# The Lived Experience of Grief Among Muslim Nurses Dealing With Death of Patients in Intensive Care Unit

Feni Betriana

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of Master of Nursing Science (International Program)

Prince of Songkla University

2018

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| **Thesis Title** | The Lived Experience of Grief Among Muslim Nurses Dealing With Death of Patients in Intensive Care Unit |
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I hereby certify that this work has not been accepted in substance for any degree, and is not being currently submitted in candidature for any degree.

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## บทคัดย่อ

การศึกษานี้มีวัตถุประสงค์เพื่อ อธิบายความหมายของประสบการณ์ภาวะเศร้าโศกของพยาบาลมุสลิมที่ดูแลผู้ป่วยและมีการเสียชีวิตในไอซียู ปรากฏการณ์วิทยาเฮอร์เมนนิวติกซ์ภายใต้ปรัชญาของกาดาเมอร์ได้ถูกนำมาใช้ในการวิเคราะห์และตีความประสบการณ์ของพยาบาลที่ดูแลผู้ป่วยและมีการเสียชีวิตในไอซียู พยาบาลจำนวน 10 ราย ในโรงพยาบาลระดับตติยภูมิแห่งหนึ่งในสุมาตราตะวันตกที่มีคุณสมบัติตามเกณฑ์ในการคัดเลือกเข้า ได้วาดภาพที่นำเสนอถึงประสบการณ์ภาวะเศร้าโศก จากนั้นได้สะท้อนเรื่องเล่าของประสบการณ์จากภาพที่วาด โดยการสัมภาษณ์แบบตัวต่อตัว ข้อมูลจากการวาดและบทสัมภาษณ์ได้ทำการวิเคราะห์โดยใช้วิธีของแวน มาแนน มีการสร้างความน่าเชื่อถือของงานวิจัยโดยใช้เกณฑ์ของลินคอล์นและกูบา

ผลการศึกษาครั้งนี้ พบกลุ่มความหมาย 5 กลุ่มหลัก และสะท้อน 5 โลกของชีวิต กลุ่มความหมายเหล่านี้ ได้แก่ การเข้าใจอย่างเห็นอกเห็นใจ การปรับสมดุลตนเอง สถานที่ของการหลีกเลี่ยง การคาดการณ์อนาคตของความตายของตนเอง และการเชื่อมโยงเทคโนโลยีในการกระบวนการต่อรอง การเข้าใจประสบการณ์ภาวะเศร้าโศกของพยาบาลมุสลิมมีความจำเป็นในการคงความอยู่ดีของพยาบาลและความเป็นมืออาชีพ อย่างไรก็ตาม สามารถนำผลการศึกษาไปใช้เสนอแนะในการให้การสนับสนุนพยาบาลไอซียูในด้านการศึกษา ด้านจิตใจ และสนับสนุนจากสถาบันเกี่ยวกับการจัดการภาวะเศร้าโศก

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**Major Program** Nursing Science (International Program)

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## ABSTRACT

This study aims to describe the meaning of the lived experiences of grief of Muslim nurses who cared for patients who died in the intensive care units (ICU). Gadamerian philosophy underpinned the hermeneutic phenomenological approach was used to analyze and interpret the lived experience of nurses who cared for patients who died in intensive care units. Fourteen nurses in an ICU at a tertiary public hospital in West Sumatera, Indonesia, met the inclusion criteria were asked to illustrate their grief experiences using graphic representations, followed by narrative reflections of their experience through face-to-face interview. Graphic representations and interview transcriptions were analyzed using van Manen. Trustworthiness was established following Lincoln and Guba's criteria.

The findings of this study revealed five major thematic categories reflecting the five life-worlds. These thematic categories included: 'empathetic understanding', 'balancing self', 'space of avoidance', 'anticipating the future of own death', and 'relating technologies in bargaining'. Understanding Muslim nurses' grief experience is necessary to maintain nurses' wellbeing and professionalism. However,

the findings can be used to suggest that educational, psychological and institutional support to manage grief should be provided to the nurses in ICU.

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Feni Betriana

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# Chapter 1

# Introduction

This chapter will present the background of the study, the objective of the study, research question, conceptual framework, scope of the study and significance of the study.

## Background of the Study

Dealing with the death of patients is a challenging experience for nurses that can often lead to grief. It is an experience that is also not well known because it is not often discussed but simply lived as a casual occurrence subsequent to death of a loved one. Grief is defined as a response of loss (Chan, Lee, & Chan, 2013; Conte, 2011) When a patient dies, grief is not only experienced by families, but also by nurses who take care of the patients both during the continuum of treatment and at the time of death. Grief may also happen before death which is known as anticipatory grief, before actual loss or death (Nielsen, Neergaard, Jensen, Bro, & Guldin, 2016).

Intensive Care Unit (ICU) is a part of hospital that provides demanding and specialized medical and nursing care to sustain and maintain life (Marshall et al., 2017). Despite the characteristic care within the ICU, its expected effect is to maintain life (Holms, Milligan, & Kydd, 2014). Nevertheless, many patients die in the ICU causing nurses to witness many deaths of patients in a short period of time. In the same time witnessing the death of the patients, nurses are also required to provide end-of-life care for patients. In ICU, nurses have roles as care provider, advocator, collaborator, and emotional supporting provider for patients and patients' families

(Enggune, Ibrahim, & Agustina, 2014; Hebert, Moore, & Rooney, 2011; Martin & Koesel, 2010). Having this role enables nurses to build relationship with patients and families closer compared to general ward.

Furthermore, nurses caring for terminally ill patients tend to experience grief. As human, nurses may feel grief after subsequent deaths while taking care of the patients. When they experience grief after patient's death, they may experience additional death of other patients. Previous studies reported that nurses experience the grief and react to patients' death by crying and verbalizing terrible feeling, feeling of sadness, feeling of guilty, and thought about patients' death (Barbour, 2016; Cook et al., 2012; Shimoinaba, O'Connor, Lee, & Kissane, 2014; Wilson, 2014). There are other factors influencing nurses' grief in dealing with the death of the patients. Previous studies reported that some factors influence nurses' grief included relationship with the patients (Boerner, Burack, Jopp, & Mock, 2015), nurses' personal factors such as nurses' belief and culture (Shimoinaba et al., 2014), delivering care to patients (Conte, 2014), and institutional factors (Wenzel, Shaha, Klimmek, & Krumm, 2011).

Even though nurses are faced with their grief, how nurses deal with this grief is not well explained. Penz and Duggleby (2012) mentioned that nursing is the first occupation with high risk to experience cumulative grief, nonetheless, nurses' grief is not considered significant. This may be caused by the professional stigma that occurs among nurses. Nurses are supposed to deliver professional care to patients and families concerning grief, but they cannot accept their own or colleagues' grief (Wisekal, 2014). This causes nurses to manage their grief without any resolution. However, if nurses cannot cope with their grief properly, this will affect the nurses themselves and the nursing profession as well where nurses reported job

dissatisfaction and intention to leave either the unit they work, hospital, or nursing profession as well (Adwan, 2014; Anderson, Kent, & Owens, 2015). Ineffective coping with grief may lead to compassion fatigue, job dissatisfaction, psychological and emotional disturbances that can lead to deficiency in the nursing profession (Adwan, 2014; Barbour, 2016; Carton & Hupcey, 2014; Wilson & Kirshbaum, 2011).

How people experience the grief is different from culture to culture and belief. In Islam, it is believed that death is something that should be accepted. Among Muslim, it is understood that everyone belongs to God and will return to God. Deaths are mentioned several times in the Quran to prepare people for death. However, not all Muslims feel prepared for the death and to accept the death. A study by Ellis, Wahab, and Ratnasingan (2013) reported that Muslims have higher death anxiety compared to members of any other religion. Their study was conducted among college students in three countries, Malaysia, Turkey, and the United States. The questions regarding fear of death and religiosity were given to a total of 3,681 respondents. The result of this study revealed that Muslims had greater fear of death compared to members of other religions. This may lead to complex experiences of Muslim nurses when caring for terminally ill patients. Muslim nurses do not only deal with patient’s deteriorating condition regarding the illness, but also the patient’s fear of death and their own anxiety.

Moreover, in Islam, it is believed that everyone belongs to God (*Allah*) and will return to God. When a Muslim dies, it is believed that the deceased will go back to God. Therefore, it is not allowed to express grief exaggeratedly. Mourning is not prohibited and it is permissible to cry. However, Muslim culture does not encourage wailing or other emotionally charged expressions of grief (Ross, 2001). This condition may influence the way Muslim nurses grieve to respond the death of the

patients. Gerow et al. (2010) explained that nurses might not express their grief and therefore keep them inside or simply neglect their feeling. However, neglect and unexpressed grief of nurses may result to burnout, cumulative stress and ineffective coping.

Several studies have investigated the experience of nurses' grief in dealing with patients' death (Conte, 2014; Gerow et al., 2010; Shimoinaba, O'Connor, Lee, & Kissane, 2014; Wilson, 2014), the consequences of nurses' grief including burnout, job dissatisfaction (Adwan, 2014) and professional compassion fatigue (Melvin, 2012), and coping management in dealing with patients' death (Cook et al., 2012; Rice, Bennett, & Billingsley, 2014). Most of the previous studies were conducted in the context of nurses caring for children (Adwan, 2014; Conte, 2014; Cook et al., 2012) and cancer patients (Conte, 2014; Wenzel, Shaha, Klimmek, & Krumm, 2011). In the context of cancer patients, nurses already know from the beginning that the patients are in terminal condition and they are more prepared for the deaths of patients. However, in the ICU, the experiences of nurses might be different since the context of patients admitted are also different and various. To date, no study was found that investigated the grief experience of Muslim nurses who cared for patients who died in ICU setting. Thus, this study aims to describe the meaning of the lived experiences of grief among Muslim nurses who cared for patients who died in the ICU.

Gadamerian philosophy underpinned hermeneutic phenomenology was used on the analysis and interpretation of the descriptions of the nurses' experiences. Since some meaning of the lived experienced is difficult to verbalize and describe in words, aesthetic expression through graphic representation may facilitate the communication

of the grief experience as lived by nurses who have experienced death of patients in the ICU.

**Objective of the Study**

The objective of this study was to describe the meaning of the lived experiences of grief among Muslim nurses dealing with the death of patients in the ICU.

**Research Question of the Study**

The research question of this study was "what is the meaning of the lived experiences of grief among Muslim nurses dealing with the death of patients in the ICU?"

**Conceptual Framework**

To understand nurses' lived experiences of grief in dealing with the deaths of patients in the ICU, hermeneutic phenomenology was used in this study as conceptual framework. van Manen (2014) proposed that hermeneutic phenomenology was a method of abstemious reflection on the basic structures of the lived experience of human existence. The term method means the way to approach a phenomenon. The word abstemious refers to reflecting on an experience that purposes to restrain from intoxication of theoretical, polemical, suppositional, and emotional. The term hermeneutic refers to the reflecting on experience which has purpose for discursive language and sensitive interpretative tools that make phenomenological analysis, explication, and description intelligible. Phenomenology begins with the questions of what and how something is and can be chased while surrendering to a miracle.

Moreover, van Manen (2014) explained that phenomenology is a philosophic method for questioning. Regarding the questioning, there will be opportunities to experience, understand, and produce cognitive and non-cognitive perception of existentialities that give the meaning of the phenomena. Phenomenology simultaneously confronts the traditions, evocations, languages, assumptions, and cognition to understand the facts of everyday lived experience.

Lived experience is defined as experience that we live through before reflecting on it (van Manen, 2014). Lived experiences are more complex, more nuanced, more richly layered and the meaning reflecting from that can be described and interpreted. The phenomenology will give meaning structures that can assist in understanding the significance of human phenomena such as grief. Since this study aims to understand the lived experience of grief in order to find the meaning of that, hermeneutics phenomenology is appropriate to guide this study. Furthermore, van Manen (2014) proposed the meaning of the lived experiences are categorized into five existential themes which are lived others, lived body, lived space, lived times, and lived things. In this study, van Manen philosophy was used to analyze the graphic representation and interview transcriptions of the participants to find the meaning structures in order to understand their lived experiences. To provide the meaning structures, the results of data analysis were categorized into five van Manen's existential themes.

Gadamerian is one of the strands and traditions of phenomenology. Gadamer viewed that art provided human experiences in a new ways of understanding the world (van Manen, 2014). In addition, van Manen (1990) also explained that art work could be source of the lived experience. By seeing the relationship and placing the art

in a human life context, an aesthetic work may provide humans with an experience of truth.

In this study, Gadamerian was used to guide an approach to understand the lived experience of nurses by illustrating their grief experience through graphic representation. Because some meanings are difficult to verbalize and describe in words, aesthetic expression may facilitate participants to communicate the meaning of their grief experiences in dealing with the deaths of patients. Aesthetic work through graphic representation is expected to provide greater and deeper understanding of the lived experiences of Muslim nurses in dealing with the death of patients in the ICU. Therefore, in this study, data were collected by asking the participants to illustrate their grief experience. Graphic illustrations were followed by reflection through individual face-to-face interviews to describe their experiences to find the meaning of this phenomenon.

## Scope of the Study

This study was conducted at an ICU in a tertiary public hospital in Bukittinggi, West Sumatera Province, Indonesia. The data were collected from October to December 2017. This study aimed to explore the experiences of grief among Muslim nurses in dealing with the death of patients.

## Significance of the Study

Understanding how the lived experience of grief among Muslim nurses in dealing with the death of patients is important to maintain nurses’ professionalism and wellbeing. The knowledge obtained from this study was expected to provide ideas for creating interventions to manage nurses’ grief in future studies. Moreover,

understanding the lived experiences of nurses' grief would enable nurses to provide professional care to patients and family at the time of dying and after the death of the patients.

# Chapter 2

# Literature Review

In this chapter, the reviewed knowledge underpinning this study includes:

1. Nurses' Grief
    1.1 Grief Model
    1.2 Factors Related to Nurses' Grief
    1.3 Reaction of Nurses' Grief
    1.4 Coping Management of Nurses' Grief
    1.5 Consequences of Nurses' Grief
    1.6 Muslim Culture Related to Grief
2. ICU Context of Care and Nurses' Role
3. Hermeneutic Phenomenology
4. Aesthetic Expression in Nursing Research

## Nurses' Grief

The term of grief is defined by several studies. Grief is defined as a response of loss (Chan et al., 2013; Conte, 2011; Smit, 2015). Buglass (2010) defined grief as natural response of human to bereavement, separation, or loss. Another definition was proposed by Cowles and Rodgers (cited in Adwan, 2014) that explained grief as a "dynamic, pervasive, highly individualized process with a strong normative component". Thus, grief refers to process or response of loss.

Many previous studies investigated the grief in patients and families. Limited studies investigated the grief among nurses. Moreover, in those limited studies, the studies conducted to explore grief among ICU nurses were more limited. However, ICU nurses are exposed to subsequent deaths of patients and have the potential to experience grief resulting from cumulative deaths of patients. Thus, to provide background knowledge of grief among nurses in a hospital setting, the studies from different contexts were reviewed.

## Grief Model

There are several theories and model explaining grief. In this chapter, the majority of them were adopted from a literature review conducted by Smit (2015). Each theory/model will be described as follows:

**Relationship/Attachment.** This theory was developed by Sigmund Freud. He defined grief as natural and normal response of loss (as cited in Smit, 2015). Based on this theory, grief consists of severe bonds with the deceased that demand detaching the bereaved persons from emotion and memories related to the deceased. Bowly extended Freud's theory by focusing on external relationships, primarily between parents and baby (Smit, 2015). It is explained that attachments and bonds remain throughout the life cycle. When the death of the close attachment person happens, the bereaved may experience disruption of the affectional bond that can be observed from the phase of the grief in the attachment theory. Bowly classified phase of grief into four phases which are: (i) shock and numbness, (ii) yearning and searching, (iii) disorganization and despair, and (iv) reorganization.

**Kübler-Ross Model.** This model was developed by Elizabeth Kübler-Ross. Based on this model, the experience of grief is classified into five stages which are

denial, anger, bargaining, depression and acceptance. This model was considered based on understanding and coping in dealing with the dying persons (Kübler-Ross, 2003). However, this model is criticized due to the limitation of the stages in reality. In real situations, the stages of grief may overlap or occur non-sequentially (Buglass, 2010).

The first stage of this model, denial, refers to the condition when people refuse to accept the truth consciously or unconsciously as a defense mechanism in dealing with the traumatic situation, especially the death. The second stage, anger, shows the condition when people express their emotion with themselves and/or with others in different way. The third stage, bargaining is the stage when people try to compromise or negotiate. In respect of death, people would try to bargain with God. The fourth stage, depression, refers to the condition where people will experience certain feelings such as sadness, regret, fear, and other upset feeling before accepting the reality. The last stage, acceptance shows that people accept the truth and integrate the loss in everyday life. People may still feel sadness at times but they continue life (Kübler-Ross, 2003).

**The Task Model.** This model was developed by Worden (as cited in Smit, 2015). In this model, grief is described as a process with a four-phase model engaged with four tasks, which are accepting loss reality, working with pain due to grief, adapting to a new surrounding and finding an eternal relationship with the deceased whilst starting to continue live without the deceased. In addition, this model also explains the importance of determining factors which explain different ways of grieving among people. Those factors include who the dead person was, how the attachment with the deceased was, how that person died, coping style and personality

including value, experience of life, belief, and level of social support from others and simultaneous sources of stress which follows the death.

