Nurses' lived experience of Strategies for tackling with moral challenges in caring for comatose patients: A phenomenological study

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ABSTRACT

Comatose patients deal with numerous moral challenges at ICU. The nurses have a significant role in recognizing these challenges and the approach to deal with them. Thus, the present study aims at clarifying nurses' lived experience for dealing with the moral challenges in caring for comatose patients. This qualitative study was done applying a phenomenological approach at Kurdistan University of Medical Sciences from 2014 to 2015. Having done a purposeful sampling 10-experienced nurse was selected. The data was collected using 14 semi-structured in-depth interviews. Data collection was continued to achieve a rich interpretation of the content and themes saturation. Data analysis was done applying Van Manen's six-step method. In data analysis, 5 main themes were driven from the nurses' experiences. These themes include resistance-focused flexibility, counselling guidelines, supportive participation, professional caring, and moral caring. The themes driven from the present study can be applied by hospital managers in dealing with moral challenges in caring for comatose patients. These themes are effective and helpful strategies for turning threats into opportunities in taking care of comatose patients.

Key words: lived experiences, nurse, moral challenges, caring, coma, phenomenology

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INTRODUCTION

One of the factors of being professional in nursing is upholding moral principles in caring [1]. Benner et al [2009] assume ethics and clinical performance as one and maintain that the nurses, while making decisions as well as performing, require virtues, moral principles, and fundamental guidelines upon which they can make decisions since they are continuously dealing with moral principles [2]. Seidi et al [2015] have found out that the way to deal with moral challenges is a needed skill for clinical judgment in taking care of the patient [3]. As a matter of fact the nurses can manage to do so by providing professional support [4]. Upholding principles including respect, keeping the patient's privacy as well as that of his family, upholding justice with respect to caring for the patient and avoiding any harm to the patients are important as moral codes in organizational guidelines for dealing with moral

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challenges [5,6]. The main issue is how to uphold these principles in clinical work especially for the comatose patients who are in the ICU and they are completely dependent on nursing care.

Coma is a clinical state in which the patient's arousal and response die and he fails to respond to internal and external stimuli[7]. The usual term of coma is 2 to 4 weeks. In the United States 8 million people are struck by concussionfrom whom 700 hundred thousands need to be hospitalized in the hospitals. Most of these individuals are provided with nursing care in the ICU [8]. Providing nursing is defined differently for different individuals. According to some, nursing care refers to conducting nursing methods based on the moral considerations including commitment to rules, regulations and standards [9].

The aim of moral consideration is providing emotional support [10], peace [11], comfort [12] and creating an appropriate for both the patient and his family [13]. Since interactive and caring roles are among the nurses' leading roles, one cannot overlook their roles in dealing with those in need of help. Besides their physical needs, comatose patients require specific moral considerations [14]. The nurses may face numerous challenges in special and critical conditions. In studying the literature on Euthanasia [15] and organ donation[16], visiting the patient [17] and family participation [18] in caring for the patient have been included as the moral challenges in the ICU. However owing to the kind of culture and the background of the study, the researcher aimed at studying this very question "how do the nurses deal with the moral challenges in the local culture and background in Iran?" Thus, the present study aimed at clarifying and explaining the nurses' lived experiences of dealing with moral challenges in caring for the comatose patients and it has attempted to study the ways of applying the strategies to deal with the moral challenges.

MATERIALS AND METHODS

This qualitative study was done applying a phenomenological approach in the ICUs of Be'sat and Tohid Hospitals (affiliated with Kurdistan University of Medical Sciences, Sanandaj, Iran) from 2014 to 2015. In the present study, hermeneutic phenomenology was applied; since the nurses' understanding of the ways to deal with the moral challenges in caring for the comatose patients and their interpretations of this very concept was intended.

The participants of this study included all the ICU nurses having at least 3 years of experience of caring for comatose patients. The sample size for achieving data saturation, researcher saturation, and themes saturation was 10 participants. Having completed each interview or observation, no new code or data was achieved and all the conceptual levels had been completed. Sampling method was a targeted one. The first interview was conducted with key informant having the most valuable experience of caring for comatose patients. Selecting the sample size of those who participated in the follow-up interviews was done purposefully and based on the data requirements as well as data guidance.

