

Registered nurses' experience of the withdrawal of treatment from the critically ill patient in an intensive care unit

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Abstract

In this article the results of research undertaken to explore and describe the experience of Registered Nurses regarding the withdrawal of treatment from the critically ill patient in an Intensive Care Unit (ICU), are discussed. Withdrawal of treatment from a critically ill patient in an Intensive Care Unit (ICU) is a very traumatic experience for all those involved. The Registered Nurse has the most contact with all those who are involved throughout the process. This raises questions regarding how the nurse experiences the withdrawal of treatment, and about guidelines that can be developed to accompany the nurse during the process of treatment withdrawal.

The study was qualitative, descriptive, exploratory, descriptive and contextual in nature. Data was gathered by means of phenomenological interviews conducted by the researcher. Trustworthiness was ensured through the implementation of Guba's model (in Krefting 1991: 214). The following themes were identified:

1. The relationships the nurse develops with individuals involved in the process of treatment withdrawal.
2. The inner moral conflict experienced by the nurse relating to the ethical aspects of withdrawal of treatment.

The focus of this article is on the discussion of these experiences of the registered nurses. Based on the identified themes, guidelines were developed to accompany the nurse during the process of withdrawal of treatment.

KEY WORDS:

Registered nurse
Withdrawal of treatment
Critically ill patient
Euthanasia
Living will

Opsomming

In hierdie artikel word die navorsing wat die beleving van geregistreerde verpleegkundiges ten opsigte van die onttrekking van lewensondersteunende behandeling, verken en beskryf. Die onttrekking van lewensondersteunende behandeling van 'n kritiek siek pasiënt in 'n kritiek sorg eenheid is 'n baie traumatise ondervinding vir almal betrokke. Dit lei tot die vraag naamlik hoe beleving van verpleegkundiges die situasie en hoe kan hulle begelei word deur die proses van onttrekking van lewensondersteunende behandeling.

Die studie was kwalitatief, verkennend, beskrywend, kontekstueel van aard. Data is deur middel van fenomenologiese onderhoude ingesamel. Vertrouenswaardigheid is verseker deur die implementering van Guba se model (in Krefting 1991: 214).

Die volgende temas is geïdentifiseer:

1. Die verhoudinge wat verpleegkundiges met individue betrokke by die onttrekking van lewensondersteunende behandeling ontwikkel.
2. Die innerlike morele konflik wat deur verpleegkundiges beleef word ten opsigte van etiese aspekte.

Die fokus van die artikel is op die bespreking van dië beleving van die geregistreerde verpleegkundiges. Riglyne om verpleegkundiges deur die proses te begelei, gebaseer op die geïdentifiseerde temas, is ontwikkel.

Background and rationale

Patients in an Intensive Care Unit (ICU) are very ill and some have very poor prognoses. Certain conditions, including surgical complications, debilitating illness or progression of illness, may result in a patient being kept alive artificially on life support machines. Mechanical ventilation and nutritional support are the two most common methods used.

Some critically ill patients, who have no possibility of recovering and living a meaningful life, are kept alive for months and even years on artificial life support. Body systems are affected by artificial life support and can result in multi-system failure. It is ultimately possible that a patient may be kept alive and, therefore, be allowed to suffer primarily because of the possible legal implications or as a result of insistence from the family. The escalating cost of health care is a factor that plays a role in the decision to withdraw treatment. Once a patient has died, families can be left responsible for paying large medical bills. This financial burden could be lessened if treatment was withdrawn earlier.

Death ends all human existence and, although it is inevitable, it is feared and avoided by most people for as long as possible. The Dying Persons Bill of Rights includes aspects such as:

- Rights to treatment as a living human being until death.
- Maintenance of a sense of hopefulness.
- Freedom from pain.
- The right not to die alone.
- The right to maintain one's individuality.
- The right to be cared for by caring, knowledgeable and sensitive people (De Laune and Ladner, 2002:483).

