

CHAPTER 1 INTRODUCTION

1.1 Introduction

This is a qualitative research study that was undertaken to investigate nurses' lived experience and the meaning of their involvement in 'end-of-life' (EOL) care after a 'do-not-resuscitate' (DNR) decision had been made on general medical units in a Saudi Arabian context. In this chapter, the background and context of the research is positioned within the existing body of literature on nurses' involvement in EOL care, and within the uniqueness of the local context. An overview of the development of the research problem, the research question and purpose, and the importance of the research study are given to portray the scope of the study. The definitions of terms that are pertinent to this study are provided prior to the conclusion of the chapter. An outline of the chapter is given to orientate the thesis.

1.2 Background and Context of the Research

Patients with chronic diseases are admitted to general medical units (hereafter referred to as medical units) to receive medical treatment and nursing care. In spite of the medical units' primary emphasis on treatment and recovery from chronicity, many patients die during the course of admission to these units. The DNR decision is initiated specifically by the treating physician at a point when the curative treatment has been exhausted. A range of EOL care options is therefore provided on these units to such patients when death is imminent. In recent years, the need to improve EOL care has received growing recognition in the literature (Becker et al. 2007; Bookbinder et al. 2005; Heyland et al. 2006; London & Lundstedt 2007; Willard & Luker 2006). Many authors have highlighted the limited research attention that has been given to date on

issues of EOL care on medical units, in hospitals, despite the fact that such units are frequently the site of patient deaths when medical treatment plans have failed to sustain life (Borbasi et al. 2005; Dunne, Sullivan & Kernohan 2005; Evers, Meier & Morrison 2002; Rogers & Addington-Hall 2005; Thompson, McClement & Daeninck 2006).

Although there are several nursing studies that have investigated patient and family experiences of EOL care, these have been conducted mainly on intensive care units (Badger 2005; Bunch 2001; Halcomb et al. 2004; Heland 2006; McGrath & Holewa 2006). As stated above, there is a paucity of nursing research on EOL care undertaken on medical units. Moreover, the available studies do not necessarily give specific direction and guidelines for daily clinical nursing practice (Borbasi et al. 2005; Weigel et al. 2007; Rogers & Addington-Hall 2005; Thompson, McClement & Daeninck 2006). Consequently, this affirms the importance of this research study on nurses' involvement in EOL care after a DNR decision in non-critical care clinical settings, such as medical units.

Nurses in non-critical clinical settings are expected to share similar challenges to critical care nurses in providing comprehensive EOL care to DNR patients (Bunch 2001; Ciccarello 2003; Cole 2003; Hohenleitner 2002; Hopkinson, Hallett & Luker 2003; Shotton 2000). Cole (2003) emphasised the importance of communication among the healthcare team members, patients, and their families, so that EOL care is aimed at achieving best possible care for DNR patients. Concurrently, the factors which require effective communication and counselling skills of nurses are the concerns of patients' families and relatives pertaining to prolongation of life (Costello 2002; Joel 2003). One such concern is the length of stay, as the decision to transfer to the home or to another healthcare facility is not always acceptable in Saudi Arabia because patients' relatives often interpret discharge as the end of medical and nursing care when a transfer is suggested.

The context of the research setting is a large multinational hospital in Riyadh, Saudi Arabia. It is a teaching hospital for both nurses and physicians, and is accredited by the Joint Commission International (JCI), United States of America. Within the hospital, there are ten (10) medical nursing units with an average daily bed occupancy of 97%. Closer scrutiny of medical records shows that there is an increasing trend in DNR decisions, which in turn means an increased frequency in encounters of healthcare team members with DNR patients.

The profiles of the nursing workforce in these medical units of the above hospital are diverse. They originate from more than fifteen (15) different countries including large numbers from Australia, Canada, Germany, Ireland, Malaysia, New Zealand, Philippines, South Africa and the United Kingdom. The expatriate nurses, who are largely non-Muslims and non-Arabic speaking, have different religious, language and cultural backgrounds from the patients, who are Muslim, Arabic-speaking and embrace an Islamic way of life. The nursing staff may not be involved in the DNR decision-making process, which is largely made by physicians who are mainly Saudi Arabian nationals with similar demographic characteristics in terms of religion and cultural beliefs to the patients. Expatriate nurses are still expected, however, to provide comprehensive EOL care, including religious and spiritual support to the Muslim Arabic-speaking patients and their families who live through the dying process of the patient.

Furthermore, the typical patient profile (except for the occasional admission of an expatriate staff member), is either a National Guard soldier or his family members, who are Arab Muslims and who incorporate Islamic principles and duties in their daily living activities. The medical diagnoses for patients on the medical units vary but include complex chronic conditions such as endocrine, neurological, pulmonary and renal disorders. Separately from these chronic conditions, patients with cancer or brain death who are fully dependent on mechanical ventilation may be admitted to specialised units.

On general medical units, it is usually terminally ill chronic patients who receive EOL care following a DNR decision.

The cultural and religious differences between nurses and patients present as a challenge and concern in the care of EOL patients (Blais et al. 2006; Clarfield et al. 2003; Schmidt 2001). There is a great need for sensitivity in EOL care delivery in relation to both cultural and religious beliefs of patients and families. A related issue is the preparation of the patients' bodies after death, which is considered as a nursing-related task in EOL care and requires further empirical investigation (Blais et al. 2006; Rassool 2000; Ross 2001). In a country like Saudi Arabia, these issues are of considerable significance, as the majority of patients are Muslims, whereas care providers, particularly nurses, are expatriates and predominantly non-Muslims. Within a hospital setting with a large multinational and multicultural expatriate nursing workforce, nurses' understanding of Islamic practices and considerations surrounding a patient's death, the dying process and support for family members in coping with death all need further investigation since there is limited literature available on these issues (Rassool 2000; Touhy, Brown & Smith 2005). The motivation for this study came from my professional experience as a clinical nurse manager which highlighted the need to explore these issues systematically and contribute to the development of appropriate clinical practice guidelines and to scholarship on this topic.

1.3 Statement of the Research Problem

Burns and Grove (2005:70) define a research problem as 'an area of concern where there is a gap in the knowledge base needed for nursing practice'. Polit and Beck (2006:509) qualify that the identified area of concern in nursing practice will generally have raised uncertainty within its setting, and is regarded as 'perplexing'. Thus,

rigorous investigation, through a disciplined pathway of research enquiry, is indicated. Burns and Grove (2005:72) and Polit and Beck (2006:113) identify that two justified sources for description of research problems are clinical nursing experience and nursing literature.

In my experience as a clinical nurse manager, I have observed that at the point of a DNR decision, it is the multinational nurses who appear to become more involved in EOL care. Some nurses have raised the point that, contrary to expectations, the majority of physicians, who are Muslims and Arabic-speaking, appear to become less involved in EOL care after the DNR decision has been made. In the context of the research setting, this paradox of increased involvement by expatriate nurses after DNR and lesser involvement of other healthcare members, particularly local physicians, is regarded as an unexplained phenomenon. Although for years there has been a large number of expatriate nurses working in Saudi Arabia, their experiences in this regard have rarely been examined by nurse researchers.

The research problem in this study is therefore focused on the involvement of nurses in EOL care after the DNR decision has been made. The concern raised for the research enquiry is the extent of multinational nurses' participation in the comprehensive scope of EOL care. Nurses, more than other healthcare team members, are the frontline caregivers for patients nearing EOL on medical units. The literature shows that although providing care for dying patients and their families on medical units is an essential component of nursing care, nurses have experienced difficulties in meeting the unique needs of these patients and their families, particularly after the DNR decision has been made (Bunch 2001; Graham, Andrewes & Clark 2005; Hopkinson, Hallett & Luker 2003; Joel 2006; Yang & Mcilfattrick 2001).

The added focus is Islamic considerations for the Muslim patients and their family during the dying process. In the light of the literature review that shows that nurses' involvement in EOL care on medical units has received limited attention in nursing research the described problem is therefore legitimate as a research investigation (Borbasi et al. 2005; Ciccarello 2003; Cole 2003; Thompson, McClement & Daeninck 2006).

In summary, the purpose of this qualitative research was to gain an understanding of nurses' lived experience and to explore the meaning of their involvement in EOL care for patients when advanced and aggressive medical treatment is considered to have no further advantage.

1.4 The Research Question

In this thesis, an attempt is made to answer the following research question: 'what is the essence of the nurses' lived experience, and the meaning of their involvement in EOL care after a DNR decision has been made on medical units in Saudi Arabia?' Data was collected in the form of reflective journals of registered nurses who had the experience of providing EOL care after DNR in a Saudi Arabian hospital. Thematic analysis and interpretation of these reflective narratives was undertaken. Details of the methodology and the findings are provided in chapters three and four respectively.

1.5 The Aim of the Research

The aim of the research was to conduct a qualitative process of inquiry that would fulfil the following specific objectives:

1. Describe the nurses' lived experience in EOL care after a DNR decision has been made on medical units.
2. Explore the meaning of nurses' involvement in EOL care on medical units after a DNR decision has been made.
3. Establish the extent of nurses' involvement on medical units as team members in EOL care after a DNR decision is made.

1.6 Significance of the Research Study

This research study is important for various reasons. It is primarily directed at improving practice in EOL care by permitting an understanding of nursing involvement after DNR. A greater understanding of how nurses experience EOL care after DNR will eventually offer opportunities for improvement in the care of dying patients and their families on medical units. This has potential value also within the Middle East setting to influence a change in nursing practice. Nurses play an essential role in providing EOL care on medical units, so establishing their involvement level in EOL care is important because it could facilitate further development of their role as patient advocates (Borbasi et al. 2005; Ciccarello 2003). LoBiondo-Wood and Haber (1998:6) suggest that conducting nursing research could empower nurses in such situations in clinical practice, for instance EOL situations, and enrich nurses with nursing knowledge and skills that would allow them to provide sufficient support for patients and families to live through the dying process of the patients.

The results of the study would enrich nursing knowledge of EOL care related to DNR decisions and nursing roles within the context of this Middle Eastern hospital. Related components of knowledge gained could contribute to continuing nursing education by improving orientation and induction programmes for newly appointed international

nurses. Furthermore, the findings of this study would serve as starting-point for enhancing the content of staff in-service education and generation of best practice guidelines on EOL care on medical units (Mallory & Allen 2006).

For nursing administration, the findings of this study could facilitate revision of nursing policy on caring for dying Muslim patients, and could possibly lead to the generation of related best practice nursing guidelines through accompanying processes in nursing education. Lastly, the findings can be utilised as a basis for decisions and strategies about how best to support nurses at the bedside in delivering culturally congruent EOL care after DNR.

1.7 Definition of Terms

A set of operational definitions that pertain to the study are provided in this section.

Do-Not-Resuscitate (DNR)

A medico-legal decision of DNR is made by the 'most responsible physician' (MRP) and includes withholding of cardiopulmonary resuscitation, endotracheal intubation, mechanical ventilation, vasopressor therapy, and any required admission to critical care units for active treatment (NGHA 2007). Within the local hospital context, the DNR decision is referred to as 'NO CODE'. The DNR decision is used with patients who are suffering from an irreversible terminal illness and who are seen to be within the dying process (NGHA 2007). The decision is based on the physician's view that no benefits to the quality of the patient's life would be attained should the patient be resuscitated in the event of a cardiopulmonary arrest. The DNR decision, once taken and documented in the patient record, will be valid for six months, including subsequent admissions to the hospital within that period of time (NGHA 2007).

End-of-life (EOL) Care

EOL care can be viewed as the total and holistic care of patients from the time when their disease is no longer responsive to curative medical treatment up until the moment of death (Nordgren & Sörensen 2003; Smeltzer et al. 2008). The ultimate goal of EOL care is to prevent and relieve suffering and to improve quality of life for patients who are facing serious terminal illness. It is directed at responding to any physical, psychological, social, and spiritual needs that occur as a result of a serious biological situation or a life-threatening illness (Griffin et al. 2003; McCann et al. 2007; Smeltzer et al. 2008). The delivery of EOL care involves contributions from all members of the healthcare team in an interdisciplinary approach to ensure management of symptoms and preservation of quality of life as death becomes imminent, while ensuring a dignified and respectful death. EOL care is provided to terminally ill patients as well as to their families who experience related challenges as loved ones approach death (Allen 2008; Barbato 2005; Rich 2005).

Medical Unit

This is a general in-patient acute care setting that provides twenty-four hours of continuous care. It is a type of hospital unit used to provide medical examinations, treatment, and therapeutic services or procedures for a range of medical cases such as respiratory, neurological, diabetic and other acute or chronic medical conditions (NGHA 2009c). The unit comprises 20 to 25 beds, with average daily bed occupancy of 97% (NGHA 2009c), and provides a multidisciplinary care approach including rehabilitation, pharmacy, respiratory services and home healthcare referral. An admission episode may result in discharge, but often patients with chronic conditions may be admitted repeatedly to medical units within a year and their hospitalisation may end in death.

Patients

Muslim Arabic-speaking individuals admitted for in-patient acute medical care that provides both curative and supportive care. The primary medical diagnoses for these patients include endocrine, neurological, pulmonary and renal disorders and other chronic diseases that may result eventually in death on medical units. Chronic medical conditions are often associated with limitation in physical activity, oedema, loss of appetite, urinary and faecal incontinence, weakness, changes in mood, and haemodynamic instability (Kapo & Casarett 2006; Smeltzer et al. 2008). The reason for recurrent hospitalisation is related mostly either to decreased level of consciousness, fever, aspiration pneumonia, recurrent urinary tract infection, pressure ulcers, or other urgent medical conditions. Patients with chronicity may live for months with multiple serious illnesses resulting in extension of the disease pathway, which makes it difficult to predict prognoses. Patients with chronic diseases often experience gradual deterioration in their health status condition associated with exacerbation of these diseases (Kapo & Casarett 2006). The profile of these patients on medical units excludes cancer, brain death, or total dependence on mechanical ventilation, since these patients are admitted to other specialised hospital units.

Physicians

Consultant medical practitioners are employed at the hospital by the Department of Medicine to treat patients or to prescribe medication rather than to perform surgical procedures. Physicians are legally qualified, licensed and accredited as internal medicine consultants with clinical privileges to treat medical patients.

Registered Nurses

A registered nurse is a licensed healthcare professional who has completed an undergraduate programme of nursing studies, and is employed at the hospital to provide direct total patient care. He/she is responsible for executing the treatment plan by

performing the practice of nursing. He/she must hold a current nursing licence that is validated by a recognised nursing authority in their own home country. He/she is expected to assume responsibility within the framework of an approved job description for his/her own actions and behaviours while ensuring professional standards of practice and conduct. All nurses must be able to speak and write in English as the language of professional health care practice in Saudi Arabia.

1.8 Conclusion: Outline of the Thesis

The outline of the thesis consists of five chapters as follows:

In chapter one (**Introduction**), the background and context of nurses' involvement in EOL care after DNR are presented and discussed. The identification of the research problem, the research question and aim are also presented. This is followed by a brief discussion on the significant and potential contribution of the study to nursing practice, education and administration and further research. The final section of the chapter includes the operational definitions used in the study and an outline of the thesis chapters.

Chapter two (**Literature Review**) presents the approach, process and strategy employed to retrieve relevant literature for the study. A comprehensive overview of all the literature consulted throughout the research process from definition of the research problem until finalisation of the research thesis in December 2009 is presented and critically appraised.

Chapter three (**Methodology**) describes the research design and methodology for the study. In congruence with the research aim of the study to gain a better understanding

of the nurses' lived experience and involvement in EOL care after a DNR decision, a qualitative research methodology was therefore adopted. Within the qualitative process of inquiry, aspects of phenomenology have been used because it takes into account the actual experiences of nurses and the essence of meaning in EOL care after a DNR decision. The sampling method and participant recruitment strategies are outlined, followed by a description of the reflective journaling instrument. Details regarding the methods and procedures employed in the collection and analysis of data are also described. The chapter concludes with a discussion on ethical considerations and scientific issues of trustworthiness and comments on the rigour of the study.

Chapter four (**Results**) presents the results and analysis of data. A modified data analysis approach based on Coffey and Atkinson (1996), Johns' model of structured reflection (Johns 2004; Quinn & Hughes 2007) and Tesch (1990) has been utilised to identify the emerging themes reflecting the participants' own perspective of providing EOL care after DNR. Several verbatim quotes are included to allow the reader to obtain a first-hand sense of the data. The main themes and sub-themes that emerged from data analysis have been discussed within the context of the literature about the research topic.

Chapter five (**Research Findings: Discussion and Conclusions**) presents a focused discussion of the study findings within the context of the clinical and research settings. This chapter begins with an approach to the discussion on the research topic in relation to the phenomenon of nurses' involvement in EOL care after DNR. The research findings are discussed in the light of relevant literature including implications and recommendations for professional clinical nursing. Methodological and theoretical limitations are addressed in the conclusions, as well as the dissemination of the thesis in the conclusion of the chapter and thesis.

CHAPTER 2 LITERATURE REVIEW

2.1 Introduction

This chapter opens with the purpose of and approach to the literature review, the literature sources and their identification, and the search strategy used to retrieve literature. The literature review was focused primarily on identifying, critiquing, synthesising and summarising available literature pertinent to the research question, 'what is the essence of the nurses' lived experience, and the meaning of their involvement in "end-of-life" (EOL) care after a "do-not-resuscitate" (DNR) is made on medical units?' The chapter presents a review of the published literature, local and international, on nurses' involvement in EOL care after DNR on medical units. Discussion of the literature in this chapter also highlights the contextual uniqueness of the study by providing an overview of the health care services, EOL care and nursing profession in Saudi Arabia, with a focus on the Islamic perspective in EOL care. The chapter concludes with a discussion on the use of reflective journaling in nursing practice.

2.2 Purpose and Approach to Literature Review

The purpose of the literature review in qualitative research studies is threefold: (i) to establish a connection between the current study and previous research studies that will achieve coherence and congruency in the knowledge development process, (ii) to defend the research proposal, design and methodology used in the qualitative research study, and (iii) to reflect the iterative nature of consulting literature in the process of qualitative inquiry throughout the research study (Creswell 2003; Silverman 2004). Researchers are hence expected to demonstrate advanced academic searching skills

for literature that contributes to the research topic. This section also provides information on the approach utilised in the literature review.

The approach to the literature review occurred throughout the qualitative research inquiry. This approach commenced at the beginning of the research study and was aimed specifically at refining the research problem and question, positioning the study within the scope of current knowledge and the local context, and finally generating the research proposal to include a congruent qualitative design and methodology. By doing a preliminary literature review, the researcher sought to obtain a general grounding in the area of the proposed study and to justify the importance of the study (Burns & Grove 2005; Polit & Beck 2008). The main concepts that guided this phase were 'nurses' involvement', 'end-of-life care', and 'do-not-resuscitate decisions'. The initial search indicated that 'EOL care' as a research topic had been extensively researched, with an exhaustive volume of published articles available. This caused the researcher to refine the literature search further for specificity to the local context and nursing roles in EOL care, and also to use a structured approach to ensure rigour, as is shown later in section 2.3.

The literature review continued after the data collection had commenced and also during data analysis. The purpose was to undertake a further contextually related literature review on the research themes that emerged in relation to the research problem and research question. The continuation of literature review in qualitative inquiry is supported widely by expert qualitative researchers (Holloway 2005; Patton 2002; Ritchie & Lewis 2003; Silverman 2004; Silverman & Marvasti 2008; Speziale 2007a; Wolcott 2001) for the following reasons:

- further literature is needed after data analysis for the purpose of discussing emerging themes in the light of existing evidence.

- it promotes and supports relevance in selection of literature especially for vast topics, so that evidence is used in relation to the research purpose and objectives.
- it reduces the likelihood of bias by the researcher, so that prior information does not influence interpretation or analysis.

Mason (2002:173) links literature review during and after data analysis to focusing on different ways to present arguments. She asserts that embracing arguments as well as literature positions the qualitative researcher to link the findings from the data to the research context and purpose, so that knowledge about the phenomenon is gained. Four ways of approaching arguments in this approach are given by Mason (2002) as:

- (i) arguing evidentially, whereby evidence that is relevant is presented logically and appropriately to support arguments in relation to the data.
- (ii) arguing interpretatively or narratively, whereby the argument is linked to data meaningfully or reasonably, and therefore the evidence is used to support the interpretation to illustrate it is valid and appropriate in nuance.
- (iii) arguing evocatively or illustratively, whereby the argument evokes understanding or empathy towards the data on the phenomenon, and thus facilitates experiential understanding. In this regard, literature is used to illustrate or convey the meaning that supports the evocative argument.
- (iv) arguing reflexively or multivocally, whereby the argument illustrates a range of meaningful experiences, understandings or perspectives encountered in the data, including critique and indications of gaps or omissions in knowledge about the phenomenon under study.

The above four ways of using evidence in the continuation of literature review were applied as appropriate by me, as the researcher, within the framework of the qualitative research design used in my study. Therefore arguments and supporting literature were

selected according to their being exploratory and descriptive in nature in constituting a convincing argument.

2.3 Process of Literature Review

The process of literature search and review was modified based on Creswell's stepped approach (2003). This systematic and methodical process was adapted and used to provide structure and maintain rigour in the selection and review of the relevant literature. In addition to Creswell's seven steps (2003:33), I added an eighth step to adapt the process for my study. Step eight is supported by Silverman (2004), whereby existing literature is reviewed in the light of the emerging themes by comparing and contrasting findings, and detecting similarities and differences. Step eight, therefore, represents a search mechanism of continuation of the literature review that directed me back to focused literature after the emergence of the themes in the research findings. Therefore, steps one to seven constituted the preliminary literature review, whereas step eight concluded this phase, and accordingly, the literature search and review was a continual process. A summary of the eight steps is as follows:

Step 1: Key terms were determined and used to locate literature relevant to the research topic from different sources. The key terms emerged from the research question and guided the initial process of literature search. These were 'end-of-life', 'do-not-resuscitate', 'decision-making process', 'nurses' involvement' and 'medical units'. On the other hand, the supportive key terms used to qualify the primary terms were as follows: 'palliative care', 'terminal care', 'comfort care', 'compassionate care', 'chronicity', 'chronic illness', 'chronic condition', 'nurses' role', 'nurses' interventions', 'nursing', 'physicians', 'death', 'dying', 'Islam', 'Muslims' and 'Saudi Arabia'.

Step 2: The identified key terms were used for searching and locating a variety of relevant literature. Axford et al. (2004), Dane (1990), Cooper (1998) and Gash (2000) suggest that various primary and secondary sources should be used for searching. Primary literature sources are mainly those articles presented by the original author(s) of an idea, concept, theoretical framework or research report and include original institutional policy documents of the hospital at which the research was conducted. Secondary literature sources are those articles that generally are prepared by authors who encapsulate and represent the original viewpoints from the primary sources (Burns & Grove 2005).

Step 3: The literature was selected according to relevance on the research topic. Results of the search process produced a range of literature resources that included theoretical and empirical articles and seminal research studies related to the research topic. The priority at this stage, however, was to focus on empiric research undertaken in nursing because it showed the most recent data on the research topic (Polit & Beck 2008). To obtain full-text articles, databases available online and the electronic library facilities of both the university and hospital were accessed.

Step 4: The selected literature was screened to identify fundamental articles on topic of the research study. This step involved systematic scanning and methodical review of the contents of the articles to identify their contribution to the overall understanding of the literature on the research topic (Burns & Grove 2005:104). The preliminary literature search and review that preceded the data collection revealed, however, that only one research study had been conducted to examine nurses' perspectives on EOL on medical units (Thompson, McClement & Daeninck 2006), thus supporting the overall need for this study.

Step 5: A literature map was designed to form a substantial picture that related the research study to the existing body of the literature on the research topic. In this regard, the relevant literature was grouped into literature subjects as follows: EOL, DNR, chronicity and reflective practice. These subject classifications were constructed to enable the researcher to locate essential information quickly and easily (Polit & Beck 2008).

Step 6: Important issues identified in the most relevant literature form the basis for developing the research proposal. Concurrently, the retrieved literature used in both in-text citations and reference lists was reviewed and checked for the purpose of maintaining consistency, congruency and completeness (Burns & Grove 2005).

Step 7: Summaries of the major themes and trends found in the literature were combined and organised in the literature review section for the research proposal that I submitted to the university and to the hospital research and ethics committees, and were assembled into the final literature review chapter of this thesis.

Step 8: The literature search and review were expanded after data collection commenced and during data analysis by use of the supportive key terms (Silverman 2004). The retrieved literature on EOL care after DNR was then reviewed in the light of the emerging themes by comparing and contrasting findings so that similarities and differences were identified (Silverman & Marvasti 2008).

2.3.1 Search Strategy

The search strategy therefore followed the modified structure of the eight steps adapted from Creswell (2003). Several specialised electronic search engines were used, including CINAHL, Science Direct, MEDLINE, Sage, Ovid, Blackwell Synergy, and

Medscape Nursing. Immediate sourcing of these databases was facilitated through organisational access at the worksite and the electronic library facilities of the university. Multiple Boolean operators (AND, OR, and NOT) formulas, which included different combinations of key words, were used in the search process to retrieve references from the bibliographic search engines (Burns & Grove 2005; Polit & Beck 2008). Related sites found on the World Wide Web were also consulted as primary source of information, including the World Health Organization (WHO), International Council of Nursing (ICN), and Joint Commission International (JCI). Relevant literature from the local organisations related to EOL care after a DNR order has been made was also included for the purpose of generating the research thesis.

The located literature was stored in the researcher's personal computer and organised alphabetically to permit easy access. Concurrently, a record sheet was developed to ensure consistent documentation of the researcher's activities in retrieving the different literature, which included search strategy, history and results (Polit & Beck 2008). Relevant sources were grouped initially in ten fields: (i) chronicity, (ii) EOL care, (iii) medical futility, (iv) DNR, (v) EOL nursing care, (vi) EOL care research on medical units, (vii) EOL care research in non-medical units, (viii) nursing education on EOL care, (ix) Saudi Arabian context and (x) Islamic considerations. Within each specific field, located literature was then subdivided into several topics pertaining to patients, families, nursing and other healthcare professionals.

2.4 Review of Literature

The following sections provide a critical summary of the current state of knowledge in relation to nurses' lived experience, and the meaning of their involvement in EOL care after a DNR has been made on medical units. The presentation and discussion of

literature is structured into four subheadings, which are chronicity in healthcare, EOL care, DNR decision, and nurses' involvement in EOL care and DNR. Under each section, key issues are identified and relevant literature reviewed and discussed.

2.4.1 Chronicity in Healthcare

An increasing number of people in Saudi Arabia have at least one chronic healthcare condition, and the prevalence of chronic conditions is regarded as accelerating dramatically (Al-Nozha & Osman 1998; Elshaer et al. 2009; Salman & Al-Rubeaan 2009; Shatoor et al. 1998). It is considered that the increasing incidence of current healthcare requirements is the result of chronic conditions, and that the burden of such care is thus continuously increasing (Al-Ghwery & Al-Asmari 2004). It is also believed that chronic conditions are responsible for a great number of hospitalisations and death annually in Saudi Arabia (Elshaer et al. 2009). The WHO (2002) predicts that by the year 2020 chronic conditions will be responsible for up to 60% of the global burden of disease.

The term 'chronic condition' has many definitions and meanings in the medical literature. For instance, Stedman's Medical Dictionary (2006:376) defines chronicity as 'the health-related state of being chronic or lasting on a long-term basis'. Chronic health conditions, according to the WHO (2002:11), are those 'that require ongoing management over a period of years or decades', and include: (i) non-communicable diseases, such as diabetes and asthma, (ii) persistent communicable diseases, such as HIV/AIDS, (iii) specific long-term mental illnesses, such as depression and schizophrenia, and (iv) ongoing disability in physical structure, such as amputation and paralysis. Chronic conditions can also be defined as medical illnesses or diseases that require a prolonged treatment course and for which complete recovery and cure are almost unobtainable (Smeltzer et al. 2008). These diseases include, for example,

chronic obstructive pulmonary disease (COPD), end-stage renal disease (ESRD), chronic heart failure (CHF), neurological disorders, diabetes and stroke (Barnett 2006; Fallon et al. 2006; Frich 2003; Kapo & Casarett 2006).

Several factors have contributed considerably to the increasing incidence of people with chronic conditions internationally and locally. Amongst these are the witnessed advances in medical sciences and technology, which have prolonged life expectancy (Smeltzer et al. 2008; WHO 2002). On the other hand, aggressive treatment of serious acute conditions, such as myocardial infarction, has resulted in prolonging the lifespan of people with coronary artery disease. Ageing, in general, is most likely to be accompanied by chronic medical conditions (Smeltzer et al. 2008; WHO 2002). Elderly people are, therefore, considered to be at an increased risk of developing multiple chronic, life-threatening and terminal illnesses (Matzo 2004). Other contributory factors, such as tobacco smoking, stress, improper dietary habits and obesity, have also increased the likelihood of people developing chronic diseases and illnesses (Al-Baghli et al. 2008; Al-Saif et al. 2002; Smeltzer et al. 2008; WHO 2002).

Patients with chronic diseases and their families often develop a variety of unique needs and demands while they seek to adapt to a new quality of life (Cumbie, Conley & Burman 2004; Smeltzer et al. 2008). Additionally, instead of dying suddenly, patients with chronic diseases generally experience a progressive deterioration accompanied by acute exacerbations of their illnesses (Kapo & Casarett 2006). Prognostication for patients with chronic conditions, however, can be difficult and unpredictable, and remains a challenge for healthcare professionals, specifically when deciding if patients have reached the terminal phase of their life (Barnett 2006; Fallon et al. 2006; Rogers & Addington-Hall 2005). Throughout, certain phases of the disease process may require advanced medical technology for patients to survive, as in the last stage of COPD, ESRD and stroke (Smeltzer et al. 2008). Others may require intermittent hospitalisation

for medical treatment and care that lasts for weeks, months or years. Quite often, however, these patients die in hospitals as the result of a concurrent progressive terminal illness that necessitates hospitalisation for treatment of chronic diseases (Auer 2008; Smeltzer et al. 2008).

Dying from progressive chronic diseases is a frequent occurrence in hospitals rather than in patients' homes (Addington-Hall & Ramirez 2006). Although the main goal of medical units is to help patients to survive acute phases of their illness trajectories, several research studies have shown that patients with chronic non-malignant diseases are less likely to receive appropriate palliative and EOL care during their stay on these units (Fallon et al. 2006; Hopkinson, Hallett & Luker 2003; Rogers & Addington-Hall 2005; Toscani et al. 2005; Wallerstedt & Andershed 2007). Jacobs et al. (2002:296), in their study on hospitalised patients dying from chronic diseases, reported that, despite a patient's death being anticipated, a paradigm shift from a 'cure-oriented' plan to palliative care was lacking. According to the WHO (2002), the existing models of acute hospital care may not necessarily be suitable for chronic health problems. Nonetheless, there is a growing awareness by healthcare professionals that patients with chronic conditions experience unique physical, psychological, social, and spiritual distress (Rogers & Addington-Hall 2005).

2.4.2 End-of-Life (EOL) Care

As mentioned in the previous section, the increasing incidence of chronic diseases and the life-prolonging measures in healthcare advancement have influenced the management of extended illness and dying trajectories, and have raised healthcare professionals' awareness of the delivery of EOL care in acute hospital settings (Costello 2001; Griffin et al. 2003; Jezuit 2000; Pang 2003; Smeltzer et al. 2008; Svantesson et al. 2006). In this regard, Matzo (2004) argues that the individual's perception of EOL

has changed dramatically from a period of life-threatening illness that usually lasts for hours or days to a period of steady decline caused by incurable chronic illnesses that may last for months or even years.

EOL care relates to dying patients and is often used interchangeably with terms such as palliative, terminal and comfort care (Ciccarello 2003; McCann et al. 2007; Nuss, Hinds & LaFond 2005; Shotton 2000). Palliative care that is usually associated with cancer has been used as an alternative definition for EOL care (Ciccarello 2003; Froggatt et al. 2006). This is perhaps because the philosophical underpinnings and components of EOL care are relatively similar to those for palliative care (Ersek & Ferrell 2005; McCann et al. 2007). It is argued, though, that the scope of palliative and EOL care is constantly evolving and expanding (McCann et al. 2007; Smeltzer et al. 2008). This has resulted in a somewhat blurred definition of EOL care (Shotton 2000) and an uncertainty in identification of the start and end points of EOL care (Borbasi et al. 2005). On one hand, a DNR decision may represent the point at which EOL care begins, while on the other hand, EOL care could be regarded as when the medical evaluation of rapid or gradual worsening of chronic conditions has been confirmed, and when all therapeutic measures have been exhausted (Smeltzer et al. 2008). The latter description is aligned to the comprehensive and widely accepted WHO definition of EOL care as 'the active, total care of patients whose diseases are not responsive to curative treatment' (Griffin et al. 2003:312S).

