TRANSITIONS IN DEATH: THE LIVED EXPERIENCE OF CRITICAL CARE NURSES

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Abstract

Critical care nurses often face the ordeal of witnessing a patient's death in a tense and stressful environment. Anecdotal stories shared among nurses reveal that unusual experiences often occur at the time of or after a patient's death. This hermeneutic phenomenological study explored the meaning of these experiences for critical care nurses. Using Parse's research method, in-depth interviews were conducted with six critical care nurses who described their experiences at the time of a patient's death as well as during the post-death period. These experiences brought a sense of peace and comfort to each individual as well as reinforced their individual belief patterns about life after death. A distinctive sense of nursing knowing at the time of death was also identified. The findings of this study indicate that the experiences of the phenomenon of death by critical care nurses have a significant impact on each individual and that further research and understanding of this impact is needed.

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Chapter 1: Introduction

Nursing is a profession with a unique perspective. Since the time of Florence

Nightingale, nurses have sought to view and care for their patients using a holistic

approach, that is, to care for their minds, bodies and spirits. Using this approach, nurses

can develop exceptional relationships with their patients, by caring for the physical body,

attending to matters of the mind, and, in certain instances, achieving a connection with

the spirit. An understanding of the spiritual connections between nurses and their patients

has been slow to develop, and the question of when such connections begin and end

remains a mystery.

This chapter includes a discussion of some of the elements of this mystery,

including descriptions of holism, spirituality and the uniqueness of the nurse-patient

relationship.

Holistic Nursing

It is the holistic nature of nursing that allows these connections to occur. These

connections, on whatever level they exist, allow nurses to facilitate healing processes

among their patients. The matriarch of nursing, Florence Nightingale, "emphasized that

the needs of the spirit are as critical to health as those individual organs, which make up

the body" (Kelly, 2004, p. 162). While it is evident that holistic care is an important

element in nursing, it means different things to different nurses. Perhaps this is why the

connection between nurses and their patients seems so intangible. Jackson (2004)

suggests that the ability of an individual nurses to provide holistic care to patients is

related to where that nurse is on his/her individual journey toward holism. Jackson

advocates that, as the nurse gains an expanded sense of self-awareness, he/she also

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becomes more aware of others and eventually begins to understand illness as part of a pattern of interaction between humans and their environment. Such patterns of interaction include the elements of holistic care: mind, body, and spirit. These elements of holism are neither unique to nor isolated from nursing. Other disciplines, such as existential psychology, offer additional perspectives.

The Eyes of Wilber

Wilber's (1990) discussion of the eyes of the soul is enlightening in terms of the journey to holism. Wilber (1990) relates that St. Bonaventure, a philosopher, described the attainment of knowledge as occurring through three channels:

> ...the *eye of flesh*, by which we perceive the external world of space, time, and objects; the *eye of reason*, by which we attain a knowledge of philosophy, logic, and the mind itself; and the *eye of contemplation*, by which we rise to a knowledge of transcendent realities. (Wilber, 1990, p. 3)

Nurses use the knowledge gained through the "eye of flesh" on a daily basis in their work. This knowledge relies on sensorimotor discernment of the environment. Critical care nurses access this realm of knowledge constantly; in-depth physical assessment, analyzing monitor patterns, and reviewing lab results, are all examples of the way in which critical care nurses utilize the knowledge gained through the "eye of flesh."

The "eye of reason" facilitates the critical thinking and problem solving abilities of critical care nurses. It allows the nurse to take the data or information that has been obtained through the "eye of flesh" and create solutions to problems that have arisen using the concepts of critical care. For example, a nurse identifies that a patient's oxygen status is poor by assessing the patient's skin color, chest sounds, and oxygenation

calculations. Utilizing the concepts of ventilator therapy, the nurse then determines whether the patient is in need of a higher percentage of oxygen, requires ventilation under greater pressure, or simply needs to be suctioned to remove the obstruction to oxygen flow. The "eye of flesh" knowledge supports the "eye of reason" knowledge, but Wilber (1990) also points out that the "eye of reason" is more than just the result of "eye of flesh" knowledge. The "eye of reason" allows a nurse to use imagination and creativity in problem solving without being in the actual situation.

It is the third eye, the ″eye of contemplation," that is engaged in the nurse's journey to holism, according to Wilber (1990):

> ...the eye of contemplation,...transcends the mental realm and...the realm of the
> sentiments (the sensory realm). This transcendence results from the
> 'supernaturally natural' function ... namely the contemplation of the Immutable, of
> the Self, which is Reality, Consciousness, and Bliss. (p. 6)

The journey into the expanded awareness of self, as described by Jackson (2004), occurs when the nurse begins to seek knowledge using the "eye of contemplation." Jackson suggests that this path to holism may require the nurse to experience wounds in mind, body, or spirit, and through his/her personal healing process, to transcend the infirmities of the human body, emerging with a new knowledge of holism and spirituality.

<p align="center">Spirituality</p>

Despite having recognized that spirituality is an essential component in the philosophy of holism, the nursing profession has been challenged to actually incorporate this into nursing philosophy and practice. Maddox (2001), suggesting that this challenge

<p align="center">3</p>

is of long standing, quotes Florence Nightingale: "Spiritualism is dormant, not dead, let us hope. How to revive it, to rekindle it into life, is the great question" (p. 134).

Conceivably, the integration of the concept of spirituality into nursing practice has been hampered by the lack of a clear definition. Scholars have provided an abundance of plausible definitions, as identified by McEwen (2004) in her content analysis of nursing literature. The definition used by Dossey (cited in O'Brien, 1999) embraces the expansive characteristics of the concept and blends well with this researcher's perspective:

> [Spirituality is] a broad concept that encompasses values, meaning, and purpose; one turns inward to the human traits of honesty, love, caring, wisdom, imagination, and compassion; existence of a quality of a higher authority, guiding spirit, or transcendence that is mystical; a flowing, dynamic balance that allows and creates healing of body-mind-spirit; and may or may not involve organized religion. (p. 5)

Individuality of understanding is a consistent theme throughout most definitions of spirituality. Certain descriptive words are also common, such as "love," "compassion," "caring," "transcendence," and congruent expressions such as "relationship with God," and "connection of body, mind, and spirit" (O'Brien, 1999, p. 6).

The nursing literature distinguishes between religion and spirituality. A common approach is to contrast the two concepts. In differentiating the breadth and scope of each concept, spirituality is generally perceived as being broader than religion. The usefulness of this comparative approach is questionable, as spirituality is an identified element within religion (Clarke, 2005; O'Brien, 1999).

While modern-day nurses are striving to integrate spiritualism as part of holistic nursing, O'Brien's (1999) narrative on the history of nursing provides a thought-provoking perspective. Using biblical references, nursing historians describe the inception of nursing as occurring in the early Christian era (O'Brien, 1999). Following the chronological story of the growth of nursing, from the early Roman Matrons to the current nursing "Sisters," it is evident that religion and spiritualism have played an influential role. In fact, O'Brien suggests that some of the modern-day difficulties of incorporating the spiritual perspective in holistic nursing practice result from the movement of nursing education towards the academic/scholastic realm.

McEwen's (2004) assessment of the spirituality content in current nursing resource textbooks supports the notion that nursing education is not putting an emphasis on spirituality. Reporting that only 0 to 13.3% of overall content of nursing textbooks has "some reference to spiritual issues," McEwen suggests that there is a large gap in the knowledge foundation of a core component of holistic nursing. As McEwen reports, "Critical care nursing books gave very minimal attention to spiritual needs and spiritual care" (p. 25).

The lack of information in nursing textbooks on spiritual knowledge in critical care may indicate an inadequacy in the provision of holistic care in this specialized environment. The critical environment in itself provides a reason why a deficit in spiritual care may exist, according to Smith (2006): "ICUs house patients who are the sickest and in the most unstable condition, patients whose physiological needs dominate" (p. 42).

The American Association of Critical Care Nurses has taken a close look at the state of holistic care in the critical care environment. As a result, they developed a

framework to assist critical care nurses in acquiring knowledge and implementing spirituality as a core component to care. The framework is known as the Synergy Model for Patient Care (Smith, 2006).

The Critical Care Setting

Imagine a place filled with sounds. Imagine three stages of cardiac alarms (all requiring a different speed of response), ventilator alarms (coughing or crisis), infusion pumps, phones, timers and overhead pagers. Then add in the sound of a colleague asking urgently for help, the patient calling in pain, and the family crying in grief. These are the sounds of the high-tech, yet human, environment of the Intensive Care Unit (ICU). It is a unique and challenging place in which to practice nursing.

The ICU setting is founded on the traditional medical model, where the focus is on "the diagnosis of disease, the provision of care/treatment, with the goal being a cure" (Blasdell, Klunick, & Purseglove, 2002, p. 231). The severity of a patient's illness dictates admission to the ICU and is often numerically calculated using tools such as the Acute Physiology and Chronic Health Evaluation (APACHE) score. ICU outcomes are measured in terms of morbidity and mortality (Gruenberg, Shelton, Rose, Rutter, Socaris, & McGee, 2006).

ICU's may be further designated into specialties such as cardiac, neurology or medical-surgical, but there are common challenges for nurses among them all. Brosche (2003) describes a situation involving concurrent demands that are commonly placed on the critical care nurse, including managing the care of more than one acutely ill patient, crisis decision making, and multidisciplinary team organization.

Critical care nurses function with a high level of autonomy and the expectation of high standards of performance from self, physicians and administration. There is a significant amount of task-related work that is never completed without the diligent application of critical thinking and assessment. Mistakes have a human cost. In critical care, the primary focus is to preserve life (Cole, Slocumb, & Mastey, 2001).

The "disease-diagnosis-treatment-cure-discharge characteristics of the medical model" (Blasdell et al., 2002, p. 231) guide the physician intervention with the patient; as a result, the establishment of the ongoing relationship with the patient and family is often passed to the nurse. It is this relationship and its unique characteristics that are of interest in this study.

Nurse-Patient Relationship in the Critical Care Environment

The importance of the nurse-patient relationship in nursing practice is well defined in the literature. In general, this relationship is considered to be foundational and central to nursing care (Baille, 2004; Hagerty & Patusky, 2003; Mok & Chiu, 2004).

The nurse-patient relationship is central to nursing care in the critical care environment. However, the high degree of specialization and intensity that exists in the critical environment, where nurses care for the sickest of patients, dictates that the nurse-patient relationships that develop will themselves be unique. The intensity of life-and-death situations can create the setting for some powerful connections to occur within a very short span of time. Conversely, in the fight to maintain life, events happen quickly and patients often have no conscious response, so that the nurse may feel that there has been no opportunity to establish a connection. In either case, chances for an exceptional

relationship to develop are high, as the critical care nurse is present for perhaps the most intense moment of a person's life, that is, his or her death.

Badger (2003) supports this idea and expands on the subject in a discussion of "role strain." Role strain results from the critical care nurse simultaneously managing patients on opposite ends of a continuum between fighting to live and dying. This diametrically opposed perspective of the nurse-patient relationship is a unique component of critical care nursing. Baille (2004), discussing the nurse-patient relationship in the Emergency department, also acknowledges the uniqueness of this situation, in which time is short and physical needs are a priority. The level of intensity in patient care in an Emergency setting is similar to that in critical care.

This intense connection between a nurse and a patient may be quite invisible to the observer; in fact, the strength of the connection may be invisible even to the nurse. Communication within the relationship may be challenging or impossible. Non-verbal communication and behaviors may dominate the nurse-patient interactions (Alasad & Ahmad, 2004).

Despite the challenges of the unique nurse-patient relationship in the critical care environment, it is truly a privileged affiliation that is best understood through the experience itself.

A Personal Perspective

The researcher has been a professional nurse for 22 years and has specialized in critical care for the last 18 years. Through years of experience, she has gained an understanding of the depth of the unique relationship between nurses and patients in a critical care setting.

Whether the connection between these individuals is visible to others or not, nurses attach meaning to it. Every experience shapes them in many, often subtle ways. Sometimes the experience is not subtle, and its effects are profound and life changing. Being present during a patient's transition from life to death, for example, is one of the most powerful experiences a nurse can have.

The researcher can still remember her first pediatric cardiopulmonary arrest situation. It is easy to recall every detail of the resuscitation sequence and to hear clearly the tortured scream of denial as the mother was told that the team had lost the battle and the child had died. The gentle face of that blue-eyed little boy is forever burned into the researcher's memory. In those agonizing and intense minutes, she felt an indescribable connection with that patient.

The way in which individual nurses integrate these experiences into their life knowledge seems to be related to their personal stage in the journey to holistic nursing. The development of an understanding and acceptance of the transition from life to death is evident in the discussions between nursing staff following a patient's death.

The researcher has heard some amazing exchanges among nursing staff relating to the transition from life to death, following the deaths of patients. Listening to her colleagues' stories and sensing the powerful impact of those experiences on them, in addition to her personal and professional journey to holistic care, have inspired her to pursue this research project. The researcher hopes that a deeper understanding of what these extraordinary experiences mean to the nurses who experience them will grow out of this research process.

The Research Question

As Polit and Beck (2004) state, the function of a research question is to identify the scope of the area of interest and to state the purpose of the exploration. The central research question underlying this study is the following: What meaning do critical care nurses make of their at-death and post-death experiences with their deceased patients?

Summary

Holism, including spirituality, is not clearly defined within the nursing profession. It is as complex as the nurse-patient relationship and perhaps as difficult to describe as the experiences that occur when a patient dies. Nurses do know that what they do impacts who they are, even if they have difficulty in articulating this meaning.

This thesis is presented in five chapters, followed by a list of references. Chapter 1 includes a description of the state of holism and spirituality in nursing, as well as the nurse-patient relationship that is unique to the critical care environment. The researcher's perspective and topic of interest are also presented in this chapter. Chapter 2 explores the current literature surrounding death experiences and related themes. Chapter 3 presents the conceptual and methodological framework used in the study. In Chapter 4, the researcher describes and interprets the results of the study using the Parse Research method. Finally, in Chapter 5, the findings are discussed in relation to current literature, as well as implications for practice.

Chapter 2: Literature Review

There is a mystery as to when the connection between nurses and their patients begins and ends. An examination of the literature follows, focusing on a search of evidence and discussion that this connection may continue, at the time of and even after a patient's physical death.

Patterns of Religious Belief

Initiating a discussion on post-death experiences may elicit a variety of responses, both positive and negative. The possibility of life after death is not always a comfortable topic. This reaction is affected by a number of factors that may influence an individual's pattern of belief as well as the willingness he or she may or may not have to share that information with someone else.

Religion plays a significant role in the belief systems of society, both now and in the past. It also has an extensive influence on people's actions and reactions to various components of life. The topic of life after death arises in the history and foundations of most religions. Haddow (1998) summarizes:

> All religions attempt to answer it in their own particular way. They have something to say of an existence after death because they believe that this present life is connected with an afterlife, and they lay down rules of conduct which, if followed, will be for the individual's well-being in a future existence. Thus observance of rituals and life-style dictated by religious creeds and dogma are deemed important in ensuring the soul not only a safe passage through death but also guaranteeing it a future life of happiness. (p. 183)

Within religious communities, belief in life after death is based on faith. The evolution of faith and belief for each religion has occurred at varying rates throughout human history. Many older, Eastern religions, such as Buddhism and Hinduism, are very progressive, with belief in life after death an accepted part of the core belief system. The literature surrounding the Eastern religions and the issue of life after death is extensive, and reviewing it is beyond the scope of this paper. Christianity, a relatively new religion, has been much slower to explore some of these issues.