A dying person needs to be treated with dignity and his/her wishes must be respected because the ethical implications of patient autonomy, and the right to decide about treatment, are becoming more of a reality within the health care sectors (medicine) today. According to Benatar (1994:254), withholding and withdrawing life support therapy, with or without palliative sedation or analgesia, are generally, but not universally, considered to be ethically and legally distinct from assisted suicide and active euthanasia. At present euthanasia is illegal in South Africa and a living will is still not a legally accepted document, as stated in Taitz (1993:440). The South African Law Commission (1997) is currently tabling an Act regarding the aforementioned subjects and, once promulgated, this will have a dramatic impact on the ethical considerations involved in medicine and, therefore, in nursing practice.

Nurses are seen as caregivers and part of the caring process is to alleviate suffering. This situation has an emotional impact on the nurse caring for the patient. He/she renders the nursing care to the patient who is clearly dying,

while the physician or intensivist makes the decisions regarding the patient's treatment (Burrows, 1994:630). It is the nurse who accompanies the patient through this period and ensures that his/her rights are respected. A patient who is dying still needs to be cared for. Symptoms need to be assessed and treated. *A nurse who has to work with a dying patient, must be dedicated to what is the bottom line in good terminal care, the highest possible degree of physical comfort available in each situation* (Ellis, 1995:53).

In order to understand the emotions that Registered Nurses experience when treatment is withdrawn from a patient and death is imminent, it is necessary to gain a deeper insight into their experience of the situation and the coping mechanisms that they use. A study undertaken as far back as 1962 by Seele (1962:100) on the "Attitudes of Medical Students and Practitioners towards Euthanasia" recommended that the above study should be carried out amongst nurses as they have more contact with patients. A deeper understanding will facilitate development of guidelines to assist Registered Nurses to be better equipped to cope with the situation in the future. Very few studies have been documented in which the experiences of the nurse have been investigated. Within the proposed study, the researcher aims to gain the insight needed to guide the nurses and, therefore, enable them to cope more effectively with the situation.

Problem statement and objectives

Many nurses working in Intensive Care Units are frequently confronted with death, especially the death of patients whom they have nursed over a long period of time. These deaths are often as a result of the withdrawal of treatment in cases where further medical treatment will have no beneficial effect on the patient's poor prognosis.

The researcher, who is employed in an environment in which withdrawal of treatment occurs, has observed, as a result of the way in which they react following the prescription of the withdrawal of treatment by the doctor, that colleagues appear to experience this process negatively. During the process of treatment withdrawal the nurse experiences a variety of emotions and the stress involved can have a significant impact on the mental health of the nurse executing the prescription. Many factors are involved which culminate in a complex experience for the Registered Nurse. The manner in which the nurse copes with the process can impact negatively on his/her emotions and influence the way in which he/she approaches a similar situation in the future.

In order to understand the experiences of the Registered Nurse in an Intensive Care Unit, specific factors that have an influence on the nurse's experience of the withdrawal of treatment from a critically ill patient were investigated. These were determined through the research process by answering the following questions:

1. What is the experience of the Registered Nurse,

Table 1: A summary of the strategies implemented in order to ensure trustworthiness

Criteria to ensure trustworthiness	Strategy	Criteria	Application
Truth Value	Credibility	<p>Prolonged and varied field experience</p> <p>Triangulation</p> <p>Peer examination</p> <p>Member checking</p>	<p>Phenomenological interviews with voluntary respondents to participate in research. Study leader has experience relating to qualitative nursing research literature and the field of research. Varied experience result by interviewing respondents from two different hospitals. Researcher is presently employed in ICU and has experience in the field of treatment withdrawal.</p> <p>Information gathered by interviewing, field notes and literature control. Analysis of data by researcher and an independent coder. The use of journals, articles, internet searches and CD-ROM's (Medline) to access data for literature control. Literature review done to determine if similar experiences have been documented during other studies.</p> <p>Independent coder, who is also a Registered Nurse, used to assist with data analysis.</p> <p>Follow up interviews held with respondents after they had studied the identified themes. This was to ensure that data had been interpreted accurately.</p>
Applicability	Transferability	Dense description	Complete description of methodology used in study, transcription of interviews, data analysis and literature control given. Relevant quotations from data received also used. Guidelines developed also discussed in detail
Consistency	Dependability	<p>Dense description</p> <p>Stepwise replication</p> <p>Code-recode procedure</p> <p>Peer examination</p>	<p>Complete description of methodology used in study, transcription of interviews, data analysis and literature control given. Relevant quotations from data received also used. Guidelines developed also discussed in detail.</p> <p>The use of an independent coder to analyse study and discuss findings with researcher.</p> <p>Should this be necessary to ensure accurate data analysis, the data will be left for two weeks after initial analysis and then be recoded. Identified themes will then be compared and used.</p> <p>Independent coder who is also a Registered Nurse used to assist with data analysis.</p>
Neutrality	Confirmability	<p>Triangulation</p> <p>Reflexivity</p>	<p>As discussed above</p> <p>As discussed above</p>