The concept of EOL care can be regarded as a continuum of care, from treatable and curable care to terminal and life-ending care, that is, from a point of active treatment regimes to therapeutic and supportive measures aimed at a comfortable dying process that ceases when cardiopulmonary functioning expires. Heyland et al. (2006) expand on EOL care as being comprehensive, quality care at an essential phase of a patient's life, and incorporating a shared responsibility of healthcare professionals, including

nurses. Griffin et al. (2003), however, confirm that the goal of EOL care, irrespective of the DNR decision, is sustaining quality of life in terms of the patient's physical, psychological, spiritual and social needs, and to provide support to his/her family. In this context, Dahlin (2004) argues that the core EOL focus is to provide comfort until death regarding patient privacy, dignity, religion, values and wishes. Pang (2003:237) encapsulates EOL care as affirming life that concludes in death as part of the life-death destiny in the human experience.

EOL care can also be defined as complete and extensive care provided at a time when a disease is no longer responsive to curative medical treatment (Nordgren & Sørensen 2003). Comprehensive EOL care not only involves provision of compassionate care for dying patients, but also helping their families to cope with the imminence of death of their loved ones (Allen 2008; Rich 2005). Therefore, the ultimate goal for healthcare professionals would be to achieve the best possible quality of life for patients and their families as death approaches. As mentioned earlier, quality EOL care acknowledges and responds to the physical, psychosocial and spiritual needs of dying patients and their families (McCann et al. 2007; Smeltzer et al. 2008). The dying process can be associated with unpleasant feelings and suffering for patients, families and the involved members of the healthcare team (Barbato 2005). The philosophy underpinning EOL care is twofold: to curtail patients' suffering and to exalt quality of life (Abu-Saad & Courtens 2001; Joel 2006; Mount, Hanks & McGoldrick 2006). Although it might be relatively easy to comprehend the philosophy of EOL care, however, it is much harder to determine how to render quality patient care during the final days and moments of the patient's life, particularly in a busy hospital setting.

One issue that is receiving notable and growing attention in the literature on EOL care is awareness and sensitivity to the cultural and spiritual disparities between dying patients and members of the healthcare team (Nolan & Mock 2004). Indeed, acknowledging and

responding to the cultural and spiritual needs of patients and families at the EOL are considered nowadays as essential determinants in providing quality EOL care, particularly in the acute hospital setting (Blais et al. 2006; Kemp 2005; Thomas et al. 2008). A study of the importance of religious practices for patients at the EOL showed that the majority of participants perceived religion and spirituality as important in their strategies for coping with death and dying (Kub et al. 2003). The most frequently cited concern by patients at the EOL is that their cultural and spiritual needs are barely addressed in hospitals, and that there is a need to enhance the awareness and knowledge of healthcare providers in these influential domains (Brown, Whitney & Duffy 2006; Mazanec & Tyler 2003; Thomas et al. 2008). Mazanec and Tyler (2003) conclude that healthcare providers cannot assume provision of quality EOL care without adequate knowledge of patients' beliefs and practices at the EOL.

The exigency for improved EOL care in hospitals is thoroughly documented in the scientific literature (Becker et al. 2007; Bookbinder et al. 2005; Campbell 1996; Evers, Meier & Morrison 2002; Heyland et al. 2006; Jacobs et al. 2002; London & Lundstedt 2007; Lynn, Schuster & Kabcenell 2000; Willard & Luker 2006), yet few strategies have been implemented and limited changes in practices have been reported. Attending to the physical, psychological, social and spiritual needs of patients at the EOL presents a real challenge to healthcare professionals, and in particular nurses, who spend more time with patients and their families than other members of the healthcare team (Mazanec & Tyler 2003). Several studies have reported considerable deficiencies in the provision of EOL care for individuals with serious life-threatening illnesses in acute hospital settings (Fallon et al. 2006; Hopkinson, Hallett & Luker 2003; Rogers & Addington-Hall 2005; Toscani et al. 2005; Wallerstedt & Andershed 2007).

Barnett (2006) argues that patients who have overwhelming chronic diseases have comparable needs to those of cancer patients, and that they are also in need of

palliative care. The uncertain prognostication and trajectories of chronic illnesses, however, could prevent dying patients on acute medical units from receiving appropriate and quality EOL care (Matzo 2004; Peden, Tayler & Brenneis 2005; WHO 2004). Chiarella and Duffield (2007) claim that existing models of acute care are less likely to meet the accelerated demand of the patients who are in need of palliative and EOL care. Stevens et al. (2007) and Rogers and Addington-Hall (2005) conclude that palliative care at the EOL should be in response to patients' needs, rather than driven by an existing medical diagnosis.

On the other hand, there is increasing recognition that the provision of holistic EOL care on medical units is a responsibility of all members of the healthcare team (Luhrs & Penrod 2007; Mount, Hanks & McGoldrick 2006). An extensive review of literature on the communication between nurses and families in EOL care is provided by Lowey (2008). She concludes that effective communication between healthcare team members, patients and families regarding the care plan at the EOL is an essential predecessor to achieving quality EOL care and to minimising conflicts and tensions that can delay the paradigm shift from curative to supportive and comfort care. According to Gauthier (2008), the most important challenge for successful communication between different parties in EOL care arises from the hectic working environment on medical units. It is nevertheless crucial for healthcare team members to work together as a collaborative professional team to support dying patients and their families if the aim is to deliver optimal EOL care after DNR (Lynn, Schuster & Kabcenell 2000; Mitchell et al. 2006; Vogel-Voogt et al. 2007). This point is reiterated by Carline et al. (2003) and Thiers (2006), who claim that interventions at the EOL can only be effective when healthcare providers communicate and cooperate effectively with each other as an interdisciplinary team. Notwithstanding that, research studies have shown that lack of efficient communication and collaboration amongst the healthcare team members continues to be a constant obstacle to the provision of quality EOL care (Beckstrand,

Callister & Kirchhoff 2006; Beckstrand & Kirchhoff 2005; Dunne, Sullivan & Kernohan 2005).

2.4.3 Do-not-Resuscitate (DNR) Decision

One of the common medical and ethical issues faced by healthcare professionals dealing with patients who have chronic illnesses or potentially life-threatening diseases is the decision to withhold cardiopulmonary (CPR) resuscitative efforts in the event of cardiac or respiratory arrest (Dahlin 2004; Joel 2006; Kinlaw 2005; O'Keefe & Crawford 2002). There is no doubt that scientific literature support exists for the DNR decision in medical care. Costello (2002) advocates withholding active measures to allow cardiac and pulmonary functioning to cease naturally, whereas Hildén et al. (2004) and O'Keefe and Crawford (2002) assert that it is a measure to prevent cardiopulmonary resuscitation (CPR), but they do not specify whether measures such as intravenous antibiotics or electrolytes should be withheld. Costello (2002), Hohenleitner (2002) and Jezuit (2000) agree that DNR decisions prevent unwanted suffering for the patient, but there is a notable omission in their perspectives on EOL care after the DNR decision. On the other hand, the DNR decision can be regarded as the turning point of medical treatment and care from a curative to a supportive and palliative approach (Heaney et al. 2007), which includes documentation of the DNR decision in the patient's chart.

The concept of the so-called DNR has primarily raised an ongoing debate and discussion in the literature about the futility of therapeutic interventions that have no meaningful purpose for patients facing terminal life illness (Shevell 2002; Slowther 2006; Von Gruenigen & Daly 2005). It has been argued, however, that the decision of DNR is medically justified by the assumption that aggressive treatment would no longer be able to achieve beneficial results in terms of patients' physiological and psychological well-being (Lawson 2004; Slowther 2006). According to Heaney et al. (2007), withdrawing

life-extending medical treatment would optimally assist dying patients to attain a peaceful and respectful death, and unwanted prolongation of life would not be caused by any advanced medical intervention. This approach is supported since the incidence of success of CPR in patients with overwhelming chronic conditions is generally regarded as fairly low, and in life-threatening situations associated with chronicity could be considered as futile (Wilson & Pace 2004).

Traditionally, physicians are considered to be legitimately responsible and formally accountable for the DNR decision (Cosgrove, Nesbitt & Bartley 2006; Hohenleitner 2002; Blais et al. 2006; Purtilo 1993), whereas other healthcare professionals are less likely to be involved in this decision-making process (Inghelbrecht et al. 2008; Benbenishty et al. 2006). The level of participation by healthcare professionals in the DNR decision-making process varies, and is usually influenced by certain social and cultural considerations. In Saudi Arabia, physicians are at the forefront of the decision-making process and are given the authority for the DNR decision by a religious ruling known as a 'fatwa' from the Ministry of Islamic Affairs (Permanent Committee for Scientific Research and Religious Jurisprudence 1989). Some authors, however, argue that the assertive style that physicians hold in promoting the DNR decision is part of their role, whereas nurses are regarded as compassionate and not necessarily in the foreground because their focus is usually the patient and dealing with emotional family situations (Brett 2002; Costello 2002; Georges & Grypdonck 2002).

It is possible, however, that although the main reason for the DNR decision is to ensure healthcare team members refrain from conducting CPR, the consequences of such a decision can lead to confusion and ambiguity for team members, and may result in harm to patients by providing them with inadequate and inappropriate medical care (Hildén et al. 2004; Jezuit 2000; Shotton 2000). At the hospital site at which this study was undertaken the specific administrative policy and procedure on DNR decisions are that

patients who have irreversible terminal illness will receive all types of medical interventions except 'CPR, endotracheal intubation, mechanical ventilation, vasopressor therapy, or admission to intensive care units' (NGHA 2007). It is advised, therefore, that the DNR decision should be highlighted sufficiently so that all concerned healthcare team members are aware of what is to be done or not to be done in the case of life-threatening event (Dubois 2005; Guarisco 2004; Kinlaw 2005).

Despite the close therapeutic relationship between nurses and patients and their families in hospital settings, the nurses' role in the DNR decision-making process remains obscure. It is noteworthy that research on nurses' involvement in the DNR decision-making process (Calvin, Lindy & Clingon 2009; Halcomb et al. 2004; Hildén et al. 2004; Hildén & Honkasalo 2006; Svantesson et al. 2006; Jezuit 2000; Werner, Carmel & Ziedenberg 2004) has produced conflicting results. Ideally, nurses, by virtue of their round-the-clock work, spend more time at the bedside with patients and their families compared with other healthcare professionals, and would then perhaps be in a better position to discuss EOL care options. There is no firm evidence, however, that nurses, as essential members of the healthcare team, would like to take part in the decision-making process (Calvin, Kite-Powell & Hickey 2007; Georges & Grypdonck 2002). Supporting that premise, a study by Heland (2006) has shown that many nurses do share concerns pertaining to their participation in the DNR decision-making process. Studies of nurses' desired and actual role in decision-making have also revealed variations of related interest (Robichaux & Clark 2006). Furthermore, there is minimal information about factors that impede the level of involvement by nurses in the decision-making process (Inghelbrecht et al. 2008). Notwithstanding that, it has not been established empirically that nurses' role in EOL care after a DNR decision has increased corresponding to the decreased interest level exhibited by physicians (Gray, Ezzat & Volker 1995; Shotton 2000).

2.4.4 Nurses' Involvement in EOL care and DNR

Nurses perform a pivotal role in helping dying patients on medical units attain freedom from pain and other distressing symptoms. They have the longest contact with patients in EOL care after DNR, and therefore have greater opportunity for communication with patients and their families than any other healthcare team member (Arnold & Boggs 2007; Mitchell et al. 2006). This unique experience therefore allows nurses to influence enormously the last moments of a person's life and the indelible memory of the death of a loved one for family members (Smeltzer et al. 2008). Nurses, however, can also influence other healthcare team members' capacity for meeting the needs of patients and their families at the EOL (Thiers 2006; Thompson, McClement & Daeninck 2006). Badger (2005:63) argues that nurses provide 'comfort care' instead of 'rescue care', and offers this term as a more suitable definition for nursing in EOL care after DNR. Nurses are, nonetheless, responsible for provision of continuous care at the EOL for patients, including provision of family support within an acute care context (Ciccarello 2003; Tuttas 2002; Yang & Mcilpatrick 2001).

Borbasi et al. (2005), Ciccarello (2003) and Hayes (2004) suggest that providing appropriate EOL care to DNR patients may present complex challenges for nurses. It is claimed that providing EOL care for patients and families is one of the most demanding and stressful experiences for nurses in their daily practice (Beckstrand & Kirchhoff 2005; Rushton, Spencer & Johanson 2004; Weigel et al. 2007). Thompson, McClement and Daeninck (2006) confirm this point in their study on nurses' role perceptions regarding quality of EOL care on a medical unit, and report that there are a range of nursing issues which require consideration, such as recognition in EOL care, provision of an EOL care plan, and nursing support to family members. Furthermore, nurses must deal with their own personal moral, cultural and emotional responses alongside the dying

process of the patient (Borbasi et al. 2005; Ciccarello 2003; Hayes 2004; Thompson, McClement & Daeninck 2006).

The quality of EOL care in hospital settings has gained focused attention in the nursing literature (Ciccarello 2003; Eues 2007; Virani & Sofer 2003). Research studies on EOL care have focused on physical and psychological needs of patients and their families and quality of life as the hallmark of care (Rogers & Addington-Hall 2005). Indeed, caring for patients at the end of life on medical units not only requires meeting the physical needs but also the psychological, spiritual and social needs of both patient and family (McCann et al. 2007; Smeltzer et al. 2008). Henderson (2004:233) suggested fundamental aspects of care at the EOL that are best achieved by nurses. Examples of the nursing care of patients who are approaching EOL on medical units may include assessing physical condition, providing wound care, managing and controlling signs and symptoms, relieving suffering and pain, restoration of functional capacity, and collaboration with other members of the interdisciplinary team (McCann et al. 2007; Smeltzer et al. 2008).

Given the key role that nurses play in EOL care in acute hospital settings, it is important therefore for nurses to be familiar with what contributions they can make to ensure patient care outcomes are achieved at the EOL (Shotton 2000). Medical nurses, in particular, are traditionally educated to provide acute care in their specific settings. When the goal of care shifts from a curative to an EOL care mode, however, these nurses may often feel ill-equipped and unprepared to deal with the unique evolving needs of dying patients and their families (McCaughan & Parahoo 2000; Weigel et al. 2007). Such feelings of unpreparedness may perhaps be because of the lack of proper education and training on EOL care in acute hospital settings (Ersek & Ferrell 2005; Ferrell et al. 2000; Meraviglia, McGuire & Chesley 2003; Raudonis, Kyba & Kinsey 2002). It is therefore necessary to equip nurses with the knowledge and skills for them

to be able to provide comprehensive and respectful EOL care (Henderson 2004; Peden, Tayler & Brenneis 2005; Rushton, Spencer & Johanson 2004).

There have been many reports in the literature regarding EOL nursing care in non-medical units. These published studies have focused primarily on the provision of comfort care to cancer patients (White, Coyne & Patel 2001) and upon the rendering of terminal care for dying patients in critical care areas (Beckstrand, Callister & Kirchhoff 2006; Bunch 2001; Calvin, Lindy & Clingon 2009). The contextual settings for these studies were diverse, with the majority being conducted in critical care units (Badger 2005; Beckstrand & Kirschhoff 2005; Gross 2006; Halcomb et al. 2004; Hov, Hedelin & Athlin 2007; Sorensen & Iedema 2007; Yang & Mcilpatrick 2001), a few undertaken in haematology units (Araújo, Silva & Francisco 2004; McGrath & Holewa 2006), and the remainder conducted in other hospital and non-hospital settings (Costello 2001; Cramer et al. 2003; Dunne, Sullivan & Kernohan 2005; Heaston et al. 2006). A considerable amount of research has also focused on exploring ethical dilemmas encountered by nurses in EOL care situations (Doutrich, Wros & Izumi 2001; Georges & Grypdonck 2002; Maeve 1998). Withholding a life-sustaining treatment such as CPR represents a recurring challenge for nurses, who, by virtue of their work, spend an increased amount of time with patients and families in EOL care after DNR in hospitals (Hayes 2004; Scanlon 2003).

Despite this, research examining the role of nurses in EOL care on medical units is sparse, with only a few studies conducted in the last ten (10) years (Graham, Andrewes & Clark 2005; Hopkinson, Hallett & Luker 2003; Mitchell et al. 2006; Thompson, McClement & Daeninck 2006; Wallerstedt & Andershed 2007). These studies utilised qualitative approaches to explore nursing care provided for dying people on medical units. It is noteworthy that the researchers all reached the same conclusion that understanding nurses' experiences in EOL care on medical units has the potential to

impact positively on initiatives to provide quality care for patients and their families at the EOL. Unfortunately, there has been no clear evidence of this, nor were studies found on nurses' lived experience and the meaning of their involvement in EOL care after DNR on medical units in Saudi Arabia.

Hopkinson, Hallett and Luker (2003), on the basis of a phenomenological study of nurses' experience of EOL care on medical units, reported that providing care for dying patients and their families tended to cause frustration and feeling of unease for nurses, as they were unable to answer questions from patients, which resulted in them subsequently, developing a sense of psychological isolation from other healthcare team members. Similarly, a phenomenological study of nurses' experience in caring for terminally ill patients in hospital settings, reported by Wallerstedt and Andershed (2007), included expressions of dissatisfaction from nurses, owing to perceptions of inadequate cooperation from the other members of the healthcare team during the final phase of a patient's life. Using data from nurses' reflections of participation in EOL care, Graham, Andrewes & Clark (2005) also report that nurses often develop a sense of failure when they are unable to achieve the predetermined goals at the EOL. The research studies outlined above emphasise the importance of nurses building a therapeutic relationship with patients and families, the establishment of efficacious and solid communication and interpersonal interactions, and support for nurses in providing quality EOL care.

2.5 Contextual Uniqueness of the Study

Describing context in qualitative research is regarded as essential, whatever methods are used. A number of expert qualitative writers (Holloway 2005; Patton 2002; Ritchie & Lewis 2003; Silverman 2004; Silverman & Marvasti 2008; Speziale 2007a) stress the

need for describing and understanding the research context in qualitative studies for the following reasons:

- to place the phenomenon under study in its real-life situations, which therefore preserves the naturalistic perspective of qualitative methodology and inquiry
- to provide sound justification and rationale for the use of research design, sampling strategy and data collection methods
- to retain links to the collected data and to analyse them as an integral part of the overall context
- to provide readers with sufficient information about the study context so that they are able to judge the credibility of the research findings
- to maintain coherence and integrity amongst the research question, purpose, objectives and data collection and analysis methods

Yin (2003) asserts that phenomena and contexts are interwoven and should not be separated in the real-life situation. The attempt to understand the phenomenon of nurses' involvement in EOL care after DNR, therefore, needs to shed light on different aspects and conditions embodied in the context that are pertinent to the occurrence of the phenomenon under study, while retaining a holistic view of the real-life events (Yin 2003). Furthermore, the context becomes the framework for understanding the nurses' lived experience and level of involvement in EOL care after DNR on medical units.

The following sections are intended to give a contextual overview of current healthcare services and EOL care practices in Saudi Arabia, with in-depth information about the hospital setting. Specific details on the nursing profession in Saudi Arabia and how nurses use reflective journaling in their daily practice are also presented. Further, the discussion will include an overview of the Islamic perspectives of health care and EOL care in Saudi Arabia.

2.5.1 Healthcare Services in Saudi Arabia

The Kingdom of Saudi Arabia (KSA) is one of the most rapidly developing countries in the Middle East, and has experienced considerable expansion of its socioeconomic status, including healthcare services, during the past two decades (Marrone 1999; Tumulty 2001). It occupies almost four-fifths of the Arabian Peninsula, which is around 2,250 million square kilometres (Mufti 2000; Sebai 1985). Arabic is the official language in Saudi Arabia. The religion of Islam is treated as both a belief system and a way of life. The presence of the two holy cities, Makkah and Madinah, has distinguished the Kingdom of Saudi Arabia from other Muslim countries (Al-Osimy 1994). Islamic law (Sharia), based on the Qura'an (the holy book) and the teachings of the prophet Muhammad, form the foundation for Saudi Arabia's constitution, civil, and legal codes (Al-Osimy 1994; Marrone 1999).

Saudi Arabia has witnessed a remarkable increase in population growth over the past two decades (Al-Osimy 1994; Mufti 2000). In order to meet the healthcare needs of this growing population, the Ministry of Health (MOH), as the main government healthcare agency in Saudi Arabia, adopted a series of five-year development plans that coordinated and planned healthcare services (Al-Osimy 1994; Mufti 2000; Sebai 1985). The seventh five-year plan (2000-2005) identified efficiency in productivity and use of healthcare services as major strategic objectives (Mufti 2000). The healthcare delivery system in Saudi Arabia is divided into two groups: government agencies and the private sector (Al-Osimy 1994; Mufti 2000). The primary governmental healthcare agency is represented by the MOH, which is responsible for about 65 per cent of healthcare services provided in Saudi Arabia (Mufti 2000). Other government healthcare provider agencies include the National Guard Health Affairs (NGHA), the Ministry of the Interior, and the Ministry of Defence and Aviation, all of which provide advanced levels of health care to their personnel and dependents (Mufti 2000).

2.5.2 EOL Care in Saudi Arabia

Despite the home environment being the preferred place of death for the majority of people in Saudi Arabia, few patients actually achieve this goal (Al-Nozha & Osman 1998; Elshaer et al. 2009; Salman & Al-Rubeaan 2009; Shatoor et al. 1998). The reasons for this vary from rapid and sometimes unexpected deterioration, to insufficient support from community healthcare services, to caregivers' physical & emotional exhaustion. As a result, the acute hospital is often the setting where patients die. Nevertheless, research studies and reports that provide detailed information about the EOL care interventions that patients and families receive in acute hospitals in Saudi Arabia are scarce. Gray, Ezzat and Volker (1995) provided a descriptive account of a palliative care service for terminally-ill patients in a large hospital in Saudi Arabia. Their study showed a considerable and positive impact on the provision of EOL care for patients and their families who were selected to be involved in this newly developed service.

The provision of quality EOL care in Saudi Arabia requires an understanding of the cultural, social and religious considerations that influence perspectives of both patients and families interpretatively on death and dying. The need to improve EOL care for terminally- and critically-ill patients was a major stimulus behind the development of palliative care services in the main hospitals in Saudi Arabia (Gray, Ezzat & Volker 1995). Recent years have seen an increase in the number of professionals involved in providing palliative and EOL care for patients with malignant and non-malignant terminal illnesses in acute hospital settings. Moreover, the last few years have witnessed several initiatives to improve EOL care in hospitals in Saudi Arabia, which included symposia, seminars and conferences on EOL care (Appendices 18 & 19). At this research study hospital site, a number of policies and procedures have been developed to guide healthcare team members involved in EOL care for terminally-ill patients,

particularly after DNR, with the aim of providing quality patient care (NGHA 2007; NGHA 2009b). It is, however, assumed that quality EOL care starts with an understanding of the disease process and dying trajectories and most include the nursing knowledge and skills required at each stage of the dying process (Matzo 2004). Nonetheless, it is apparent that minimal resources are available for expatriate nurses in Saudi Arabia to guide them in the provision of culturally competent EOL care for Muslim patients and their families.

2.5.3 King Abdulaziz Medical City-Riyadh (KAMC-R) Health Facility

The King Abdulaziz Medical City-Riyadh (KAMC-R), which is the main hospital of the National Guard, is located in Riyadh, the capital city of Saudi Arabia. The KAMC-R, which has recently increased its bed capacity to 850, was established to provide primary, secondary and tertiary health care for National Guard personnel and their families, as well as other eligible and sponsored patients (NGHA 2009a). In recognition of its provision of safe and quality patient care, the hospital was awarded an accreditation in 2006 and 2009 by the Joint Commission International (JCI), the largest accreditor of healthcare organisations in the United States of America (JCI 2008). The hospital is also affiliated with the King Saud bin Abdulaziz University for Health Sciences in Riyadh, Saudi Arabia which has resulted in an increased emphasis on medical and nursing research at the facility. Because of its solid reputation within the local Saudi community, the hospital has experienced a constant increase in its bed occupancy rate, which in 2008 and 2009 reached more than 95% (NGHA 2009a). Three essential components constitute the KAMC-R: Medical, Nursing and Ancillary services. The Department of Medicine, which is one of the largest medical departments at KAMC-R, accommodates about 20 per cent of the total number of hospital beds, with an average bed occupancy of 170 patients on daily average bed census (NGHA 2009a).

The philosophy of nursing services at KAMC-R is based on the provision of quality nursing care for patients and families that is culturally congruent and respectful (NGHA 2009a). There are more than 3,000 positions available to staff within its expanding medical facilities. The expatriate nursing staff recruited from more than fifteen (15) countries constitutes more than 95 per cent of the total nursing personnel employed at the hospital (NGHA 2009a). According to recent human resource staffing reports (NGHA 2009c), nurses on these units are largely (96%) non-Muslims (assumed to be mainly Christians). The expatriate nurses, who come from disparate ethnic backgrounds, are often non-Arabic speakers (NGHA 2009c).

2.5.4 Nursing Profession in Saudi Arabia

In Saudi Arabia, nursing was not traditionally considered as a suitable female profession, as compared with other healthcare professions such as medicine and pharmacy. The latter professions were perceived to be more socially acceptable and appropriate for Saudi women (Al-Osimy 1994; El-Sanabary 1993). In a recent study to explore public opinion of nursing as a profession, Alsuwaida (2008) interviewed 199 Saudi adults, and found an overall low perception of nursing compared with other healthcare professions. Alsuwaida (2008) concluded that factors such as long working hours and the risk of developing infections from working with ill people also influenced the image of nursing in Saudi Arabia. This perception has been a major consistent factor influencing the recruitment of large numbers of foreign nurses for work in Saudi Arabia (Marrone 1999; Tumulty 2001). Over the years, nursing care in Saudi Arabia was predominantly provided by a multicultural expatriate nursing workforce (Al-Osimy 1994; Marrone 1999; Tumulty 2001). The safeguard of safety and the rights of patients and community in Saudi Arabia in relation to nursing practices are governed within the framework of ethical and professional codes of conduct developed by the GCC Health Ministers' Council Executive Board (Khoja 2001).

2.5.5 Reflective Journaling in Nursing Practice

The use of reflective writing as a means of reporting clinical and professional situations is widely practised by nurses working in different hospital settings (Jasper 1995; Lindseth et al. 1994; Ruth-Sahd 2003; Taylor 2006). Consequently, nurses' lived experience of phenomena in the hospital setting is often communicated through writing reflective reports and journals (Clouder & Sellars 2004; Taylor 2006). It is worth emphasising that the process of reflective writing provides confidence for nurses working in a hospital, and can be viewed as a fundamental element of their ongoing development as healthcare professionals (Ritchie 2003; Taylor 2006). The extent of nurses' reflective practice and writing may range from reflecting on particular clinical situations to summaries of their knowledge and skill deficiencies. Also, reflective practice has been used extensively in hospital settings as a significant component of nurses' professional development, career pathways and promotion process (Burrows 1995; Edwards 1996; Taylor 2006). This contextual uniqueness has served to assist the researcher in designing and modifying the data collection method. Details are presented in chapter 3 of how the reflecting journaling technique was used in the present study.

2.5.6 The Islamic Perspective in Healthcare and EOL Care

Theoretical literature and findings of recent research on EOL care highlight the need for healthcare professionals to expand their focus on EOL care by acknowledging and responding to the cultural and spiritual needs of dying patients (Arnold & Boggs 2007; Blais et al. 2006; Kociszewski 2004; Kub et al. 2003; Nolan & Mock 2004; Wong & Yau 2009). The religious aspect is an especially noteworthy consideration in the context of my study because the patients and the local physicians are mainly Muslim. For this reason, healthcare professionals should be aware of and sensitive to aspects related to

Muslim practices and rituals at the EOL (Al-Shahri & Al-Khenaizan 2005; Ross 2001). Rassool (2000) claims that awareness and respect of Islamic considerations at the EOL would ensure a dignified, peaceful and comfortable death for Muslim patients, and provide a degree of comfort to their families.

Muslims' understanding of health and illness is embedded in their belief in Allah (God), the creator and originator of the whole world and humankind (Al-Shahri & Al-Khenaizan 2005; Smith & Haddad 2002). Although Muslims view illness as the atonement for their mistakes and sins (Bülow et al. 2008), they nevertheless are encouraged to seek appropriate treatment if they become ill (Al-Shahri & Al-Khenaizan 2005; Clarfield et al. 2003; Rahman 1998). Health, illness, suffering and death are all believed by Muslims to be predestined by Allah (Al-Shahri & Al-Khenaizan 2005; Smith & Haddad 2002). According to the Islamic worldview, death is considered as the inevitable phase of human existence, and it is the ultimate pathway to the final destination of returning to God (Smith & Haddad 2002). For Muslims, death in this world is not considered as absolute death, but is just a transitional period between life and the hereafter or eternity (Al-Shahri & Al-Khenaizan 2005; Smith & Haddad 2002). Islam belief affirms that resurrection takes place after death, when people will be judged for their works and deeds in this life. Muslims also believe that human longevity and time of death are already predetermined through the omnipotence of Allah only (Al-Shahri & Al-Khenaizan 2005; Smith 2001). The emphasis in Islam is on the quality of life rather than quantity of life (Rahman 1998). According to modern Islamic scholars, although every effort should be made to save people's lives, prolongation of the final stages of terminal illness by applying futile medical interventions should be discouraged (Clarfield et al. 2003; Rahman 1998).

In contrast to many secular Western cultures, in Islam spirituality and religion are bound together and cannot be separated. According to Rassool (2000:1479), in the view of

Islam, 'there is no spirituality without religious thoughts and practices, and the religion provides the spiritual path for salvation and a way of life'. Muslims express their religion and spirituality around death by various rituals. These rituals are, for the most part, to help cope with suffering and pain at the EOL (Puchalski, Dorff & Hendi 2004). Muslim rituals and practices as death becomes imminent may include recitation of the Qura'an at the bedside of the dying patient (often done by a spiritual caregiver), positioning the patient in the direction of Makkah, and uttering of the final testimony of faith, the Shahadah [that expresses that there is no God but Allah, and that Muhammad (Peace and Blessings upon him) is His Prophet and His Messenger] (Al-Shahri & Al-Khenaizan 2005; Kemp & Bhungalia 2002; Ross 2001). In this regard, therefore, it is important to be aware that some facets of the contemporary healthcare models regarding EOL care, may not be appropriate for Saudi Muslim patients (Rassool 2000).

In summary, the uniqueness of context in this research study is manifested in the first instance by the authoritative power of physicians to initiate a DNR decision for patients who have irreversible terminal illness and for whom aggressive treatment would be considered as futile. The second contextual consideration is that multinational nurses from different religious, language and cultural backgrounds are not involved necessarily in the DNR decision-making process. Nevertheless, the expatriate nurses are required to provide holistic care to dying Muslim patients and their families on medical units. In this regard, awareness of and respect for the religious and spiritual needs of Muslim patients and their families at the EOL requires focused attention. In this regard, reflective journaling could be implemented as a technique for nurses on medical units to consider and evaluate how they deal with the difficulties, challenges and ethical dilemmas pertaining to EOL care for Muslim patients and their families. In doing so, nurses would engage in a process of reflecting critically, delineating problems and recognising possible consequences which may emerge from their lived experience of EOL care after DNR.

2.6 Conclusion

The value of the initial literature review contributed primarily to the conceptualisation and development of the study and formulation of the data collection instrument. The continuation of the literature review after data collection and during data analysis enhanced my understanding of the complexity of the studied phenomena. This chapter has presented topics and trends found in the literature on nurses' lived experience and involvement in EOL care after DNR. It also outlines the contextual uniqueness of the study by shedding light on EOL care after DNR, the nursing profession and Islamic perspectives of health care in Saudi Arabia.