**Continuing-Bond Model.** This model was developed by Klass, Silverman, and Nickman (as cited in Smit, 2015). This model explained grief as a duration in which the mourners find a new method to connect with the deceased. Silverman and Nickman explained Continuing-Bond as the continuous memory and connection between the bereaved person and the deceased one that is maintained over time (as cited in Currier, Irish, Neimeyer, & Foster, 2015). Continuous-bond may require telling stories about the deceased, keeping memories about the deceased, engaging in acts of remembrance, experiencing the presence of the deceased, or engaging in conversations with the deceased (Currier et al., 2015).

Practically, the Continuing-Bond model could be adaptive and maladaptive depending on the way of accommodating the deceased's presence. The continuing model could be adaptive when it keeps comforting memories with the deceased. Conversely, the continuing-bond model might become maladaptive when it fails to accommodate in a logical way, such as hallucination of the deceased (Currier et al., 2015). Due to the varying consequences of the continuing-bond model, it is important to understand how the continuing-bond affects the bereaved persons.

**Dual-Process Model.** This model was promoted by Stroebe and Schut (as cited in Smit, 2015). This model proposed that human revolve between two dimensions, those are a restoration-oriented response and a loss-oriented response. Buglass (2010) explained that restoration-oriented response refers to the lifestyle changes, adjusting with everyday life, and developing new roles and relationships. Loss-oriented response refers to factors related to death experiences, such as visiting places or listening to music that reminds the bereaved of the deceased and creates

sorrow. It is highlighted that significant factors which are culture, gender and circumstances of the death explain different ways of people coping with their grief. Buglass (2010) stated that this model considers the effect of culture and religion during grief that makes the experience of grief and loss of each individual different from another.

**Meaning-Making Model.** This model was developed by Niemeyer et al (as cited in Smit, 2015). This model describes that death can challenge people's assumptions about the world to find the meaning in experience of loss. In finding the meaning, people will question, look for, and change the global meaning, such as purpose of life, the meaning of death, and the nature of the life after. A study by Wortmann and Park (2009) on evidence for a meaning making model after bereavement revealed that people experience and form religious/spiritual meaning after significant loss.

Based on the explanation above, it can be concluded that there are six theories explaining about the grief, which are relationship and attachment theory, Kŭbler-Ross model, continuing-bond model, the task model, dual process model, and meaning-making model. Those theories explained the variation of phases and responses of people dealing with the grief and proposed the knowledge to understand the experience of grief. Overall, those theories explain grief as process or response regarding the loss. Nonetheless, the differences among each theory focus on the phases and response during the time people experience grief. The relationship and attachment theory classifies the phases of grief into four phases, Kŭbler-Ross model classifies into five phases, the task model consists of four phases, the continuing-bond model highlighted the connection between the bereaved person and the deceased, dual

process model focuses on restoration-oriented and loss-oriented response, and meaning-making model focuses on finding the meaning of loss experience.

## Factors Related to Grief among Nurses

Based on review from previous studies that discussed factors related to grief among nurses in other setting, several factors came up. The most common factor was the relationship with patients, followed by nurse's personality including gender, characteristics, coping and nurse's personal loss experience, how nurses delivered care to patients, institutional factors and witnessing patient's condition. From those factors, it is agreed that the relationship between nurse's and patients and nurse's personality needs to be considered for assessing how nurses cope with grief. Those factors will be explained as follows.

**Relationship with the patients.** Among other factors, relationships built between nurses and patients became the most common factor contributing to nurse's grief (Boerner, Burack, Jopp, & Mock, 2015; Chan et al., 2013; Conte, 2014; Funk, Waskiewich, & Stajduhar, 2013; Nielsen, Neergaard, Jensen, Bro, & Guldin, 2016; Shimoinaba et al., 2014; Wenzel, Shaha, Klimmek, & Krumm, 2011). A study by Shimoinaba et al. (2014) was conducted to describe palliative care nurses' experience about grief and loss in Japan. To explore nurses' experience, this study was conducted by face-to-face interviews to thirteen Japanese nurses who worked in palliative care unit. The result revealed that nurses experienced relationships with patients which were described as "special", "deep", and "close". After the patient died, nurses were faced with loss of this relationship and grieved. Moreover, when the relationship becomes very deep, the nurse's sense of sadness and loss is deeper.

Another study by Conte (2014) was conducted to explore the experience about work-related loss among pediatric oncology nurses. This study was conducted by single unstructured interview with the total of eleven pediatric oncology nurses who were in charged in inpatient and outpatient department in United States. This study reported that the relationships increase the meaning which the nurses obtain from interactions affecting their sense responses to grief and loss. It is also reported that the absence of a relationship increased emotional reactions when the patient died which caused nurses to experience guilt and helplessness. On the other hand, a study by Boerner et al. (2015) revealed that grief increased when the relationship was close and lasted for long time. Furthermore,  Chan et al. (2013) reported that nurse's relationships with patients make it hard for nurses to witness a patient's death thus experiencing negative emotions, such as frustration, guilt, and helplessness which cannot be ignored. From these studies, it can be concluded that relationships built between nurses and patients influence nurses' grief. The deeper and longer the relationship is built, the deeper the grief will be.

**Nurse's personal factors.** Nurses' factors are reported as factors related to nurse's grief. Nurse's factors include nurses' personality, belief, and assumptions about the nurses themselves, others, life and values, and nurses' personal loss experience that guides emotional experience (Shimoinaba et al., 2014). A study by Shimoinaba et al. (2014) stated that seeing patients' death resulted in nurses remembering their personal loss and experience of grief, particularly when the patients were similar with their loved ones. Similarities can be symptoms, age, circumstances of death and family structure. This condition creates the possibility of recalling painful memories and emotions that cause a cumulative grief.

Another study by Boerner et al. (2015) was conducted to determine characteristic associated with grief experienced by staff in homecare and nursing homes. This study was cross sectional study to 140 certified nursing assistants and eighty homecare workers. The result reported that lack of emotional preparedness for patient's death became an important factor that increased grief. In addition, Nielsen et al. (2016) reported that women experienced grief at a higher degree than men and caregivers with high grief are more likely to report previous stressful life events.

**Delivering care to patient.** Delivering care to the patient is reported as factor that influences nurse's grief regarding patients' death. A study by Shimoinaba et al. (2014) revealed that when nurses disclaimed themselves for not providing good care to support patient's needs, nurses appeared to grieve ineffectively after the patient's death. In addition, it is also reported that for some nurses who felt inability to deliver professional care to patients, this feeling could stay for a long time and causing hesitation whether the nurses themselves have provided professional care for their patients or not. Conte (2014) also reported that nurses felt guilt and helplessness when they perceived they were not able to deliver optimum care to the patients.

Moreover, it is also reported that grief was also experienced before a patient's death as nurses saw the patients' deterioration. A feeling of sadness led nurses to distance themselves from patients to prevent experiencing emotional pain (Shimoinaba et al., 2014).

**Institutional factors.** Institutional factors are reported as one factor that influences nurses' grief. Institutional factors refer to lack of time and space to grieve (Wenzel et al., 2011), high demands of work (Wilson, 2014), and support availability provided by supervisors and coworkers (Boerner et al., 2015).

A study by Wenzel et al. (2011) about perspectives of nurses regarding professional bereavement during working through loss and grief showed that nurses experience lack of time and space to grieve in dealing with patients' death. That study was conducted by focus group discussion with 34 nurses from outpatient and inpatient adult and pediatric oncology unit. In that study, the nurse participants revealed that they were not prepared for patients' death and felt not being supported by the institution at the bereavement period. Another study by Wilson (2014) explored how health care workers and nurses experience patients' death in acute medical setting. That study was conducted by individual interviews to thirteen staffs. The result showed that organization pressure influenced nurses' grief in dealing with patients' death. Nurses experienced demands for available beds and the need to carry out other nursing duties after patients' death.

**Reactions of Nurses' Grief**

Reaction of nurses' grief in dealing with the deaths of the patients has been investigated in previous studies showing the variety of nurses' reactions. Some reactions were reported as crying and verbalizing terrible feelings (Cook et al., 2012; Shimoinaba et al., 2014; Wilson, 2014), feeling sadness (Barbour, 2016; Shimoinaba et al., 2014; Wilson & Kirshbaum, 2011), feeling guilty (Conte, 2014; Cook et al., 2012; Shimoinaba et al., 2014), and thoughts about patients' death (Wilson, 2014; Wilson & Kirshbaum, 2011).

**Crying and verbalizing terrible feelings.** Previous studies reported that the nurses react to the death of the patients by crying and verbalizing terrible feelings (Conte, 2014; Cook et al., 2012; Shimoinaba et al., 2014; Wilson, 2014). Wilson (2014) revealed that the participants reported that behavior in order to release emotion

after the death of their patients. Moreover, Cook et al. (2012) revealed that some nurses reacted openly emotional while some other nurses were self-contained. Those who were openly emotional reacted with the death by crying and verbalizing terrible feelings.

**Feeling sadness.** Nurses reported to have feeling of sadness in dealing with the death of their patients (Barbour, 2016; Shimoinaba et al., 2014; Wilson & Kirshbaum, 2011). Barbour (2016) reported that sadness of grief is a common emotion that is experienced by the nurses when the patients die. Moreover, Shimoinaba et al. (2014) reported that grief is experienced by nurses as they witness patients' deterioration. In their study, nurses expressed feeling of loss and sadness when a patient is going to die and feeling pain after losing the patients.

**Feeling guilty.** Feeling guilty is reported as a reaction to the grief experienced by the nurses in dealing with the death of their patients (Anderson, Kent, & Owens, 2015; Conte, 2014; Cook et al., 2012; Shimoinaba et al., 2014). In their study, Shimoinaba et al. (2014) revealed that nurses felt guilty after the patients' death because they thought they could not save the patients' life. The nurses who reported blaming themselves for patients' death appeared to have less ability to grief adaptively.

A study by Anderson et al. (2015) explored nurses' experience of patients' death in clinical practice. This study was conducted by individual face-to-face semi-structured interview to twenty registered nurses as participants. The result revealed that nurses are burdened with ongoing guilt and regret after patients' death. They felt they could do more things to confront with the dying.

**Thoughts of patients' death.** Nurses were reported to have continued thinking of patients' death (Wilson, 2014; Wilson & Kirshbaum, 2011). A study by

Wilson (2014) revealed that the response of nurses participants toward patients' death included feeling upset, shock and thought about patients' death in the night when they went to bed. In addition, another study by Wilson & Kirshbaum (2011) regarding effect of patients' death on nursing staff revealed that thinking about death was commonly reported by nurses after patients' death.

## Coping Management of Grief

From review of previous studies about coping management used by nurses to deal with their grief, five coping management strategies came up. The common coping management methods used by nurses are peer storytelling and distancing from the situation, followed by normalization, emphasizing positive aspect, and maintaining contact with bereaved families. Each coping management strategy will be described as follows:

**Peer story telling.** Story telling was reported as one of coping management method used by nurses to cope with their grief. Previous studies mentioned that peer story telling or sharing experiences helped nurses to cope with their grief in dealing with patients' death (Anderson et al., 2015; Carton & Hupcey, 2014; Rice, Bennett, & Billingsley, 2014; Shimoinaba et al., 2014; Wenzel et al., 2011; Wilson, 2014).

A study by Anderson et al. (2015) explored nurses' experience of patient death. Result of individual face-to-face interview to twenty registered nurses revealed that nurses who were unable to share their experiences seemed to experience more ongoing emotional distress, while those who were able to share in a team appeared to cope easily. Moreover, it is also reported that nurses turned to their colleagues to talk with and support them.

Furthermore, Rice et al. (2014) conducted a mixed-methods approach to examine peer storytelling as a coping method for grieving oncology nurses. Their study involved focus group and surveys to the total of nine participants from acute and ambulatory oncology unit. They used a web-based, three-dimensional (3 D) virtual world technology (second life) to facilitate peer story telling. The result revealed that peer storytelling assisted nurses to find the meaning and identify the benefit of their grief experiences.

**Distancing from the situation.** Distancing from the situation is reported as a way used by nurses to cope with their grief (Conte, 2014; Cook et al., 2012; Melvin, 2012; Shimoinaba et al., 2014; Wenzel et al., 2011; Wilson, 2014). Distancing from the situation includes distancing either nurses themselves or their loved one from the situation or from talk about the death of their patients. Distancing from the situation is used to protect the nurses themselves and their loved ones.

**Normalization.** From ten reviewed studies, four of them revealed that normalization is used by nurses to cope with their grief (Conte, 2014; Cook et al., 2012; Funk et al., 2013; Wilson, 2014). Normalization refers to acceptance the death, controlling emotion, and labeling. Funk et al. (2013) revealed that the participants in their study coped by accepting that death is normal part of life. Moreover, Cook et al. (2012) found that nurses coped with patient's death by labeling the day of the death using words or phrase such as "bad day" or "busy day" instead of telling that there was a death of patient' at that day.

**Emphasizing positive aspects.** Emphasizing positive aspects is reported as a coping management used by nurses in dealing with patients' death (Cook et al., 2012; Funk et al., 2013; Wilson, 2014). Emphasizing positive aspects includes emphasizing jobs, the patients, and the nurses themselves. Funk et al. (2013) reported that focusing

on positive aspects of the job that they have done and emphasizing that the person has lived a good life helped nurses to manage their grief. In addition, Cook et al. (2012) revealed that nurses felt assisted when coping if they maintained positive memories of the patients.

**Maintaining contact with bereaved families.** Maintaining contact with bereaved family members was reported as one of coping management strategies for nurses to deal with grief (Cook et al., 2012; Funk et al., 2013; Wenzel et al., 2011). Funk et al. (2013) reported that nurses continued to connect with bereaved family members in order to cope. Moreover, Cook et al. (2012) mentioned that nurses maintained contact with families after patients died.

## Consequences of Nurses' Grief

From review of previous studies regarding consequences of nurse's grief, seven types of nurses' grief consequences came up. The most common consequences reported are psychological and emotional distress followed by compassion fatigue, burnout, sleep disturbance, disenfranchised grief, intention to leave, and job dissatisfaction. Each consequence of the grief will be described as follows:

**Psychological and emotional distress.** Psychological and emotional distress were reported as consequences of nurses' grief (Anderson et al., 2015; Carton & Hupcey, 2014; Melvin, 2012; Shimoinaba et al., 2014; Wilson & Kirshbaum, 2011). Psychological and emotional distress refers to feeling sad, crying and thinking about death (Wilson & Kirshbaum, 2011), feeling guilty and regrets regarding patient's death (Anderson et al., 2015).

**Compassion fatigue.** Compassion fatigue is mentioned as one consequence of grief experienced by nurses dealing with patients' death (Barbour, 2016; Carton &

Hupcey, 2014; Melvin, 2012; Wilson & Kirshbaum, 2011). Carton & Hupcey (2014) conducted a systematic review regarding health care provider grief. They found that inadequately grief after patients' death can lead to compassion fatigue. Compassion fatigue is defined as a product resulting from caring of traumatized people that can cause exhaustion and biological, psychological and social dysfunction (Papadatou as cited in Carton & Hupcey, 2014).

**Burnout.** Previous studies reported that that nurses' grief can result in burnout (Adwan, 2014; Carton & Hupcey, 2014; Melvin, 2012). Burnout is defined as a syndrome affecting individuals with caring occupations, such as nurses, psychologists, and therapists, that consists of depersonalization, feelings of emotional exhaustion, and low levels of achievement (Maslach, Schaufeli and Leiter, cited in Adwan, 2014). In his study, Adwan (2014) revealed that grief has statistically significant positive correlation with burnout.

**Sleep disturbance.** Sleep disturbance was reported as one of nurses' consequences of their grief (Anderson et al., 2015; Carter, Dyer, & Mikan, 2013; Wilson, 2014). Sleep disturbance refers to poor sleep quality, such as non-restorative and fragmented sleep, difficulty falling asleep, and thoughts about patient's death that occur when going to bed (Carter et al., 2013; Wilson, 2014). Carter et al. (2013) revealed that nurses exposed to chronic bereavement reported moderate-to-severe sleep disturbance.

**Disenfranchised grief.** Disenfranchised grief is reported as consequences of nurses' grief (Shimoinaba et al., 2014; Wilson, 2014; Wilson & Kirshbaum, 2011). Disenfranchised grief is explained as unknowledgeable grief that is not recognized publicly (Doka, 1987 as cited in Wilson, 2014). Disenfranchised grief was reported as result of nurses' grief (Wilson, 2014; Wilson & Kirshbaum, 2011). In his study,

Wilson (2014) revealed that the effect of patients' death was not acknowledged openly or socially by nurses until their behavioral change was recognized by colleagues and family members and they realized that it was their reaction of a patient's death.

**Intention to leave.** Intention to leave is reported as consequences of nurses' grief (Adwan, 2014; Anderson et al., 2015). Nurses who experience a higher level of grief have an intention to leave either the unit they work in, hospital, or nursing profession (Adwan, 2014). In addition, Anderson et al. (2015) reported from their study that after a patient died, nurse participants took time off work, extended leave and never returned to the unit where the death occurred.