working in an Intensive Care Unit, of the withdrawal of treatment from a critically ill patient?

2. What guidelines can be developed to support the Registered Nurse in this situation?

The goals of the research were, therefore, to:

- Identify, explore and describe the experiences of the Registered Nurse, working in an Intensive Care Unit, with regard to the withdrawal of treatment from a critically ill patient.

- Develop guidelines for the accompaniment of the Registered Nurse throughout the process of withdrawal of treatment.

Research design and method

The research was qualitative in design and descriptive and exploratory in nature, since no such work amongst Regis-

tered Nurses has yet been documented within a South African context. The approach was contextual because it covered the experiences of Registered Nurses in Intensive Care Units. The study was also phenomenological by way of the researcher exploring the actual *lived experience* (Haegert, 1997:48) of the Registered Nurses regarding the withdrawal of treatment from critically ill patients.

Data was collected by means of phenomenological interviews using the principles of interviewing as defined in Kvale (1996:30).

Data Collection

Purposive sampling was utilized to recruit participants. Purposive sampling is based on the assumption that a researcher's knowledge about the population can be used to handpick the cases to be included in the sample (Polit and Hungler, 1999:229). The sample population from which participants were chosen comprised Registered Nurses working in two private hospitals in Port Elizabeth for a minimum of three months.

Appointments were made with participants who were randomly chosen to participate in the study. Data was collected by phenomenological interviews with six participants. A seventh interview was executed in order to ensure adequate data saturation. All the interviews were audiotaped and transcribed verbatim. Field notes were taken.

The question on which the interviews were based was as follows:

"Describe your experience related to the withdrawal of treatment from a critically ill patient."

Data Analysis

Data analysis followed the verbatim transcription of the interviews. This was done by the researcher, as well as an independent coder. Data analysis was done using the steps described by Tesch (in Creswell 1994:155). All the transcribed interviews were perused and ideas were jotted down in the margins. Categories and themes of the Nurses' experiences were identified and formulated. Once this process was completed, discussions were held between the researcher and the independent coder to confirm the identified themes.

Trustworthiness

Guba's model (in Krefting 1991:214) was used to ensure trustworthiness in the research. The four criteria of trustworthiness, viz truth-value, applicability, consistency and neutrality were used. The strategies of transferability, consistency, dependability and confirmability were also used and applied to the study in order to attain the criteria.

Ethical considerations

Ethical principles were maintained throughout the study in order to protect the participants from harm. The principles, as set out in the Ethical Standards for Nurse Researchers

(South African Society for Nurse Researchers, 1996:74), were adhered to. These include maintenance of confidentiality and anonymity, avoidance of harm and obtaining of informed consent from the institutions involved, as well as each participant. The participants were given the option to withdraw from the research at any time. The quality of the research was ensured by informing participants fully about the goal of the study, the method of research, what was expected of them, how results would be used and published and that confidentiality and anonymity would be maintained throughout.

Discussion of results

The following is a study of the results. All statements have been supported by quotes from the original text. A literature control was done to verify the findings. Results of the research are summarised in table 2.