On the basis of the literature review discussed in this chapter, the conclusion can therefore be drawn that there is a dearth of knowledge on the research topic, the majority of earlier studies being undertaken in critical care units. There were a limited number of studies that explored the essence of nurses' lived experience when providing EOL care after DNR on medical units. Unfortunately, no research studies were found that examined the meaning of nurses' involvement in EOL care after DNR on medical units in Saudi Arabia. The present study therefore aims to bridge this gap in the literature by concentrating on understanding the experience of nurses on medical units in this significant, sensitive and demanding role. The following chapter articulates details of the actual research process including the research design and methodology utilised in this study.

CHAPTER 3 METHODOLOGY

3.1 Introduction

In the preceding chapter, a comprehensive review of literature on the 'do-not-resuscitate' (DNR) decision, nurses' involvement in 'end-of-life' (EOL) care, and the context in which the present study was undertaken were provided. This chapter discusses the research design and methodology. It begins with an overview of the qualitative process of inquiry, including a discussion of phenomenology as a qualitative research approach, and the rationale for using the reflective journal technique as a data collection method. Sampling methods, data collection procedures and the reflective journal instruments for data collection are also discussed. The chapter concludes with the strategies used to establish the rigour and trustworthiness of the study.

3.2 Research Design

The study is a qualitative, exploratory and descriptive investigation that used related methods in a process of inquiry aimed at fulfilling the research objectives (Axford et al. 2004; Babbie 2007; Carpenter 2007b; Speziale 2007a). The aim of the qualitative study was to find common themes and patterns describing the lived experiences of nurses in EOL care of DNR patients on medical units. Exploratory research studies are regarded as appropriate when the phenomenon of interest is neither sufficiently understood nor studied (Babbie 2007; Burns & Grove 2005; Polit & Beck 2004). The descriptive perspective of this study utilises data on the essence of nurses' lived experience in EOL care after DNR, so that approaches to nursing practice can be understood, including how to provide nurses with the necessary education and support in these situations. In descriptive research, researchers are able to depict details about the phenomena of

interest, which therefore adds to existing knowledge (Axford et al. 2004; Babbie 2007; Burns & Grove 2005; Polit & Beck 2004).

The naturalistic underpinning of qualitative methodology matches the research purpose of gaining understanding of the nurses' lived experience and meaning of involvement in EOL care after DNR, because events are revealed without prediction or control of the real-life context and natural factors (Patton 2002). Another significant reason for selecting a qualitative approach was its potential for rich description and enhanced understanding of phenomena encountered in clinical nursing practice (Burns & Grove 2005; Denzin & Lincoln 2008; Polit & Beck 2006; Richards & Morse 2007; Snape & Spencer 2003; Speziale 2007a). It was particularly pertinent to my role as clinical nurse manager of a medical unit to explore and describe a real-world context that is unique to Saudi Arabia while also having implications for the wider nursing community.

The qualitative research approach in this study used aspects of phenomenology to study nurses' reflective accounts of their lived experience and discovered meanings in EOL care of DNR patients on medical units (Carpenter 2007b; Greenwood 1993; Riley-Doucet & Wilson 1997; Williams 2001). Such a methodology provides nurses with an opportunity for introspection, disclosure and feedback, which matched the stated aim of the study that focused on the lived experiences of the nurses (Burrows 1995; Edwards 1996; Jasper 1995; Lindseth et al. 1994; Riley-Doucet & Wilson 1997; Ruth-Sahd 2003).

3.2.1 Phenomenology as a Qualitative Research Approach

In this study, aspects of phenomenology were selected to guide the study design in order to answer the research question. Phenomenology is regarded as a philosophy and a science that has roots in different disciplines, such as sociology, psychology, education, nursing and health sciences (Carpenter 2007b; Creswell 2007). Further, it

has been used as a method to formulate and proceed with a qualitative process of inquiry. From a research point of view, Carpenter (2007b:76) defines phenomenology as a methodology that aims at conceptualising and understanding a particular phenomenon as lived experience through the individuals whose existence comprises the phenomenon. This allows the researcher to be oriented to each individual's meaning of the experience, and then to draw a unified meaning that reflects the essence of that phenomenon (Carpenter 2007b; Creswell 2007). It is generally agreed that phenomenology is highly effective in describing lived experience vividly (Denzin & Lincoln 2005; Carpenter 2007b; Creswell 2007; Morse & Field 2006). Richards and Morse (2007) affirm that the cornerstone in phenomenology is to describe the lived experience by people who are embodied in their real worlds in order to provide an understanding of and meaning to things that unite in a comprehensive whole.

The philosophical movement of phenomenology has been influenced primarily by two German philosophers, Edmund Husserl and Martin Heidegger, who are regarded as prominent leaders in phenomenology (Carpenter 2007b; Koch 1995; Walters 1995; Webb 2003). Both Husserlian descriptive phenomenology and Heideggerian hermeneutic phenomenology have been used extensively in phenomenological nursing research (Koch 1995; Walters 1995; Webb 2003). Although, there are several philosophical assumptions and levels in phenomenology, distinctions between these are outside the scope of this research. Descriptive phenomenology is concerned with the faithful and pure understanding of lifeworld experiences (Todres 2005; Walters 1995), whereas the hermeneutic phenomenological approach to inquiry seeks a deeper understanding of phenomena through analysing accounts of human lived experience in a specific context. Hermeneutic phenomenology asks 'what is the nature and meaning of everyday experience?' through asking those who have lived it to provide a rich description of that experience (Van Manen 1990:9). The hallmark of the hermeneutic phenomenological inquiry, then, is that its task is the 'interpretation of texts, the words

people use to describe and explain cultural mores, behaviours, events and actions and the relationship between ordinary language and daily social life' (Rapport 2005:8). The methodological approach in this study reflects aspects and features that are derived from both descriptive and hermeneutic phenomenology. The descriptive phenomenology approach was to satisfy the research objective of providing rich descriptions of nurses' lived experience in EOL care after DNR, whereas hermeneutic phenomenology was adopted because of its interpretative approach to finding meanings embodied in the lived experience (Van Manen 1990).

A separate review was undertaken at the outset of the present research study to understand the various dimensions of conceptual frameworks for phenomenology. The ontological perspective in phenomenology is concerned with the reality of human lived experience (Schwandt 1998). In this regard, Richards and Morse (2007) note that two significant assumptions constitute a phenomenological approach. First, individuals' perceptions distinguish the reality of the world as it is lived as human experience. Second, human existence is meaningful and is only understood when it is unfolded within its related context. The ontological perspective in this research was concerned with the multiple realities (Schwandt 1998) of nurses' lived experiences in EOL care after DNR. On the other hand, the epistemological stances outlined are concerned with the researcher's efforts to understand the essence of the lived experience (Snape & Spencer 2003; Schwandt 1998; Walters 1995). This, according to Carpenter (2007b), illustrates the responsibility of the researcher to transform the gathered data about the phenomena into meaningful texts which capture the essence that underlies the lived experience of the phenomena. The research perspectives supported by phenomenology are constructivism within the interpretative paradigm (Appleton & King 1997; Denzin & Lincoln 1998; Guba & Lincoln 1998).

It is notable that several research orientations are implied in phenomenology, perhaps related to its philosophical underpinnings (Carpenter 2007b). Phenomenology has been subjected to various interpretations and movements that have provided researchers with a variety of methodological options and applications in conducting research studies (Carpenter 2007b; Walters 1995). According to Van Manen (2002), orientations and movements in phenomenology can be distinguished as follows:

- Transcendental phenomenology as 'constitution of meaning': describing phenomena that are embodied in our human consciousness.
- Existential phenomenology is where the phenomena are moved from being situated in consciousness to being located in the lived experience in the world.
- Hermeneutical phenomenology as 'interpretation': a belief that interpretation is constantly evolving and is inseparable from understanding phenomena.
- Linguistical phenomenology is concerned with the meaning that is inherently presented as a textual linguistic rather than as consciousness, understanding or the lived experience.

The appropriateness and relevance of phenomenological inquiry in this research study was based on careful consideration by me as the researcher of the different viewpoints that potentially governed the research topic and phenomenon under study. Essentially, phenomenology was selected since the study purpose was to explore the essence and meaning of nurses' lived experience in EOL care after a DNR decision on medical units. On the other hand, the holistic perspective that underpins the philosophy of phenomenology matches the holistic approach of the study (Carpenter 2007b; Rose, Jayne & Parker 1995) by focusing on the dying process and nurses' involvement in EOL care after DNR. The humanistic perspective of nursing as healthcare profession is always seen as the core value in provision of care for people (Blais et al. 2006). Because the cornerstone in nursing practice is to provide holistic care of body, mind and

spirit of patients and families, the nurses' lived experience is considered well-suited for and better understood by a phenomenological inquiry since the focus is on understanding the integrated whole (Carpenter 2007b).

Another consideration for selection of phenomenology in this study was based on the ambiguity of the studied phenomenon to the observer, and the somewhat incomplete description of its elements and the embodied experiences by the key players, nurses and physicians. The shared observation by the clinical nurse managers of medical units was that nurses, despite the cultural and religious differences with patients and families, are seemingly becoming more involved in EOL care after DNR than other healthcare team members. The phenomenon of interest, however, represents the essence of phenomenological studies: the formulation of descriptions of the life-world events experienced by people (Creswell 2007). Polit and Beck (2008) assert that phenomenology is best used when the phenomenon is not clearly defined and its elements are not vividly described and understood. Further to this, Carpenter (2007b) advocates the use of phenomenological inquiry by researchers when a paucity of literature is available surrounding a particular phenomenon. Nurses' lived experience in EOL care for Muslim patients, and as explained in chapter 2, section 2.4.4, is an area where limited research studies have been conducted.

The literature on EOL care illustrates that multiple nursing studies on EOL care (for instance, Borbasi et al. 2005; Dunne, Sullivan & Kernohan 2005; Halcomb et al. 2004; Heland 2006; McGrath & Holewa 2006; Touhy, Brown & Smith 2005), have all used phenomenology as a qualitative research method. These authors all concede that phenomenology has contributed to a better understanding of nursing involvement in EOL care because it provides nursing practitioners with in-depth knowledge of actual experiences and related meaning, thus influencing improvements in the care of dying patients.

3.2.2 Rationale for Reflective Journaling Technique

The rationale for using the reflective journaling technique as a data collection method will now be discussed to illustrate its relevance to phenomenology, and its suitability in the context of this research study. Johns (2004), Quinn (1998) and Taylor (2006) concur that reflective practice is used in different disciplinary fields to refine existing knowledge and practices by unfolding the meanings embraced in people's interactions and relationships. Humans' lived experience, according to Taylor (2006), is a rich and valid source of reflection, because it involves reciprocal interactions amongst individuals, on a daily basis, and within different contextual settings. She further defines human reflection as a cognitive process within which people analyse and evaluate previous experiences in order to make sense of things which often reside in the unconscious, with the aim of improving behaviours and practices. Quinn (1998), on the other hand, believes that a fundamental focus of reflection on experience is to generate knowledge that guides practices by healthcare professionals, including registered nurses. Van Manen (1990) supports the notion that reflective journals are suitable for data collection in phenomenological inquiry since reflection assists participants to consider important aspects of their lived experience of phenomena. He further argues that valuable accounts of the human lived experience that are of interest to researchers incorporate use of reflective journals as a data collection method.

Reflective journals refer to a reflective tool and record within which participants can revisit their lived experience in order to describe and explain phenomena, and to ascertain the evolving meanings embodied in that experience. Reflective journals help participants to 'think aloud' about their involvement and to evaluate their level of participation (Gray 2007). Traditionally, journals have been used as a valuable method to facilitate human reflection and promote self-evaluation (Chirema 2007; Croke 2004; Epp 2008). Reflective journals function as a personal record which includes written

thoughts, description of self-awareness and experiences of a phenomenon (Chirema 2007; Gray 2007). Writing reflective journals is a process whereby participants can 'think aloud objectively and transfer their thoughts and perceptions onto paper, documenting subjective and objective observations, scrutinizing alternatives, exploring, critiquing their ideas, analyzing and evaluating experiences' (Simpson & Courtney 2007:204).

In nursing, reflective journals have been used extensively in several domains, including education, clinical supervision and professional staff development (Taylor 2006). Moreover, there is wide literature support for the use of reflective journals as a data collection method in qualitative research (Walker 2006). This is because it facilitates disclosure of experiences lived by participants after the actual event (Burrows 1995; Edwards 1996; Johns 2004; Polit & Beck 2004; Riley-Doucet & Wilson 1997; Williams 2001). Taylor (2006:167) states that reflective journals 'generate subjective, context-dependent, relative knowledge that resonates as truth for the individual and for other people who recognize similar experiences'. Another valuable aspect is that reflective journals offer rich narrative accounts of participants' lived experiences (Croke 2004; Plack et al. 2005; Ritchie 2003; Taylor 2006; Walker 2006), and provide a safe and private opportunity for RNs to freely review and examine their practice experiences (Burrows 1995; Edwards 1996; Minghella & Benson 1995; Riley-Doucet & Wilson 1997; Van Manen 1990). The structured approach of reflective journals in this research was used primarily to guide participants to offer relevant information about their lived experiences, thus providing the means to answer the research question (Johns 2004).

The decision to use reflective journals in this study was made primarily after consideration of the context of the study and population selected for participation (Lewis 2003). At the hospital site, reflective journals are often used in professional development activities as an established method for safe and comfortable personal

written notes aimed at practice improvement. In this way, use of reflection is congruent with the naturalistic inquiry that is required by the phenomenological process of qualitative research inquiry.

In this research, the reflective journals' entries contained nurses' reflections about their lived experience in EOL care of DNR patients, which included interpersonal interactions with patients, families, and other healthcare team members, and a reflection on the meaning of the experience for them. Entries by participants in the reflective journals are accomplished away from the clinical site of practice, thus minimising disruption to work schedule activities, and without the need to take nurses away from their primary patient care giving assignment. Additionally, the privacy of writing reflective journals away from the clinical setting would permit quality time for participant reflection and sharing of experiences in EOL care after DNR (Johns 2004).

3.3 Sampling Method

Qualitative researchers attempt to capture a comprehensive and extensive account of the phenomena of interest and therefore use non-probability sampling methods that allow them purposively to select participants for research studies (Burns & Grove 2005; Ritchie, Lewis & Elam 2003). There are, however, different strategies that researchers may use to select participants in conducting qualitative research (Patton 2002). The qualitative sampling method used in this research was purposive sampling. In purposive sampling, the participants are selected for the research study based on the likelihood that they will be able to provide rich descriptions of the phenomena (Burns & Grove 2005; Polit & Beck 2006). Patton (2002:230) asserts the importance of purposive sampling in selecting 'information-rich cases' that are able to provide worthy information about a phenomenon. Information-rich cases, according to Patton (2002:230), are

those whose contribution to explaining a phenomenon are critical, and their input should provide answers to the research question. Purposive sampling was selected to recruit participants in this qualitative study because the study aim was to describe and understand the phenomena, rather than to generalise the findings (Babbie 2007; Burns & Grove 2005; Polit & Beck 2006; Speziale 2007a). Therefore, the purposive sample of participants was anticipated to provide in-depth reflective accounts of their experiences in the phenomenon under investigation.

3.3.1 Study Population and Eligibility Criteria

The participant population for this study was all registered nurses (RNs) practising as direct caregivers on medical units in a large tertiary-level teaching hospital in Riyadh, Saudi Arabia. The intention of this study was to recruit participants who had experienced the phenomenon of interest and who would be able to articulate what it was like to have lived that experience.

Eligibility criterion refers to the selection process of cases, based on their predetermined characteristics which qualify them for selection as potential subjects in the research (Patton 2002; Polit & Beck 2008). Burns and Grove (2005) relate this type of sampling strategy to the nature of the phenomenon under study and to the research question. The significance of criterion sampling in this study lies in the inclusion of participants who share similarity in the lived experience of EOL care after DNR, and hence who would be regarded as 'rich-information' individuals in a position to provide in-depth information about the studied phenomenon (Patton 2002; Richie et al. 2003).

The eligibility of RNs invited to participate in this project was determined by the application of the following exclusion criteria:

1. RNs employed at the hospital for less than one year on medical units, as they were judged to still be in their adjustment phase to a new and different cultural and religious environment (Blais et al. 2006), particularly since the majority were expatriates and were probably not familiar with local perceptions of health, illness and death.
2. RNs whose last experience in EOL care on medical units was more than two (2) years ago.
3. RNs who had experienced any level of emotional distress resulting from either a patient or a personal family member's death, and/or who had undergone counselling related to EOL issues in nursing practice. It was assumed that such an emotional situation would possibly restrict their participation, and so it would have the potential to interfere with the credibility of data gathered (Polit & Beck 2008).

The exclusion criteria used were suitable for the study because participants who satisfied the eligibility criteria were judged to be able to provide an accurate or relevant description of their lived experiences and involvement in EOL care after DNR on medical units. Other categories of nursing staff, such as clinical nurse managers, clinical nurse educators, patient care technicians and unit assistants, were also excluded from the study in view of their minimal contact and indirect involvement with patients generally, and in particular during periods of EOL care following a DNR decision.

3.3.2 Selection and Recruitment of Participants

The researcher approached the clinical educators in this hospital context, referred to as clinical resource nurses, on medical units at their bi-weekly clinical education meeting to introduce the aim and objectives of the research study, and to explain the recruitment process of RNs for this study. At this meeting, participant screening sheets (Appendix

5) were distributed to the clinical nurse educators. The participant screening sheets were initially designed to gather data about RNs working on medical units, and subsequently to determine the potential RN candidates who met the eligibility criteria. I followed up this initial contact personally within a week to collect the sheets. Thereafter, a follow-up session was conducted with the research co-supervisor to determine which RNs were fully eligible for participation in the study.

3.3.3 Sample Size

A significant feature of qualitative sampling is that it deals with a small and non-random sampling population (Polit & Beck 2008). It was advised by the co-supervisor that twenty (20) to twenty-five (25) reflective journals would be required to obtain narrative data until saturation of themes had been achieved (Polit & Beck 2008; Speziale 2007b). The total number of eligible RNs who constituted the pool of potential participants was sixty-eight (68), which formed the basis for the sample. Potential participants were then invited to attend information sessions on the research study. A total of fifty-three (53) eligible RNs attended these sessions, and twenty-seven (27) RNs agreed to participate in this study and subsequently signed the informed consent form. One (1) additional RN participant was willing to participate despite not having the opportunity to attend the information sessions. Of the twenty-eight (28) reflective journal sheets distributed, a total of twenty-six (26) were returned to the researcher, while two (2) respondents decided not to participate.

The small sample size was considered as adequate in this qualitative study following consultation with the co-supervisor at the research site. Ritchie, Lewis and Elam (2003) identified three reasons why qualitative samples are seemingly small in size. First, saturation of qualitative data is considered to be achieved when no further themes emerge from analysis of data, and where redundancy of information obtained for the

participants has been reached. Second, the incidence or prevalence of the phenomenon of interest is not the focus of the qualitative research, but the depth and profundity of the retrieved data. Third, the qualitative research study usually results in providing rich and vivid information on the studied phenomenon.

3.4 Reflective Journaling Instrument for Data Collection

The instrument that was designed for reflective journaling was based on Johns' original model of structured reflection (1992), and informed by the modifications given by Johns (2004) and Quinn (2007).

3.4.1 Theoretical Basis for Reflective Journaling Instrument

Johns (2004) describes a series of cue questions that serve to trigger reflective thinking about past experiences. He provides five (5) major areas in his structured approach to reflection, namely (i) description of the experience with a specific focus on the phenomenon, context and clarification of the essential aspects, (ii) meaning of the reflection to the person, (iii) influential factors that are internal and external to the person, (iv) choices and consequences made or resulting from the experience, and (v) components of learning and related appreciation of new learning from the experience.

The research value of using a structured approach to reflection was threefold. First, the key focus was to guide the participants to transform their reflection into a written form such as a journal, thereby minimising any hesitation or discomfort that could perhaps be associated with reflection (Johns 2004; Walker 2006). Second, the intent was to guide the participants to a deeper level of thinking and to motivate them to gain an advanced level of critical thinking (Croke 2004; Johns 2004; Simpson & Courtney 2007). Lastly,

the use of a structured model was intended to support the participants to explore meanings from their lived experiences in EOL care after a DNR decision, with the potential to gain insight that would lead to changes in their future practice (Johns 2004; Williams & Wessel 2004). The overall purpose therefore of using the Johns' original model of structured reflection (1992) in this study was as an explanation for journalling reflective recall rather than as a prescriptive guide in the reflective thinking of participants.

3.4.2 Construction of Research Instrument for Reflective Journalling

The construction of the research instrument utilised the open-ended style of cue questions from the work of Johns' model of structured reflection. The instrument consisted of twelve (12) pages, with an introductory paragraph addressed to participants. The introductory paragraph served to remind participants not to disclose confidential information about a patient or the treating healthcare team members (Appendix 8). Furthermore, it gave advice on how to approach the process of reflection and related answering. Details of how I could be contacted if needed, and a time-frame for returning the completed reflective journals, were also provided. The ten (10) reflective questions were pre-written on each of pages 2 to 11. For each reflective question about twenty (20) ruled lines were provided for reflective writing, to allow free verbalisation by the participant. Table 3.1 that follows summarises the list of reflective journalling questions used in the research instrument (Appendix 8).

The final page (12) of the reflective journal instrument included a courtesy reminder on how to return the completed journal, with a note of thanks for the time taken for participation. The research instrument was then finalised and used for data collection subsequent to discussion and agreement with the research site co-supervisor of my study.

Table 3.1 Summary List of the Questions in the Research Instrument

No.	Reflective Journal Questions
1	What does EOL care mean to you within the context of your current unit?
2	Without providing the name of the patient, family or the attending physician, describe a situation during the past two years when you cared for a patient for whom DNR was decided. Include a description of your care for the patient and family.
3	Outline your role as a nurse in the DNR decision-making process. Include comments on which of the team members, in your opinion, were active in the DNR decision-making process.
4	Provide an account of the reaction of the patient and/or family when the DNR decision was made.
5	Summarise the medical treatment plan of the physician for the patient after the DNR decision, and outline the role that the physician played thereafter until the moment of death.
6	Explain details of your EOL nursing care plan and your role as a nurse in caring for the patient after the DNR decision, including support given to the family.
7	Give an account of the Islamic considerations you encountered during your nursing role as explained in (6) above. Describe how you dealt with the Islamic considerations within your role in EOL care for the patient and family.
8	Outline the role played by other members of the healthcare team in the EOL care of the patient and/or family after the DNR decision was made.
9	Describe any support system(s) that you may have used during the above experience of EOL care, particularly after the DNR decision.
10	Offer any specific aspects or comments related to your EOL nursing care and experience with your patient and/or family after the DNR decision until the moment of death.

3.5 Data Collection Procedures

I approached the clinical nurse managers and the clinical nurse educators on medical units at their bi-weekly departmental meeting to present the aim and objectives of the research study. The intention was to orientate them to the process of recruiting potential RN participants and to the data collection process. This also provided them with an opportunity to clarify any aspects that were unclear to them. Both managers

and educators verbalised their willingness and commitment to facilitate data collection activities.

It was discussed and agreed with the Director of Clinical Nursing, Medical Units that prior to data collection I would conduct a half-day workshop on reflective practice and reflective journal writing (Quinn & Hughes 2007). The workshop was targeted at clinical nurse educators assigned to the medical units. The workshop was intended to include theoretical and practical sessions on reflective practice and reflective journal writing, using the data collection instruments that had been pre-designed. The inclusion of clinical nurse educators (job title is CRN - clinical resource nurse) as research facilitators was based on their approved job description regarding facilitation and support of research in practice. Further, their high clinical visibility and responsibility for assessing nurses' needs and for developing learning plans were considered significant, so that participants were well supported for their reflective journal entries. Another consideration was their congruence with RN participants as the sampling population (Polit & Beck 2008). It was agreed that the workshop would be integrated into the forthcoming orientation programme for newly promoted clinical nurse educators on medical units, and compulsory attendance by all clinical nurse educators was ordered by the Director of Clinical Nursing for medical units. A pre-reading package of reflective practice articles was distributed in advance in order to prepare workshop participants for the concept of reflective journaling. There were thirteen (13) session attendees and the focus of the workshop was on the importance of their role as research facilitators to encourage participants to complete their reflective journal entries (Polit & Beck 2008).

Further to this, clinical nurse educators (known as CRNs) were provided with a research facilitator manual (Appendix 4) that included suggestions and guidelines to assist participants to complete their reflective journals. The aim of the manual was also for clinical nurse educators to become familiar with the data collection instruments that

were based on the reflective journal writing from the practice setting. It was emphasised during the research facilitator training workshop that the clinical nurse educator's role was to facilitate completion of reflective journals by the participants, and they were not meant to assist the participants with the answers; rather, their role was to encourage the participants to find answers by themselves (Taylor 2006). The literature justification for reflective journals was shared and questions were invited from the attendees on any aspects of the data collection procedures.

The scheduling of information sessions for the RNs on medical units was discussed and agreed upon with nurse managers to minimise disruption to the patient care on the units (Creswell 1998). In this regard, two data collection forms were developed, namely: attendance sheet (Appendices 11 and 12) and participant tracking sheet (Appendix 13). The two forms were used initially as records facilitate recruitment of potential participants, and the latter one was used as a database to facilitate follow-up communication with participants (Burns & Grove 2005; Polit & Beck 2008). At the scheduled information sessions, the researcher provided information to potential participants regarding the research study. Confidentiality, privacy, risks, and possible withdrawal from the study were all discussed with potential participants. Attendees at these sessions were provided with the information sheet (Appendix 6) on how to participate in the study (Parsons & Oates 2004:106), and the process for completion of the informed consent form. In total there were six (6) information sessions.

The RNs were advised to read the participant information sheet carefully and to discuss any related question or concerns with me before deciding on participation. If they had no further questions regarding the study, interested participants were requested to sign the informed consent form and to return it to me. I followed up personally within a week to collect the signed informed consent, and to inform the participants of the time and venue for the scheduled training sessions on the use of reflective journal sheets.

The reflective journal training sessions were conducted in a conference room at the hospital, and included the use of reflective journals to record nursing experiences which was subsequently practised by the participants. The agreement made with clinical nurse managers was to allocate participants to the scheduled reflective journal training sessions without disrupting the unit's staffing schedule. It was also agreed that participants would attend these sessions as official educational sessions rather than in their own time in view of the mutual benefit to the research study and to their nursing practice. After each session, I made notes on the process, contents and teaching approaches used. In total there were six (6) reflective journal training sessions.

The training sessions were conducted after the morning shift handover, as advised by clinical nurse managers, since the units' ongoing educational activities were usually presented at the same time in the morning. Each session lasted for about 90 minutes. The average number of attendees at each session was five (5). Clinical nurse educators from the matched medical units were invited to attend these sessions as a support system for participants. The reason for conducting small group sessions was for participants to discuss and practice reflective exercises freely with each other and in my presence, as the researcher. Practice for writing reflective journals was included using their recent experiences related to non-EOL patient-care (Burrows 1995; Croke 2004; Plack et al. 2005). In these sessions, I used a flipchart to allow interactive discussions on the reflective process by attendees. In preparation for these reflective journal training sessions, I approached the two clinical nurse educators assigned to my medical unit to review the non-EOL scenarios that would be used in the reflective exercises with participants. Figure 3.1 that follows presents examples of the clinical scenarios and topics that were used in the reflective journal training sessions.

Reflective Journal Exercises

1. What does wound care mean to you within the context of your current unit?
 2. Without providing the name of the patient, family or the attending physician, describe a situation during the past two years when you cared for a patient in whom a percutaneous endoscopic gastrostomy (PEG) tube was inserted. Include a description of your care for the patient and family.
 3. Provide an account of the reaction of the patient and/or family when the chest tube was inserted.
 4. Outline your role as a nurse in the discharge decision-making process. Include comments on which of the team members, in your opinion, were active in the discharge decision-making process
-

Figure 3.1 Examples of Reflective Journal Exercises

The participants confirmed their ability to record their reflective accounts of how they lived through the nursing experience, which was aimed at preparing them for a data collection method on EOL care (Van Manen 1990). In these sessions, participants were given practical advice as suggested by Taylor (2006) to complete their reflective journals within the period of data collection, as shown in Figure 3.2.

Practical suggestions for writing reflective journals

- Choose appropriate time
 - Choose comfortable place
 - Make the effort
 - Have courage
 - Be honest
 - Express yourself freely
 - Be spontaneous
 - Write full sentences
 - Write clearly
-

Figure 3.2 Practical Suggestions for Writing Reflective Journals

(adapted from Taylor 2006)

At the end of each session, the researcher distributed the reflective journal data sheets, which included a specific numeric identification system that was shared only between the researcher and the participants for the purpose of confidentiality. Participants were encouraged to keep their reflective journals private and confidential, so that they became a safe place for self-disclosure and self-reflection. The participants were reminded of the right to withdraw from participating at any time without professional repercussion.

Participants were given four (4) to six (6) weeks to complete reflective journal entries in a safe and private environment of their choice. The respondents returned the reflective journal data sheets individually to the researcher by reaching him via his contact details as provided at the end of the reflective journal data sheet. The reflective journal response rate is presented at the beginning of chapter 4, section 4.2. The reflective journal entries were transcribed by the researcher into an electronic document file, and were saved on a password-protected computer to which only the researcher had access.

During data collection, I kept my field notes to document my observations (Bryman & Bell 2007; Morse & Field 2006). The compiling of field notes is an activity that occurs during data collection and which contributes to a better understanding of the research context (Mason 2002; Patton 2002). The purpose of keeping field notes was to enrich the description of the findings, to ensure 'thick description' had been retained (Lewis & Ritchie 2003), and to ensure idiosyncratic descriptions or expressions heard or seen in the field had been recorded meticulously. The field notes included summaries of events that took place at the time of data collection, and my preliminary reflections about the data collection process. Bryman and Bell (2007) argue that participants' behaviours are influenced by contextual considerations, and that qualitative researchers need to pay attention to these behaviours when conducting qualitative research. It was assumed that handwritten field notes would be used in data analysis to support the emergent themes. Throughout data collection, I used the hospital electronic network as a means of communication with clinical nurse managers, clinical nurse educators and participants.

3.6 Data Analysis Process

The data analysis process at the outset was intended to be based on Tesch's work (1990), which is supported by Creswell (2007) as a classical approach to qualitative data analysis. As data analysis progressed, however, it became necessary to expand the theoretical basis for data analysis and to review other qualitative experts so that the final approach to data analysis was more comprehensive and included consideration of the opinions of contemporary qualitative data analysis experts. In an editorial, Morse (2008) pointed out that often the terms 'categories' and 'themes' are confused and used interchangeably. For this purpose therefore it was intended to clarify the related theory on data analysis in order to safeguard the scientific integrity of the findings of this study.

The theoretical basis for data analysis which has Tesch's work (1990) as its fundamental framework is supported by a host of qualitative experts (Coffey & Atkinson 1996; Creswell 2007; Richards 2005; Silverman 2006; Wolcott 1994). Admittedly, my first attempt at data analysis resulted in a confusing list of descriptions until I gained further understanding of differentiating between 'categories' and 'themes'.

For the purpose of this study, and after extensive debate with the research site co-supervisor, we agreed to use the following understanding of data analysis to facilitate the process:

- Coding process – based on Coffey and Atkinson (1996) and Richards (2005), this was taken to show how data text was segmented to convey a sense of the descriptive characteristics in the research. An integral component of this process was data reduction as a basic means of organising data to portray the descriptive characteristics.

- Categories – based on Coffey and Atkinson (1996), Richards (2005) and Creswell (2007), this was taken to be the process of arranging data into groups to permit identification of similar recurring patterns. These patterns then portray an organisation of similar descriptions occurring as a result of rearrangements, changes and/or renaming of the data until the patterns of data displayed reveal similar identities or definitions (Morse 2008).
- Interpretation - this was based on Coffey and Atkinson (1996) and Richards (2005), and was taken to be the meaning that emerges from the data when they are questioned and interrogated. Such meanings are gained by reviewing data for discovery of relationships between sets of data, different categories, linkages to contextual situations and logical ideas that may become apparent in the process of reviewing data.
- Themes – this term was based on the work of Coffey and Atkinson (1996), Morse (2008) and Richards (2005) and it depicts the recurrent essence of meaning that emerge as a repetition related to a basic topic conveys the main ideas in the narrative.