Apparently Christianity was too slow for some members of the scientific community. In 1885, Williams James, an American psychologist, founded the Society for Psychical Research (SPR), similar to the group formed three years earlier in Europe (Haddow, 1998; Krippner, 2003). The SPR aimed to scientifically investigate any phenomenon that could provide evidence of life after death. So began the evolution of parapsychology, which Krippner defines as "the scientific study of anomalous interactions between organisms and their environment, and between organisms and other organisms" (p. 108). One of the phenomena that underwent investigation was the use of a medium as a means of communicating with the deceased. A medium is a person whose body, while in a trance state, serves as a communication tool for deceased spirits.

The concept of Spiritualism emerged in 1848, promoting the use of such intermediaries. This new concept provoked concern, and in 1920, the Church of England began its own investigation into Spiritualism and communication with the deceased. The subsequent report concluded that such events should not be accepted as evidence without scientific investigation, an interesting perspective considering that the Church expects faith to develop without scientific investigation. Another perspective would be that

Christianity sought to suppress or reject knowledge of life after death as indicated by its condemnation of reincarnation as heresy in 533. Reincarnation supports the premise of life after death and is described as rebirth of the soul into another human body or "transmigration of the soul" (Haddow, 2002, p. 189).

Beck and Miller (2001) sought to investigate the extent of the influence of the Church and religion on an individual's belief system. For the purpose of their study, they differentiated between "paranormal phenomena (e.g., extra-sensory perception, or ESP; telekinesis; clairvoyance; precognition; communication with the dead) and the supernatural phenomena typically associated with Christian belief systems (the activity of supernatural agents such as angels or demons, the present-day occurrence of miracles, the causal power of prayer)" (pp. 277-278). Beck and Miller inferred that subjects would differentiate between these two terms, that is, they would accept some and reject others, based on previous religious influence and personal experience. They described this process as "metaphysical chauvinism, whereby one rejects certain quasi-empirical claims if they are not consistent with one's metaphysical assumptions, despite simultaneously holding beliefs that equally unverifiable from an empirical point of view" (p. 278). Beck and Miller proposed that this process was a dynamic one that would change and adjust in accordance with the individual's needs. They conducted their quantitative study in a small, Christian university in Tennessee, administering a questionnaire to 94 undergraduate psychology students. The results indicated no significant relationship between religiosity and supernatural beliefs, and a negative association between religiosity and paranormal beliefs.

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Another purpose of Beck and Miller's (2001) study was to identify any relationship between the impact of negative life events and belief in the supernatural or paranormal. In this area a difference was noted in the responses of religious and non-religious persons. Non-religious participants tended to display increased belief in both paranormal and supernatural phenomena during negative affect, while religious participants tended to maintain the same belief of paranormal phenomena in comparable circumstances. Supernatural belief tended to decrease for the religious group during periods of negative effect. The authors noted that the sampling of participants from a Christian university limits generalization to other populations but argued for further investigation into this dynamic relationship.

Orenstein (2002) used a Canadian sample to investigate the connection between religion and belief in paranormal phenomena. He discussed three hypotheses that consistently emerge in research surrounding religion and paranormal beliefs. The first two hypotheses are contrasting, that non-religious persons would tend to have more belief in paranormal phenomena and religious persons would tend to have less belief in those same phenomena. The third assumption is that persons not involved in religious services would tend to have a higher belief in the paranormal. In his review of the literature, Orenstein identified a lack of consistency in outcomes when these hypotheses are explored and sought to provide more definitive evidence of the relationship (or lack of relationship) between religion and paranormal beliefs.

To collect the data used in the analysis, Orenstein used a 20-page questionnaire intended to gather information from a representative group of Canadians. The total sample size was 1,765. When quantitative analysis was conducted on the data, the results

indicated that, while no increased belief in the paranormal was associated with non-religious persons, an increased belief was associated with religious persons. Persons who attend religious services demonstrated a higher level of belief in the paranormal. The author also compared belief in paranormal phenomena to levels of education and found that the effects were small; education did not seem to play a major role in development of paranormal beliefs.

The results of both Orenstein's (2002) study and Beck and Miller's (2001) study, as well as the issues identified in Orenstein's literature review, indicate that while there is some evidence of the significance of the relationship between religion and paranormal belief, it is not conclusive or consistent.

Culture and Beliefs About Life After Death

Culture also plays an influential role in beliefs about life after death. Tick (2004) describes the unique and respectful perspective held by the Vietnamese, a perspective that encompasses all generations of their culture:

> [The Vietnamese] believe that when somebody dies, the soul of that relation remains with the family for 100 years. Thus they keep altars in their homes that honor their dead ancestors for four generations. When the next generation starts to die, they believe the fourth generation back is released and can then move on in its cycle of reincarnation. (p. 66)

This connection with the deceased is an accepted part of Vietnamese culture. Native American cultures are also known to be respectful in honouring the spirits of their deceased warriors and hunters (Tick, 2004; Williams, 2000). In African cultures, people perform ritualistic ceremonies to assist the spirits of the deceased in their journey from

the world of the living. Eastern Indian cultures observe similar rituals, and interaction with spirits of the deceased is described within the Japanese culture (Willliams, 2000). The literature concerning cultural beliefs and life after death is extensive, and a detailed discussion is beyond the scope of this thesis.

The Influence of Social Factors

Markovsky and Thye (2001) investigated the influence of social factors in relation to belief in the paranormal. They identified a knowledge gap and aimed their research at correcting this deficit:

> To our knowledge, this is the first experimental demonstration of the interpersonal transmission of paranormal beliefs and the first time that all three of social impact theory's "source" factors -- strength, immediacy, and number -- have been tested in a single controlled experimental setting. (p. 731)

This quantitative study used a pyramid, a box, a plastic container, and bananas. After completing a questionnaire comprised of a paranormal belief scale, the participants were exposed to an experimental situation where they ranked the state of the bananas that had been preserved under either the box, the plastic container, or the pyramid. A randomly selected group of participants received a review of the historical perspective of pyramids that included information on the preservation of entombed bodies. Some subjects were also exposed to a third person who, when asked first (as prearranged), always chose the pyramid banana as appearing fresher. The perceived status of the third person, either equal or higher, was also introduced as a factor.

Markovsky and Thye (2001) proposed four hypotheses drawn from social impact theory. The results are interesting. First, as hypothesized, they found that the subjects

who were exposed to the third person opinion tended to rate the bananas with a similar freshness rank in line with that opinion, and that this thought process continued after the experiment was completed (as exhibited by private post-test completion). This demonstrated that a person's response to the paranormal is influenced by the response of others. Secondly, the researchers hypothesized that this influence would be less when using a paranormal context as compared to using a non-paranormal one. The evidence supported this idea by revealing an even higher influenced response rate when the pyramid situation was removed. The impact of status was also considered and found to be significant when the third person with perceived higher status was present, but showed no significance in response in the private post-test setting.

The final question focused on the effect of immediacy, that is, whether the same effect would occur if the third person's freshness rankings were merely described instead of demonstrated. The authors report an unexpected lack of difference in these two settings; this result did not support their hypothesis. In discussing the results, Markovsky and Thye suggest that, while their evidence provides some support for the social impact theory, there are identifiable limitations and further research is needed.

Paranormal Beliefs

The discussion around the patterns of belief in paranormal phenomena obviously encompasses many realms, including religion, culture, and social impact. However, the state of the research clearly indicates that we have not truly achieved a concrete understanding. Perhaps we are limiting our own ability to understand these phenomena by seeking to describe these experiences as dysfunctional processes. Several areas have been investigated with interesting outcomes.

Musch and Ehrenberg (2002) investigated the relationship between paranormal beliefs, the aptitude to assess probability, and cognitive function. Their literature review notes prior research that both supports and negates the idea that paranormal belief is a lack of ability to accurately judge the probability of chance occurrences. It also identifies research that utilizes cognitive ability as a predictor for paranormal belief. The stated purpose of Musch and Ehrenberg's study was to demonstrate the concept that belief in the paranormal is more closely associated with low cognitive ability, and that the presence of poor probability judgement is a result of that level of cognitive aptitude. Questionnaires containing paranormal belief scales, probability tests, and cognitive assessments were administered to 123 university students. Several methods of statistical analysis were employed, and the results demonstrated a strong correlation between low cognitive ability and paranormal belief. After controlling for this relationship, the impact of probability judgement displayed no significant impact on paranormal belief. The authors note that a variety of other factors may have influenced the results, and suggest that further research should attempt to establish control over these elements. The power of this research is in influencing the mind of the reader, who may not look beyond the demonstrated correlation between paranormal beliefs and low cognitive ability.

Roberts and Seager (1999) conducted a study using similar probability assessments but selected a different participant group. They used a sample of 65 volunteers selected from a group of the investigators' colleagues and acquaintances. The purpose of their study was to determine if the relationship between probability scores and paranormal belief existed in a group that did not contain university students. The results indicated that there was no difference in outcome between university students and non-

university participants when evaluating reasoning ability and paranormal belief. A small link was identified between a lower ability to reason and paranormal belief but, unlike the previously discussed study, the results presented no link between broad cognitive ability and belief in the paranormal. The authors suggest further studies to gain insight into this relationship.

Auton, Pope, and Seeger (2003) sought to describe the relationship between personality traits and belief in the paranormal. This quantitative study engaged a sample of 105 students of psychology. The instrument was a questionnaire that contained several previously validated scales designed to assess paranormal belief and personality traits. The results showed little difference in personality traits among participants with low and high rates of belief in the paranormal. The presence of non-pathological characteristics in both groups of believers was also considered and found to differ very little.

The research that has been conducted around paranormal beliefs and human mental function has failed to show any clear and consistent outcomes. There has been a call for more research, but one might wonder if we will ever truly be able to measure the relationship between the human mind and the paranormal, or if understanding will come only after acceptance.

Related Topics of Investigation

The journey to understanding paranormal phenomena has taken investigators down varying and interesting paths. The following discussion will focus on two of these paths, or topics, that have been discussed extensively in the literature. Both of these topics demonstrate that life after death is indeed a possibility that must be considered.

Human Energy

The first area of investigation surrounds human energy. Different people have different levels of energy, not the kind of energy that helps us get through the day, but rather a vibratile life force that makes us who we are. Benford (2001) addresses this idea in her discussion of the energy seen during studies of "hand-mediated healing sessions" (p. 132). These studies evaluated the level of gamma radiation emitted from the human body as the sessions proceeded. Benford provides a detailed illustration of how this gamma radiation is related to quantum physics; explaining the "zero-point energy field" (p. 133) and its relationship to human energy, she provides excellent food for thought about the possibilities. Benford suggests that the by-product of this energy utilization is released from the body, accounting for changes in levels during healing sessions and possibly for the energy that is displayed in auras.

Maher (1999) addresses the theory behind auras in a similar fashion and goes one step further, suggesting that this same human energy is unending and is possibly related to a form of survival after death, as may be manifested in the form of apparitions:

What survives death may be one and the same as this energy, which transcends the vessel of the body and escapes into space. After death the energy may be perceived in human apparitional form, perhaps with the same rare frequency (or potential) as it formerly manifested as an aura. All of the information needed for the reconstruction of the dead personality in visible human form is coded in the energy. (p. 56)

Unfortunately, Maher's discussion appears to be weakened by the lack of evidence of energy and by the abundance of psychic-related data in the meta-analysis she provides of

her own studies. However, one of the potential strengths of both Maher and Benford is their apparent openness to the possibilities of life after death.

Gough and Shacklett (2001) also consider the human energy concept, describing the energy as existing in different levels of vibration. They suggest that all forms of life contain vibratile energy at different levels, and that some limited exchange or communication, described as feedback, can occur between the levels. Gough and Shacklett propose that this feedback from higher vibratile levels is responsible for many of the paranormal phenomena that occur. They refer to previous studies that investigated energy feedback through the use of electronic equipment. In conclusion, these authors suggest that they have provided a roadmap for further research.

Wiseman, Watt, Stevens, Greening, and O'Keeffe (2003) conducted a study in the United Kingdom investigating two specific locations that had historical reports of paranormal phenomena. They conducted the study using two instruments for each of the two sites. The instruments were not used concurrently, to avoid any potential participant bias. The 462 participants in the study were randomly assigned to two groups and then given a questionnaire to complete following a visit to one of the aforementioned sites. The questionnaire asked them to report any unusual occurrences that they may have experienced during their visit. The authors noted that each location was commonly known to have a history of unusual events. The second instrument utilized equipment that mapped and measured magnetic fields at each of the two sites. Statistical analysis was completed on the data. The results indicated the following:

> [There were] no significant differences in the mean strength of the magnetic field
> between the two types of areas. However, the variance of the local magnetic field

was significantly greater in 'haunted' than 'control' areas, and there was a

significant relationship between the magnetic variance and the mean number of

unusual experiences reported by groups of participants. (p. 203)

Wiseman et al. discussed many factors that may have influenced the results and

provided suggestions for further research. They concluded that the results were more

likely caused by the human reaction to normal environmental changes in magnetic fields

than by paranormal activity.

While there appear to be many ideas about the possibilities of life after death,

science is struggling to define those possibilities. To add a further dimension to the

discussion, it is worth considering another prominent human experience that may support

the idea of life after death.

Near-Death Experiences

In the past decade, a significant amount attention has been paid in both the

popular and the scholarly literature to the phenomenon of near-death experiences. For the

purpose of this discussion, no popular literature will be reviewed.

Description of the phenomenon known as near-death experience is quite new in

the scientific world. According to Greyson (1999), "the near-death experience was first

named by Moody in 1975" (p. 8). This doesn't necessarily suggest that near-death

experiences were not occurring before 1975; it simply indicates the relative newness of

the formal identification of near-death experience as a phenomenon. There has since been

much discussion surrounding the definition of a near-death experience. It is often

described in terms of the features that occur in the experience. Greyson (1998), who has

conducted extensive research on near-death experiences and is well published in the

scholarly arena, provides the following definition:

> Near-death experiences (NDEs) are profound psychological events with
>
> transcendental or mystical elements typically occurring to individuals close to
>
> death or in situations of intense physical or emotional danger. (p. 14)

There are many components to the near-death experience, as described by the

persons who have had this experience. Greyson (1998) describes the range of

components:

> The following classification provides a broad depiction of the components: (a)
>
> cognitive features of time distortion, thought acceleration, a life review, and
>
> revelation; (b) affective features of peace, joy, cosmic unity, and an encounter
>
> with light; (c) paranormal features of vivid senses, apparent extrasensory
>
> perception and precognitive visions, and "out-of-body experiences," and (d)
>
> transcendental features of otherworldly encounters with mystical beings, visible
>
> spirits, and an uncrossable [sic] border. (Greyson, 1998, Components section, ¶ 1)

Specific measurement scales have been developed to explore the near-death

experience based on these components (Lange, Greyson, & Houran, 2004), and focused

analysis on the particular components of these experiences has also been conducted. For

example, Kelly (2001) focused on near-death experiences that involved an encounter with

a previously deceased person.

