capture the individual experiences and describe their unique features.
	CHALLENGING DEATH	***Reason for exclusion:*** Incorporated into the **'ED DEATHS to REMEMBER'** super-ordinate theme as more relevant to that category.
	DEALING WITH DEATH	***Reason for exclusion:*** Theme discussed within the Higher Order Concept **'Influenced by death in the ED',** as discusses how participants live with the consequences and effects of these experiences.
	A DIFFERENT DEATH	**OBJECTIFYING AND HUMANISING DEATH** ***Reason for change of name:*** After revisiting the emergent themes and original transcripts, this name seemed to better capture the individual experiences and describe their unique features.

Appendix N Original Super-Ordinate and Emergent Themes across cases

SUPER-ORDINATE & EMERGING THEMES – MARGARET

WORKING IN ED	Worst day
	Mystery factor
	The little things
MEMORABLE DEATH	Emotionally difficult
	Unexpected death
	Age similarity
	Death becomes personal
	Coping with the family
	Meeting the family
	Emotionally extroverted
	End of natural life
MANY FACES OF DEATH	No fear of death
	Dignified death
	Peaceful death
	Horrible death
	Brutal death
	Pointless death
SWITCHING ROLES	Hard switch
	Short fuse
	Boundaries
DEATH INFLUENCE	Giving back
	Giving good care
	More mature
	Emotionally extroverted
	Role model for staff
	Learning by observing
	Enjoying emergency

SUPER-ORDINATE & EMERGING THEMES – DAVID

WORKING IN ED	Generous with feelings
	Organized and efficient
	Uncertainty
COMPLICATED DEATH	Ramification of death
	Act of death
	‘Auto-pilot’ mode
	Reminder
	Refuge
	Family relationships
	Accountability
	Difficult deaths
LEARNING FROM DEATH	Supporting the team
	Optimizing care
	Lack of control
	Background knowledge
	Insufficient training
	Sanitized view
SUPPORTING THE FAMILY	Sharing the experience
	Readily available
	Sharing yourself
COPING WITH DEATH	Group debrief obstacles
	Talking about experiences
	Talking with close friends
	Running
	Talking
	Socks as coping

SUPER-ORDINATE & EMERGING THEMES – RACHEL

WORKING IN ED	Terrible and amazing
	Dark sense of humour
	Adrenaline junkie
	Quick improvements
MEMORABLE DEATH	Meeting the relatives
	Young and sudden
	Known death
	Sudden death
	Humanizing death
	Young and tragic
	Irreversible
CHALLENGING DEATH	Differences in death
	Unexpected grief
	Challenging clinically
	Challenging emotionally
	Losing compassion
COPING WITH DEATH	Weird humour
	Not bottling up
	Support network
EFFECTS OF DEATH	More mature
	More honest
	Changed interaction
	Professional improvement
	Learning by experience
	Acknowledging feelings
	Not ready
	Value life
	Life’s perspective

SUPER-ORDINATE & EMERGING THEMES – ROBERT

WORKING IN ED	Meaningful existence
	Surprise
	Entirety of care
MEMORABLE DEATH	Cultural values
	Traumatic deaths
	Child deaths
	Humanizing death
	Feeling helpless
	Emotional burden
	Moving on
	Moral CPR
	Reset
INTERPRETING DEATH	Natural end of life
	Regret
	Influence
	Conscious
CELEBRATING DEATH	Good death
	Celebrating death
	Positives in death
	Death awareness
DEATH INFLUENCE	Talking
	Changed perspective
	Having a structure
	Informal relationship
	Team priorities
	Changed behaviour
	Positivity and cynicism
	Appreciating life

SUPER-ORDINATE & EMERGING THEMES – CHARLIE

WORKING IN ED	Practical experience
	Sense of family
	Undervalued
DEATH INFLUENCE	A sense of failure
	Feeling rubbish
	Couldn’t sleep
	Feeling useless
	Talk and run
	Closure
	Feeling useful
	Process it better
	Ethical dilemma
	Self care
	Supporting others
THE BRIGHT SIDE OF DEATH	Better place
	Celebrating life
	Talk about death
	Compassionate care
MEANING OF DEATH	Too common
	Seasons of death
	Dying alone
	Bad attitude to death
COMPLICATED DEATH	Unexpected death
	Traumatic death
	Family involvement
	Develop a shell
	Not a place to die
	Not a place for compassion

SUPER-ORDINATE & EMERGING THEMES – MARY

WORKING IN ED	Perseverance
	Variety
	Constant change
CHANGED BY DEATH	Not invincible
	Greater acceptance
	Little things
	Different experiences
	Unprepared
	Obstacles
	Talk and cry
	Comforting talk
	No negative memories
REACTION TO DEATH	Boxing feelings
	Lack of closure
	Guilt
	Reassurance
	Armour
	Boundaries
DEATH WEIGHED BY VALUES	Moral CPR
	Normal death
	Sudden death
	Unique features
EMOTIONAL LABOUR OF DEATH	Hardest part
	Great suffering
	Empathy with parents
	Being a parent
	Multiple emotions
	Professional grief