Inclusion criteria included: voluntary participation in the study; having at least 3 years of experience of working in the ICU; having valuable and helpful experience of caring for comatose patients. Inclusion criteria also included the participants' withdrawing from the research at anytime and the participants' being prevented to release or publish the recorded interviews.

Although the researcher's experiences and attitudes could not be excluded completely, it was attempted to avoid the researcher's attitudes affecting the collected concepts and data. The researcher's experiences and attitudes were used to write questions (reminders) in both the interview manuals and during the interviews. Besides, the researcher's attitudes and experiences were applied in data analysis for classifying and relating the themes and subthemes. According to Heidegger, this step is referred to as interpretation in interpretation (19).

The researcher collected the data by applying 14 individual semi-structures on 10 participants (table 1) and also informal observation through using field note. Explicit codes were extracted from the interviews and the field note helped the researcher know from whom and where to conduct the next sampling. This led to a question in the researcher's mind which was used as implicit codes to direct and guide data analysis.

Data analysis was conducted simultaneously with its collection. In this study, Van Manen's six-step method was used for data analysis. The researcher's mind was first involved with "the way of applying nurses' strategies in dealing with moral challenges in caring for comatose patients". In the next step, the researcher investigated the very phenomenon as it was lived and as it was conceptualized in the interview texts. Focusing on the natural themes, in

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the third step it was attempted to clarify the phenomenon's features. In the fourth step the phenomenon was describes by writing and rewriting codes and themes. In the fifth step, the researcher must establish a powerful and conscious relationship with the phenomenon being studied. In the last step, the way of applying the nurses' strategies to deal with the moral challenges in caring for the comatose patients was studied. This was done through continuous examination of all the parts of this very phenomenon in the present context and adjusting them to the nurses' experiences.

In data analysis, the researcher first analyzed the data manually using Word Software and then MAXQ DATA version10 was applied to help the researcher classify codes and themes.

To promote rigor, four criteria were taken into account: credibility, dependability, confirmability, and transferability. For credibility, continuous simultaneous data collection and analysis, gaining the participant's trust, listening carefully, reflecting on the data, and member check was done. For dependability, different interviews were integrated. Moreover, the data, recorded interviews, and handwritten drafts will be kept for two years so that they will be accessible to the participants and observers for two years. For confirmability, peer check was used. The transferability of this study was promoted with the maximum of variance.

Ethical consideration includes: obtaining permission for entering the research environment; providing necessary explanation about the method and aims of the study for the participants; getting the participants' consent whether spoken or written for participation in the study; selecting the environment based on the participants' views; obeying the principle of secrecy; keeping the information confidential in all steps of the study; keeping the participants' anonymity; participants' freedom and the right to refuse from the study at anytime as well as step of the study; reflecting the findings to the authorities and the participants themselves; assuring the participants of the deleting the recorded interviews after transferring them and analyzing the data, keeping honesty and ethics in data interpretation and analysis.

REULTS

The data analysis led to 920 primary codes, 15 subthemes, and 5 themes. These themes include resistance-focused flexibility, counselling guidelines, supportive participation, professional caring, and moral caring (table 2).

1. Resistance-focuses flexibility
This theme indicates the nurses' resistance against immoral and illegal claims and reasonable flexibility to turn these immoral claims into reasonable and moral ones. Throughout the caring, the nurses face euthanasia from the comatose patients' doctors, colleagues, and families. In response to these requests, they resisted and provided cogent and convincing reasoning. "The brain death patient's son asked me to withdraw his father from the ventilator to suffer less. I tried to persuade him that his request does not conform to the rules of the hospital and he had better think of organ donation" (nurse 1). The other immoral challenge against which the nurses need to show flexibility is the oral requests of some doctors. "Dr. …. Asked me to insert the central venous catheter for the comatose patient. Although I could do so, I refused and reasoned that it was not my duty and would be legally prosecuted. The doctor agreed and he himself came to the ICU and did that" (nurse 2).