There has also been a significant amount of investigation into why this

phenomenon happens for some people and not for others. As with other phenomena,

there have been attempts to define near-death experience as a dysfunction in brain

process. Depersonalization, dissociation, and imagination have all been suggested as possible psychological causal agents (Greyson, 1998, 2000). There have been some attempts to explain this phenomenon physiologically as well. Hypoxic and metabolic causes as well as medication-induced hallucinations have been proposed as causative agents for this experience in the literature; however, no conclusive argument has been provided for either realm (Greyson, 1998; Parnia & Fenwick, 2002)

A longitudinal study on near-death experience with persons who had survived cardiac arrest was conducted by van Lommel, van Wees, Meyers, and Elfferich (2001) The sample consisted of 509 successful cardiac resuscitation events for 344 patients, yielding 62 reports of some level of near-death experience. While the majority of the results are displayed in quantitative measures, the authors use a qualitative approach as well, and support the evidence with narrative responses. The outcomes provide strong support for refuting the psychological and physiological causative postulation:

> Our results show that medical factors cannot account for occurrence of NDE; ...
> furthermore, seriousness of the crisis was not related to occurrence or depth of the
> experience. If purely physiological factors resulting from cerebral anoxia caused
> NDE, most of our patients should have had this experience... Medication was also
> unrelated... Psychological factors are unlikely to be important... (p. 2043)

Van Lommel et al. identified another interesting perspective, that effective memory is required for recalling the near-death experience, since patients who displayed deficits in memory reported fewer instances of near-death experience.

Howarth and Kellehear (2001) provide insight about instances when near-death experiences have been shared with other people; that is, a second person was taken along

for the experience. They supply anecdotal narratives as evidence of this experience but note that this type of incident is rare.

Although most of the components of the near-death experience appear to be positive, consideration must be given to any possible negative impact that may occur. Depending on the depth of the near-death experience, the individual may be forced to perform a complete re-evaluation of his or her belief system. It may also be difficult for the person to share this experience with another who is accepting and understanding (Greyson 1998; van Lommel, et al., 2001).

Greyson (2001) also investigated the association between near-death experiences and a form of post-traumatic stress syndrome. The results indicated that, while a degree of post-traumatic stress was evident, the levels were below those considered to be clinically diagnostic of the syndrome. Still, these results have great implications for those who are in a professional position, such as nurses, to respond to patients who have had a near-death experience.

Nurses' Exposure to Patients Having Near-Death Experiences

Many nurses have been exposed to patients who have had near-death experiences, as evidenced by the anecdotal narratives published in nursing journals (Hayes, Hardie, Bucher, & Wimbush, 1998; Schoenbeck, 1993). However, simply being exposed to patients who have had a near-death experience does not mean that nurses have the knowledge adequately or appropriately to provide the care that the patients need to deal with such experience.

Cunico (2001) surveyed 335 nurses from three hospital sites in Italy. The instrument was a questionnaire that utilized a previously validated tool, "Thornburg's

(1988) Near-Death Phenomena Knowledge and Attitudes Questionnaire, translated into Italian" (p. 40). Cunico stratified the participants by area of work, specifically critical or non-critical care areas. Of these nurses, across the three sites, 34 percent had cared for patients who had near-death experiences. The results showed that general knowledge scores overall were lower than the minimum score designated by the tool to indicate good near-death experience knowledge, and that nurses from critical areas scored lower than those from non-critical areas. The attitude scores were at a higher level for non-critical nurses compared to their critical counterparts. Interestingly, head nurses demonstrated an increase in attitude scores but not in knowledge scores, when compared to general nurses. Age, gender, and site specifics were also considered in the analysis. While this study was conducted in a European setting, there are implications for the nursing profession in general. Further research needs to be conducted in other settings, and nursing knowledge deficits related to near-death experiences require attention.

James (2004) provides suggestions for addressing this concern, encouraging further research and utilization of all available resources. She also outlines some specific interventions that may be helpful in caring for patients who have undergone a near-death experience. Although the context for her recommendations is the Emergency room setting, they are applicable to nurses who provide care in all environments. Clearly, the nursing profession must become more engaged in this arena if we are to continue to provide patients with the best holistic nursing care possible.

Life After Death in Other Settings

The intent of this literature review is to examine literature related to the continued connection between nurses and their patients, even after death. It must be noted that there

is an identifiably large gap in the research and literature in this area. In fact, the current

literature provides no evidence to indicate that this possibility has been considered. The

alternative, then, is to review any literature that relates to identified connections after

death within other settings.

Sormanti and August (1997) conducted a study evaluating the ongoing connection

between parents and their deceased children. Their literature review covers several areas,

including issues of grief and bereavement as well as considerations of cultural impact.

The authors identified a gap in the research surrounding this phenomenon. They

determined their potential sample through a review of the medical records of cancer-

related pediatric deaths in the five years prior to the study start date. The initial contact

with the families was made through a letter that defined the study; a return postcard was

included to allow the families to indicate their interest in participation. Families that

agreed to participate were then sent a questionnaire developed by the authors. Since the

questionnaire had not been previously validated as an instrument, it was evaluated by

colleagues and a group of bereaved parents for wording and sensitivity prior to

distribution, in an attempt to increase validity. The questionnaire consisted of nine open-

ended questions designed to elicit information about parents' "spiritual" connections with

their deceased children and their beliefs about life after death. The authors considered the

return rate to be low, with only 43 out of 309 forming the final sample.

All the participants identified one or more ways that they felt an ongoing

connection to their children. Many described patterns of behaviour, such as visiting the

graveside and other experiences, that kept them connected and reminded them of their

children. Some also described phenomena related to feelings, sensations, and unusual

occurrences that they perceived as being signs of their children's continuing existence even after death. Interestingly, some parents also described events that had been experienced by others as signs from their children. Overall, the parents related these events as positive: "[They seemed] comforted because the experiences confirmed that their child was in a safe place, with other deceased family members or with God; for them, this was a confirmation of an after-life" (p. 466). This finding closely relates to comments by people who have had near-death experiences, that the experiences were positive and comforting. The parents also related that, overall, sharing these occurrences with others was a positive experience, but that they carefully considered which people they chose to share this experience with. Furthermore, they reported changes in their belief patterns following these events.

Sormanti and August (1997) note the inability to generalize the results to a larger population as a limitation of the study. They make several suggestions for further research into this area, including investigation in different death circumstances and the development of a standardized tool.

Klass (1993) also identified a continuing bond between parents and their deceased children, in his discussion of solace. Based on evidence accumulated in a 10-year ethnographic study of a self-help group for parents who had lost children to death, Klass noted a recurrent pattern that emerged from the descriptions of the parents in the group. He described the pattern as an interaction between the parent and an "inner representation of their dead child":

Phenomena that indicate interaction with the inner representation of a deceased person are a sense of presence, hallucinations in any of the senses, belief in the

person's continuing active influence on thoughts or events, or a conscious

incorporation of the characteristics or virtues of the dead into the self. (p. 345)

Klass (1993) related that these phenomena occurred in dreams or during ordinary

consciousness, and that the parents felt that these experiences were deeply personal. The

author also discussed the previous literature examining the position of the inner

representation model within grief theory. The clinical implications of this model are

presented, with two situations highlighted as potential areas of difficulty surrounding the

inner representation of a deceased child. Those situations are described as conflict when

the perception of the inner representation is not shared by support systems, as may occur

in the case of miscarriage, and when there is an interaction between the inner

representation and a pathological situation. Klass concluded that clinical knowledge and

attitude are the key to success in helping parents deal with the issues that arise following

the loss of a child.

Kelly (2002) contributed the most closely related, and possibly most significant,

research related to experiences of life after death among clinical people. He evaluated the

experiences of emergency workers who identified forms of "post mortem contact" (p. 25)

with victims of fatal injuries. The impetus for this research came from previous

descriptions of similar events by six emergency responders who were undergoing critical

incident debriefing and from their identified need to explore the extent of this

phenomenon. The total sample of 90 participants (including emergency responders,

firefighters and police officers) was assembled from three sources. Sixty-two of the study

participants were respondents to a questionnaire distributed to trainees involved in the

management of critical incidents, and 28 participants were identified from case review

and subsequently interviewed. To minimize the effect of compounding variables, criteria were created to guide the selection of participants:

> The subject had to be an emergency service worker with a previously established confidential relationship with the researcher, and with no indication of mental illness or extraordinary distress, who had been physically near the deceased; and the case had to involve a sudden or traumatic fatal event, and could not be the emergency service worker's first death experience. (pp. 28-29)

In both the questionnaire and the interview, the participants were specifically asked if they had ever experienced, felt or perceived an interaction with the victim. Five of the six original describers of this phenomenon were also re-interviewed as a control measure. The results are very interesting. Of the total sample of 90 participants, 25 recounted "contact with deceased individuals in the form of a presence, communication, or feeling of attachment" (Kelly, 2002, p. 30). Significantly, in all cases this was the first time the participants had shared these experiences with another.

Kelly (2002) identifies some of the weaknesses in this study, including the brevity of the questionnaire and the limited sample size. However, he firmly states the significance of the results, which are drawn from a group of persons who have a unique connection with the victim as emergency responders and are also considered profoundly credible. The results indicate that there is, on occasion, some manner of attempted communication by the dying or deceased victim that may have similarities to the near-death experience. The suppression of information in these cases may, like its suppression by those who experience near-death, result from fear of negative social response. It may also have implications for the well being of the emergency responder. Kelly argues the

need for further research with larger samples and in other settings to develop an understanding of the scope of this phenomenon. He explains the gap in the literature poignantly: "The answer may be as simple as that no one has asked" (p. 33).

Summary

While there appear to be several areas of discussion occurring in society and science around the possibility of life after death, there is no evidence in the literature of post-death experiences between nurses and their patients. However, this researcher knows that these experiences are happening to critical care nurses. The identified gaps in the literature related to near-death and after-death experiences further support the need to examine this topic.

Chapter 3: Methodology

A qualitative research design was chosen to assist in discovering the meaning for critical care nurses of the experiences they had when their patients died. In this chapter the researcher outlines the background of nursing research and explains the strong reasons for using a phenomenological method. A review of the assumptions and principles of the Human Becoming Theory is included to explain the Parse research methodology that was used in this study. Ethical considerations and trustworthiness of the data and research process are also described.

Nursing Research

As a nurse, the researcher prefers to conduct this project within the realm of nursing research, which Polit and Beck (2004) define as "systematic inquiry designed to develop knowledge about issues of importance to the nursing profession" (p. 3). For many decades, those involved in nursing have worked not only to define nursing as a profession, but also to define what constitutes nursing research. It has been suggested that nursing research is an outflow of the established research philosophies that exist within other disciplines, including sociology, anthropology, and psychology (Annells, 1999; Corben, 1999; Kleiman, 2004; Polit & Beck, 2004; Parse, 1992; Todres & Wheeler, 2001; Walker, 1996; Yegdich, 2000). This may be considered a strength, as opposed to a weakness, in nursing research since nursing is a very diverse field with a vast knowledge base. Consequently, the use of different approaches in nursing research can extend the richness of new knowledge (Polit & Beck, 2004).

A review of the philosophical base for nursing research serves to enhance readers' understanding (Corben, 1999). Another way to view the philosophical base is to outline

the conceptual framework used within the research. Use of conceptual frameworks in nursing research is important, as Parse (1996) explains: "Using these frameworks and theories to guide such work contributes to fortifying nursing's identity as a scientific discipline, the practice of which is unique in the health care system" (p. 55).

In seeking the appropriate research method and conceptual framework to use for this project, the researcher sought an approach that would support the scholarly investigation into an abstract concept but would still serve to advance nursing knowledge. Given its perspective on the significance and diversity of the human-universe interaction, Parse's research method seemed a good choice to fulfill these requirements.

Researchers enhance the trustworthiness of a study by using an established research method such as Parse's; by stating and explaining the conceptual framework of the study; and by providing "sufficient detail and context for the reader to assess our interpretation and our trustworthiness" (Pyett, 2003, p. 1171). As Nixon (1992) further explains, "The reader has to decide how valid this research is from the themes that emerge and how they implicate the reader as well" (p. 108).

Theoretical and Conceptual Perspective

The conceptual framework used in this research is Parse's (1992) theory of nursing, the Human Becoming Theory. Parse first published the theory in 1981, naming it as man-living-health, but restated it in 1987 as the Human Becoming Theory of nursing, in an attempt to reconcile changes in the definition of man (i.e. to avoid association with gender).

The Human Becoming Theory arose from the simultaneity concept, where "human wholeness is a patterned configuration… a human being recognized through

33

patterns of mutual process with the universe" (Parse, 1992, p. 35). It encompasses the meaning of the lived experience in this mutual process. Pilkington (1999) summarizes the assumptions that create the philosophical base of this theory:

> Parse views humans as open and present with the universe. The term *universe* indicates the multidimensionality of human reality; it goes beyond the physicality of environment to encompass infinite possibilities of meaning. Humans experience as coexistence with others and the universe and cocreate situations with the universe. As free-willed beings, humans participate in shaping their universe through choosing situations and ways of being with situations. (p. 21)

For this researcher, the concept of post-death experiences emerges from the belief that all we are as humans results from this constant interaction with our universe, even though full understanding of these experiences may lie beyond our mental capabilities.

Further support for the use of this conceptual framework for this research project comes from Parse's (1997) three assumptions about human becoming:

1. Human becoming is freely choosing personal meaning in a situation in the intersubjective process of relating value priorities.

2. Human becoming is cocreating rhythmical patterns of relating in mutual process with the universe.

3. Human becoming is cotranscending multidimensionally with emerging possibles. (p. 171)

Based on these assumptions, Parse (1992) identified three major themes or principles of the Human Becoming Theory. The depth of the principles and their supportive assumptions led the researcher to embrace the framework of the Human

Becoming Theory. The transcendental nature of the research topic required the use of a

methodology that would sanction discovery of meaning without limits.

Parse's (1992) first principle is that "structuring meaning multidimensionally is

cocreating reality through the languaging of valuing and imaging" (p. 37). This principle

relates to the ways in which individual humans derive meaning from the interactions with

the universe that occur within their own lives. Its focus is that the meanings emerging

from these interactions are interpreted uniquely within the reality of each individual

(Walker, 1996). The second principle is that "cocreating rhythmical patterns of relating is

living the paradoxical unity of revealing-concealing, enabling-limiting while connecting-

separating" (Parse, p. 37). This principle addresses the unique patterns that arise as

humans interact with the universe. The ability of humans to move beyond the now, create

change and envision new ways of knowing and being is addressed in the third principle

(Walker, 1996), that "cotranscending with the possibles is powering unique ways of

originating in the process of transforming" (Parse, p. 38).