Theme 1: Nurses developed relationships with certain individuals related to the process of treatment withdrawal from a critically ill patient in an ICU.

Category 1: Intrapersonal relationships which the nurse developed. The nurse stood in relationship with himself/herself and experienced the process of treatment withdrawal as very emotional.

In the first sub-category *the emotions that the nurse experiences* throughout the process of treatment withdrawal were identified.

- Through the interview process, some of the participants expressed feelings of guilt related to the process of withdrawal of treatment. The participants also reported experiencing conflict because of the decision, since nurses are taught to preserve life and now the prescription is given to allow death to take place by withdrawing life-sustaining measures. "*Indirek is jy verantwoordelik vir daai....die dood van die pasiënt*" (*Indirectly you are responsible for the patient's death*). Cartwright, Steinberg, Williams, Najman & Williams (1997:81) state that, since nurses are trained to prolong life they may be distressed when active medical intervention for a dying person is stopped.

- The participants expressed feelings of sadness for the loss of the life of a patient who had been looked after for a long period of time. Despondency was caused by the fact that, no matter what was done for the patient, death was inevitable and, thus, the time spent caring for the patient appeared futile. "*We have got to go through all that and then switch off the ventilator in the end. Which I have done only once and which I will never do again.*" Schneider (1997:179) confirms the feeling of sadness that nurses experience associated with the situation of the withdrawal of treatment.

Table 2. Identified themes of the Registered Nurses' experience of the withdrawal of treatment from the critically ill patient in an ICU

Themes:	Categories:	Sub-Categories:
1. The relationships the nurse develops with certain individuals related to the process of treatment withdrawal from a critically ill patient in an ICU	<p>1.1 Intrapersonal relationships which the nurse develops with him/herself throughout the process of treatment withdrawal from a critically ill patient in an ICU</p> <p>1.2 Interpersonal relationships the nurse develops with other individuals related to the process of treatment withdrawal from a critically ill patient in an ICU</p>	<p>1.1.1 The emotions the nurse experiences throughout the process of withdrawal of treatment</p> <p>1.1.2 The coping mechanisms the nurse employs to protect him/herself within the situation of withdrawal of treatment</p> <p>1.1.3 An expressed need for emotional support and knowledge regarding the process and the ethics involved during the withdrawal of treatment</p> <p>1.2.1 The nurse's relationship with the patient for whom he/she is caring</p> <p>1.2.2 The nurse's relationship with the family of the patient from whom treatment is being withdrawn</p> <p>1.2.3 The professional relationship the nurse develops with the doctor treating the patient</p>
2. The moral conflict the nurse has within him/herself related to the ethical aspects of withdrawal of treatment	<p>2.1 The influence of religion on the nurse's experience of the process of withdrawal of treatment from a critically ill patient in an ICU</p> <p>2.2 The role of a living will/advanced directive in the process of treatment withdrawal from a critically ill patient in an ICU</p> <p>2.3 The role of the nurse as patient advocate</p> <p>2.4 The role of the nurse in accompanying the patient to a dignified death</p>	

- The participants expressed feelings of helplessness. This was based on the fact that, although everything was attempted to save a patient's life, there was no possibility of recovery and treatment was therefore withdrawn. *"I mean you just feel so helpless, there is nothing you can do"*. In a study done by Schneider (1997:174), she stated that nurses experienced loss and helplessness.

- The participants expressed feelings of frustration where unnecessary treatment was prolonged in situations where patient recovery seemed impossible but the doctor was not prepared to make the final decision to withdraw treatment. Anger, especially at the doctor concerned, was also identified through the interviews. *"They mustn't prolong that agony because that waiting is just too terrible for words. I don't think they should. I think if they are going to stop treatment, they must make a decision be-*

cause obviously they must be very clear in their minds that they are going to stop treatment and stop it and that is the end of it."

