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Constructing and Managing Patient Death

A Narrative Inquiry

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Abstract

This research inquiry has sought to explore how medical consultants construct and manage patient death. Previous research in this area has focused on the influence of patient death on nurses and medical students or on family members. However no research could be found that specifically investigated what the influence of patient death was on medical consultants nor on how medical consultants constructed and managed patient death. This thesis aims to break new ground by examining this topic. Twelve consultants across six different specialities: Emergency medicine, Anaesthetics, Intensive care, General surgery, Internal medicine and Paediatrics; volunteered to be interviewed for this research project. Interviews were recorded, transcribed and then analysed using narrative inquiry in order to gain insights into the influence of patient death on consultants and also how they understand and manage patient death. Findings are discussed in two parts. The first part focuses specifically on the values that consultants hold and how these values underpin their particular identity as consultants. The research shows that consultants value being responsible, having support from others, being rational decision-makers, being good communicators, however they also value keeping their emotions compartmentalised until they felt it appropriate to display them. Consultants used these values to build the identity of a good doctor as one who is ethical and compassionate. Furthermore, consultants used these values to help them project the protagonist position they held within their narratives. The second part explores how consultants construct and manage patient death; both in a broad sense and with reference to specific cases. These findings indicated that consultants consider death not only as a relentless force without discriminatory power, but also as a natural process. Viewing death in these ways allowed consultants to construct death in two ways, depending on whether the death was due to an acute or chronic condition. For patients who died in acute circumstances, the consultants constructed death as a lost battle. For patients who died following long term illness, death was constructed as a merciful end. The case examples emphasized that these two distinct constructions of death allow consultants to manage patient death. They were able to resolve their own internal conflicts of feeling that they should be able to save all patients versus the reality that it is not possible to save everyone. This research contributes to the limited research in this area and fills a gap in the literature by specifically looking at consultants, a group that has not previously been considered.

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CHAPTER ONE

INTRODUCTION

Even at our birth, death does but stand aside a little. And every day he looks towards us and muses somewhat to himself whether that day or the next he will draw nigh. (Bolt, 1978, p. 103)

No matter where one was born; how one was raised or where one lives, there is a common link that all who are alive will inevitably share and that is, death. In most countries, the majority of people to whom one talks, will have an opinion on death and can share a story or stories about the deaths of those they were either close to or have known of. Depending on the part of the world that one lives in, death may either occur on a daily basis or alternatively, it might be an event that is only experienced sporadically. Death could be celebrated (Conway, 2007), as in Mexico where a day is set aside to celebrate the dead (Día de Muertos), or it could be honoured through religious ceremonies. Regardless of our experiences around death, it is internationally still considered a sensitive topic. Research indicates that it remains a topic that is uncomfortable for many people to talk about as it creates fear and distress particularly since it reminds them about their own mortality (Lyons & Chamberlain, 2006).

Lyons & Chamberlain (2006) noted that dying is more of a social phenomenon that affects not only the person who is dying but their loved ones and any persons who may be caring for them. The social protocols that have evolved around death, especially in the western world, includes not openly discussing death; having closed caskets at funerals and often, not allowing children to be present at funerals, perpetuating the idea that death is taboo (Seale, 1998). This results in individuals refraining from talking about death with others. This includes individuals in the medical profession, such as nurses and doctors, who deal regularly with death as part of their day-to-day work environments. This chapter will focus on the change in the landscape of death and discuss key themes from previous research within thanatology (the study of death and dying) (Webster, 2014), including the definition of death. After these preliminary discussions, the aims of this research project will discussed in detail.

Lyons & Chamberlain (2006) noted the landscape of death has changed dramatically over the last 200 years. In the nineteenth century, death was often due to a variety of infectious diseases and in particular, waterborne diseases such as cholera. This situation changed dramatically when water sanitation and waste disposal was introduced (Baum, 2008). After this point, more common causes of death were from other infectious diseases including influenza and tuberculosis. As medicine knowledge and expertise expanded over the last century, vaccinations were developed for many of these previously fatal ailments (Baum, 2008) which resulted in fewer people dying each year from those particular diseases. When we reflect on the current causes of death, we realise that death is no longer predominantly caused by infectious disease but rather by chronic illnesses such as cancer and coronary heart disease (World Health Organisation, 2014). As a result of this change, death is presently a much slower process than what it once was.

Just as the causes of death have changed over different generations, society has shifted the location of death (Conway, 2007; Kaufman, 2003). Conway (2007) highlights that as individualism grew within society, death also became increasingly an individual event (Illich & Illich, 1977; Seale, 1998). Death used to be open and visible in the community with most people dying at home, it was a social event and involved the family and community members being present (Conway, 2007). Presently however, death occurs mostly in hospitals or care facilities that are out of sight of the general public and away from the dying person's community (Conway, 2007; Lyons & Chamberlain, 2006). This shift from death typically occurring in the home environment, towards more deaths occurring in hospitals, has been termed the "*medicalization*" (Conway, 2007, p. 198) of death.

As a result of this *"medicalization"* of death which resulted in many more people going through the process of dying in the hospital environment, doctors and nurses were being placed in the position of caring for dying patients on a much more frequent basis. However whilst the location of death had changed markedly, the medical curriculum however had not changed (Clark, 2007). This mismatch with doctors feeling unprepared to care for dying patients yet having to cope with an increasing number of people dying in hospitals, led to families complaining that doctors were uncaring (Doyle, 1996; Seale, 1998). This perception that doctors were uncaring was often due to the lack of pain and symptom management (comfort care) that arose because doctors felt uncertain about providing

appropriate care (Clark, 2007; Doyle, 1996). This mismatch between the patients' needs and the doctors' perception of their own ability reached crisis point in the mid 1960's resulting in palliative care institutions opening and taking over the care of the dying, especially caring for those dying of cancer (Clark, 2007; Doyle, 1996).

At this stage, research interest in grief and bereavement grew. This lead to the seminal work on grief by Elizabeth Kübler-Ross (Kübler-Ross, 1970) which resulted in increased research interest in the field of thanatology. Since then the field of thanatology has focused on various aspects of death including: looking at how families cope with having a relative die (Hudson, 2006; Pochard et al., 2005); looking at the situation of the terminally ill to see how these individuals cope with dying (Penman & Ellis, 2014); looking at the medical professionals involved and specifically the impacts on the doctor-patient relationship when a patient is terminally ill (Lenherr, Meyer-Zehnder, Kressig, & Reiter-Theil, 2012; Weitz, 1999); looking at whether doctors feel that they had adequate training to deal with families of terminally ill patients and finally looking at whether doctors feel prepared to deal with terminally ill patients (Janvier, Barrington, & Farlow, 2014).

Whilst the increasing 'medicalization' of death was first recognized as social and medical phenomenon over a century ago, it has however only been during the past thirty years, that researchers have started looking closely at the progression of palliative care medicine. Specifically they began to investigate why it originally started (Doyle, 1996) and also why nurses and doctors were seen as distant and appeared uncomfortable when they were caring for the dying.

Literature in this area has highlighted several key themes with regards to why nurses and doctors appear to be uncomfortable around death. These themes included: lack of training in palliative care; lack of communication training; the hidden curriculum and lack of support.

Lack of palliative care training

Research that has included interviews with nurses, doctors and medical students, show that one of the most noteworthy themes related to patient death is the lack of training that medical staff received either as students or as professionals (Jackson et al.,

2005; MacLeod, 2001; Sheward, Clark, Marshall, & Allan, 2011; Wear, 2002; Yim Wah, Vico Chung Lim, & Wai To, 2013). Nurses, according to the research, have received the most training on patient death (Bailey, Murphy, & Porock, 2011; Kent, Anderson, & Owens, 2012). However the research indicates that the nurses feel that more training, especially around learning how to cope with their own emotions, would be beneficial to them. Additionally nurses want further communication training in order to become more competent when communicating with families (Braganza, 2014; Meier, Back, & Morrison, 2001; Peterson, Johnson, Scherr, & Halvorsen, 2013; Sheward et al., 2011; Yim Wah et al., 2013).

Research conducted with medical students and doctors show that an overwhelming proportion of them feel that their medical training could have included more palliative care training (Jackson et al., 2005; MacLeod, 2001; Moores, Castle, Shaw, Stockton, & Bennett, 2007; Wear, 2002). This opinion from the medical students was because of the fact that during their entire degree programmes, a maximum of 15 hours was spent on palliative care training. (MacLeod, 2001; Rhodes-Kropf et al., 2005). One exception to this general lack of training, related to work conducted in New Zealand, at the Otago Medical School where the students were requested to keep a portfolio whilst they cared for a dying patient (MacLeod, Parkin, Pullon, & Robertson, 2003). This meant that the students had to be with a dying patient from the time of initial prognosis until their death. The students were requested to see this patient every day and to write reflections with regard to their emotions and their experiences whilst caring for this particular patient (MacLeod et al., 2003). The students reported that this specific exposure and along with being able to write their reflections about the experience, allowed them to come to grips with their own emotions regarding the death of patients (MacLeod et al., 2003). It appears however, that this was only conducted as part of a research project and is not standard within the New Zealand Medical School curriculum.

Similarly to the research with nurses and doctors, the medical students wanted more classroom training about patient death and they also wanted more education on how to deal with their own emotions (Bailey et al., 2011; Jackson et al., 2005; Meier et al., 2001; Moores et al., 2007). Interestingly the research indicates that all medical students valued learning through experience (MacLeod, 2001; Zambrano & Barton, 2011). The most frequent request for improvements to the medical curriculum about this subject was to not

only to include more training about dealing with patient death in the classroom (MacLeod, 2001; Sheward et al., 2011; Wear, 2002), but also to have dedicated clinical time to deal with patient death, as illustrated by MacLeod, Parkin, Pullon & Robertson (2003).

Lack of communication training

Doctors, nurses and medical students all noted that one of the hardest aspects to deal with regarding patient death was communication (Peterson et al., 2013; Sheward et al., 2011). Communication in this regard is twofold; communication within the medical team and communication with the families (Bedell, Cadenhead, & Graboys, 2001; Carline et al., 2003; Cherrington, 2011; Peterson et al., 2013; Rhodes-Kropf et al., 2005; Sheward et al., 2011; Weitz, 1999). Within-team communication about when to move from active treatment to comfort care was often difficult. Nurses indicated that they often feel that they know when patients should move to comfort care before doctors (Sheward et al., 2011). Often there is a lack of within-team communication that prevents this from happening in a timely manner. Medical students noted that not only was communication within the team minimal but the communication with families was also negligible (Bedell et al., 2001; Peterson et al., 2013). Some research indicated that most of the students had not once witnessed a consultant breaking bad news to the families of deceased patients (Wear, 2002). Literature among both nurses and doctors indicate that they often feel unconfident about breaking bad news to families and that this is often one of the hardest aspects about patient death (Braganza, 2014; Cherrington, 2011; Rhodes-Kropf et al., 2005; Sheward et al., 2011; Yim Wah et al., 2013).

The hidden curriculum

Medical students reported a lack of classroom training on how to deal with dying patients, their own emotions and communication with families (Bedell et al., 2001;Jackson et al., 2005;Meier et al.,2001;Rhodes-Kropf et al., 2005). The research conducted with medical students has revealed the idea of the '*hidden curriculum',* defined by Rhodes-Kropf et al., (2005) as the attitudes, beliefs and values that are inadvertently taught to them from senior doctors during their clinical rotations. For example the research indicates that the hidden curriculum frequently teaches medical students that displays of emotion are unprofessional and a sign of weakness (Rhodes-Kropf et al., 2005;Rousseau, 2003;

Zambrano & Barton, 2011). As a result medical students learn to hide or suppress grief and tears when a patient dies (MacLeod, 2001). Furthermore, the literature has shown that the hidden curriculum often teaches medical students that death is a failure on their part (Jackson et al., 2005; Moores et al., 2007; Redinbaugh et al., 2003; Rhodes-Kropf et al., 2005; Sheward et al., 2011; Wear, 2002; Weitz, 1999; Wilson, 2014). Pessagno, Foote and Aponte (2013) concluded that death may be seen as a failure especially in acute medical wards, since the aim of these wards is often to cure and to treat, whereas death is not seen as such a failure in places such as terminal care wards (Pessagno, Foote, & Aponte, 2013).

Research among nurses indicates that the hidden curriculum is not a problem for them in regards to patient death. The nurses report that they receive more support both as training nurses and registered nurses to help them cope with the emotions associated with patient death (Kent et al., 2012; Peterson et al., 2013; Wilson, 2014; Yim Wah et al., 2013).