Taken together, these assumptions and the principles provide strong evidence that

use of the Human Becoming Theory as a conceptual framework is appropriate for this

nursing research project. As described earlier, the events that occur in the critical care

setting impact who nurses are and how we give meaning to our interaction with the

universe, key concepts of this theory. The Human Becoming Theory also provides an

intriguing conceptual framework for nursing practice (Cody, 2000; Parse, 1996;

Pilkington, 1999; Walker, 1996). While this model will not be presented for discussion, it

is introduced to further support the use of this theory as an effective concept for nursing

knowledge.

Research Method

The method chosen for this study is the Parse research method, a nursing research method that arises from Parse's Human Becoming Theory (1992). Parse (2001) describes this method as "a phenomenological-hermeneutic method used to discover the meaning of lived experiences through a study of persons' descriptions of experiences" (p.167). There is clear support in the literature for the use of phenomenology-based methods as valuable tools for nursing research (Kleiman, 2004; Todres & Wheeler, 2001; Yegdich, 2000). Lopez and Willis (2004) explain: "Phenomenology offers nurse scholars and clinicians an approach to inquiry that has a good fit with nursing philosophy and nursing art: understanding unique individuals and their meanings and interactions with others and the environment" (p. 726).

Phenomenological Hermeneutics

Edmund Husserl, a German philosopher and mathematician, developed the phenomenological research method in the early 20th century. One of the key concepts included in this method was bracketing. Husserl contended that the researcher must suspend all personal knowledge and bias in order to fully comprehend the lived experiences under study (cited in Byrne, 2001). As Lopez and Willis (2004) explain, the goal of the concept of bracketing was to achieve "transcendental subjectivity": "Transcendental subjectivity means that the impact of the researcher on the inquiry is constantly assessed and biases and preconceptions neutralized, so that they do not influence the object of study" (p. 728).

Realizing the personal futility of an attempt to suspend prior knowledge in the chosen research setting, this researcher moved away from Husserl's method and towards

hermeneutic phenomenology. Martin Heidegger, a student of Husserl, determined that phenomenology needed to go beyond the description of the lived experience and into an exploration of the meaning of those experiences. As Lopez and Willis (2004) explain, "It is not the pure content of human subjectivity that is the focus of hermeneutic inquiry but, rather, what the individual's narratives imply about what he or she experiences every day" (p. 729).

This form of interpretive phenomenology focuses on the meaning that individuals give to their world, their choices and their experiences. These meanings are gleaned from the narrative of the participants and blended with the researcher's interpretation of that narrative. The interpretations are blended because, as Heidegger argued, bracketing is not possible, since researchers cannot detach themselves from the world (Lopez & Willis, 2004). Priest (2004) explains "Within hermeneutics, pre-existing personal experiences and pre-judgements or prejudices should not be eliminated or suspended, but rather acknowledged as exerting a profound influence on the understanding of the phenomena; therefore they are important to the interpretation" (p. 6).

Situating the Researcher

This researcher has personal knowledge of the research topic, having herself had experiences related to death. At age 15, she experienced what she describes as a visual visitation from her father at the time of his death. She remembers the conversation and her perception of a goodbye. Her father was a patient in an Intensive Care Unit 120 miles away and died during the night that this visitation occurred.

The other related experience occurred in 1989, when the researcher, who was working as an RN in an Intensive Care Unit, received word that her best friend had been

killed in a motor vehicle accident. While traveling home about one hour later, the researcher distinctly felt the presence of the friend beside her in the vehicle, telling her that that she was okay. While the researcher has had no such experiences in her professional context, she is aware that her experiences in her personal life have influenced her interpretation of the narrative.

The research setting of this study is familiar to the researcher, and the potential participants are colleagues, factors that will also influence the interpretative process. By acknowledging these pre-existing biases, the researcher strengthens the hermeneutic phenomenological research process embraced by the Parse research method. This method has been used by other researchers investigating the associated realms of presence and grief (e.g., Carroll, 2002; Cody, 2000; Daly, 2001; Northrup, 2002).

To summarize, the purpose of this study is to identify the meaning of the experience for critical care nurses who have had at-death and post-death experiences with their patients. The Parse research method (1971) is used to identify the meaning of these experiences.

In its processes, this method honours the assumptions and principles of Parse's Human Becoming Theory, which advocates that only the participants in the research can relate the meanings of their lived experience (Parse, 2001).

<div align="center">Data Collection</div>

Sampling Design

Critical Care nurses from the Intensive Care Unit (ICU) of the Lethbridge Regional Hospital in Lethbridge, Alberta, Canada, who have had post-death experiences with their deceased patients were invited to participate in this research. Posters explaining

the research and extending an invitation to participate (see Appendix A) were placed

strategically in the ICU. Criteria for participant selection included having had a post-

death experience with a deceased patient or patients and possessing the ability to

articulate that experience verbally. The researcher is currently employed in this setting

and was available to answer all inquiries with the hope of encouraging participation.

Participants contacted the researcher individually, either in person or initially by email.

A sample size of six to ten participants was desired, and a final sample of six was

achieved. The researcher felt that this number satisfied the need to explore the diversity

of this particular lived experience (Polit & Beck, 2004). Purposeful sampling of this

population was used to allow for thick description of the experience and meaning in this

specialized environment. As such, generalization to a larger population of nurses was not

the intention of the study. It was also anticipated that some degree of snowballing would

occur, since the Intensive Care unit is an intimate setting and both the researcher and the

topic of this research are well known to the staff. One of the challenges of this sampling

design was connecting with interested participants, as they worked shifts and had busy

lives. A period of 12 months was required for the researcher to meet conveniently with all

interested participants.

Interview Design

Participants were encouraged to discuss their experience individually with the

researcher. Parse (2001) describes this process as "dialogical engagement... a true

presence of the researcher with the participant" (p. 170). The researcher centered her

attention on each participant and used supportive statements and paraphrasing techniques

to foster the discussion of the experience. She also used open-ended questions as probes to encourage the dialogue, as described by Patton (2002).

For participants' comfort and security, the researcher ensured that all discussions occurred in an environment that they had chosen. In addition, it was anticipated that participants' awareness of the researcher's patterns of belief and voiced acceptance of possibilities such as post-death experiences would increase their comfort about sharing their experiences.

The interview questionnaire (see Appendix B) was developed through a review of examples provided by Polit and Beck (2003) and Patton (2002), and expanded with assistance from the research supervisor. Discussion with each of the six participants occurred in a separate, private location of their choice, at a time convenient to them. While the term "interview" is used in the discussion of the process, every attempt was made to utilize the "dialogical engagement" (Parse, 2001, p. 171) component of the Parse research method. To accomplish this, the researcher made a conscious effort to ensure that she remained in "true presence" (p. 171) with each of the participants as they described their experiences. All of the participants volunteered to share the story of their experience with a patient during the time of death transition to assist the researcher in completing this study.

Consent forms were reviewed and signed by all participants. The researcher explained the assurance of confidentiality of the interviews. In the reporting of results, all participants are referred to using an alias name to protect their identity.

No time restrictions were placed on the interview process; participants were encouraged to talk until they felt they had no further information to share. On occasion,

the researcher sought clarification and expansion of ideas using open-ended prompts, such as, "Can you explain that further?" and "I'd like to hear more about how that made you feel."

Each interview was audiotaped and then transcribed by the researcher. The process of transcription afforded the researcher the opportunity to immerse herself in the dialogue of the participants. During transcription, attention was also paid to voice tones and conversation tempo.

The researcher recognized that discussing their experiences might create emotional distress for participants. Consequently, contact information for the Employee Assistance Program was given to participants when they signed the consent form. They were advised to refer themselves to this agency in complete confidentiality if they experienced distress. All of the participants questioned this component of the process, voicing a desire to share their stories with the researcher and denying that they felt any stress about choosing to share their experience. At the end of each session, the researcher issued an open invitation for further discussion; however, none of the participants took up this invitation. Participants frequently inquired as to the status of the project and encouraged the researcher to complete it.

Ethical Considerations

The participants in this research project were employees of the Chinook Health Region (CHR) in southern Alberta, Canada; therefore, initial project approval was sought from the CHR Research Committee. The initial project proposal was the subject of extensive discussion related, as relayed to the researcher, primarily to committee members' discomfort with the research subject. However, the proposal was not rejected

but rather sent to the CHR's Ethics Committee for review. At their request, the researcher

presented a brief synopsis of the project as well as her reasons for pursuing it. The

committee members asked a range of questions and expressed a significant degree of

skepticism and, in some cases, discomfort. The researcher firmly believes that her

passion for the topic and her expression of the importance of the meaning of these

experiences to nurses ultimately influenced the committee's perspective. The Senior

Director of Acute Care Nursing also attended this meeting in a supportive capacity; her

assistance in gaining the committee's approval is truly appreciated. After the CHR Ethics

Committee approved the research proposal, the CHR Research Committee did the same.

Ethical approval for this project was then requested from the University of

Lethbridge Ethical Review Committee for Human Subjects. Approval was granted

following submission of the supportive approval documents from the CHR.

Participants were asked to sign a consent form (see Appendix C) allowing the

researcher to audio record the conversations, to submit all the components of the research

to the University of Lethbridge for grading, and to allow any possible publication of this

research following its completion. The consent form included a guarantee of participants'

confidentiality through the deletion of any identifying items on the transcript as well as

destruction of the audiotapes once transcribed. Participants were informed of their option

to withdraw from the study at any time without bias, and of the researcher's retained right

to terminate the participation of any individual at her discretion. A copy of the signed

consent form was given to each participant.

Following successful defense of the thesis based on this research, all supportive documentation will be destroyed and a bound copy of the completed project will be provided to each participant.

Data Analysis

Extraction-Synthesis

Parse's (2001) process of extraction-synthesis was used to discern the core ideas that arose from each participant's description of the experience. This process involves the following steps:

a. Constructing a story that captures the core ideas about the phenomenon of concern from each participant's dialogue.

b. Extracting-synthesizing essences in the participant's language from recorded and transcribed descriptions. The essences are succinct expressions of the core ideas about the phenomenon of concern as described by the participants.

c. Synthesizing-extracting essences in the researcher's language. These essences are expressions of the core ideas conceptualized by the researcher at a higher level of abstraction.

d. Formulating a proposition from each participant's essences. A proposition is a nondirectional statement conceptualized by the researcher joining the core ideas of the essences in the researcher's language. The essences arise directly from the participant's descriptions.

e. Extracting-synthesizing core concepts from the formulated propositions of all participants. Core concepts are ideas (written in phrases) that capture the central meaning of the propositions.

f. Synthesizing a structure of the lived experience from the core concepts. A

structure is a statement conceptualized by the researcher joining the core

concepts. The structure as evolved answers the research question. (Parse,

2001, p. 171)

Honouring the Individual Story

As Nixon (1992) explains, it is also important to respect the fecundity of

individual cases:

This perspective goes beyond a phenomenological description of the common

themes of the co-researchers' stories in that, while it recognizes that there are

important common themes in the stories of the co-researchers, it also recognizes

that there may be unique fecund instances in the individual stories that need to be

addressed. (p. 106)

In this study, the "co-researchers" are the participants. The researcher strives to find the

common themes in their stories, while being alert to unique elements that deserve

attention. The common themes are outlined as "essences" (a term used by Parse, 2001) or

concepts in Chapter 4. The fecundity of each individual story is reflected in the passages

quoted from the individual dialogues.

Heuristic Interpretation

As part of the Parse research method, the researcher used heuristic interpretation

to weave the concepts arising from the analysis with the Human Becoming Theory, in

order to derive a new understanding of the meaning of participants' experiences. Given

the hermeneutic philosophical base and the identification of the implicated researcher, it

was anticipated that the perspective of the researcher would influence this process of interpretation.

The complexity of the steps involved in the Parse Research Method became apparent during data analysis. In Chapter 4, each step of the Parse Method is outlined and the corresponding elements from the narrative are identified.

Chapter 4: Results

Introduction

The purpose of this phenomenological hermeneutic study using the Parse research method was to explore the meaning for critical care nurses of the experiences that they have had at and after their patients' deaths. This chapter begins with a synopsis of the participant demographics. Since the richness of meaning in the individual experience is portrayed in the participants' stories, portions of these stories are reported verbatim. Each step in the analysis of the dialogues with participants is identified, in order to facilitate understanding of the inductive manner of interpretation used in the Parse research method. The chapter concludes with the heuristic weaving of the principles of the Human Becoming Theory with the concepts that arise from the analytical process. Other nurse researchers (e.g., Bunkers, 2004; Kagan, 2004) who embrace this particular research method have used this presentation format.

Participant Demographics

All of the participants in this study are female, ranging in age from 33 to 55, with the average age being 47 years. All participants began their nursing career with diploma preparation; two acquired post-diploma bachelor degrees, and one obtained a master's degree in education. Their years of critical care experience range from 6 to 21, with the average being 11. All but one participant described a professional background that included experience on either surgical or medical wards prior to specializing in critical care. Three participants stated that they have a spiritual, religious perspective, while three stated that they have none.

Table 1 lists the age, gender, marital status, spiritual/religious perspective, nursing education and professional background of the participants, using their own terminology.

Table 1. Demographic Data

Name	Age	Gender	Marital Status	Spiritual Religious Perspective	Nursing Education	Professional Background	Years of Critical Care Experience
Edi	51	F	S	None	Diploma	Critical Care	12
Pat	49	F	M	None	Diploma A.C.C.N.	Medical/Palliative Critical Care	13
Sue	33	F	M	None	Diploma1991 B.N. 1994 M.Ed. 2000	Medical/Surgical Critical Care	8
Vi	43	F	M	Christian Protestant Reformed	Diploma B.N.	Surgery Continuing Care Critical Care	15
May	52	F	M	Not a member of organized religion.	Diploma1995 A.C.C.N.	Surgery Critical Care	6
Pam	55	F	M	Lutheran	Diploma	Oncology Surgery Critical Care	21

The Stories of Experience

Edi's Story

Edi recalls that her experience with a patient at the time of death occurred 22 years ago in a facility that has since been replaced by the current regional hospital. She describes the setting as a small Intensive Care Unit (ICU) that had only two Registered Nurses (RN) working at the time of the experience:

> We had had this man come in who was not super old. He had a really bad MI *(myocardial infarction)*. In those days, we didn't send people for angios *(angiography)* and we didn't have clot busters. We didn't have IV nitro *(intravenous nitroglycerin)*. He had really bad chest pain. We finally got it under control with morphine and sublingual nitro. I got him to sleep and it was getting late; his rhythm looked normal and he seemed to be sleeping for a while. I don't know how long it went on, but he started to moan and cry in his sleep, saying, "Help me, I'm dying, help me, help me, I'm dying." We went over to the bed and I said, "You had better wake him up." I said, "You better wake him up because, you know, if you die in your sleep, you die." We didn't really want to wake him because he had just gone to sleep and he had chest pain. All of a sudden we looked at the monitor and his heart rate started to drop; he'd brady'd *(bradycardia)* down. We didn't have doctors there, so we just quickly gave him some atropine and called [the doctor]. Then he went asystolic and we had to call a code. He never survived. I've never forgotten that.