In a study done by Asch, Shea, Jedziewske and Bosk (1997:1661) *many nurses revealed frustration with the physicians and frustration with their own limited ability to intercede on their patients' behalves.*

- The involvement of the nurse with the patient and the family may cause the nurse to become very emotionally drained. This concern was expressed by some of the participants during the interviews. The participants were perceived to be very empathetic towards the families and their suffering but showed a reluctance to become too involved with the families, as this could drain them emotionally. *"It is draining on the nursing staff to have these people.... This emotion around you all the time."*

- The participants wanted to keep the flame of hope alive for the patients and the families but often reality intruded making it difficult to stay hopeful. *"I actually spoke to the daughter and to the son.. uhm.. and you know he was just saying if there is hope then prolong yes, then go for it. But if there is no hope what is the point in going on? And then coming in and seeing their father like this, you know, uhm...and just getting worse and knowing that actually he has got no prognosis so "*. One of the patient's rights, according to the Dying Persons Bill of Rights (De Laune and Ladner, 2002:483), is the maintenance of a sense of hopefulness.

- Notice was taken of the emotional fluctuations experienced by the participants. The sadness of losing a patient was contrasted with the joy of having a patient transferred as his condition improved. *"I mean especially in ICU you see the whole spectrum. You see the utmost joy and the real, real misery. So you have got the broad spectrum of emotions."* Curtin & Flaherty (1982: 233) explain that the emotional effect of the conflict the nurse experiences should never be underestimated.

In the second sub-category it was identified that *the nurse employs coping mechanisms* to protect himself/herself within the situation of withdrawal of treatment.

- Nurses used rationalisation or justification to construct logical or socially acceptable explanations for the decision-making process regarding treatment withdrawal. When the process is justified it is more acceptable for the nurse and, thus, easier to execute. The steps involved in treatment withdrawal need to be prescribed by the physician. Participants reported that this helped them to justify treatment withdrawal and alleviated those feelings of guilt that may have occurred, as they were executing a doctor's prescription. *".. if I believe that I am doing the right thing I can justify it"*. A phenomenological study done by Viney (1996:182) confirms the findings of nurses justifying their actions.

- The nurses also explained that, at times, they withdrew emotionally from the patients by distancing themselves or avoiding involvement. This coping mechanism was used by some of the participants in order to protect their own emotions and prevent themselves from becoming too involved in the suffering of the patient and the family. In reality, in order to protect their own sanity, the participants relied on the utilization of the coping mechanisms of avoidance or withdrawal. *"You will probably withdraw"*. Wilson & Kniesel (1989:138) confirm that one way individuals cope with stress is to *withdraw physically and/or emotionally*.

- Sometimes the nurses coped by turning to a comforting person. This coping strategy was identified as the nurse seeking another figure for nurturing and protection (Wilson & Kniesel. 1989:138). Within the situation of withdrawing treatment, the participants reported that this figure was often one of their colleagues who had been through similar situations and could empathise with them. *"But*

generally your colleagues are there, they understand the situation because they go through it themselves." Curtin & Flaherty (1982:233) explain that the emotional effects of the conflict the nurse experiences should never be underestimated.

- Another method used by nurses was to *"work it off"*. The individual executes certain actions to relieve the tension caused by the experience of treatment withdrawal. Some of the participants identified certain actions that helped in relieving the tension that had built up within them. *"I just go home and cry"*.

- By using the coping mechanism of self-discipline some of the nurses employed a strategy of self-control. This encompasses personal admonitions to *"keep a stiff upper lip"*, *"bite the bullet"* and *"get over it"* and to suppress one's emotion. This forces the participant to maintain professionalism in such a manner that emotional involvement is wholly avoided. By acting in such a manner, the nurse is able to maintain a clinical approach to the process of withdrawal of treatment. *"Uhm you basically cut your emotions, not to become too involved. You know you basically almost deal with it uhm.. in a clinical way. You can be very empathetic towards the patients but you make sure that your emotions do not become involved"*.