Although the literature shows that this hidden curriculum appears to be prevalent, the literature also indicates that doctors do have emotional reactions to patient death (Jackson et al., 2005;Meier et al., 2001; Moores et al., 2007). However since the doctors are 'socialised' to not display emotions, this may lead to what Doka (2008 p. 224) termed *"disenfranchised grief".* Disenfranchised grief is grief that is experienced but is not socially validated. For example grieving over the loss of an ex-spouse could be considered disenfranchised grief (Doka, 2008). Doka notes that this type of grief often occurs when the griever is not family or close friends with someone who has died (Doka, 2008). Wilson (2014) noted that this grief is possibly the grief experienced by doctors and nurses when a patient dies. They want to grieve but feel that their grief is not socially validated as they were taught that doctors should not display emotions and that emotional displays could be seen as unprofessional (Rousseau, 2003).

Disenfranchised grief could also be associated with negative emotions such as anger and anxiety. People may feel angry because their grief is not socially validated. Or people may become anxious that they are grieving and that they have no right to. Alternatively people may also then become depressed because they have not been able to properly grieve. The literature shows that doctors go through stress and anxiety to some degree in

their day-to-day clinical activities but especially so when a patient dies (Jackson et al., 2005; Moores et al., 2007).

Lack of support

The research among medical students show that the vast majority of them want more support from their seniors be that from house officers or consultants when it comes to dealing with patient death and the associated emotions (Redinbaugh et al., 2003). Consultants who have been interviewed on the topic also agree that there should be more support for all doctors, either through team debriefing or more formal counselling, depending on the team (Wear, 2002). Interestingly the consultants also noted that they wished they were able to provide better support for their students but since they did not receive any training, they felt uncertain and uncomfortable about trying to guide them (Wear, 2002).

In 2008 the New Zealand Medical Council released a newsletter covering all aspects of a doctor's health. The Council understood the influence of a doctor's job on both the doctor's physical and mental health (Medical Council New Zealand, 2008). As such the newsletter contained information for doctors about where to seek help, how to help colleagues and what risk factors, associated with burnout, to look out for (Medical Council New Zealand, 2008). Interestingly, the Council recognised and wrote about the influence that patient death may have on doctors but other than mentioning that this may have a particularly big influence on the doctor, the newsletter did not comment on coping strategies or mention services that the doctors could utilise in order to deal appropriately with patient death.

All the literature reviewed here, highlighted that doctors feel unprepared about how to deal with a patient's death and the associated emotions (Jackson et al., 2005;Moores et al., 2007;Rhodes-Kropf et al., 2005; Wear, 2002). Interestingly this literature had one overarching goal; to improve the medical curriculum (MacLeod, 2001; Moores et al., 2007; Zambrano & Barton, 2011). Whilst this is an important goal for continual improvement, none of the research has aimed to gain a deeper understanding of how doctors construct patient death. In the last year 30,000 people died in New Zealand (MacPherson, 2014) and the majority of these deaths occurred in a hospital or in a hospice, where doctors were

responsible for the patients' end-of-life care. Despite this, there has been little research that specifically looks at how patient death affects doctors in New Zealand, even though the New Zealand Medical Council has acknowledged the influence of patient death upon doctors.

Summary

In summary, the literature shows that there are four key points regarding the influence of patient death on doctors. Firstly the doctors feel that they received inadequate training to manage the physical aspects of patient death. This also included feeling that they received inadequate training on how to manage their emotions. Secondly the doctors feel that they need more training on how to better communicate within a team when a patient is dying. Most importantly the doctors wanted more training on how to better communicate with the families of dying patients. Thirdly, the literature highlights that doctors are not socialised to express their emotions around patient death. This has been termed the hidden curriculum. This could lead to doctors experiencing disenfranchised grief and negative emotions. Lastly the doctors feel that there is a lack of support and services for them to utilise when a patient dies.

Defining death

Although death is seen in epidemiology as a fixed point, because no one can be both dead and alive at the same time, the definition of death has changed over the last century. In the 20th century it was widely accepted that "death" was the loss of function in the cardiopulmonary system. This was originally considered to be "medical death" and "true death" was the loss of brain function (Appel, 2005). With the rise of life-sustaining technology however, doctors and families have been able to keep people "breathing" via a ventilator even though there is no apparent brain function. Therefore without the ventilator, they would be unable to breathe or sustain life. This lead the Harvard Medical School to re-examine the definition of death and as such, death is now defined as a cessation of the brain, including the brain stem (Appel, 2005).

In New Zealand there is no legal definition of death. For someone to be defined as dead in New Zealand, there has to be either no brain function or the complete cessation of

blood circulation in the body (The Australian and New Zealand Intensive Care Society, 2013; The Life Resources Charitable Trust, 2011). In order for a doctor to declare death, observation of the patient and medical testing is required.

Firstly, a minimum of four hours of observation has to occur and the patient must be unresponsive to all stimuli, including mechanical ventilation, where the person shows no spontaneous effort to breath, has no cough or gag reflex and their pupils show no reaction (The Australian and New Zealand Intensive Care Society, 2013; The Life Resources Charitable Trust, 2011). After this observation period, doctors may begin testing to determine brain death. Testing for brain death requires two medical practitioners to perform a set of tests. The tests performed by each practitioner is identical, however the practitioners are not allowed to simultaneously conduct the tests. Below is a quote highlighting the testing required to declare brain death (The Australian and New Zealand Intensive Care Society, 2013):

> "…brain scans or other tests show sufficient brain pathology to cause death; and body temperature is normal; and blood pressure is normal and sufficient to not faint; and sedative drugs and other drugs are not causing coma; and significant electrolyte, metabolic or endocrine (hormone) disorders are absent; and neuromuscular function – the transmission of signals from nerve to muscle – is intact; and examination of brain stem reflexes is not prevented by, for example, severe injuries to the eyes or ears; and it is possible to confirm the absence of any ability to breathe without blood oxygen levels falling too low…
>
> And then:
>
> …absence of brain reflex responses to all stimuli including pain; and absence of brain-stem reflexes – the basic reflexes that protect the body and maintain life; and complete absence of any breathing efforts even when the patient is not connected to the mechanical ventilator for much longer that anyone would be able to hold their breath – breathing is a basic instinct that is essential for people to stay alive."
>
> (The Australian and New Zealand Intensive Care Society, 2013, p. 2)

We can see from the above statement that determining brain death is not a simple test. Determining brain death requires a lot of analysis on the doctor's part and as such, there is room for self-doubt. This self-doubt could invariably influence the reaction to the patients' death and the subsequent coping strategies.

This research project

This research aims to look at how doctors, specifically consultants, construct patient death from a narrative perspective. Consultants are defined as doctors who have worked for a minimum of seven to nine years since graduation and have completed specialist training in their chosen field (Medical Council New Zealand, 2011) Consultants have specifically been chosen for this research because there is a lack of research that looks specifically at this specific population. Additionally, there appears to be a contradiction within the literature; medical students and junior doctors often report that caring for a dying patient is not satisfying, however the limited amount of work that has been conducted with consultants show that they often report gaining huge satisfaction from caring for a dying patient (Moores et al., 2007). Research conducted by Pessagno et al., (2013) indicated that perhaps only consultants view death is a failure because the overall responsibility of patient care lies with them (Pessagno et al., 2013). Lastly the research indicated that consultants, like medical students, often feel that they have received inadequate training in both dealing with the emotions associated with patient death and communicating with families (Jackson et al., 2005; MacLeod, 2001; Meier et al., 2001; Moores et al., 2007; Neimeyer, Currier, Coleman, Tomer, & Samuel, 2011; Redinbaugh et al., 2003; Rhodes-Kropf et al., 2005; Wear, 2002). However none of the research reviewed here has looked specifically at how consultants have learnt to deal with patient death. Therefore this research aims to see how consultants construct and manage patient death.

Since the research indicates that a patient dying in an acute medical ward may be harder to deal with than a patient in terminal care (Wilson, 2014), this research will explore both avenues to see whether consultants feel this way. To enable this, this research will talk to consultants from: Accident and Emergency, Anaesthetics, General Surgery and Intensive Care and Internal Medicine. No oncologists were asked to participate in this research since the hospital of choice for this research does not have any oncologists. Paediatricians were also asked to participate in this research as the literature indicates that deaths of children are some of the hardest cases for consultants to cope with (Braganza, 2014; Sahler, Frager, Levetown, Cohn, & Lipson, 2000; Serwint, Rutherford, & Hutton, 2006).

Additionally this research aims to explore how consultants manage patient death. Management in this instance refers to the process that the consultants engage in and the strategies that they use to emotionally and psychologically accept that a patient is dying or has died. For example, do doctors utilise counselling services, play sport or write a letter of condolence to the families to help themselves as well as the grieving families cope with the loss.

In conclusion the key aims of this research are:

- To see how consultants construct patient death
- To see how consultants manage patient death.

CHAPTER TWO

METHODOLOGY AND METHOD

Research is formalized curiosity. It is poking and prying with a purpose.

(Zora Neale Hurston)

The purpose of this chapter is to provide an overview of the methodology and method that have been chosen for this research project. This chapter will therefore include an outline of qualitative research, including a rationale for choosing this type of research. Secondly an overview and rationale will be provided for using narrative analysis for this project. This chapter will then finish with a detailed description of the method used for this research.

Qualitative Research

Qualitative research has been largely disregarded in Psychology for many years (K Chamberlain & Murray, 2008; Crossley, 2000; Lyons & Chamberlain, 2006). It has been argued that the focus on quantitative research was for Psychology, as a discipline, to be seen as a true science alongside Chemistry and Physics (Camic, Rhodes, & Yardley, 2003; K Chamberlain & Murray, 2008). Recently however, this focus has started to change and Psychology, alongside other disciplines, is becoming more aware of the great potential that qualitative research offers. A useful metaphor about the differences between quantitative and qualitative research is provided by Camic, Rhodes & Yardley (2003). These authors describe quantitative research as a map, which provides us with the location of something and its relationship to other locations in terms of direction and proximity. Qualitative analysis, on the other hand, is described by these authors as being a video recording on the location. The video of the location provides one with detailed information of the location, what it looks like, what kinds of people live in this location, the experience of walking between one location and the next. Importantly the video recording shows the change in perspective from the observer (Camic et al., 2003).

Chamberlain (2014) argues that psychologists need to further reflect on their research and to understand the epistemological assumptions that their research is based on (K. Chamberlain, 2014). This ties in with the work from Crotty (1993), who states that

methodology is an action plan for research. It provides us with a system of methods that we can use for research. Crotty (1998) emphasises that epistemology, methodology and methods should have a clear and coherent link (Crotty, 1998).

Since this research project is qualitative in nature and is concerned with the experiences of patient death from the consultants' viewpoint, social constructionism is the logical epistemological basis for this research.

Social constructionism is the idea that knowledge is created from interactions between investigators and objects (including people, places and material objects). A key idea in social constructionism is that the interaction generates knowledge but also that the knowledge that is generated is generated for a particular purpose (Andrews, 2012; K. Chamberlain, 2014; Crotty, 1998; Gergen, 2009). A second important factor in social constructionism is the idea that knowledge is always located socially, historically and culturally (K. Chamberlain, 2014; Gergen, 2009). Related to this idea is that knowledge is not stable, as society changes and what we believe to be true at a particular time is always subject to change, therefore knowledge is provisional (K. Chamberlain, 2014). Since social constructionism assumes that objects or ideas are constructed through interactions (Andrews, 2012), it should be noted that this construction of an object will change depending on the audience it is being given to (K. Chamberlain, 2014). It is important therefore to note that for this research, the manner in which the consultants construct death in conversation with me, not only as a researcher but also as a Master's student of Psychology, is only one of the possible ways in which they could construct patient death. The position that I hold, in comparison to the consultants, potentially influences the language that they choose to use when constructing patient death (Berger, 2013). It is important not only to note this influence but to simultaneously understand that the differences in the way patient death is constructed by the consultants to me as a researcher compared to family, friends or colleagues, is congruent with the epistemological basis for this research. Social constructionism does not claim that any one of those accounts would be more accurate than another rather that those different accounts are accurate in that specific context and that all accounts have something meaningful to offer (Andrews, 2012; Gergen, 2009).

Narrative Analysis

A key idea in social constructionism is that realities are co-constructed depending on our relationships and interaction with others. For this co-construction to take place, language in all forms (spoken, written and symbolic) is utilised. Therefore, language is central to social constructionism (Gergen, 2009). Narrative analysis as a methodology, equally argues for the importance of language. Proponents of narrative analysis state that most of our communication with each other is done through narrative. They argue that information is contained in a story with a discernible beginning, middle and end. Proponents of narrative analysis strongly argue against the idea that we factually pass on information (Riessman, 1993, 2008). Furthermore, narrative analysis suggests that we organise life events into stories to help us, both as individuals and communities, in order to make sense of the world in which we live (Crossley, 2000; MacIntyre, 1981; Riessman, 1993, 2008). In addition, various authors (Ezzy, 1998; Gergen, 2009; Riessman, 2008; Smith & Sparks, 2006) argue that narrative analysis allows us to see the identities that people form of themselves and present to others. These identities are important to understand, as the identity that someone creates of themselves affects their perception and understanding of the world. It is important to note that whilst these authors argue that identities can be seen through narrative, the identities presented are always fragmented and incomplete since the identity will be context dependant (Gergen, 2009; Langellier & Peterson, 2004).