**Job dissatisfaction.** Job dissatisfaction is reported as one of the consequences of nurses' grief (Adwan, 2014). It is reported that nurses' grief is associated with job dissatisfaction that leads to career change.

## Muslim Culture Related to Grief

Islam is a monotheist religion that was conveyed by the Prophet Muhammad as a messenger of God. In Islam, there are several points of belief and five pillars in carrying out religious practice. The belief includes belief to: (a) oneness of God, (b) angels, (c) prophets, (d)holy scripture, and (e) divine justice. The five pillars in religious practice include: (a) *shahada* (mentioning a statement that there is only One God and Prophet Muhammad is the messenger of God), (b) daily prayers, (c) yearly fasting, (d) paying tithe, and (e) pilgrimage once in a life time.

In Islam, it is believed that God is the owner of everything, including the human themselves. In the holy Qur'an, it is written that "every soul shall taste death" (Quran, 29: 57) and "indeed the death which you flee, indeed it will meet you"

(Quran, 62:8). Death means transition from one form of existence to another, and to be in the presence of God. At the dying time, a Muslim is required to recite the Qur'an near the dying Muslim person. Before a Muslim dies, it is required for other Muslims around to assist the dying person to recite *shahada* (the statement of the oneness of God, "There is no God but Allah and Muhammad is the messenger of Allah"). As it is believed that every soul belongs to God, when a Muslim died, the Qur'an recommends saying "to God we belong and to Him is our return" (Quran, 2:156). Death is mentioned several times in the Qur'an to prepare Muslims for the death and to accept death.

In Islam, it is not prohibited to mourn. Crying is permissible as crying is believed as representation of a soft heart. Attending the funeral procession and the burial of the dead is recommended in Islam. However, it is not encouraged to wail, moan or to make over emotionally expressions of grief (Ross, 2001). Kassis mentioned that previously women were not encouraged to attend funeral processions in order to prevent ritual lamentation, for example tearing at one's hair, striking one's face or other over expression of emotion (Ross, 2001). In respect of grief in Islam, there is no limitation of the time in which a person is expected to recover from grief, especially for a sudden and violent death. Nonetheless, the grief should not interrupt one's everyday life and relationships (Hedayat, 2006).

## ICU Context of Care and Nurses' Roles

This section provides knowledge regarding ICU context of care and nurses' role in ICU. Knowledge regarding ICU context of care and nurses' role is beneficial to understand how the grief exist and affect nurses in ICU.

**ICU Context of Care**

The ICU is a system organized for critically ill patients to maintain life for a period of life-threatening organ system insufficiency by providing intensive medical and nursing care, with enhanced capacity of monitoring and multiple modalities of physiologic organ support (Marshall et al., 2017). Ministry of Health, Republic of Indonesia (2011) stated that an intensive care unit (ICU) is an independent part of a hospital with special staffs and equipment that aims to observe, care, and treat patients with acute ill, injuries, or other life threatening diseases that are still reversible.

The ICU is classified into three levels. A level one ICU (primary ICU) is expected to provide noninvasive monitoring, oxygen, and more intensive nursing care than on a ward. The level two ICU (secondary ICU) provides support for basic life and invasive monitoring for a short time. Level three ICU (tertiary ICU) provides a whole spectrum regarding life support technologies and monitoring, as a regional resource for the care of critically ill patients and plays an active role to build the specialty of intensive care by research and education (Marshall et al., 2017).

Caring in the ICU is done by multidisciplinary professions who work in a team with single management (Ministry of Health, Republic of Indonesia, 2011). Based on the technical guideline of ICU management (Ministry of Health, Republic of Indonesia, 2011), the resources of an ICU consist of chairman of ICU, medical team, nurses, and non-medical team. Regarding the nurses, all the nurses in primary ICU have to be certified nurses for basic life support. In secondary ICU, at least 50 % of the total nurses are skilled and certified ICU nurses while in tertiary ICU it is required to have at least 75% of nurses who are skilled and ICU certified.

Regarding the serving of ICU, the scope of serving in the ICU includes: (a) diagnosis and treatment of acute and life threatening illness, (b) supporting the

function of vital organ and carrying out emergency treatment in supporting life, (c) monitoring of vital organ function from complication, and (d) providing psychological care for patients and families. In respect of end of life care, an ICU is required to provide a special room for patient at the end of life (Ministry of Health, Republic of Indonesia, 2011).

## Nurses' Roles in the ICU

Nurses play significant roles in the ICU. Knowledge regarding nurses' role is necessary to understand factors that influence the grief experience of nurse dealing with patients' death. Nurses' roles in the ICU include care provider, advocator, collaborator, and emotional supporting provider. Each role will be described as follow.

**Care provider.** One of the important roles of nurses in ICU is as a care provider (Enggune et al., 2014; Holms et al., 2014; Martin & Koesel, 2010). A study by Enggune et al. (2014) revealed that nurses provide care at the end of life by assisting patients to die peacefully and presenting the families to give support at the dying time. Their study was conducted in neurosurgical critical care unit (NCCU) in Indonesia by semi-structured interview with the total of eight participants. Their study was conducted to explore the nurses' perception toward end of life care.

In addition, Holms et al. (2014) conducted a qualitative study to explore ICU nurses' experience to provide end of life care for patients and families. The setting took place in an ICU in United Kingdom. This study was conducted by semi-structured interview with five ICU staff nurses as the participants. The result of this study showed that nurses play role as end of life care provider and integrated care system has been used by nurses to improve end-of-life care practice. Furthermore,

Martin & Koesel (2010) stated that as a team member in establishing the goals of care in the ICU, nurses may strive with understanding the relationship between the diagnosis, prognosis, and treatment plan during providing the care.

**Advocator.** Nurses in ICU play important role as patients' advocator (Hanks, 2010; Hebert et al., 2011; Martin & Koesel, 2010). As an advocator, nurse does advocacy for the patient. Advocacy of nursing is explained as communicating with the patients and family, protecting patients' right, speaking out for patients, and establishing relationship with the patients (Hanks, 2010).

Regarding end of life care in ICU, nursing advocacy include pain and symptom management, ethical decision making, caring based on patients' culture, and assistance during the death and the dying process (Hebert et al., 2011). Morover, in their study, Hebert et al. (2011) explained that the foundation of nursing advocacy is based on nurse-patient's relationship where patients are mostly helpless, powerlessness, dependency, and loss of self-control. Another study by Martin and Koesel (2010) also elaborated nurses' role as facilitating communication with critically ill patients and their families, and being advocate for patients and families.

**Collaborator.** Nurses play role as collaborator with other professional health care team in ICU (Kryworuchko, Hill, Murray, Stacey, & Fergusson, 2013; Orchard, 2010). A study by Kryworuchko et al. (2013) explained that nurses should be collaborator and do collaboration in ICU setting. Collaboration among health professional, patient and also families is important especially to provide guidance in decision making.

In addition, a study by Orchard (2010) about nurses' role in interprofessional collaborative practice revealed that nurses are expected to be collaborative members by re-socializing, understanding about nurses' role, knowledge, and skill to others,

sharing with other health providers, identifying where shared roles, knowledge, and skill exists, and learning to works in collaborative teams.

**Emotional supporting provider.** Nurses in ICU are reported to play role as emotional supporting provider for patients and families (Bloomer, Tiruvoipati, Tsiripillis, & Botha, 2010; Enggune et al., 2014). A study by Enggune et al. (2014) that investigated the perception of nurses in a neurosurgical critical care unit toward caring at the end of life in Indonesia revealed that nurses' roles at the end of life includes being provider of emotional supporting provider for a patient's family.

## Hermeneutic Phenomenology

Phenomenology is a philosophical discipline that reflects the living meaning of the phenomena in a phenomenological manner (van Manen, 2014). Phenomenology is used as a method to give meaning that provides the way to enter the world as we live in and we live through.

Under the term 'phenomenology', there are multiple methods of meaning that ensure phenomenology conveys a variety of productive directions, which are ethical phenomenology, existential phenomenology, gender phenomenology, embodiment phenomenology, hermeneutic phenomenology, critical phenomenology, literary phenomenology, oneiric-poetic phenomenology, sociological phenomenology, political phenomenology, material phenomenology, and deconstruction phenomenology (van Manen, 2014). In this study, the phenomenology used was be focused on hermeneutic phenomenology.

Hermeneutic phenomenology is an approach or way of a reflection on the fundamental structures of human lived experiences (van Manen, 2014). Hermeneutic

is defined as reflecting on human experience that has purposes for discursive language both sensitive interpretative and enable analysis, explication and description. Furthermore, van Manen (2014) also stated that phenomenology is a method for questioning that allows for experiencing openings, understanding, and producing cognitive and noncognitive existentialities and gives chance of the meaning of phenomena. Phenomenology is said to face traditions, languages, assumptions, evocations and cognition in order to understand the existential truth of everyday lived experience.

Lived experience is explained as experience which we live through before taking reflection of it (van Manen, 2014). The experience that we live through will result in the meaning that is reflected from the experience. Hermeneutic phenomenology provides meaning structures which assist to understand the significance of human phenomena. To explore the phenomena in a heuristic manner, van Manen (2014) classified the themes into existential themes which consist of existential lived relation (relational), lived body (corporeality), lived space (spatiality), lived time (temporality) and lived things and technology (materiality). Each of the existential themes will be described as follows:

**Relationality-lived other.** The relationality guides the reflection to ask how self and others experienced the phenomenon which is being studied. Lived other is the lived relation that is maintained with the other in the personal space that is shared with them.

**Corporeality-lived body.** Lived body points the fact that a human is bodily in the world. The corporeality guides the reflection about how the body is experienced the phenomenon which is being studied, as a subject or as an object.

**Spatiality-lived space.** Lived space is defined as felt space. The spatiality guides the reflection to ask how space is experienced about the phenomenon that is studied. The space can be experienced as the sense of close or far, sense of small or big depends on how the phenomenon in that certain space are experienced.

**Temporality-lived time.** The temporality guides the reflection about how time is experienced regarding the phenomenon that is being studied. Space is a facet of time and vice versa. Lived time can also be experienced as the plans, wishes, and goals that are arranged in the life.

**Materiality-lived things**. The materiality guides the reflection about how things, for example technologies or materials are experienced regarding the phenomenon that is being studied. The things connect human and the world and provide the meaning regarding the particular phenomenon.

Based on the explanation above, it can be summarized that hermeneutic phenomenology is a method to understand every day lived experiences. To get understanding about the structure of the lived experiences, the meanings are classified into existential themes which are lived relation, lived body, lived space, lived time, and lived things.

## Aesthetic Expressions in Nursing Research

This section provides information regarding aesthetic expression in nursing research, including the introduction of Gadamerian and previous studies using aesthetic expression in nursing research.

Hans-Georg Gadamer (1900-2002) was the German philosopher and one of Heidegger's students and his philosophy emerged from Heidegger's ontological structure of understanding of fore-meanings and prejudices (Austgard, 2012). Based on Gadamer, interpretation does not only circulate around the text, but also implicate the human being and their interaction with the world (Austgard, 2012).

Gadamer developed philosophical hermeneutics and focused on classical philosophy as a phenomenology of human understanding. According to Gadamer, once we make an experience into an object, the truth of the lived meaning of the experience will become deeper (van Manen, 2014). Gadamer wanted to exhibit that art provides human with experiences as a new ways to understand the world. When the relationship of art in human life context can be seen clearly, the aesthetic will provide human with the experience of truth (van Manen, 2014). van Manen (1990) agreed that art is considered as a source of lived experience. Objects of art are visual, tactile, auditory, kinetic texts that consist of not a verbal language but a language with its own grammar that can reflect the lived experience.

Aesthetic expressions have been used in nursing research. Previous studies used drawing (Kongsuwan & Locsin, 2010; Locsin, Barnard, Matua, & Bongomin, 2003), poem (Jack, 2015; Jack & Tetley, 2016), and sculpting material (Sabo & Thibeault, 2012). The followings are example studies used aesthetic expressions in nursing research.

A study by Locsin et al. (2003) used artistic representation to explore the experience of surviving ebola hemorrhagic fever. The participants were asked to draw picture reflecting the meaning of living as survivor of ebola hemorrhagic fever. After drawing, the participants were asked to explain the meaning of the pictures. The meaning of the lived experience of an ebola survivor was revealed from analysis of

the pictures and verbal description. For data analysis, Locsin et al. (2003) used a phenomenographic approach using seven steps to categorize the description and outcome space which were familiarization, condensation, comparison, grouping, articulating, labeling, and contrasting.

Moreover, Kongsuwan and Locsin (2010) used illustrations to illuminate the lived experience of caring for persons who had a peaceful death. The participants participated in face-to-face interviews and van Manen' hermeneutic phenomenological approach was used for data analysis. Their study resulted in sixteen thematic categories and two thematic categories were selected to represent each lived world. Drawings were used to show the lived experience of the participants.

In addition, Jack and Tetley (2016) used poems to explore the meaning of compassion to undergraduate nursing students. In this study, they used interpretative phenomenological approach to explore the experiences of the participants. Narrative coding and theming were used to analyze the data. Another study, Sabo and Thibeault (2012) collaborated with an artist to develop lifelike torsos from two survivors of breast cancer and interviewed the survivors to describe the meaning of the experiences of their cancer journey. In their study, thematic analysis was carried out using the van Maneen approach (1997) and Benner (1994) to analyze the interview transcript from the participants.

## Summary of the Literature Review

Grief is explained as a process or response of loss. When a patient died, nurses were reported to experience grief. The ICU is one setting where repetitive deaths

occur and may lead to the grief which will be experienced by nurses. However, literature review regarding experience of grief among ICU nurses dealing with the death of the patients is limited. Thus, the concepts of grief among nurses were reviewed from other settings to provide the background knowledge of nurses' grief in hospital settings. Based on literature review, some important points were highlighted. The factors related to nurses' grief were reported as relationship with the patients, nurses' factors, delivering care to the patients, institutional factors, and patients' condition. Reaction of nurses' grief included feeling upset, shock, thoughts about patients' death, crying, and verbalizing of terrible feelings. Consequences of nurses' grief were reported as psychological and emotional distress, compassion fatigue, burn out, sleep disturbance, disenfranchised grief, intention to leave, and job dissatisfaction. In respect of coping management of grief, peer storytelling, distancing from the situation, normalization, emphasizing on positive thing, and maintaining contact with the bereaved families are reported as coping managements used by nurses to deal with the grief related to patients' death.

In Islam, it is believed that death should be accepted. Therefore, over reaction to grief is not recommended. However, how Muslim nurses deal with the death of the patients has not been examined. van Manen's hermeneutic phenomenology is used to explore the grief experiences of Muslim nurses dealing with the death of patients. Since not all meaning can be expressed verbally, Gadamerian approach is used as guidance to explore the experience of grief that is lived by Muslim nurses. When an experience is formed into an art work, the meaning will be explored and understood deeply.

# Chapter 3

# Research Methodology

This chapter discusses research methodology which consists of the research design, setting of the study, participants, researcher background, instrumentations, data collection procedures, ethical consideration, data analysis, and trustworthiness.

## Research Design

This study was a qualitative research design with hermeneutic phenomenological method based on van Manen and Gadamerian philosophy. Hermeneutic phenomenology was used to describe the lived experiences of Muslim nurses dealing with the death of the patients. The participants were asked to illustrate their grief experience in dealing with the death of patients through graphic representation and followed by reflection through individual face-to-face interview.

## Setting of the Study

This study was conducted in the ICU of a public hospital in West Sumatra Province, Indonesia. This hospital is a teaching and referral hospital in West Sumatera Province, Indonesia. This hospital provides services of special and sub-special disease and consists of 299 beds. The ICU of this hospital is the level two ICU which provides invasive monitoring and basic life support for a short period. This ICU is merged with the cardiovascular care unit (CVCU) which consists of 8 beds with total of 16 nurses. All the nurses are Muslim. The shift of nurses is divided into three shifts.

The morning shift that starts from 08.00 a.m. to 02.00 p.m., the afternoon shift starts from 02.00 p.m. to 09.00 p.m. and the night shift which is from 09.00 p.m. to 08.00 a.m. Nurses are given day off after two days of night shift in a week. The day off are given for two days. Regarding the patients, the length of stay in the ICU is approximately two to three days while in the CVCU, it is about one to two days. Cases of patients' death are around two to three cases per month (Lily, personal communication, 23 June 2017).

According to the regulations of this hospital, nurses working in the ICU are required to follow training for the ICU to prepare nurses for the ICU environment and critical conditions. In this ICU, the nurses take care of the patients until the patients are transferred to general unit or die. Bereavement support for patient and family is given by nurses since the patients are at the end of life until their death. Most of the patients are Muslim. At the time of dying, nurses invite family to accompany the patient and recite Quran near the patients. Care of the corps is given soon after a patient dies until a patient is transferred to general unit. Nonetheless, bereavement support for family after patients' death, such as follow up or further consultation is not provided. In addition, there is no specific regulation regarding support for nurses who are dealing with the death of the patients.

**Participants**

Prospective participants were Muslim nurses who cared for patients who died in the ICU of a tertiary public hospital in Bukittinggi, West Sumatra Province, Indonesia. The participants participated in this study were those who followed the inclusion criteria: (1) being a Muslim nurse, (2) having experienced of dealing with at least five patients' death, and (3) working for at least one year in the ICU.

