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

***Participant: NICHOLAS (pseudonym) (12C)***

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| **Codes** | **Transcript line and quote** | **Description of the code** |
| Variety | 27-29: The variety. Variety is a big thing for me. No two days or two shifts are the same. Generally you have no idea what is going to happen. | Variety of cases |
| Excitement | 21-24: It’s because I wanted a job involving communication, so face-to-face patient contact and then I like the variety, I like the excitement, so Emergency Medicine really ticks all the boxes. Then I kind of looked into other specialties such as Medicine, but all the negatives I have seen in these, drive towards Emergency Medicine. | Excitement, adrenaline rush as a job motivation |
| Fleabag | 33-34: And the fact that we are the ‘fleabag’ of health provision, you know, when everything else is failing they come to us. | ED is the fleabag of health provision |
| Death is certain | 37-40: Very interesting question actually. I would probably say in a pragmatic way, it is the end of life, the end of circle of life, we know that are body will eventually give up and it’s a natural process that will come to us all. The classic expression pops in my mind that tax and death is only certain, it’s something that I always had in my head. | Only death and tax is certain in life |
| Emotional package | 40-42: There is a huge amount of emotional package associated with it. Especially if it’s a personal association, when someone close to you has died. It is something that we see often in our job. | The emotional package associated with death |
| Pretty upsetting | 47-50: There is a huge amount of emotional package associated with it. Especially if it’s a personal association, when someone close to you has died. It is something that we see often in our job. | Experiencing death in personal life was pretty upsetting |
| Seen a lot | 54-56: I don’t think so. You know, it’s been a long time since that happened, and I have seen a lot of death at work. Some very unpleasant, others expected and everything in between. I don’t think it has negatively impacted me. | Seen a lot of death in practice and not affected by personal death experiences |
| Different deaths | 69-74: You have those who come in and die unexpectedly and then you have the cohort that by looking into the medical history, you realize they have deteriorated quite a lot before even getting to your doorstep. And then you have those, where you palliate them, or decide to give them a 24 hours treatment to see if you achieve any change in their condition, but then they also pass away later down the stream. | Three different death categories in ED |
| Stick with me | 77-84: There is definitely one that I had which sticks with me since I was F1 or F2, a very junior doctor. I was working on a ward and there was a colleague supervising me when we heard the crash buzzer going off. There was this patient that we never met before, didn’t knew anything about him and was having faecal vomit. By the time we finished, the floor was covered, there were towels all over the place and having gloves on didn’t made any difference. In essence, this guy, unfortunately was vomiting so much that he chocked on his own vomit and I remember all specialities coming in and this patient was drowning in his own vomit. I mean it was pretty awful and horrific. | Memorable deaths that will stick with him |
| Eye contact | 87-88: was a horrible experience as he was making eye contact with me while he was going and going and he had glassier eye, glassier eye. It was pretty awful. | The dying patient making eye contact |
| Hard questions | 89-92: 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. | Family asking hard questions causing a moral dilemma |
| Run from it | 92-93: I certainly wanted to run from that situation. | Willing to run from that situation |
| Used to it | 104-105: So by the end of my foundation year I have seen a tremendous amount of death and you learn to get used to it. | Getting used to seeing death |
| Approach to death | 105-108: . 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, because you know it’s not going to actually help them. Not lying but to know how to phrase them. | A changed approach to death due to witnessing death often |
| Just shooting | 112-114: It’s hard to know. I’m not a drinker, I don’t take drugs. I am not an overly sporty person, just looking at my waistline after the Christmas period. Sometimes when it comes to dealing with stress, I am into games, sometimes just shooting some people. | Playing videogames as a method of coping |
| Pause | 115-116: 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. | Just pausing when he gets overwhelmed by an experience |
| Age matters | 118-120: That being said I once had a child who had multiple arrests and I remember that child because of his age and not because we had a connection and because it was so unexpected. I always knew the child death will always be the hardest. | Age of the dying patient matters even if there is no emotional connection (child death) |
| Keep it for yourself | 124-127: So, the benefit of debrief is certainly well established, but for me when I have a horrible case, most of the case you just keep it for yourself, you manage to deal with it in yourself or sometimes talk it through with a colleague if there is something I’ve missed. “What we could have different?” “Have we missed something here?” | Coping with the experience by himself |
| Meaningless death | 133-134: There was an 18 years old who died in taxi after taking drugs and everyone was shaken by this, but in the same time it was just good to talk about it. | Circumstances and young age account for a meaningless death. |
| Cultural differences | 161-170: And then the third difficult point is having a discussion with the family. Mainly because you can still be very blindsided by responses by people who are naturally upset. 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. | Cultural differences in how some people deal with death |
| Boundaries | 178-183: And then the third difficult point is having a discussion with the family. Mainly because you can still be very blindsided by responses by people who are naturally upset. 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. | Drawing the line between professional and personal aspect of grieving |
| Cut back | 183-186: Sometimes you have to cut back, as a professional and say “I’m sorry” and you have to make sure as a consultant, that the rest of the department is not falling apart. So it really depends on the circumstances around you. It depends on the individual case but also on the wider department. | Cutting back emotions when the department is very busy |
| Supporting others | 192-197: Yes and no. Having to support other staff or the department in it’s entirety as a leader, I would definitely support my colleagues first maybe because that is encoded in my personality, to help others first rather than myself. And I don’t find that many cases where I need to go and have 5 minutes just to get my head around things and address my issues. I find it very helpful to help other people especially if they find the situation very difficult. I find it very helpful to support them. | Supporting others as a leader during the death experience |
| Very cynical | 201-203: I think it does impacts you to a degree. You get very cynical with some patients especially if you come out of a cardiac arrest and then you see a patient who comes in with a minor issue in the great scheme of things. | Getting cynical with some patients coming with minor issues after seeing a death |
| Part of the package | 215-217: Yes, I would say to a degree. I would probably say it’s less applicable now compared to when I have finished my training when I had the choice to sub-specialize. When I have started my Emergency Medicine training I knew that I will see horrible stuff on the field as it is part of the package. | Seeing death is part of the package |
| Pursuing good death | 218-221: Thinking now as a consultant, 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. So how this care applies does interest me. I would probably be inclined to explore at a later stage to strengthen my role. | Seeking to have dignified death whenever possible. |
| Macho attitude | 240-242: . In Emergency Medicine as a whole there is a slightly a ‘macho’ attitude, go ahead, there is a next task waiting, don’t worry, just put your head down. And those are the issues that I recognize as problems. | Going tot he next task after a death |
| Normalize death | 259-260: No, I think that we just need to normalize death more and I think in ED we are in a privileged position where we can support each other and make a difference.  225-227: The first part is we need to acknowledge it, we have to talk about, be open about it, because horrible things will happen. And death is a normal process, at the end of the day, it happens to us all. |  |
| Can’t train for death | 227-233: I don’t think there is anything you can train people to manage death per se, because it is such an individual response to it. Experiencing someone dying is very, very unique. For such an experience I don’t think there is much that can prepare you for it. We can watch a video on YouTube or a film where the actress is playing dead but that is not the same as being invested in the resuscitation process of actually someone dying. I don’t think you can be truly trained for it. | Impossible to have formal training preparing for the death experience |