Narrative analysis is described by Riessman (2008) as an umbrella term for a variety of methods that analyse narratives. Riessman (2008) and Smith and Sparks (2006) also note that there is considerable tension between those who use narrative analysis, each pitching different perspectives (Riessman, 2008; Smith & Sparks, 2006). Riessman proposes for three different forms of narrative analysis: thematic analysis, structural analysis and performance analysis.

Thematic analysis is described as a method for focusing on the content of what is said. There is little emphasis on how the story is told, how speech is structured or how the narrator involves the audience. Riessman warns that thematic analysis of narratives fundamentally different from thematic analysis from a grounded theory perspective, whereby the data is often fragmented for coding (Riessman, 2003). For example, thematic

analysis of this research topic would result in a final list of the common themes that arose from all the consultants' narratives about patient death. There would be very little or no further analysis into why those themes arose or what purpose they may serve.

The second form, structural analysis, is defined as a focus towards how the story is told. Importantly the content of the story is not forgotten but it is not the emphasis of analysis (Riessman, 2003). Riessman (2008) notes that structural analysis looks at whether narratives follow a prescribed or privileged way of storytelling. Structural analysis can highlight deeper political issues and issues of power. For this research topic, utilising this form of narrative analysis would mean focusing on the way that the consultants talk about patient death. Looking specifically at their use of language and whether it privileges certain ethnicities or patients or what power relations arise from their narrative.

Performance analysis is the last of the three forms that Riessman (2008) defines. Performance analysis for narrative is looking at not only how the narrative comes about or what is said, but also at looking at who is the narrative told to and why? Performance analysis utilises aspects of thematic and structural narrative analysis but goes beyond those forms and into the storytelling aspect of narratives (Frank, 2006; Riessman, 2008). Looking at what identities are being created and presented. Whether the narrative serves a specific purpose. When does the narrative take place? For this research, utilising performance analysis would mean seeing the identities that the consultants create and present, which can be derived from themes that arose. It would look at whether or not there is a purpose behind the stories of patient death that the consultants talk about. Furthermore it would look at the performance aspects of the consultants' narratives such as the characters that they use, including when and where they use specific characters and for what purpose. Since this form of narrative analysis is more closely aligned to the aims of this research, this form of narrative analysis will be utilised for the purpose of analysing the consultants' narratives.

According to Riessman (1993) there are five levels of representation of an event that enable the specific event to be analysed using narrative analysis (Riessman, 1993).

Firstly there is attending to the experience. This occurs during the experience itself and represents what one notices and attends to in the experience, including what emotions

are felt. Narrative analysis with its ties to social constructionism, argues that at this level, what one notices is dependent on past experiences and past and present interactions (Gergen, 2009; Riessman, 1993). For this research, this level is the experiences of patient death for the consultants. This includes what they felt and what they attended to during those experiences.

The second level of representation is the telling of the experience. This is where the story is told to another. Often the story is co-constructed through conversation between the teller and the listener. For this research this level would be the interviews with the consultants where the narrative about patient death is co-constructed between myself, as the researcher and the consultant, as the interviewee. Importantly, Riessman notes that there is always a time lapse between the experience and the telling of the experience (Riessman, 1993).

The third level is transcribing. This is where the experience is represented in text, the actions of the experience including the setting, who did what, what was said and what emotions were felt become fixed. For this research, transcribing will be the level where the experience of patient death from a specific consultant is recorded. This includes any examples of patient death that are talked about and emotions that were felt and relayed during the interview and descriptions of the scenario. Riessman states that since other aspects of the experience is lost in transcription, transcription is almost always incomplete (Riessman, 1993). For this research, transcription occurred as soon as possible after each interview alongside notes of the interview and any impressions that were gathered during the interview. This was to facilitate a transcript that was as complete as possible.

The fourth level of representation is analysing the experience. It is at this level that the form of narrative analysis (thematic, structural or performance) that one chooses becomes important Therefore depending on the form, analysis might be identifying and selecting themes, structure or attending to the storyline. The ultimate goal is to be able to create an overarching story that demonstrates key aspects from the different narratives (Riessman, 1993). For this research, transcripts were analysed using the performance form of narrative analysis, seeing not only how the consultants talk about patient death but also

what they say and for what purpose. What impact I have as a researcher on the consultants' narrative is also taken into consideration (Berger, 2013) .

The final level of representation is reading the experience. This is where a reader encounters the text and imposes his/her own interpretation onto it. This may also include having participants read a draft and their comments and feedback are then incorporated into the final copy. Clifford (1986) stated that no one can be a master of narrative, because all narrative stands on moving ground. It is constantly being co-constructed by the researcher, the participants and readers (Clifford, 1986; Riessman, 1993). For the purposes of this research project, this particular phase included having my supervisor read and comment on the drafts in addition to taking account of this feedback in constructing the final product. This thesis explores how consultants construct patient death, including the identities consultants created of themselves and how these identities influenced their construction of patient death.

Method

Ethics

Prior to the commencement of the research ethical approval was sought from Massey University Ethics Committee and full approval of the research was granted on May 12th, 2014, application 12/020. Since the research is not part of a PhD, it did not need to go through the ethics approval process from the Health and Disability Ethics Committee. Instead, ethical approval was sought from the hospital's internal Research and Ethics Committee. This was approved by the Chairperson in writing, stating that this research did not pose any problem for the committee since it did not work with vulnerable populations.

Massey University Ethical Code clearly states that unnecessary harm to participants is unacceptable and goes on to define harm as stress including emotional stress (Massey University, 2013). Since this research asked participants about events that could be traumatizing to them, a protocol was developed to ensure that the consultants felt comfortable talking about patient death and that they had access to support services should the interview have caused them any distress. This protocol had three aspects: Firstly, prior to the interview, I engaged in conversation with the consultants to ensure that they felt emotionally prepared to talk to me. Secondly, an information card detailing a list of

appropriate support services was provided to all consultants. Lastly, at the end of the interview, I engaged in conversation with the consultants for a few minutes to ensure that they were not distressed. No consultants showed any distress either prior to the interview or the end of the interview.

As this research was conducted in New Zealand, cultural issues needed to be addressed. Whilst cultural diversity was not an aim or prerequisite for participation in the research, no participant was turned away on the basis of ethnicity. New Zealand is a bicultural society and the Maori worldview is different to the western world view, especially around the topic of death. Maori funerals or Tangi are usually three days long (Beaglehole & Beaglehole, 1945) and include a variety of rituals such as washing the body of the deceased and sleeping in the same room as the deceased (Beaglehole & Beaglehole, 1945) that enable not only the close family members but also the wider family (whanau, iwi and hapu) to grieve (Cherrington, 2011; Nikora, Masters-Awatere, & Awekotuku, 2012). Furthermore unlike those of European descent, Maori do not view death in such a black and white manner. For Maori, communication with their deceased loved ones is possible and they see the deceased as being similar to guardian angels who help guide them through the world.

Consultation with the Massey University Kaumatua was sought prior to the commencement of the research. This consultation was to ensure that I was safe, as a researcher, to conduct this research in a culturally sensitive manner and to ensure that the principles of Te Tiriti 'O Waitangi would be upheld during the research process. No cultural issues arose during the interviews with the consultants.

Recruitment

Consultants were recruited for this research through contact via the Chief Medical Officers' (CMO) office. The CMO office was contacted via phone and the research was briefly discussed after which the CMO office requested that the formal letter and participant information sheet be emailed to them. After this was done and approved by the Ethics Board of the hospital and the CMO, a mass email was sent from the office of the CMO to the participating departments requesting that they consider participating in the research. A second email was sent by myself adding clarification and reminding all consultants that if they had any questions regarding the research, they were welcome to contact me. A week

after my initial email, I sent a follow up email to all participating departments. No further emails were required as most participants were recruited within these two weeks. One participant was recruited during the interview time. One other participant was recruited after the interviews, as they were on holiday during the initial recruitment and interviews. A day and time was set up to interview this particular participant via Skype.

After participants were recruited, consultants were emailed directly asking for a suitable date, time and place for an interview within a two-week period. The consultants were reminded that the location of the interview was for them to decide and that it could be in any place where they would feel comfortable enough to have the interview.

Informed written consent was provided by the participants prior to the commencement of the interviews. For the participant who was interviewed via Skype, the consent form was sent via email and the participant signed, scanned and sent back the consent prior to the interview. The participant information sheet was explained to them prior to this and additionally, consultants had the opportunity to ask any questions about the research. The participants were also made aware of the confidentially constraints of the study and provided with a list of support services. There were a total of 12 participants across six different departments: Anaesthetics, Intensive Care, Emergency Department, General Surgery, Paediatrics and one consultant Physician.

Interviews

All participants were asked to select a time and location for the interview for their own comfort. To ensure I was safe, a family member was made aware of the location and time of each interview and if I did not return home after the interview, the family member was contacted and updated. Interviews ranged between 15 minutes and 60 minutes, although a total of 90 minutes was allocated for each interview. When I felt that the interview was reaching the end, the participant was then politely asked whether they had anything else to contribute before we mutually agreed to finish the interview.

Although I had a list of prepared questions for the interview, the interviews were conversational in nature and if I felt that an avenue opened up, then the time was taken to explore that avenue before moving on to the next prepared question. The conversational

nature of the interviews allowed for uninterrupted talk from the participants and also allowed me to word or reword the questions to better fit within the world of the participant. This ultimately allowed the participant to tell me, as the researcher, a story and to invite me to understand that story from their perspective.

At the conclusion of the interview, I engaged in general conversation with all the participants to ensure that they were not in any way distressed as a result of the interview and also to allow themselves and myself, time to reflect on the interview. No participants appeared or stated that they felt distressed after the interview, although all of them were given a card detailing support that they could use. Many of the participants thanked me for asking questions that they thought were important and many participants stated that they found the interview thought provoking in a positive way.

All interviews were voice recorded so that I could listen to what participants' stories were without taking notes. All participants had the right to request that the recorder be switched off at any point during the interview process.

Interview schedule

The following questions were asked of all participants although there was freedom to explore avenues that the participants raised if I felt that those avenues should be further explained.

Can you tell me about your experiences, broadly speaking, where a patient has died since being a consultant?

Can you tell me about a particular case where a patient has died since being a consultant?

How did you cope with this patient's death?

When a death occurs does this have any impact on your relationship with your colleagues?

When a patient dies do you ever find it hard to go home and see your family?

Can you please explain to me in your own words how you think about patient death?

Do you think medical school prepared you in any way to deal with patient death?

Do you think that your perception of patient death has changed from being a junior doctor to now as a consultant?

Transcription

Transcription occurred immediately after each interview with one exception due to travel. All of the interviews were transcribed verbatim after the interview. After the initial transcription, the interviews were listened to a second time and anything that was missed in the initial transcription was added so that transcripts were an accurate representation of the interviews. All participants were offered a copy of their transcript for their own personal record and two participants took up this offer. Participants were not asked to provide final consent over the transcript being used for analysis since this research is narrative based. The way in which the participants spoke was fundamental to this research and therefore participants were not given the opportunity to alter the transcripts. Two participants asked for copies of this thesis, rather than copies of their transcript and all participants asked to receive a summary of the findings.

The participant information sheet, given to all participants prior to the interview, notified participants that they had a ten day period from their interview date to withdraw their interview data. No participants selected to have their interview data withdrawn and no participants added any information after the interview. Since the consultants who participated, all resided in a smaller metropolitan area, the risk of identification was high. To protect the consultants' identities and for their personal safety, identifiable information such as the consultants' names, the names of their colleagues, the names of surrounding towns or cities and other place names, were removed from the transcripts for the purposes of confidentiality. Whilst no notes were made on the transcripts identifying the speciality that the consultants worked in, the consultants often made reference to this during the interview. To further protect the consultants' identities, aliases were generated for each of the consultants to be used in this thesis and this was marked at the top of each transcript so that no documentation linked the names of the participant to their transcript.

Analysis

Analysis of the data started after the first interview. Notes were made about the interview including ways to improve future interviews and further questions to address. Ideas that arose from the interview, which could be incorporated in further interviews, were

noted down alongside my impression of the interview. Following this, transcription occurred, after which more notes were taken and key ideas from the interview were noted. Links to the literature and theory were also noted. This process was repeated for all 12 interviews.

