**TRANSCRIPT ANALYSIS – Sudden Death in Emergency Department**

***Participant: ADAM (pseudonym) (14R)***

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| **Codes** | **Transcript line and quote** | **Description of the code** |
| Detective work | 11-13: I like the challenge of working out what’s going on, when a patient comes in, trying to figure out what the problem is. I like that kind of challenge of trying to diagnose and give the right treatment and seeing people improving. | Trying to figure out what the problem is |
| Flat hierarchy | 19-22: I like the teamwork, I like that it’s quite flat hierarchy, everyone working together closely and I like the fact that you can make a difference quite quickly and also you have the privilege of being the first doctor or nurse to see a patient when they arrive at the hospital, which is a really good opportunity to give them a really good experience | Everyone working on the same level. |
| Making a difference | 28-29: I think I really enjoy the variety that every shift brings and the fact that I come to work and feel that I have made a difference, help some people, reassure people and come home. | Making a difference in patient’s life |
| Having control | 41-45: I think sometimes I don’t enjoy it when you know what’s best for the patient, you try having the best outcome, but sometimes you face barriers between different specialities feeling like it’s not their responsibility to look after this patient and that can be a challenge sometimes, trying to have the patient looked after by the right people. But I think I am better now then I used to be, but that is still one of the challenges and … I can’t really think of much else. | Having control over a situation gives job satisfaction |
| No longer alive | 48: Death for me is when a person is no longer alive in a physical sense. | End of physical activity |
| Separation | 49-52: 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. | Not to be present anymore |
| Complicated grieving | 64-66: However, when my mum’s dad died I was 22 or 23, I felt I had more of a connection because I was seeing him as I grown up into an adult so that affected me more in terms of a grieving process. | Profound connections creats complicated grieving processes |
| Similarity in death | 66-70: When my cousin died that affected me in a different way because he was same age as me. That was quite a shock and it took longer to get over and definitely it had an impact on me at that time. I took a break from my medical training for several months, I did a research, I did a BsC for a year, I didn’t see any patients for a year after that happened so it was good. | Similarities with a deceased person can complicate grief. |
| Reminds me | 75-83: I probably made a few connections with my grandpa especially when I was at the beginning of my career, but I don’t make a connection anymore as it’s been quite a long time ago now. With my cousin I have not seen that many people die as it’s not common for people in their 20’s to die but when I had people trying to end their own life, it obviously reminds me of that. Especially I had someone the other day who tried to use a ligature … you know … I just felt in that moment kind of sad you know, that someone would feel that sad that they would do that for themselves as it happened to my cousin. But it didn’t affected me for the rest of the shift, it was just a moment of … you know … feeling sad that a young person is trying to do that, kind of desperate that they are doing that. | Reminded by personal experiences at work |
| Sudden deterioration | 95-98: I have had some situations when patients come in and suddenly deteriorated in Resus and they’ve died. Those can have the most impact because you’ve seen the patient alive, you’ve seen them talking, you know or they are younger, so yeah … the less expected. | Unexpected death has a higher impact/influence |
| Memorable death | 112-114: That was quite shocking as she was only 49 and hadn’t been in hospital much before. Having to deliver that news to the family was quite difficult. | There are certain features that make a death memorable |
| Not expecting to die | 118-119: I think when it’s about someone who in normal circumstances you would not expect to die, so someone in their forties, it’s quite rare to get unwell enough to die. | Social and personal norms for dying |
| Surprise | 119-122: Or when someone comes in and you don’t expect them to be so unwell, so from the handover it didn’t sounded as someone who is about to die, so when it comes as a surprise to you how quickly they deteriorate, this what makes it quite memorable I think. | The element of surprise in patient deterioration |
| High emotional element | 122-128: Also the interactions with the family because it was quite an emotional situation because, her mum and dad was there, they were in their 70’s or something. Also her granddaughter, who was a kid, a whole spectrum of ages, to whom you need to break the bad news you know. Trying to do this in a way that is quite sensitive, but also it gives the right amount of information. I think the things that makes it unforgettable for me is if it’s unexpected, if it’s a high emotional element to it where you know that family is really not expecting it and that can also add. | Meeting the family involves a high emotional element that complicates the experience. |
| Quite draining | 131-132: I think I remember on the day, it takes physically something out of you, when communicating with the family, it’s quite draining. | Delivering the bad news to the family is quite draining |
| Acknowledgement | 142-144: I think basically you need to acknowledge that these situations are emotional and acknowledge the impact that can have on you and be kind to yourself and not rushing to kind of just get on with the shift. | Accepting the realities of death experience |
| Talking through | 146-149: probably speaking to a colleague and discussing what were the difficult parts of it. Not for ages, just for a little bit, I think that is really helpful.  155-156: I would mention it to my wife so that she kind of can understand if I’m a bit tired or you know, yeah.  164-166: I had to speak with one of the consultants about it, to just get some advice, if there is anything we could have done differently or anything like that and so I think kind of allowed me to debrief so but it wasn’t kind a like a formal debrief when everyone is involved | Talking about the experience with colleagues and at home. |
| Hard decisions | 170-171: Personally, I think it’s making the decision about when to stop, when to say that you’ve done everything you can do. I think that can be a hard decision to make. | Stopping resuscitation is the hardest part of the death experience |
