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

***Participant: JOHN (pseudonym) (13S)***

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| **Codes** | **Transcript line and quote** | **Description of the code** |
| Detective work | 17-22: 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 |
| Purest form | 17: I think it’s the purest forms of practising medicine. | ED is the purest form of medicine |
| All in this together | 25-28: Working in ED I really like the very approachable consultants and registrars, very skilled and knowledgeable nurses and hca’s. I like that we are all in this together when people are queuing and there is 9 hours wait. The ability to chat with each other and offer help. In ED you just go on and do things no matter of your skills or background. | Comradery, lack of hierarchy |
| Glorified triage | 35-37: All this turns into a glorified triage of is this patient staying or going, what do we need to do to get this patient out of the department rather then what we need to do to offer a solution. | Patients become statistical data that needs to be moved away |
| Can’t do it again | 44-46: Death and caring for the dying patient is really important. So, I lost my Dad when I was 19 due to pancreatic cancer, so care for the end of life patient is really important to me. You can’t do it again if you get it wrong. | No second chance to provide a better care for the dying |
| Social death | 48-51: 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. | People die before they physically die |
| Different person | 52-56: I’ve experienced this when my Dad past away. I’ve seen that in ITU during this pandemic. Relatives waving goodbye to their loved ones, leaving in an ambulance, then seeing them 3 weeks later, with lots of tubes hanging out of them, with weight loss and the person in the bed looks like a different person. This hits them like a truck and it’s hard for the nursing and clinical staff as well. | Emotional disconnect with the person they can’t recognize anymore |
| Soft spot | 61-63: Having said that, I have a soft spot for pancreatic cancer patients, sometimes I would stay with them longer than with the other patients. I would stay longer just to make sure they are looked after. | Providing special care for those reminding him of a personal death experience |
| Something missed | 75-81: In anticipation of this I had a thought about this and it wasn’t hard to stir up the greatest hits if I may say it like this. There are four cases. First one, I was out of hours, covering two surgical wards. There was a lady who was going off every night and as a junior I didn’t really knew what to do, I was constantly asking the day team for a plan to know how to play out the out of hours. Then she had an acute GI bleed and she bled out with one of my colleagues on a night shift and I came in and I felt, and I still feel, what did I missed? I highlighted this case as one that requires further digging.  123-124: Then the other element is what did I missed, what did I do wrong, what could I do better? So, yeah I think these two elements. | The doubt that not everything has been done to save that patient |
| Meaningless death | 81-87: The second was a bloke that had drinking issues, had better times when we thought he is getting better, then suddenly was getting worse, with spontaneous prostatic bleeding, horrendous haematuria. He was one of those customers that doesn’t want to give up drinking. One night he passed away and for the whole team it was just a sombre feeling, because we’ve seen him for more contact hours then most of our families for that 3 months period. That was so sad. Pathology patients to deal with is more emotional because you see them for so long. | Death that could have been prevented |
| Good death | 107-114: The last one was a bloke in ITU during the second wave of the pandemic, was there for 4 weeks, wasn’t intubated, his condition although declined rapidly and we decided to take the oxygen away, not to let him suffer. The bedside nurse didn’t felt comfortable, but stepped up to do it as I felt she would not be able to manage that emotional burden. I wasn’t as invested emotionally as she was, because I was looking after several patients that shift, but she was looking after only one. I felt very confident doing that because in my had I felt it was in his interest and giving him sedatives and pain relief we’ve eased his suffering in those last moments. It took about an hour and a half for him to pass away and we had a mini debrief afterwards. | Stopping futile treatment when that became pointless. |
| Emotional attachment | 121-122: So, the emotional element makes some to stand out either because you get attached to them or because the acuteness made it so emotional. | Emotional reactions due to attachment with or acuteness of the deceased patient |
| Experiential learning | 118-121: This is why book learning is crap for this job in my opinion, you have to put your hands on. Experiential learning for me is the true way of learning no matter what healthcare professional you are because that is the only way to make things stick properly.  233-239: I value experiential learning, as I think these are the things that will stick with you. It will develop you clinically and emotionally. Medical school is teaching how to pass exams, not how to be a doctor, you learn that once you graduate. The best way of learning, I think it’s being attached to a team and I wish now I could have had these experiences earlier. That’s what I would say would help. You can read a book, you can have a lecture, but with death, that is a very emotive thing and experience is the best way of learning in our jobs. Audio-visuals are very good for learning. | Learning by being exposed in practice to death |
| Defining experiences | 127-130: Yes, I think you carry all your defining experiences with you in this profession, doctor, nurse, whatever. When you’ll see anything similar later that bell will ring a bit louder, for example a hypoxic patient might respond in the same way as the lady that arrested ergo I am starting to get worried. So from a clinical perspective that helped. | Experiences that stick with them and helped developing professionally. |
| Affected emotionally | 130-134: Emotionally that first death affected me emotionally more, because I was beating myself up and it stuck with me for longer. I met the family a lot and they had a lot of questions and I always thinking that I’ll bump into them in WestQuay and they’ll go, “You are the doctor who looked after my Mum”, not because I am worried about myself but the guilt maybe, associated with that. | Emotionally affected due to acuteness and relationship with family |
| Can’t take back | 143-145: 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. | A changed approach, over the years towards the dying |
| Therapeutic chat | 153-155: So how I cope, chatting with the right peers I found that very therapeutic. Was my action justified? What one of my other colleague would have done? That helps you process. But also getting advice from seniors how you can improve your care. | Talking about the experience mainly with colleagues |