The other moral challenge in caring for the comatose patient is their negligence in reporting the errors owing to fear or lack or responsibility. These nurse reasoned that while the comatose patient is about to die, what is error reporting needed for? "As the ICU head-nurse I realized that some of my nurse colleagues agree on settling the problems and errors before handing over the night shift. I did not accept this and, in return, offered a system for error reporting in the ICU which was based upon trust and motivation" (ICU head-nurse).

2. Counselling guidelines
This theme indicates that in dealing with moral challenges the nurses came to applying counselling guidelines. In dealing with moral challenges, the nurses attempted to provide counselling programs to guide and inform the families. "One of the challenges we face is the unnecessary visits and incorrect interventions of the accompanying persons. For instance, once I let an accompanying person, claiming to be the patient's son, enter the ICU and then I realized that he was trying to fingerprint the patient. I stopped him doing so immediately. Following this event, cooperating with management staff we prepared educational brochures in different fields for the families which was really effective" (nurse 3).

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Another moral challenge was the offering organ donation to the patient's family by nurse colleagues or doctors without realizing the appropriate mourning procedure. "When I offered organ donation to the patient's father; he attacked me aggressively saying that you want to mutilate my poor child. He upset me by saying that. However, having participated in the briefing classes of organ donation and counseling, I found out that it was my fault" (nurse 4).

The other moral challenge is the lack of agreement on brain death confirmation by the doctors which confuses the patient's family and releasing contradictory news by the doctors and nurses. This made the nurses ask for appointing someone to be in charge of confirming the patient's brain death and consult with the other colleagues. "In our unit there was a lack of agreement on confirming a patient's brain death between the neurologist and the anesthesiologist and for this very reason they reported contradictory news to the patient's family. This led to the family's complaint. The hospital's committee decided to hold an educational workshop and appointed someone to respond the patient's family (ICU head-nurse)".

3. Supportive participation

This theme indicates the nurses' response to the moral challenges such as emotional and sensory deprivation, patients' safety, and respecting the patient and his family. One of the moral challenges is establishing limits on visiting the patients and isolating them. In return, the nurses attempted to help the patient's family participate in providing the patient's care and safety. "The comatose patient with consciousness score of 3 promoted to 11. To stimulate the patient's sensory system and reinforce his memory we asked his family to provide the patient with his favorite songs (through headphones). Moreover, his parents were continuously beside his bed and participated in some of the caring services. This led to family satisfaction and also improvement in his recovery process" (nurse 4). The other challenge in caring for the comatose patient was the relative participation of the doctors and other nurses. In response to this challenge, the nurses attempted to build an appropriate interaction with the doctors and other clinical colleagues trying to participate in the very process of caring. "Our views about some of the patients and the way of reporting brain death to their families were quite different. Following some joint meetings with the doctors, we came to this conclusion that every decision must be made based on the colleagues' consensus and participation.

4. Professional Caring

In caring for comatose patients, the nurses are facing challenges such as the nurses' intervention in medical affairs and imposing medical intervention on the nurses. In response to this challenge, the nurses attempted to fulfill their duties as I was expected. "Due to the brain death, some doctors handed over most of the medical interventions to us such inserting central venous catheter, inserting tracheal tube, inserting …. which I refused to do, as I was expected" (nurse 5). Another challenge in caring for the comatose patient was conducting medical and nursing intervention without obtaining the family's consent. The nurses gained written consent with respect to the patient's legal matters to have legal and disciplinary support to conduct any nursing intervention. "When the patient's family insisted on weaning the brain death patient from the ventilator in order to transfer him on their own consent, I referred them to the legal unit of hospital to obtain written consent" (nurse 1).

With respect to obeying the caring standards, the nurses attempted to take care of the comatose patients according to the clinical guidelines and ethical regulations and codes. "I explained the ethical codes to the nurses and installed them in the unit to be applied. Also, I installed some guidelines (in the ICU) on the legal procedure of ventilator weaning and the norms of brain death confirmation" (ICU head-nurse).