| Situational awareness | 176-182: So that is the commonest situation, where I didn’t had a case where people were in a lot of pain and died, if you see what I mean. But I think that must be hard. I mean I have had situations when someone was diagnosed with something that resulted in them dying and they are fully aware of that. You know, awake, alert and that is whole different situation, compared to someone that comes in with a leaking aneurism for example and the decision is that they are not going to operate on it and the patient is aware that they something in there that is going to kill them and that is a really hard conversation. | The difficulty of dealing with a patient being aware he is going to die. |
| Conflicted | 183-194: The other thing that I have found quite conflicted about is when you are doing these interventions on someone that may well be in the last moments of their lives you making that balance of giving out the treatment, investigations versus giving them a dignified last moment of their life and that is a very hard balance to get it right sometimes. You don’t really want to do very invasive procedures and trying multiple times to kind of getting IV access or take blood gases if someone is clearly dying and that’s quite hard. You want to do your best to make it as comfortable for them as possible. In an ideal situation you’ve tried everything and you realize it’s futile and then you can stop and they’ll have a few hours or enough time for their families to be there and then they’ll die, you know. I don’t really like when people had lots of interventions up to the point of them dying. Because for me it feels like its not as dignified. It’s really hard, it’s not an easy balance, because sometimes people do recover, because you do everything you can medically, you know. | Active treatment vs dignified death |
| Family and chaplaincy | 201-213: So I think just being very sensitive and making families aware that they don’t look how they would normally look, especially if they had lots of CPR, intervention and staff. Just to kind of preparing the family. From my own practice, it was especially hard in Covid, not always being able to let families be there, that was really hard. But thankfully we are better at it now, as we allow people to come in when they are obviously dying. But in terms of how death has affected me, I am always keen to have the family involved as soon as possible, if possible get them to be there, if we can do that I think it’s really important, the family and the patient. 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. But often in A&E all is happening so quickly, you can’t always have them involved but I think if the situation was that it had a bit longer then we can ask if they want to speak with a chaplain or see a chaplain. This is something that I would be, I would try to incorporate that more into my practice. | Early involvement of family and chaplaincy in the dying process |
| Going against | 228-229: it goes against everything you want to do as a doctor or a nurse, | Dying goes against everything in healthcare |
| Scary place | 237-244: Because I think you kind of forget what it’s like seeing it from a patient’s perspective. Resus is probably a scary place to be. I’ve spent so much time in Resus, it does not feel abnormal to me, as I have spent so many hours there. But as a patient it might feel like a strange place with all of the monitors and other patients. Probably we can try sometimes better to get someone some place quieter, with their family. It’s not always easy, but if we aim towards something I think even like a designated space, when you decide to stop all active treatment, even if its on AMU or on a ward somewhere, it could be a place where they can spend the last few hours with their family. | ED is a scary place to die |
| Know when to stop | 248-256: When I was a junior doctor before doing emergency medicine, I’ve seen people dying and deteriorate on the wards. I can see that people do die and reach a natural end of their life and because I have seen a lot more, like looking back, some of the patients that I looked after on the wards, it would have had more peace of mind, let’s get their family, let’s … while there was time I was trying to get them better, recover … where as now I feel like death is part of what people go through in the hospital, despite you’ve tried your best. 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. | Offering a dignified death has become more important |
| Not robots | 268-274: Yeah, I think it’s good to have insight on things that affect us and how to look after each other and be aware that we are not robots, we are human beings and we have emotions. One of the things that I enjoy in Southampton is that I feel like the team is quite aware of that. Aware that people need kindness and need to be looked after. We all need kindness and we need to look after each other. I think when that’s missing, people get too much focused on getting to the patient, the outcomes. People suffer as a result if there is no understanding for people to look after each other. | Understanding that staff are human, being influenced by people’s death |
| Carry on | 287-291: I don’t know if there is a certain criteria, such for example a patient dies, in their late sixties and triggers a TRIM practitioner to contact the team involved and say, do you need to have a debrief rather than having an emphasis on moving to the next shift and just carry on and won’t necessarily seek help or think that everyone else is getting on with it and he is the only one who suffered from it. | Being proactive in offering support to staff instead of just carrying on with the shift. |
| Talk about death | 304-305: We don’t really talk about it too much, because we don’t really like it when it happens. I think it’s good to talk about it. | Shouldn’t be scared talking about death. |
| Blame | 305-308: I think some people might blame themselves, feel like a failure that someone died and so there is a tendency not wanting to talk about it because they would wonder if they could have done something differently. It’s important to learn from cases but I think you can’t beat yourself up when someone dies. | Blaming yourself for someone’s death |
| Cultural grieving | 308-312: I did heard that some people from different cultures grieve differently, so it would be interesting to have a conversation with people from different countries and cultures on how the grieve because you, a Western European experience of death might be different to someone from another part of the world, that would be quite interesting to see. | Being aware of how people grief in different cultures |