Edi reported that she did not sense anything different at that point but stated she remembered the bizarre nature of the whole thing. She truly thought he was sleeping but

that he was "telling us to help him, that he was dying." When probed further as to how

this experience made her feel, Edi replied that she found it "spooky" that he would have

sensed that he was going to die, even though she thought he was just sleeping.

As Edi explained, the significance of this experience to her was that it supported

what she had known as an "urban legend," one that she had known all of her life. She was

unable to recall where this knowledge had come from. When asked to describe this urban

legend further, she related:

> If you die in your sleep, you'll die. That's why you never hit the bottom of the
>
> cliff, because you will die. So if you dream that you're falling, as long as you
>
> wake up before you hit the ground, you won't die.

Edi also recalled another time when this "urban legend" impacted her memories.

She described a childhood dream in which she and her mother were faced with disaster as

a result of a nuclear war. Together they were going to poison themselves, and Edi recalls

that she was putting the poison into her mouth and woke up. When questioned as to what

her beliefs were about the death process, Edi gave this response:

> Seriously, I think, [if] you die, you die. Your body, you either get cremated or you
>
> go back into the earth where you came from and that's it. Spiritual-ness is not a
>
> big focus of mine. I'm not religious. I'm not into ghosts and things. "You're not
>
> religious, you're a humanist," people have said to me before. In spite of my
>
> cynicism and stuff, I believe in the goodness of mankind.

Edi was unsure of the personal impact of this experience on her but related a

situation when a close friend was dying. Edi expressed hope that her friend hadn't known

what was coming and that it had happened quickly. There was a strong professional

impact from this experience; Edi related that she would definitely wake the patient up should this ever happen to her again.

When asked if she had shared this experience with others, she reported that she did share it with some family members but got only a minor response. However, in the discussion of this experience with her professional colleagues, she reported that she was not alone in her experience:

> It's just another one of those spooky things that happen to you as a nurse. You listen to nurses that have had, like, heard a voice first, or think they heard someone call for help and they haven't, but they go right in to the bedside and the person's in trouble.

Edi described the impact of these experiences as positive and said that she considered them "just part of the job."

Edi has strong ideas about the role of education surrounding the death process for both the nurse professional and the public. She stated that there was little instruction in this area in her formal nursing training. She feels not only that such education would help the nurses at work, but that the nurses would then be able to educate the public on the options that they have when they enter the hospital. She feels that education on "how to die gracefully and how to accept death as an inevitable natural event" would benefit both sectors.

Edi also identified a difference between the end-of-life care in the ICU as compared to a palliative care setting. She felt that in the ICU setting people were often made to suffer for a longer period of time before dying; however, in palliative care, "You're just there to make them as comfortable as possible." She concluded that it

shouldn't matter which area a patient was in, as the staff should be comfortable with death and know that their job was to "make it easier."

Edi's comfort with the death process was evident to the researcher throughout the interview. When asked about this, she summarized:

As time goes on, I am much more comfortable with the concept of death. Because to me, it's a part of living, everything dies, and I think that we interfere too much with that process. Which is odd, working in ICU, to say that, but there's a time and a place. I think how I feel about death is mostly from my professional life.

Pat's Story

Pat recalls her experience of 13 years ago vividly. She describes the setting as the same regional hospital where she still works. The experience occurred during one night shift, while she was working with another RN named Sue. Pat relates that it was late at night when she and Sue were working on charting at the nursing station. One of their patients, in a room beside the nursing station, was an elderly native lady who was expected to die some time in the near future. Pat remembers that this patient was unresponsive and that they had been very aware of hearing her breathing pattern from their position at the nursing station. Pat's auditory senses were on full alert when she thought she heard something else from that patient's room:

I thought I heard Sue say, "It's time to go, let's go." But Sue said, "No, that wasn't me." So I thought the family was in the room still, because they stayed until late at night. So I just continued to chart for about half an hour, and then I thought, "That's strange that they haven't left yet, because they said, 'Let's go, it's time to go.'" Everything was quiet. I said, "Oh my God, she's dead," and went running to

the room, and sure enough, she was gone. It was really freaky. She was saying, "Let's go, it's time to go," and she was gone. She was still breathing, but the impression was that she was gone -- gone, but her body was there. She was breathing but she was gone, and she was already going into an arrest state.

Pat expressed confidently that the voice she heard belonged to her patient and confirms that her colleague, Sue, heard the same statement. She clearly remembers that this occurred at 0100 and that there was an overwhelming sense of quiet at the time, "the sound of quiet." Pat stated that the patient was comatose. Resuscitation of the patient was attempted without success. Pat said that it was a peaceful experience, and that "we were fighting a losing battle because she wasn't going to come back."

She went on to share her beliefs about death:

I believe that there's another dimension. Like, I don't believe that you go up there or down there or whatever. I think that there's something alongside us and that's just where she was. It didn't really bother me.

When asked where this belief had originated, Pat explained that she did hold this belief prior to the event but had difficulty determining where it came from: "Probably just a way to cope. Yeah, I think more of coping. It just reinforced it." Pat stated that this experience had reinforced her existing beliefs. She went on to describe knowledge about her patients at death that had developed from her experiences as a nurse:

Just things like knowing that, like they're gone, you know, or if they've died, their hearts stopped, they're not breathing but they're not gone yet. You feel it, you smell it. It's kind of related to a temperature thing. I won't wrap them until I know they're gone.

Pat's nursing colleagues had reported to her similar perceptions at the time of patients' deaths and had often asked her to confirm their perceptions. Pat stated that this sharing of perceptions about patients' deaths has caused conflict with some of her colleagues in the work environment: "I don't think they think the same that I do, but I don't discuss it really. I just don't get into it." Pat's delay in wrapping the patient often causes conflict, when the push to clear the bed comes from her colleagues. However, she feels that honoring her perception is worth the discomfort resulting from the conflict, both for herself and for her patients. Pat also reported that she feels irritated when life support continues in the ICU on a patient who she perceives is gone, but she explained that it is "just our nature" to persist.

Pat explained that the potential for conflict and the desire to avoid it are the reason why she does not share her experiences, such as the one she described, with her colleagues. She remains very private about those experiences in the work environment and again sought assurance that our conversation would remain confidential. Her family, husband and children, are the only ones with whom she has shared these experiences and their impact on her.

While Pat believes that education about the death process would be beneficial for nurses, she is doubtful that it would be successful because of the presence of different patterns of belief within the ICU setting. She feels strongly that some areas of conflict need to be addressed in the interest of best patient care:

> I think that people need to look at it as more than black and white, because it's not. I mean, some people are gone and they're still breathing, and you know it's just time, but they're gone. Other people are not breathing and there's no heartbeat

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and there's no nothing, but they're still there. I think we need to respect one another in that, when it's time to finish, it's time to finish, and when it's not, it's not. I don't think it should be a time thing: "Well, we need the bed," or that kind of stuff. There needs to be that kind of respect. To learn that not everyone does it the same way. People are different in how they perceive it.

Sue's Story

Sue's story is the only reported experience that involved a pediatric patient. It was obvious during the conversation from Sue's body language and voice tone that the fact that it had involved a child impacted her greatly. Although the event occurred 11 years ago, Sue was able to describe the experience in great detail:

I got called in to watch a 3-month-old little girl who was theoretically just having apnea spells. She got to the unit and she looked good. I turned to get something, and when I turned back, I could see a black halo all around her. It was, I guess, what they call an aura, or whatever it could be, but you could just see, everything in the background was kind of foggy, and I couldn't see anything else other than her. I saw, I felt death. I started yelling for them to call Dr. S, and I remember Ms. M came running in and said, "What's happening?" I said, "Just phone her [Dr. S]." They know, everyone knows you have feelings, so they phoned her. When Dr. S hit the unit, yeah, the little girl started to die. It was only for that period of time that I first looked at her and I could see it [the halo], and she was kind of lying on her belly with her knees up. I just saw it. I think that she was gone out of the body at that time, her spirit or whatever, because it was no longer a baby. It was, I don't know what it was, just, it was death. It looked like death to me.

When asked how it impacted her, Sue described the experience as one of the "worst" and added, "It was the first time I've had a negative, not a peaceful, experience with it. I think it was because I was horrified, that I was not peaceful and calm. I was, I was freaked right out." The chaotic situation added to Sue's stress, and she related that she felt the child could not be at peace with death since they, the staff, were not. Follow-up autopsy results revealed that the child had a huge cardiac defect, but that knowledge did not bring comfort to Sue at the time.

When asked to expand on the concept of peace, Sue described another experience with a patient who was awaiting a very high-risk surgery. During the nurse-patient interaction, the patient expressed to Sue that he was ready to go and see his wife, who had died 15 years earlier. Sue remembered that the experience was "peaceful, kind and nice," and that the patient was content: "I think that he was more content with the notion of dying then I was content with hearing that he was going to die."

Wanting to provide yet another example, Sue related an event with a patient after he (the patient) had had a near-death experience. The patient was able to state the exact words that Sue had used while outside the room during his resuscitation. Sue felt comfort in hearing this from her patient, but said that it also reminded her to be careful what she says during those stressful resuscitation situations. She expressed the impact of these experiences on herself as a nurse:

> I'm very small in the overall scheme of things, and what we do sometimes doesn't
> matter. What I mean by that is that, if something is going to happen, like
> someone's going to pass away, or the inevitable is going to happen, you can try
> and intervene. You think you have all sorts of power and control, and ultimately

you don't. You can let them die now versus later, and death is really not a

horrible, rotten thing. It's inevitable, it's quite kind, and it's quite peaceful.

Sue also articulates very clearly the impact of these experiences on her as a person:

I've always kind of felt this way, that life isn't fair sometimes and maybe there's a

bigger meaning. I don't necessarily think it's a religious thing, but I think that

there's something else to it, there's a spiritual part of it. I do know that it's kind

and that it's peaceful. That it's not something to be afraid of.

Sue explained that she gained this understanding following her move from

general nursing into the critical care environment. Early in the transition, as she grew

comfortable in the new environment, she began to realize that not all things were within

control and that, if her experienced colleagues told her a patient was not going to do well,

despite contradictory physiological data, they were usually right. Time and a repeated

pattern of stories greatly influenced her thinking. She also shared that she has developed

an increased sense of knowing from those experiences as a critical care nurse. She

described this sense of knowing or awareness in terms of a different energy:

It's like when you walk past a room and you know that the person inside is dead

before you even walk in, when you're out on the unit. You just know, you can

sense it and you can feel it, but you can't put your finger on it. You just know. It's

not painful, but the sense or the energy in the room is not in the body anymore, it's

somewhere else.

To expand on her concept of an energy, Sue described a time when she assisted

with a patient in a morgue setting. She had no perception of any energy being present and

attributed this to a time factor:

These experiences are based on the time sensitivity where, if it's too far removed, it's done, it's over. But there is just that little period of time when that switch or whatever it is, is happening, or the crossing over, or whatever, that's when that stuff happens, when that energy is there. If you walk in beyond that when that energy is gone, you don't feel anything or sense anything. The only time that I've ever had any kind of those experiences is when it's very time sensitive.

This awareness has also impacted Sue in her personal life. She described being present and knowing at the time of her grandfather's death. This brought her peace during his passing, as she felt his "energy shift" about 10 minutes before he died.

When asked if she could describe this sense of knowing further, Sue clearly articulated the physical and mental components:

It starts in the pit of your stomach, it spreads out a little bit, and it's a bit of an adrenalin rush. Then it's up to your mind, when you get that adrenalin rush, instead of freaking out, just going '"Okay, relax" and just being open to it. It starts in the belly and kind of spreads out everywhere, and then you get a sense of calm.

Sue had not shared these experiences with anyone in her personal life. She stated that she is a peaceful, calm, happy person and has a strict rule to leave work at work to avoid mental exhaustion. She had discussed her different experiences with her colleagues and found them to be quite comfortable at times with the topic, summarizing these experiences with the notion that "it's common." However, Sue also admitted that she was very selective in choosing the colleagues with whom she had discussions. She was alert to a sense from some that indicated, "They think you're going to be full of it or that you're wacky." She described the entire situation as being "a very individual, personal

experience, that you have the honour of being present at that moment when you experience a patient's death."

As a nursing educator, Sue brought a unique perspective on the role of education about the death process. She identified an important concept, that such education must be timely. Nurses can be open to education surrounding death only when they have assimilated the many tasks that they must learn. Her experiences with novice nurses have shown Sue that sometimes there is a "glimmer" that they can't quite put their finger on, so they write it off, or it has completely gone past them without them feeling anything at all. Sue also mentioned the issue of a variety of belief sets existing among nurses, stating that death education often "begs the assumptions that people believe that there is a spiritual or religious piece to us," and that is not always the case.

Vi's Story

Although Vi's experience with a patient at death occurred approximately 15 years ago, she was still able to recall the event in amazing detail:

> We were taking care of an elderly gentleman, and he was very sick. They didn't
> know for sure if he was dying or not, but he was. They had told the family that he
> probably wouldn't have long to live and they (the family) were out in the hallway
> because we had to turn him. He was kind of mumbling a bit once in a while, but
> he wasn't saying too much anymore. When we were turning him, I had turned him
> one way, and then Pam had turned him the other way. And then, you know, when
> you turn them and they're kind of out of it -- all of a sudden he sits straight up in
> bed. Like we're turning him, and he's not doing anything for himself, and all of a
> sudden he's sitting bolt upright in bed. He is screaming at the top of his lungs, just

this petrified scream, like it was terror, that's the only way I can describe it. Then he lies down, he flopped back down, and he was dead. He was dead.

Vi related that she and her colleague were both "beside ourselves because it was just so sudden and it was terror -- he was terrified. I've never heard anybody screaming like that." Vi also described her memory of the experience through other senses: "…my heart was pounding like crazy, we were sweating, and he was so dirty, I remember the smell." She also remembered hearing the family outside the room, hearing commotion and crying. She acutely remembered that all of the other staff on the floor had heard it as well. In the discussion on the floor following the event, she recalled that her colleagues commented to her that most of them perceived that he was a "bad man" and that he was not going to live for long.

When asked how the experience made her feel, Vi's memory was very precise. She described her emotions: "I was quite upset, like for weeks, still when I think about it." She talked to her father about the experience when she returned home and clearly recalled the impact of what her father said about the event: "When I said to my Dad what had happened, he said to me that he (the patient) went to meet the Lord and that it was terrifying to stand before the Lord if you had done wrong." She continued:

> From that point on, I guess it was a confirmation for me to know that how I was
> brought up and taught, looking at creation and how everything's been created, it
> was an affirmation. I believe that he was going to go to hell. I believe he didn't
> love the Lord and he didn't need a saviour because all his life was a testament to
> that. That's what I believe.

As Vi recalled, her sharing of the experience had a lasting impact on her father as well. Before he passed away, he said on several occasions, "Don't forget that experience." To this day, Vi said, she speaks with her children openly about death, and tells them, "You're going to die. I've never met anybody that's not [going to die]. That is reality and you have to be ready."