- Intellectualisation was used by nurses because it separates their emotions from the situation of treatment withdrawal by concentrating on the theoretical information related to the process. The nurse gives a rational explanation for the situation he/she is in and, thus provides a verbal means of coping with the anxiety he/she is experiencing (Wilson & Kniesel. 1992:96). *"All the one's that I have nursed, have had, I mean every system has been damaged. They had been in renal failure, they have got no neuro activity, you know, that is worth mentioning, they have all been on major doses of inotropes and... you know you have to.. I think sometimes ...you don't have to save a life, you don't have to pull out all the stops, because you have got to think about the quality of that person's life afterwards..."*.

- Some nurses also relied on previous experience of similar situations. The memory of how they coped during a prior experience of treatment withdrawal plays a role in the experience of a current situation of treatment withdrawal. *"You can't experience it every day, but I think that every time you are exposed to it, it actually helps uhm.... "Dit berei jou voor vir die volgende situasie"..." ("It prepares you for the next situation")*. Schneider (1997:180) describes how treatment withdrawal situations can be more upsetting for the inexperienced nurse.

In the third sub-category *the need for emotional support and knowledge* regarding the process and the ethics involved during the withdrawal of treatment was expressed. A need for knowledge of the ethical aspects of death and dying related to the process of treatment withdrawal, as well as the need for skill involved in the accompanying of

patients and relatives involved in the process of the withdrawal of treatment, was identified within the interviews. "*Daar is 'n geweldige grote behoefte aan die voorbereiding wanneer die dag dokter vir jou sê spuit, sit af die ventilator....*" (There is a great need for preparation for the day when the doctor says inject, switch off the ventilator.) Schneider (1997:183) also identified a need for educating nurses with regard to the issues relating to treatment withdrawal.

Category 2: The interpersonal relationships developed between the nurse and other individuals related to the process of treatment withdrawal from a critically ill patient in an ICU.

The first sub-category identifies the development of a *relationship between the nurse and the patient* for whom he/she is caring.

Often a patient from whom treatment is being withdrawn is sedated or comatose but the nurse still has contact with the individual and, through this contact, a bond is formed. The nurse sees the pain on the patient's face when turned. He/she tends to the patient's hygiene and wounds and is aware of his/her general condition. "*Your relationship with the patients themselves, the relationship with the relatives.. Uhm some are easier to do than othersif you have been nursing the patient for a length of time or the patient has just come in and it depends on the age of the patient.. but....there comes a time that you know it is the right time to do just that and if you know that then it ... then it does make it a bit easier*". Cartwright et al (1997:82) describes the empathetic relationship that develops between the nurse, the patient and their family.

The second sub-category identifies the development of a *relationship between the nurse and the family* of the patient from whom treatment is being withdrawn.

- The nurse patiently tends to the family's questions, fears, uncertainties and frustrations regarding the patient's condition and also observes and experiences the family within this situation of illness and treatment withdrawal and develops an empathy for what they are experiencing: "*Uhm I just feel for them standing around the bed. I feel for them not understanding what's really going on. This hopeless situation and you build up a bond with the relatives and uhm...I do find the relatives a big part of dealing with the ... with the.. actual decision to stop the treatment on the patient*". Schneider (1997:179) also identifies the closeness of the relationship between the nurse and the family resulting in the likelihood of the nurse empathising with the feelings and the experience of the family.

- The nurses also expressed uneasiness in terms of the family with regard to the financial implications of prolonged treatment. "*... you know the family financially can't cope with this. That they have got these fears of what if the medical aid doesn't pay*" Atkinson et al (in Schneider, 1997:174) identifies that ICU care is very expensive, with the greatest expenditure likely to be allocated to non-survivors.

The third sub-category was the *professional relationship the nurse develops with the doctor* treating the patient. Within this situation, the participants experienced the doctor as uninvolved, distant and not open to discussion with staff and the families of patients regarding the decision of continuing or withdrawing of treatment. Participants also suggested a reluctance in the doctors concerned to face the reality of the situation, that no matter what treatment was being administered the patient would not get any better: "*They don't lift the blankets and look at the wounds, they don't ... they don't look at that person as a husband or a father or a part of a family and they don't think of the suffering*". In the study done by Asch et al (1997:1661), the nurses were noted as having discussed physicians' roles in caring for seriously ill patients and many of these comments were critical of the practices of the physicians.