**FINAL CODES EMERGING THEMES**

|  |  |  |  |
| --- | --- | --- | --- |
| 1 | Detective work | 1 | Detective work |
| 2 | Flat hierarchy | 2 | Flat hierarchy |
| 3 | Making a difference | 3 | Making a difference |
| 4 | Having control | 4 | In control |
| 5 | No longer alive | 5 | Cessation of life |
| 6 | Separation | 6 | Separation |
| 7 | Complicated grieving | 7 | Complicated grieving |
| 8 | Similarity in death | 8 | Similarity in death |
| 9 | Reminds me | 9 | Reminder |
| 10 | Sudden deterioration | 10 | Sudden deterioration |
| 11 | Memorable death | 11 | Memorable death |
| 12 | Not expecting to die | 12 | Unexpected death |
| 13 | Surprise | 13 | Surprise |
| 14 | High emotional element | 14 | Emotional investment |
| 15 | Quite draining | 15 | Draining conversations |
| 16 | Acknowledgement | 16 | Acknowledgement |
| 17 | Talking through | 17 | Coping with death |
| 18 | Hard decisions | 18 | Decision to stop |
| 19 | Situational awareness | 19 | Situational awareness |
| 20 | Conflicted | 20 | Dignified death |
| 21 | Family and chaplaincy | 21 | Family and chaplaincy |
| 22 | Going against | 22 | Out of norm |
| 23 | Scary place | 23 | Scary place |
| 24 | Know when to stop | 24 | Know when to stop |
| 25 | Not robots | 25 | Not robots |
| 26 | Carry on | 26 | Carry on |
| 27 | Talk about death | 27 | Talk about death |
| 28 | Blame | 28 | Blame |
| 29 | Cultural grieving | 29 | Cultural grieving |

**SUPERORDINATE THEMES**

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| --- | --- |
| **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 |