SUPER-ORDINATE & EMERGING THEMES – WILLIAM

WORKING IN ED	Working under pressure
	Easily bored
	Variety
	Friendly working environment
EMOTIONAL LABOUR OF DEATH	Avoiding emotions
	Internalizing emotions
	Shared emotions
	Child death
	Internal struggles
	Dealing with family
	Tough experience
	Defining moment
ETHICAL ASPECTS OF DEATH	Boundaries
	Almost inhumane
	Walk away
	Ethical dilemma
	Judged
	Inevitable things
DEATH INFLUENCE	Theory in practice
	Changed perspectives
	Demystifying death
COPING WITH DEATH	Expressing concerns
	Practical discussion
	Offload
	Lack of support
	Barriers of debrief
	Internal struggles
	Team priorities

SUPER-ORDINATE & EMERGING THEMES – JULIE

WORKING IN ED	Love to help
	Fixing someone
	Variety
	Overarching care
SPIRITUAL DIMENSION OF DEATH	Praying
	Driven by spirituality
	God's plan
	Happier place
	Spiritual coping
	Comforting faith
	Good times
COMPLICATED DEATH	Child death
	Same age
	Innocence
	Unfair death
	Soften by death
	Stronger by death
DEALING WITH DEATH	Debrief
	Bereavement career
	Lack of training
	Supporting colleagues
MEANING OF DEATH	Double self
	Part of the job
	Sitting on a fence
	Shield
	Special kind of person
	Responsibility

SUPER-ORDINATE & EMERGING THEMES – ISAAC

WORKING IN ED	Fast paced
	Constant learning
	Political
	Disaster management mode
MEMORABLE DEATHS	Relative's presence
	Impactful death
	Unusual deaths
	Early career deaths
	Lack of dignity
	Relatives' experience
	Personal responsibility
	Futile treatment
EFFECTS OF DEATH	Risk management
	Relationship with own family
	Carrying on
	Mental box
	Talking
	Professional reflection
	Better overview
MEANING OF DEATH	Pragmatism
	Impossible to teach
	Similarities
APPROACH TO DEATH	Positive approach
	Moral judgement of death
	No rapport

SUPER-ORDINATE & EMERGING THEMES – ANDREW

WORKING IN ED	No hierarchy
	Surprise
	Variety
EMOTIONAL LABOUR OF DEATH	Emotional investment
	Job component
	Lack of personal experience
	Professional boundaries
	Emotional awareness
	Talking
	Emotional acceptance
	Pause
	Private conversations
MEMORABLE DEATHS	Reality vs Perception
	Child death
	Moral CPR
	Moral justification
	Unprepared
	Wellbeing CPR
	Young age
SUPPORTING THE FAMILY	Human connection
	Family relations
	Confident conversations
	Sharing emotions
DEATH INFLUENCE	Importance of debriefs
	Not hiding death
	Theory vs Practice
	Supporting others
	Change of priorities
	Next patient

SUPER-ORDINATE & EMERGING THEMES – NICHOLAS

WORKING IN ED	Variety
	Excitement
	Last resort
INTERPRETING DEATH	Approach to death
	Death is certain
	Familiar with death
	Different deaths
COMPLICATED DEATH	Emotional package
	Upsetting experience
	Eye contact
	Hard questions
	Escaping
	Child death
	Memorable deaths
	Meaningless death
	Cultural differences
COPING WITH DEATH	Coping virtually
	Pause
	Privacy
	Supporting others
LIFE AFTER DEATH	Macho attitude
	Cynicism
	No time to grief
	Boundaries
	Normalize death
	Exposure to death
	Pursuing good death

SUPER-ORDINATE & EMERGING THEMES – ANNABELLE

WORKING IN ED	Adrenaline rush
	Fix something
	Lack of opportunities
	Cutting corners
REACTION TO DEATH	Death avoidance
	Professional experience
CULTURAL CHARACTERISTICS OF DEATH	Cultural differences
	Similar background
	Belief
DEATH INFLUENCE	Expression of pain
	Devastating
	Failing
	Frozen
	Heartbreak
	Memorable death
	Reasoning death
	Increased emotions
EFFECTS OF DEATH	Changed care
	Making memories
	Blocking emotions
	Branded
	Situational awareness
	Confidentiality
	Face-to-face