3.6.1 Steps in the Data Analysis Process

The steps used in data analysis were based on Tesch's work (1990), but were modified in view of the works of Coffey and Atkinson (1996), Richards (2005) and Carpenter (2007b). Philosophical stances from Babbie (2007), Johns (2004), Van Manen (1990), and Williams and Wessel (2004) informed the modified steps described below to encapsulate aspects of phenomenology and reflective approaches that generated descriptive evidence on the essence of the lived experience and which were linked to understanding the phenomenon of interest. In the context of my study, this was the lived experience, and the meaning of this experience, of nurses in EOL care after DNR. The modified data analysis steps are outlined as follows:

- Step 1. Read two to three reflective journals to obtain a sense of the whole experience, and make notes as ideas occur relating to the coding process.
- Step 2. Select one section of the reflective journal and work on it to arrange categories related to the underlying meaning and experiences, and continue making notes and/or write memos to self as ideas occur related to the context or phenomenon.
- Step 3. Select the next section in the reflective journal, and repeat step 2 above but move to interpretation and linkages between segments of data. Continue to make notes on interpretation and/or write memos to self where aspects of data trigger thinking in relation to field notes, contextual data and/or content of other reflective journals.
- Step 4. After completion of four to five reflective journals, the analysis as undertaken in steps 1, 2 and 3 should be reviewed in combination with field notes and memos that have been generated. The review includes the coding process, naming of categories and arrangements thereof, emerging interpretations and any notes made.
- Step 5. Following careful review in step 4 above, the content is scrutinised to identify recurring and/or similar topics. These are assessed critically to identify depiction by words related to the essence of meaning. This identification represents emergent themes. The emergent themes are then arranged into columns, and the data from the four or five reflective journals that have been reviewed are arranged accordingly as the themes and content of categories are matched.
- Step 6. Repeat step 1 to step 5 above until all the reflective journals have been reviewed and analysed accordingly.
- Step 7. Devise a system of labelling for each theme with a symbol, as in coding, and arrange the themes in separate columns to include the reflective journal

code and related extract of narrative text.

- Step 8. Review the themes that do not conform to the recurrent topics in the emergent themes. Assess whether they are unique themes or redundant themes, and make notes on the related justification.
- Step 9. After completion of all reflective journals following steps 6, 7 and 8 above, the themes in columns are reviewed for further assessment as major themes and their sub-themes, to portray the experiences of the RN participants in EOL care after DNR.
- Step 10. The major themes and sub-themes are finalised according to logical arrangement to reflect the essence of experience and meaning that has emerged.

This modified data analysis process was considered as a milestone in my research activities. I disclosed to the research site co-supervisor initially that the data analysis process was tedious because as a novice in qualitative data analysis, I could not distinguish between categories, codes and themes. In-depth discussion and debates with the co-supervisor characterised the many hours and sessions on data analysis. Eventually after confusion and intensive submersion in the randomised list of words and concepts, I emerged with a degree of clarity and jointly with the co-supervisor identified the emergent themes. We agreed that the final arrangement of major themes and sub-themes was congruent to the research purpose and objectives.

3.7 Ethical Considerations

Ethical considerations primarily include organisational and participants' informed consent (Carpenter 2007a). The ethical considerations include upholding universal ethical principles, of which confidentiality and anonymity are foremost (Carpenter

2007a), because levels of disclosure and possible implications linked to the nurse and patient in EOL care are regarded as personal and sensitive. Approvals from the University of New England Human Research Ethics Committee HE07/202 dated 12/12/2007 (Appendix 3) and the NGHHA Hospital Research and Ethics Committee RCO7/O47 dated 8/12/2007 (Appendix 2) were obtained before data collection commenced, in keeping with universal ethical principles of research (Parsons & Oates 2004; Carpenter 2007a) and in accordance with KAMC-R hospital policy. In order to protect the rights of participants in this research, the three fundamental ethical principles stated in the Belmont Report (1978 cited in Polit & Beck 2008:169) - beneficence, respect for people and justice - were taken into consideration.

Participant's rights were assured by my attempts to protect them from harm or exploitation (Polit & Beck 2008). My approach as a researcher in recruiting participants was therefore informative, respectful, and non-threatening. It was clearly explained to potential participants that participation in this research was voluntary and would not in any way affect their performance appraisal nor would the information they provide ever be used against them. The participants were also made aware that they were not obliged to answer any reflective journal question if they felt they were violating their rights of confidentiality. Further, participants were encouraged to withdraw from the study should the completion of reflective journal questions lead to feelings of discomfort and professional referral would have been considered based on the situational context.

Attention was also paid to the two ethical elements involved in expressing respect to RNs as research participants, which included their right to self-determination and full disclosure (Polit & Beck 2008). Participants were given the information sheet and consent form, which clearly stated my verbal information that they had the right to withdraw from the study at any stage without providing reason(s) to the researcher (Carpenter 2007a). This was emphasised to participants during the information and

training sessions that discontinuation at any time in the research project would be respected with no explanation to the researcher. Importantly, to safeguard the relationship and ethics between me and potential participants, the medical unit that was managed by me, the researcher, was excluded from the study sample. Eligible participants were encouraged to contact me by telephone or email to discuss any questions and/or concerns relating to the research project.

The participants guaranteed of the confidentiality of the collected data by use of a specific numeric identification system for reflective journal returns, which was known only to me as the researcher and the individual participant. Participants were allocated specific codes and their real names were not used, to ensure confidentiality and anonymity. Access to data was provided to the academic supervisors after transcription of reflective journal sheets and removal of all personal identification of the participants. No reference was made to participants' names or any other detail that might identify them. Furthermore, the participants were made aware that the results of the study would be presented at local and international conferences without any textual descriptions that could possibly identify the source or participant. This point was presented clearly in the information sheet for participants and in the consent form as a separate sentence, which the participants agreed to and signed. The collected data were stored in a locked cupboard in the researcher's office, to which only I had the key at all times. The word-processed transcripts were saved and protected on a password-protected computer to which only I had access. The consent forms and reflective journals will be destroyed five years after the study, in keeping with the research policies of both the Human Research Ethics Committee of UNE and those of KAMC-R hospital (Carpenter 2007a; Ketefian 2001).

3.8 Scientific Integrity

There is increasing emphasis on rigour and scientific integrity in qualitative research (Denzin & Lincoln 2005; Polit & Beck 2008; Speziale 2007b). Although, there is unanimous agreement that quality in qualitative research is crucial because of the effects that research has on our ability to know (Cutcliffe & McKenna 2002), the criteria for appraising qualitative research remain debatable (Horsburgh 2003; Polit & Beck 2008; Speziale 2007b). Devers (1999) relates this ongoing debate first to the philosophical complexity that underpins qualitative research methodologies and second, argues that the concept of qualitative research has been used in a variety of contexts such as paradigms, philosophical perspectives and a set of methods, which have subsequently resulted in a lack of consensus on how quality criteria for qualitative research should be judged (Devers 1999). Notwithstanding the above points, it is worth noting that in order to achieve scientific integrity in this research study, the researcher was cognisant that scientific rigour should be maintained in all activities throughout the research process.

There are different standards and criteria for evaluation of qualitative research (Horsburgh 2003). Two widely-used criteria to judge rigour in qualitative research, namely trustworthiness and authenticity (Speziale 2007b; Koch 1994; Manning 1997), are believed to maintain scientific rigour in the research process. Guba's updated model of 1981, cited in Krefting (1991:215) and in Morse and Field (2006:118) includes four aspects of trustworthiness that are applicable to qualitative methodologies. These are given as credibility (truth value), transferability (applicability), dependability (consistency), and confirmability (neutrality). It is maintained that these aspects contribute to the rigour of qualitative research and ensure accurate description of the phenomenon of interest that reflects authentic experience accurately (Baker, Wuest, &

Stern 1992; Speziale 2007b). Table 3.2 presents these aspects, together with the strategies used to ensure the rigour and trustworthiness of this study.

Table 3.2 Measures Used to Establish Trustworthiness of the Study

Criteria	Strategy	Applicability
Credibility (Truth Value)	Prolonged engagement	The researcher is working as a full-time clinical nurse manager of an acute medical unit at the hospital. Trust and rapport with the participants were established through multiple information and training sessions that lasted for three months of data collection. At a secondary level, extensive time was spent with the reflective journal transcripts that deepened understanding while clarity was gained.
	Field notes	Field notes were kept by the researcher during data collection.
Transferability (Applicability)	Authority of participants	The participants were selected by purposive sampling owing to their lived experience in EOL care after DNR on medical units.
	Thick description	The researcher provided sufficient descriptive data on the context, the research methodology and the researcher's epistemological stance. The design of the reflective journal instrument with an open-ended question on each page and twenty (20) lines for expanded expressiveness contributes to rich and vivid descriptiveness.
Dependability (Consistency)	Reflective journal training sessions	The reflective journal training sessions were conducted with participants prior to completion of their reflective journal entries. The established use of reflective practice and journaling by registered nurses at KAMC-R contributed to participants adapting easily to the reflective journal instrument for data collection.
Confirmability (Neutrality)	Authority of the researcher and ongoing site co-supervisor	The researcher has completed the university coursework on research methodology. The research was supervised by an experienced qualitative researcher (co-supervisor) with expertise in reflective journaling who was available at the research site.
	Reflexivity	Field notes were used to preserve recorded information. Weekly sessions were held with the research site co-supervisor at which topics and field notes concerning data collection were discussed extensively.
	Memos	The memos were used during data analysis to identify and document the researcher's own biases or perspectives. Several teleconferences were conducted between the principal supervisor at UNE and the research site co-supervisor. As appropriate, teleconferences included me as researcher that permitted discussion of concerns that I had noted in the memos. This approach facilitated bracketing as a qualitative mechanism to circumvent bias from my perspectives.

Credibility is the criterion used to establish confidence in the truth of the findings for participants and the context in which the study was undertaken (Krefting 1991; Polit & Beck 2008; Speziale 2007b). Credibility was enhanced in this study through prolonged engagement with the participants in the field (Krefting 1991). The sufficient period of time spent with the participants on the medical units allowed me as the researcher to expose different perspectives on the phenomenon of interest, and to establish trust and rapport with participants who had been selected according to the eligibility criteria so that they were comfortable with offering in-depth information on the phenomenon of interest. Another method used to establish credibility was the taking of field notes during data collection (Mason 2002; Patton 2002). Field notes outline the procedures of data collection including interactions with participants, participants' responses to events and situations, observation of events and the researcher's reflection on the data collection process.

Transferability refers to the probability that the findings of the study can be applied in other contexts or with other groups (Morse & Field 2006; Krefting 1991; Polit & Beck 2008; Speziale 2007b). Guba and Lincoln (1989) claim that transferability is more the responsibility of those who intend to transfer the empirical findings to another context or population rather than the researcher(s) of the original study. To achieve transferability of research findings, I provided a detailed description of the study context, the purposive sampling strategy employed, data collection method of reflective journaling and analysis methods, and my role within the context, so that decisions regarding transferability could be made by the potential users of the research methodology (Devers 1999).

Dependability is the criterion used to determine that the research findings would be consistent if the qualitative inquiry were replicated with the same participants or in the same context (Morse & Field 2006; Krefting 1991; Polit & Beck 2008). Dependability in

this study was enhanced by conducting reflective journal training sessions with the participants prior to them completing their reflective journals (Simpson & Courtney 2007; Taylor 2006). The training commenced at their level of experience in reflective practice and journalling, then advanced the participants to the level of reflective journalling as a data collection instrument. The reflective writing exercises, based on situations in their lived clinical experiences, were related to a non-EOL patient situation in which they were guided to respond to structured questions similar to the ones included in the reflective journal data return sheets (Burrows 1995; Croke 2004; Plack et al. 2005).

Confirmability is the criterion used to enhance accuracy of the findings and the freedom from bias in the research procedures and results (Morse & Field 2006). This criterion is concerned with demonstrating that the data represent the information participants provided, and that data analysis and interpretation reflect only the participants' own experiences and are free from the researcher's bias or perspective (Krefting 1991; Polit & Beck 2008). Confirmability was ensured by the involvement of the research site co-supervisor, who is an experienced qualitative researcher with expertise in reflective journalling and who was available at the research site, to avoid the researcher's bias. The researcher and the co-supervisor conducted several meetings for the purpose of bracketing (Creswell 2007; Patton 2002; Speziale 2007b) and to discuss data analysis and reached an agreement on the themes and sub-themes identified from the collected data. Another method of achieving confirmability was the researcher's writing of field notes and memos throughout the analytic process that was used as a basis for weekly supervision meetings. The aim of the contextualising the use of memos was to minimise the researcher's biases. This was achieved by keeping a record of the researcher's subjective thoughts, opinions and ideas of events (Corbin & Strauss 2008) while studying and analysing the reflective journals. In consultation with the supervisor, the written notes and memos were discussed later using the technique of bracketing so that biases were identified and isolated conceptually.

My introductory exposure to bracketing was challenging, however, with time I became comfortable in the supervisory discussions and realized that it was an intentional and focused skill to ensure rigour and reduce biases in the study, I realized the value of bracketing and reflexivity as qualitative techniques to avoid researcher assumptions being inadvertently integrated into the data (Corbin & Strauss 2008; Creswell 2007; Patton 2002). Bracketing ensures authentic description of the phenomenon by minimising preconceived assumptions or presupposition regarding the phenomenon under study (Dunne, Sullivan & Kernohan 2005; Rose, Jayne & Parker 1995; Speziale 2007b; Webb 2003). Rose, Jayne and Parker (1995) advocate that scientific rigour is established at the start of phenomenological research through the process of bracketing. Bracketing was commenced in this study by performing a narrow literature review at the beginning of the study, and specifically before and during data collection and analysis particularly during supervision discussion. The likelihood of developing bias about the phenomenon of interest was therefore reduced and the phenomenon that unfolded was based on the participants' viewpoints rather than the preconceived beliefs or opinions of the researcher (Burns & Grove 2005; Silverman & Marvasti 2008; Speziale 2007a). It is argued, however, that bracketing is an iterative process that should be acknowledged persistently throughout data collection and analysis (Polit & Beck 2008; Speziale 2007a). In this study, keeping field notes during the time of data collection helped me as the researcher to distinguish between my own thoughts and beliefs versus the actual data collected from the participants or from the field (Mason 2002; Patton 2002). On the other hand, memos to me as researcher that record the context of all data analysis procedures and the link to the phenomenon under study are also extremely useful to make clear the researcher's personal ideas and thoughts about the collected data (Corbin & Strauss 2008). Bracketing therefore became meaningful through the ongoing consultation and discussion with the research site co-supervisor during data collection and analysis, so that the overlap owing to being both researcher

and a clinical nurse manager on the medical unit became distinct to ensure neutrality in my approach to maintain trustworthiness.

In summary, scientific integrity was a core consideration throughout the research process so that I was able to differentiate clearly between my roles.

3.9 Conclusion

This chapter discussed the design and methodology for the research. The chapter first provided an overview of phenomenology as a qualitative research approach to collect data outlining the rationale for using the reflective journal technique in the research. It then described issues pertaining to sampling strategy, selection of participants and the reflective journaling instrument used for data collection. This was followed by a discussion on the measures used to conduct data collection and analysis. Ethical considerations and aspects of scientific integrity were also discussed. In the next chapter, the analysis and results from the data collected are reported, and chapter five provides a discussion of the research findings.

CHAPTER 4 RESULTS

4.1 Introduction

This chapter is a presentation of the data analysis process and results that are the empirical findings obtained from the reflective journals. It will be shown that the research objectives of the study were achieved, in that the nurses' lived experience and meaning of their involvement in 'end-of-life' (EOL) care after a 'do-not-resuscitate' (DNR) on medical units became evident.

4.2 Preparation of Data Analysis

Twenty-eight (28) reflective journal sheets were distributed and a total of twenty-six (26) reflective journals were completed and returned to the researcher. Telephone follow-up calls to all potential respondents were done to thank individuals for time spent in participation. Two (2) potential respondents indicated their decision not to participate, which was respected (Polit & Beck 2008), and therefore the study continued with twenty-six (26) respondents. The contents of the returned journals were transcribed by the researcher into a word-processed document file, which was password-protected, in keeping with both university and hospital ethics requirements, and therefore only the researcher had access to the actual content of the reflective journals on the personal computer. Two measures were taken to ensure maximum protection of the identity of the participants. A system of double-coding was used, whereby the participants at source in the field allocated themselves a 'participant code' on their reflective journal return sheet (Appendix 9), and a 'research code' was allocated by the researcher during data capture entries from the reflective journals into the personal computer using a logging format (Appendix 10). The specific research code assigned by the researcher

was a numeric system for reflective journal returns to ensure confidentiality, and therefore the printed copies of the reflective journals for data analysis did not indicate identifiable details of the participants. Each transcript was preceded by 'RJ' for reflective journals then the numerical research code. These printed copies could therefore be used for discussion on data analysis between the researcher and the co-supervisor without compromising the confidentiality and anonymity of participants.

4.3 Data Analysis Process

The data analysis process was a dynamic process with extensive iterative interactions between myself as the researcher and the university appointed co-supervisor at the research site in Saudi Arabia. The research co-supervisor, who is a qualitative researcher and who has related experience in the use and analysis of data from reflective journals, was consulted throughout the process of data analysis at the research site.

In the original research proposal submitted to the University, it was anticipated that the qualitative data analysis approach of Tesch (1990) would be used. During ongoing iterative and frequent meetings with the research co-supervisor, however, the data analysis approach of Coffey and Atkinson (1996) was integrated into the original work of Tesch (1990). This integration was regarded as congruent because Tesch (1990) is extensively referenced in the data analysis approach of Coffey and Atkinson (1996).

The transcripts of the returned reflective journals were read repeatedly by me as the researcher to gain a sense of the whole and familiarity with the content and context of responses (Ritchie, Lewis & Elam 2003; Tesch 1990). The intention was to go beyond the nurses' lived experience in EOL care after DNR to gain an understanding of the

meaning of their involvement and to establish the extent of their involvement as team members. Field notes during data analysis and memos to the researcher (Appendix 14) during data analysis (Corbin & Strauss 2008) added depth and clarity to the contextual perspective of the data, especially when identifying emerging themes in the final part of data analysis.

Concurrently, the researcher used memos as a method of recording significant aspects of findings in data analysis, and kept them for further discussion with the co-supervisor. Subsequently, the preliminary themes from all transcripts were developed and marked on each transcript and were translated onto the data analysis template (Appendix 15). A list of initial categories of themes that emerged from this stage of data analysis is presented below in Table 4.1. It is important to note that the categories are listed in a random manner and have no hierarchical relationship in terms of importance.

Table 4.1 List of Initial Categories and Themes in Random Order

Continuity of nursing care	Exhausted treatment	Professionalism of nursing
Tender nursing care	Empathy	DNR is a physician decision
Nurses excluded in DNR decision-making	Physicians less responsive after DNR decision	Physicians provide same response after DNR decision
After DNR nurses more responsive	Team less responsive after DNR decision	Muslim nurses' duties
Non-Muslim nurses sensitive to Islamic aspects	Modified nursing care	Focused nursing care
Support system	Extending care to the family	Physicians must be involved
Language as a barrier	Compassionate nursing care	Family participation
Support from colleagues	Multidisciplinary approach	Training and education on EOL care
Challenging nursing care		

4.4 Emergence of Themes

The three main themes that emerged from the data analysis were: (1) exhausted medical treatment, (2) continuity of nursing care, and (3) Islamic considerations in nursing care. The main theme 'exhausted medical treatment' included two sub-themes namely (1A) 'nursing excluded from DNR decision-making' and (1B) 'varying physician involvement after the DNR decision'. The second main theme was 'continuity of nursing care' that included (2A) 'compassionate and comfort nursing care', (2B) 'focused comprehensive nursing care' and (2C) 'nurses coordinating care contributions' as sub-themes. The third main theme was 'Islamic considerations in nursing care' that included (3A) 'recognition of Islamic aspects in nursing care' and (3B) 'integrating Islamic aspects into education on EOL nursing care'. Once data analysis was completed, the literature was then reviewed selectively to position the main themes and sub-themes within the context of what was already known about the research topic (Silverman & Marvasti 2008; Speziale 2007a). The representation of the main themes and the sub-themes, as well as the supporting empirical evidence from the reflective journals, is illustrated in sections 4.5, 4.6 and 4.7.

Table 4.2 Emergent Main Themes and Sub-Themes in the Study

Main-Themes	Sub-Themes
1. Exhausted medical treatment	1A. Nursing excluded from DNR decision-making
	1B. Varying physician involvement after the DNR decision
2. Continuity of nursing care	2A. Compassionate and comfort nursing care
	2B. Focused comprehensive nursing care
	2C. Nurses coordinating care contributions
3. Islamic considerations in nursing care	3A. Recognition of Islamic aspects in nursing care
	3B. Integrating Islamic aspects into education on EOL nursing care

A contextual consideration in the use of journals was the writing ability of the participants. Arnold and Boggs (2007) confirm the universal observation that nurses need standardisation in approach to language use when transitioning to the electronic patient documentation. This situation over the past five years in our hospital, added to English being a second language to the majority of nurses, needs explanation regarding the verbatim use of reflective journals excerpts. It was somewhat frustrating initially to understand the written raw data owing to grammatical and spelling errors. However, after understanding the intended written text, it added authenticity because it meant prolonged engagement (Manning 1997) by me with each reflective journal and therefore meant that I had to develop a greater understanding of the language and expressive style of each participant within their unique use of syntax.

Based on the above, whenever missing letters or incomplete words were found, the following symbols '[' and ']' and the missing letters were inserted subsequently by the researcher to complete the words for purposes of logic. In the written presentation on the emergent themes that follows below, three full-stops (...) are used frequently to indicate non-essential omissions from the original transcriptions of the reflective journal data segments, which aimed to maintain the logic and original meaning of the respondents. By doing this, the researcher ensured complete and correct presentation of the empirical evidence while maintaining the integrity of the data (Morse & Field 2006). The subsections of paragraphs are numbered with a first decimal point such as 4.5, 4.6, 4.7 and so forth. This style of numbering the paragraphs was aimed at clarity and to avoid cumbersome numeration after the decimal in the sub-sectional descriptions of the emerging themes. The conclusion statements embraced the main themes and sub-themes that are given as a completed summary.

4.5 Main Theme 1: 'Exhausted Medical Treatment'

The first main theme 'exhausted medical treatment' refers to the inability of the medical interventions to achieve progress in the medical condition of patients with chronic and terminal diseases during their stay on the medical units. This theme description is supported by Slowther (2006), who reaffirms that treatment exhaustion is often reached when medical treatment is no longer successful in producing effective medical outcomes. The following quotes from participants show how EOL care relates to patients whose medical condition was regarded as having seriously deteriorated to a level where no further treatment would lead to an improvement:

End-of-life care within the context of my current unit is taking care of terminally-ill patients whose condition is unremarkable with no chance of prognosis (RJ 02)

EOL care is provided to those patients with chronic illness and patients [who] are not responding to medical treatment and the prognosis is very poor (RJ 03)

EOL refers to those patients with multiple medical problems that are irreversible considering the age and survival rate (RJ 09)

The above three (3) excerpts confirmed the main theme of 'exhausted medical treatment'. This is reiterated by Cumbie, Conley and Burman (2004) and Smeltzer et al. (2008), who state that chronically ill patients often have complex medical problems that lessen the chance of a positive outcome. Consequently, patients with chronicity often experience a gradual worsening in their medical condition, associated with exacerbations of symptoms leading to hospitalisation, followed by either short-term

stabilisation or death (Kapo & Casarett 2006). In this regard, two essential factors, namely the age and the existing medical condition, were considered to necessitate EOL care for patients with chronicity, as one participant confirmed:

End-of-life care is very common in the unit where I work. It is because every day we deal with patients who have multiple medical problems and mostly with elderly people (RJ 06)

Reaching a consensus on the definition of exhausted treatment by the physicians is not always easy. During the information sessions on the research project, as recorded on a field note, nurses disclosed their concerns about differences of opinions regarding patients' treatment plans between the general medical consultant at unit level and the intensive care physicians. My field notes also had an entry of a clinical incident that occurred on a medical unit during data collection, whereby a conflict regarding the patient's treatment plan had emerged between the treating general unit physician and the intensivist, when referral had been made for consultation with the latter on the worsening patient condition. The recommendation by the intensivist was that aggressive treatment should be minimised, which the treating physician on the unit decided not to accept and then proceeded further with aggressive treatment. Despite nurses being placed in this difficult situation, they nevertheless continued to monitor the patient closely and a one-to-one patient-nurse ratio was applied. According to the participants, exhausted medical treatment was an indicator to recognise a dying patient. This posed a significant challenge for nurses in managing patients on the medical units because of the opposing views of the doctors and a lack of consensus on when the EOL stage had been reached. The following reflective journal excerpt illustrates this situation:

End of life means when a pt [patient] is so gravely ill [and] that death is imminent and inevitable at any time. At this time the pt [patient] is considered in the terminal phase of a progressive, irreversible dying process. Having a pt [patient] in a terminal phase, is not easy at all
(RJ 16)

In such a situation, if the patient approaches death on the unit, then the nurses pay focused attention to the importance of the patient's right to die, providing dignity and enabling accompanying family support. In the following exemplar a participant described honouring the patient's dignity at death:

End-of-life care mean[s] the patient in the terminal phase of life and ending disease process ... mean[s] to allow patient to die with considering his dignity and avoid[s] any inappropriate prolongation of d[y]ing (RJ 25)

The main theme of 'exhausted medical treatment' consisted of two (2) sub-themes: 'nursing excluded from DNR decision-making' and 'varying physician involvement after DNR decision', which were derived from the analysis of the reflective journal data. The sub-themes elucidate the nurses' lack of involvement in the DNR decision-making process when physicians consider that their medical treatment plans are exhausted, and related to this was the portrayal of physicians as varying in level of attendance once the DNR has been made.

4.5.1 Sub-Theme 1A: 'Nursing Excluded from the DNR Decision'

The DNR decision-making process is regarded by Hayes (2004) and O'Keefe and Crawford (2002) as a collaborative process in which physicians, nurses and other

healthcare team members work closely with patients and their families to obtain consensus on no further aggressive treatment, respecting patients' and families' rights and values, and reflecting the medical perspective. A sense of exclusion from the DNR decision-making process was expressed by the RN participants. This sense of exclusion from DNR decision-making is best illustrated by the following quote from one of the reflective journals.

In our organization nurses are not involve[d] in the DNR decision-making process. It is the responsibility of the physician. Once they see the patient is very sick, with multiple medical problems, with poor prognosis or after being seen by critical care response team with same assessment after further discussion, then they [physicians] make the [DNR] decision and explain to the family. If accepted by the family, that is the time the patient is put on DNR [officially] (RJ 06)

This sub-theme of 'nursing excluded from DNR decision-making' was reinforced by the clinical nurse managers of the medical units during the reflective training sessions as documented in my field notes. They confirmed that nurses working on medical units are generally isolated from the DNR decision-making process. Moreover, they reported that even if nurses have different opinions, the treating physicians nevertheless will proceed with the DNR decision-making in isolation. One of the RN respondents explains in her reflective journal entry how her involvement in DNR decision was outside the scope of her nursing care.

I can continue by only reporting what is under the scope of nursing, but the decision of DNR mainly are the doctor[s'] own judgment and with the help of other consultants. The primary physician has to initiate it [DNR] and to be agreed by the second consultant or senior resident

[doctor]. The order of DNR must be written on progress notes with 3 [physicians'] signatures and activated by the primary physician / consultant on physician order for ... legality of the order (RJ 09)

The frequent comment recorded in my field notes was that several participants, despite their hourly contact with the patients, were not involved in the DNR discussion. Hohenleitner (2002) asserts that whereas physicians hold the primary responsibility on the unit for the DNR decision, nurses, by virtue of their extensive contact with patients and their families, should be expected to participate in the DNR decision-making process. In the absence of nurses' participation in the DNR decision-making process, practical safety issues might arise for nurses. For instance, I documented in my field notes that I recalled an incident in my role as nurse manager where physical violence by family members erupted against a nurse working on my unit owing to their misunderstanding or lack of information regarding the DNR decision and the subsequent death of the patient. An assumption appeared to have been made by the family members that the nurse had somehow neglected the care of the patient by not attempting to resuscitate him, whereas the DNR decision had been made by the treating physician without informing the family or ensuring that they understood what it meant. The following exemplar reflects the common concern that RNs on medical units are being left out of the DNR decision-making process:

I observed that my role as nurse in DNR decision-making process in this hospital is very minimal, because most of the time, doctors are initiating the DNR decision. Nurse[s] can ask only to [of] the doctors on DNR status of the patient if we observed that the prognosis of the patient is very poor ... or when the patient level of consciousness is very poor or deteriorating continuously. Usually we [have] asked the doctors or physician what is their plan for that patient. In my opinion as a nurse

and one of team members, I must be also active in giving ideas and opinion because I know ... what is happening to the patient in [my] clinical area; in [on the] medical side I also understand the process of disease (RJ 01)

In this exemplar from a reflective journal, the participant describes the extent of involvement by RNs, with physicians believing that their input as nurses should be minimal, and that it requires RNs to inquire persistently about the stage of the dying process of the patient. This extent of involvement was confirmed by another RN participant, who showed self-awareness regarding the cultural and religious differences that possibly influence the non-participation of nursing in the DNR discussion. She also raised the concern that the majority of nurses who are working in the hospital are expatriates and non-Arabic speakers, and as such are excluded from the DNR decision-making process, stating that:

As nurse[s] we play a very minimal role in decision-making as a 'No Code'. But nurses also can contribute factors like nutrition, family support, psychological and physical condition, emotional condition of the patient when they discuss about 'No Code'. But here in the hospital, no doctor will ask the nurse's opinion before taking a decision. May [be] [because] lot of western and foreign nurses [are] working in this country, and language is a barrier (RJ 03)

It is a noteworthy observation that the above participant, despite acknowledging the status of nurses as 'foreign', has nevertheless outlined that nurses could still be involved in EOL care in 'nutrition, family support, ...' related to the physical and emotional needs of the patient. The sub-theme that follows provides empirical evidence of the differences in physician follow-up interventions in EOL care of DNR patients, and further illustrates

the main theme of 'exhausted medical treatment' that perhaps may mean that physicians as well become somewhat 'exhausted'! This unintended pun on usage of the word 'exhausted' arises from my field notes where I documented that a colleague nurse manager was annoyed by a physician who complained to her that a nurse had called him at night regarding a patient who was already decided as DNR, thus "disturbing" his rest.

4.5.2 Sub-Theme 1B: 'Varying Physician Involvement after the DNR Decision'

The second sub-theme linked to the main theme of 'exhausted medical treatment' was 'varying physician involvement after the DNR decision'. This sub-theme refers to the variable attendance of some physicians on medical units, because the empirical evidence portrayed that their input in the EOL care and treatment plan after DNR decision was variable, to say the least. This sub-theme is supported by the following reflective journal entry that demonstrated the modified and sometimes reduced physician input after the DNR decision:

After the DNR decision, [a] consultant might follow up the patient by himself or through the team on daily basis and as needed. Some will not follow on [a] daily basis and keep the patient under routine and palliative care till [until the] patient's death. Some consultants or doctors from the team will come to support the family at the time of patient's death (RJ 11)

On one hand, physicians may continue their interventions and follow-up of patients irrespective of their resuscitation status. It is unclear, however, whether in this case the primary physician was a palliative care consultant or not, given that this is sometimes the practice on the medical units, although not necessarily part of standard medical

practice. In this regard, it is worth noting that the current medical practice in the hospital permits the palliative medical team to respond primarily to oncology patients whose metastasis level is advanced and who are approaching death. However, there is evidence that the trend is changing. The exemplar that follows illustrates changes in current practice:

There was no change of medical treatment except not to initiate resuscitation. The physician is still aggressive to correct hypotension, laboratory and X-ray investigation if required, ... of nutritional support like tube feeding and referral to dietician to modify diet. The primary physician visit[s] the patient everyday, update[s] the family with the recent situation and condition of the patient until the moment of death (RJ 09)

It is generally understood, however, that some physicians may challenge the DNR decision and may even reverse it upon a request from the family. From my experience as nurse manager on general medical units, I recorded a clinical situation that I had witnessed when a DNR patient was dying on the unit and the family members, who were present at that time, had insisted that nurses must initiate cardiopulmonary resuscitation. Upon the arrival of the treating physician on the unit, and in response to a state of denial by family members regarding the terminal phase of their patient, a reversal of the DNR decision was made, and the critical care response team was called to administer advanced resuscitation, but the inevitable outcome was death.