After all the interviews were completed and transcription was finished, the transcripts were read specifically to see what shared values the consultants had. This included looking specifically at the overall identity of consultants that was portrayed. Values in this instance, refer to ideals or standards that the consultants use internally, both as markers of good practice and of being a good doctor. The transcripts were initially read to examine and explore the identity of consultants, as the manner in which one makes sense of the world is influenced by one's identity, including one's shared identity. During the first reading of the transcripts, I noted down all values mentioned by the consultants. This came to a total list of 20 values. As a result of further reading of the transcripts, this list was reduced to 12 values in order to reduce redundancy. Through further detailed readings of the transcripts, the list of values was reduced further to a final list of five values. These five values were chosen because they encompassed the most prominent values within the transcripts. Additionally, these five values were the quintessential values that underpinned the consultants' identity. This process of reading, revising and finalising the shared values, enabled me to see not only the values that they had, but also the identities that they created of themselves, as doctors and as ordinary people, both of which were presented to me in the research setting.

After identifying the values and the overall identity of consultants, the transcripts were re-read. This time I was specifically looking at the constructions and management strategies that the consultants had around patient death. Looking more closely at both the transcripts and the initial themes allowed me to reduce repetition within the themes. From there, a more detailed reading of the transcripts helped me to develop an understanding of the consultants' constructions and management strategies around patient death. Although the consultants came from different areas of medicine and were also ethnically diverse, their descriptions and understanding of patient death was similar, resulting in the same constructions of patient death across consultants. As with the interview process, notes about the key ideas, constructions and management strategies were made with each

reading of the transcripts. Additionally notes were also kept on the storyline within the consultants' narratives and links to the literature and theory. For most of the consultants, the key storyline was often around a particular case of patient death; what it meant to them; what they learnt and how they coped with that particular case.

From there, directed reading of the transcripts allowed me to analyse the narrative structure, specifically looking at the performance analysis aspects of the transcripts. This included examining the transcripts to see what characters (such as heroes, villains and supporting characters) the consultants used and when, during their narratives, they chose to use them. Additionally, the transcripts were read in detail to analyse what the purpose was behind the specific narratives and what key messages the consultants were attempting to convey. Finally the transcripts were read and re-read to explore the overall story of death that the consultants had created.

This process of reading through the literature, discussions and reviewing the transcripts was repeated until a coherent story could be developed. A story that not only shows the consultants' diversity but more importantly, a story that illustrates the influence that patient death has on consultants; how they construct patient death and how they manage to work in these stressful situations.

The reading of transcripts and literature enabled me to generate ideas for chapters. Initially three ideas: constructing death, identities portrayed and literature links (examining how the data linked with literature, what theories tied into the data and whether the data filled any gaps within the literature) were developed. After further examination of the data, reading of literature and discussions with my supervisor, the chapter ideas were reduced down to two ideas: constructing death and identities portrayed. The original third chapter idea was to be incorporated into the first two chapters. Through discussion and examination of the written chapters and chapter ideas, another chapter idea was then developed: narrative structure (looking specifically at performance elements, such as storylines and temporal sequences). This chapter was developed to bring the ideas of performance analysis back into the foreground as they appeared to be getting lost behind the analytic work. After this chapter (narrative structure) was written, it was critically examined and discussed between my supervisor and myself. This discussion lead to the

decision to rework the previous chapters and to incorporate the ideas from the narrative structure chapter to ensure that the performance aspects stayed in the foreground.

Rigour

All researchers aim to produce quality research that adds something to the existing literature on any given topic. Whilst quantitative researchers have clear external criteria to measure their research against, qualitative researchers are not as fortunate. Whilst the idea of specific criteria for qualitative research is contested, Spencer and Ritchie (2012) offer some guiding principles for qualitative researchers to reflect upon, namely they ask qualitative researchers to consider the contribution, credibility and rigour of their research (Spencer & Ritchie, 2012). The following sections will look at each of these in turn as it relates to this research project.

Contribution is a question of relevancy and asks researchers to examine how relevant their research is, to whom and for what purpose (Spencer & Ritchie, 2012) the research was conducted? This research is examining how consultants think about, manage and understand patient death. When considering the relevancy of this research, I reviewed the literature and noted that whilst the phenomena of dying and patient death had been examined with medical students, junior doctors and nurses, an alarming absence existed specifically with consultants. This research therefore provides unique insight into how consultants deal with these matters and adds a different perspective to the existing literature. Aside from the contribution to the literature, it could be argued that this research provides personal insight to the participating consultants through the provision of summary findings. Furthermore this research may provide awareness to medical professionals more broadly and health-care facilities on the issues faced by consultants around patient death, and perhaps highlight to them, various aspects of the doctors' working environment that could be improved.

The credibility principle asks researchers to consider two questions: how believable the findings are and how easily others can see how the conclusions were drawn (Spencer & Ritchie, 2012). For this project, the quotes that have been selected have been chosen because they illustrate a specific point or have a specific purpose. The point illustrated by

the quote is then examined and discussed to allow the reader to see how conclusions were drawn. The detailed explanation of transcription and analysis given above clearly shows the documentation process that occurred thus providing evidence for the rigour of this project.

CHAPTER THREE

BUILDING IDENTITIES AND PRACTICES

Life isn't about finding yourself. Life is about creating yourself.

(George Bernard Shaw)

One of the key functions of narrative analysis is being able to see what values are being communicated and what identities people build of themselves. It has been argued that narrative allows individuals to build their identity whilst simultaneously representing themselves to another (Riessman, 1993, 2008). The manner through which values are communicated is usually through examples of what behaviour the teller believes to be appropriate. The consultants displayed this in their narratives, communicating values through examples of what they believed to be appropriate behaviour in specific circumstances. Furthermore the consultants demonstrated how these values influence their practice and vice versa. Additionally the consultants constructed their narratives so that they were the protagonist (main character and hero) of their story. As a result, the identity that the consultants constructed of themselves was often based on them being in the heroic, main character role. The purpose of chapter is to understand the viewpoint from which the consultants construct death. In order to do this, an understanding of the consultants' identity is required. This is due to the fact that the manner in which one understands oneself is a reflection on the manner in which one understands one's experiences. This chapter therefore, is dedicated to exploring how the consultants, using narrative, have built an identity of consultants; what values they communicated during the interview and how these values influenced their practice.

The first value that the consultants talked about was responsibility and that it is important to take responsibility when a patient dies. Their narratives reflected that taking responsibility or being responsible, is one characteristic of being a good doctor, as well as an action that they engage in as part of their practice. This value, therefore, reinforces the heroic aspects of the protagonist role that they hold in their narratives. Throughout the narratives, the identity that the consultants constructed of themselves reflected this value, showing that the value of responsibility was part of their identity as a consultant.

Dr Marsh*: "So there comes a point where a baby's born and there's no heartbeat; where you either get them resuscitated or you don't and you've got to make a decision on it…. I really try to involve the families as much as one can do in that situation so that they know what is occurring… they are kept up with what's occurring, umm… when we get up to a certain number or amount of time then I'll go resuscitation attempts are futile and it becomes the job of the most senior person involved and it becomes the job of the most senior person involved in paediatric care to make a decision that enough is enough."*

Dr White*: "When you are the named consultant you have … professionally your understanding is that you have ultimate responsibility for that person's care so death is a 100% thing you need to be able to accept that people are going to die because they are and have a clear understanding of umm… what your role is."*

Dr Hunt: *"I think because our ICU is basically consultant lead and there is no junior tier apart from the ICU house surgeon during the day umm… I think most consultants see that the withdrawal from care actually through or at least you know if it was extubation umm… and I think that makes it so much easier probably for the family but also the nursing staff to … … you know the tricky questions or any emotions can actually you know can actually come to someone who has actually made the decision rather than you know, be bounced off the nurses."*

As the above quotes highlight, responsibility is not an aspirational quality of what the consultants believe make up a good doctor. Rather the quotes demonstrate that responsibility is seen as a value that is an integral part of the consultants' identity and can therefore be considered to be the foundational value upon which the consultants built their identity. Further, since being responsible is so important for the consultants' identity, it is easy to see that this value would have a bearing on the manner in which the consultants think about, understand and manage patient death.

The literature indicates that all ranks of doctors wanted more support around patient death, both in the ability to provide support to others, as well as having support services that could be utilised (Medical Council New Zealand, 2008; Redinbaugh et al., 2003; Weitz, 1999). This was frequently tied up with the idea that consultants should be, and are, rational decision makers; that decisions to stop resuscitations were valid and rational under the circumstances. The narratives indicated that rational thinking was another value held by the consultants. To further examine the impact of this value on the consultants' identity, the following section will explain the support process talked about by the consultants and how rational thinking was intertwined within this.

Most of the consultants talked about the support process being in three parts: an informal team debriefing process that usually happens right after a patient has died; informal debriefing with colleagues within the days following the event; lastly the formal case review process.

The first process, the initial informal team debrief, was where the consultant and all other team members briefly talk to each other about what happened and how people feel. This is usually led by the consultant, illustrating the responsibility value. Since this debriefing is an informal process, there may not always be time for this type of debrief. When debriefing does occur however, consultants noted that this was something that they found useful because it allowed them to reflect on their decisions and therefore help them come to terms with the patient's death. It was during this reflection process that the consultants often illustrated that they value rational thinking and that it has become a cornerstone for them to build their identity on.

Dr Summers: *"The first step we do always is to discuss it between ourselves as colleagues because a lot of these people we go as a team because it's… ah… resus one we call so we call the team… all the team are here, if the specialities are here they come so after the death we, we… we do a quick rev …ah.. debriefing and we discuss our cases and then specially there is another consultant with me, we discuss what happens what do you think happened what you did what we should do what we … didn't do, did we do right, so that's, that's very, very, very, very important."*

The second support process that consultants mentioned was debriefing with one of their colleagues. Again this was an informal procedure that allowed the consultant time to reflect alongside his/her colleague and together with his/her colleague, brain storm about what, if anything, could have been done differently. This was something that the consultants found extremely helpful and supportive and is often something that they engage in even if they have already gone through an informal team debriefing process. It was often whilst talking about this part of the support process that the consultants stressed the importance of rational decision making to me and thus further illustrated how much this value was tied into their identity as consultant.

Dr Carter: *"When we are involved in cases like this we, we umm… share the experience in the sense that we rally around each other and I got a lot of support from my colleagues, and one or two in particular helped me go through thing and were reassuring to*

me that you know that we did, we had a case review uh internal one that people go through the case and they are able to tell me that there was nothing I could've done from the moment they got here, that they would have done that strengthens your relationship with your colleagues."

Dr Marsh: *"I like to think about the facts so I am a fact person as well as the emotional side in the… in the aftermath of a baby dying, my response to it will often depend on ... whether I feel there's anything I feel I could have done better that might have helped the result. Usually being a somewhat.. umm….ah…umm …self…umm… critical person, I can often identify I could have done better. There will never be a perfect resuscitation. There will usually something I could've done differently or better or whatever so I'll often try in the case review, which often happens later, I will often just talk it through with a colleague that has some understanding… so often a paediatrician so that's a different process … umm… but me talking through another colleague is really valuable. I am able to say what happened. I am able to share. I know they've been through a similar experience. Usually it won't be exactly the same and I am able to reflect on the facts and check and kind of a bit of… a just… check kind of… a bit of a checking back whether there is anything they would've done differently."*

The last process that was often talked about by the consultants, although not truly a form of support, was case review. These appeared to be reserved for the more serious cases where all those involved in the case are invited to a meeting with external consultants. The meeting is designed so that all the consultants share their knowledge, as it relates to the case, to review what happened and what could be done differently. It was emphasised that these reviews were not meant as a "witch hunt" but rather to review overall systems and system errors. Despite the system approach, consultants noted that the review process was often a chance for them to review the facts of the case without having to experience or re-experience the emotions that they felt or the pressure of the situation, as this was usually held a few weeks after the event. This again highlighted the importance that the consultants placed on being rational decision makers. Most of the consultants noted that this process of reviewing the facts of the case without emotion was very helpful for them and often left them feeling better about the whole event. It is interesting to note the contradiction about emotions in the consultants' narratives here. They state that by reviewing the facts and not having to go through the emotions that they felt at the time is helpful but the consultants fail to realise that this process is enabling them to deal with their emotions about the event. This process appeared to reinforce to the consultants, the importance of rational decision-

making by illustrating its importance in practice and its application to managing patient death.

Dr Lawson: *"I think it is important that you go through that process and actually share your side of the story because it is umm…the nagging doubts in the quiet hours of morning umm… when you think 'Oh my God' and there's the kind of devil and angel thing going on, on your shoulders if you're in this scenario where the devil typically wins and tells you all the things you did wrong, whilst the case review meeting tells you all the things that are right and reassures you that umm… that actually umm… this was not your fault."*

Dr Lee: *"I think that umm… even if something really bad happens if we can learn from it and prevent it happening again it's still a tragedy but there's something positive that can be taken out of it and I think that reviews and formal process like that are good analysing both our individual knowledge basis and also the process, the way things are done in hospitals. Umm… so I think they're useful for learning."*

Support in itself was an important value for the consultants. Whilst their narratives show that support has strong ties to the consultants' value of rational thinking, the narratives also show that during the process of talking about support, the consultants are also trying to resist stereotypes.