In terms of how the experience impacted her professionally, Vi said that she was worried that the family might think perhaps the nurses had done something wrong when they were turning the patient. Ease from that worry came from knowing that the door was open and just the curtain pulled, so the family was able only to hear all that happened. She returned to the comment made by her colleagues at the time: "Someone said, 'He's going to hell because he's a bad guy.'" However, as Vi stated, this reinforced her belief as a nurse that "You can't treat anybody different. No matter if you think they're good or they're bad, they're still patients and it's not for me to judge. They all need your help." Vi's religious affirmation was evident in her comments: "I believe that we're all sinners and we have things that we have to work on and to try to do things that are pleasing to the Lord."

Vi commented that she uses this experience when instructing her nursing students. She has noted the individual biases that her students bring to nursing and works hard to encourage them to view patients as sick and needing help, regardless of any socio-economic, cultural, and language barriers that arise. When asked if she had shared this experience with any of her present colleagues, she admitted that she was selective about whom she talked to. She related this to a difference in belief patterns and stated that,

while she believed in the authenticity of her experience, others would dismiss it, saying, for example, "It's just Vi, that's just what Vi is like."

This perception that her colleagues would dismiss her beliefs underlies her position on education in this area. While Vi feels that debriefing is helpful after traumatic experiences, the benefits of education would be limited by each individual's pattern of beliefs. She returned to her point that all patients under care should be treated equally well, and that nurses should support one another in this endeavour.

May's Story

May's story is different in that she volunteered information on two different experiences that had occurred within the last six to seven years:

> We had this old lady who should have been left alone, but no, we had to keep her here, and you know, keep her going for a couple of months before she died. I'm positive that there was someone standing beside the bed and it was the middle of the night. I thought I saw someone by the bed twice in one night. It was a person in an isolation gown, or some kind of a long gown, just walking by the window. Then, a couple of days after that, the call bell was going off in that room. She [the patient] was gone. She had died, but the call bell was going off in that bathroom and there was no one there. The other time, I was emptying a Foley and somebody walked behind me and brushed against me with the curtains. I saw her feet going by, and I thought it was Sue, but when I looked around the curtains there was nobody there. I didn't imagine it. It's not like I had a feeling there was someone there; I saw somebody there in a white gown, doing something.

May related that, in the first instance, another nurse had thought that there was somebody in that room as well at the time. In the second, another nurse had seen the chair rocking in the same spot where the curtains had moved against May.

When asked what these experiences meant to her, May replied that she viewed them with a positive perspective. There was nothing that she found scary about the experience, and she only felt sad for the families. Professionally, these experiences have led her to the point where she perceives herself, as the nurse, to be "quite privileged to see people dying" and strives to help her patients have a dignified death.

May described her perception of an energy associated with the death process and made an the interesting observation: " Right across the wall is labour and delivery, where people are checking in, and then on this side of the wall they're checking out, so I think, like, we're in this vortex… There's definitely an energy associated with that." When asked to describe this idea of energy with death, May stated, "I do get a sense of them departing, not negative, like relief for them." She further explained that she has seen deaths that were "the most peaceful thing I have ever seen… peaceful and relaxed, like they were going to someplace good."

These experiences in her professional life have also impacted May as a person. She stated that they have "absolutely" changed her and that, "If you asked my husband, he would tell you the same thing." She is certain that death is not a bad thing: "I am more at peace with death. I'm not worried about death or what happens after death." May continued, saying that she is not certain of what happens after death, but whatever it is, there is no worry.

May had shared these experiences with her husband and related that he's "good with it" but that her in-laws were too frightened to discuss these events. Interestingly, May stated that her son has had auditory experiences in the house that he now owns. There has been a mixed reaction from the colleagues with whom May chose to share her experiences. Some, she stated, are frightened and don't want to hear about such events, thinking that they are related to evil and the devil. There are a few others, however, who are interested, people who have had such things happen as well and are fine with it. May added, "I'm sure there's people here who think I'm just nuts."

May felt that education in this area might be ineffective: "[People will have to] come to it from their own experiences, and everybody has their own take on dying patients." She also stated that the critical care setting and the level of chaos in the environment impact her perceptiveness at the time of a patient's death. Interestingly, most of May's experiences occurred at night, when the unit tends to be quieter. She said that her ability to perceive things at death was better during the quiet of night, when she was less busy and distracted with tasks.

Pam's Story

Pam was not able to recall the date of her experience but stated that it was "a few years ago." Even with this gap in chronology, Pam was able to describe her experience in detail:

> I was away when we did our first HOPE (Human Organ Procurement and
>
> Exchange) transplant and didn't know anything really about the person that they
>
> had HOPEd. I came back, and at that time ICU 14 was vacant; there was nobody
>
> in that room. I was coming around the corner and caught a glimpse of red, and at

that point the respiratory techs were wearing red. I kept seeing it, so after about

the fourth time, I said, "So why are there respiratory techs in that room and what

are they doing there by the window?" It felt to me that there was presence there,

you know, and then somebody explained to me that this person [the patient] had

had a red coat. Once that was explained, it was only for maybe a day, a day and a

half, and then the feeling, the presence, left. That was the only time I could say

that I actually saw a presence.

When asked to expand on that last statement, Pam shared the following:

I feel like I can feel the soul, the spirit, when somebody's dying, when they're

finally released. When the physical person that they are is dying, there's a

difference between your soul leaving and your body dying. Sometimes it's a

matter of minutes, sometimes it's at the same time, but I just feel a soul.

When this was paraphrased back to Pam and she was asked if this idea about

length of time was related to the circumstance, she replied:

It's probably just a physiological thing, but I can feel like, all of a sudden, that

patient seems more at peace. Sometimes it will go on, their heart rate and stuff

will go on for a longer period of time, but what I perceive as their soul, what I

perceive as who they are -- I can't tell you that there's a physical thing or that I see

anything -- I just feel that their soul is gone. I know that the soul has gone.

Pam described this awareness of the soul as being very positive for her and said

that as a nurse she always tries to ensure her patients have a "positive death." Even in the

most traumatic circumstances, Pam said, she tries to provide a peaceful and calm

transition into death. She is able to bring "a sense of peace for most." Turning this

discussion of a good death back to her experience, she stated that she later found out that the patient with the red coat had had difficulties with his wife just prior to his death. "Putting it all together, I just felt very, very sad that this person, for whatever reason, hadn't had what I call a good death."

When asked if these experiences had impacted her personally, she explained they had reinforced her beliefs: "I have a belief that there is something on the other side. It doesn't really matter what's on the other side, you still have to be at peace… Generally, dealing over the years with people dying, it's just made me very comfortable." Speaking of her personal life, she expressed regret that, due to circumstances at the time, she was not able to afford her father a "peaceful death."

Pam's colleagues are aware of her experiences and her position on a "good death." She related that this has caused some conflict, especially when the topic of sedation and analgesia arises: "My priority is to give my patients the best possible care. If that means, when they are dying, to give them as much medication as they need so that they can die peaceably, then that's my job." Pam expressed the feeling that the ICU environment is much less efficient at providing a good death and end-of-life care than the oncology ward that she had worked on. From her perspective, ICU nurses are not comfortable with palliative care.

Pam shared her experiences with her husband, who did not believe her; this she attributes to his being a "concrete thinker." Other than her minister, with whom she had extensive discussions, she had not told anyone else in her personal life about her experiences.

In response to a question about the role of education in this area, Pam's answers were very specific. There is a distinct need to provide information to nurses that will facilitate discussions about end-of-life care. Pam feels that the focus in ICU tends always to be on improving health rather than accepting death. Futile interventions are often carried out, without consideration for the patient's true needs. This, she stated, is directly proportional to the level of comfort that the staff (physicians and nurses) have with death. She suggested that there is a need to develop a "spiritual" acceptance of "the fact that we're all going to move on."

Pam also mentioned a generational and experiential component to the death process and the comfort that nurses have with it: "I've watched over the years, and I just find that if they [nurses] are around 30 or under 30, it's not in their plans to think about end-of-life care."

Pam suggested that informal discussions around end-of-life care might be effective. She felt very strongly that the nursing staff need and deserve more pastoral care and that improving this situation might lead to better end-of-life care by the nurses.

Extracting-Synthesizing and Synthesizing-Extracting the Essences

Essences are "succinct expressions of the core ideas" (Parse, 2001, p. 171) that are first described by each participant and then "conceptualized by the researcher." Ten essences emerged from the transcripts of the dialogues with participants, and all were identified as emerging as their own entity versus emerging from one another. The names of each essence emerged from the conceptualized language of the researcher. Together, the essences portray a conscious awareness of how each individual interpreted the sensory experience of the event described. The ordering of the essences results from the

general order in which participants described the experiences, beginning with the event, expansion on concepts of death, and finally attachment of individual meaning.

The ten essences are: enduring memories, descriptive recall, selective sharing, common occurrences, nursing privilege, tenet affirmation, tranquility of self, peaceful presence, knowing, and kinetic energy. Each will be presented in the order of its emergence from the transcripts. A brief discussion of each essence, the identified language of the participant, and the conceptualized language of the researcher will be provided.

Synthesized Essence: Enduring Memories

Some of the experiences that were shared by the participants occurred a long time ago and clearly have not been forgotten. Some participants stated this directly, and some were able to recall the exact time of the event.

Language of the Participants:

Edi: I've never forgotten that.

Pat: It was 1 o'clock in the morning, the end part of 1992.

Vi: I won't forget it too quick.

Language of the Researcher:

Experiences have been integrated into memories of each life.

Synthesized Essence: Descriptive Recall

The powerful nature of these experiences became evident, as each participant was able to outline the events with descriptive detail. Edi, for example, remembered the specific medical interventions that were used during an experience that occurred some 22

years before. Other participants used memories acquired through different senses to describe the experience.

Language of the Participants:

Sue: She smelled like a baby and had big blue eyes.

Edi: We finally got it under control with morphine and sublingual nitro.

Vi: My heart was pounding like crazy, we were sweating, and he was so dirty, I remember the smell.

Language of the Researcher:

Different components of the experience are vividly remembered and described by each individual.

Synthesized Essence: Selective Sharing

Each participant viewed the decision to share any or all of the experience differently. Vi reported that she had been selective as to whom she spoke with about her experience, because she felt that others would not share her belief patterns and would dismiss the event as being "that's just what Vi is like." Other participants shared a similar perception.

Language of the Participant:

Pat: I don't think they think the same that I do, but I don't discuss it really... Like I just don't get into it.

Sue: They think you're going to be full of it or that you're wacky.

May: I'm sure there's people here that think I'm just nuts.

Language of the Researcher:

People seek to share with others who are capable of achieving the same depth and understanding of the experience, so as to avoid contrary comments.

Synthesized Essence: Common Occurrences

A surprising common thread that appeared in the dialogues was that most had heard similar experiences discussed by their colleagues. Pat shared that there were times when her colleagues had shared similar perceptions at a patient's death and that she had been asked to confirm them. May shared that her experiences were similar to those experienced by another nurse on the same shift.

Language of the Participant:

Edi: You listen to nurses that have had, like hear a voice first, or they think they hear someone call for help…

Sue: It's common.

Language of the Researcher:

Nurses share experience through common occurrences of unique events.

Synthesized Essence: Nursing Privilege

All of the participants in this project were experienced nurses who had specialized in critical care. Many of the experiences described were considered part of the spectrum of nursing itself. Edi described her experience as being part of the job of being a nurse. Others described it as being a privilege to be a nurse.

Language of the Participants:

Sue: You have the honour of being present at that moment when you experience a patient's death.

May: …quite privileged to see people dying.

Language of the Researcher:

Being a nurse provides the individual with outstanding and honoured opportunity to share in life's most intimate moments.

Synthesized Essence: Tenet Affirmation

The unique opportunity to share in the moment of a patient's death brought a wealth of other perspectives to each participant. In all of the dialogues, participants expressed that their personal beliefs on death were reinforced through the nursing experience.

Language of the Participants:

Edi: I think how I feel about death is mostly from my professional life.

Pat: I believe that there's another dimension…and that's just where she was.

Sue: I'm very small in the overall scheme of things, and what we do sometimes doesn't matter…I've always kind of felt this way, that life isn't fair sometimes maybe there's a bigger meaning.

Vi: I guess it was a confirmation for me to know that how I was brought up and taught; looking at creation and how everything's been created, it was an affirmation.

May: I'm more certain that it isn't a bad thing.

Pam: I have a belief that there is something on the other side… Generally dealing over the years with people dying, it's just made me very comfortable.

Language of the Researcher:

Experiencing death through the lens of a nurse gives the individual an opportunity to integrate personal belief patterns into a life perspective.

Synthesized Essence: Tranquility of Self

Another of the perspectives that came to the participants from these experiences was a stated sense of calm about the death process. Edi and Pam both used the word "comfortable" in their narratives, while Sue and May talked about other aspects of what the experience brought to them.

Language of the Participants:

Edi: As time goes on, I am much more comfortable with death.

Sue: I do know that it's kind and that it's peaceful. That it's not something to be afraid of.

Pam: Dealing over the years with people dying, it's just made me very comfortable.

May: I am more at peace with death, I'm not worried about death or what happens after death.

Language of the Researcher:

Experience with death creates tranquility and calmness for the self.

Synthesized Essence: Peaceful Presence

The sense that death could be a peaceful event for their patients was very important to the participants. Pam described her desire to provide her patient with a "good death," which she viewed as a peaceful happening. Sue related that she believed

death to be peaceful and kind but did not feel her pediatric patient could be at peace with death as they, the staff, were not. The term "peace" recurred in the narratives.

Language of the Participants:

> Sue: Death is not a horrible, rotten thing. It's inevitable, it's quite kind and it's quite peaceful.

> May: The most peaceful things I have ever seen, peaceful and relaxed, like they were going somewhere good.

> Pam: …so that they can die peaceable, then that's my job.

Language of the Researcher:

> Peaceful nursing presence brings serenity to death.

Synthesized Essence: Knowing

> The discussion of peace at death revealed the presence of a unique knowledge component that some of the participants shared. They described the difference between physiological death and spiritual death in a manner that emphasized the use of the senses. They articulated this awareness or knowing clearly but acknowledged that it was difficult to describe in precise words.

Language of the Participants:

> Sue: It's like when you walk past a room and you know that the person inside is dead before you even walk in when you're out on the unit. You just know, you can sense it, and you can feel it but you can't put your finger on it, but you just know.

Pam: I feel like I can feel the soul, the spirit, when somebody's dying, when

they're finally released.… I just feel that their soul is gone. I know that the soul

has gone.

Pat: Just things like knowing that, like they're gone, you know, or if they've died,

their heart's stopped, they're not breathing but they're not gone yet. You feel it,

you smell it. I won't wrap them until I know they're gone.

Language of the Researcher:

The sense of knowing by nurses transcends common capacity.

Synthesized Essence: Kinetic Energy

When asked to expand on this area of knowing, participants introduced the

abstract notion of energy in their comments. They described their awareness of a patient's

death as being based on the transfer of the energy of the person at death to somewhere

else, away from the physical body. The transference and movement of the patient's

energy was also seen as time dependent.