| Validation and education | 155-156: So validation from your colleagues and education from your bosses, to not make the same mistake twice. | Support from fellow colleagues and seniors in coping |
| Greater grief | 157-159: With the emotional part it’s a grieving process just as it would be with a loved one. Obviously not at the same degree but I feel there is a period of mourning for all emotional attachments, and the greater the attachment, the greater the grieving period will be. | The greater the attachment, the greater the grief |
| Right people | 162-165: With my other half yes, when I felt flattened I had a chat with her. My Mum and my brother, I don’t really talk with them about such things. So yeah, my other half and some peers, but with the right peers, because some would tell me that I shouldn’t have done this or I would have done that. | Talking with the right people, who can understand him. |
| Debrief | 168-179: I think it depends on the situation, the purpose of the debrief and who is it for. For the lady that passed away in ED for example, as we were working as a team, I felt that a team debrief is needed. I felt the emotional part of the debrief was more needed by the nurses than myself and I wanted to be in that debrief for them, more than anything but also for a team learning it was more useful for the whole team to be exposed to. What we felt it went well, what we should have done better so all similar things. From an emotional point of view you need to understand also what other people are going through so that in the future in a similar situation, if someone for example felt uncomfortable with a certain situation we ask if they need help and support. Doesn’t matter what comes with your job title just be there for a junior member of staff, asking how are you emotionally, from a skill, clinical delivery point of view and therefore how can I look after you and the patients. And that’s good for the team so that we can walk in each-others shoes a little bit.  255-261: I would be offering a hot debrief especially where there is an arrest or trauma, whether they’ve passed away or not. I think hot debrief is incredibly important. I have witnessed some good and bad examples while I was a student. Once a team led by a nurse practitioner was doing a hot debrief after a trauma case, while another team in the same time led by Registrar didn’t, and the difference between the two was so visible. It took only five minutes before they’ve returned to work but it made such a big difference. I think personally stirring up emotions in cold debrief is not useful, but discussing things in a hot debrief is very helpful. | Doing team debriefs as part of processing the experience. |
| Meeting the family | 186-194: The difficult part is with the relatives, when they arrive to the hospital after saying goodbye to their loved ones in the morning, that person was involved in a car accident for example, and they come and sit in the relatives room with a bunch of strangers walking around with very bare and cold walls. And you go in and you want to do the conversation properly, but you don’t have the time because other areas are busy and you are tannoyed every five minutes to review a patient. | Meeting the family is the most difficult part of the death experience. |
| Chip a little | 205: Every case chip a little bit and steer your practice | Every case leaves a mark in his identity, personality |
| Quality of life | 208-209: Every case chip a little bit and steer your practice | These experiences has changed his view on providing care for the dying |
| Professional identity | 209-215: I don’t know if it changed me as a person because in a vocational job, your professional identity is linked with you as well. It’s not like a bank manager who takes the briefcase at the end of the day and go home. You are a doctor, a nurse, whatever … I think they part of the collage of my personal and professional identity. It is a piece of a puzzle that makes me a doctor and it gets bigger every time I work and will continue till the end of my career. And the day I feel I stopped adding pieces will be a dangerous day, because it means you’ve stopped learning so you should retire that day. | He has changed as a result of these experiences |
| Pseudo-experience | 240-251: When I was in ED, I was a teaching fellow and we were creating virtual reality simulations. The students were wearing headsets and they were in Resus with a simulated trauma and being immersed in it rather then just hearing something beyond somebody else’s shoulder, so getting that kind of experience makes a difference. Experience and emotions are my key words. Why I say this? I am watching Scrubs, the TV show and there is this episode of this doctor meeting an old lady who then passes away. And this sticks with me. Especially in my junior year, because the TV show wrote it so well, as you are part of the attachment of the main character, the doctor had for that lady. When he was mourning, you were mourning somewhat. I think some sort of exposure to audio-visual tools might help. I know this is utilized with driving safety promotion for example. Some of the adverts are using the same principle, such the current Covid adverts with the masks and looking into people’s eyes trying to bring some change. Something in that format could be useful, as a pseudo experience. | Simulation scenarios for better learning |
| Small gestures | 263-265: Or in other instances the nursing team goes, ‘Would you like a cup of tea?’ and they go have a chat and sort things out, that is also very helpful. Basically, being nice human being and colleagues goes a long way.  284-288: Often, I feel we could do so much more for patients and relatives. Moving them to a butterfly room, offering a tea. The power of a brew. And in parallel with that, the kindness we could give them despite all the pressures. Those are things that could help them. In essence we need more doctors, nurses, spaces and quitter hospitals. If you could arrange that, that would be great. | The power of small gestures that can help processing the event. |
| Not a robot | 265-278: Doctors often go straight after a hard trauma case to see another patient, which could be a drunk person on a Friday night, or an overdose case who’s being seen for the same thing the 5th time over a week and you have to try and treat them in the exactly same manner knowing that there is someone who just died next door. My frustration with this comes through the language I use and I think that is very difficult, because you are not a robot. In Covid times going from an area where people are grasping for air to someone who has broken curfew to go on mess with their mates and has fallen down the stairs or done some drugs and now have palpitations. Dealing with that after having such a raw experience, I just want to slap them and take them and show them that other person and give them the care they deserve, when I am personally feeling unaware of my emotions it’s very tough. | Treating patients straight after a death experience without having a break |