Regarding the number of participants, based on Cresswell (1998), the number of participants of phenomenology ranges from 5 to 25 participants. However, the number of participants participated in this study were based on data saturation. Data saturation was established when the information was complete to reproduce a study with two conditions which were obtaining the ability to reach new information and further coding was no longer possible (Fusch & Ness, 2015). Furthermore, according to van Manen (2016) there is no point of saturation in the context of phenomenological meaning. Since the researcher began with a question, it is impossible to get the whole meaning of human phenomena. Therefore, there is no point of saturation in phenomenology.

**Researcher Background**

The researcher was a Muslim and also a registered nurse with experience as an instructor and teaching staff member at a mental health nursing department in a nursing college in West Sumatera Province, Indonesia. Previously, the researcher undertook practicum in an ICU for one month and other wards of a state hospital in West Sumatera Province, Indonesia for one year as student while completing bachelor degree. The researcher had her own grief experience dealing with the death of the patients during the clinical practice in hospital. The researcher's earliest memory of first patient's death could still be recalled vividly. The experience and feeling of that first death patient's experience could still be shared which later on the researcher understood it as the grief experience. Thus, the researcher assumed that the experience of grief lived by nurses was a significant event. In addition, the researcher has also experience in palliative care training that discusses issues regarding grief at the end of life.

## Instrumentations

The instrumentations used in this study were:

1. Demographic data form (Appendix A) that were used to collect information including age, gender, marital status, years of experience in nursing, years of experience in the ICU, educational level, time of last patient's death, and experience of being trained in palliative care or grief and loss.
2. A semi-structured guided interview questions (Appendix B) that consisted of questions which asked about the experience of nurses including grief reactions, coping strategy, and factors related to grief reaction and grief coping strategy.

The instrumentations were validated by three experts. Two experts were in Faculty of Nursing, Prince of Songkla University, Thailand, with the expertise in palliative care and qualitative study. One expert was a senior ICU nurse from Achmad Mochtar Hospital, Bukittinggi, West Sumatera Province, Indonesia, with the expertise in end-of-life care in ICU (Appendix C).

## Data Collection Procedures

Data collection consisted of preparation phase, drawing phase, interviewing phase, translation process, and ethical consideration.

**Preparation phase.** In this phase, the researcher carried out the following steps:

1. Conducting preliminary study.

   Preliminary study aimed to assess the acceptability and feasibility of the study and to engage researcher in qualitative research. The preliminary study has been

undertaken with three participants. The data have been analyzed and the findings have been categorized based on van Manen's existential themes.

2. Obtaining ethical approval.

   Ethical approval was obtained from Social and Behavioral Sciences Institutional Review Board, Prince of Songkla University.

3. Contacting and submitting a permission letter to the hospital where this study was conducted for data collection after ethical approval was granted.
4. Explaining the details of the study to the head nurse, including how the study would be conducted, the benefits and risks of the study, and the inclusion criteria of the participants that could participate in this study.
5. Contacting eligible participants by the head nurse based on the explanation given by the researcher.
6. Contacting the participants who would willingly participate in the study after permission were obtained and informing them about the study plan, including the process of how the participants can participate, the benefits and the risks that may result from this study. After obtaining the information, the participants were required to sign the informed consent.

**Graphic illustrating phase.** This phase was started after the informed consents were obtained. Firstly, the participants were required to illustrate their experiences of grief dealing with the deaths of the patients. The participants were required to illustrate on an A4 blank piece of paper and were able to use colors. Using different colors provided different meaning for the participants. The participants were given time to draw as long as they wish. The participants were able to draw in a private room inside ICU. Participants also could take time to draw at home and return

the drawing to researcher at the time agreed between the participants and the researcher.

**Reflection phase.** After illustrating their experience, the participants were required to reflect the meaning of their graphic representation through individual face-to-face interview based on the pictures and the guided interview questions. The questions given were open ended. The guided interview question was attached in appendix A. The interview was conducted in Indonesian language (*bahasa Indonesia*) and lasted about 45-60 minutes. The interview was recorded by two recorders and notes were taken. The researcher carried a journal or diary which was used to note time of day and date of the data collection, any features of the context, the physical setting where the data collection take place, the researcher's own reflection, questions and interpretation that comes during the drawing and interview phase.

## Translation Process

The whole interview transcriptions of three participants were translated from Indonesian language into English by the researcher and validated by the expert who was bilingual in English and Indonesian language. The expert was a senior nurse who was a nurse consultant in the hospital setting and also the visiting lecturer in a nursing college in Bukittinggi, West Sumatera Province, Indonesia. Those three transcriptions were then analyzed with advisor. This aimed to establish the trustworthiness of this study and as training for researcher in data analysis. The data of another eleven participants were analyzed for the first analysis in Indonesian language with the expert. Those data were then translated into English by the researcher and were validated by the expert. The translated versions then were further analyzed with thesis advisor.

**Ethical Considerations**

Ethical approval was obtained from The Social and Behavioral Sciences, Institutional Review Board, Prince of Songkla University, number 2017NSt-Qn 039 (Appendix D) before data collection. The approval to access the setting was obtained from the head of the human resources department of the hospital setting who issued the permission number 099/250/RSAM-SDM/X/2017 (Appendix E). After obtaining ethical approval, the researcher explained about the study to the head nurse in the ICU, Achmad Mochtar Hospital. The head nurse noted eligible participants for the study. After the head nurse contacted the participants and the participants agreed to participate in the study, the researcher contacted the participants. The researcher explained information regarding the study, how the study would be conducted, the risks and benefits of this study, the right to join or withdraw from this study without any penalty. A risk which may occur was recalling emotionally charged memories that might lead to psychological disturbances for the participants. A benefit that participants obtained from this study was enabling them to facilitate their lived experiences that might be covered during the period of caring for the patients. Moreover, by joining this study, the participants were able to share the suggested coping or intervention strategies that could help them to deal with this situation which could be suggested for institutions in the future. The participants willing to participate were required to sign a consent form (Appendix F) after explanation was given. The researcher also asked for permission before recording the interview.

The sensitivity of this topic and its potential as an emotionally charged topic was recognized. Interviews were conducted in participants' preferred place which was quiet room in the hospital. The nurses were advised if they needed psychological support and prefer to speak to a psychologist. The researcher contacted the

psychologist before data collection. The participants could stop the interview anytime if they felt uncomfortable without any penalty. All the information regarding this study was kept confidential. The participants' names were not substituted with code number in reporting this study. The data were kept in researchers' personal computer that was secured by password and could be accessed only by the researcher. The data would be kept for five years.

## Data Analysis

The graphic representation and interview transcriptions were analyzed using van Manen's hermeneutic approach. van Manen (1990) viewed that the source of lived experience was not only limited in interview, but also art works for example drawing and graphic illustration. van Manen's approach is an interpretative approach, thus it can be used to interpret the graphic representation. In this study, the data analysis was started from the graphic representation illustrated by the participants with the supported statements from the interview transcriptions line by line.

Based on van Manen (1990), there are six steps of hermeneutic phenomenological approach which will be described as follows.

***Turning to the nature of lived experience.*** Every topic of phenomenological investigation starts from a commitment to turn to a significant interest. This commitment shows the totality of thinking. A phenomenological research comes from a deep questioning about a phenomenon.

***Investigating experience as living it rather than conceptualizing it.*** Phenomenological research intends to develop a renewed contact with the original experience. The researcher explores the lived experience in its fullness and needs to understand the nature of the lived experience itself.

***Reflecting on essential themes which characterize the phenomenon.*** To understand the phenomenon, the reflection of the lived experience should be thoughtful and reflecting on what things that offer the significance on the certain phenomenon. In phenomenology, the reflection is brought into impendence that tends to be vague to evade the clearness of everyday life attitude.

***Describing the phenomenon through the art of writing and rewriting.*** Describing the phenomenon means the implementation of thoughtfulness and language into a facet of lived experience that shows itself exactly. In phenomenology, thinking and language are unlikely to be separated to bring the meaning of the phenomenon.

***Maintaining a strong and oriented pedagogical relation to the phenomenon.*** In phenomenology, a researcher needs to build an intense relation with a phenomenon. In order to be oriented to an object, a researcher should be spirited by the object fully and human science. To be intense in orientation refers that a researcher does not resolve for shallowness and untruth.

***Balancing the research context by considering parts and whole.*** In phenomenological research, it is imperative to see the wholeness at the contextual given. It is also necessary to see how each part contributes toward the total because the parts play role in the total structure of human lived experience.

The themes obtained from this study were categorized into existential themes which consist of existential of lived relation (relational), lived body (corporeality), lived space (spatiality), lived time (temporality) and lived things and technology (materiality).

**Relationality-lived other.** The relationality guides the reflection about how self and others experienced the phenomenon which is being studied, which is the grief

experience. Lived other is the lived relation that is maintained with the other in the personal space that is shared with them.

**Corporeality-lived body.** Lived body points the fact that a human is bodily in the world. The corporeality guides the reflection about how the body is experienced the grief. The body may react by several reaction in experience the grief.

**Spatiality-lived space.** Lived space is defined as felt space. The spatiality guides the reflection about how space is experienced regarding the grief. The space can be experienced as the sense of close or far, sense of small or big depends on how the phenomenon in that certain space are experienced.

**Temporality-lived time.** The temporality guides the reflection about how time is experienced regarding the grief. Space is a facet of time and vice versa. Lived time can also be experienced as the plans, wishes, and goals that are arranged in the life.

**Materiality-lived things**. The materiality guides the reflection about how things, for example technologies or materials are experienced regarding the grief experience. The things connect human and the world and provide the meaning regarding the particular phenomenon.

## Trustworthiness

Trustworthiness in this study was maintained by using four criteria developed by Lincoln and Guba (1985) which are credibility, transferability, dependability, and confirmability.

**Credibility.** One of the criteria to ensure the trustworthiness is credibility. Credibility is defined as the confidence in the 'truth' of the findings. Credibility established the confidence that the truth of the findings were congruent with the

reality. In this study, the data were collected from the participants who had the grief experience and could reflect and describe the experience.

**Transferability.** Transferability assures that the findings can be applied in other context. Transferability was achieved by thick description in which the researcher described the phenomenon in the detail.

**Dependability.** Dependability was achieved by external audit to evaluate the accuracy and whether the results, discussion, and conclusion are consistent with the data. External audit was done by consultation with a thesis advisor and peer review from an expert.

**Confirmability.** Confirmability shows that the findings are formed by the respondents, and not by the researcher bias, motivation, or interest. Confirmability was achieved by triangulation which used multiple data resources including graphic representations, interview transcriptions, and reflexivity using a daily journal that was written by the researcher during data collection.

# Chapter 4

## Findings and Discussion

Gadamerian philosophy underpinned hermeneutic phenomenology was used to describe the meanings of the lived experiences of grief among Muslim nurses who cared for patients who died in the ICU. The findings of this study will be presented into three sections: (1) the description of the participants, (2) the lived experience of grief among Muslim nurses dealing with death of patients in intensive care unit (ICU), and (3) discussion.

### The Description of the Participants

Demographic data obtained from participants included age, gender, marital status, years of experience in nursing, years of experience in ICU, educational level, personal loss experience and experience of training in palliative care or end-of-life care. The participants' demographic data are described in table 1.

**Table 1**

*Participants' Demographic Data*

| Participant | Age | Gender | Marital status | Years of experience in nursing | Years of experience in ICU | Educational level | Personal loss experience | Palliative care/ EOL Training |
|---|---|---|---|---|---|---|---|---|
| 1 | 28 | Female | Single | 4 | 1 | Bachelor degree | No | No |
| 2 | 33 | Female | Married | 7 | 5 | Bachelor degree | No | No |
| 3 | 40 | Female | Married | 20 | 2 | Bachelor degree | No | No |
| 4 | 33 | Female | Single | 11 | 11 | Vocational | No | No |
| 5 | 25 | Male | Married | 3 | 1 | Vocational | Yes | No |
| 6 | 31 | Female | Single | 8 | 4 | Bachelor degree | No | No |
| 7 | 28 | Female | Married | 6 | 3 | Vocational | No | No |
| 8 | 30 | Female | Single | 7 | 3 | Vocational | No | No |

**Table 1**

*Participants' Demographic Data (Continued)*

| Participant | Age | Gender | Marital status | Years of experience in nursing | Years of experience in ICU | Educational level | Personal loss experience | Palliative care/ EOL Training |
|---|---|---|---|---|---|---|---|---|
| 9 | 27 | Female | Married | 5 | 1 | Vocational | Yes | No |
| 10 | 32 | Female | Married | 8 | 4 | Bachelor degree | No | No |
| 11 | 39 | Female | Married | 17 | 2 | Vocational | No | No |
| 12 | 30 | Female | Married | 7 | 6 | Bachelor degree | No | No |
| 13 | 37 | Male | Married | 14 | 1 | Bachelor degree | Yes | No |
| 14 | 32 | Male | Married | 6 | 2 | Bachelor degree | No | Yes |

Table 1 shows the description of 14 participants. Eleven participants were women and three participants were men with ages ranged from 25 years to 40 years (mean=32). Four participants were single and ten participants were married. The length of experience in nursing ranged from 3-20 years (mean=9). The length of experience in ICU ranged from 1-11 years (mean=3.3). Thirteen participants did not have experience in palliative care or end-of-life care training and one participant had experience in end-of-life care training.

The graphic representations, the background and experience of grief of each participant will be presented as follow.

**Table 2**

*Participants' Graphic Representations*

| Participant | Graphic Representation | Note |
|---|---|---|
| P1 | | The smile lady in the left and the nurse with the patient at the right.<br><br>The left side is the representation of hope and right side is the reality when the caring is not successful.<br><br>The participant stated: 'sad' and 'disappointed'. |
| P2 | | The picture of book and the watering flower.<br><br>The book represents the valuable knowledge in ICU and the watering flower as representation of care. |
| P3 | | The picture of crying nurse near patient's bed.<br><br>"Perawat" in the left means nurse.<br>"Pasien" means patient<br>"Sedih" means sad |

**Table 2**

*Participants' Graphic Representations (continued)*

| Participant | Graphic Representation | Note |
|---|---|---|
| P4 | | The picture of nurse in the middle between the patient in the bed and the family member. The participant stated the expression of nurse as empathy but should not get carried away with the death of the patient. |
| P5 | | The fallen leaves from a big tree represent the participant's feeling of empathy and sadness when he experienced the death of patients with the similar characteristic with his family members. |
| P6 | | The picture of stair and cloud at the end of the stair.<br><br>The stair is representation of her grief experience towards the cloud which is hereafter. |
| P7 | | The picture of patient's husband holding the baby represents the concern of the participant about the bereaved family member. |

**Table 2**

*Participants' Graphic Representations (continued)*

| Participant | Graphic Representation | Note |
|---|---|---|
| P8 | | The picture of a nurse with the expression of sad near patient's bed. |
| P9 | | The picture of patient's bed with the cloud of two persons shows nurses thought when caring for patient with the same characteristic as family members.<br><br>The book in the right side is the representation of knowledge |
| P10 | | The picture of blossom flower in the left and the withered flower in the right side.<br><br>The blossom flower is the representation of life and the withered flower as the death. |

**Table 2**

*Participants' Graphic Representations (continued)*

| Participant | Graphic Representation | Note |
|---|---|---|
| P11 | | The patient in the left side and the crying patient's child in the right side to show the concern of participant's about the bereaved family member, especially the child. |
| P12 | | The picture of patients with the monitor representing the technologies in ICU. |
| P13 | | The picture of patient's family in the center as the concern of the participant about the bereaved family member. |
| P14 | | The picture of the patient in the bed with the angel of death in the right side and the patients' family in the bedside. |

**Participant 1.** Participant 1 is a female nurse. She is 28 years old. She has four years experiences in nursing and one year experience in ICU. Previously she worked in psychiatric hospital for two years and then moved to general hospital. She is a bachelor graduate. Her latest experience in dealing with patient's death was one week before demographic data was taken. She does not have experience in palliative care or end-of-life care training. The memorable death of her patient which caused her grief was a death of a post-partum young lady. She felt the grief because the patient was still young and should have more chance to live. She also expressed her expectation that the patient got better. She stated that the goal of caring was to make patient recover, but sometimes the reality did not meet her expectation. She described that memorable patient as a 25 years old woman who should have chance to live. She drew a picture of a smile woman in the left side as a representative of chance to live as what she expected and a picture of a patient with nurse at the bedside in the right side as the reality. She expressed her grief story dealing with patient's death with the word 'sad'and 'disappointed' because unsuccessful caring that ended up with the death of the patient.

**Participant 2.** Participant 2 is a female nurse. She is 33 years old. She is married and bachelor graduate. She has seven years of experience in nursing and five years of experience in ICU. Her latest patient's death was two weeks before demographic data was taken. She had experience in ICU training but no experience in palliative care or end-of-life care training. She expressed her grief story by stating feeling sad, feeling guilty, and neglecting the situation of death. She shared a story of a patient's death in which she did not have chance to deliver direct current (DC) shock to save that patient. She expressed as if she had chance to deliver DC shock at that time, the patient might still alive. She was teary and neglected eye contact with

the researcher while telling that story. The feeling guilty does not disappear until now. This condition influenced her reaction later on. She tried to maintain patient's life during her shift by bagging and doing what she could do until her shift ended. She admitted to avoid the death's situation by maintaining patient's life or hiding from the situation. She drew the picture of book as a representative of valuable knowledge in ICU to maintain patient's life and watering flower as a representative of nursing care. She reflected the patient as the flower. If the flower is not watered and looked after carefully, the flower will wither and die. So does the patient. If the patient is not cared carefully, the patient may die. Nevertheless, she valued the importance of knowledge in providing care for the patients.