Participants also described how the involvement of physicians in the provision of EOL care contributed to a successful collaborative outcome. The following quote demonstrates how a participant appreciated a physicians' sustained input after the DNR decision had been made, and which further illustrated aspects of physicians'

interventions such as frequent reassessment of patients, ongoing education for families, and professional referral to other healthcare team members.

Mostly they [physicians] treat the NO CODE patient base[d] on their medical problem. During their rounds they will gather all patients' medical information and they will discuss it in the conference including all important issues in[with] regards to the patient every week. They also monitor the blood [laboratory] works twice a month ... for investigation; [and] prevention of other complications. They refer the patient to occupational therapy and physiotherapy for patient's muscle tone and to prevent contractures. They refer them to the dietician for the proper nutrition. They also educate the family / sitter to participate in the care of their patients as a preparation for the home discharge. They also refer them to the social services; home healthcare department in terms of financial status. They will be sure that even [when] the patient will be discharge[d], they will be [have] met their healthcare needs (RJ 19)

This scenario did not emerge commonly in the empirical data because it was considered unique, although it served to confirm the sub-theme of varying physician involvement after the DNR decision. A concern expressed, however, by other participants was that physicians seem to avoid responding appropriately to the needs of patients and families. The quote below illustrated the concern that physicians were sometimes reluctant to intervene after the DNR decision had been made.

I observed that after the DNR decision has been made, the medical treatment of [by] the physician for the patient are [was] limited; almost [as if] they don't [do not] want to order any procedure, and [neither] to

do any invasive treatment. Usually the physician just order to provide a supportive measure only ... If the patient is really very sick or about to die, you call up the physician [but] they are hesitant to come immediately to [re-]assess the patient and they will ask if the patient is for DNR [resuscitation or not], [and] if they know that patient is DNR, the physician will tell you, just call me if the patient is [has] died or if you have flat EKG tracing [absence of heartbeat] (RJ 01)

This finding of decreased involvement by physicians after the DNR decision is supported by Shotton (2000), who claimed that, unlike nurses who spend more time at the bedside with patients and families at EOL, treating physicians become less involved, resulting in a decrease in their medical contact and visits to the patient. Furthermore, the nurse observed that physicians, as well as other healthcare team members, were seemingly not interested in joining the patient's family when death occurred on the unit.

It is [a] very rare happen[ing] that the physician is present at [the] patient[s] bedside upon [at] the moment of death of [the] DNR patient. They [physicians] are hesitant to provide emotional support for the family. Usually they will ask the nurse to call patient relation [officers] to settle the family ... it [is] very seldom that the physician or any multidisciplinary team [members] are present [at] the time or moment of death of any DNR patient (RJ 01)

In the opinion of the respondents, the withdrawal of physicians from active involvement with patients occurs either because of reduced need for active medical intervention or because patients who are DNR are possibly considered as a low physician priority. This was regarded as a major concern for nurses who look after these patients, as a participant explained in the following extract:

Honestly, when referral is sought to the medical [physician]-on-call, especially at night they initially ask about the code [resuscitation] status of the patient. And if they know that the patient being referred to them is “no code” [not for resuscitation] patient, they won’t [would not] attend to this referral right away because the priority is “full code” patient. The “no code” patient will be attended to as “least priority”. Sometimes, if the problem of the “no code” patient does not require any urgent intervention (during the night) the medical on call will just wait for the [medical] team to decide for the intervention during the following day. The team will not always make rounds to see the “no code” patient (RJ 13)

4.5.3 Summary of Theme 1: ‘Exhausted Medical Treatment’

Medical treatment is regarded as exhausted in patients with chronicity when further treatment is likely to be unsuccessful in producing restorative results, and where death is either imminent or inevitable. The consequent decision for DNR status, from which nurses are usually excluded, is made by physicians. The level of involvement in follow-up care by physicians fluctuates, with variation in the frequency of physician attendance to EOL patients after DNR.

Whereas the first main theme relates to recognition of futile treatment and the exclusion of nurses in the DNR decision-making process, the second main theme describes the care involvement by nurses after DNR decisions have been made.

4.6 Main Theme 2: 'Continuity of Nursing Care'

The second main theme that emerged from the data was 'continuity of nursing care'. This theme indicated that nurses rendered care in an ongoing manner so that patients' and families' needs are acknowledged, irrespective of the patients' resuscitation code status. Continuity of nursing care throughout the process of EOL care is regarded as important for patients and families, as it reassures them of their right to receive appropriate EOL care (Henderson 2004; Joel 2003). Lynn, Schuster and Kabcenell (2000) contend that continuity is the essence of care for dying patients and their families. The following empirical evidence confirmed that nursing care is given on a continuum before and after the DNR decision:

After the DNR decision there is still continuity of care [to be] given to the patient. I would say there is [should be] no change and we [should] maintain the quality of care including the support to [the] patient [s] family (RJ 21)

End-of-life care within the context of the current unit I am working in means to provide all the necessary care to a dying or NO CODE patient (RJ 26)

The nursing approach of continuity of care is further supported by another participant, who claimed that 'end-of-life' was not seen as the 'end-of-care', by stating that:

The patients will be taken care of; support will be given to the family. For us [nurses] the end-of-life does not mean the end-of-care ... My care was not different after the decision has been made (RJ 07)

This excerpt from RJ 07 which vividly provides the essence of the approach to EOL patients is also evident in the previous excerpts from RJ 21 and RJ 26, which confirmed the full extent of involvement by participants in EOL care after the DNR decision. Barnett (2006) asserts that the provision of nursing care for patients at the EOL after DNR should be based on the patient's needs, rather than the medical diagnosis or the disease itself. This perspective in nursing practice is epitomised in the following exemplar, in which a participant explained how EOL nursing care on medical units was provided on the basis of patients' needs, rather than the patient diagnosis or resuscitation code status:

We really try our best to provide them with excellent care and give them their remaining dignity and quality of life. In our unit, on nursing side we care [for] patients not base[d] on their code status, but providing equal right[s] as a patient. We give care base[d] on their daily needs ... Most of our care we provide [relates to] their daily living activities such as feeding, grooming, dressing, etc ... We continuously help them by providing emotional and other supports from other team or healthcare team, EOL is also a religious and moral issue (RJ 14)

Another RN participant asserted this by confirming that EOL care was a part of basic nursing for both the patient and the family.

The care is the same for a no code or full code patient from the basic nursing care [perspective] ... In addition to that care, we have to look more after the patients' family, because they will be more anxious and worried about their patient (RJ 04)

Most participants acknowledged involvement of patients' families in EOL nursing care and related it to their valuable support as family when patients were approaching death in the hospital. For instance, one participant confirmed the extent of nursing involvement that included the family in the reflective journal entry:

EOL care then extends to patients' family since they are the patients' support group. We involve them in the care, we educate them about the patient condition and prepare both the patient and family of what might be the outcome of the illness or condition that the patient is [was] having (RJ 02)

This view that continuity of nursing care was important for patients was supported by another participant in the journal entry about involving families in the EOL nursing care:

Both the patient and patient's family should be the centre of care considering all aspects like physically, emotionally, spiritually, and likewise the social aspect (RJ 23)

The above empirical data from participants in RJ 02, RJ 04 and RJ 23 all portray and reinforce the extent of the continuity of nursing care and nursing involvement in EOL care after the DNR decision. The participant below embraced not only the concept of continuity of nursing care when the patient is alive, but indicated clearly in the reflective journal extract that the understanding meant that EOL care extends beyond the moment of death to include nursing care after death.

End-of-life care is being given to the dying patient, providing dignified care maintaining his/her continuity of life if possible, either medical,

physical, religious and nursing intervention until post-mortem care (RJ 22)

In the following excerpt from the reflective journal, a participant summed up the perceived understanding of continuity of nursing care in EOL, using various related terms that illustrated the extent of the caring philosophy. For me, as researcher and nurse manager, the reflective journal (RJ 13) below vividly captured and encapsulated the full sense of the meaning in the term 'continuity of nursing care'. The participant uses philosophically appropriate terms to convey the caring attitude in EOL care. These include 'tender', 'loving', 'patiently', 'devotedly', 'relieve him', 'very fragile', and 'best care'. After reading this poignant reflective journal entry, I experienced my own sense of professional renewal before being able to continue with the data analysis process.

End-of-life care is a tender, loving, comprehensive and full of sympathy kind of care rendered to a very terminally ill and dying patient ... So the nurse will have to patiently and devotedly turn him frequently, feed him as prescribed, give medications to relieve him from pain and discomfort. Wash him tenderly because the skin is already very fragile ... We want the best care for them before they die (RJ 13)

Arising from the second main theme of 'continuity of nursing care' were three (3) sub-themes, namely: 'compassionate and comfort nursing care', 'focused comprehensive nursing care', and 'nurses coordinating care contributions.' These three (3) sub-themes that emanated from the analysis of the reflective journals are congruent with the embedded main theme of 'continuity of nursing care'.

4.6.1 Sub-Theme 2A: 'Compassionate and Comfort Nursing Care'

The expressions 'empathy', 'tender care', 'comfort care' and 'compassionate care' were used by the participants to describe the nature of the sub-theme 'compassionate and comfort nursing care' for patients and families after a DNR decision has been made. Provision of compassionate nursing care is considered as a fundamental element in EOL care (Ciccarello 2003; McCann et al. 2007; Peden, Tayler & Brenneis 2005; Rushton, Spencer & Johanson 2004). Peden, Tayler and Brenneis (2005) claim that nurses are compelled to provide compassionate EOL nursing care, which includes relieving patients' pain and affording physical ease and well-being. Arnold (2007) and Boggs (2007a) attribute the means of demonstrating compassion to the empathetic ability to communicate with patients in a sensitive way that shows awareness and understanding of their feelings of both physical and abstract pain. The following excerpt demonstrates how a participant, despite the deep level of understanding of the patient's pain at EOL, was able to control the extent of emotional involvement with the patient. Although it was a challenge to remain calm and not to show concerns openly, the participant was aware by reflective disclosure that this was an important contribution to caring for patients who were dying:

However during his last admission I know it would be the last time though I prayed that he will still get well. I know this was the same prayer his parents had. I always try to provide the best care I can for my patients ... as I gave my last nursing care few days before he passed away, my heart was in pain too. I still wanted to save him or to prolong his life if I could, [.] [The] the day before he died, every time I entered the room, he was reaching out to me as he wanted to be held or carried out of bed (RJ 06)

The level of relating to needs of EOL patients by nurses who frequently care for those with chronic illness and who develop compassionate relationships based on trust with both patients and families places them in a unique position to provide the level of assistance as needed (Boggs 2007a). A participant described the EOL care and the compassionate relationship that had developed with a patient and her daughter, which according to the participant was based on empathy and trust.

It really touches me that she [the patient] had that dignity and pride and it was a pleasure to help her every step of the way, putting her back in bed and made [making] her comfortable. I was trying to comfort her daughter to the best of my ability with my broken [faulty] Arabic. I believe at the end of the day there was a bond between us (RJ 08)

In EOL care situations, the nurse-patient relationship is intimate in nature, and involves the provision of compassionate and comfort nursing care. The following reflective exemplar shows that compassionate nursing care was the cornerstone in provision of EOL care:

The most important [aspect] is – we are giving the most compassionate specialized care for the living. It is base[d] on comprehensive understanding of patient suffering and focuses on providing effective pain and symptoms management to seriously ill patients while inquiring [ensuring] quality of life. Providing appropriate end-of-life care became a primary concern of each and every one of us [as nurses] (RJ 21)

4.6.2 Sub-Theme 2B: 'Focused Comprehensive Nursing Care'

The second sub-theme 'focused comprehensive nursing care' refers to nurses' ability to recognise that patients at EOL stage have particular needs related to the dying process within the spectrum of total nursing care. It is the essence that underlies the participants experiences of 'focused comprehensive nursing care' that was expressed through the use of various descriptions including 'holistic care', 'comprehensive care', 'complete care', 'supportive care' and 'modified care', that were subsequently collapsed into this sub-theme, based on a review of related empirical data from the reflective journals. In the three (3) selected reflective journal excerpts given below, the participants portray their understanding of focused, comprehensive EOL care that is targeted on the needs of dying patients.

End-of-life care means that still you are taking care of the patient almost dying [at the moment of death], but I must always remember that in this [type of] care patient needs more support, physically, ... and emotionally (RJ 01)

Patients with serious illness at end-of-life require modifications of nursing care plans. Our nursing plans [are] focused on giving / providing dignity to the patient until the time of death (RJ 02)

It's [It is] a complete care, same like other types of patients [without differentiation in the scope of patient care], receiving complete handover from the last shift, report any abnormalities [deviations in care], [and] include physical, social, psychological, emotional and family problems (RJ 15)

In keeping with the professional expectation that nurses remain with patients until the moment of death, Smeltzer et al. (2008) argue that nurses working with patients at EOL are required to extend their care beyond the medical perspective to include the person as a whole. Ciccarello (2003) concurs with this notion, and goes further to emphasise that EOL nursing care should be focused on the patients' physical, psychological, social, and spiritual needs. The quotes in the present study show that the participants in the present study engaged in providing comprehensive EOL care.

We have to remember that [in nursing & healthcare] there is [a] human approach, respecting patient [patient's] goal and preference, and choices, [which involves] attending to medical, emotional, social & spiritual need [needs] of a dying person and involving [involves] the strength of multidisciplinary resources (RJ 12)

Pain [is] not only physically but they [patients] are also in pain inside emotionally. Support should be physical, emotional, if possible even spiritual. Physical support like if in pain [then] give analgesia, [for] emotional support like[such as] this time [a] patient in [a] family is at the stage of denial [then] be extra patient with them. Listen, [and] [be] extra caring. Sometimes they [the patient and family] are so irritating [that] what I did is I just imagine myself as them [, which] shows an empathy [nursing side to...] the patient and family. If possible I reassure the patient. I pray for them even though were not the same religion [as I] (RJ 10)

This reflective journal extract represents the depth of involvement of nurses, almost all of whom are non-Muslims, and reinforces the argument that comprehensive nursing care can indeed be focused, irrespective of differences in religion. In the context of the

general medical units, nurses seemingly approach different team members to engage in a contributory role for continuity of EOL care. The sub-theme that follows delineates the extent to which nurses ensure that patients' and families' needs at EOL are regarded as pivotal in the patient-centeredness approach adopted by nurses in continuity of EOL care.

4.6.3 Sub-Theme 2C: 'Nurses Coordinating Care Contributions'

The third sub-theme 'nurses coordinating care contributions' extends the depth of the main theme of 'continuity of nursing care', and shows the collaborative approach with other healthcare team members that is promoted by nurses to ensure delivery of integrated EOL care. Nursing staff use coordination as a skill to marshal available hospital resources effectively in response to patients' and families' needs in EOL care (Blais et al. 2006; Joel 2003; Lindberg, Hunters & Kruszewski 1998). Rushton, Spencer and Johanson (2004) report that nursing has an important role in leading the interdisciplinary team to address the patients' and families' needs collaboratively in EOL care. The following empirical evidence from the reflective journals explicates the commitment of a participant to coordinate EOL care for the dying patient:

Another role [for nurses in EOL care] is being the bridge between the doctor and family or patient, because some of them [patients or families] just consented [to DNR] without really understanding what is it. As a nurse [I] just tell the doctors to give some explanation to the family. For other team members, respiratory therapist for example using a nebulisation if patient is desaturating. For [the] dietician [I] can suggest diet of the patient. [Physicians] should visit patient from time to time, daily won't [would not] hurt because if not it makes family more anxious (RJ 10)

In this regard, my field notes include a reference to my own professional experience as a medical unit nurse manager with a DNR patient whose condition was worsening and whose life became threatened owing to a partial airway obstruction. The most responsible physician (MRP) ordered the urgent insertion of a tracheostomy tube, which was to be carried out in the Operating Room (OR). However, when the patient arrived in the OR, the procedure was cancelled by the anaesthesiologist, who claimed that DNR patients were 'not entitled' to the insertion of tracheostomy tubes. The family members who had agreed to the procedure raised questions and concerns about the rights of their loved one to comfortable EOL care and death. I took the initiative as the unit nurse manager to discuss the DNR policy with the MRP in my role as patient and family advocate. In turn the MRP raised the issue directly with the anaesthesiologist who was not aware of the details of the hospital policy. The policy clearly states that the DNR patients are entitled to this kind of surgical intervention for any comfort measure and/or to relieve pain (NGHA 2007). On the following day, the patient was taken to the OR and the tracheostomy insertion procedure was undertaken successfully. The incident raised concerns about the awareness and knowledge of healthcare team members of the current hospital policy on treatment options for DNR patients. My own professional experience and the reflective journal outline of the nurses' role in RJ 10 above underline the key role nurses can play in coordinating team contributions to EOL care. The coordinating role by nurses must continue to evolve, as earlier attempts by nurses to marshal care contributions by team members have had a negative result. The participant responsible for the empirical journal evidence below revealed that other members of the healthcare team were reluctant to intervene in situations involving patients in EOL care after DNR. The respondent indicated a level of disappointment with experiences in which some team members appeared to 'de-prioritise' the care of EOL patients after DNR.

Sad to say some members of the health team its [are] not fully active doing their responsibilities. I think they are considering, when working [with] this kind of patient [that] there's [there is] no use or benefit on [of] it. That's why when they will visit this kind of patient [,] they will not stay longer [than] even 5 minutes. (RJ 21)

This profile provided by the respondent in reflective journal RJ 21 draws attention to the different prioritisation applied in approaches to care between nurses and other healthcare team members. This variation in approach reaffirms the role of nurses in coordinating care contributions via assuming an EOL advocacy and leadership role to ensure continuity of care for patient and family. The sub-theme of nurses coordinating care contributions reveals the burden of EOL care that defaults to nursing staff. The vivid reflective journal extract below from RJ 04 sketches the intensity of need and related anxiety that nurses may encounter. The reflective journal respondent also identifies the importance of patient and family education in such situations. This empirical evidence justifies the role that nurses need to embrace in coordinating care contributions. For instance, in this scenario, the Arabic-speaking patient educators in the healthcare team could be involved in educating the patient and family members, and therefore as nurses coordinate the diversity of contributions in EOL care, the collaborative effort thereby ensuring continuity of care. The detailed description from a reflective journal illustrates the burden of EOL care that defaults to nurses. This confirms the paradox in the local context as described in section 4.5.2, where it emerged that varying physician involvement occurred, and nurses seemingly stepped forward to assume a coordination role in EOL care. In direct relation to this, nurses would be better positioned to coordinate care contributions rather than defaulting to an all-embracing role that allows the entire burden of care to rest with nurses. In this note, the reflective journal respondent RJ 04 concludes in the affirmative entry that nothing has changed for nurses.

Most of the time when the patient newly [is] put on DNR status, the family will get anxious. They wanted us [nurses] to come quickly for even a small thing that they noted, like if the Dinamap [electronic blood pressure device] will alarm they think that something happen or even if the IV [infusion] pump will alarm, they will call to come quickly and that is related to the poor education about the DNR status and about the nursing care post and pre DNR. The family keep on thinking that their patient will be neglected after No Code status, so they will keep on calling the nurse to check and recheck every now and then, but for me I was doing my care forgetting that patient is No Code or full code, and keep on explaining to them that we are doing the best for him and for us as nurses nothing changed (RJ 04)

Furthermore such level of familial anxiety can generate aggression if not all family members are informed of the DNR decision and subsequent EOL care. During data collection, one of my field notes related to a clinical nurse manager colleague who disclosed an incident where family members, particularly the son of the patient, did not accept the DNR decision. As a result, and despite the one-to-one nurse-patient ratio, the son became aggressive and physically assaulted the nurse assigned to the patient. The incident was reported initially to the patient relations officer and the Investigation Department at the hospital, and as a result, the son was not allowed to be with the patient to ensure safety of the nurse. Concurrently, the clinical nurse manager called for an interdisciplinary team conference to explain to all of the family members the rationale for making the DNR decision, and to reassure them that care would continue even after the DNR decision had been made. In essence, the clinical nurse manager played a dual role in coordinating care, as both patient and family advocate for EOL care after the DNR decision and as staff advocate to ensure the safety of the nurse. In the absence of a structured and coordinated support system, data from the reflective journals show that

nurses appear to coordinate support for one another to best position the nursing team to provide support for the family. This discovery, for me as a clinical nurse manager, was an interesting and unexpected observation in my field notes, because this sub-theme of nurses coordinating care contributions extended to nurses caring for one another in the nursing team. The following exemplar from the reflective journals evidences this:

Support from co [colleagues] staffs in continuity of quality nursing care as well as the support from the patient's family members are also used in EOL care. They are also our partners in dealing [with] our own turmoil in caring for the patient because sometimes we have to be strong to share our strength, to be brave, to give encouragement to others especially those who care [for] EOL patients (RJ 02)

4.6.4 Summary of Theme 2: 'Continuity of Nursing Care'

Continuity of nursing care reflects the extensive level of ongoing care involvement by nurses with EOL patients and their families in response to understanding their needs, particularly after DNR decisions have been made. Fundamental elements of this approach in nursing care include empathy, comfort and compassion that are delivered as tender care. This humanistic nature of nursing care demonstrates to both patients and families that their EOL situations are understood, and that nurses are aware of their related needs. As part of providing comprehensive nursing care, nurses' involvement remains focused on the physical, psychological, social and spiritual needs at EOL. Therefore continuity of nursing care is targeted according to the unique and individual needs of patients and families while maintaining holistic care. In EOL care after DNR, nurses have a pivotal role of coordinating the collaborative care delivered by team members to ensure that integrated aspects of holistic care are provided. Nurses must take on a leadership role in liaising with various hospital services for interdisciplinary

involvement to ensure that comprehensive EOL care continues after DNR. Related nursing involvement concerning collaboration is determined according to the frequency and nature of both patient and family needs, despite the varying intensity of involvement of other team members.

Whereas the second main theme illustrates the extensive level of nurses' involvement in EOL care after DNR, the last main theme portrays specific Islamic considerations that highlight the need for nurses to be more aware and sensitive to patients and family needs so that culturally congruent patient care is provided at the EOL after DNR.

4.7 Main Theme 3: 'Islamic Considerations in Nursing Care'

The final main theme that emerged was 'Islamic considerations in nursing care', which refers to Islamic and cultural aspects pertaining to the way of life in Saudi Arabia that must be taken into account during nursing interventions in EOL care. Blais et al. (2006) state that nurses need to be aware of and sensitive to the cultural beliefs and practices related to death and dying of persons in different communities. In the local setting, this constitutes non-Muslim non-Arabic speaking nurses from a variety of ethnic backgrounds providing EOL care to Muslim patients who are mainly Arabic-speaking. The extract from the reflective journal data that follows reveals how the participant acknowledged the importance of cultural and religious practices, yet expressed concerns about the safety of the patient in relation to the medical care equipment.

When death is imminent, the family expects that the patient be dealt with differently e.g. [for example] [blessed] olive oil be applied all over the whole body. If the patient is on tube feeding, ordinary bottled water should not be used to flush the feed, instead "zam-zam" [water obtained

from the well in Holy Mosque in Saudi Arabia]. And again, the dying patient's bed is positioned to face Mecca [the Muslim holy city in Saudi Arabia]. This [at] times creates a little bit of concern for the nursing staff as this position might be pulling the patient away from the necessary [medical] equipment i.e. oxygen and /or suction apparatus. Yes, nurses have to show respect for the culture and religion especially during this critical time (RJ 05)

The main theme related to Islamic considerations in nursing care emerged as two (2) key issues that are reflected as sub-themes. The first sub-theme illustrated actual awareness and sensitivity to Islamic aspects of care by the RN respondents, whereas the second sub-theme portrayed an awareness of participants that went further to specify that education on Islamic aspects of nursing care for patients was required.

4.7.1 Sub-Theme 3A: 'Recognition of Islamic Aspects in Nursing Care'

Nurses' recognition of daily Muslim rituals at EOL care, and the subsequent delivery of respectful EOL nursing care to patient and family, is regarded as essential in the Saudi Arabian context (Al-Shari & Al-Khenaizan 2005). Ross (2001) argues that nurses' understanding of Muslim traditional practices related to death would ensure provision of culturally congruent EOL nursing care. The following empirical evidence illustrates the respect and sensitivity shown by a participant towards the Muslim practices in EOL care:

As for near death patients, if the family requested an Imam or any religious person that can offer prayers for the patient, for me, it must be allowed, for the spiritual preparedness of the patient and also in respect to their beliefs (RJ 20)

The importance of respecting the patients' and families' beliefs, knowing the unique needs and responses of dying patients and families, and trying to show respect for them is confirmed and characterised by the reflection on experience of one of the participants:

I have observed here that the family tries to use different cultural and traditional way of treating the sick member of the family. They use prayers, ..., putting oil to the whole body, applying herbal medicine ..., applying henna [herbal medicine] over the pt's [patient's] head. And for me, as a nurse, I respect what these people believe as long as it would not compromise the pt's [patient's] deteriorating condition and safety. I understood that it is not only the pt [patient] who suffers the pain from the disease but also the pain that's in the heart of the family as they watch / see the near death of their loved ones. All I can offer is to give my support both to the pt. and his family (RJ 16)

The depth of respect shown in the above excerpt further portrays the extent to which non-Muslim nurses demonstrate respect for Muslim traditional practices, even when they encounter them as new experiences. This approach is further demonstrated in the descriptive evidence from the reflective journals, as outlined below:

I honour and respect the Islamic tradition here in the kingdom. I don't care what the family wants to do [to] their own patient. We can't forbid them because they have the right to do. Reading Qur'an [Holy Book of Islam] of different "mutawa" [a religious individual who provides spiritual and religious advices] and some members of the family at bedside is a lot of help spiritually. That's why we should respect their belief (RJ 21)

It was noteworthy that the need for education on Islamic aspects of EOL nursing care was raised by several participants. This is further described and discussed in the next sub-theme.

4.7.2 Sub-Theme 3B: 'Integrating Islamic Aspects into Education on EOL Nursing Care'

In their caring for DNR patients, participants raised the need for 'integrating Islamic aspects into education on EOL nursing care'. This need refers to the essential Islamic aspects that are identified as part of an education strategy on EOL nursing care. Shotton (2000) argues that nurses need to be prepared in both the theoretical and practical skills of EOL care in order to provide adequate EOL nursing care. Tuttas (2002) concurs with this, and goes further by asserting that ongoing nursing education on all aspects of EOL care is a strategy that can be used to enhance nurses' knowledge and skills relating to EOL care so that all components of care are culturally and religiously congruent. The importance of Islamic aspects of education for EOL nursing care is portrayed in the following exemplar by a participant, who indicated that appropriate training and education regarding nurses' involvement in EOL care is needed in Saudi Arabia, so that their previous training in this regard is expanded to match the expectations in the local Muslim context.

As a nurse we should be well trained in caring [for] this type of patients for they only depending on the nurses, especially if the patient [is] still fully awake and oriented. Those patient [s] who are No Code are on their hopeless situation and the family as well. They [their] everyday life is distorted, as a nurse we should undergone seminar which specifically teaching on how to take care [of] such patient and their family. Losing someone is a very difficult situation. That's why when dealing [with]

such patients, nurses must be more compassionate, understanding and very caring (RJ 14)

This projection of an educational need in the local context again reaffirms the extensive involvement of non-Muslim nurses in ensuring that comprehensive nursing care that is responsive to all needs, including religious, is provided as part of EOL care. The issue of how best to meet the educational needs of the nurses in relation to improving their understanding of cultural, spiritual and religious needs of Muslim patients is discussed in chapter 5.

4.7.3 Summary of Theme 3: 'Islamic Considerations in Nursing Care'

Most of the participating nurses showed an awareness of and sensitivity to needs of Muslim patients and their families during EOL care after DNR. By rendering this level of culturally congruent care, nurses demonstrate respect and responsiveness to the EOL patient and awareness of patient and family needs while ensuring safe care. Nonetheless, the nurses indicated the need for ongoing training in Islamic aspects of EOL care to facilitate an integrated approach that embraces holistic health care as well as essential Islamic considerations.

4.8 Conclusion

In this chapter, I have described the preparations that took place before actual data analysis commenced. The modified process of data analysis was tailored specifically to enable analysis of contents of the reflective journals, and justified so that evidence of methodological rigour was maintained. With the use of this modified approach to analysis, nurses' lived experience and meaning of their involvement in EOL care after

DNR have been successfully presented and illuminated without fragmentation or de-contextualisation of participant data. The main themes and sub-themes that emerged from data analysis and the related empirical evidence for the returned reflective journals were presented with relevant support from literature. In the following chapter, a discussion is provided on the research findings, relevant related literature is discussed, implications and recommendations are offered, and a synopsis of the way forward is presented prior to the conclusions.

CHAPTER 5 RESEARCH FINDINGS: DISCUSSIONS AND CONCLUSIONS

5.1 Introduction

In this chapter, the research findings of emergent themes and their constituent sub-themes are examined and argued from the perspective of existing literature. These arguments are contextualised and scrutinised through the lens of the research question, 'what is the essence of the nurses' lived experience, and the meaning of their involvement in "end-of-life" (EOL) care after a "do-not-resuscitate" (DNR) is made on general medical units in Saudi Arabia?' This is followed by the implications of the research findings and the recommendations for clinical practice guidelines that arise from this investigation. In the final section, possible limitations of the study and suggestions for further research are also presented.

5.2 Approach to Discussions on Research Findings

In order to describe and explore the meaning that nurses attach to their experience in EOL care after DNR, it is necessary for the researcher to employ an approach to discussion on research findings that will present an interactive and reciprocal interplay between the original research question, the research findings and the previous work discussed in the literature review chapter (Silverman & Marvasti 2008). This practice is usually referred to as an iterative process, and is regarded as a key characteristic of qualitative research (Bryman & Bell 2007; Holloway 2005). In this context, 'iterative' describes the repetitious and recurrent interactions of the researcher with the research and the qualitative process of inquiry. The iterative approach to discussion on research findings allows the researcher to work back and forth between: (i) emergent themes and sub-themes, (ii) perspectives and findings from other research studies in the literature

(Wolcott 1994), and (iii) ongoing review and examination of the research question, problem and objectives.

In my discussion on the research findings, the approach has been developed to gain an understanding of the findings and aims to integrate empirical findings (Burns & Grove 2005) of the real-life experiences of nurses' involvement in EOL care after DNR with the existing knowledge on EOL care as found in the literature. The purpose of the iterative approach, however, is twofold: to construct critical arguments by the employment of inductive, deductive and retroductive logical reasoning in an iterative manner (Creswell 2007; Masson 2002), and to generate vivid descriptions and convincing explanatory (Masson 2002) links regarding the nurses' involvement, experience and meaning of EOL care after DNR, in the context of the qualitative research findings.

The iterative approach to discussion on research findings pertains to three outcomes. First, the provision of answers to the research question (Burns & Grove 2005) about the essence of nurses' lived experience and the meanings of their involvement in EOL care after DNR decisions. Second, the discovery and outline of gaps or contradictions that have been identified in the literature of EOL care. Lastly, an outline is given for implications for professional nursing practice as well as recommendations for future research.

The findings are discussed iteratively and focus predominantly on three (3) perspectives:

(i) An international perspective – contemporary healthcare organisations are focusing on improvement in EOL care for patients by ensuring peaceful and comfortable death. This is an international focus specifically with agencies that publish and accredit hospital standards as a global joint agreement in relation to care standards of patient delivery. The Joint Commission International (JCI), the United States of America – based

organization has accredited the hospital of the research site and therefore has specified standards pertaining to provision of EOL care in hospitals. This focus of standards has related EOL care measurable elements that are surveyed during the accreditation process of hospitals (JCI 2008). This emphasis by JCI has contributed to the evolving image of nursing as a profession and influences the nurse's involvement in EOL care.