SUPER-ORDINATE & EMERGING THEMES – JOHN

WORKING IN ED	Detective work
	Pure medicine
	Comradery
	Objectification
SOCIAL DEATH	Social death
	Different person
	Meaningless death
HUMANIZED DEATH	One chance
	Special care
	Good death
	Emotional attachment
	Quality of life
DEATH INFLUENCE	Memorable deaths
	Emotional influence
	Greater grief
	Relationship with family
	Not a robot
	Influence on practice
	Professional identity
	Something missed
LEARNING FROM DEATH	Experiential learning
	Validation and education
	Pseudo-experience
	Right people
	Debrief
	Therapeutic chat
	Small gestures

SUPER-ORDINATE & EMERGING THEMES – ADAM

WORKING IN ED	Detective work
	Flat hierarchy
	Making a difference
	In control
MEANING OF DEATH	Cessation of life
	Separation
	Out of norm
DIGNITY IN DEATH	Decision to stop
	Situational awareness
	Dignified death
	Family and chaplaincy
	Scary place
	Know when to stop
MEMORABLE DEATH	Complicated grieving
	Similarity in death
	Reminder
	Sudden deterioration
	Memorable death
	Unexpected death
	Surprise
	Emotional investment
	Draining conversations
DEALING WITH DEATH	Acknowledgement
	Carry on
	Coping with death
	Not robots
	Talk about death
	Blame
	Cultural grieving

SUPER-ORDINATE & EMERGING THEMES – ZOE

WORKING IN ED	Desired profession
	Rewarding profession
	Role model
MEANING OF DEATH	Death as loss
	Good death
	Dignified death
	Memorable death
	Auto-pilot mode
SPIRITUAL DIMENSION OF DEATH	Comfort in faith
	Moral judgement
	Unchanged values
	Praying
	Values and priorities
	Humbling experience
EMOTIONAL LABOUR OF DEATH	Emotional numbness
	Emotional involvement
	Emotional investment
	Connecting with the dying
	Embarrassment
	Being human
	Resemblance
	Empathetic
	Thankful
	Closure
COPING WITH DEATH	Walking and running
	Talking
	Learning from experience
	Holistic approach
	Being strong
	Unnoticed influence

Appendix N

SUPER-ORDINATE & EMERGING THEMES – ERICA

WORKING IN ED	Scary but loved
	Rewarding
	Stressful
EXPECTATIONS OF DEATH	No concept of death
	Oversimplification of death
	Fear of death
MEANING OF DEATH	Horrific
	Real loss
	Death is not pleasant
	Shock
	Horror film
	Bizarre and surreal
	Death not normal
	Part of the job
	Difficult decisions
	Family presence
	Age
	Duty of care
DEATH INFLUENCE	Paralyzed
	Insomnia and nightmares
	Avoidance
	Less trauma
	Less impact
	Detachment
	Struggle to process
	Effects on practice
	Self protection
LIFE AFTER DEATH	Active involvement
	Talking about death
	Value of life
	Support for colleagues and families

	Closure
	Dignity
	Preparation

SUPER-ORDINATE & EMERGING THEMES – CHRISTINE

WORKING IN ED	Adrenaline rush
	Comradery
	Survival medicine
A DIFFERENT DEATH	Meanings of death
	Readiness for death
	Age and situation
	Shocking death
	Dignity
DEALING WITH DEATH	Blame and reflection
	Duty of care
	Numbness to death
	Part of the job
	Detachment
LEARNING FROM DEATH	Closure
	Empathy
	Understanding death
	Talking about death
	Coping with death
	Influence on self
	Prepared for death
LIFE AFTER DEATH	Family support
	Colleague support
	Limitations
	Career plans

Appendix O Original Higher Order Concepts and Super-Ordinate Themes

HIGHER ORDER CONCEPT	SUPER-ORDINATE THEMES
UNFORGETTABLE DEATH	MANY FACES OF DEATH
	COMPLICATED DEATH
	MEMORABLE DEATH
	CHALLENGING DEATH
	DEALING WITH DEATH
	A DIFFERENT DEATH
VALUE DRIVEN DEATH	WORKING IN ED
	SWITCHING ROLES
	MEANING OF DEATH
	EXPECTATIONS OF DEATH
	INTERPRETING DEATH
	THE BRIGHT SIDE OF DEATH
	CELEBRATING DEATH
	HUMANIZED DEATH
	DIGNITY IN DEATH
	DEATH WEIGHED BY VALUES
	ETHICAL ASPECT OF DEATH
	SPIRITUAL DIMENSION OF DEATH
	CULTURAL CHARACTERISTICS OF DEATH
	SOCIAL DEATH
	EMOTIONAL LABOUR OF DEATH

INFLUENCED BY DEATH	**DEATH INFLUENCE**
	LEARNING FROM DEATH
	SUPPORTING THE FAMILY
	COPING WITH DEATH
	EFFECTS OF DEATH
	CHANGED BY DEATH
	REACTION TO DEATH
	DEALING WITH DEATH
	APPROACH TO DEATH
	LIFE AFTER DEATH

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