**Participant 3.** Participant 3 is a female nurse and married. She is 40 years old. She has 20 years experiences in nursing and two years experiences in ICU. She is a bachelor graduate. She started working after her diploma and later on continued her bachelor degree. Previously she was in charge at general ward and hemodialysis unit. Last two years, she was moved to ICU. She does not have experience of being trained in palliative care or end-of-life care. Her latest patient's death was one month before the demographic data was taken. She expressed her grief by stating sad, crying, and close connection with the patients. She described the environment in ICU as the limited number of the patients, exposed beds in front of nurse station, total care type of patient in which nurses assist to fulfill patients' need, and longer contact with the patients compared in other ward. These conditions create close relationship with the patients. She admitted she once cried when the patient died. She drew a crying nurse near the dead patient at the bed to represent her grief experience in dealing with the death of the patient.

**Participant 4.** Participant 4 is a female nurse and single. She is 33 years old and vocational graduate. She has eleven years of experience in nursing and ICU. She started working as a nurse in ICU and never being transferred to other ward. Her last patient's death was three months before demographic data was taken. At the time demographic data was taken, she was just back to work after three months leave for ICU training in another province. She does not have experience in palliative care or end-of-life care training. Regarding her grief experience in dealing with the death of the patients, she expressed by upset and disappointed when the patients could not be saved. She emphasized 'total care' as the characteristic of ICU patients in which nurses help to fulfill every patient's need. Therefore, the relationship between nurses and patients in ICU is close. She admitted to feel satisfied when the patient recovered and felt upset when the patient died. She drew the picture of a nurse near patient's bed with the ICU equipment surrounding as the environment of everyday life in ICU and a family member. She stated the expression of nurse as 'expression of empathy' as she reflected the picture she has drawn. She expressed feeling empathy but should not get carried away when the patient died.

**Participant 5.** Participant 5 is a male nurse and married. He is 25 years old and vocational graduate. He has three years of experience in nursing and one year experience in ICU. He does not have experience in palliative care or end-of-life care training. His last patient's death was one month before demographic data was taken. Regarding his grief experience, he drew a big tree with the fallen leaves. He reflected himself as a big tree, having strong heart and unlikely to get carried away. However, he admitted to feel sadness in some conditions when the patients died, particularly kids patients and elder patients. He shared that he has many little nephews and they are close to him. He also shared that his father already passed away. The death of the

patients with the similar characteristic with his family member recalled his memory of his own loss. When he cared for the corpse, he directly remembered his parents. In such condition, he felt sadness and empathy for the patient as he drew as fallen leaves from the tree. He mentioned the fallen leaves as his feelings concerning the death of the patients which are sadness and empathy.

**Participant 6.** Participant 6 is a female nurse and single. She is 31 years old and bachelor graduate. She has eight years experiences in nursing and 4 years of experience in ICU. Her last patient's death was one month before demographic data was taken. She had experiences in ICU, Intensive Cardiac-Care Unit (ICCU) and Basic Trauma and Cardiac Life Support (BTCLS) training but does not have experience in palliative care or end-of-life care training. Regarding her grief with patients' death, she expressed empathy, sad and disappointed due to expectation of patients' recovery. Moreover, she also expressed obtaining the meaning from her experience. Witnessing the death of the patients cause her to think about her future death and after life. She drew the pictures of a stair and a cloud at the end of the stair. A stair is representative of her grief experience and the cloud is hereafter. The stair is like a journey toward the cloud, as same as her experience leads her to be aware about hereafter.

**Participant 7.** Participant 7 is a female nurse. She is 28 years old. She is married and vocational graduate. She has six years of experience in nursing and three years experiences in ICU. Her last patient's death was two weeks before demographic data was taken. She had experiences in BTCLS and Advanced Trauma Care for Nurses (ATCN) but she did not have experience in palliative care or end-of-life care training. Regarding her grief experience with the deaths of the patients, she mentioned getting carried away if the dead patient was postpartum women. She shared that she

once shed tears when a patient after giving birth died. She reflected the condition of the patient as her condition. She shared that she also has a baby. She drew the picture of a patient's husband carrying the baby as representative of her concern with patient's condition.

**Participant 8.** Participant 8 is a female nurse and single. She is 30 years old and vocational graduate. She has seven years of experience in nursing and four years of experience in ICU. Her last patient's death was one day before the demographic data was taken. She had experience in ICU training but she did not have experience in palliative care or end-of-life care training. Regarding her grief experience with the death of the patients, she expressed feeling of sadness as she imagined as if the patient was her family. With her role in ICU, she built close relationship with the patient and family. She admitted that close relationship with her patient and the way the family lost influenced her reaction in dealing with the deaths of the patients. She drew the picture of a sad nurse near the bed of the patients to represent her grief experience.

**Participant 9.** Participant 9 is a female nurse. She is 27 years old. She is married and vocational graduate. She has five years experiences in nursing and one year experience in ICU. She had experience in ICU basic training but she did not have experience in palliative care or end-of-life care training. Regarding her grief experience with the death of the patients, she expressed feeling empathy because she reflected the situations to her personal life. Caring for the elderly patients reminded her of her parents. Caring for the young post-partum woman reminded her of her postpartum memory. Caring for the young man reminded her about her late brother who passed away when he was 21 years old. Therefore, she tried to provide best care for the patients. In providing best care, she valued the importance of knowledge. She drew the picture of patient in bed with the cloud above the beds as she imagined the

patient as her family members. Under the bed she wrote "21" as she told her brother died in his 21 years old. In the right side, she drew a picture of book as an emphasizing of the importance of the book.

**Participant 10.** Participant 10 is a female nurse and married. She is 32 years old and bachelor graduate. She has eight years of experiences in nursing and four years experiences in ICU. She had experience in BTCLS training and did not have experience in palliative care or end-of-life care training. Her last patient's death was two weeks before demographic data was taken. Regarding her grief experience with the death of the patients, she expressed finding the lesson. Witnessing many deaths of the patients increases her awareness of her future death and preparation to face the death. She drew the picture of two flowers. The blossom flower in the left side is the representative of life and the withered flower in the right side is the representative of death.

**Participant 11.** Participant 11 is a female nurse. She is 39 years old. She is married and vocational graduate. She has 17 years of experiences in nursing and two years experiences in ICU. She does not have experience of being trained in palliative care or end-of-life care. Her last patient's death was one month before demographic data was taken. Regarding her grief experience with the death of the patients, she admitted feeling sad and got carried away when the dead patients were post-partum women. She reflected patient's condition to her personal life as she is also a woman, a mother, and has experience in giving birth. In addition, she also mentioned that her reaction was influenced by the family members. When the patient died, the family cried, she would also cry because she felt as if the situation happened to her and her family. She drew the picture of a patient at the left side and the crying child at the

right side to show her concern of the left family member particularly the child of the female patient who died after giving birth.

**Participant 12.** Participant 12 is a female nurse. She is 30 years old. She is married and bachelor graduate. She has seven years experiences in nursing and six years experiences in ICU. She had experience in ICU basic training and did not have experience in palliative care or end-of-life care training. Her last patient's death was one month before demographic data was taken. She shared the story of one memorable death of her patient who died eight years ago. When she cared of the corpse, she saw black fluid flowed from patient's nose. She really regretted why she did not insert naso gastric tube (NGT) in advance. She expressed her feeling by saying regret, disappointed, and feeling guilty which linger for long time. She expressed that after the patients died she would recall her memory to find out what she missed to do and wondered why she did not do such and such thing in advance to save the patients. She drew the picture of patients in the bed with the monitor to show the environment of the ICU that is surrounded by the technologies that she wished she could have chance to apply or insert some in advance to save the patients.

**Participant 13.** Participant 13 is a male nurse. He is 37 years old. He is married and bachelor graduate. He has 14 years of experiences in nursing and one year experience in ICU. He did not have experience in palliative care or end-of-life care training. Her last patient's death was two weeks before the demographic data was taken. Regarding his grief experience due to the death of the patients, he admitted that his reaction was influenced by the conditions of the family and by his relation with the patients. He mentioned about his concern for family because he imagined as if the situation happened to him or his family. He drew the picture of the patient in the bed, and a family member in the center. Around that family member, there are several

things surrounding to express the concern of the family member which is also become the concern of him that influence the way he responded to the death of the patients.

**Participant 14.** Participant 14 is a male nurse and married. He is 32 years old and bachelor graduate. He has six years of experience in nursing and two years experiences in ICU. He had experienced in palliative care training. His last patient's death was two weeks before demographic data was taken. As he had been trained in palliative care, he expressed that in dealing with the deaths of the patients, he focused on the preparation of the patients in facing the deaths. For him, he emphasized on the spiritual support for patients and families. He drew the picture of patient in bed with three family members reciting the holy Quran near patient's bed. In the right side, above patient's bed, he drew what he called as the grim reaper, and above all he wrote "Allah" in Arabic letter. While reflecting the meaning of the drawing and the relation between the picture and his grief experience with the death of the patients, he stated that he focused on the spirituality in finding the meaning through his grief experience.

## The Lived Experience of Grief among Muslim Nurses Dealing with Death of Patients in ICU

This study revealed five thematic categories reflecting van Manen's life-worlds which are lived other, lived body, lived space, lived time, and lived things. Each thematic category will be described as follows.

**Lived other: Empathetic understanding.** The participants understand their own feeling of losing the patients as their own loss and the feeling of the bereaved family. Those conditions caused nurses to feel empathy as the response of their grief experience. Under empathetic understanding, there are two sub-themes: (1)

understanding the death of the patients as nurses own loss and (2) empathy with the loss of the bereaved family. Each sub-theme is described as follow.

***Perceiving the death of the patients as nurses own loss.*** Participants experienced grief towards the death of the patients because they perceived patients' death as their own loss. In this condition, the participants reflected the patients' conditions, such as age, gender, and other personal condition and they related to their personal life that created grief and more sympathy. When the dead patient was child, participants thought about their children at home and imagined as if it was their child who died. A female participant, 33 years old, who is married and has kids mentioned:

> *"If the kid patient was admitted, I felt stress. I thought about my child at home. Even after I got home, I still thought about that patient".* (P.2, L101-103)

Moreover, the grief towards patient's death was also experienced by nurses when they met the patients with the same characteristic with their family members who already passed away. The same characteristic included age, the physical appearance, and the circumstance of death and the patients' family. The death of those patients reminded them of their own loss and resulted to the grief. A female participant, 39 years old, whose father already passed away, declared:

> *"If the patient was man at the same age with my father, and he had children who visited him, I remembered my father, maybe because my father already passed away. I remembered my father right away. I remembered that moment when my father passed away".* (P.11, L23-25)

Another participant, 27 years old female nurse stated:

> *"If the dead patients were elderly, I reflected on them as my parents. I saw them as my own parents. That was for the elderly patients, for those people who were at the same age as my parents. So, I imagined if that situation*

*happened to my parents. Oh God, suppose the patient was my mother. I thought about my family, my parents".* (P.9, L2-L7)

The illustration of this grief experience is depicted by fallen leaves from a big tree. The picture was drawn by participant 5, a 25 years old male nurse. He described the big tree as a representation of a nurse with the strong heart, but when he was faced with the death of the patients who shared similar characteristics as his family members, he felt sadness and empathy in his heart like the leaves fell from a big tree. His picture is presented as follow.

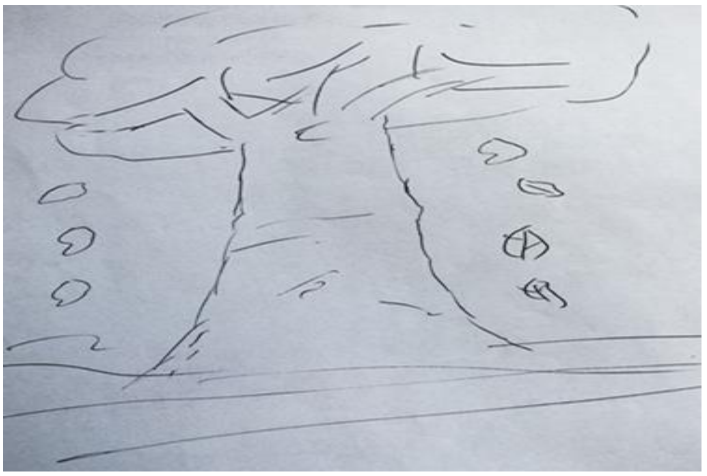

*Figure 1.* The fallen leaves

***Empathy with the loss of the bereaved family*.** Participants' grief towards patient's death is connected with the patient's family bereavement. Nurses understood the feeling of loss felt by the family and they appreciated it as they felt the same.

A female participant, married and 28 years old, drew a picture of a patient's husband holding the baby left by the dead patient as representative of her concern for patient's family. She mentioned that she got carried away if the dead patient was postpartum woman. She stated:

*"If the patient died, I thought about how the baby's life would be and how the husband would take care of the baby"* (P.7, L11-12)

In addition, the reaction of the family influenced nurses' grief of the patients' death. A female participant, 28 years old and has one year experience in ICU stated:

> *"Yes, it was sad. When I saw the patient died, the family cried, and I cried too".* (P.1, L71-72)

Participant 8, a female nurse, 30 years old and has four years of experience in ICU expressed feeling of sadness as she imagined as if the patients were her family. She admitted close relationship with patients and families influence her reaction in dealing with the death of the patients. She stated:

> *"From the way they (families) lost, I got carried away sometimes. I was once almost… almost cried*". (P.8, L58-60)

Participant 11, a female nurse and 39 years old who has 17 years of experiences in nursing admitted that her reaction was influenced by the family members. If the family members cried when patient died, she would also cry because she felt as if the situation happened to her and her family. She declared:

> *"Then, if I saw their family cried, I felt sad. …….. If they (patients' family) cried, I would cry also. But if they didn't cry, I was okay. However, I felt… you know when people die, there must be sad*". (P.11, L16-23)

*Figure 2.* Empathy with the loss of the bereaved family

**Lived body: Balancing self.** Balancing self indicates how participants react with their grief due to patients' death. When the participants experience grief, they perceive the death as the loss of their successful caring. Nevertheless, at the same time nurses feel grief, they are supposed to continue their professional duty. This condition puts the participants in the middle position in which they need to balance their grief reaction due to loss of their successful caring and continue their professional duty by controlling their emotion. Under this thematic category, there are two sub-themes which are: (1) loss of successful caring and (2) emotional control.

***Loss of successful caring.*** In this study, nurses experienced the grief due to the loss of their successful caring. When nurses provide care for patients, they have goal to make patients better. However, some patients cannot be saved and die. They might blame themselves for the death of the patients caused by the unsuccessful caring given to the patients. Feeling the loss of successful caring was expressed by a

female participant, 33 years old and has eleven years of experience in ICU, as follows.

> *"Those patients whom we thought would get better. With appropriate care, the patients should get better. But sometimes, when we thought like that, the patient died. I felt upset, because I felt when I took care of them, the patients would be better".* (P.4, L37-40)

The illustration of this grief experience was depicted by a picture of smiling woman on the left to show nurses' goal of caring and the patient in the bed and nurse at the bedside to show the reality. The participant stated:

> *"Maybe I feel disappointed. Because when I take care of the patients and the patients show improvement, I feel happy, the caring is successful. But if the patient dies, I feel disappointed and sad".* (P.1, L41-43)

*Figure 3.* Loss of successful caring

***Faith controls emotion.*** At the same time nurses experience the grief, they understand that they have to continue and maintain their work professionally. Therefore, they tried to control their emotion. The excerpts of this sub-theme are stated below:

*"I kept it inside so my tears were not shed. I thought it did not seem good if my tears were shed. So, I hold them back inside".* (P.1, L79-80)

*"I have learnt from the experiences that involving your emotion…. it is okay to involve your emotion but it shouldn't interfere with your work".* (P.6, L98-100)

*"I anticipate not being too much empathy because being too much will disregard other patients".* (P.13, L48-49)

The participants employed spirituality and rely on faith to help them controlling their emotion. Participant number 11, female and 39 years old, stated that she relied on prayer to help her control her emotion. She stated:

*"For me personally, I prayed. "Oh Allah, please strengthen me not to shed my tears". Sometimes I recite prayer".* (P.11, L38-39)

Another participant, female and 32 years old, who has four experiences in ICU mentioned that religion teaching regarding death assisted her to deal with patients' death. She stated:

*"Since there is a statement in our religion that the death is already decided, so I feel it affects my psychology to deal with patients' death".* (P.10, L50-L52)

The illustration of this experience is depicted by a picture of a nurse standing near the patient's bed and family members. The participant stated:

*"When we just can explain to the family the condition of the patients, we are not supposed to get carried away".* (P.4, L31-32)

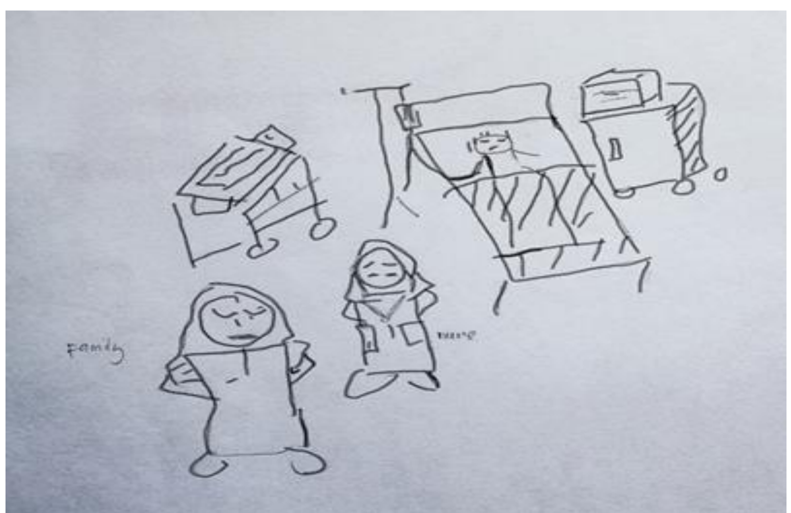


*Figure 4.* Emotional control

**Lived space: Space of avoidance.** In this study, lived space guides the reflection about how space is felt by nurses in their grief experience. The space influenced the experience of nurses as the nurses built the relation with the space they lived in.