Theme 2: The nurse experiences a moral conflict within him/herself related to the ethical aspects of the withdrawal of treatment.

Withdrawal of treatment is a highly controversial act due to the fact that one is hastening the death of an individual. This leads to a situation in which the nurse is faced with an ethical problem. The following ethical dilemmas were identified:

Category 1: The influence of religion on the nurse's experience of the process of treatment withdrawal from a critically ill patient in an ICU.

Through the development of moral values within a religious perspective, withdrawal of treatment can be very controversial. Within this perspective the question is raised, "*Who has been given the right to take life?*" Participants experienced conflicts and questions within themselves, irrespective of the higher power to whom they felt accountable. This also influenced their experience of the withdrawal of treatment. "*The big part is feeling helpless that you want to do so much more and being a religious person you know that you have done everything humanly possible and the rest is in God's hands*".

Category 2: The role of a living will/advanced directive in the process of treatment withdrawal from a critically ill patient in an ICU was described.

An advanced directive/living will, in which the patient signs a document stating that he/she does not want life-prolonging treatment, can also assist the nurse and the doctor in the dilemma inherent in the decision-making process in treatment withdrawal. Participants referred to a living will and the effect it would have on the decision to withdraw treatment. However, only one participant noted that a living will had actually been used in the ICU in which that Registered Nurse practised. "*Baie van ons pasiënte het...uhm... vorms geteken vir genadedood – 'to stop treatment'. Dan dink ek nie ons verpleegsters moet daarteen*

gaan nie, ons moet die pasiënt se laaste wil, moet ons respekteer. Daarom moet dit toegestaan word uit die pasiënt se oogpunt uit en sy laaste wil en testament moet ons dan respekteer" (Many of our patients have.... signed forms... to stop treatment. Then I think we as nurses must not go against them, we must respect the patient's last wish. Therefore, from the patient's viewpoint, it must be executed, and we must respect his last will and testament.) In a study done in Australia amongst ICU nurses on issues of death and dying (Cartwright et al. 1997:83) the majority of nurses strongly agreed that advanced directives would be useful in medical care.

Category 3: The role of the nurse as patient advocate was described.

Advocacy is the defence of basic human rights on behalf of those who cannot speak for themselves (Wlody 1994:26). In nursing, advocacy involves speaking up for the patient, promoting the patient's rights and ensuring that the patient is assisted towards recovery. By withdrawing treatment, the patient is assisted to die. The moral dilemma in which the participants find themselves is that of preservation of life versus withdrawal of treatment and thus taking a life.

"... ek het geleer in 'nursing' jy moet 'n pasiënt help...en regtig nie om 'n, om 'n einde te maak aan lewe nie" (In nursing I was taught to help a patient, not to make an end to life). Hoyt, Harvey & Wlody (1996:973) discuss the role of the critical care nurse as follows: *Critical care nurses are patient advocates, who focus on their comfort and recovery.*

Category 4: The role of the nurse in accompanying the patient to a dignified death was described.

Some of the participants mentioned that, by prolonging the treatment, the patient was made to suffer longer and his/her dignity was not maintained. The participants felt that it was the caregiver's responsibility to maintain this dignity and, if withdrawing treatment is the only option, then that path of action must be initiated and executed. "Sometimes it feels like we don't allow the people to die. When they are in ICU there is just no... I mean.. if they are a certain age and are very ill, allow them to die. Sometimes we don't want to. We just want to hang on and hang on and hang on and eventually they do die and it's a lot of... trauma." Sjøkvist, Berggren & Cook (1999:167) state that helping our patients die with dignity and without unnecessary suffering is one of the duties of the intensive care nurse.

Guidelines

The insights gained from the themes were used to develop guidelines for the accompaniment of Registered Nurses during the process of withdrawal of treatment:

1. Development of a unit policy with regard to the institution and maintenance of life prolonging treatment
Guidelines must be set up with regard to resuscitation of patients. The use of scoring scales to determine prognosis will facilitate earlier withdrawal of treatment and prevent prolonging of suffering. Ethical Committees must be insti-

tuted to assist in decision-making. These support systems will lessen the feelings of guilt and enable the nurse to execute necessary processes, feeling justified and secure that what is being done is the correct action for the specific patient.