(ii) Local healthcare delivery system – the meeting of JCI requirements by local organisations has resulted in consequent changes and expansion in healthcare delivery systems in Saudi Arabia which continue to influence the nurse's involvement in EOL care. Initiatives to improve EOL care for patients and their families in acute hospital settings are increasing in Saudi Arabia (Gray, Ezzat & Volker 1995; NGHA 2006). Concurrently, Islam as the dominant religion in Saudi Arabia plays a significant role in the nature of care delivery because its considerations are ultimately embedded in EOL decisions such as DNR.

(iii) Nurses' role on medical units - increasingly, nursing research is undertaken to investigate the significant roles of nurses in providing EOL care. A widespread but focused component is the scope of nurses' involvement in EOL decisions such as the DNR decision-making process within complex healthcare systems (Calvin, Lindy & Clingon 2009; Halcomb et al. 2004; Hildén et al. 2004; Hildén & Honkasalo 2006; Svantesson et al. 2006; Jezuit 2000; Werner, Carmel & Ziedenberg 2004). In tandem with this, added emphasis has been placed on awareness of and sensitivity to cultural and religious beliefs as fundamental in the provision of appropriate EOL care in the Muslim context (Rassool 2000).

5.3 Exhausted Medical Treatment

The theme of 'exhausted medical treatment' is characterised by medical treatment being regarded as unsuccessful in patients with chronicity when restorative results are unlikely, and where death will be the outcome. The findings of the present study suggest that nurses and physicians experience difficulty in determining when medical options have been exhausted, just as families experience difficulty accepting that the death of a loved one is imminent. These results are confirmed by Calvin, Lindy and Clingon (2009), who also identified the realisation of possible exhausted medical treatment for patients approaching EOL among participants of interviews. They state that nurse participants were unsure whether these patients would or would not recover from a life-threatening condition. A qualitative research study by Heland (2006) showed that colleague nurses practising in a hospital unit held varied personal views on the meaning of exhausted medical treatment. The decision of exhausted medical treatment, however, depends on the ability of clinicians to recognise that the patient's medical illness is no longer responsive to treatment, and that a shift in the team members' care paradigm is required, whereby comfort care, as part of EOL, becomes part of the treatment plan of the entire healthcare team for dying patients.

The lived experience of nurses in this study illuminates specific areas of interaction and cooperation between nurses and healthcare team members that could be the focus for improvement in the care of patients at the EOL on medical units. Unlike oncology patients, patients with chronic illnesses usually deteriorate over a long period of time, resulting in frequent hospital admissions and unpredictable prognosis, causing healthcare professionals at hospitals to be uncertain about the potential for continued future decline that eventually may lead to death (Addington-Hall & Ramirez 2006; Auer 2008; Barnett 2006). The uncertainty of progression of worsening conditions for patients with chronicity on medical units could be the starting-point where all healthcare

team members come on board and approach the plan of care together, aiming at rendering quality EOL care.

Becker et al. (2007) found that cancer patients received sufficient comfort and terminal care, whereas patients with chronic diseases received little care at the EOL. They believed that this is perhaps because of the inability of clinicians to recognise the gradual dying of these patients. Their findings were in correspondence with those of Jacobs et al. (2002), who reported that little change had been made pertaining to a shift in focus from cure to care for patients with chronicity and for whom death was inevitable. Dying patients are particularly vulnerable to inappropriate care from healthcare teams because of their chronic illnesses and undetermined prognosis. Therefore, an interdisciplinary EOL care protocol in which contributions by all healthcare professionals are included and valued may have significant influence on the care that dying patients receive on medical units.

The findings of my study have demonstrated that there is an uncertainty amongst physicians about what constitutes exhausted medical treatment, resulting in confusion for both nurses and families involved in patient care thereafter. Von Gruenigen and Daly (2005) and Lawson (2004) concur that there is an absence of clinicians' agreement and a lack of common understanding of the term exhausted medical treatment. Trotochaud (2006) observed that, despite the extensive research focus on exhausted medical treatment, clinicians' consensus on the actual meaning has yet to be derived. In the absence of such consensus, Trotochaud suggests the generation of procedural statements and organisational guidelines that support health team members' views in the decision-making process regarding exhausted treatment, while ensuring respect for the wishes and interests of patients and their families.

The American College of Obstetricians and Gynecologists (2002), discussing medical futility, recommended the establishment of institutional policy and procedures whereby agreement amongst health team members with patients and their families is reached, and further shared interpretations concerning EOL care plan achieved. Thus, adoption of this approach at this Middle Eastern hospital is regarded as worthwhile. As this study has shown, nurses' lived experiences pertaining to uncertainty about exhausted medical treatment raise the need for hospital leaders to develop a policy and procedure specific to EOL care, which would reinforce an interdisciplinary approach to secure and validate the participation of nurses in EOL care decision-making.

A positive way of looking at EOL and the exhausted treatment prognosis without being confrontational is the approach suggested by Kapo and Casarett (2006:18), who regard EOL not as sudden death, but place chronicity in perspective by stating that 'rather than dying suddenly, patients with these diseases often experience a gradual decline in health punctuated by exacerbations of their diseases'. This philosophical approach to EOL care may provide a comfortable way for physicians and nurses to approach family members as the pathway to EOL becomes imminent. Maintaining open communication between patients, families and healthcare team professionals at the EOL is of paramount importance to both parties, and it facilitates understanding of and trust in the approach to reaching a decision of exhausted medical treatment (Heaney et al. 2007). In this way, information on the gradual decline is shared and becomes less threatening for team members and the family, as all travel the same pathway in a supportive manner. Additionally, such an approach would allow nurses to become effectively involved in provision of quality EOL care.

5.3.1 Nursing Excluded from DNR Decision-Making

The first sub-theme associated with the main theme 'exhausted medical treatment' was that nurses were excluded from the DNR decision-making process, and that physicians were making the DNR decisions in isolation from the other health team members. The nurses' role in the DNR decision-making process remains debatable, according to the literature. On the one hand, involvement in the DNR decision-making process could be regarded as totally outside the scope of nursing practice, despite the close relationship with patients and families. The DNR decision in such situations is shared only between patients or their families and the physician. On the other hand, nursing involvement as essential patient advocacy, might be considered pertinent in the DNR decision-making process. The patient advocacy role is reflected by nursing support to patient and family, which includes ensuring that they are informed and educated about the DNR decision.

This exclusion of nurses from the DNR decision-making process is evidenced by Georges and Grypdonck (2002), who claim that nurses are unassertive in approaching serious decisions that impact on patients' lives. Dealing with life and death is known to be a major moral challenge that nurses encounter in their practice, particularly as life-saving technology has dramatically advanced in the twenty-first century (Blais et al. 2006; Joel 2006). In our organisation, between 30 and 40% of nurses originate from the sub-Asian continent, including the Philippines, Malaysia and India. It is my experience that these nurses tend to be less assertive in the physician-nurse relationship, and therefore a focus is suggested for assertiveness training for these nurses, which would include clinical-decision making that can be utilised as part of their involvement in the DNR decision-making process.

Not all nurses in this study had the same standpoint regarding participation in the DNR decision-making process. Despite the fact that nurses were closely engaged in the daily

care activities for patients and their families in EOL, some showed reluctance to become involved in the DNR decision-making process. The reason for nurses being reluctant to participate in the DNR decisions seems to be primarily because of the differences in language and religion between nurses and patients and their families in Saudi Arabia. From a nursing profession perspective, the nurses' hesitancy to assume an active role in the DNR decision-making process might be seen as a paradox in view of their recognised role as patient advocates. The findings of my study mirror those reported by Werner et al. (2004), who conducted a study of nurses' and social workers' attitudes and beliefs about involvement in life-sustaining treatments at the EOL. They found that, although nurses were more involved in the daily care processes of the terminally-ill patients, they were less willing to participate in the EOL decision-making, whereas social workers expressed more eagerness to be involved in making such decisions. This particular finding from my study could perhaps be used to promote nursing education strategies to assist nurses in developing assertiveness skills to facilitate their participation in DNR decision-making. On the other hand, a true interdisciplinary approach in EOL care would probably encourage nurses, as equal professional partners, to take a more active part in the DNR decision-making process.

An array of feelings was revealed by nurses in this study regarding their role in the DNR decision-making process. Feelings of acceptance, satisfaction, emotional stress, powerlessness, unpreparedness, dissatisfaction, frustration and anger have all been described by nurses in my study and occurred as a consequence of their exclusion from DNR decisions. Numerous research studies, however, have reported that nurses in their daily practice may hold a range of views regarding their involvement in the decision-making process at the EOL. For instance, Jezuit (2000), in a qualitative study on the difficulties experienced by critical care nurses pertaining to care for DNR patients, found that most nurse participants perceived themselves to be patient advocates by ensuring that the patient and the family had received all necessary

information beforehand, in order to be able to make an informed decision about DNR, whereas other nurses felt it was unnecessary for them to be involved at all in the decision-making process. The results of Jezuit are similar to those reported by Calvin, Kite-Powell and Hickey (2007), who studied neuroscience intensive care unit (ICU) nurses' perceptions regarding their role in the EOL decision-making process, and reported that colleague nurses had different feelings about their participation. Nurses' participation in the EOL decision-making process was considered by some as overwhelming, and it somehow resulted in a 'lonely and challenging' experience (Calvin, Kite-Powell & Hickey 2007:143). Nursing leaders in particular, and the nursing profession in general, perhaps need to review existing literature and practices on the nursing role in EOL decisions, so that clarity is gained by nurses at the bedside regarding their scope of practice and participation in EOL care.

The nurses in this study believed that it is the responsibility of the treating physician to make the DNR decision after discussion with both the patient and the family members. They nevertheless raised professional concerns and described feelings of frustration from being excluded by physicians from the DNR decision-making process. Costello (2002) regarded physicians as displaying a somewhat paternalistic approach in their exclusion of nurses and other healthcare team members from the DNR decision-making process. Costello attributes this issue to two significant reasons. First, physicians appear to rely on identified medical measures in making the DNR decisions. Second, because the DNR decision is a medical one, physicians therefore perceive themselves as the ultimate decision-maker. This, according to Costello, has caused nurses to feel that they have been overlooked by physicians in the decision-making process.

It is possible that in my study physicians might not have been particularly sensitive to input by nurses and other healthcare team members in the DNR decision-making process. Another possible explanation is that the perceived lack of physician sensitivity,

in particular to nurses' involvement in the DNR decision-making process, is perhaps owed to their limited awareness about the prominent role that nurses, as professional partners, are able to play in such a decision. The rather poor image of the nursing profession in Saudi Arabia, the existing lack of nurses' current involvement in the DNR decision-making process, and a definite lack of nursing authority within the interdisciplinary team all seem to have contributed to the physicians' view of nurses' role in the decision-making process. On the other hand, the autonomy of physicians, from a local perspective, notwithstanding the growing emphasis on the importance of the interdisciplinary team approach, would further reinforce physician hesitance to invite input from nurses and other health team members regarding the DNR decision-making process. A recent study by Benbenishty et al. (2006) of physicians' perception of the role of the intensive care nurses in EOL decision-making process in seventeen (17) European countries reported that physicians acknowledged the essential role of nurses in EOL decisions. This finding appears to emphasise a dramatically different perspective from that outlined above. What is perhaps required of nurses within our organisation is to work together with physicians in the DNR decision-making process so that living with the consequences of such decisions is easier for both groups.

It is notable that some nurses in my study expressed eagerness to be involved in the DNR decision-making process and indicated a desire for a more active role and participation as primary care providers. This is perhaps related to the extended time they spend engaging with patients and families at the bedside, compared with the limited time that physicians and other healthcare team members allocate to DNR patients (Hohenleitner 2002). Noteworthy is the emphasis in the nursing literature that has been placed on the pivotal role that nurses can embrace in the DNR decision-making process, which has been supported in different professional statements, protocols, guidelines and publications by leading international nursing organisations (Briggs & Colvin 2002; O'Keefe & Crawford 2002; Shoher & McKay 2004). In essence,

these documents recommend that nurses honour patients' rights and choices at the EOL, educate patients and families about treatment options and advance directives, that they be involved in development of DNR policies and procedures, and that they provide comprehensive and compassionate EOL care (Blais 2006; Joel 2003; Joel 2006). Briggs and Colvin (2002) found that nurses often develop close relationships with patients and their families at the EOL, which may place them in a better position when discussing the DNR decision. From another perspective, it is argued that, in order for nurses to participate effectively in the DNR decision-making process, they need adequate knowledge and skills that would better situate them to communicate clearly issues surrounding the DNR decision with patient and the family (Briggs & Colvin 2002).

The findings of my study confirm that nurses are currently not readily involved in the DNR decision, and that physicians somewhat fail to appreciate their extensive contact and involvement with the patient and family in EOL care. Given the evidence, however, it is a valid suggestion that nurses could be more forthcoming in their professional scope and play an assertive advocacy role to ensure their active involvement in DNR decision-making. To achieve such an end, however, within the local context, nurses at the bedside need to be empowered by the organisation to discuss matters related to EOL care and DNR, and, further, to be provided with specific education and training that will fully prepare them regarding the nurses' role in the DNR decision-making process.

5.3.2 Varying Physician Involvement after the DNR Decision

'Varying physician involvement after the DNR decision' emerged as a sub-theme within the main theme of 'exhausted medical treatment', whereby physicians vary in their follow-up care and level of medical interventions at the EOL after the DNR decision. The apparent physician detachment from EOL care after DNR that currently happens is a significant concern for the organisation, as patients and their families expect that

physicians will sustain an adequate clinical presence and involvement until the moment of patient death. Families in Saudi Arabia generally need a significant amount of help to understand complex medical conditions and associated treatments and, for the most part, accept the physician's perspective and authority to make decisions that affect the patient's life.

It is worthwhile to mention the seminal work by Glaser and Strauss (1965), who studied the process of care provided for dying patients at six hospitals in San Francisco, USA. The resulting evidence showed that working with dying patients appeared to be a major challenge for nurses and physicians, particularly in relation to communicating with one another about patients' worsening condition and imminence of death. Glaser and Strauss proposed four types of social situations as 'awareness contexts' that encapsulate the interplay between patients and surrounding personnel in the hospital in regard to terminal illness and imminence of death. These are: (i) 'closed awareness' in which the patient is not aware of his/her terminal case, although others are aware, (ii) 'suspicious awareness' when a patient suspects that he/she is dying and strives to verify this with the people around him/her, (iii) 'mutual pretence', when everyone, including the patient, is aware of the terminal condition but pretends otherwise, and finally (iv) 'open awareness' whereby awareness of the dying process is shared and openly acknowledged by the patient, family and healthcare team members (Glaser & Strauss 1965:11).

Kübler-Ross (1969) and students at the Chicago Theological Seminary conducted a research project to study individuals' reactions to the awareness of a terminal illness and to the imminence of death and dying. Terminally-ill patients whose death was inevitable were interviewed in hospital, to explore their coping and defence mechanisms while facing the crisis of death. The stages of grief identified and proposed by Kübler-Ross include: denial and isolation, anger, bargaining, depression, and acceptance. A

notable observation arising from the study was that treating physicians generally expressed great resistance to the research topic, and were the most reluctant amongst the healthcare team to participate in discussions on death and dying. The seminal works of Kübler-Ross and Glaser and Strauss are regarded as classical contributions to the understanding of the dying process and as such are compulsory reading for those planning to undertake further nursing research on EOL care.

The findings of my study showed that successful EOL care was attained when physicians were able to respond appropriately and constantly to patients' and families' needs after the DNR decision had been made. Carline et al. (2003), in their qualitative study on physicians' interactions at the EOL, reported that consistent accessibility to physicians is paramount for patients, families, nurses and other healthcare team members as patient death becomes imminent. These findings are congruent with the findings of my study whereby nurse participants experienced satisfaction with continuity of EOL care after DNR particularly when physicians remained accessible by patients and their families. It is worth emphasising that open discussion between patients, families, nurses, physicians and healthcare team members can only lead to a peaceful and respectful death because both patient and family needs have been acknowledged and met (Heyland et al. 2006; Lowey 2008). In the local context it is recommended that further research studies are undertaken to investigate physicians' interactions with patients, families, nurses and other health team members in EOL care after DNR decisions have been made.

It is possible that the withdrawal of physicians may indicate their awkward feelings regarding death and dying, which is then evidenced by their avoidance of family near the moment of death. My experience of Saudi family members is that they usually expect the physician to do something even when the DNR has been discussed, agreed upon and signed in the patient record. In my study, withdrawal of physicians from

active intervention and their hesitancy in responding to the DNR patient needs were a major concern for nurses working with dying patients and their family members, as active physician involvement was identified by nurses to be essential in facilitating quality EOL care after DNR.

As mentioned earlier, in her classical work 'On Death and Dying', Kübler-Ross (1969) introduced the discussion surrounding the death of terminally-ill patients at hospitals, and interpersonal relationships within the healthcare team members as patients approached death. Kübler-Ross raised the concern that physicians focus on curative treatment, and often ignore the fact that there is nothing that can be done to restore patients' physiological condition. In the local context, I believe that physicians' withdrawal is possibly related to their lack of education regarding principles of EOL care for chronic and terminal illnesses. Kübler-Ross recommended that physicians should be properly trained to work with dying patients in hospital settings, so that they feel confident to face deterioration in patients' conditions, and to consider patients' needs and wishes at the EOL appropriately. Kübler-Ross's findings were echoed in the 2003 study by Sullivan, Lakoma and Block, who found that a large number of medical students and residents in the United States felt unprepared to provide appropriate EOL care. It is not surprising, therefore, that physicians in our organisation appear to have such difficulties in engaging in EOL care. These aspects should perhaps become a topic for physician education and training on EOL care within this organisation in particular, and in Saudi Arabia in general.

The findings in this study indicate that effective collaboration between nurses and healthcare providers would enhance improvement of EOL care. Nurses and physicians can offer extraordinary support and help to one another in EOL care after DNR. Agreement with this perspective can be found in the report by the Breakthrough Series team from St Thomas Health Services in Nashville, Tennessee, USA (Lynn, Schuster &

Kabcenell 2000:98), in which physicians were found to be hesitant to participate in change projects on EOL care. An innovative approach to changing the perspective of physicians included generation of a checklist entitled 'The Packet: Communication Guide for Care of the Patient with Life Threatening Illness' (Lynn, Schuster & Kabcenell 2000:98). The checklist included steps that guided clinicians in providing appropriate EOL care. Alongside the improvement achieved in interactions between physicians and patients and their families, nurses gained confidence in communicating on EOL care plans and objectives with patients, other nurses and healthcare team members. The development of a similar checklist to guide healthcare providers within this organisation may have the potential to improve care at the EOL.

5.3.3 Implications and Recommendations

Nurses were found to have considerable responsibilities in EOL care after DNR but limited participation in the DNR decision-making process. Nurses, therefore, should be encouraged to participate actively in the DNR decision-making process, although this would require them to express themselves in an assertive and direct manner, without encroaching on the rights of others and without curtailing their standing (Boggs 2007b; Fry & Johnstone 2002; Marquis & Huston 2009). Nurses also need to be encouraged to assert themselves in building a model of interdisciplinary team practice that will promote the provision of best possible care for dying patients and their families, and which will assuage frustrations they may experience after the DNR decision has been made (Curtis & Shannon 2006). Furthermore, nurses can develop interventions to foster better discussion between patients, families and physicians involved in EOL care. Regular patient and family conferences that involve nurses, physicians and other healthcare team members are also needed so that nurses are able to communicate their preferences regarding possible medical decisions and EOL care approaches (Thiers 2006).

This study raises the need for nurse managers to act as advocates for the right of patients and families to receive optimal EOL care after DNR, including their involvement at the time of DNR decision-making and by ensuring that the entire interdisciplinary team understands the unique needs of patients and their families regarding EOL care (Thiers 2006). It is essential that nurse managers on medical units work together with all members of the healthcare team to improve communication with patients and families in EOL care after DNR. Nursing administrators also need to influence hospital administration regarding promotion of interdisciplinary collaborative team work in EOL care after DNR.

Role modelling of nurse managers in leading EOL care after DNR can be used to inspire and motivate bedside nurses, and to reinforce desired changes in nurses' behaviours regarding EOL care after DNR (Marquis & Huston 2009). Nursing administration would need to reinforce the confidence in team leadership of bedside nurses (Evans 2007; Roussel, Swansburg & Swansburg 2006, Shaw 2007; Tomey 2000; Tuttas 2002) so that nurses participate in discussions with patients, families, and other healthcare team members about EOL care after DNR, thereby being empowered to shape future practices in EOL care after DNR.

5.4 Continuity of Nursing Care

The second theme 'continuity of nursing care' identified by nurses described a sustained level of care for patient and family before and after DNR decisions had been made, and outlined how they attempted to meet the evolving needs of patient and families. Nurses revealed that they regarded continuity of care after the DNR as an important element in EOL care for both the patient and family members. A constant level of nursing involvement in EOL care would result in reassuring dying patients and their families that

their needs at the EOL were acknowledged and were integrated into the daily practices of nurses on medical units. Ensuring continuity of care for dying patients and their families on medical units has been described in the literature as requiring effective communication and collaboration amongst nurses and other healthcare team members (Henderson 2004; Hov, Hedelin & Athlin 2007; Vogel-Voogt et al. 2007). The findings of my study also indicated that nurses at the bedside pay significant attention to providing the necessary physical nursing care for dying patients.

The findings of my study describe nurses' ambitions to render quality EOL care to DNR patients and their families, while at the same time being responsible for providing care for other patients in a curative phase of their disease process. This is parallel to the findings of a similar qualitative study by Thompson, McClement and Daeninck (2006) who interviewed ten (10) nurses working on an acute medical unit in order to explore their perspective on quality EOL care. They found that nurses make great efforts to provide quality care for dying patients and their families 'despite being pulled in all directions' (Thompson, McClement & Daeninck 2006:169). Providing continuous nursing care at the EOL appeared to be a challenge for nurses in my study, particularly if the assignment included concurrently caring for both dying patients and those in the curative phase. Lack of sufficient time dedicated to dying patients and their families, owing to the increased acuity of other patients, or the complexity of tasks and clinical procedures on medical units, is an added challenge to the provision of continuity of nursing care at the EOL after DNR. Beckstrand, Callister and Kirchhoff (2006) found that lack of sufficient time to care for dying patients and their families was a significant concern for nurses in the context of a complex acute hospital setting. Wallerstedt and Andershed (2007), on the basis of findings from their qualitative study of qualified nurses, concluded that if nurses were to provide quality EOL care, then they needed sufficient time to allow them to respond promptly to the evolving needs of patients and their families. The findings of my study suggest that the current staffing levels in my

organisation are probably not adequate to meet the increased demands of patients and families who require EOL care on medical units. It is my observation as a clinical nurse manager that the one-to-one nurse-patient ratio, whereby the nurse assumes total responsibility during the time on duty for meeting the needs of one patient, appeared to be successful in providing quality EOL care after DNR on medical units. The proposal, therefore, is for senior nursing management at the study hospital to review and update the staffing policy and procedure in order to meet patient care needs better on medical units at EOL after DNR.

A noteworthy consideration with regard to continuity of nursing care is the response of nurses in this study to the evolving needs of patients and their families at the EOL. Nurses emphasised the importance of including families in the scope of EOL care and articulated their beneficial role in facilitating patient care at the EOL in order to achieve positive and comforting outcomes. Although family members are considered to be in a unique position to care for their loved one, they are themselves also in need of care and attention by nurses and other healthcare team members. In interviews with nurses who cared for dying patients and their families, Dunne, Sullivan and Kernohan (2005) concluded that family members are in need of equal consideration and therapeutic care to help them cope with the expected loss of their loved ones. Dealing with family members was clearly a difficult area for many nurses in the findings of my study, as many of them felt that they became emotionally involved by their lived experiences, further contributing to the subsequent sub-theme of providing compassionate and comfort nursing care for dying patients and their families.

A core consideration in nurses' involvement in the context of continuity of care at the EOL is the quality of the nursing handover. In this regard, the JCI (2008) has mandated improvements in communication amongst healthcare team members and has outlined this as one of the International Patient Safety Goals. Effective communication of patient

information and needs between nurses at the bedside handover report has always been considered as an indicator of both quality and continuity of care (Kassean & Jagoo 2005; Payne, Hardey & Coleman 2000; Wong, Yee & Turner 2008). Hopkinson (2002), on the basis of the result of a phenomenological study to explore nurses' experiences of caring for dying patients in medical wards in the United Kingdom, concluded that nursing handover was perceived to be helpful and supportive for nurses when caring for dying patients in hospital. Hopkinson attributes this to two important reasons. First, nursing handover seemed to be used as an opportunity for nurses to communicate their feelings on caring for dying patients. Second, it offered an avenue for nurses to exchange patient information and practice recommendations that served as a basis for developing the plan of care for dying patients and their families on the unit.

As a clinical nurse manager, it is my observation that in nursing handover reports, nurses tend to emphasise biomedical information and aspects of physical care, rather than comprehensively focusing on holistic patient care. It is therefore suggested that hospital nursing leadership should focus on ways to improve nursing handover, which would ensure a more comprehensive approach to continuity of care at the EOL. Fenton (2006) conducted a study on the development of a handover guide based on the essence of nursing care. Fenton reported significant improvement in the information transfer process between nurses after implementation of the handover guide. The development of a structured nursing handover at the study hospital has the potential to play a significant role in improving care for dying patients.

Separately from physician involvement, the findings related to continuity of nursing care illustrate that nursing as a discipline needs to ensure nurses' involvement in EOL care by implementing approaches that promote continuity of care by nurses as caregivers in the dying process, thus rendering comprehensive care to both patients and their families.

5.4.1 Compassionate and Comfort Nursing Care

'Compassionate and comfort nursing care' as a sub-theme of the main theme 'continuity of nursing care' showed the level of nurses' involvement through their awareness of patient and family needs in EOL care after the DNR had been made. The findings of the study confirmed that nurses responded to these needs in a compassionate manner. Participants exemplified many of the compassionate vivid descriptions generally attributes to nurses, such as empathy, comfort and tender care. These fundamental components of nursing care should assure patients and their families that their perspectives on the EOL situation are respected and understood by nurses. These supportive nursing behaviours in EOL care are further identified in the work of Arnold (2007) as having great impact on dying patients and their family members. The findings of my study have similarities with those identified by Halcomb et al. (2004) in their interview study of ICU nurses. They concluded that EOL care involved ensuring that patients' physical care and comfort were preserved. In essence, the lived experience of nurses' involvement embodied comprehensive nursing care for dying patients and their families within the context of an acute healthcare environment, similarly to the medical units under discussion in this paper. They aimed to relieve patient physical symptoms and suffering, and to provide emotional support to family members of dying patients. Within this therapeutic relationship, patients and their families were able to feel supported and could maintain their dignity in a comfortable and peaceful passage to the moment of death.

Empathetic and compassionate responses have been identified by nurses in my study as crucial in addressing the needs of dying patients and families, particularly after DNR decisions have been made. Furthermore, nurses reported being totally and compassionately involved with patient and family in EOL care, which allowed positive experiences for patient and family, and also for the nurses themselves. Importantly,

attending and responding to patients' and families' needs at EOL appear to provide the foundation for a trusting relationship. In 2004, a research study was conducted by Mok and Chiu to study the nurse-patient relationship in palliative care using open-ended unstructured interviews with hospice nurses and terminally-ill patients. The authors found that a trusting relationship between patients, families and nurses developed when nurses responded appropriately to the evolving needs of patients and families in EOL care. A significant finding from their study was that when a trusting relationship was formed, nurses were then considered by the patients as being close enough to be considered the same as a family member or close friend. The sense of mutual trust and respect for patient and family at the EOL was seen by nurses in my study as the keystone for establishing a therapeutic relationship. It can be argued, however, that the developed trust between both parties may be related to the consistency and continuity of nursing care at the EOL. Working closely, and with continuity of nursing care, for patients and families at the EOL allows nurses to understand patient and family needs and to respond properly to them.

In summary, compassionate and comfort care provided by nurses is seen as a powerful manifestation of continuity of nursing care which does not require a physician's order, but rather portrays unique nursing skills as nurses share the EOL journey with patients and their families.

5.4.2 Focused Comprehensive Nursing Care

'Focused comprehensive nursing care' emerged as a sub-theme from the main theme 'continuity of nursing care', whereby nurses' involvement allowed patients receiving EOL care and their families to be treated in a holistic manner which aimed primarily at responding to their distinct physical, psychological, social and spiritual needs after the DNR decision had been made. The theme is also described as a process of containing

a focus of nursing care in which family members and caregivers are involved in the care because of their concerns and fear of losing their loved one. Attention to the holistic aspects of care was reported by nurses in this study as a key component in continuity of nursing care for patients and families at the EOL. The findings of my study, in this regard, echo JCI (2008) recommendations for acknowledging the unique needs of patients and families at the EOL while maintaining delivery of total care.

A noteworthy consideration in rendering comprehensive nursing care at the EOL is the ability of nurses to integrate the psychosocial and spiritual needs of patients and families into their daily EOL care practices on busy medical units. Even though participants in this study stated the importance of psychosocial care at the EOL, it is my observation that the main priority for nurses working with dying patients on medical units seems to be ensuring that patients' physical needs rather than their psychosocial and spiritual needs are acknowledged and have been met. An ethnographic study by Costello (2001) exploring the experiences of patients, nurses and physicians in EOL care in geriatric wards in the United Kingdom (UK) also found that, despite nurses demonstrating knowledge and awareness of patients' psychological and emotional needs at the EOL, the primary focus of their interventions was upon the physical aspect of care for these patients. The continuation of physical treatment, even when patients were approaching death, was thus regarded as reflecting the status of treatment in the acute hospital setting, as well as raising the suggestion that nurses' interventions were perhaps influenced by somewhat routine and ritualistic care practices. This assumption was further supported by a UK study by Willard and Luker (2006) exploring EOL nursing care in acute hospital settings. The authors reported that nurses were engrossed in curative treatment approaches and were compelled to provide routine physical care for patients and their families in EOL care with little emphasis upon psychosocial considerations. They also found that there seemed to be a reluctance to discuss alternatives to medical options with patients and families, and even amongst the

healthcare team members themselves. It is, therefore, unsurprising that in my study DNR patients may receive treatment and care that are standard for all patients admitted to the medical units regardless of the expected outcomes.

The findings of my study showed that nurses sometimes found themselves faced with requests from family members and relatives to provide aggressive treatment which they believed to be contradictory to the DNR decision. This appeared to cause significant emotional distress for these nurses while providing care for dying patients and their families. Graham, Andrewes and Clark (2005) conducted a phenomenological study to uncover the meaning of nurses' lived experience in caring for dying patients on acute wards in England. They found that nurses sometimes experienced emotional discomfort and a sense of failure owing to their lack of ability to achieve what they intended in relation to provision of quality patient care. In another study, Yang and Mcilpatrick (2001) studied intensive care nurses' experience of caring for dying patients and found that nursing interventions in the context of EOL care were usually driven by feelings that included fear, guilt and a sense of powerlessness to respond to the unique needs of patients and families. It is perhaps the case in my study that nurses will need emotional and psychological support if they are to care with compassion and empathy for patients and their families at the EOL after DNR. This contention is supported by Araújo, Silva and Francisco (2004) who, on the basis of their qualitative study to explore how nurses coped with the suffering of dying patients in an inpatient medical unit, concluded that nurses should receive psychological and emotional support in order to provide appropriate EOL care for terminally-ill patients. Therefore, although my study confirms the compassionate and comfort care approach considered essential for focused and comprehensive nursing care, it becomes apparent that nurses too, need, support so that they are able to focus on comprehensive nursing care delivery which is matched to their identification of the unique needs of patients and families in EOL care.

5.4.3 Nurses Coordinating Care Contributions

The last identified theme, 'nurses coordinating care contributions', emerged as a sub-theme of the main theme 'continuity of nursing care' in which nurses used their interactive skills to coordinate services by physicians and other healthcare team members for the purpose of rendering comprehensive interdisciplinary care for patients and families at the EOL. This integral aspect of the nursing role was demonstrated by nursing leadership, in serving as a liaison between different hospital services, so that interdisciplinary involvement was attained, thus ensuring holistic EOL care after DNR. The nurses' collaborative initiatives in EOL care after DNR were in response to the unique needs of dying patients and their families, particularly considering that involvement by other health team members appeared to fluctuate. The findings of my study are similar to those of Thompson, McClement and Daeninck (2006), who found that nurses adopted different collaborative strategies and techniques to ensure that patients' needs at the EOL were met by interdisciplinary team members and that comprehensive care was therefore delivered. The coordinating role in EOL care after DNR in my study was perhaps motivated by the nurses' desire to provide quality patient care and to improve patient and family satisfaction across the continuum of care at the EOL.