Under this thematic category, there are two sub-themes: (1) the closer space, the deeper grief, and (2) not being there. Each sub-theme will be described as follows.

***The closer space, the deeper grief.*** The environment of the ICU supported the nurses' role to create a close connection with patients. The environment of the ICU was described by participants as having a small number of patients, arranged beds in front of the nurse station, and the types of patients are total care. In those conditions, the space of ICU was experienced as a close space which created a deeper connection with the patients. Deeper connection with the patients caused deeper grief felt by nurses when their patients died. One participant, female nurse and 40 years old who has twenty years of experiences in nursing expressed that the environment of ICU make closer relationship with the patients compared to other wards as she was previously in charged. She said:

*"Here in ICU, because we help to fulfill every patient's need, so there will be feeling like… how to say? The relationship is closer. For example, in the morning, we helped patients for bed bath, we feed them so that we feel closer to them ………………. Here (in ICU), the patients are in front of our eyes, the number is quite few, there are monitors, and we feel closer to them, so that the grief because of their deaths is deeper too".* (P.3, 91-105)

Another participant stated:

*"You know, when we work in ICU, half of our soul is with patients and their family. I mean, if in general ward, most of them are partial care and they have their family with them. But in ICU, the patients are total care and we fulfill their needs. So, I felt upset when the patient died".* (P.4, L51-54)

The closeness between the nurses and patients was described by one participant by the picture of a crying nurse near the dead patient.

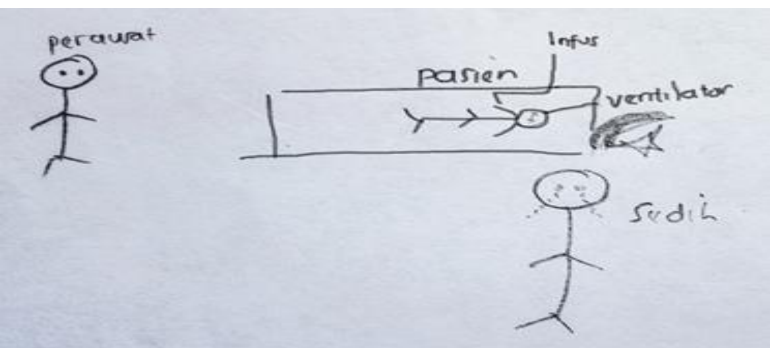


*Figure 5.* The closer space, the deeper grief

***Not being there.*** The environment of ICU where nurses experienced the grief due to the death of the patients makes the memory stays. Even though the feeling of the grief disappear somewhile after the death took place, the feeling of the grief may come again when nurses experience the same situation.

With such that situation, the grief experienced by nurses due to the deaths of the patients became a hurtful experience that some nurses did not want to be in that situation of patients' death. One participant stated:

> *"Sometimes I ran away, hiding. That's it. I ran away. I hid. Sometimes my colleagues will call me. But, I feel pity easily. Sometimes I cannot face that (patients' death)".* (P.2, L71-L73)

Other participants stated:

> *"My coping is by looking away for a while. I will look away for a while*". (P.5, L36-37)
>
> *"For me personally, it's better to avoid (when the patient died) otherwise I would get carried away".* (P.1, L75-76)

**Lived time: Anticipating the future of own death.** Lived time can be experienced as the wishes, plan, and goals that are found from dealing with the death of the patients. Anticipating the future of own death indicates hope and expectation for future death. When the participants feel grief due to the death of the patients, the time is experienced as anticipating the future of own death which will be described into two sub-themes, which are: (1) awareness of their future death and (2) journey towards hereafter. Each sub-theme will be described as follows.

***Awareness of their future death.*** Witnessing the death of the patient increases their awareness of future death. Seeing many deaths makes them think about their future death and how they want to die. A participant stated:

> *"When I dealt with the dead patient, I thought this is how I will be later".* (P.1, L23-24)

Other participants stated:

*"For me, I think death is a must and will come. But we don't know the time. There are different responses of patients at the dying time. Some are calm, some others are lamented. There, I got lesson, which way I will be later. That's the reflection*". (P.5, L49-53)

*"For me personally as a Muslim, I'm looking at myself. You know whether elderly, young, in sudden, when the time comes, then people just go. Maybe it's like I'm asking myself whether I'm ready to face my death. So, automatically, there will be motivation for us to do good things, to do good things as what I learnt in my religion to prepare myself for the death. Because everyone will go there (to die). But, yeah… when patient died whether in sudden or not, it will affect me. Nevertheless, I will reflect to myself where I will go after this (after die). When I saw those patients, I thought I would be like them one day".* (P.13, L98-107)

This grief experience is depicted by the picture of the blossom flower and withered flower as the illustration of life and death. Life is illustrated as the blossom flower and death as the withered flower. The picture is presented as follows.

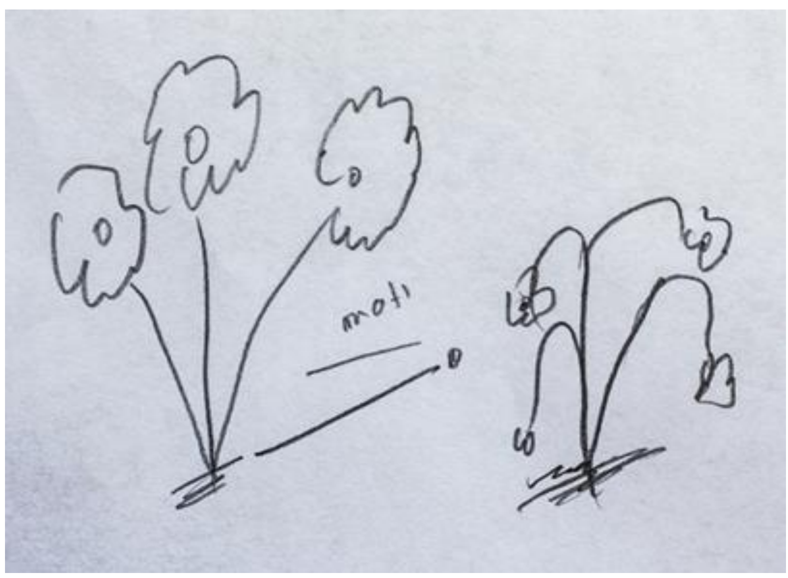


*Figure 6.* Present life and future death

***Preparation for hereafter.*** As the participants' awareness of their own death increases, they think about the preparation to face death and there hereafter. The excerpts are presented below.

*"Yeah, it got me thinking whether my good deeds are enough already"* (P.1, L27)

*"Death is a must. Death has been decided, but the point is how our preparation is. So, I have to prepare myself and my faith. So, when the death comes, I'm prepared to face the days after life".* (P.10, L3-L8)

*"Yes… this experience reminds me that during this life, I should be tawakkul (trusting in God's plan) because age doesn't guarantee me anything".* (P.11, L58-59)

The illustration of this grief experience is depicted by a picture of a stair and cloud at the end of the stair. The stair is the representation of her grief experience towards the cloud which is the hereafter.

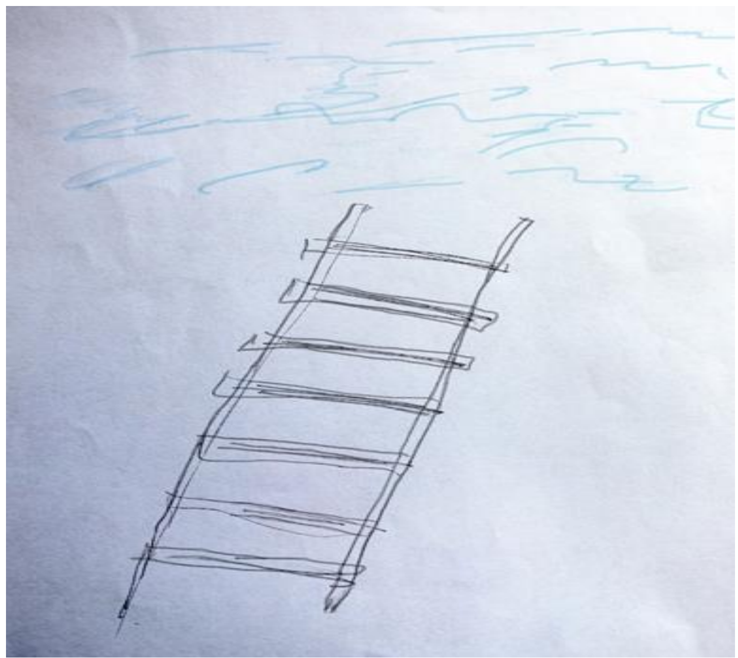

*Figure 7.* Preparation for hereafter

**Lived things: Relating technologies in bargaining.** Regarding the grief, lived things guide the reflection about how things or technologies are experienced by nurses in dealing with the death of the patients. Under this thematic category, there are two sub-themes which are: (1) technologies as life-saving things and (2) lack of proficiency in technologies of care. Each sub theme will be described below.

***Technologies as life-saving things.*** The ICU is a setting surrounded by technologies described by participants as direct current (DC) shock, mechanical ventilator, endotracheal tube (ETT), etc. Those technologies become the nearest materials or things to the participants. When their patients died, the participants bargained by stating if they could deliver or had sufficient knowledge and skill about those technologies, their patients would be saved. They bargained with technologies because in their grief experience, they felt technologies were as life-saving things which could save their patients' lives.

One participant said:

> *"For example the patient got VT (Ventricular tachycardia), then I had no chance to use DC shock at that time, then the patient died. Then, I keep remembering it. Oh, why didn't I use DC shock at that time? Suppose that I used DC shock, the patient might still be alive".* (P.2, L36-39)

Another participant expressed:

> *"There was a patient with pneumothorax. He was inserted with ETT. Before he died, his condition decreased rapidly. He was restless. He died finally. Then, I felt…. Hhmm, how could that happen? I asked myself why the patient was restless before he died. Why didn't I fix his ETT in advance? Maybe there*

*was trouble with his ETT. Maybe there was trouble with his airway. I regretted*". (P.9, L243-245)

The illustration of this sub-theme is depicted by a picture of patients in their beds with the monitor to show the environment of the ICU that is surrounded by technologies that she wished she could have chance to apply or inserted in advance to save the patients.

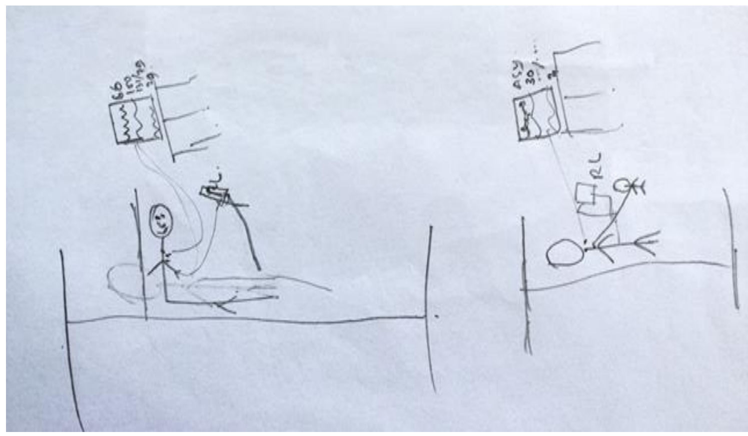


*Figure 8.* Technologies as life-saving things

***Lack of proficiency in technologies of care.*** As they are surrounded with the technologies, they realize that knowledge and skill about technologies are valuable in the ICU. Lack of proficiency in technologies of care in the ICU made them feel powerless and guilty when their patients died. Some of the excerpts are presented below.

*"But, that knowledge, sometimes I feel I don't get them all. So, I think knowledge is important……… For example, here we use a ventilator. We have to know how to control it. If it beeps, sometimes its volume decreases, or something is wrong, and we need to know what we should do. Mostly, if it beeps, then we observe a while whether it still beeps or not. Actually, for those who are expert with a ventilator, like anesthetists, they know. If it beeps, then*

*what to increase. So, we need to have basic knowledge about that, like from training, we can update our knowledge".* (P.9, L22-44)

*"Sometimes I feel I don't have sufficient knowledge and skill. I mean, in ICU, nurses need to have basic skill about ICU, for example how to operate ventilator, how to control the ventilator, what to do if the ventilator is leak. Sometimes I thought my knowledge was not enough, so I couldn't provide optimum care for my patients".* (P.13, L82-88)

The illustration of this sub-theme is depicted by a picture of a book as a representative of a valuable knowledge in the ICU to maintain a patient's life and watering a flower as a representative of nursing care. Like the flower, if the patient is not cared for carefully without adequate knowledge and skill, the patient may die. The picture is presented as follows.

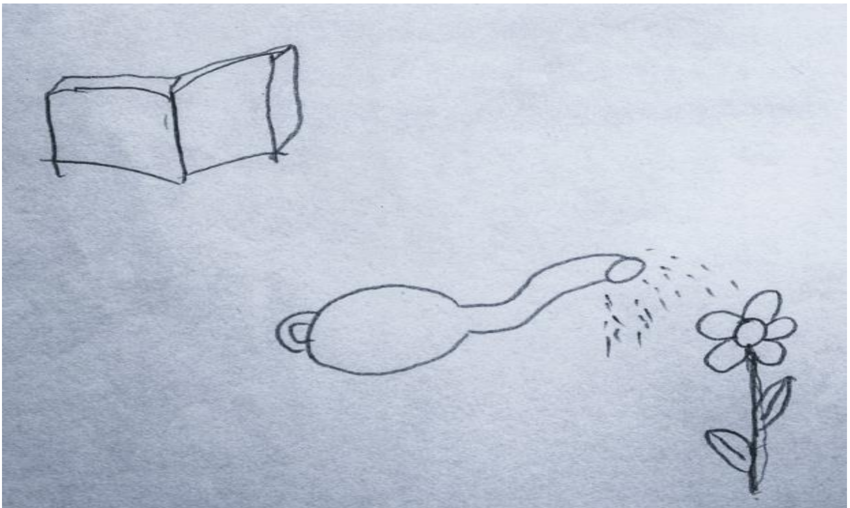

*Figure 9.* Realizing not proficient in technologies of care

## Discussion

The discussion of the findings will be presented based on the category of the five life-worlds as below.

**Lived other: Empathetic understanding.** Lived other is explained as lived relation that gives a guidance to reflect how a phenomenon is experienced by self in the personal space that is shared with others (van Manen, 2014). In this study, the grief among Muslim nurses is experienced as empathetic understanding. Empathetic understanding is defined as a condition to be more self-aware by learning and trying to feel other's feeling (Harvey, 2007). The grief among Muslim nurses is influenced by their relation with others, particularly patients and families. The participants responded as empathetic understand because they felt the deaths of the patients as their own loss and they understand the loss felt by the bereaved family.

Feeling patients' death as nurses own loss is experienced by nurses as they reflected on patients' personal life and they related it to their life. They understand as if the same situation happens to them. This finding accords with the previous study by De Swardt and Fouché (2017) about the experience of ICU nurses delivering post mortem care on patients who died in the ICU which revealed that ICU nurses referred to patients as their family members resulting in personalizing the deaths of the patients.

In addition, it is also connected as they met patients with the same characteristics as their family member who had already passed away. The death of those patients recalled their memories about their own loss. Due to having a similar experience about loss, nurses understand how the bereaved family feels. Similarly, a previous study by Shimoinaba et al. (2014) stated that seeing patients' death resulted in nurses remembering their personal loss and experience of grief, particularly when the patients were similar to their loved ones. Similarities include symptoms, age, circumstances of death and family structure. This condition creates the possibility of recalling painful memories and emotions that cause grief. Moreover, the participants

also felt empathy dealing with patients with same characteristic with their family members even they are still alive. They experience the grief before the actual death of the patients. The grief that occurs before the actual death refers to anticipatory grief. Nielsen et al. (2016) described anticipatory grief as a reaction or feeling or grief which appears before the death. Anticipatory grief becomes a factor of coping style after loss which is connected to the relationship between nurses and patients.