Medical stereotypes and stereotypes of doctors have existed for numerous years. Recently the British Medical Journal had an article outlining the various stereotypes that have existed and persisted over the years (Oxtoby, 2013). The article argues that older stereotypes of doctors, and of certain specialities are fading but new ones are constantly being created and reinforced in the media, especially with the rise in medical shows on television (Oxtoby, 2013). Literature further shows that there are definite stereotypes that exist for medical professionals, including that doctors are arrogant, uncaring, emotionally unstable and that they are averse to seeking help or support (Carpenter, 1995; Harris, 1981; Medical Council New Zealand, 2008; Oxtoby, 2013). It is interesting to see that the consultants' narratives on a different subject displaying their attempts to resist negative stereotypes.

One manner in which the consultants displayed their resistance against negative stereotypes was to illustrate that they valued the support they received, especially when that support came from another colleague. Furthermore the consultants talked about external support such as supervision or having access to a psychologist, which consultants

believe would be beneficial for them in dealing with patient death. Interestingly when the topic of external support came up, the consultants indicated that they were "not against" it. Perhaps this is a further attempt to overcome the stereotype that doctors do not want, support or see its value (Carpenter, 1995; Harris, 1981). Whilst talking about support, the consultants were quick to point out the coping mechanisms that they do utilise. This might be a further demonstration of their attempt to break certain preconceived stereotypes (Medical Council New Zealand, 2008).

Dr White: *"I am very open about things because I feel that people mostly learn by modelling so and so you… one of the other things I wanted to mention was that I have supervision. I go to supervision so that's another thing that I talk about with my junior doctors. This is a hard job. I have supervision because I need it… you know, like psychiatrists and social workers… like clinical supervision."*

Researcher*: Yup*

Dr White: *"So I think demonstrating that you can be an emotionally whole person because expressing emotion is part of being a whole person but that you can still be cognitively intact so that… but you need to take space to deal with those emotions and respond to them and we will go and have coffee and talk about how we are feeling and why that is and then we go back to the next person because we need to clear ourselves… you know we… you know we need to actually deal with that… put it aside otherwise you are going to be messed up for the next 10 people really."*

Dr Marsh: *"I know other colleagues who've got professional supervision and I have often though that would be a good thing for me to get an good thing for me to do… I probably find it a easier thing to do if it was something that became the norm… I am quite happy to do those things if they become one of those things that I am supposed to do… so to a certain extent, I wonder whether if someone set that up if that would be a good idea and if most of our department were doing it then I would probably find time to do it but you know you're so busy with sort of… life - it's often sort of…"*

Researcher: *Why would it be helpful?*

Dr Marsh: "*Umm… I think, ah you worry, I worry about what you might internalise and what I am not expressing to people and whether there's stuff that is potentially psychology damaging for you… the burden of time, I mean the kind of the kind of things which, ah, I would want to guard against, would be becoming blasé in those situations… becoming, you know, it's just another… it's just another day… it, you know, just another baby dying… you know you wouldn't want that to occur. I don't think that the deaths are happening that frequently. As individual clinicians that, that's likely that would be one thing to guard or secondly that … you know maybe not dealing with stuff and therefore there a whole lot of unexplored angst or guilt or anger or whatever the things that I may not be aware of… I just wonder from the psychological point of view, would be cleaner and*

healthier… an impartial third party who has some experience in these areas who can do who can talk to what is actually helpful."

***Researcher**: So how did you cope with having.. to go through all of that in such a short period of time?*

***Dr Gray**: "Umm… Not with alcohol, I went home and talked to my wife 'cos she's a pretty good sounding board and umm… the next staff… the next day I, I was feeling quite… miserable umm…. and umm… uhm I arranged with our Head of Department then umm… I would have the next week off so I took annual leave."*

Looking more closely at the consultants' narratives about their need for support, we see that they value rational thinking and support especially from colleagues. These are values that they believe are part of being a good doctor and part of their identity as a consultant. It is an interesting position that the consultants have placed themselves in. On the one hand they have shown that they value rational thinking and that this is part of their identity and practice as a consultant, all of which is congruent with the stereotypical doctor (Carpenter, 1995; Harris, 1981). However the consultants have simultaneously positioned themselves to show that they do experience emotions when patients die and that they are not above seeking support or seeing its value, thus challenging other stereotypes (Medical Council New Zealand, 2008). It appears from the narratives that the consultants attempt to reinforce only some of the stereotypical characteristics that are helpful to them in practice and that are part of their identity as a consultant. At the same time they are also challenging the stereotypes that show a false image of medicine and consultants which are not helpful to them in practice and therefore not part of their identity as a consultant or part of the values that they believe make a good doctor.

A central component to the consultants' identity was being good communicators. The literature indicated that communication was often something that was considered lacking both between consultants and families and also within the team communication (Bedell, Cadenhead, & Graboys, 2001; Carline et al., 2003; Cherrington, 2011; Peterson, Johnson, Scherr, & Halvorsen, 2013; Rhodes-Kropf et al., 2005; Sheward, Clark, Marshall, & Allan, 2011). Communication, in all forms, was a key topic among all the consultants' narratives. The consultants commented on the cohesive nature of communication within

teams, portraying their attempt to be good communicators, demonstrating that this is something that they value and is central to their identity as a consultant.

All of the consultants commented that they were the person who would signal for the end of a resuscitation when they knew that a patient had died and that any further attempts were futile. However all consultants stated that when this occurs, they ask for the agreement of the team to ensure that everyone agrees with the decision. If someone doesn't agree then resuscitation is likely to continue as described below

Dr Yates: *"I think at the end of those say when we, when we call a resus insofar as you should stop now… this is actually no longer gonna benefit this patient and we should stop jumping up and down on their chest. Mmost of us usually ask around if anybody has a problem with that and if somebody strongly feels keep going, particularly if they are a young person, we would normally honour that… so that's that respect so you do kind of make a team approach to that rather than one person standing up and saying it's my call you guys, stop doing what you are doing…"*

The above quote demonstrates the cohesive nature of within-team communication that is central to the consultants' identity as good communicators. Additionally the above quote demonstrates that whilst good communication is central to the identity and practice of the consultants, it is also tied in with the idea of responsibility, mentioned earlier. This demonstrates the intertwined nature of the consultants' values and how they influence their identity and practice.

The fact that the consultants seek agreement amongst the whole team to stop resuscitation, challenges the notion of the doctor-nurse game. Stein argued in 1967 that the doctor-nurse game was played by both parties to maintain the hierarchy between doctors and nurses (Stein, Watts, & Howell, 1990; Svensson, 1996). Doctors held ultimate decision making power and the nurses never challenged doctors' decisions (Stein et al., 1990; Svensson, 1996). In 1990 Stein reviewed this idea and argued that nurses had stopped playing the game, as a way to rebel against the doctors. He went on to argue that this left both parties unsure of where they stood in relation to each other, leading to doctors feeling frustrated and angry (Stein et al., 1990). The consultants' agreement-seeking behaviours and willingness to honour someone, including a nurse who is disagreeing with them, is perhaps an indication that doctors have also stopped playing the doctor-nurse game.

Alternatively it could show that both parties have moved on from the traditional hierarchical roles to a shared space, where everybody is respected for their knowledge and skill.

Looking at the topic of communication more closely, the consultants recognised that talking to each other within a team or department after a patient died, was beneficial for all the consultants as to some degree, it helped them come to terms with the patient death. In addition, consultants believed that within-team communication was cohesive in nature and beneficial to all team members, however, between-team communication was also perceived as disjointed. Between-team communication was considered to be an aspect of communication that required improving because, if this was done poorly, then it resulted in poor communication with the patient and family due to the different expectations between the teams.

Communication with the patient and the family was highlighted as the most important aspect of the consultants' practice but equally one of the harder aspects. The consultants noted that they were not necessarily formally trained in medical school to develop effective communication with families, especially when it came to breaking bad news to the patient or the family. However, the consultants noted that there are professional development courses available for them, specifically focusing on communication and that this was something that they took part in, in order to address their potential lack of skills in this area. Two key aspects of communication noted by the consultants were firstly that communication should be frequent enough so that the patient, as well as the family, knows what is going on and secondly, so that realistic expectations can be set.

Dr Summers: *"I think one of our biggest mistake is communication; we don't communicate well. Especially with the family so I… I my, if I involved with something I maybe every ten, fifteen minutes I go say something to the family… problem with the family sometimes, they have a really unreasonable expectation…"*

Furthermore, all the consultants stated that they broke the news to the patients' family when they had died and felt that it was their responsibility to do so. This further demonstrates that they value responsibility and that it is an integral part of their identity.

The fact that the consultants personally broke the bad news to the families is incongruent with other literature that showed medical students overseas had not witnessed a consultant break bad news to the family (Braganza, 2014; Rhodes-Kropf et al., 2005; Wear, 2002). Additionally all the consultants stated they would take a junior doctor with them (provided that the junior doctor was part of the patient's care team), whilst breaking bad news, to role model the process to them. This active role modelling behaviour by consultants appear to stem from their own training, where they were often taught by role modelling the appropriate manner to break bad news or anti-role modelling by showing inappropriate or insensitive ways in which to break bad news. This showed that the consultants value good communication and see it as an integral part of not only their identity as consultants but to doctors' identity as a whole. Some consultants mentioned providing the opportunity for junior doctors to break bad news but reported going in with them to support them during the process and debriefing with the junior doctor afterwards to make sure that they were not emotionally distraught afterwards. The consultants' behaviour, both in personally breaking bad news and providing support for junior doctors, is perhaps a further attempt to resist negative stereotypes about doctors. The caring nature of their behaviour directly contradicts the stereotype that doctors are uncaring (Carpenter, 1995; Harris, 1981). Protagonists are the characters within a story to which the audience relates the most. They are usually compassionate and heroic. The consultants choosing to break bad news to families, illustrates the heroic aspect of the protagonist role, since the literature indicated that breaking bad news is something that consultants avoid. In addition to the heroism being displayed, the consultants also display compassion, by supporting junior doctors when they break bad news to families. Therefore, this behaviour reinforces the protagonist role on which they have built their identity.

Below is an extract from Dr Lawson who, upon clarifying that he would never ask a junior doctor to break bad news rather than himself, stated:

Dr Lawson: *"So a SHO or a junior registrar … no way in hell that he's got the skills so therefore I will always protect them but I will make sure they are there with me if at all possible and then I will run the story umm… and I will always make sure and there are certain rules that I follow when I am talking to relatives pretty much… no I will not let a registrar on his own, have fun kind of thing"*

And upon being asked if he would talk to the junior doctor after this, Dr Lawson remarked

"Very much so, very much so and I try to make them realise umm… which kind of psychological techniques I had used in order to break the news, deal with the conflict umm… deal with the stress so I'm, I'm going through the steps I have taken including non-verbal language, posture, position that I, on purpose used in that scenarios to de-escalate and facilitate the whole process so there's very much the psychology that I utilise which is a big part of my job as far as I'm concerned, which I then teach the registrar."

The last building block of consultants' identity was that the consultants perceived themselves to be compartmentalised, especially with regard to their home and family life as opposed to their work life. This was another interesting position that the consultants placed themselves in. On the one hand, they demonstrated that they see the value of emotions, feeling and expressing them and that it was part of being a complete person. On the other hand, the consultants talked about being compartmentalised, especially compartmentalising what happens at work so that their experiences at work, such as patient death, does not unnecessarily influence their family life. Their compartmentalisation was not only about separating out their home life from their work life, but also about compartmentalising emotions and expressing those emotions at a more appropriate time.

Dr Chambers*: "I might tell her yeah… probably wouldn't tell her… those two particular incidences. I don't think I told her those two. I try to keep things moderately separate.*"

Dr Yates:*" I don't tend to share a lot of my work when I go home. I don't go home and offload 'cos I don't think my family necessarily want to know umm… about my grief.*"

Dr White: "*When the kids were little and I walk in the door, I do have this thing - Hi guys I'm home - just give me five minutes… I need to go and change… I need to sit down and have a drink and then I will be here… let me just break off that and then I will be here fully for you but it will take me five minutes."*

Dr Carr: "... *that catharsis doesn't happen on the floor, it happens when you are watching a movie, it might happen when you are riding your bike. You just… or you're in a really time-reflecting mode at home and you look out the window and go, that is really crap."*

This positioning suggests that the consultants have internal "rules" about when, where and to whom to express emotion but that this rule hardly ever includes family. The value that the consultants place on compartmentalising their home and work life subtly

reinforces their portrayal of being an ethical doctor; one that does not talk about work at home, because it would be unethical to do so. Whilst the two values of support/emotions and compartmentalisation may appear to contradict each other; from the narratives we see that both factor into the consultants' practice. A practice that is not only ethical but one that ultimately helps the consultants to manage patient death in a constructive manner.