2. Provision of access to proper counselling services for nurses working in ICU

Debriefing facilities need to be instituted so that the nurse has the opportunity to share emotions experienced with a counsellor and to receive the necessary assistance. The counsellor can also teach the staff coping mechanisms relating to treatment withdrawal and death.

3. Preparation during basic training with regard to the ethical principles of withdrawal of treatment

Student nurses need to be exposed during their basic training period to all the ethical implications and the raw emotions related to treatment withdrawal. This accompaniment of the student through the process will assist in preparing him/her to deal with it as a registered nurse.

4. Implementation of legislation regarding the Bill on Euthanasia (see South African Law Commission, 1997) and a living will/advanced directive as a unit policy

This will make the situation of treatment withdrawal easier for the nurse involved because, firstly, it should help to reduce guilt feelings and, secondly, the knowledge that he/she is acting within the acknowledged legal parameters should alleviate anxiety.

5. Development of skills by the Registered Nurse to assist him/herself in coping with the family of the patient from whom treatment is being withdrawn

The registered nurse has the responsibility of accompanying the family through the process of treatment withdrawal with all of its related uncertainties. He/she therefore needs to develop the skills necessary to assist the family with regard to informed decision-making and, thus, accompany the family in such a way that they are reassured that their loved one is being cared for by empathetic nurses.

6. Improvement of relationships with doctors involved in treating patients in the ICU

The registered nurses experience doctors as lacking involvement in the actual process of treatment withdrawal. This situation needs to be addressed by instituting multi-disciplinary meetings where withdrawal of treatment can be discussed openly and related feelings can be expressed. The institution of a decision-making body, such as an Ethical Committee, with medical and nursing representation, should also facilitate the development of improved relationships.

Recommendations

The recommendations are made with specific reference to nursing practice, nursing education and nursing research

- **Nursing Education:** The expressed need for knowledge regarding the process of the withdrawal of treatment must be addressed. The extent of the ex-

perience of withdrawal of treatment and death needs to be included in the curriculum during basic training of nursing students.

- **Nursing Practice:** By implementing the guidelines as mentioned above, the nurse will be accompanied in his/her practice when treatment has to be withdrawn. Involving all the members of the multi-professional team will allow each to have an impact on how the nurse experiences his/her practice of nursing. Ethical committees instituted within each hospital, as a decision-making power regarding ethical concerns, may be beneficial in the situation of treatment withdrawal.
- **Nursing Research:** The study can be used as a basis for further research regarding the phenomenon of treatment withdrawal or passive euthanasia. The impact of the Bill on Euthanasia (see South African Law Commission, 1997), once legalized, can be a basis for further research in nursing. This field of study can also be used to determine the medical practitioner's viewpoint on the withdrawal of treatment.

Limitations of the study

The researcher identified the following limitations:

- Difficulty was encountered in securing interviews with certain participants. After the second unsuccessful attempt to secure an interview, the next participant was contacted.
- A multi-cultural approach was not obtained, as all the participants interviewed were Caucasian.
- There was lack of supporting data regarding the Registered Nurse's experience of the withdrawal of treatment from a critically ill patient in an ICU.

Conclusion

Through the study, the researcher realised that many nurses experiencing the situation of treatment withdrawal appear to experience it in isolation. Many of the nurses employ such good defence mechanisms that they are reluctant to actually share how they are really feeling.

Through this study, some of those feelings and experiences were shared. It is the researcher's intention, through this study, to show other nurses working in ICU's that the experiences of nurses associated with the withdrawal of treatment are similar and that they do not have to deal with them alone. Through the literature control the experiences were confirmed as universal and, thereby, deduced to be normal amongst nurses experiencing the withdrawal of treatment from a critically ill patient in an ICU.

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