The capability of nurses to coordinate care in EOL appeared to be a major challenge, and was overwhelming for some nurses, particularly after DNR decisions had been made. Nonetheless, nurses in my study took the initiative to lead other healthcare members in responding appropriately to patients' and families' needs at the EOL. The strategies associated with coordinating patient care at the EOL after DNR appeared to be driven by the nurses' belief in the importance of their being patient advocates. This is perhaps because nurses spend more time with patients and families in EOL care after DNR than any other healthcare members. An ethnographic study was undertaken by

Sorensen and Iedema (2007) to gain an understanding of how nursing advocacy in EOL care is perceived by nurses working in an intensive care unit. Their study found that lack of nursing operational autonomy and the absence of organisational authority granted to nurses in EOL care were regarded as barriers to nurses' complete assumption of the role of patient advocacy.

Effective communication and collaboration amongst healthcare providers were identified by nurses in my study as essential both for responding to the needs of patients and families at the EOL after DNR and for facilitating and maintaining collegial interdisciplinary relationships in EOL care. They observed how, without mutual trust and sufficient support from other healthcare team members, their ability to coordinate effective care for DNR patients and their families was a challenge. Hopkinson, Hallett and Luker (2003) interviewed twenty-eight (28) qualified nurses who worked with dying patients on medical wards in two hospitals in the UK to develop an understanding of EOL care from the nurses' point of view. They found that nurses developed a sense of isolation from other health team members when they cared for dying patients. The nurses' impression was that they were left alone with the patients and their families to face patients' death (Hopkinson, Hallett & Luker 2003). Therefore, nurses' autonomous role as patient advocates, as well as their legitimate and significant contributions to the interdisciplinary approach to EOL care, must be acknowledged by all team members if feelings of isolation in EOL care are to be avoided.

Thus, caring for dying patients and their families is a fundamental nursing role that requires valuing patients as vulnerable human beings and recognising the importance of including families in the scope of care. To provide this type of nursing care, nurses must enact a leadership role that is focused on facilitating care contributions by other healthcare professionals. Collaboration, coordination and information exchange are indeed essential to accomplish such a nursing role. These strategies are captured by

Blais et al. (2006), who claim that, in order for nurses to fulfil this role, two significant considerations need to be addressed. First, nurses need to embrace accountability as an essential professional component of their daily nursing practice. Nursing accountability in my study was evidenced by the emerging theme of nurses coordinating care contributions in EOL care after DNR. The nurses, however, assumed accountability for providing continuity of nursing care according to organisational standards of practice, and for collaborating with other healthcare team members to obtain quality EOL care after DNR. Second, nurses' authority in leading quality patient care alliances needs to be enhanced. It is perhaps the responsibility of nursing administration to initiate the necessary changes inside the hospital, and to move forward to achieve the desired outcome of empowering nurses to assume leadership for reshaping the practices at the EOL after DNR.

5.4.4 Implications and Recommendations

Nurses who are involved daily with the care of dying patients and their families were found to be capable of assuming a much wider perspective on the provision of comprehensive and holistic aspects of EOL care after DNR. It is important, therefore, to enhance nurses' professional and leadership development by providing them with ongoing support in day-to-day practices relating to EOL care after DNR. The success of improving nurses' involvement in EOL care after DNR is dependent, however, on development of their leadership skills and confidence levels, so that they are well-positioned to coordinate care contributions and to facilitate the transition of patients, families and healthcare team members into the EOL care perspective (Shaw 2007; Evans 2007). Developing nurses' leadership skills in EOL care after DNR can happen in different ways. For instance, in the local context, nurses with less exposure to EOL care after DNR would benefit from being mentored by senior nurses who have significant experience in the care of dying Muslim patients and their families on medical

units (Gaberson & Oermann 2007; Quinn & Hughes 2007). The selection of preceptors for new staff should therefore take into account their ability to demonstrate self-confidence, effective communication skills, solid professional values and positive attitudes towards EOL care (Gaberson & Oermann 2007; Marquis & Huston 2009).

The study indicated nurses' need for reflection on their lived experience and involvement in EOL care after DNR on medical units. Nurses, therefore, should be afforded the opportunity to address their own emotions and their reactions to working with dying patients and their families on medical units after DNR decisions have been made. One way of facilitating reflective practice in the clinical setting would be through the use of debriefing sessions. Debriefing sessions, offering nurses the opportunity to talk about their experiences in caring for dying patients and their families and the effect of providing EOL care after DNR on their own emotions and work attitudes, can be invaluable (Gaberson & Oermann 2007; O'Connor 2006). By sharing their experiences in providing EOL care after DNR, nurses will come to recognise that their feelings are not unique, and that a great deal can be learned from others involved in the same situation (Gaberson & Oermann 2007; O'Connor 2006). Debriefing sessions should focus on allowing bedside nurses purposefully to reflect on their experiences in EOL care after DNR, in order to distinguish the meaningful contributions they can offer to patients and their families (Emerson 2007).

On the evidence of this study, it seems important that nurses are offered the opportunity during the nursing handover to talk to one another about their experiences in providing nursing care for dying patients and their families, so that their thoughts and feelings are communicated and exchanged, and that continuity of EOL care after DNR can be ensured (Hopkinson 2002). Another way to do this would be to offer nurses the opportunity in the monthly staff meeting to talk about particular experiences with dying patients and families and to review ideas and problems associated with providing EOL

nursing care. Furthermore, psychological and emotional support for nurses involved in EOL care after DNR should be provided by the hospital in view of the potential benefits that such support could bring to patients, families and nurses involved in EOL care after DNR (Lynn, Schuster & Kabcenell 2000; McCann et al. 2007). It would be beneficial to have a 24-hour hotline service at the hospital for bedside nurses involved in providing EOL care after DNR to provide assistance and support at any time they are needed. Such a service should be accessible at any time after an unpleasant clinical experience in EOL care to provide essential emotional support at times of crisis (Rich 2005). In addition, grief and bereavement counselling should be offered to all nurses involved in EOL care in order to support them in coping with patients' deaths and family needs, and to help them become aware of their own perceptions about death and dying, as well as supporting them while they seek to provide compassionate EOL care (Lynn, Schuster & Kabcenell 2000; McCann et al. 2007).

Improvements in EOL care after DNR should include the development of new methods to assist nurses, physicians and other healthcare team members to work collaboratively as an interdisciplinary team (Lynn, Schuster & Kabcenell 2000). This includes integrating the contributions of each discipline in such a way that the common goal of providing quality EOL care for patients and their families is achieved (Ciccarello 2003; Eues 2007; McCann et al. 2007). For DNR patients, the ultimate goal of EOL care should be to achieve the best quality of life for patients and their families. Effective collaboration in EOL care after DNR requires shared competence among healthcare team members, shared responsibility and accountability, mutual professional trust and respect, positive communication, assertiveness, mutual support and cooperation, professional autonomy, and coordination (Schober & McKay 2004). Physicians and other healthcare team members must be aware of the key role that nurses can play in achieving the best-quality care for patients and their families in EOL care after DNR on medical units.

This study encourages hospital nursing leadership to comprehensively consider involvement in EOL care after DNR, and to develop policies and procedures that take into account the unique needs of patients and families in EOL care after DNR. It is considered somewhat unrealistic to expect the wider emerging needs of patients and families in EOL care on medical units to be met by current staffing levels alone. Instead, expanding the knowledge and skills of nurses, together with reviewing the nurse-patient ratios in EOL care after DNR, would provide a better solution. This would result in sufficient numbers of adequately prepared nurses being available to provide the level of EOL care required by patients and families (Marquis & Huston 2009). Therefore, it is recommended that both the staffing and the mandatory education policies of the hospital are reviewed and modified as needed to meet the goal of providing quality EOL care after DNR.

5.5 Islamic Considerations in Nursing Care

The theme of 'Islamic considerations in nursing care' identified that nurses were informed and that they recognised the importance of the cultural beliefs and religious practices in the care of dying Muslim patients in the Saudi Arabian Islamic community. Religious practices during terminal illness, as death approaches, and after death, were regarded by the participants as an essential consideration in provision of holistic care for patients and families at the EOL after DNR decisions had been made. Touhy, Brown and Smith (2005) reported similar findings in a study on healthcare professionals' perceptions and attitudes towards patients' spiritual needs and spiritual care practices at the EOL in nursing homes. They found that nurses and physicians viewed spiritual care as an integral component of holistic care at the EOL.

Spiritual and religious considerations are, indeed, a key constituent of comprehensive care for terminally-ill patients and their families at the EOL after DNR (Blais et al 2006; Lynn, Schuster & Kabcenell 2000; McCann et al. 2007; Smeltzer et al. 2008; Smith & Haddad 2002). These authors all contend that these aspects of care warrant significant attention to detail, as opposed to other components of EOL care. In a study describing patient perspectives on spiritual needs in EOL, Kub et al. (2003) found that the majority of patient participants identified their religious needs as a significant component in helping them cope with a serious and life-threatening illness. Nurses in my study appeared to realise that meeting the cultural, spiritual and religious needs of dying patients and their family members was as important as providing quality physical nursing care. Although several research studies have discussed nurses' role in providing spiritual care for dying patients and their families, they originated in the Western world, where Judaeo-Christian traditions, values and culture are manifested (Lynn, Schuster & Kabcenell 2000; McCann et al. 2007; Rassool 2000; Smeltzer et al. 2008). In direct contrast, there has been scant attention in the literature about nurses' involvement in the spiritual care of dying Muslim patients, particularly those from a conservative Muslim community. Thus, the findings of my study have the potential to provide researchers with evidence of the need for additional research to examine the role of nurses in addressing the spiritual and religious needs of dying Muslim patients and their families.

In the context of EOL care, there seems to be willingness by nurses to accept cultural and religious beliefs different from their own and to work with patients of different beliefs in order to achieve a trusting therapeutic relationship. Mazanec and Tyler (2003) argue that healthcare professionals cannot expect to deliver quality EOL care for patients and families without an orientation to patients' beliefs, religious practices and rituals at the EOL. Mitchell et al. (2002), on the basis of an interview study exploring nurses' ability to provide culturally competent care at the EOL, found that nurses frequently encountered

challenges that impeded their ability to render sensitive EOL nursing care in a culturally diverse healthcare system.

As a Muslim nurse manager, I believe that my study has raised an important component of nursing care that I had not previously considered as particularly significant for non-Muslim nurses. The emergence of this theme, therefore, is an essential consideration for holistic nursing practice in Saudi Arabia.

5.5.1 Recognition of Islamic Aspects in Nursing Care

The first sub-theme emerging from the main theme 'Islamic considerations in nursing care' confirms the importance of recognising Islamic aspects in nursing care, whereby nurses showed consciousness of and appreciation for the spiritual and religious needs of Muslim patients and families at the EOL after DNR. It is interesting to note that, although providing culturally congruent EOL nursing care was perceived by participants in this study as an essential component of EOL care, the undisputed goal of such care was to maintain safe and holistic care across the entire continuum of EOL care. This finding is in line with those of Kociszewski (2004), who concluded that awareness of the spiritual needs of patients and families was something nurses experienced to be a core consideration in their daily nursing care.

Attending to the spiritual needs of dying patients enables them to find meanings in the range of their suffering, and to have the opportunity for compassion, love and worthwhile relationships in their final journey towards death (Puchalski, Dorff & Hendi 2004). Although the nurses in my study demonstrated an awareness of the spiritual and religious considerations of caring for Muslim patients and families at the EOL, they appeared to be unable to give exemplars of their direct involvement in spiritual care, which further contributed to the emergence of the last sub-theme of incorporating

Islamic aspects into nursing education on EOL care. This parallels the findings from the phenomenological study of Wong and Yau (2009), who reported that nurses did not receive adequate knowledge and skills to help them to provide effective spiritual care. The most frequently cited intervention by nurses in this study, however, was the referral of patients' and families' cultural and religious requirements to their direct nurse managers or to other (Muslim) healthcare professionals, particularly social workers. Nurses appeared to have confidence that they could always contact someone who was familiar with Muslims patients' religious needs.

Notwithstanding that, it was important for nurses in my study to convey respect and sensitivity to Muslim patients and families at the EOL by offering opportunities for patients and families to practise specific cultural and religious traditions, despite being faced with the dilemma of whether or not these cultural traditions might be regarded as a threat to patient safety. According to Al-Shahri and Al-Khenaizan (2005), providing competent and respectful EOL care by healthcare professionals to Muslim patients necessitates an understanding and awareness of the Islamic perspective of death and its related rituals. Ross (2001) concurs, asserting that, having this level of understanding and knowledge about Islamic practices at the EOL, nurses would be able to provide sensitive and respectful care at the EOL. In my specific situation, when nurses are involved in EOL care on medical units, they are required to attain specific knowledge and skills pertinent to caring for Muslim patients and families at the EOL after DNR.

Rassool (2000), on the other hand, claims that there seems to be a misapprehension regarding Islamic concepts and principles in the healthcare context in general, and in the nursing profession in particular. The spiritual healing practices for patients and their families, such as recitation of verses of the Holy Qur'an and Prophetic supplications, as evidenced in the findings of my study, are considered crucial for patients and families,

particularly as death approaches. Contemporary nursing care models, in general, are largely based on non-Muslim paradigms, and may not necessarily be congruent to the care of Muslim patients, particularly as Islamic beliefs, norms and traditions play a significant role in daily Muslim life (Rassool 2000).

5.5.2 Integrating Islamic Aspects into Education on EOL Nursing Care

'Integrating Islamic aspects into education on EOL nursing care' emerged as a sub-theme from the main theme 'Islamic considerations in nursing care', whereby nurses raised the need for continuing education and training pertaining to Islamic aspects of EOL care, in order to be able to deliver culturally and religiously congruent EOL care. This need is based on the premise that the holistic and religious integrity of patients in EOL must be maintained, from the moment the DNR decision has been made until the moment of death, including the aftercare of families. The findings of my study are consistent with those of Raudonis, Kyba and Kinsey (2002), whose descriptive study reported the level of EOL care knowledge among nurses in long-term care units and found that nurses need education on fundamental principles and aspects of EOL care, such as religious considerations, in order to improve the quality of care at the EOL. The findings of my study can, therefore, be incorporated into basic and continuing education programmes to assist nurses at the bedside to provide culturally congruent EOL care for Muslim patients and their families.

This assertion is supported by several research studies that have provided evidence on the lack of nurses' orientation and awareness of the spiritual domain as an integral part of the holistic nursing care at the EOL. Ferrell et al. (2000), for instance, conducted a research study to investigate the effectiveness of education in EOL care in the USA, and surveyed 2,333 oncology nurses. The findings showed that most participants were seemingly less confident about rendering spiritual care for patients at the EOL, which

was attributed to a possible lack of focus in their basic nursing education regarding EOL care. Similarly, Meraviglia, McGuire and Chesley (2003) conducted a survey of 352 nurses to assess their educational needs in relation to EOL care. They found that nurses appeared hesitant and uncomfortable about engaging in spiritual care for terminally-ill patients at the EOL.

In this study, nurses acknowledged that they believed they were inadequately prepared to assess and implement nursing care plans that support culturally and spiritually diverse perspectives. The nurses particularly identified that lack of knowledge regarding Islamic traditions and rituals at the EOL was a challenge in the provision of culturally congruent nursing care. Indeed, to provide culturally congruent EOL care for Muslim patients and families, nurses need information about the patients' and families' cultural and religious views regarding health, death and the afterlife. Such, however, is often the case when nurses with little or no EOL care training are expected to provide holistic EOL care (Ersek & Ferrell 2005). Such is, perhaps, the case in my study, where expatriate non-Muslim nurses, whose cultural backgrounds are divergent from the local cultural and religious perspectives in Saudi Arabia, are expected to care for dying patients. These nurses, therefore, require education about Islamic traditions and rituals at the EOL during their nursing orientation programme, so that their confidence and cultural competence in this regard are established concurrently with their familiarisation with local general contextual factors.

Ongoing nursing education regarding spiritual and socio-cultural aspects of patient care has been considered as important for development of nurses' competence in the provision of spiritual care in general, and in EOL situations in particular. It can be argued, however, that despite the growing focus on educating nurses about spiritual care as an integral component of EOL care research has offered few suggestions on how this could best be implemented (Baldacchino 2008). It is notable that initiatives in

teaching about spiritual care are gradually evolving in the nursing education field. For example, Kwekkeboom, Vahl and Eland (2005:169) developed a four-month undergraduate nursing course entitled the 'Palliative Care Companion Program' in the USA. It consisted of three components, namely, orientation, companion service and optional education. Nursing students were provided with an opportunity to spend an expanded amount of time with patients in EOL care. The evaluation of the programme revealed that student nurses gained an increased knowledge of EOL care and showed positive attitudes towards and increased confidence levels in working with dying patients.

Similarly, Thompson (2005) reported the effect of a specialised course on EOL care for baccalaureate nursing students. After completing the course, students rated an increase in both their comfort level and confidence in meeting patients' unique needs in EOL care. These initiatives, therefore, prove the need for a contemporary nursing education curriculum to embrace EOL care as a distinct subject, so that future nurses are adequately prepared to provide sensitive and respectful nursing care for dying patients and families. The findings of my study will be used to encourage inclusion of spiritual nursing care and interventions in both the undergraduate and the continuing nursing education curriculum in Saudi Arabia, in order to ensure congruency and competence in spiritual care at the EOL.

5.5.3 Implications and Recommendations

Based on the finding that nurses practise in a culturally and spiritually diverse environment and may not necessarily have the education or experience to deal with EOL situations, it becomes the responsibility of the hospital administration to make sure that nurses are adequately prepared to meet their patients' cultural needs. Hospital management should also ensure that sufficient resources and tools related to EOL care

are available for nurses delivering care for dying Muslim patients and their families. The findings of my study can be used to encourage inclusion of spiritual nursing care and interventions in both the undergraduate and the continuing nursing education curriculum in Saudi Arabia, in order to ensure congruency and competence in spiritual care at the EOL.

The findings of this research indicate that nurses working on medical units must undertake continuing education so that they are well-positioned to deliver a level of EOL nursing care that is congruent with Muslim practices in Saudi Arabia. Nurses are placed in a unique position to facilitate EOL care communication and decision-making between patients, families and physicians. Without proper training and support however, this may not occur. The evaluation of the reflective journals has provided evidence of the need to facilitate nursing interventions in EOL care after DNR. Adequate education, training and development of leadership skills, associated with psychological support, would doubtless result in increased work satisfaction among nurses, and would perhaps reduce stress or burnout that may develop from being involved in EOL care after DNR on medical units. Concurrently, nurses should welcome activities and opportunities that could help them understand the position of patients and their families in EOL care after DNR and their key role in coordinating the care contributions of other health professionals.

Educational courses should be offered to provide nurses, physicians and other healthcare team members with both theoretical and practical experiences in EOL care after DNR, with emphasis upon the benefits of a collaborative team approach. The different members of the healthcare team should avail themselves of the ever-increasing body of educational resources and published articles on EOL care to improve their communication and collaboration with patients' families in EOL care after DNR. Nurses should be provided with adequate knowledge and skills to enable them actively

to participate in open forum about DNR decisions with patients, families, and other healthcare team members. It is also important for nursing educational approaches to focus upon development of patient advocacy skills as part of an overall educational strategy.

It is imperative that during hospital and unit-based orientation, newly appointed nurses on medical units should be provided with specific information about Islamic considerations and principles in EOL care after DNR (Al-Shahri & Al-Khenaizan 2005). Following this introduction to the contextual uniqueness of Saudi Arabia, newly appointed nurses should then be mentored in their clinical assignments, which should include the comprehensive and contextual aspects of EOL care after DNR (Gaberson & Oermann 2007; Quinn & Hughes 2007).

5.6 Synopsis of Research Findings: Way Forward in Healthcare Practice

A synopsis of the research findings in relation to the way forward in an interdisciplinary healthcare practice context was triggered by reflexivity on the key findings that emerged from my research study. Patton (2002:64) confirms that reflexivity has entered the qualitative lexicon that involves 'self-questioning and self-understanding'. This process was undertaken by me with the supervisors of my research study, and involved extensive discussions on what the overview of the research findings mean in a pragmatic sense of a developing healthcare system with multicultural staff. From another perspective, Seale (1999) envisages reflexivity as being sensitive to contemporary contextual reality as a result of self-awareness. Seale et al. (2004) advise that controversial questions aimed at understanding research findings in cross-cultural situations require the ability of a heterogeneous team to think through elements that would converge on what is common and what is different as a starting-point for

achievement in the realities of diversity. This understanding of reflexivity guided our discussions on the research themes as we contemplated the way forward for interdisciplinary healthcare practice.

Arising from the main themes that include 'exhausted medical treatment, continuity of nursing care, and Islamic considerations in nursing care', there is an identified need for collaborative service development that is congruent with the International Council of Nurses (ICN) document on collaborative practice in the twenty-first century (Schober & McKay 2004). The authors emphasise that collaborative service development denotes the contemporary need of modern times for interdisciplinary action in approaches to improving healthcare delivery. They assert that collaborative service development is best positioned by an integrated approach where healthcare providers are considered equal in their roles and functions. In relation to this, the interdisciplinary approach is grounded by common health goals, shared decision-making and 'nourished by a climate of mutual respect, trust and support' (Schober & McKay 2004:8). Integrating leadership concurrently with team building is a core purpose for continuing professional education that includes all members of the healthcare team (Marquis & Huston 2009). The content of such an educational programme is suggested to include the involvement of nurses in clinical decision-making with their physician partners and team members, continuity of care contributions by all team members and not nurses alone, and the integration of religious and cultural considerations into the multifaceted nature of care delivery.

Shaw (2007:82) provides four (4) key components as success criteria for developing leadership in health care, which are: relevance, effectiveness, impact and sustainability. These key success components are upheld in relation to the emerging themes to guide multicultural and interdisciplinary professional development blended with the four (4) elements of Koestenbaum's (2002:41) strategies to achieve harmonious leadership in

the light of heterogeneous participants. He lists them as: vision, reality, ethics and courage.

The adoption of these concepts in interdisciplinary and collaborative service development could be as follows:

- A relevant vision for comprehensive patient care delivery.
- Effectiveness of professional manner in grasping reality of the clinical contextual factors.
- Impact of interdisciplinary ethical codes and conduct.
- Sustainability of professional courage to achieve and respect collaborative leadership.

Lastly, collaborative service development would be underpinned by education for research that contributes towards a continuous process of interdisciplinary evolution that is contemporary and aligned to health team involvement, sharing and contributions to collaborative clinical input on care delivery.

5.7 Approach to Conclusions of the Study

The threefold approach to the conclusions of the study includes: (i) limitations and transferability, (ii) future research agenda, and (iii) dissemination of the thesis. Morse and Field (2006) and Wolcott (2001) concur that at some point a researcher makes a decision to conclude the thesis but propose that this ending needs to project the worthiness of the study in terms of raising questions on what the setbacks were and the future considerations for continuity of scientific inquiry on the interest generated around the topic.

5.7.1 Limitations and Transferability of the Study

There are several potential limitations to this qualitative study, which largely stem from the qualitative methodology used in the research. First, the study was concerned with describing and exploring the lived experience of registered nurses in EOL care after DNR on medical units. It is therefore acknowledged that the study is limited by this qualitative approach because it focused only on experiences within the context of one hospital in the Kingdom of Saudi Arabia. Therefore, the main limitation of the study is that the meaning of nurses' experience and the essence of their involvement in EOL care after DNR are unique to the research context and therefore cannot be readily generalised to other settings. Although the findings of this study may not be generalisable outside the local context, however, knowledge of the meanings and essences identified in the nurses' lived experience are likely to be transferable to other hospitals in Middle Eastern countries, and to nurses with similar backgrounds to those studied (Krefting 1991).

The second limitation of this study was the use of purposive sampling to recruit participants. Although this may mean that the study was to a degree biased from the start, the purpose of the study was to seek out the phenomenon and to find meaning and understanding in its occurrence, which would have not been achieved without careful selection of participants. The small sample included in this phenomenological research could also be regarded as a limitation. In the light of the methodology used and the density of the gathered data, however, measures of what is considered sufficient to understand the phenomenon under study do not relate to the number of the participants, but rather to the sense of richness bestowed by the findings. The relatively low participant numbers, however, allowed for dense and thick description of the phenomena, so that readers could determine how their own situations matched the research context (Patton 2002; Krefting 1991).

Another limitation of the study is that it is retrospective in nature and therefore relied on each participant's recall of the lived experience in EOL care after DNR. The narratives included in the reflective journals cover a period of two years on medical units in the hospital. Therefore, the accuracy of recall may have been distorted as a result of the passing of time, whereby previous personal or family experiences in EOL care after DNR could have been used to answer the reflective journal questions. It is difficult to determine the impact of one approach versus the other. It should be stated, however, that it was apparent that the experience of participants was both vividly recalled and thoroughly described.

The multicultural diversity of nurses employed in the hospital represented a particularly unique limitation, although it added authenticity as argued in section 4.4. Language, in particular, is an important factor for consideration when data collection relies on reflective journaling. The participants had varying levels of English fluency, and therefore had various levels of ability in identifying and addressing issues related to their experience in EOL care after DNR.

5.7.2 Future Research Agenda

The study has raised several issues that suggest the need for further investigation and research. This research was conducted on the assumption that the researcher's background as a nurse manager would inevitably influence the research process and findings. Further research on this topic by a different researcher would add greater depth to our understanding of the phenomenon of EOL care after DNR on medical units in Saudi Arabia. Such research should also be directed towards determining nurses' perceptions and attitudes regarding their role and level of involvement in the DNR decision-making process in culturally diverse healthcare settings. Another suggestion for research is to investigate nurses' spiritual views, their religious perspectives, and the

association of these factors with the provision of EOL care of dying Muslim patients and their families. The complexity of the situation and issues that nurses encounter in their daily practice of EOL care after DNR may be further explored to evaluate implications for nursing practice, education and leadership.

On the other hand, it may be more worthwhile to examine the experiences of other personnel such as physicians, social workers, patient relation officers and care coordinators, who are also involved in EOL care after DNR on medical units. This could be achieved by focus group interviews with representative samples from all healthcare disciplines involved in EOL care after DNR. Such research has the potential to develop a richer picture of EOL care after DNR, and would possibly facilitate improvements in interpersonal communication with patients and their families and amongst healthcare team members. Finally, this study has provided the researcher with evidence of the need for additional research to examine physicians' interactions with patients, families, nurses and other healthcare team members in EOL care after DNR on medical units.

It is worthwhile to consider that EOL care and related considerations be researched outside the hospital setting. Research on community perspective of the family, particularly in the context of home health care services, would add valuable further insight to my research findings. Beyond the societal aspects, but nevertheless still within the community setting, it would be insightful to research the perspectives held by Islamic scholars on EOL care. These research findings would be pertinent and potentially contribute to a review of local religious rulings on which DNR decisions are made.

5.7.3 Dissemination of Research Thesis

It was anticipated at the commencement of the study that the research findings would be presented at national and international nursing, university and healthcare conferences after acceptance of symposium abstracts (Burns & Grove 2005; Carpenter 2007d). Two abstracts outlining aspects which have arisen from this research study were submitted and accepted for oral scientific presentation during 2009 (Appendices 20 and 21). The first (Appendix 20) was presented at the 4th International Nursing Conference in Jeddah, Saudi Arabia 19 – 20 April 2009. The second (Appendix 21) was accepted for oral presentation at the 20th International Nursing Research Congress Focusing on Evidence-Based Practice, in Cancun, Mexico, on 15 July 2009, but the conference was cancelled owing to the outbreak of novel AH1N1 virus as an epidemic.

The dissemination of study results through local, national and international symposiums and conferences will continue. A summary report will also be made available to the hospital authorities. Furthermore, it is hoped that the results of this study will be disseminated by journal article submissions which will be accepted for publication. Publication of such articles means the results of this study will gain scientific credibility, thus supporting its recommendations for practice (Carpenter 2007d).

5.8 Conclusion of the Study and Thesis

This study has uncovered the essence of nurses' lived experience and the meaning of their involvement in EOL care after DNR on medical units in Saudi Arabia. All of the objectives of the study have been achieved through this investigation (see chapter 1, section 1.5). These were:

1. Describe the nurses' lived experience in EOL care after a DNR decision has been made on general medical units.
2. Explore the meaning of nurses' involvement in EOL care on general medical units after a DNR decision has been made.
3. Establish the extent of nurses' involvement on general medical units as team members in EOL care after a DNR decision has been made.

The description and exploration of the reflective accounts of nurses has provided worthwhile insight into their lived experience of caring for dying patients and their families on medical units. The experience of participants, however, facilitates a new level of understanding about the phenomenon of EOL care after DNR, by clearly articulating the perspectives of the involved nurses.

The study has confirmed that nurses are not necessarily included in the DNR decision-making process, and that the authority to initiate the DNR decision rests solely with physicians. The experience for nurses, however, reveals that physicians varied in their attendance regarding meeting the evolving needs of patients and families in EOL care after DNR. Furthermore, lack of effective collaboration and communication amongst the healthcare team members was perceived as a major challenge impediment to the provision of quality EOL care after DNR on medical units.

This study highlighted that nurses working on medical units continue to maintain a constant level of care for patients and families after a DNR decision has been made. It can be inferred, however, that the essence of nurses' lived experience is the continuity of care itself. The compassion that nurses felt towards DNR patients and their families further reveals the essence of their lived experience: the ability to identify with the suffering of patients and families as they approach the patient's death, and the willingness of nurses to help and to provide relief and support at this time. Furthermore,

nurses in this study found meaning in EOL care after DNR, which they regarded as necessary to sustain them throughout their involvement in EOL care after DNR, particularly when other health team members appeared to be less interested and less involved.

Nurses found caring for dying patients and their families to be a rewarding and worthwhile experience, albeit a challenging and demanding one. Being involved in some of the most sensitive moments of people's lives appeared to enrich their lived experience. Nurses were able to demonstrate that dying patients and their families were important persons, and that nurses ultimately cared deeply about them, particularly after the DNR had been made. On the other hand, nurses identified a perceived lack of effective communication and collegial relationships with other healthcare team members to be a significant impediment to the provision of quality EOL care after DNR.

Caring for dying patients and their families who had different cultural and spiritual beliefs provided nurses with an opportunity to enrich their lived experience through awareness and appreciation of the differences of others. Awareness of and respect for Islamic practices at the EOL were part of a unique experience for nurses in this study. It is important at this point to reiterate that the participants experienced lack of knowledge and understanding in relation to Muslim cultural and religious practices at the EOL. Consequently, these results point to the need for improving education for all nurses, especially expatriates, in the local context about Muslim traditions and rituals in relation to death and dying, so that they are better equipped to provide holistic and culturally congruent EOL care.

The study demonstrates the complexity of EOL care after a DNR decision has been made on medical units in Saudi Arabia. The experience of caring for dying patients and

their families is different for each individual nurse. The study describes nurses' endeavours to provide quality EOL care after DNR on medical units through the adoption of a variety of methods and approaches to care. The study affirms that nurses working on medical units have an important contribution to make in EOL care after DNR for both patients and their families. It is acknowledged that, although this may be the completion of the research report, it really marks the beginning of a wider research awareness regarding nursing's involvement in EOL care after a DNR decision within the current hospital study site and hopefully across different hospital settings in Saudi Arabia.

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Kingdom of Saudi Arabia
National Guard-Health Affairs
King Abdulaziz Medical City



Ref# AEDN07-00824

المملكة العربية السعودية
الحرس الوطني - الشؤون الصحية
مدينة الملك عبدالعزيز الطبية

Date: 27 August 2007

To: Ms. Joan Murray
Associate Executive Director, Nursing Services

Through: Mr. Mustafa M. Bodrick *Mustafa B*
Director, Clinical Nursing/ Medical and Protocol Care

From: Ibrahim K. Abu Ghori, BN 46150
Master of Nursing (Honours) Candidate
University of New England, Australia
Student No.: 220009044

Subject: Permission to Conduct MNH Research Project in Nursing Services



Attached is a letter ref: SED07/69 dated 31 January 2007 from the University of New England, Australia that confirms the appointment of Mr. Mustafa Bodrick as co – supervisor for my MNH research thesis.