**FINAL CODES EMERGING THEMES**

|  |  |  |  |
| --- | --- | --- | --- |
| 1 | Detective work | 1 | Detective work |
| 2 | Purest form | 2 | Pure medicine |
| 3 | All in this together | 3 | Comradery |
| 4 | Glorified triage | 4 | Objectification |
| 5 | Can’t do it again | 5 | One chance |
| 6 | Social death | 6 | Social death |
| 7 | Different person | 7 | Different person |
| 8 | Soft spot | 8 | Special care |
| 9 | Something missed | 9 | Something missed |
| 10 | Meaningless death | 10 | Meaningless death |
| 11 | Good death | 11 | Good death |
| 12 | Emotional attachment | 12 | Emotional attachment |
| 13 | Experiential learning | 13 | Experiential learning |
| 14 | Defining experiences | 14 | Memorable deaths |
| 15 | Affected emotionally | 15 | Emotional influence |
| 16 | Can’t take back | 16 | One chance |
| 17 | Therapeutic chat | 17 | Therapeutic chat |
| 18 | Validation and education | 18 | Validation and education |
| 19 | Greater grief | 19 | Greater grief |
| 20 | Right people | 20 | Right people |
| 21 | Debrief | 21 | Debrief |
| 22 | Meeting the family | 22 | Relationship with family |
| 23 | Chip a little | 23 | Influence on practice |
| 24 | Quality of life | 24 | Quality of life |
| 25 | Professional identity | 25 | Professional identity |
| 26 | Pseudo-experience | 26 | Pseudo-experience |
| 27 | Small gestures | 27 | Small gestures |
| 28 | Not a robot | 28 | Not a robot |

**SUPERORDINATE THEMES**

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| --- | --- |
| **ED WORK CHARACTERISTICS** | 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 |