5. Moral caring

This theme indicates the nurses' reaction to social and cultural challenges. With respect to sympathy and affinity, the nurses attempted to establish a close rapport with the comatose patient. "In caring for comatose patient I assumed that I was a family member (nurse 8). The nurses treat the comatose patient's family with kindness and respect. "We tried to pacify the family when they were crying in the ICU" (nurse 6). Realizing the family's mental and emotional state, the nurses also attempted to talk about realities in simple and understandable words. "When they were prepared to accept reality, I informed them about the brain using their own language and sympathized with them" (nurse 4).

With respect to spiritual health, the nurses attempted to provide a suitable place to conduct religious and social affairs. "Whenever the patient's family requested to take a clergy to say prayers in the ICU, we met their request

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(nurse 7). Another nurse added, "Respecting their religious, cultural, and social believes, we tried to obtain the family's consent of the brain death patient for organ donation" (nurse 10).

With respect to the comatose patient's privacy, the nurses tried to dress the patient for both examinations and visits. "When someone came to visit the comatose patient I controlled his clothing. If he was naked owing to uneasiness, I dressed him and then he was visited" (nurse 3). "While examining, we only undressed the necessary parts" (nurse 9). With respect to the visits, different individuals sometimes violated the patient's privacy, and thus they were abused whether financially or personally. "Once the comatose patient's brother struggled with the visitor and it turned out that the visitor was the comatose patient's ex-husband. Later on, we controlled the visitors' identity card to enter the ICU" (nurse 6). "As the ICU head-nurse, I attempted to appoint male nurses for male patients and female nurses for female patients. However, owing to lack of on-call nurses, it was not always possible" (ICU head-nurse).

Table 1. The participants' demographic features

Number (percentage)	Demographic features	
(%40)4	Male	Gender
(%60)6	Female	
(%70)7	B.S	Academic Degree
(%20)2	M.S	
(%10)1	Ph.D.	
9±37	Age (mean ± standard deviation)	
9±15	Working experience (mean ± standard deviation)	

Table 2. Themes and subthemes

Subthemes	Themes
Resistance and flexibility against the families' requests Resistance and flexibility against the doctors' requests Resistance and flexibility against the nurses' requests	Resistance-focused flexibility
Guiding the family based on counselling Counselling programs with the nurses Counselling with the doctors Counselling guidelines for the hospital staff	Counseling guidelines
Asking for support and helping the family participating in the caring for comatose patient Team participation in caring for comatose patient	Supportive participation
Obeying the disciplinary-professional regulations Obeying the standards of nursing in caring for comatose patient	Professional Caring
Respecting the patient's prestige and privacy Establishing sympathy and rapport with the patient Respecting the patient's spiritual health Serving justice in caring for the patient	Moral caring

DISCUSSION

The strategies of dealing with moral challenges of caring for comatose patients differ in different texts that have similarities and differences with the findings of the present study.

Resistance-focused flexibility
In the present study, the resistance-focused flexibility indicates the nurses' resistance against the immoral and illegal request and showing proper flexibility. In a study done by Atashzadeh Shooridehet al(2012) honesty has been mentioned as a moral principle in nursing (20). The most important factor affecting all the sub-themes is work ethic and responsibility in caring (21). In the present study, the nurses were likely to face euthanasia request, doctors' illegal oral requests, and colleagues' negligence in reporting the errors owing to fear or lack of responsibility. In these situations, the nurses attempted reasonably to turn these request into reasonable and logical requests. This kind of dealing with the moral challenges conforms to the previous studies. However, the findings indicate that the way of dealing with the challenges differ from those of the previous studies.

Counselling guidelines
In the present study, in response to the moral challenges, the nurses attempted to provide necessary guidelines in different ways such as consulting the patient's family, nurse colleagues, doctors, and ICU staff. Atashzadeh