Summary

Narrative inquiry allows us to see the identity that the consultants have constructed of themselves as well as the influence that these values have on their practice. We have seen that the consultants' identity is built on five key values: being responsible, valuing support, being rational thinkers, being good communicators and being compartmentalised. We have also seen how the consultants' narratives subtly challenge medical stereotypes and traditional hierarchy within medicine. This chapter has demonstrated that the values that the consultant have built their identity on, are not discrete or separate values that have tidy borders. Rather, the narratives show the inter-related nature of the values that shape the consultants' identity, practice and management of patient death.

CHAPTER FOUR

CONSTRUCTING DEATH

"All the world's a stage,
And all the men and women merely players;
They have their exits and their entrances" (Shakespeare, 1603 Act II Scene VII)

The purpose of this chapter is to explore the ways in which consultants construct and manage patient death. The previous chapter investigated how consultants built their identity based on values that were important to them, since one's identity is inherently tied to the way in which one makes sense of the world. The consultants' identity and values will continue to flow into this chapter, insofar as these values influence the manner in which the consultants construct and manage patient death.

In order to provide a detailed examination of the constructions and management of patient death, this chapter has been split into two parts. The first part looks at how consultants talk about patient death in broad terms to illustrate their intellectual understanding of death and to see how this understanding influences their constructions of patient death. The second part looks at case examples of patient death that the consultants used. Case examples are thought to be inward reflections of doctors' understanding about a specific case (Radley & Chamberlain, 2001). Therefore by looking at case examples, we can explore the intricacies around the various constructions of patient death. Additionally case examples provide a platform for consultants to showcase the various ways in which they manage patient death.

Death: A broad understanding

All the consultants were asked to describe what patient death meant to them. This question was an attempt to gain an understanding of their broad sense of patient death rather than what death meant in specific circumstances. Consultants showed similarities in answering this question, indicating that there are some definite ways in which the consultants understand patient death, despite being from various specialities. This is understandable when one considers that the consultants had shared values and ideals, and built their identity based on these values, which they shared with their consultant

colleagues. It is also possible that these similarities stem from their training or alternatively, is a function of their working environment, or even perhaps, a combination thereof.

The first recurring theme around patient death was that death was relentless. Consultants personified death as a force without discriminatory power, highlighting that it does not care about race, age, gender or time of day. Comments from consultants about death being relentless stress that not only does death not discriminate about who dies and who lives but it also does not discriminate between consultants. Having patients die happens to all consultants regardless of their experience. The consultants also emphasized that death does not discriminate about how a particular consultant may feel at that time, or what may be happening in his or her personal life.

> **Dr Hunt:** *"It is not necessary the old or you know… the older age group that we have to face or make those decisions … it can be young patients, post trauma umm… or even suicide attempts so yeah, it is umm… a challenge."*

> **Dr Lee:** *"It's 24 hours a day my… it's got no respect for how I may feel or what time of day it might be."*

Since death is viewed as being a force without discriminatory power, and as the quotes highlight, is relentless, it becomes easier to understand why the consultants place such emphasis on support and why support is one of the values that underpin their identity. It is perhaps, through the process of receiving and providing support to colleagues, which has allowed consultants to reflect upon their experiences and come to the understanding that death is relentless. This understanding of death, in turn, has led to the personification of death as being a force without discriminatory power.

The second recurring theme around patient death was the consultants' description of death being a natural process. Through viewing death as relentless, as a force without discriminatory power, consultants were able to realise that patient death affected all consultants and all people. The personification of death in this manner allowed them to mentally prepare for any death. However by also viewing and describing death as a natural process, the consultants were able to remind themselves that everybody dies at some stage, a fact that appeared to bring comfort to the consultants. These two descriptions and understandings of death, are therefore, key management strategies for consultants when a patient dies. Through viewing death as relentless, consultants are able to remind

themselves that they are not alone in this experience and that they can seek collegial support. Furthermore, through viewing death as a natural process, they are able to reassure themselves that they are not failures, thus allowing them to accept and move on from the patient's death.

> **Dr Lawson:** *"It's natural… it's natural. I was hunting Saturday night, I killed four animals. It is normal. Death is part of living and it doesn't matter if it is an animal or human being, you want it to be as quick and as painless as possible and you want to look after, in the case of a human death."*
>
> **Dr Carter:** "*Patient death, well, well we try hard to ward off death and illness but it is a reality that is… it's fixed… everybody's gonna die umm… I think the younger you are and the more tragic it is and that we always try hard, obviously, prevent death. We do everything we can umm… to a certain point umm… but death is… is part, part of how the universe works umm… and the universe doesn't grantee anybody anything or owe anybody anything."*
>
> **Dr White:** *"Death is a 100% thing. You need to be able to accept that people are going to die."*

For all the consultants, palliative care training was minimal, which is congruent with the literature (Braganza, 2014; Doyle, 1996; MacLeod, 2001; Moores, Castle, Shaw, Stockton, & Bennett, 2007; Rhodes-Kropf et al., 2005). The consultants all stated that they felt Medical School did not prepare them well to deal with patients dying. However they were quick to point out that although more training in this area would be beneficial, they are not sure whether that could be taught in a classroom environment, without a practical element. Bearing in mind the absence of adequate training on dealing with patients' death, the consultants were asked how they learnt how to deal with patients dying and most responded that they learnt either through positive role modelling or negative role modelling from their consultants when they were juniors. Regardless of whether role modelling experiences were positive or negative, the consultants emphasized that one way in which they dealt with death as junior doctors and as consultants was through providing a dignified death.

Providing a dignified death, or a death free from suffering was the third recurring theme within the narratives. Upon further exploration during the interviews with some of the consultants, it became clear that being able to provide a dignified death, whatever that may mean to the specific consultant and patient, was an important part of how the consultants managed patient death. For them, following procedures to ensure that a patient has a dignified death enables the consultants to prepare themselves for the patients' eventual fate, thus allowing the consultant to accept the patient's fate more easily. Providing a dignified death ties into the consultants' value of responsibility and being responsible when a patient dies. Responsibility appears to have become a foundational aspect of consultants' identity, as a result of having watched patients die in a manner that the consultants considered to be inhumane. For example, watching people die of a secondary infection because they had been kept on a ventilator for too long. Due to the consultants' exposure to these "inhumane" deaths, consultants have placed the utmost importance on ensuring that their patients die in the most humane and dignified manner possible as reflected in their narratives.

> **Dr Carr:** *"The saddest ones are when people die on their own, alone in the department and we will often umm… one of the nurses will be taken off the floor just to sit with that person or you know, someone who is available depending on the day, just to sit with that person just so they won't die alone, because there is still human side to it, I say it's a job but you still… still think of what you would like if it was your turn and you wouldn't want to die alone in the department."*

The fourth recurring theme within the narratives was the code of patient classification used by the consultants. The consultants tended to classify their patients and patient death into two categories: one, comprising patients who die from chronic illness so their care is more long-term, and two, patients who come in acutely unwell and then die. Across all consultants, there appeared to be a distinct pattern that the chronic long-term patients were easier to come to terms with, as intellectually, consultants understood that death was the inevitable end of this illness and as a result, constructed death to be a merciful end for these patients.

> **Researcher: "***You said before that the chronic causes when you've seen the baby since birth and then you know… provided paediatric care for such a long time and then they die, how do you come to terms with something like that?*

Dr Moss: "*Maybe it's too simple for me if I know the family well and we have an open… relationship, I will share what is going on and we know over there, this will end at some time. It's a matter of do life as good as you can as long as it lasts. Personally I, when we have trickled along the same path a long time, for me, it's not a problem at all, I share in their grief and they know me and they know I share in their grief, but this was the end of the journey and there wasn't much else you can do so…"*

Dr Gray's response upon being asked why longer term patients were easier deaths to come to terms with:

"*Because you can see it coming and because umm… we know if you've gone through days of supportive treatment ahhh… it becomes obvious that whatever you are doing isn't working and that physiologically they're not going to make so it's easier to cope with that sort of death rather than somebody that comes in acutely unwell and you try everything and they die on you straight away umm… ICU is more about supporting while people make themselves better so we are giving them an opportunity which they wouldn't have if ICU wasn't there so it's kind of easy… its relatively easy to rationalise that we gave them that opportunity but they didn't take it, yeah!*"

However patients who died suddenly were harder for consultants to come to terms with. Interestingly one could argue that since they did not have time to build rapport with the patient, it should be easier to deal with their death but the findings from this project show that it is quite the opposite, similar to the findings of Wilson (2014). The consultants do not know whether they are going with or against the patient and the families' wishes, what the bigger picture is, what the patients' history is and ultimately, it appears that some are left wondering if they did everything they could for the patient. Intellectually the consultants all agree that they always try to do the best and everything that they can, given the information that they had at the time, but there appeared to be undertones of "if only I knew more, then I could have perhaps saved this patient."

This extract is from Dr Marsh describing an acute situation:

"When the baby's born, there's either a very good feeling of relief because the baby starts crying you think, gosh that's good and that's what most births are like and that's fantastic. Umm… but there can sometimes be this worrying silence where the baby just doesn't cry and umm… everyone's looking very anxious umm… you know the obstetricians are looking pretty pale and you know there all that kind of feeling that it's not going well."

In contrast with death being constructed as a merciful end for patients who died due to chronic illness, death in acute circumstances was constructed as a lost battle. This

idea of death as a lost battle is the last recurring idea of the consultants' talk about patient death in a broader sense. Gawande (2014) talks about how strongly science and technology has changed our daily life, especially with the advances there have been in medical technologies. Gawande (2014) further notes that doctors have become accustomed to seeing medicine and the advance in technology pull acute patients through even in the most ominous of circumstances. This author notes that death appears to have become a medical experience that is to be managed and when technology or medicine fail to save patients, the doctors are unprepared, at a total loss and feeling as if death was a failure (Gawande, 2014).

Previous research (Gawande, 2014; Jackson et al., 2005; Moores et al., 2007; Pessagno, Foote, & Aponte, 2013; Redinbaugh et al., 2003; Rhodes-Kropf et al., 2005; Sheward, Clark, Marshall, & Allan, 2011; Wear, 2002; Wilson, 2014) indicated that consultants may view death, particularly acute patient death, as a failure as a result of the hidden curriculum. The hidden curriculum idea suggested that it teaches all doctors that they should save lives and the inability to do so is a failure, therefore death can be seen as a failure (Gawande, 2014; Jackson et al., 2005; Moores et al., 2007; Pessagno et al., 2013; Redinbaugh et al., 2003; Rhodes-Kropf et al., 2005; Sheward et al., 2011; Wear, 2002; Wilson, 2014). The consultants in this project talked about their intellectual understanding of all patient death, which is a natural process that death is a fate we all must face. Simultaneously the consultants talked about acute patients dying "despite everything" or using phrases such as, "there was nothing more that we could do", suggesting that the consultants on some level felt that medicine had failed to save the patient. The consultants' narratives suggest that death, specifically of acute patients, is not viewed as a failure as a result of the hidden curriculum. Rather that the hidden curriculum aids doctors into believing that medicine is an all-powerful force that can save everybody, resulting in death being viewed as a lost battle.

> **Dr White:** *"I am not going to be able to save this women umm… and also you know that kind of why this happened to this person and reconciling that whole issue of… There isn't ever going to be any fairness about it really."*
>
> **Dr Yates:** "*I think the ones that stick in my mind are the ones when, as a clinician, you feel a little bit helpless that you want to do something but you really can't."*

Dr Moss: "*Well it's a disaster when we are not able to do what we want to do.*"

Dr Lee: "*And… umm… you know despite all my best efforts she died umm… and I know now, now why but that was from the Coroner's report.*"

It is possible that the consultants' construction that acute patient death is a battle that they have lost is one way in which the consultants are able to manage acute patient death. The narratives illustrate that the consultants know, intellectually, that death is a fate we all must face. However it seems, that despite this knowledge, it does not make facing acute patient death any easier. The consultants appear to realise and understand that death is not a failure because they view death to be a natural process. However, in order for the consultants to cope with the competing ideas between having to save lives and understanding that death is not a failure, the consultants appear to have constructed this as a battle with death. The construct of a battle with death, allows the consultants to resolve the internal conflict between these two ideas, move past any internal blame, and accept the patients' fate without any unnecessary distress. Additionally constructing death in this way allows consultants to present themselves as good doctors who uphold the values upon which they built their identity. This in turn strengthens the protagonist role that they have placed themselves in.

One aspect that was made clear amongst all the clinicians was that the death of a child or young person was always hard, regardless of whether the death was due to a long term illness or an acute death. The consultants appear to agree with the Western idea that if an old person dies, upon reflection, we can say that they have experienced life, but when a child dies, life is taken away prematurely and this is considered to be unfair (Braganza, 2014; Sahler, Frager, Levetown, Cohn, & Lipson, 2000; Serwint, Rutherford, & Hutton, 2006). Consultants unanimously uphold the notion that the death of a child is unfair whilst simultaneously acknowledging that death is a fate everyone must face. Consultants still appeared to apply the two constructions of death (a merciful end and a lost battle) when the patient was a child. However the management of patient death appeared to change depending on whether the patient was a child or an adult. The management of a child's death seemed to take longer and consultants often utilised collegial support as a manner in

which to manage the child's death. An interesting management strategy used by consultants was to talk or debrief with the parents of the child. The process of reviewing and talking through all aspects of the child's death with the parents and offering support to them seemed to help the consultants come to terms with the child's death.