Language of the Participants:

Sue: These experiences are based on the time sensitivity, where it it's too far

removed, it's done, it's over. But there is just that little period of time where the

switch or whatever it is, is happening or the crossing over, or whatever, that's

when that stuff happens, when that energy is there. If you walk in beyond that,

when that energy is gone, you don't feel anything or sense anything. The only

time that I've ever had any kind of those experiences is when it's very time

sensitive.

May: Right across the wall is labour and delivery, where people are checking in, and then on this side of the wall, they're checking out. So I think, like, we're in this vortex…there's definitely an energy associated with that.

Pam: When the physical person that they are is dying, there's a difference between your soul leaving and your body dying. Sometimes it a matter of minutes, sometimes it's at the same time.

Language of the Researcher:

The energy or essence of a person can be perceived as it leaves this earthly plane at its own moment.

<center>*Formulating Propositions*</center>

The next step for the researcher is to formulate a proposition from the participant essences. These propositions are the core ideas that arise from the dialogues and are then conceptualized into a reflective statement (Parse, 2001).The following section identifies the propositions for each of the participants:

Edi: Experiences with death transitions are enduring, detailed memories creating tranquil comfort, affirming beliefs and transcending what it is to be a nurse.

Pat: Experiences with death transitions are guarded, enduring interpretive memories sustaining calm belief and giving rise to timely nursing knowing that transcends human existence.

Sue: Experiences with death transitions are selectively shared, descriptive recollections bringing peaceful tranquility and understanding to the knowing nursing presence, as it perceives the unique energy transcending the earthly realm.

Vi: Experiences with death transitions are enduring, sensory memories affirming a peaceful faith and influencing the pedagogical posture of the nurse.

May: Experiences with death transitions are selectively shared, definitively remembered privileged moments affirming peaceful tranquility while evoking nursing knowing of human energy.

Pam: Experiences with death transitions are descriptive, remembered moments affirming faith in the timely knowing of nursing presence as the spirit is transcending peacefully.

Extracting Core Concepts

A core concept is an idea that captures "central meaning of the propositions" (Parse, 2001, p. 171). As a result of thoughtful evaluation of the participant dialogues, the synthesized-extracted essences and the propositions, three core concepts emerged: vivid memories, tranquil tenet affirmation, and transcendental ways of nurses` knowing.

The core concepts and the supportive components from the participant propositions are outlined in the following section.

Core Concept: Vivid Memories

Edi: enduring, detailed memories

Pat: enduring interpretive memories

Sue: descriptive recollections

Vi: enduring, sensory memories

May: definitively remembered privileged moments

Pam: descriptive remembered moments

Core Concept: Tranquil Tenet Affirmation

Edi: creating tranquil comfort, affirming beliefs

Pat: sustaining calm belief

Sue: bringing peaceful tranquility and understanding

Vi: affirming a peacefully deserved faith

May: affirming peaceful tranquility

Pam: affirming faith

Core Concept: Transcendental Ways of Nurses` Knowing

Edi: transcending what it is to be a nurse

Pat: timely nursing knowing that transcends human existence

Sue: understanding to the knowing nursing presence as it perceives the unique

energy transcending the earthly realm

Vi: influencing the pedagogical posture of the nurse

May: evoking nursing knowing of human energy

Pam: timely knowing of nursing presence as the spirit is transcending peacefully

Structure of the Lived Experience: Synthesized from the Extracted Concepts

Conceptualization of the structure of the lived experience is the next step in this

process. The intent of the statement that addresses the structure of meaning of the lived

experience is to answer the original research question (Parse, 2001), which in this study is

the following: what meaning do critical care nurses make of their at-death and post-death

experiences with their deceased patients?

Thoughtful immersion in the participant dialogues and the process of qualitative

analysis has enlightened the researcher to the fact there is a much broader concept of

meaning than originally anticipated. This is reflected in the conceptualized statement that honours the structure of the lived experience. This statement emerged from the integration of the core concepts.

The structure of meaning of the lived experience is this: Experiencing death means vivid memories bestowing tranquil tenet affirmation while enriching transcendental ways of nurses` knowing.

Heuristic Interpretation

"The heuristic inquiry component of phenomenological research focuses on the intensity of the human experience, both from the perspective of the researcher and the participants. The interest is with the meaning, not with the measurements" (Patton, 2002).

In the final steps of the Parse research method, the researcher is required to weave the structure of meaning of the experience with the principles belonging to the human becoming theory (Parse, 2001). To facilitate this process, the principles of the human becoming theory will be outlined, followed by the woven interpretation of the structure of meaning for each principle. The researcher's unique understanding of this theory and the meaning of the experiences for the participants enhance this step.

Principle One

"Structuring meaning multidimensionally is cocreating reality through the language of valuing and imaging" (Parse, 1992, p. 37).

The assumption of this principle is that individuals build a personal meaning for experiences through their own perspective of the universe: "What is real for each individual is structured by that individual" (Parse, 1992, p. 37).

Each participant created the meaning of the experiences based on her own perspective of the world. The core concept of *tranquil tenet affirmation* emerged from the participant dialogues, and a variety of belief patterns were revealed. Edi identified her belief pattern as an acceptance of an "urban legend," while Vi`s grew from the life-long teachings that were part of her religious affiliation.

Irrespective of the differences in belief patterns, each participant drew meaning from the experience in a manner that provided comfort and affirmation for her individual perspective on death. A personalized interpretation was apparent for every participant.

Principle Two

"Cocreating rhythmical patterns of relating is living the paradoxical unity of revealing-concealing, enabling-limiting while connecting-separating" (Parse, 1992, p. 37).

The assumption underlying this principle is that humans relate to the universe in a paradoxical, rhythmic pattern. The paradoxical nature of the principle provided a challenge for the researcher during the process of heuristic interpretation. Through repeated immersion in the assumptions and components of the human becoming theory, an understanding was developed.

The relationship between individuals and the universe is multi-dimensional and dynamic. The constant motion of this relationship is the basis for Principle Two of the human becoming theory. Individuals choose their own direction as they move with the universe.

Parse (1996) provides additional clarification of this principle in her discussion on the challenges of incorporating the human becoming theory into practice. This principle

refers to the notion that humans disclose and hide meanings all at once, as opportunities and limitations arise in everyday life, while they move with and away from others, ideas, objects and events (p. 56). A simplified example is identified in the participant dialogues: individuals chose to move away from discussing their experiences with those colleagues who were not receptive towards those who had shared a similar experience. For similar reasons, these participants engaged with the researcher in this project.

Principle Three

"Cotranscending with the possibles is powering unique ways of originating in the process of transforming" (Parse, 1992, p. 38).

Further explanation of the three key concepts within this final principle will provide a foundation for deeper understanding. Parse (1992) identifies the concept of *powering* as the push-pull rhythm of life that sparks a movement to go past the moment and create a new view on life. The concept of *originating* relates to individuals making connections and interpretations that are not the usual or common ones. The final concept of *transforming* refers to changing the individual point of view as new meaning is attached to different experiences.

These three concepts speak firmly to the possibilities that arise from the structure of meaning, "enriching transcendental ways of nurses` knowing,*"* that emerged through the interpretive process. The participants described a manner of knowing that extends beyond the realm of ordinary cognition. Their statements reflect the transcendental nature of this knowing: "You just know, you can sense it, and you can feel it," "I know that the soul has gone," and "I won't wrap them until I know they're gone."

The transcendental quality of this knowing also includes the perspective of the kinetic energy associated with human life and death. "If you walk in beyond that, when that energy is gone," and "There's definitely an energy associated with that" reflect the extension beyond common understanding.

Summary

Despite the difficulties of applying this method, the original reasons for choosing it hold true. As a nurse, the researcher is intimately aware of the transcendental ways of knowing described by the participants. The assumptions and principles of the human becoming theory support the personal perspective of the researcher, that there are endless possibilities of meaning as we, human beings who are nurses, interact with the universe.

Chapter 5 includes a discussion of the core concepts and their links to the current literature. The achievements and limitations of this study are addressed, as well as implications for nursing practice.

Chapter 5: Discussion

The findings of this study help to explain the meaning that critical care nurses give to at-death and post-death experiences they have with their deceased patients. This chapter includes a discussion of the core concepts outlined in Chapter 4. The researcher identifies the associations between the core concepts and current literature and suggests implications for practice.

First Core Concept: Vivid Memories

Memory and the ability to remember things in our lives are very important concerns for most people. Health food store shelves display a long array of alternative remedies designed to improve the capacity of human memory. The medical community endeavours to find ways to prevent memory loss in the elderly population. Memories are important; they are "the glue of our personal experience" (McGaugh, 2003, p. 2).

The participants in this study were able to recall events that occurred up to 20 years previously, with uncanny detail. These are vivid memories. The intensity of these memories relates to the significance of the experiences for the participants. Experiences that generate a deep, emotional response create enduring memories, even though the exposure to those events may have been brief (McGaugh, 2003).

The process by which these memories are stored within the human brain and the tools we use to recall them are beyond the scope of this project. Memory itself is a complex entity. However, one does not need a deep understanding of how memories are physiologically deposited to recognize the value that they have and their impact on individual life stories. It is sufficient to know that memories are "essential to human

experience, allowing us to integrate our past into who we are today" (LaVoie & Cobia, 2007, p. 135).

The individual stories that were revealed in this study have an important role in explaining how these nurses make sense of their experiences. As Abma (2005) explains, stories are the vehicle that humans use to give meaning to dramatic events that occur in their lives. The manner in which these individual participants recalled their stories demonstrates how they processed their experiences and how they will understand other situations that may occur in the future.

Nursing theorist Jean Watson (1985) argues that a person brings to any lived moment components of past experience that influence the interpretation of that moment. Watson describes this as an individual's "unique causal past" (p. 47). Death is a part of critical care nursing. Thus these stories and their meanings can help to explain how these nurses approach death.

Second Core Concept: Tranquil Tenet Affirmation

The patterns of belief identified by the participants in this study were diverse. Three participants stated they had no spiritual/religious beliefs, two listed membership in a specific religious denomination, and one simply stated that she did not belong to an organized religion. Despite this diversity, all participants confirmed that their experiences served to reinforce or affirm their existing belief patterns.

The reinforcement of these belief patterns brought these participants a sense of acceptance of death, both for themselves and for the patients that they cared for. Possessing a belief pattern has a direct benefit for the nurse and can aid in the management of stress during a patient's death: "In general, strong beliefs (whether

spiritual or nonspiritual, positive or negative) can have powerful effects on the body and the mind and can bring a sense of comfort" (Tuck, Alleyne, & Thinganjana, 2006, p. 246). Individuals who sustain a pattern of belief have an increased capacity to successfully manoeuvre through life's stressors (Tyler & Raynor, 2006; Tuck, Alleyne, & Thinganjana, 2006; Villagomza, 2006).

Nowatzki, Grant-Kalischuk, and Sanders (2007) found a similar theme in a phenomenological hermeneutic study of post-death encounters and grief. The post-death encounters of their 18 participants strengthened the individuals' belief in life after death. Their participants identified the concepts of peace without fear of death and comfort in the grief process as the outcome of their experiences.

The strength and value of the second core concept emerge when the significant role of stress for the critical care nurse is acknowledged. Death in the critical care setting can be challenging, complicated, and stressful for nurses (Beckstrand, Callister, & Kirchhoff, 2006; Beckstrand & Kirchhoff, 2005; Costello, 2006; McSteen & Peden-McAlpine, 2006; Tuck, Alleyne, & Thinganjana, 2006). The nature of the critical care environment makes death the most vicious opponent, and the battle is often tense. The impact of persistent tension and stress on nurses has been discussed in the nursing literature. Poncet, Toulilic, Papazian, et al. (2007), for example, found that the significant stress associated with the critical care environment was associated with an increased incidence of burnout in nurses. Beckstrand and Kirchhoff (2005) identified a relationship in nurses between unmanaged stress and depletion of physical and emotional reserves; this in turn was connected with higher rates of performance decline and job turnover.

As a critical care nurse, the researcher is aware that one does not need to turn to the literature to confirm the presence of stress in this environment. Mere observation of a busy day in the critical care unit will identify repetitive stressors. Stress in the critical care environment is constant.

Participants identified their need to provide adequate care at the time of and after death as a potential source of stress. They described the importance and privilege of providing a "good death" to their patients despite the potential for conflict with their colleagues. Not all nurses are on the same level of understanding or perspective or comfort about death; some, for example, are fixated on the tasks, such as wrapping a body, clearing the bed to prepare for the next patient, and so on. The current nursing literature yields similar findings. In a study by Calvin, Kite-Powell and Hickey (2007), the nurses in a Neuroscience ICU described feeling a sense of privilege in providing care at a patient's death. The 12 participants in the study also described their stress when difficulties arose while they were providing end-of-life care.

Beckstrand, Callister, and Kirchhoff (2006), using a large questionnaire sent to 1409 critical care nurses throughout the United States, identified the major theme of a "good death" as being important in the care that they were able to give to their patients. These participants also identified what they perceived to be barriers preventing them from providing a "good death" and thus resulting in stress.

The importance of facilitating a humane death and a peaceful transition during death emerged in a hermeneutic phenomenological study conducted by Hawley and Jensen (2007). The 16 nurses who participated were from Western Canada and had a similar demographic background to those who volunteered for this study. The

participants identified similar issues with stress related to end-of-life care. While Hawley and Jensen discuss the identified importance to the patient of a feeling of "connectedness to God" (p. 670), they do not discuss the nurses' belief patterns.

Costello (2006) reminds us that the perception of a "good death" is not limited to critical care nurses. His ethnographic study provided observational information on nurses who cared for aged dying patients. Having observed 71 deaths over a period of 20 months, Costello found that "good deaths were socially constructed and perceived by nurses to involve elements of control and implied passivity on the patient's behalf" (p. 598). Similarly, peace at a patient's death was important to his nurse participants; when they were not able to achieve that, it was perceived as a "bad death," creating stress for the nurses. In other words, stress was part of a "bad death" (p. 599). Costello associated the nurses' stress as having a direct impact on the their emotional stability.

The links between end-of-life care, a nurse's stress, and a nurse's individual pattern of belief are exemplified across current literature and supported by the findings of this study.

Third Core Concept: Transcendental Ways of Nurses' Knowing

Several key essences and notions emerged on the journey to discovery of the third core concept. While they are all part of the whole, each merits its own discussion.

Knowing

"I just know" is a phrase that appeared repeatedly in the participants' narratives. Clearly, different sensory pathways facilitated their awareness: sensing, feeling, smelling, and hearing. These pathways converged to reveal a deeper meaning for the concept of

knowing. This abstract interpretation of knowing is reflected in both the general nursing and the critical care nursing literature.

Godkin (2001) argues that the ability to sense is an integral part of nursing presence. Being present with a patient enables the nurse to recognize and interpret imperceptible changes in the patient. Sensing and presence have unique meanings for nursing, as is well reported in the nursing literature on palliative care. In the critical care setting, nurses often know when a patient is deteriorating before physiological change occurs (Hams, 2000; Pattison, 2004). A perception of "things not looking right" often occurs before the common indicators of blood pressure, heart rate and respiratory show a deterioration pattern.