**FINAL CODES EMERGING THEMES**

|  |  |  |  |
| --- | --- | --- | --- |
| 1 | Variety | 1 | Variety |
| 2 | Excitement | 2 | Excitement |
| 3 | Fleabag | 3 | Last resort |
| 4 | Death is certain | 4 | Death is certain |
| 5 | Emotional package | 5 | Emotional package |
| 6 | Pretty upsetting | 6 | Upsetting experience |
| 7 | Seen a lot | 7 | Familiar with death |
| 8 | Different deaths | 8 | Different deaths |
| 9 | Stick with me | 9 | Memorable deaths |
| 10 | Eye contact | 10 | Eye contact |
| 11 | Hard questions | 11 | Hard questions |
| 12 | Run from it | 12 | Escaping |
| 13 | Used to it | 13 | Familiar with death |
| 14 | Approach to death | 14 | Approach to death |
| 15 | Just shooting | 15 | Coping virtually |
| 16 | Pause | 16 | Pause |
| 17 | Age matters | 17 | Child deaths |
| 18 | Keep it for yourself | 18 | Privacy |
| 19 | Meaningless death | 19 | Meaningless death |
| 20 | Cultural differences | 20 | Cultural differences |
| 21 | Boundaries | 21 | Boundaries |
| 22 | Cut back | 22 | No time to grief |
| 23 | Supporting others | 23 | Supporting others |
| 24 | Very cynical | 24 | Cynicism |
| 25 | Part of the package | 25 | Familiar with death |
| 26 | Pursuing good death | 26 | Pursuing good death |
| 27 | Macho attitude | 27 | Macho attitude |
| 28 | Normalize death | 28 | Normalize death |
| 29 | Can’t train for death | 29 | Exposure to death |

**SUPERORDINATE THEMES**

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| --- | --- |
| **REASON FOR 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 |
| **LIVING WITH DEATH** | Macho attitude |
| Cynicism |
| No time to grief |
| Boundaries |
| Normalize death |
| Exposure to death |
| Pursuing good death |