Below is a quote from Dr Marsh about providing opportunities to parents after the death of a child. This is followed by quotes from Dr Carter and Gray who describe why the death of a child is harder to manage.

> **Dr Marsh:** *"I give them the opportunity and sometimes that bringing them back gives us an opportunity to reflect on the child's life and what happened and what went well. The good times we've had and then also to talk through the process of the child dying or what actually occurred and I think that's a really important issue for them and it helps me as well to go through the notes and to realise how sick the person was and what we did and that we did a good job and I think that probably has a certain… healing aspect."*

> **Dr Carter:** "*I think umm… death in young people, children, infants. …hits everybody harder because it is usually less expected. It seems more tragic, more, more life, years… lots more future lost."*

> **Dr Gray***: "Deaths in the Emergency Department are slightly harder to deal with than on the ICU. I had a baby die on me umm… two… three years back which wasn't very pleasant."*

This case was further explored with Dr Gray to enable me to understand why this particular death stood out in his mind:

> **Dr Gray:** *"I was called to ED to assist one the paediatricians who umm… umm.. down there with … how old was the baby? Only a few months old umm… came in… umm… ashen and grey… shut down but still responding to mum and to us but very low blood pressure… very poor peripheral perfusion, horrible tachycardia, temperature and developing a rash… meningococcal septicaemia and over the space of the next… several hours between myself and the umm… paediatric consultant umm… we gave antibiotics, we gave fluid, we … umm… we gave pressors umm… we intubated and ventilated the child… everything we did, just didn't work and … uhm …. umm… went from having a …. a child who was actually looked like a baby to having a umm… a discoloured bag of fluid who was just dead and it was very unpleasant."*

> **Researcher***: Can you pinpoint a particular reason as to why it was such a unpleasant experience?*

> **Dr Gray**: *"Because nothing we did worked umm… umm…most of the time the… we did all the right things… but most of the time they work and on this occasion umm… either the child had presented too late or the level of physiological*

derangement was too high and nothing worked and umm… the… the mother brought the child umm… and umm… in front of us all, went from being a baby to being not."

Section summary

This section has examined the ways in which consultants talk about and construct patient death in a broader sense. This section has illustrated that consultants construct patient death in two key ways as a merciful end and as a lost battle. This binary conceptualisation links in to the doctors' classification of patients as either being long-term or acute. For long-term patients, death is thought about as a merciful end. For acute patients, death is considered a lost battle, potentially due to the idea that medicine is an all-powerful force that should be able to save everybody (Gawande, 2014). This section has questioned the possibility that this is fuelled by the hidden curriculum that teaches doctors that death, particularly acute patient death, is a failure (Gawande, 2014; Pessagno et al., 2013; Redinbaugh et al., 2003; Rhodes-Kropf et al., 2005; Wear, 2002; Wilson, 2014). This section has further illustrated that doctors' understanding of death is that it is a natural process, albeit a relentless force without discriminatory power. Lastly this section has shown that in terms of managing patient death, doctors fall back on their understanding of death as a natural process and their desire to provide a dignified death for patients. The desire to provide a dignified death for patients means consultants turn to procedures as one way of managing patient death. The constructions of death that they have for their patients allow them to resolve any internal conflict that they may have, therefore further aiding in their management of patient death. Lastly consultants tended to turn to collegial support as another way in which to manage patient death. Through employing these management strategies, the consultants are setting themselves up to emotionally and cognitively come to terms with patients' death.

Constructing death: case examples

Radley and Chamberlain (2001) have argued that case examples or case studies are useful tools both in medicine and in psychology. These authors argue that cases are such a routine part of medical practice, patients are seen as cases as well as talked about and presented as cases to colleagues (Radley & Chamberlain, 2001). Furthermore the authors argue that case examples not only serve as exemplars but they are also a demonstration of

the co-construction between patient and doctor. Case studies are thought to be the inward reflections of the doctor, on the patient's portrayal of symptoms, their understanding of those symptoms and communication with the patient and family (Radley & Chamberlain, 2001) . Case studies, the authors argue, is one tool that can be used to encapsulate the unusual, the norm departure and to raise the hard questions (Radley & Chamberlain, 2001). All of the consultants were asked if they could talk about a specific case where a patient died. This was an attempt to gain a deeper understanding of the intricacies around their constructions and management of patient death.

The examples that the consultants gave tended to be exactly the cases that Radley and Chamberlain (2001) argued for. The patient deaths were traumatic, complicated or ethically challenging situations, including a suicide attempt, diseases that are hard to pinpoint and treat and patients with co-morbidities. As expected, these case examples were presented as narratives and therefore they were able to be analysed using narrative inquiry. Riessman states that narrative has certain core characteristics: narratives are usually told in a sequential manner; that there are ideas that the narrator assumes the listener would understand; and that the narratives account for norm departures or a break between the ideal and reality (Riessman, 1993).

When analysing the case example narratives, it becomes clear that they contain the characteristics Riessman argues for. When talking about specific examples, the consultants tend to talk from their personal viewpoint using statements such as "I did this". They position themselves in the narrative as the hero; death is the villain and the rest of the medical team and the patient are the supporting characters to illustrate the consultants' battle with death. The narratives also always included a temporal plotline that included a sequence of five parts:

1. *Setting the scene*: Including the age of the patient, the location and the time of day.
2. *Diagnosis:* When the consultant realises what is wrong and that death is likely.
3. *Trying to save the patient*: The time spent attempting to save the patient and the therapy that was utilised.
4. *Patient death:* The point where the consultant realises that there is a break between the ideal and the reality, often including descriptions of how the consultant felt emotionally.

5. *Aftermath:* When the consultant had to talk to the families, or write out death certificates and how they then went on to deal with the death.

Dr Carter: *"The one that sticks out for me was a couple of years ago… it was a boy who … think he was about four months…. and he came with… from (small town) with… a rash, no actually he came from (small town) with tachycardia. It was misdiagnosed as a heart problem and he got here, he had a rash and a fever and he had meningococcal disease and we treated him for about… probably, six hours… couldn't save him."*

Researcher*: Did… did umm… why that case, why does it stick out for you?*

Dr Carter *"Well we don't have THAT many deaths in paediatrics. Certainly some of the deaths are expected, or they umm… relate to conditions that everybody knows… that from the time that the child is born, they are not going to survive, or, you know they are often sort of half-expected deaths but this was a previously healthy well child who only became unwell the same day he died. And so umm… and I was with him and his mum from the moment they got here, initially expecting, that it wasn't going to be a life threatening condition but quickly realising that it was life threatening but even through the first … five and three quarter hours umm… expecting that, that he would recover or that we would be able to get on top of the condition because we were treating him aggressively with all the appropriate things umm… and having to deal with the shock that his disease was progressing faster than what we could keep up with it and he died and umm… you know, I had to, it was late night and I only had a junior doctor with me as well as the emergency doctors and I had to tell mum that we couldn't save him."*

Dr Yates: "*I looked after him but he was on a… on a… area where people were mostly well… became acutely short of breath and I watched him die through the night over a period of probably four or five hours and there was nothing I could do about it and umm… I think I would have probably a few more tools with experience and technology to do something about that but at the time all I could do was to give this guy a diuretic which was a drug to try and get rid of some of the fluid and despite that he just… died on me."*

Dr Lee: "*Probably two or three months ago there was a 83 or 84 year old lady that came in with an abdominal problem and she became direly unwell 10, 11 ,12 'o clock at night and I spent five hours… trying to keep her alive and she was completely… sound of mind. She didn't know what was wrong. I didn't really know what was wrong with her either. I didn't know why she was dying. I was trying a lot of different things to try and keep her alive. She wanted to be kept alive… and she just kept saying Dr C am I going to get better? What's the matter? You know umm… what's happening to me? And umm… you know despite all my best efforts she died umm… and I know now, now why but that was from the Coroner's report."*

Researcher: *So why did those two case, what was it about those two cases that make it really stick in your mind?*

Dr Lee: "*Umm… I think I was quite traumatised by them personally. I know that you are… personally I know you're probably gathering that from just listening to me but umm… the second time because I couldn't do what that lady wanted she wanted to live and umm…. and umm… and I couldn't keep her alive and I guess.. Because of her age and her other illness … I … I chose not to give her the full treatment that I would've given … ah someone that wasn't her age and with her medical problems… so for example I didn't put her on a ventilator, I didn't put her on an artificial kidney machine because the medical basis for that… if she can't fix herself up with umm… with things that I was doing then, probably undertaking more intensive intervention wouldn't ultimately save her life… they would just prolong her death, so I wasn't convinced that was in her best interest. So I was disappointed that I had to… because I guess that I had made that decision … that she died anyway."*

Dr Lawson: "*I remember a few years ago I did a… I was called into the Emergency Department to a chap in his early seventies with a ruptured aortic aneurysm so it's basically a large cavity in a normally pristine vessel that has ruptured and it was slowly rupturing so there was enough time for him to get to the hospital. So I could see him, I could talk to him. We had the same sense of humour. Hee was actually a really nice guy - one of those guys that you gel immediately with and I took him to theatre and sent him off to sleep and as an anaesthetist, I've got a strong belief that I always want to make the nicest… I want to set the nicest circumstances when a patient goes off to sleep because I know from now and then that my words are the last word that the patient hears… on this earth umm… and I'll do that religiously with every single patient, regardless if I love them, hate themmm.. if it is the largest biggest piece of shit, I will still do exactly the same thing so with this patient… So with this patient… he went off to sleep. I did my job, and I did my job well, or maybe too well umm… It was actually clear with hindsight from the surgical setting where this aneurysm was that umm… the survival chances were incredibly slight I was umm… somehow I didn't want to accept that and I was working like a crazy man and I kept him alive for hours and hours whilst the surgeon tried his best so I gave this guy the absolute best chance and then finally I had to concede that it had nothing to do with my abilities… yes I did my job way beyond my duties but umm… whoever throws the dice in this life… if it is God, Allah or karma… whatever… it was clear that this patient was not meant to be and uh… that was just interesting because I was on the top of my game I was so shit hot as an anaesthetist and I had all the skills and they just flew out of my brain and into my fingers and whatever I did… it worked well but here was this guy who was just not supposed to survive.*"

As the above quotes emphasize, when talking about specific cases, the consultants stressed the point where there is a break between the ideal and reality. This was often

followed by sentences such as “probably a few more tools with experience and technology” or “I had all the skills and they just flew out of my brain and into my fingers and whatever I did it worked well but here was this guy who was just not supposed to survive” showing the consultant’s frustration at not being able to save this patient despite their knowledge and skill. Sentences such as these also create the idea that the patient dies due to medicine failing rather than the consultant not having the skills to save the patient. Therefore through their examples, the consultants exemplify their frustration and feelings of guilt, which is mitigated through constructing death, specifically acute patient death, as a lost battle

Case examples, as outlined by Radley and Chamberlain (2001) raise “hard questions.” The consultants in this project used case examples to raise the question of futility. Medical futility and what it means is debated in the literature (Botha, Tiruvoipati, & Goldberg, 2013; Mohammed & Peter, 2009). There appears to be three different types of futility: physiological (where therapy does not have a physiological effect); qualitative futility where therapy or intervention is thought to be without a purpose; and lastly quantitative futility where the therapy or intervention has a small chance, usually less than one percent; of being beneficial to the patient (Botha et al., 2013). The consultants in this research project did not distinguish between different types of futility; for them, futility appeared to be a combination of what has been labelled qualitative and quantitative futility. These two categories appeared to be linked for the consultants. If therapy had small chance of being beneficial, the consultants questioned its purpose. For the consultants in this project, futility could be defined as engaging in therapy simply because the therapy has not yet been used with this specific patient, despite the fact that the therapy has a small chance of being beneficial. The literature indicates that futile situations are fraught with intense emotions among the patients’ family, and a lack of consensus on what is futile amongst the patients’ care team. This makes it harder for those involved to resolve the ethical and moral questions or to ultimately make a decision as to whether or not treatment is futile (Botha et al., 2013). The consultants in this project described similar situations and stressed that they needed to realise and decide sooner when situations are futile to avoid any unnecessary distress to themselves and the patients’ family.