Hawley and Jensen (2007) noted that the critical care nurses in their study identified a similar awareness and increased knowing. Those nurses described their ability to "sense" subtle changes in patients' conditions, or "to feel when something was not quite right" (p. 670). These qualities are seen as strengths in the critical care environment, where life-saving actions are often initiated based on intuitive knowledge before physiological data are evident.

Hams (2000) suggests that critical care nurses are responding to a "feeling state" and identifiable sense that the patient "just doesn't look right" when they perceive a deterioration before it is reflected physiologically. Similar descriptors are used in the participant narratives of this study.

Intuitive Knowledge

Nurses understand what it is to use intuitive knowledge. Parallel to the growth in concrete nursing knowledge, interest and exploration into this unique phenomenon have

been gathering momentum in recent decades. The broad range of definitions associated with intuitive knowledge creates a challenge for the exploration of this phenomenon. Intuitive knowledge has been described as "clinical intuition, nursology, creativity, or understanding without rationale" and "…the instant understanding of knowledge without evidence of sensible thought" (Billay, Myrick, Luhanga, & Yonge, 2007, p. 147).

While anecdotal evidence of nurses' intuitive knowledge may exist within the nursing community, prior to 1980 the subject had been overlooked in nursing literature (Rew & Barrow, 2007). There has since been a steady rise in the quantity of published studies that reflect the use of intuition in nursing.

Hams (2000) reviewed 11 qualitative studies in an attempt to understand nurses' use of intuition in the critical care setting. The common themes shared between the studies were a description of the attributes that assisted in intuition, the use of sensing and knowing as components of intuition, and the role of tacit awareness. Hams also discussed the associations between intuition and the continuum of novice to expert practice.

Rew and Barrow (2007) published a cumulative review of 611 articles that were associated with the search term *intuition* within the Cumulative Index of Nursing and Allied Health Literature (CINAHL) database. Of these, 287 were published in nursing journals. In these studies nursing researchers had utilized a wide variety of methodologies (both qualitative and quantitative) to evaluate the science of intuitive knowledge in nursing.

Billay et al. *(*2007) explored intuitive nursing knowledge and its place within nursing practice. Their investigation included the use of focus groups that were comprised of three different levels of critical care nurses: beginner, intermediate and

expert. Billay et al. determined that the ability to utilize intuitive knowledge expanded as the nurse moved along the continuum of professional development and experience.

There is consistency in the findings of these studies and in the narratives of the participants in this research, demonstrating that development of intuitive nursing knowing occurs over time. Benner's (2001) landmark work on novice to expert nursing practice, adds strength to this position, confirming that expertise and the grasp of intuitive knowing happens through experience.

The Soul

Participants used the terms *soul* and *spirit* in their stories to describe occurrences at the time of a patient's death. They identified their awareness of a transitional state during a patient's dying process. One participant stated that she would not wrap the body until she "knew they were gone," while another participant described her ability to walk into a patient's room and sense when death had occurred. A third mentioned her ability to know when the soul had left the body. Lemmer (2005) echoes a similar perspective:

> The nurse who has stood by the bedside of someone who has just died recognizes not only cessation of vital signs, mottling, and cooling of the body, but also the absence of the unique spirit of the person with whom they previously had interacted. (p. 311)

In Chapter 4, the researcher interpreted this phenomenon in relation to Parse's theory of human becoming. A similar perspective is illustrated in Watson's (1985) theory of human science and human care. The metaphysical stance of Watson's theory asserts that human existence transcends nature and is unconstrained by linear space and time. The second basic premise of the theory outlines Watson's perspective on the soul:

A person's body is confined in time and space, but the mind and soul are not

confined to the physical universe. One's higher sense of mind and soul transcends

time and space and helps to account for notions like collective unconscious,

causal past, mystical experiences, parapsychological phenomena, a higher sense

of power, and may be an indicator of the spiritual evolution of human beings. (p.

50)

The philosophical perspectives of both Parse's and Watson's theories support the

existential nature of the third core concept identified in this study.

Kinetic Energy

The participants mentioned in their stories the existence of human energy and

energy transference at death. They also noted the timely nature of this process. Together,

these ideas provide additional illustration of the existential nature of the third core

concept.

The concept of energy is well described in the nursing literature through reference

to Roger's (1970, 1992) science of unitary human beings. Rogers (1992) defines the

unitary human being as "an irreducible, indivisible, pan-dimensional energy field

identified by pattern and manifesting characteristics that are specific to the whole and

which cannot be predicted from knowledge of the parts" (p. 29). The science of unitary

human beings identifies the dynamic and continuous interaction between the energies of

human beings and the energies of the environment in an infinite state. The pan-

dimensional framework of this science embraces transcendental occurrences that are

often viewed as paranormal (Rogers, 1992).

Energy and Grief

While the participants in this study did not associate their experiences with grief, the stance of the science of unitary human beings has also been used as an interpretive tool in discussions on the grieving process.

Malinski (2006) reasoned that, if energy is not lost but transformed at the time of physical death, the grieving process "involves coming into a new and qualitatively different relationship with the loved one, rather than having to let go and move on" (p. 296). Todaro-Franceschi (2006) used the lens of the Science of Unitary Human Beings as the philosophical standpoint for her exploration of healing in bereaved individuals. She found that using the pan-dimensional perspective of unending energy and "synchronicity" (p. 298), or meaningful coincidence, facilitated acceptance and healing after the loss of a loved one.

In a study by Nowatzki, Grant-Kalischuk and Sanders (2007), participants described a greater understanding about what they called the changing of life's energy and explained that their experience helped to support them in their grief experience.

Achievements of the Study

The intent of this study was to generate new knowledge, adding to the existing fund of unique nursing knowledge. This has been accomplished through the actualization of the structure of meaning of the lived experience of critical care nurses: *Experiencing death means vivid memories bestowing tranquil tenet affirmation while enriching transcendental ways of nurses` knowing.*

Adherence to Parse's research methodology has expanded the researcher's general understanding of the theory of human becoming. This study has made a further

contribution to nursing research as a whole by using the methodology in its intended format. To broaden the theoretical perspective, comparisons and connections within the findings were discussed in a cross-sectional manner with the nursing theories of Watson (1985) and Rogers (1992).

Limitations of the Study

The small and purposeful sample chosen for this qualitative study limits the researcher's ability to generalize the findings to a larger population of nurses. All the participants in the study were experienced critical care nurses; consequently, the meaning of experiences at death from the novice nurse's perspective has not been addressed in this study. In addition, the depth of the study would have been enhanced had any male nursing colleagues from the researcher's ICU volunteered to participate. Since men are now increasingly choosing the nursing profession, an investigation to determine if gender plays a role in how these experiences are interpreted would have been valuable.

Implications for Practice

The findings of this study have a number of implications for practice. While those implications relate potentially to nursing in general, they are presented in the context of critical care nursing.

Acknowledging the Stories

Stories are one of the tools that nurses use to share their experience and knowledge with others. Their stories demonstrate all that is nursing: the passion, the caring, the giving and receiving, the struggles with life and death. Each story has meaning and brings richness to all who experience its telling.

The participants in this study voluntarily shared their stories with the researcher and continued to follow through over time, just to check up on the progress of the project. Even though the essence of selective sharing arose from the narratives and anonymity of the participants is assured, the personal significance to these participants and the importance of the opportunity to share their stories are apparent.

The researcher was also amazed at the number of nurses from a variety of practice areas who, upon hearing of this project, stepped forward to share their stories of similar experiences. As noted, most were experienced nurses whose careers had spanned many years. The other consistent feature was the participants' clarity of recall about both the events and the emotions involved in their experiences. It is clear that their memory of these stories is not diminished by time.

Nursing is a *sui generis* profession. Stories are an essential element to the past, present, and hopes for the future of nursing. Nurse leaders need to listen to and recognize the worth of these stories. Nurses who feel that they have been heard and that their stories are valued bring a positive attitude to work. When they reflect this attitude in their interactions with colleagues and patients, positively charging the environment, everyone benefits.

The culture of nursing will benefit if decision makers who are not nurses endeavour to understand the value of nurses' stories. The challenges encountered during the ethics approval process for this project clearly indicate to the researcher that global acceptance of such experiences as an integral part of nursing does not yet exist.

Belief and Stress Management

Stress will never be eradicated from the critical care setting; it is inherent in the intense nature of the environment. However, steps can be taken to decrease the effects of persistent stress on nursing staff. The literature shows that having a belief pattern, spiritual in nature or not, improves individuals' ability to cope with life's daily stressors. The participants in this study identified a lack spiritual support in their work environment; however, they referred to a significant level of support that existed before the onset of lean financial times in the health care setting. Decreased funding in health care, they felt, took away the spiritual support for the staff. Formerly, they felt there was more administrative support for them in the ICU to discuss the different experiences that they were having. Basically, there was no longer a safe sounding board consisting of people who understood the critical care environment.

The findings of this study and the evidence in the current literature suggest that decision makers should revisit the need for increased spiritual support for all nurses, especially those working in critical care. As previously noted, nurses who feel listened to, valued and supported also feel less stressed and, having a better attitude, provide better care for their patients, positively affecting the healing process. This should be the ultimate goal of decision makers.

End-of-Life Care

Another area of stress identified by the participants involved the challenges that surround end-of-life care in the ICU setting. Difficulties with communication, the perception of futile care, lack of appropriate education, and the need for palliative care in

the ICU setting are well documented in the literature and are not unique to the work environment of these participants.

Along with the wealth of research available, various models have been suggested to improve practice during end-of-life care in the ICU setting. Health care institutions need to dedicate resources to the implementation of end-of-life care practice models in order to improve the culture of nursing and patient care.

Nursing Intuition

If asked how they "know" things, nurses' response will often be, "I just know." While other nurses may understand this statement, the mandate for evidence-based practice in nursing demands that we take to another level this knowledge about the use of intuition in nursing care.

Rew and Barrow (2007) suggest that there are valid tools that can be used to measure the diverse elements of intuition. Broad utilization of these tools would help researchers to discover how prevalent the use of intuitive knowledge is in the nursing profession. Further qualitative studies would advance understanding of how nurses use intuitive knowledge.

Future research may also reveal if there is a role for education about intuitive knowledge. At present, it is apparent that this way of knowing is acquired through experience. A deeper understanding of the phenomenon may lead to the emergence of new ways of sharing this knowledge.

<div align="center">

Summary

</div>

This nurse researcher has always maintained that everything that happens to us as nurses impacts who we are forever. The intent of this study was to explore what it means

for critical care nurses when they have at-death and post-death experiences with their patients. Through the dialogues with the participants and the process of interpretation, the complexity of meaning for these experiences became apparent and the original premise of the study was reaffirmed for the researcher.

The researcher hopes that readers of this study will gain a deeper understanding and appreciation for the all-powerful meaning in the simple phrase, "I am a nurse."

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Appendix A: Poster Inviting Participation in Study

Volunteer Critical Care Nurses Needed…

Research into the Post-Death Experiences of Critical Care Nurses

Investigator: Nancy Campbell, RN, BN
Academic Supervisor: Dr. Ruth Grant Kalischuk

Are you a critical care nurse, and have you had a post-death experience with a deceased critical care patient? Have you seen something, heard something, felt something? What did this mean to you? Are you willing to share your story?

This research is being conducted as part of the Master of Science (Nursing) Program at the University of Lethbridge and seeks to explore the meaning of these experiences for critical care nurses. Involvement includes an interview with the investigator that will last approximately 1.5 - 2 hours. All attempts will be made to ensure that confidentiality and anonymity are maintained.

If you are interested in participating in this research project or desire further information, please contact:
Nancy Campbell
(403) 553-4644 (home)
(403) 388-6188 (office)
email: campnm@uleth.ca

Appendix B: Interview Questionnaire

Date:

Place of interview:

Contact information for participant:

Age: Gender: Cultural/ethnic perspective:

Spiritual/religious perspective: Marital status:

Education:

Professional background:

Time between death and post-death experience:

Time between post-death experience and interview:

Nature of the post-death experience (visual, auditory, tactile, taste, sense, feel):

Reason for participation:

Other probes:

     Experience/behaviour:

- "Describe your post-death experience."

- "What setting did this occur in?"

- "Was the patient known to you?"

- "What time – in relation to day/night, month/year – did this occur in?"

- "What were you doing at the time?"

- "What was happening in your life at the time of this experience?"

     Value/feeling:

- "How did this experience make you feel?"

- "What did this experience mean to you as a person? As a nurse?"

- "How has this experience impacted you personally? Professionally?"

- "Has this experience impacted your attitudes towards death and dying?"

- "Have you shared this experience with your family? Friends? Co-workers? Other health care professionals?"

- "If so, what reactions did you receive? How have those reactions impacted you?"

- "Was this experience positive? Negative? Uncertain?"

Knowledge:

- "Do you know of other nurses who have had a similar experience"?

- "Is there a role for education surrounding these experiences for nurses?"

Appendix C: Participant Consent Form

Research Project Title: Research into the Post-Death Experiences of Critical Care Nurses

Investigator: Nancy Campbell, RN, BN

The research project is being conducted as a requirement for the thesis component of the Master of Sciences (Nursing), School of Health Sciences, University of Lethbridge.

The intent of this project is to explore the meaning of post-death experiences between critical care nurses and their deceased patients. The process includes audiotaped interviews with critical care nurses who have had this experience, interview transcription, extensive transcript analysis and interpretation, cumulating in the final submission to the School of Health Sciences.

The interview process will take approximately two hours of time and will be conducted in the environment deemed by you as most appropriate and comfortable. Your identity will be kept confidential. All audiotapes and transcripts will be coded, and your name will not be used. The audiotapes and transcripts will be accessible only to the researcher and the listed academic supervisor. The audiotapes will be destroyed following transcript review for accuracy. The transcripts will remain the property of the researcher and may be quoted in the final submission to the School of Health Sciences. At no time will any written and/or published material contain your identifying information.

Participation in this research is voluntary, and there is no remuneration for your time. You have the right to withdraw from participating in this project at any time without bias. The researcher also retains the right to request your withdrawal at any time.

Contact information for the Employee Assistance Program will be given to you at the time of consent, as the researcher understands that there is a possibility that the discussion of this subject may create emotional distress. The Employee Assistance Program will provide free counselling and referral services with complete confidentiality assured.

Your signature on this consent form indicates that you understand the information that has been provided to you and that you agree to participate in this research project. If you have any further questions or concerns regarding this research project, please feel free to contact the researcher or the academic supervisor. Questions of a more general nature may be addressed to the Office of Research Services, University of Lethbridge (403–329–2747).

Investigator: Nancy Campbell
                                 School of Health Sciences
                                 University of Lethbridge
                                 (403) 553-4644 (home)
                                 (403) 388-6188 (office)

Academic Supervisor: Dr. Ruth Grant-Kalischuk
                                 School of Health Sciences
                                 University of Lethbridge
                                 (403) 329-2724

Participant's Name: _____

Signature: _____

Date: _____

A copy of this consent has been given to you to keep for your records and reference.