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Shorideh et al(2012)found out that in caring for the patient, the nurses need to establish an atmosphere of proper interaction, support, and bilateral respect and be responsible for meeting the patient's needs(20). In the review of the literature (22, 23) the researcher realized that family-based caring includes knowing the family and its potentials, facilitating family participation, and respecting family norms and values. Quality caring calls for staff cooperation and lack of doctor-nurse cooperation makes the workplace unbearable for the staff (4). With respect to counselling guidelines, the findings of the present study conform to those of the previous study. Reporting contradictory news to the companion by the doctors and nurses was another moral challenge that confused the families. Having faced this challenge, the nurses offered the hospital's committee to appoint a doctor to confirm the patient's brain death and report it to their family. Moreover, some educational workshops were held for the medical team to deal with this challenge. In the study done by Masoumian Hoseini et al (2014), although the doctor confirmed brain death, the patient's family was still uncertain whether their patient has died or not (24). In other studies

(25,26), there seemed to be uncertainty as for the brain death among the family members and by stating that their patient is still alive, the staff attempted to find vital signs in the patient .

Supportive Participation
In the present study, the strategy of supportive participation indicates the nurses' response to the moral challenges such as emotional and sensory deprivation, establishing limits on visiting the patients and isolating them, and the low level of team participation in caring for comatose patient. In response to these challenge, the nurses attempted to help the patient's family participate in caring for the comatose patient. They were always seeking interaction with the medical team to offer team participation. Seidi et al (2014) found out that professional support guarantees team participation in caring for the patient (4). With respect to supportive participation, the closest person to the patient was allowed to touch the patient and talk to him. In studying the literature, therapeutic touch and emotional management have been taken into account (27).

Professional caring
In the present study, the nurses face numerous challenges in caring for comatose patients including nurses' intervention in medical affairs, imposing medical intervention on the nurses, and conducting nursing without obtaining the family's consent. In response to these challenges, the nurses obeyed the disciplinary-professional regulations and followed the standards of nursing in caring for comatose patient according to clinical guidelines and ethical regulations and codes to provide professional caring. Based in literature review, one of the themes obtained was the experience- based knowledge and formal learning, which affected the quality of nursing, cares (28). The nurses and families, coming from different cultures, brought with them certain believes and perceptions to the caring environment and this can affect the caring process (29).

The findings of the study done by Seidi et al (2015) indicated that, obeying the regulations, standards, and moral considerations, the nurses attempted to provide professional clinical judgment in caring for the patients (3). In other studies (30, 31) the importance of the caring to obtain the patient's consent as well.

Moral caring
In the present study, the nurses attempted to manage social and cultural challenges by applying these strategies: respecting the patient's prestige and privacy; establishing sympathy and rapport with the patient; respecting the patient's spiritual health; serving justice in caring for the patient. The findings of the study done by Shokati Ahmad Abad et al (2012) indicated that, in caring for comatose patients the nurses attempted have the following features: attempting to live with the patient; having work ethics and responsibility. These factors helped the nurses try hard to provide proper nursing care, and do whatever they can to recover the patient and finally if they don't recover, provide them with a peaceful death which is one of the comatose patient's rights and values (8). With respect to sympathy, the nurses tried to treat the comatose patient and his family with kindness and compassion. Moreover, realizing the family's mental and emotional state, the nurses also attempted to talk about realities in simple and understandable words. One can understand the patient's basic needs through caring, sympathy, respectable interactions with the patient and his companion (32).

With respect to spiritual health, the nurses attempted to provide a suitable place to conduct religious and social affairs. The nurses even attempted to obtain the family's consent and respect their suggestions and believes, and provide them with a suitable environment to conduct their religious affairs and even inviting a clergy to the ICU.

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Farnia et al (2014) found out that trust-based caring was based on spiritual caring, so that [in addition to effort, hardworking, and expediency] both the patient and the nurse sought inward power (33).

CONCLUSION

The nurses spend a lot of time to deal with moral challenges in their workplace. They face numerous social challenges and moral questions and this calls for the necessity of having qualified nurses capable of responding these challenges and questions. When the nurses realize their patients' believes and respect the religious duties of both patients and their families and this helps the human aspects to be established. Concerning the culture, present background, and local conditions in Iran, the present study helped us clarify the meaning and concept of dealing with the moral challenges in caring for comatose patients. The findings of the present study can be regarded as the keystone for planning and obeying the moral principles in caring for the patients and specifically comatose patients. In conclusion, one of the moral aspects of caring for the patient is defending the patient rights and this is regarded a main duty in nursing.

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