Your kind permission to conduct my nursing research project within Nursing Services as a commencement to the University and hospital approval processes. It is my clear understanding that after obtaining the necessary university approval, the research protocol will be submitted to the hospital research and ethics committees for approvals according to policy before the research project is undertaken.

The research project is entitled: 'Nurses Involvement in End-of-Life Care after the 'Do-not-resuscitate' decision'. Informed consent is planned for use before registered nurses agree to participate and the project will not involve patients, their families, and furthermore, it will exclude the access to patients' medical record and does not require patient identification.

Kindly consider granting permission for Nursing Services at KAMC – R to be the contextual site of the proposed MNH research project, pending the required University and Hospital research approvals.

Thank you and kind regards.



Permission granted, pending University and Hospital Research approvals

Ms. Joan Murray, RN, MBA
Associate Executive Director, Nursing Services

Date: 27/8/7

P. O. Box 22490, Riyadh 11426
Tel. 2520088
Telex : 403450 NGRMED SJ

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تلفون : ٢٥٢٠٠٨٨
تلکس : ٤٠٣٤٥٠ NGRMED



King Saud Bin Abdulaziz University for Health Sciences
National Guard Health Affairs

CMO-E4741 08 Dec. 2007



Medical & Health Sciences
Research Center



13509



1515



252-0772



research1@ngha.med.sa

MEMORANDUM

Reference: 7



Date: (G) 8 December 2007

(H) 25 Thul-Qedah 1428

To: Mr. Ibrahim K. Abu Ghori
Researcher/Masters of Nursing (Honours) Candidate

Subject: RC07/047 : 'Nurses' involvement in 'end-of-life' care after a 'do-not-resuscitate' decision on general medical units.

Thank you for submitting the above proposal, which was exempted by the Research Director to be reviewed by selected members of the Research Committee. Upon recommendation of the selected reviewers, We grant you permission to conduct your study.

Your research proposal is **approved for one year**, which you will require to forward us a request for an extension, if needed.

We are requesting to be informed of the development and/or the final outcome of the study.

Dr. Mohammed Al Jumah
Chairman, Research Committee
National Guard Health Affairs

Dr. Bandar Al Knawy
Chief Medical Officer
National Guard Health Affairs

Kingdom of Saudi Arabia
National Guard-Health Affairs
King Abdulaziz Medical City
Institutional Review Board (IRB)



المملكة العربية السعودية
الحرس الوطني - الشؤون الصحية
مدينة الملك عبدالعزيز الطبية
CLNResearch1@ngha.med.sa

MEMORANDUM

Reference #: IRBC/030/09

Date: **(G) 17 May 2009**
(H) 22 Jumada 'l 1430

To: **Ibrahim Abo Ghori**
Researcher/Master of Nursing
University of New England, Australia

Subject: **EXTENSION FOR ONE (1) YEAR**
Protocol RC 07-047 "Nurses' Involvement in 'end-of-life' Care After a 'do-not resuscitate' Decision on General Medical Units in Saudi Arabia

This is in reference to your request to extend the above noted study. After reviewed, in behalf of the Research Committee, we therefore approved the request **one (1) year** to complete the study, starting today, **17th of May 2009**.

Thank you for updating us on the status of your proposal. We are requesting to be informed of the development and final outcome of the study, through reprints of publications in peer review journals.

APPROVED BY:

Prof. Amin Kashmeery
IRB
National Guard Health Affairs

AK/mia

HUMAN RESEARCH ETHICS COMMITTEE

MEMORANDUM TO: Dr R Hussain, Mr M Bodrick & Mr I Abu Ghori
School of Health

This is to advise you that the Human Research Ethics Committee has approved the following:

PROJECT TITLE: Nurses' involvement in 'end-of-life' care after a 'do-not-resuscitate' decision on general medical units in Saudi Arabia.

COMMENCEMENT DATE: 01/01/2008

COMMITTEE APPROVAL No.: HE07/202

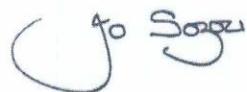
APPROVAL VALID TO: 01/01/2009

COMMENTS: Nil. Conditions met in full.

The Human Research Ethics Committee may grant approval for up to a maximum of three years. For approval periods greater than 12 months, researchers are required to submit an application for renewal at each twelve-month period. All researchers are required to submit a Final Report at the completion of their project. The Progress/Final Report Form is available at the following web address: <http://www.une.edu.au/research-services/forms/hrecfinalreport.doc>

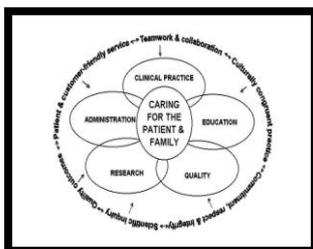
The *NHMRC National Statement on Ethical Conduct in Research Involving Humans* requires that researchers must report immediately to the Human Research Ethics Committee anything that might affect ethical acceptance of the protocol. This includes adverse reactions of participants, proposed changes in the protocol, and any other unforeseen events that might affect the continued ethical acceptability of the project.

In issuing this approval number, it is required that all data and consent forms are stored in a secure location for a minimum period of five years. These documents may be required for compliance audit processes during that time. If the location at which data and documentation are retained is changed within that five year period, the Research Ethics Officer should be advised of the new location.



Jo-Ann Sozou
Secretary

12/12/2007



NURSING SERVICES

Medical and Protocol Care

Research Project Title: **Nurses' involvement in 'end-of-life' care after a 'do-not-resuscitate' decision on general medical units in Saudi Arabia**

CRN Research Facilitator Manual

Contents:

1. Hospital Permission to Conduct the Research Study
2. Information Sheet for Participants and Consent Form
3. Reflective Journal Data Return Sheets – Training Set (A)
4. Reflective Journal Data Return Sheets – Training Set (B)
5. Quinn, F.M. (eds) 1998, *Continuing Professional Development in Nursing: A Guide for Practitioners and Education*, Stanley Thornes, Cheltenham. pp. 121 –124, 130, 131, 138.
6. Burrows, D.E. 1995, 'The nurse teacher's role in the promotion of reflective practice', *Nurses Education Today*, vol. 15, pp. 346 – 350.
7. Walker, S.E. 2006, 'Journal writing as a teaching technique to promote reflection', *Journal of Athletic Training*, vol. 41, no. 2, pp. 216 –221.
8. Taylor, B. 2006, *Reflective Practice: A Guide for Nurses and Midwives*, 2nd edn, Open University Press, Berkshire. pp. 84-51, 59-61.

Ibrahim K. ABU GHORI
 (A) Nurse Manager, Ward 15
 Master of Nursing (Honours) Programme
 University of New England, Australia

Research Project Title: Nurses' involvement in 'end-of-life' care after a 'do-not-resuscitate' decision on general medical units in Saudi Arabia

Participant Screening Sheet
(Data Collection Form)

Ward: 12, 13, 19, 20, 23, 24, 25 (kindly circle your unit)

(kindly circle page no)

Page: 1

2

3

No.	Staff nurses for possible participation in Research project (Research Population)	Inclusion Criteria			Leave Dates in Jan, Feb or March 2008	For use by Nurse Researcher only	
		1. Employed for one year or more on medical unit	2. Has nursed 'no- code' patient in last 2 years	3. Has not needed any NM counselling over past 2 years related to death of a patient or personal family member		E	NE
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School of Health
Armidale, NSW 2351
Australia

Date: / /2008

INFORMATION SHEET FOR PARTICIPANTS AND CONSENT FORM

RESEARCH PROJECT NAME:

Nurses' involvement in 'end-of-life' care after a 'do-not-resuscitate' decision on general medical units.

INVITATION TO PARTICIPATE

You are being invited to take part in this Master of Nursing (Honours) research project. Please read the following information, which explains the purpose of this research and what the participation involves. Should you require further information about this research, please contact the researcher on the contact details as shown at the end of this information sheet.

PURPOSE OF THE RESEARCH:

The aim is to fulfil the research purpose of gaining an understanding of the nurses' lived experience and meaning of their involvement in end-of-life (EOL) care after a do-not-resuscitate (DNR) decision is made on general medical units. The research purpose will be realized by conducting a qualitative process of inquiry on general medical units that will describe nurses' lived experience in EOL care after a DNR decision is made, explore the meaning of nurses' involvement in EOL care after a DNR decision is made, and verify the extent of nurses' involvement as team members in EOL care after a DNR decision is made.

RESEARCH METHOD:

The data will be collected by reflective journalling within the privacy of a safe environment away from the clinical site. The use of reflective practice is similar to how it is done in professional nursing practice currently used in the hospital on various units. About 20-25 registered nurses (RNs) will be offered the voluntary opportunity to participate and complete the reflective journals after learning how use them in specific training sessions.

Interested RNs participants are requested to sign the informed consent and return it to the researcher who will announce the time and venue of the scheduled training sessions. At these sessions, the researcher will distribute the reflective journal data sheets, which will include a specific numeric identification system that is shared only between the researcher and the participants for the purpose of confidentiality. RNs participants will be given four (4) to six (6) weeks to complete reflective journal entries in a safe and private environment of their choice. Respondents will return the reflective journal data sheets individually to the researcher by reaching him at the contact details provided.

RESPONSIBILITY TO THE PARTICIPANTS:

Participation in this research study is voluntary based on informed consent. You retain the right to withdraw at any stage without providing reasons to the researcher. Kindly be informed that confidentiality of identity is assured because all consent forms and the reflective journal returns will have a numeric identification system, which will be known only to the researcher and the participants. **The supervisors will have no access whatsoever to the reflective journal data sheets as a measure of confidentiality between the researcher and participants.** Access by the supervisors will be only to the typewritten transcriptions of the reflective data sheets that are de-identified ie, do not contain personal identification of the individual participants. The data will be stored in a locked

cupboard in my office, for which only I as the researcher have a key. The reflective journals will be kept for five years in a locked cupboard after the study, and then destroyed in keeping with the policies of the university and hospital.

DESSIMINATION OF FINDINGS

Results of the research study will be disseminated as a thesis requirement for a Master of Nursing with Honours. Also, findings of this research study are proposed for presentation at national or international conferences or for publication as a journal article if accepted. At all levels where data will be used from this study, **confidentiality of individual participants will be strictly maintained.**

IMPORTANT CONSIDERATIONS:

- Individuals are **under no pressure to participate** as consent is voluntary.
- All participants are **free to withdraw or discontinue at any time** with no explanation to the researcher.
- **Withdrawal** from or **non-participation** in this research will have **no professional impact.**

Any questions concerning the project entitled “**Nurses’ involvement in ‘end-of-life’ care on general medical units after the ‘do-not-resuscitate’ decision**” are welcomed by the researcher, Ibrahim K. Abu Ghori, Tel: (01) 2520088 Ext.11694, Email: ghorii@ngha.med.sa .

If you need to make further enquiries about this project, you can contact the study supervisors:

Associate Professor Rafat Hussain
School of Health, University of New England, Armidale NSW 2351, Australia
Tel: +61 2 6773 3678, Email: rhussain@une.edu.au

Mustafa M. Bodrick
Honorary Associate, University of New England
Member, Hospital Research Committee, National Guard Health Affairs
King Abdulaziz Medical City, Riyadh, Saudi Arabia
Tel: (01) 2520252 ext. 11865, Email: bodrickm@ngha.med.sa

This project has been approved by the Human Research Ethics Committee of the University of New England (Approval No HE07/2002, Valid to 01/01/2009) and the Research and Ethics Committees of King Abdulaziz Medical City for National Guard Affairs, Riyadh, Saudi Arabia (Approval No. RC07/047)

Should you have any complaints concerning the manner in which this research is conducted, please contact the Research Ethics Officer at the following address:

Research Services
University of New England
Armidale, NSW 2351
Telephone: +61 2 6773 3449 Facsimile +61 2 6773 3543
Email: Ethics@une.edu.au

CONSENT FORM

I (RN participant) have read the information above, and any question I may have asked has been answered to my satisfaction. I agree to participate in this activity, realizing that I may withdraw at any time. I agree that research data gathered for the study may be published, provided my name will not be used.

..... RN Participant Date
..... Witness Date

RETURN INSTRUCTIONS:

Kindly return this consent form directly to me by contacting me at the telephone extension below, or by email. I will come to you personally to collect this form and inform you about the time and venue for the training sessions on the use of reflective journal sheets as a data collection method.

Thank you

Ibrahim K. Abu Ghori
Researcher/Master of Nursing (Honours) Candidate
Ext. 11694 Email: ghorii@nqha.med.sa



School of Health
Armidale, NSW 2351
Australia

Date: / /2008

COVERING LETTER: REFLECTIVE JOURNAL SHEETS

Dear RN Participant, Ms/Mr.

Thank you for agreeing to participate in my research project regarding nurses' involvement in 'end-of-life' care after a 'do-not-resuscitate' decision on general medical units.

I have enclosed a copy of the reflective journal data return sheets. Should you wish to discuss any aspects related to this research or regarding the reflective journaling technique as a data collection method, **please do not hesitate to contact me on ext. 11694 or email ghorii@nghi.med.sa**.

Thank you once again for your assistance and participation in this research project.

Kind regards

Ibrahim K. Abu Ghori
Researcher/Master of Nursing (Honours) Candidate
Ext. 11694 Email: ghorii@nghi.med.sa

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REFLECTIVE JOURNAL DATA RETURN SHEETS

Date: / / 2008

Dear RN Participant

Please ensure that you do not include anything that might identify the patient or staff treating them.

Below are ten (10) open-ended questions relating to 'end-of-life' (EOL) care after the 'do-not-resuscitate' (DNR) decision is made on general medical units. Kindly reflect on each question and answer them at your convenience in a safe and private environment of your choice. **At the end of the four (4) to six (6) weeks** (date to be entered), **please call me at ext 11694 or email me** to collect your completed data return sheet personally.

In advance, thank you for the time taken to reflect on the questions and answer them.

Much appreciation and kind regards

Ibrahim K. Abu Ghori

Researcher/Master of Nursing (Honours) Candidate

Ext. 11694 Email: ghorii@ngha.med.sa

**Master of Nursing (Honours) Programme
University of New England, Australia**

Research Project Title: **Nurses' involvement in 'end-of-life' care after a 'do-not-resuscitate' decision on general medical units in Saudi Arabia**

Participants' Data Codes

No.	RN Participants	Code
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Ibrahim K. ABU GHORI
Researcher/MNH Candidate

**Master of Nursing (Honours) Programme
University of New England, Australia**

Research Project Title: **Nurses' involvement in 'end-of-life' care after a 'do-not-resuscitate' decision on general medical units in Saudi Arabia**

Reflective Journaling Data Collection Logging

No.	Participants' Data Code	Date	Research Data Code
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Ibrahim K. ABU GHORI
Researcher/MNH Candidate

**Master of Nursing (Honours) Programme
University of New England, Australia**

Research Project Title: **Nurses' involvement in 'end-of-life' care after a 'do-not-resuscitate' decision on general medical units in Saudi Arabia**

Information Session

Attendance Sheet

Venue:

Date:

No.	RN Participants	Unit
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Ibrahim K. ABU GHORI
Researcher/MNH Candidate

**Master of Nursing (Honours) Programme
University of New England, Australia**

Research Project Title: **Nurses' involvement in 'end-of-life' care after a 'do-not-resuscitate' decision on general medical units in Saudi Arabia**

Training Session

Attendance Sheet

Venue:

Date: 28 January 2008

No.	RN Participants	Unit
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Ibrahim K. ABU GHORI
Researcher/MNH Candidate

**Master of Nursing (Honours) Programme
University of New England, Australia**

Research Project Title: **Nurses' involvement in 'end-of-life' care after a 'do-not-resuscitate' decision on general medical units in Saudi Arabia**

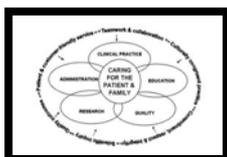
Participants Tracking Sheet

Batch:

No.	RN Participant	Date							Comments
		Information session	Consent form signed & returned	Training session	Follow up 1	Follow up 2	Return of RJ		
1.									
2.									
3.									
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7.									

Candidate: **Ibrahim K. Abu Ghori** Student no: **220009044** **May 2008**
Project Title: **Nurses' involvement in 'end-of-life' care after a 'do-not-resuscitate' decision on general medical units in Saudi Arabia**

Research data code	Themes							
	Major	Sub	Major	Sub	Major	Sub	Major	Sub
RJ 01								
RJ 02								
RJ 03								
RJ 04								
RJ 05								
RJ 06								
RJ 07								
RJ 08								



NURSING SERVICES

Medical and Protocol Care

Our Ref: **IAG 04/08**
 Date: **(G) 25th February 2008**
(H) 18th Safar 1429

Mail Code: **1410**
 Fax # **11516**

MEMORANDUM

To: **Mr./Ms. (Name of NM)**
Nurse Manager, Ward , Medical Units

Through: **Mr. Mustafa M. Bodrick**
Honorary Associate, Co-Supervisor, UNE, Australia
Director, Clinical Nursing, Medical & Protocol Care

From: **Ibrahim K. Abu Ghori**
Master of Nursing (Honours) Candidate, UNE, Australia
(A) Nurse Manager, Ward 15

Subject: **Appreciation for Support on Research Activities**

Research Project Title: Nurses' involvement in 'end-of-life' care after a 'do-not-resuscitate' decision on general medical units in Saudi Arabia.

NGHA Research Committee Approval No.: RC07 / 047

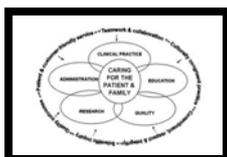
UNE Human Research Ethics Committee Approval No.: HE07 / 202

The above University of New England research project, which is being conducted presently at King Abdulaziz Medical City, Riyadh, refers.

Appreciation is extended to you as my nurse manager colleague for your invaluable support on the research activities relating to the approved project. The positive influence on your team for nursing research as an essential component in nursing practice has made a significant difference in the RN response for participation. Thank you.

It is indeed your nursing leadership that was a key support to me, which directly contributes to developing a nursing research culture at KAMC-R.

My best regards.



NURSING SERVICES

Medical and Protocol Care

Our Ref: **IAG 03/08**
 Date: **(G) 25th February 2008**
(H) 18th Safar 1429

Mail Code: **1410**
 Fax # **11516**

MEMORANDUM

To: **Mr./Ms. (Name of CRN)**
Clinical Resource Nurse, Ward , Medical Units

Through: **Mr. Mustafa M. Bodrick**
Honorary Associate, Co-Supervisor, UNE, Australia
Director, Clinical Nursing, Medical & Protocol Care

From: **Ibrahim K. Abu Ghori**
Master of Nursing (Honours) Candidate, UNE, Australia
(A) Nurse Manager, Ward 15

Subject: **Acknowledgement & Appreciation for Research Participation**

Research Project Title: Nurses' involvement in 'end-of-life' care after a 'do-not-resuscitate' decision on general medical units in Saudi Arabia.

NGHA Research Committee Approval No.: RC07 / 047

UNE Human Research Ethics Committee Approval No.: HE07 / 202

The above University of New England research project, which is being conducted presently at King Abdulaziz Medical City, Riyadh, refers.

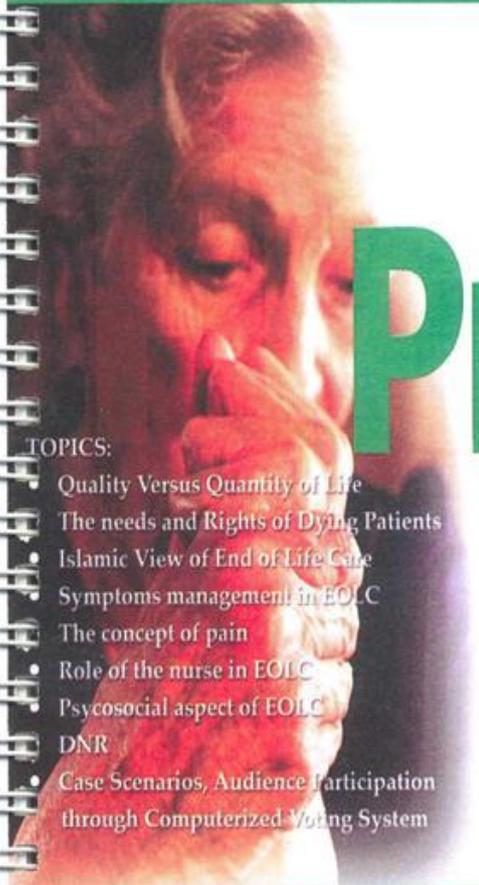
This letter acknowledges your significant contribution to the data collection process of the above research project. A special regard is noted for your assistance and input in the selection process of the eligible RN candidates for research recruitment. Appreciation is also extended for your participation and attendance at the CRN research facilitator workshop, which was conducted at the beginning of the data collection process. Your valuable effort in supporting RN participants to complete their reflective journaling sheets has contributed to the research worthiness of the effort.

Your assistance is highly appreciated, not only in this research project, but also in promoting nursing research at KAMC-R

Thank you and kind regards.

1st End of Life Care Mini Symposium - 24 May 2006

King Abdulaziz Medical City - NGHA - Department of Medicine in
Partnership with the Nursing Services.
Postgraduate Training Center



Program Book

TOPICS:

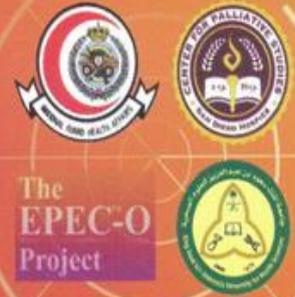
- Quality Versus Quantity of Life
- The needs and Rights of Dying Patients
- Islamic View of End of Life Care
- Symptoms management in EOLC
- The concept of pain
- Role of the nurse in EOLC
- Psychosocial aspect of EOLC
- DNR
- Case Scenarios, Audience Participation through Computerized Voting System



Postgraduate Training Center - KAMC, Riyadh
Tel. No. +9661-2520252 ext. 45446/ 48/ 49



King Abdulaziz Medical City - NGHA, Riyadh, Saudi Arabia
in collaboration with Center for Palliative Studies, San Diego Hospice
U.S.A. California



Education in Palliative & End of Life Care (EPEC) Workshop

The First of its kind in the Middle East

October 13-15, 2008

Postgraduate Training Center
King Abdulaziz Medical City - NGHA

PARTICIPANTS WILL GET:

- › "EPEC Professional" Certification from U.S.A
(Based on 100% attendance & completed course evaluations).
- › San Diego Hospice (SDH) Certificate of Attendance.
- › American Medical Association (AMA) 21 Category I CME Credit Hrs.
for Physicians and CEUs for nurses.
- › CME certificate from Saudi Council for Health Specialties.

TARGET AUDIENCE :

- › **Physicians** who are caring for patients with cancer or any incurable illness from all medical and surgical specialties and subspecialties.
- › Other health care providers who are interested in the area are welcome.

TOPICS INCLUDE :

- › Pain Management
- › Symptom Management
- › Skeletal Complications
- › Palliative Emergencies
- › Last hours of living
- › Palliative Care in ICU
- › **Effective Communication**
- › **Negotiating goals of care**
- › **Advance Care Planning**
- › **Conflict Resolution**
- › **Professional Burn-out**

COURSE FEES :

	PHYSICIAN	NON-PHYSICIAN
› Early Registration - (up to 31st August)	SR 1,500	SR 700
› Late Registration - (until September 21)	SR 2,000	SR 1,000
- Limited Seats - No On-site Registration -		

For registration and
more information, pls. call
Postgraduate Training Center
King Abdulaziz Medical City - NGHA
Ms. Zahra Al Rayes - Coordinator
Tel. No. : 0661-2520252 ext. 45051/45440



**King Faisal Specialist Hospital & Research Centre
(General Organization) – Jeddah
4th International Nursing Conference
CARING AT THE BEDSIDE: WHERE KNOWLEDGE MEETS PRACTICE:
19 – 20 April 2009**

ABSTRACT FORM

*** Please read the guidelines before completing this form ***

Submission by: 23 NOVEMBER 2008 (25 Dhul-Qa'da 1429)

PRESENTATION TITLE			
Nurses' involvement in 'end-of-life' (EOL) care after a 'do-not-resuscitate' (DNR) decision on general medical units in Saudi Arabia			
PRESENTER*: <input type="checkbox"/> DR <input type="checkbox"/> PROF <input checked="" type="checkbox"/> MR <input type="checkbox"/> MISS <input type="checkbox"/> MRS		AUTHOR(S)**	
ABU GHORI	Ibrahim	K.	Mustafa M. Bodrick RN, MPH, MSc (Nsg) Associate Professor Dr. Rafat Hussain
Last	First	Middle	** Including co-researchers & members who added significant scientific contribution, who will be acknowledged in abstract booklet
* Only one speaker per presentation			
<input checked="" type="checkbox"/> PRESENTATION		<input type="checkbox"/> POSTER	
The Scientific Committee reserves the right to propose abstracts forwarded for oral presentation be considered for poster presentation			

ABSTRACT (Max. 200 words)

Introduction:

Research studies have examined nursing issues of end-of-life (EOL) care mainly on intensive care units. Other focus has been patients, families and treating physicians. Less research has been conducted specifically on EOL nursing involvement on general medical units, which also are the frequent sites for death when chronicity cannot be treated.

Key concepts:

This paper reports on a qualitative exploration of EOL nursing experience. The research study aimed at understanding their lived experience, and the meaning of involvement with patients where do-not-resuscitate (DNR) decisions were made by physicians when treatment was futile.

Methodology and results (if research project):

A qualitative process of inquiry with purposive sampling of 26 reflective journals from Muslim and non-Muslim registered nurses were used. The research context was general medical units in a multicultural teaching hospital in Saudi Arabia. An integrated approach of Tesch (1990) and Coffey and Atkinson (1996) was used for data analysis. The nursing specific themes that emerged included compassionate care, continuity of care, coordination of care contributions, and Islamic aspects of care.

Conclusion:

Recommendations for clinical practice, nursing policy and nursing research specifically for the Saudi Arabian nursing context will conclude the presentation.

PARTICULARS OF PRESENTER:

CURRENT EMPLOYER: National Guard King Abdulaziz Medical City in Riyadh		SUBMIT ABSTRACT BY E-MAIL TO: Ms Carol Morgan Nursing Conference Coordinator King Faisal Specialist Hospital & Research Centre PO Box 40047, Jeddah 21499, Saudi Arabia Tel: +966-2-667-7777 ext 5082 Fax: +966-2-663-5380 E-MAIL: cmorgan@kfshrc.edu.sa
CITY/ COUNTRY: Riyadh, Saudi Arabia	NATIONAL PRESENTERS: SCFHS LICENSE # Not required by employer	
TELEPHONE +966 1 2520088 ext. 17887	MOBILE +966 56 5051540	
EMAIL ghorii@ngha.med.sa	FAX +966 1 2520088 ext. 17828	

- **Soft copy of the abstract form is available via e-mail or on website: www.kfshrcj.org**
- **An email confirming receipt of your abstract will be sent to you.**
- **If you have not received the confirmation within one week, please contact us.**
- **Applicants will be notified whether their abstract has been accepted by December 20th 2008**
- **All decisions on abstract acceptance are final. Once the decision has been rendered on an abstract, no further correspondence will be undertaken**

☆ from "mabelle@stti.org" <mabelle@stti.org> [hide details](#) Jan 29
reply-to mabelle@stti.org
to abumich@gmail.com
date Jan 29, 2009 4:33 PM
subject 20th International Nursing Research Congress Focusing on Evidence-Based Practice
Notification Letter
mailed-by confex.com

30 January 2009

Congratulations, Ibrahim K. Abu Ghori, RN, BSN, MNH(C)! The abstract you submitted for 20th International Nursing Research Congress Focusing on Evidence-Based Practice, "Nurses' Involvement in End-of-Life care after a Do-not-Resuscitate decision on general medical units in Saudi Arabia", has been selected for an oral presentation. The abstracts submitted were exceptional! The presentations selected are an excellent reflection of current nursing research and timely issues. We look forward to your participation in this prestigious event. The opportunity to collaborate with nursing scholars from around the world involved in the advancement of nursing science promises to be rewarding and stimulating.

YOUR ABSTRACT:

Title: Nurses' Involvement in End-of-Life care after a Do-not-Resuscitate decision on general medical units in Saudi Arabia

ID#:

Password:

To view your abstract, click the link below

<http://stti.confex.com/stti/congrs09/researchpop/extra/index.cgi?EntryType=Paper&username=41915&password=279616>

PRESENTER ACCEPTANCE POLICY can be viewed at

<http://www.nursingsociety.org/STTIEvents/ResearchCongress/Pages/SpeakerCorner.aspx>

Please note that the honor society has instituted a new presenter policy that will be strictly adhered to for all of our events.

If you have any questions, please contact Mabelle Fisher (email: abstracts@stti.org; phone: 888.634.7575 US/Canada or +1.317.634.8171 International).

Thank you,
Philip Esterhuizen, RN, BA(Cur), MScN, PhD
Chair, 2009 Congress Planning Committee

Barbara G. Robinette, RN, MSN
Director of Educational Resources
Sigma Theta Tau International
Honor Society of Nursing



[Start](#) | [Browse by Day](#) | [Author Index](#) | [Keyword Index](#)

Nurses' Involvement in End-of-Life Care after a Do-Not-Resuscitate Decision on General Medical Units in Saudi Arabia

Wednesday, 15 July 2009: 2:25 PM

[Ibrahim K. Abu Ghori, RN, BSN](#), School of Health, University of New England, Australia, Riyadh, Saudi Arabia

Rafat Hussain, MBBS, MPH, PhD, School of Health, University of New England, Armidale, Australia, Armidale, New South Wales, Australia

Mustafa M. E. Bodrick, RN, MSc(Nsg), MPH, Nursing Education, University of the Witwatersrand, Johannesburg, South Africa, Riyadh, Saudi Arabia

Learning Objective 1: describe the contextual setting of nursing practice and research that arise as a challenge in Saudi Arabia

Learning Objective 2: discuss qualitative research findings on end-of-life care with Muslim patients by multicultural nurses

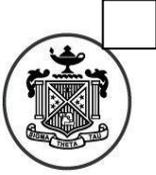
Purpose: To present qualitative research undertaken on multicultural registered nurses for end-of-life care after the do-not-resuscitate decision of Muslim patients on general medical units in Saudi Arabia.

Methods: Qualitative research using data collection from reflective journals of multicultural registered nurses on their lived experiences on end-of-life care

Results: Emergent themes from the reflective journals revealed fluctuating involvement of local physicians, and a deeper involvement of non-Muslim nurses intertwined with Islamic considerations of spiritual care. Actual extracts from the empirical data will be used to illustrate the vividness of the findings.

Conclusion: Lessons and recommendations for changes in nursing practice for cultural congruency in Saudi Arabia will conclude the presentation.

See more of: [End-of-Life Care](#)
See more of: [Research Sessions – Oral Paper & Posters](#)



**Sigma Theta Tau International
Honor Society of Nursing®**

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U.S./Canada 888.634.7575

DATE: 20 June 2009

TO: Mustafa M. Bodrick
Ibrahim K. Abu Ghori

FROM: Cynthia Vlasich, RN, BSN
Director, Education and Leadership

RE: Relocation of 20th International Nursing Research Congress

Amid concern about the Influenza A[H1N1] ("Swine Flu") pandemic as determined by the World Health Organization, the Honor Society of Nursing, Sigma Theta Tau International (STTI) has relocated its 20th International Nursing Research Congress from the current Cancun, Mexico, location to Vancouver, British Columbia, Canada. The conference dates are unchanged, 13-17 July 2009. Information about the 20th International Nursing Research Congress is online: www.nursingsociety.org. This change in location was done in accordance with the recommendations of the U.S. Centers for Disease Control and Prevention (CDC) and the European Centre for Disease Prevention and Control (ECDC) discouraging all non-essential travel to Mexico.

It is our understanding that you are withdrawing your respective oral presentations that had been accepted as part of the program for the 20th International Nursing Research Congress due to difficulties associated with this change in venue.

Please allow this to serve as formal notice of the cancellation of the congress in Cancun, Mexico and relocation of the event to Vancouver, British Columbia, Canada.