Moreover, empathetic understanding shows nurses' ability to feel others' feeling. Nurses feel grief towards patients' death because they witness how the patients' family reacted to their loss. One of the fundamental patterns of knowing in nursing is aesthetic knowing. Carper (1978) emphasized empathy as the capability of nurses to feel another's feeling. This leads to the empathy that nurses experienced as they responded to the situation. They understand the loss experienced by family that leads to an empathetic response and grief. Their understanding of the family's loss also links with the first sub-theme, understanding the loss of patients as their own loss. Nurses understand other's loss because they have experience with the loss. Similarly, previous study by Wilson (2014) revealed that the reaction of patients' family influenced nurses in dealing with the deaths of the patients.

**Lived body: Balancing self.** Lived body explained the reflection how a body is experienced about the phenomenon that is studied (van Manen, 2014). In this study, lived body guides the reflection how the nurses react to the death of the patients. Balancing self is the situation where nurses place themselves in the middle position between feeling the death of the patients as loss of their successful caring and controlling their emotions.

As the grief is a response of loss, nurses experienced the death of the patients as loss of their successful caring. They experienced the grief not only due to the loss

of their patients, but also loss of their success in caring the patients. When nurses take care of their patients, they have goals and expectation that their patients get better. However, when their expectations were not met and the patients cannot be saved, they perceived the causes of the deaths as their unsuccessful caring. They lost their successful caring which they expressed by feeling guilty, upset, disappointed and sad, being unable to provide the best care, and recalling their memories to find any mistakes they could probably have made.

This finding concurs with the previous study by Conte (2014) that investigated experience related to loss and grief among pediatric oncology nurses. This study revealed that in conditions where nurses perceived their care was not optimum, they expressed feelings guilt which can impose on them psychologically. Kavanaugh's behaviors and feeling concept (as cited in Brosche, 2003) proposed seven stages in grieving which can explain more practically nurses' grief experience of the death of the patients. In the fourth stage of this model, guilt, explained that after the death of the patients, nurses begin to question their care and skill as healthcare providers. In this stage, they feel the patient's death as their own personal failure.

Despite the feeling of unsuccessful caring, nurses are expected to maintain a professional attitude in dealing with patients' death. In this study, it was revealed that at the same time they felt grief, they also controlled their emotion. Controlling emotion was expressed by trying not to shed tears or not to involve too much emotion in order not to interfere with their work or disregard other patients. Controlling their emotion can be related to two points. Firstly, 'professional stigma' that occurs among nurses in which nurses are supposed to deliver professional care to patients and family concerning grief, but they cannot accept their own and their colleagues grief (Wisekal, 2014). In this study, it was found that the participants admitted it does not seem good

if their tears were shed. Secondly, this related to ‘disenfranchised grief’. Doka (as cited in Wilson, 2014) explained disenfranchised grief as an unknowledgeable grief that is not recognized publicly. The grief experienced by nurses due to the death of patients was not supposed to be acknowledged openly causing them to control their behavior and emotion in the way that is socially accepted by the community.

**Lived space: Space of avoidance.** Lived space guides reflection on how space is felt regarding the phenomenon that is studied (van Manen, 2014). In this study, lived space guides the reflection about how nurses’ relationship with the space related to their grief experience. Lived space described how space is experienced by nurses before the deaths of the patients, at the time of death, and after the deaths. The space influenced the experience of nurses as the nurses built the relation with the space they lived in.

In this study, the space of the ICU is experienced by nurses as closer space which leads to deeper connection between nurses and patients. The space of the ICU is described by participants as a limited number of patients, an arrangement of beds in front of the nurse station, limited presence of family members, and total care of patients that allows nurses to fulfill every patient’s need. Those conditions caused nurses to build deeper connection with the patients. The majority of participants who were previously in charge of a general ward highlighted that their relationships with patients in the ICU are deeper compared to those in a general ward. In expressing their connection with the patients, most of them emphasized “Here in the ICU” to confirm that it was the space of the ICU which allowed them to build deeper connection with the patients.

This closer space creates deeper grief when nurses lost the patients. Deeper grief resulted to some longer memories of the deaths of the patient. Some memories

cannot disappear because somehow they experience the same situation and causes the memories back which could be guilty, regret, sad, etc. Those uneasy feelings will later affect the way nurses feel about the space they are in. Some participants did not want to be in the death situations of the patients. They expressed their avoidance by stating "hid", "ran away", "looked away", and "better to avoid". The participants admitted their avoidance was the way they cope with the situation.

Previous study by Shimoinaba et al. (2014) revealed that nurses distanced themselves from patients and family in order to protect themselves from emotional pain because of the loss. In addition, another study by Conte (2014) found that 'alienation' was used by nurses as a method of self-protection from emotional distress caused by experiencing the deaths of the patients. The avoidance of the space shows the ineffective way of coping with grief which may lead to complicated grieving. In this study, from the total of fourteen participants, only one participant had experience of end-of-life care training. The remaining participants did not have experience in palliative care or end-of-life care training and admitted having their own way to cope with their grief experience. Thus, this finding proposes the needs of professional grief management which will be beneficial in the long run in adjusting to the everyday space they live in.

**Lived time: Anticipating the future of own death**. Lived time guides the reflection about how time is felt by nurses regarding their grief experiences in dealing with the death of the patients. Lived time can be experienced as the wishes, plans, and goals that are found from their grief experiences. In this study, lived time is experienced as anticipating the future of own death. Witnessing the death of the patients gives them time to think about their own death which increases their awareness about their future death and what they will face after death. Awareness is

defined as knowledge and understanding that something is happening and real (Merriam-Webster dictionary). Seeing various conditions of patients at their time of death leads nurses to plan and wish how their future dying time will be, what they should prepare to face their death and hereafter.

Nurses expressed their understanding that death is a must and will come at an uncertain time. They come to realize that ways to die are various and they wished for the way they want to die. This finding coincides with an earlier study by De Swardt and Fouché (2017). Their study found that ICU nurses verbalized how they wish to die if there was a choice. They expressed their wishes to die peacefully in their home or in a vehicle car accident, not suffering so much and their covered body in post mortem care. This support that nurses' awareness of their death increased when their patients died.

Furthermore, this study also revealed nurses wishes of the hereafter. This finding links with Islamic teaching that the Muslim will encounter the hereafter in which Muslims will face an eternal life and will be rewarded or punished based on how they live their life. One of the verses in Holy Quran stated: "Say, "God causes you to live, then causes you to die, then He will assemble you for the Day of Resurrection, about which there is no doubt", but most of the people do not know" (Quran, 45: 26). The participants understand that they will meet the eternal life after death for which they have to prepare from now.

**Lived things: Relating technologies in bargaining.** Lived things guide the reflection about how things are felt in the grief experience in dealing with the death of the patients. Heidegger (as cited in Adam & Yin, 2017) defined things as what are the nearest from human. Things are not merely objects without the meaning, but the things are lived and connect humans with the outside of them. As the ICU is a setting

surrounded by technologies, what becomes the nearest to nurses are technologies. In this study, lived things are experienced as relating technologies in bargaining. This experience is resulted from valuing technologies as life-saving things which can save patients, but which also cause them to realize their lack of proficiency in technologies of care.

Based on Kübler-Ross (2003), the third stage of grief is bargaining. In this stage, people try to bargain or compromise the death with another thing. In this study, as technologies are the nearest things in nurses' everyday life in ICU, they refer to technologies in their bargaining. As Adams and Yin (2017) stated that things give the tone of meaning, the participants implicitly described the tone of the things as life-saving tone because they perceived the technological devices could save life and prevent the deaths. The participants stated if they could insert NGT, fix the ETT, or deliver DC shock in advance, the patient might still be alive. Furthermore, they realized the importance of knowledge and skill concerning the technologies. Lack of proficiency in technologies of care caused them to feel powerlessness and guilty when they could not help the patients. The death of those patients could stay for long time in their memory which causes longer grief.

There are several theories explained the concept of grief, including relationship/attachment theory, Kübler-Ross model, the task model, continuing model, dual-proses model, and meaning-making model. However, not all theories can be used to explain nurses' grief concerning the death of the patients. This is because the majority of the theories referred to individual loss of the loved ones and can be used more appropriate for the patients' family grief. Nevertheless, since the nurses' grief is a professional grief and the relationship between nurses and patients is different from

family and patients, the majority of grief theory cannot be applied for nurses' grief. However, some of the theories can be used to explain the situation of nurses' grief.

Kübler-Ross model explained five stages of grief which are denial, anger, bargaining, depression, and acceptance. However, this model was criticized due to the limitation of the stages. In reality, some stages don't occur in sequence and may over-lap each other. In this study, the most obvious stage that is experienced by nurses is bargaining. Kübler-Ross (2003) explained that bargaining is the stage when people try to compromise or bargain the death with something else. In this context, as nurses are surrounded with technologies in their everyday environment, they tried to relate those technologies in their bargaining stage. The bargained the death with something that they could do using some certain technologies. They bargain the death with the technologies of care.

Another theory also explains about the meaning from the grief experience. Meaning-making model by Niemeyer et al (as cited in Smit, 2015) explained that people find the meaning of life, death and the nature of life after from the experience of loss. Wortman and Park (2009) stated that people form spiritual meaning after experiencing loss. In this study, under the thematic category of lived time: anticipating the future of own death, the participants increase the awareness of their future death and try to prepare for their death and life after death.

Among those theories, Kavanaugh's seven behaviors and feeling as part of coping process (Brosche, 2003) can better explain nurses' grief. The seven behaviors are shock and denial, disorganization, volatile reactions, guilt, loss and lonely, relief, and reestablishment. Even not every stage is experienced by the participants, but some stages can explain the meaning of their grief experience, which are shock and denial, volatile reactions, and guilt.

The first stage is shock and denial. In this stage, nurses cannot accept the death and deny the death. In this study, under the thematic category of lived space: avoidance, it was found that the participants tried to neglect the situation of death, tried to maintain the life, and deny the death of the patients. The third phase is volatile reactions. The griever reacts by having certain feelings inside such as helplessness, hurt, and frustration, but they have to deny and bury the feeling. In this study, this phase was described as lived body: balancing self. In reality, nurses felt the grief inside but they tried to control their emotion as they believe they are supposed to do. Those cause them to balance themselves during the situation of grief.

Furthermore, in this study it was revealed that the participants used religion teaching to help them balancing themselves. They admitted doing dhizkr (prayer) to control themselves and rely on the Islamic teaching that the death has been decided and when a Muslim dies, the deceased will go back to God. In Holy Quran, it is stated that “To God we belong and to Him shall we return” (Quran, 2: 156).

The fourth phase, guilt. The griever feels guilty concerning the death. In this phase, the nurse could question his or her care and in a sense, could probably perceive the death of the patients as their personal failure. In this study, under the thematic category of lived body, a sub-theme ‘loss of successful caring’ was revealed. The participants expressed that the goal of care is to make patients recover. However, in the condition where the patients could not be saved, they expressed that their caring were not successful. Those theories explained several phases which were experienced by the participants even though not all stages were experienced in sequent in reality. The summary of thematic category is presented as the following diagram.

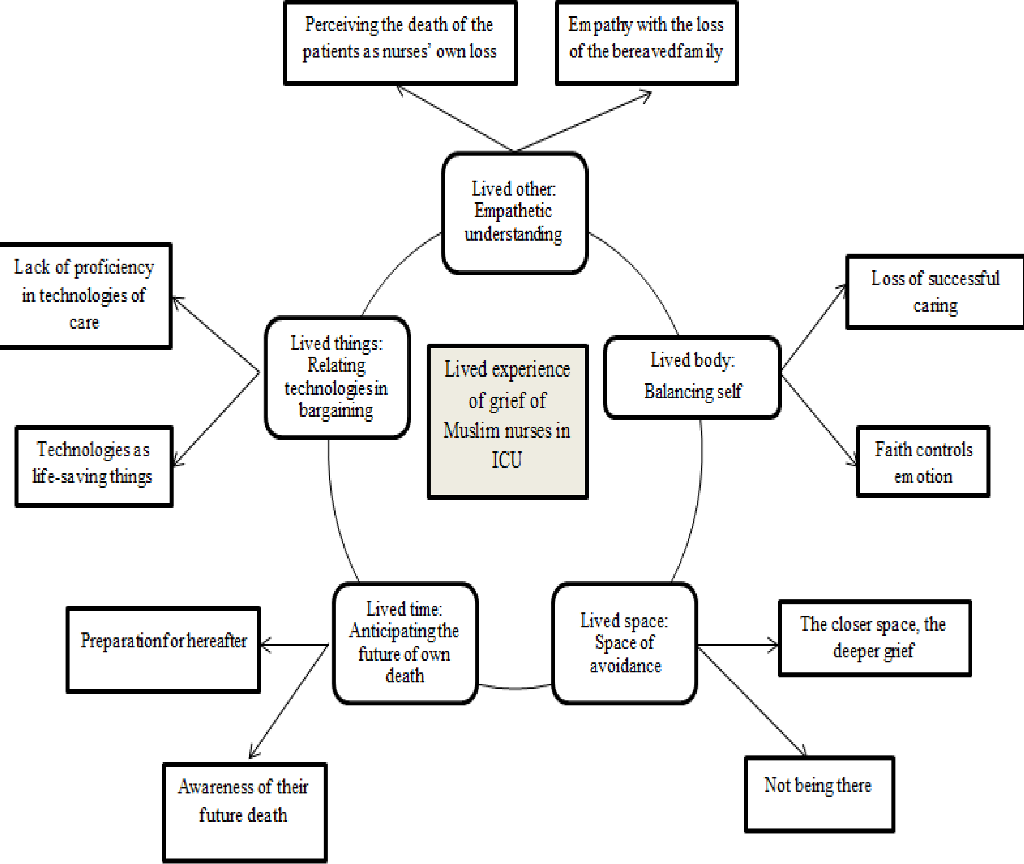


*Figure 10.* The life-worlds and each thematic category

# Chapter 5

# Conclusion and Recommendations

Gadamerian philosophy underpinned hermeneutic phenomenological approach was used to describe the meaning of the lived experiences of grief among Muslim nurses who cared for the patients who died in intensive care unit in a tertiary public hospital, West Sumatera, Indonesia. This study was conducted from October to December 2018. The researcher conducted data collection by asking the participants to illustrate their grief experience in dealing with the death of the patients by graphic representations and followed by reflexivity through individual face to face interview. The participants were given open ended questions for reflexivity which took time around 45-60 minutes for each interview. The data were analyzed using van Manen's hermeneutic approach. The summary of the findings, strength and limitation of the study, and recommendations are presented in this chapter.

## Summary of the Findings

In this study, there were fourteen participants participated. Eleven participants were women and three participants were men with ages ranged from 25 to 40 years (mean=32). Four participants were single and ten participants were married. One participant had experience in end-of-life care training and thirteen participants did not have training experience in palliative care or grief. The length of experience in nursing was from 3 to 20 years (mean=9) and length of experience in ICU was 1-11 years (mean=3.3).

This study revealed meanings of the lived experience of grieving of Muslim nurses who cared for patients who died in ICU within the context of five life-worlds. The description of the meanings of the lived experience is *empathetic understanding and balancing self with anticipating the future of own death while avoidance and relating technologies in bargaining*.

Under lived other: empathetic understanding, there were two sub-themes: understanding the death of the patients as nurses own loss and empathy with the loss of the bereaved family. In this thematic category, nurses empathetically understand how they feel and how the patients' family feels due to the loss of the patients. In the context of lived body, the participants reacted to their grief by balancing themselves between feeling the death of the patients as loss of their successful caring and controlling their emotion. The lived space is experienced as space of avoidance in which some nurse participants felt the closer space created deeper grief and they did not want to be in the situation of death. Lived time is experienced as anticipating the future of own death. The death of the patients increases their awareness of their future death and triggers them to prepare for their death and life after death. In respect of lived things, the participants related technologies in bargaining. They preferred to the technologies in bargaining the death of the patients. Therefore, valuing the knowledge and skill about technology of care is valuable for the participants.

**Strength of the Study**

This study provides understanding about how grief is experienced by Muslim nurses in dealing with the death of the patients in ICU setting. In addition, this study used drawing method and followed by reflexivity which allowed deeper understanding meaning of the phenomenon.

## Limitations of the Study

This study was conducted in a single unit in a tertiary public hospital. The majority of the nurses do not have experience in palliative care or end-of-life care training. Moreover, it was also found that some participants had personal loss experience and related their grief experience about patients' death with their prior loss experience. Therefore, the experience of grief among the participants may be relatively homogenous and limited to this group. Further study with the nurses from a different context, educational background, and without personal loss experience is recommended to overcome this issue.

## Recommendations

Following the findings and discussion, the recommendations are proposed for nursing practice, nursing education, and nursing research as below.

**Nursing practice.** Findings obtained from this study can help nurses dealing with their grief experience due to the death of the patients, particularly nurses in the ICU who perceived the death of the patients as loss of their successful caring. Informal coping strategies were identified and some of them were effective coping strategies such as relying on faith to balance themselves while others were not effective such as avoidance. Thus, a professional grief management program integrated with spiritual approach should be provided for nurses to facilitate nurses' grief and help them to manage and cope with their grief. If nurses know how to manage professional grief, negative consequences from ineffective grief for example burnout, professional fatigue, and disenfranchised grief can be prevented.