It is possible that the reason futility was raised by the consultants through case examples was because the concept of futility links to the values that they use to underpin

their identity. Two of these values were being responsible and being rational thinkers. Futility and deciding whether or not a certain situation is futile, challenges these values. If a consultant decides to engage in active treatment and later realises that doing so was futile and resulted in an undignified death, it would contradict the value of responsibility, which required ensuring a dignified death. From this alone, we can understand why the consultants wanted to be able to realise sooner rather than later, that a situation was futile. If they could achieve this, then it would mean they are able to provide a dignified death for the patient and that they are therefore responsible doctors. Futile situations also challenge the notion that consultants are always rational thinkers, because if consultants were always rational thinkers, they would be able to determine quickly which situations are futile, something which the consultants have stated they struggle to do. It is interesting to note the contradiction here. In the previous chapter, consultants talked about rational thinking as a value which both underpins their identity and a behaviour which they engage in. However here, the consultants appear to challenge that notion, specifically in futile situations. Perhaps, through raising the issue of futility, consultants are challenging themselves to uphold the value of rational thinking in futile situations.

> **Dr Yates:** *"I suppose another patient that strikes me … umm… is a patient who was a young a women who came to the Emergency Department with an acute asthma attack and umm… she came in quite unwell with asthma and we treated her with the normal inhalers that you do for asthma and she got better and she was sitting up in bed chatting… well enough actually to have her… her family come in and see her and then about an hour later she suddenly had a second umm… i episode and got really sick and despite all efforts umm… of acute treatments umm… died and that was hard because we thought we'd done a good job to get her better and then she had a relapse and we ended up having to intubate and then we intubated her and… I don't know if you know anything about asthma but if you intubate someone with asthma you can't ventilate them because the lungs are so… so stiff so we just had this women and she just died… in our hands and she was only about 30 and she got her family so I think… it's… it's… more difficult on those cases when you're helpless."*

> **Dr Carr:** "*There is nothing more we can do for this patient and make that decision because you are not just dealing with the emotions what you are actually deciding is… is this person worth investing a tube in and a ventilator and an intensive care space? Are the chance of me turning around their whole body functions practical or is this like a old motor and there are no parts available but there is*

nothing you can fix so all you are doing is prolonging their death by sending them to the Intensive Care?"

Dr Hunt: ***"****You are confronted with life and death situations you know almost daily and… they are sometimes not easy decisions to make umm… and to work you know, together with families on realistic expectation and, and then moving on to maybe end of life care decision and what that would look like and umm… getting them on board in a way as well umm… or … or seeing your view point on that sort of active therapy, has not had the right, or you know, the expected response, i.e. restoring quality of life or reasonable life and umm… that there's umm… significant burden put on the patient by pursuing aggressive therapy that we know realistically had no umm… real benefits in terms of… life prolonging but certainly death prolonging."*

Radley and Chamberlain (2001) ask researchers to consider why certain patients become medical cases. The authors argue that if a patient presents with something that could challenge medical knowledge or is a new variant of a particular disease or illness (Radley & Chamberlain, 2001) then they are more likely to become a medical "case". Riessman also invites students of narrative inquiry to consider why people give certain examples, to contemplate the purpose of their use and what the teller was trying to achieve (Riessman, 1993, 2008). Applying this to this project, invites us to think about why consultants chose those specific cases and what purpose those cases serve to them and to me as a researcher.

Upon reflecting why the consultants chose those specific cases to tell me as a researcher, one who is specifically looking at how they, as consultants construct and manage patient death, a number of ideas are apparent. Firstly the cases that the consultants chose had a specific purpose such as highlighting that dealing with death is not as fast or uncomplicated as medical television shows make it appear; highlighting that the death of a child, regardless of speciality or experience, is difficult to manage, and highlighting that death is not always a negative experience. Ultimately the consultants used cases to highlight and demystify the numerous misconceptions that exist about death. The cases provided by the consultants illustrates the multifaceted nature of death as a phenomenon and the diverse influence that this may have on the medical team and on their families. Additionally the cases were a way for the consultants to convey and illustrate their

world views and their perceptions of life so that a better understanding of the manner in which they construct and manage patient death, can be achieved.

Section summary

This section has looked at case examples of patient death to gain a deeper understanding of the intricacies around consultants' constructions of patient death and management strategies. This section has highlighted that the construction of acute patient death as a lost battle, enables consultants to manage their feelings of guilt and frustration when they realise there is a break between the ideal and reality. Secondly this section has shown how consultants used case examples as a platform for them to illustrate their protagonist roles. Additionally the case examples illustrated the core narrative characteristics, thus allowing us to see the underlying structure of the consultants' narratives. Lastly this section has shown that consultants used case examples to reveal that medical futility is a key concern that consultants feel needs addressing.

CHAPTER FIVE

RECOMMENDATIONS AND CONCLUSION

Life and death have been in love for longer than we have words to describe. Life sends countless gifts to death and death keeps them forever.

("I make stuff sometimes," 2014)

Previous work in this field has examined the influence that patient death has on medical students and nurses (Kent, Anderson, & Owens, 2012; MacLeod, Parkin, Pullon, & Robertson, 2003; Rhodes-Kropf et al., 2005). This work found that doctors felt unprepared when dealing with dying patients as result of having little palliative care training during medical school (Jackson et al., 2005; MacLeod, 2001; Sheward, Clark, Marshall, & Allan, 2011; Wear, 2002; Yim Wah, Vico Chung Lim, & Wai To, 2013). Furthermore, the literature also indicated that doctors felt they needed more training in communication, including communicating amongst colleagues about the best care for a dying patient and communicating to the patient and their family (Bedell, Cadenhead, & Graboys, 2001; Carline et al., 2003; Cherrington, 2011; Peterson, Johnson, Scherr, & Halvorsen, 2013; Rhodes-Kropf et al., 2005; Sheward et al., 2011; Weitz, 1999). The doctors also felt that they lacked support from their colleagues and other support services when a patient died (Redinbaugh et al., 2003; Wear, 2002). Lastly, the previous literature highlighted the idea of the *hidden curriculum* which ultimately taught doctors that patient death was a failure and that expressing emotions when a patient dies was a sign of weakness (Rhodes-Kropf et al., 2005).

The purpose of this research project was to explore how consultants construct and manage patient death. This research project, therefore, has added valuable insight by specifically looking at consultants, a population that has not been exclusively looked at previously. This research project was completed using narrative inquiry. Whilst some previous work was conducted qualitatively, the majority of the literature in this field was quantitative. Through using narrative inquiry, this research was able to explore the intricacies around the constructions of patient death as well as explore the various strategies that consultants use to manage patient death.

Since this research was qualitative in nature, it rests upon the constructionist epistemology, an epistemology that considers that knowledge is created from interactions, for a particular purpose and is socially, historically and culturally located (Chamberlain, 2014). Both social constructionism and narrative inquiry recognize that because knowledge is created through interactions, a person's background, history and understandings influence the interaction and the knowledge that is created. For this reason, this project first looked at the identity that the consultants constructed of themselves, specifically looking at the key values that underpinned their identity. This project then looked at how the consultants constructed and managed patient death.

This research found that the identity constructed by the consultants rested on five key values: being responsible; being good communicators, having support, being rational thinkers and being compartmentalised. The narratives showed that these values not only underpinned the consultants' identity but also illustrated their practices and what they believe are the practices and characteristics of a good doctor. The consultants used their narratives to subtly challenge medical stereotypes and the traditional medical hierarchy, showing that they are caring, responsive, that they value support (Carpenter, 1995; Harris, 1981; Oxtoby, 2013) and that they value and respect all members of the medical team (Stein, Watts, & Howell, 1990).

After looking at the identity the consultants had constructed of themselves, this research examined how the consultants constructed death. The identity illustrated provided insight into the world view and the mind-set of the consultants. This insight proved important to understand the constructions of death the consultants gave and the purpose that they served. The analysis showed that overall death was thought of not only as a relentless but also as a natural process. In order for the consultants to make sense of patient death, they constructed death in two ways. For patients who die due to chronic illness, death was constructed as a merciful end. This construction of death allows them to hold onto the belief that death is a natural process, as well as enhancing their understanding of the reality that everyone must die at some stage. Importantly this construction of death for long term patients allows consultants to manage the conflict between feeling that they should save all patients as well as provide a dignified death for patients.

For patients who died in acute circumstances, death was constructed as a lost battle. From the consultants' narratives, this construction arose because consultants felt that medicine and medical technology had failed. The consultants' narratives highlighted that they felt medicine should be able to save people and when it failed, for them it was a battle that was lost. Gawande (2014) noted that doctors often felt medicine was all-powerful and could do anything and when patients, and specifically acute patients, died, doctors were devastated and felt as if the patient death was a failure on their part (Gawande, 2014). That research argued that it is the hidden curriculum which encourages doctors to believe in the power of medicine and medical technologies, aiding the idea that death, specifically acute patient death, is a failure. To manage this idea, doctors have constructed death as a battle so that they can resolve their internal conflict between realizing that death does not discriminate and feeling as if they should save all patients.

The last aim of this research was to see how consultants manage patient death. The consultants' narratives show that in order to manage a patient dying, they often fall back on protocol and providing good end-of-life care. By going through this process, the consultants are preparing themselves, mentally and emotionally, for the eventual death of the patient. The narratives also highlight the large support network that the consultants utilize to manage patient death, including informal team debriefing, debriefing with another consultant and going through case reviews. The analysis showed that through utilizing support, they are able to come to terms, emotionally and intellectually, with the patient's death. This in turn ensures that patient death does not unnecessarily influence the consultants' work or personal life.

Limitations

All research has limitations. It is these limitations that often inspire further research. This research project is no exception. The first limitation to this research relates to the sample. The sample used for this research was wide enough to encompass a variety of consultants but not all specialties were included in the sample. The findings of this research should, therefore, not be applied to specialties that were not included such as oncologists and specialist surgeons such as obstetricians/gynaecologists and orthopaedic surgeons. It is important to note that the goal of this research was not to obtain a representative sample, but rather to gain in-depth information from the consultants about their experiences.

The second limitation relates to the geographical location of the consultants. Whilst the location was specifically chosen for this research, it is an urban hospital in a small city and not a major hospital. Therefore the consultants within this project are not exposed to all the patient death scenarios that may occur as New Zealand law requires them to send certain high-risk patients to a major hospital.

Recommendations for future research

This research focused on how consultants within a public hospital setting construct patient death. Future researchers may wish to examine how consultants construct patient death in a private clinical setting. Private healthcare involves a smaller team of medical professionals that are responsible for all aspects of the patients' care, which results in more intimate team dynamics. It would be interesting to see the influence of being part of an intimate team on the constructions of patient death. Additionally private healthcare settings do not have all medical technologies available to them in crisis situations, which may also influence the manner in which patient death is constructed in such a setting.

The location of this research was specifically chosen to ensure that it was a manageable project. Future researchers may want to conduct this research in a larger hospital in one of the major cities. Larger hospitals often have a wider range of facilities and often more lifesaving technologies. Gawande (2014) noted the devastation that doctors felt when these technologies failed to save patients. Future researchers may wish to examine the influence of having more lifesaving technology on the construction and management of patient death. Additionally larger hospitals often have a broader range of specialist consultants, resulting in larger patient care teams. Future researchers may wish to explore the influence of being part of a larger care team on the construction and management of patient death especially since being part of a larger group may result in consultants not claiming overall responsibility for the patient.

This research has demonstrated that consultants construct death in a very particular manner and that their construction of death often functions to resolve the internal conflict between feeling the need to save all patients and realising that death is a fate everyone must face. Future research may wish to further explore this internal conflict, looking at how the hidden curriculum influences this internal conflict.

This research has also shown that there is a substantial informal support network amongst consultants. It would be interesting to see how and why this network started. Or to explore what type of consultants utilise this network and for what purpose. For example, do they only seek support when a patient dies or does the support they receive act as a buffer from the daily stresses they encounter?

Lastly, a key issue that the consultants raised was the idea of futility. The consultants stressed the need for them to realise when resuscitation or active therapy was futile so that they are better able to provide a dignified death for the patient. Further researchers may wish to examine what futility means to various consultants, specifically looking at how consultants determine what is and is not a futile situation and how this decision influences constructions of patient death. Additionally a productive area for future research would be to explore the influence of futile patient death on consultant and patient family relations since research indicates that there is often a lack of consensus between family and doctors in futile situations (Botha, Tiruvoipati, & Goldberg, 2013).

Conclusion

In conclusion, this research project has given consultants the opportunity to share their experiences of patient death. This research has demonstrated the protagonist identity that the consultants create and uphold within their narratives, including the consultants' challenge of certain stereotypes. Additionally this research has illustrated that there is no longer a nurse-doctor game in place to maintain hierarchy, but rather that all members of a medical team are respected for their contribution.

This narrative study has primarily contributed to the gap in the literature by providing a detailed in-depth understanding of how consultants construct and manage patient death. This research has demonstrated the construction of patient death for consultants enables them to resolve internal conflict which stems from their medical training. This research has also shown that the management of patient death includes a variety of strategies to ensure patients have a dignified death whilst simultaneously emotionally and cognitively preparing consultants for the patients’ eventual fate.

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