**Nursing education.** Findings of this study show that the participants valued the technologies of care in the ICU and admitted lack of proficiency of technologies

of care. Hence, educational support such as training about nursing knowledge and skill related nursing intervention in the ICU is recommended to address lack of proficiency in technologies of care.

**Nursing research.** This study provides understanding about the grief experienced by Muslim nurses in dealing with the death of the patients. In this study, some participants related their grief experience with their personal loss experience. This condition might be different from those who do not have personal loss experience. In addition, they employed some coping managements to help them cope with their grief. However, there is no formal intervention to help them cope with their grief experience, such as debriefing session with supervisor or coworkers. Further research investigating nurses' grief experience with no prior loss experience and intervention to assist nurses cope with their grief is recommended.

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# APPENDICES

**Appendix A**

**Demographic Data Form**

Participant no: _______

Instruction: Please answer the following questions by filling in the answer and / or mark in the box □

1. Age : ……………………………….. years old
2. Gender : □ male □ female
3. Marital status : □ single □ married
   □ divorced/separated □widowed
4. Years of experiences in nursing : …………………………………………
5. Years of experiences in ICU : …………………………………………
6. Educational level : □ vocational □ bachelor degree
   □ master degree □ others: ………...
7. Last patient death : ………………………………………….
8. Experience of being trained in palliative care or grief and loss:

   □ No

   □ Yes, please give detail as below:

   Name of training: ……………………………………………………………….

   Year : ……………………………………………………………….

# Appendix B

## Guided Interview Questions

1. Please draw the pictures that reflect your grief experience in dealing with the death of the patients in ICU. You can draw now if you wish or you can take time and take it home to draw and please return the drawing after you finish. If you wish to draw now, you can close your eyes and recall the memories when you were faced with patients' death.
2. Can you tell me about the picture that you have drawn?
3. How did you feel when you deal with the deaths of your patients?
4. Why did you feel like that?
5. Where are you in this picture?
6. What are your reactions dealing with the deaths of the patients?
7. What do you do to make you feel better in dealing with the deaths of the patients?

## Appendix C

## List of the Experts for Validity

1. Assoc. Prof. Dr. Kittikorn Nilmanat

   Faculty of Nursing, Prince of Songkla University, Thailand

2. Asst. Prof. Dr. Tippamas Chinnawong

   Faculty of Nursing, Prince of Songkla University, Thailand

3. Hj. Misfatria Noor, M.Kep, Ns, Sp.Kep.MB

   Dr. Achmad Mochtar Hospital, Indonesia, Bukittinggi, West Sumatera, Indonesia

# Appendix D

## Ethical Approval

Certificate of Approval of Human Research Ethics
Center for Social and Behavioral Sciences Institutional Review Board,
Prince of Songkla University

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Document Number: 2017 NSt – Qn 039

Research Title: The Lived Experience of Grief among Muslim Nurses Dealing with Death of Patients in Intensive Care Unit (ICU)

Research Code: PSU IRB 2017 – NSt 033

Principal Investigator: Feni Betriana

Workplace: Master of Nursing Science (International Program) Faculty of Nursing, Prince of Songkla University

Approved Document:
1. Human Subjects
2. Instrument
3. Invitation and Informed Consent

Approved Date: 29 September 2017

Expiration Date: 29 September 2019

The Research Ethics Review of Center for Social and Behavioral Sciences Institutional Review Board, Prince of Songkla University approved for Ethics of this research in accordance with Declaration of Belmont.

(Assoc. Prof. Dr. Aranya Chaowalit)
Committee Chairman of Center for Social and Behavioral Sciences
Institutional Review Board, Prince of Songkla University

## Appendix E

## Permission Letter for Data Collection

**BIDANG SUMBER DAYA MANUSIA**
**RSUD Dr. ACHMAD MOCHTAR BUKITTINGGI**
**Jl. Dr. A. Rival – Bukittinggi**

No : 099/ 232 /RSAM-SDM/X/2017
Lamp : -
H a l : Pengambilan Data & Izin Penelitian

Bukittinggi, 28 Oktober 2017,

Kepada Yth:

1. Ka Bidang Pelayanan & R Medik
2. Ka Bidang Keperawatan
3. Ka Ruangan ...ICU.................
4. Ka Poli.................................

RSUD Dr.Achmad Mochtar Bukittinggi
di-
Bukittinggi.

Dengan hormat,

Bersama ini kami sampaikan bahwa yang tersebut dibawah ini :

**Nama** : **Feni Betriana**
**No.Kartu Identitas** : **1373024401880001**
**Prog.Studi** : **S2 Keperawatan Prince Of Songkla University**

Akan melakukan Pengambilan Data Awal / Penelitian dengan judul " **The Lived Experience of grief among Muslim Nurses dealing with death of patiens in ICU** "

Demikian disampaikan atas perhatian dan kerja samanya diucapkan terimakasih.

**Kabid SDM**
**RSUD Dr. Achmad Mochtar Bukittinggi,**

**Drg.Sesmarry**
**Nip. 19650925 199903 2 002**

Yth: Karu ICU/ICCU

PEMERINTAH PROVINSI SUMATERA BARAT
DINAS PENANAMAN MODAL
DAN PELAYANAN TERPADU SATU PINTU

Jln.Setia Budi No.15 Padang Telp. 0751-811341, 811343 Fax. 0751-811342
http://dpmptsp.sumbarprov.go.id

SURAT KETERANGAN
Nomor : B.070 / 150 - PERIZ/DPM&PTSP/X-2017

REKOMENDASI PERMINTAAN DATA

Menimbang :
a. Bahwa untuk tertib administrasi dan pengendalian pelaksanaan penelitian dan pengembangan perlu diterbitkan rekomendasi penelitian;
b. Bahwa sesuai konsideran huruf a diatas, serta hasil Verifikasi Dinas Penanaman Modal dan Pelayanan Terpadu Satu Pintu Provinsi Sumatera Barat, berkas Persyaratan Administrasi Penelitian telah memenuhi syarat.

Mengingat :
1. Undang-Undang Republik Indonesia Nomor 18 Tahun 2002 tentang Sistem Nasional Penelitian, Pengembangan dan Penerapan Ilmu Pengetahuan dan Teknologi;
2. Undang-Undang Republik Indonesia Nomor 23 Tahun 2014 tentang Pemerintah Daerah;
3. Peraturan Menteri Dalam Negeri Republik Indonesia Nomor 20 Tahun 2011 tentang Pedoman Penelitian dan Pengembangan di Lingkungan Kementrian Dalam Negeri dan Pemerintah Daerah;
4. Peraturan Menteri Dalam Negeri Republik Indonesia Nomor 64 Tahun 2011 Tentang Pedoman Penerbitan Rekomendasi Penelitian yang telah Dirubah dengan Peraturan Menteri Dalam Negeri Nomor 7 Tahun 2014 tentang Penerbitan Rekomendasi Penelitian.

Memperhatikan :
Sesuai Surat Assistant Professor Dr. Waraporn Konsuwan Faculty of Nursing, Prince Of Songkla University Nomor : MOE 0521.1.05/2495 tanggal 25 September 2017 tentang Permintaan Data.

Dengan ini menerangkan bahwa kami memberikan Rekomendasi Permintaan Data kepada :

| | | |
|---|---|---|
| Nama | : | Feni Betriana |
| Tempat / Tanggal Lahir | : | Sawahlunto, 04 Januari 1988 |
| Pekerjaan | : | Mahasiswa |
| Alamat | : | Jl. Jorong Balai Selasa,-Kampung Pinang, Lubuk Basung Kabupaten Agam |
| No. Kartu Identitas | : | 1373024401880001 |
| Maksud / Judul | : | The lived experience of grief among Muslim Nurses dealing with death of patients in ICU |
| Lokasi Pengambilan Data | : | RSUD Dr. Achmad Mochtar, Bukittinggi |
| Jadwal Pengambilan Data | : | 2 (Dua) Bulan (November – Desember 2017) |

Dengan ketentuan sebagai berikut :
1. Wajib menghormati dan mentaati peraturan dan tata tertib di daerah setempat/Lokasi Penelitian;
2. Pelaksanaan penelitian agar tidak disalahgunakan untuk tujuan yang dapat mengganggu Kestabilan Keamanan dan Ketertiban di daerah setempat;
3. Melaporkan hasil penelitian dan sejenisnya kepada Gubernur Sumatera Barat melalui Dinas Penanaman Modal dan Pelayanan Terpadu Satu Pintu Provinsi Sumatera Barat;
4. Bila terjadi penyimpangan dari maksud/tujuan penelitian ini, maka surat rekomendasi ini tidak berlaku dengan sendirinya.

Demikianlah Rekomendasi ini dibuat untuk dapat dipergunakan sebagaimana mestinya.

Padang, 25 Oktober 2017

A.n. GUBERNUR SUMATERA BARAT

KEPALA DINAS PENANAMAN MODAL DAN PELAYANAN TERPADU SATU PINTU PROVINSI SUMATERA BARAT

MASWAR DEDI, AP.M.Si
NIP. 19740618 199311 1 001

## Appendix F

## Informed Consent

Title of the Study: The Experience of Grief among Muslim Nurses Dealing with Death of Patients in ICU

My name is Feni Betriana. I am a master student in Faculty of Nursing, Prince of Songkla University, Thailand. I'm also working as a teaching staff in Fort De Kock Health Science College, West Sumatera, Indonesia. I'm conducting the study entitled The Experience of Grief among Muslim Nurses Dealing with Death of Patients in ICU, Achmad Mochtar Hospital, West Sumatera province, Indonesia. This study aims to find out new information regarding the experiences of grief among nurses dealing with patients' death. This study is also conducted as a requirement to fulfill my master degree.

All the procedures of this study have been reviewed by Ethical Board Committee of Prince of Songkla University, Thailand. As participants, you will be required to draw the picture that reflects your grief experience dealing with the death of the patients. After drawing, you will be required to reflect the meaning of the picture by face-to-face interview. This study might require you to recall your memories about your patients' death and may cause risk for emotional disturbance. You can stop the interview anytime you don't feel comfortable without any penalty. Nonetheless, you will be advised if you need psychological support and prefer to speak to a professional and will be free of charge.

All the information gathered in this study are used to find the result of this study. The information regarding to this study are confidential. I will not use your name when reporting this study.

The participation of this study is voluntary. It is your decision if you want to participate in this study or not. If you wish to participate, you will be free to change your mind after joining this study. You can stop your participation any time and there will be no penalty of withdrawal. Your participation will contribute to the finding of this study and might be beneficial for nursing profession in the future.

If you wish to participate in this study, please sign this form. If you have something to ask, feel free to discuss with me any time before or during the study by the following contact number/email. Thank you for your attention.

**Respondent's Agreement**

I certify that I have received information regarding this study and I decide to participate in this study voluntary.

| Respondent's Name: | Researcher's Name: | Date: |
|---|---|---|
| ______________________________ | ______Feni Betriana_________ | __________________ |
| Respondent's Signature: | Researcher's Signature: | Date: |
| ______________________________ | ____________________________ | __________________ |

| Advisor: | Researcher: |
| --- | --- |
| Assoc. Prof. Dr. Waraporn Kongsuwan | Feni Betriana |
| Faculty of Nursing, | Faculty of Nursing, |
| Prince of Songkla University, Thailand | Prince of Songkla University, Thailand |
| Email: waraporn.k@psu.ac.th | Email: fenibetriana@gmail.com |
| Phone: (66-74) 286404 | Phone: +62 82174315441 |

**Appendix G**

**Letter for Data Collection**

FACULTY OF NURSING

PRINCE OF SONGKLA UNIVERSITY

P.O. BOX 9, KHOR HONG, HATYAI
SONGKHLA, THAILAND, 90112
FAX NO. 66-74-286421
TEL NO. 66-74-286456,
66-74-286459

MOE 0521.1.05/ 2435

September 25, 2017

To The Health Ministry of West Sumatera Province,
Indonesia

This letter is to inform you that Miss Feni Betriana ID. 5910420001, a master student of the Faculty of Nursing, Prince of Songkla University, Thailand, is taking a thesis in this semester. As part of the requirement of the course, she has to conduct a research study in Indonesia. Her thesis is entitled: "The Lived Experience of Grief Among Muslim Nurses Dealing with Death of Patients in Intensive Care Unit (ICU)". The thesis proposal has been approved on September 5, 2017. Therefore, she will collect the data on Intensive Care Unit (ICU) in Dr.Ahmad Mochtar Hospital and Solok Hospital during October to December 2017.

I will be greatly appreciated if Miss Feni Betriana is permitted to collect her data in those hospitals, as it will provide valuable information for nursing profession in the future.

If you need any further information regarding his study, please do not hesitate to contact us at the above address or e-mail us at: waraporn_kongsuwan@yahoo.co.uk

Sincerely Yours,

Waraporn

(Assistant Professor Dr.Waraporn Konsuwan)
Associate Dean for Research, Graduate Studies, and International Affairs
Faculty of Nursing
Prince of Songkla University
Hat Yai, Songkhla
THAILAND

PRINCE OF SONGKLA UNIVERSITY

P.O. BOX 9, KHOR HONG, HATYA
SONGKHLA, THAILAND, 90112
FAX NO. 66-74-286421
TEL. NO. 66-74-286456,
66-74-286459

MOE 0521.1.05/ 2493

September 25 , 2017

To Director of Dr. Achmad Mochtar Hospital
Bukittinggi, West Sumatera, Indonesia

This letter is to inform you that Miss Feni Betriana ID. 5910420001, a master student of the Faculty of Nursing, Prince of Songkla University, Thailand, is taking a thesis in this semester. As part of the requirement of the course, she has to conduct a research study in Indonesia. Her thesis is entitled "The Lived Experience of Grief Among Muslim Nurses Dealing with Death of Patients in Intensive Care Unit (ICU)". The thesis proposal has been approved on September 5, 2017. Therefore, she will collect the data on Intensive Care Unit (ICU) in Dr. Achmad Mochtar Hospital, Bukittinggi, West Sumatra, Indonesia during October to December 2017.

I will be greatly appreciated if Miss Feni Betriana is permitted to collect her data in your hospital, as it will provide valuable information for nursing profession in the future.

If you need any further information regarding her study, please do not hesitate to contact us at the above address or e-mail Associate Professor Dr. Waraporn Kongsuwan, her adviser at: waraporn_kongsuwan@yahoo.co.uk.

Sincerely Yours,

(Associate Professor Dr. Waraporn Kongsuwan)
Associate Dean for Research, Graduate Studies, and International Affairs
Faculty of Nursing
Prince of Songkla University
Hat Yai, Songkhla
THAILAND

**Appendix H**

**Letter of Data Collection Completion**

PEMERINTAH PROPINSI SUMATERA BARAT
RUMAH SAKIT UMUM DAERAH Dr.ACHMAD MOCHTAR BUKITTINGGI
Jalan Dr.A.Riva'i Bukittinggi -26114
Tep. Hunting (0752) 21720 – 21492 – 21831 – 21322
Fax (0752) 21321 Telp. Dir (0752) 33825

No : 073/15358/SDM-RSAM / XII / 2017 Bukittinggi, 29 Desember 2017
Lamp : -
Hal : Pengembalian Mahasiswa

Kepada Yth.
Ibu Kepala Dinkes Provinsi Sumatera Barat
di-
PADANG

Dengan hormat,

Sehubungan dengan telah selesainya Pengambilan data dan Penelitian Mahasiswa S2 Keperawatan Faculty Of Nursing Prince Of Songkla University Thailand , maka bersama ini kami kembalikan ke Institusi Pendidikan atas nama :

**Nama** : **FENI BETRIANA**
**No. NIM** : **1373024401880001**
**Institusi** : **S2 Keperawatan Prince Of Songkla University Thailand**

Dengan judul Penelitian " **The Lived Experience Of Grief Among Muslim Nurses Dealing With Death Of Patiens In Intensive Care Unit ICU** "

Untuk keperluan pengembangan Bidang SDM (Seksi Diklit) RSUD Dr. Achmad Mochtar Bukittinggi diharapkan kepada Saudara untuk dapat memberikan hasil penelitian mahasiswa tersebut diatas kepada kami sebelum Ijazah yang bersangkutan diberikan.

Demikian disampaikan atas perhatian dan kerja samanya diucapkan terimakasih.

**an Direktur,**
**Wadir Penunjang & SDM**

**Dra. Trizayenni, Apt, M.Sc**
**NIP. 19690124 199503 2 001**

# VITAE

**Name** Miss Feni Betriana

**Student ID** 5910420001

**Educational Attainment**

| Degree | Name of Institution | Year of Graduation |
|---|---|---|
| Bachelor of Nursing Science | Andalas University, West Sumatera, Indonesia | 2011 |
| Clinical Educational Program (Nursing Profession) | Andalas University, West Sumatera, Indonesia | 2012 |

**Scholarship Awards during Enrolment**

Thailand's Educations Hub for The Southern Region of ASEAN Countries (THE-AC) Scholarship

**Work-Position and Adress**

**Work-Position** Lecturer at Fort De Kock Health Science College, West Sumatera, Indonesia, Soekarno-Hatta Rd, No 11, Manggis Ganting, Koto Selayan Bukittinggi, Indonesia