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Negotiated Re-orienting: A Theory Generated through International Collaborative Research

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Introduction

The theory presented here was generated from a research project that involved researchers in five countries. To our knowledge, this is the first classic grounded theory generated by such an international collaborative effort. This article starts by describing the collaborative process, then the theory is presented.

The project

This research project was co-ordinated by researchers in the United Kingdom (UK). They were quantitative researchers, quite unfamiliar with qualitative research in general, but decided to use grounded theory without any knowledge of the methodology other than being aware that it is effective at generating theory. I was invited to join the project and together with colleagues from Brazil, Germany, Ireland, Palestine, and the UK, we held our first meeting in the UK. It became clear that everyone had a different view as to what GT is. The Brazilians were intent on using constructionist GT, the Germans advocated that situational analysis GT should be used, while the Palestinians and British did not know anything about the methodology. To ensure that we were collecting data and doing data analysis in a similar way, I gave a presentation on classic GT. The quantitative researchers thought of qualitative research as weak and non-scientific. However, following the presentation, they had changed their minds and became even more convinced that classic GT was very suitable to investigate the substantive area of Intensive Care nurses' perception of their role in end-of-life care.

Semi-structured interviews were conducted and included 51 participants in five countries. Although contrary to classic GT, this is a compromise that at least initially had to be made for the sake of the study. Nonetheless, researchers in each country were encouraged to use theoretical sampling by following up on what was said at previous interviews. The project team in each country participated in-person or via Skype in a two-day analysis workshop at the University of Surrey in order to discuss analysis of each country's dataset. It involved a lot of discussion and convincing others that what seemed like differences were in fact not so when the data were conceptualised. This was not surprising given the different ways that researchers were approaching analysis. This proved to be a very effective way of analysing and agreeing on the core and other categories. Memos with supporting quotes and full transcripts of three interviews from each country were prepared and circulated to all team members. Researchers in each country independently read all of the transcripts and coded them separately, looking for patterns.

An additional two meetings took place in the UK, in person or via Skype where the team discussed patterns relating to the core category. Following these two meetings, a template was circulated with sections of memos and interviews from each country in order to reach consensus. At the team meeting in Ireland we finalised the core concept and discussed dissemination of the results.

The theory

Nurses' main concern in Intensive Care end-of-life care is to shift the emphasis from active treatment to palliative care. However, this is problematic given the uncertainty surrounding prognosis. Patients in ICU are often in what Glaser and Strauss (1967) referred to as uncertain death and unknown time when the question will be resolved. This idea is central through negotiated re-orienting. The shift from uncertainty to a greater certainty of impending death implies that activities orientate to curing are now ending and replaced by activities prompted by the dying process. Nurses actively seek to bring this about by facilitating the shift from a narrower to a broader and more holistic practice emphasising comfort and support. This is brought about through negotiated reorienting, where nurses engage in consensus seeking and emotional holding.

Through consensus seeking, nurses coax physicians to realise that further treatment is futile. They encourage physicians to withdraw, de-escalate or limit treatment by directly expressing their views such as detailing the deteriorating condition of the patient. Through information cuing, nurses try to figure out how much relatives know and whether they accept that the patient is not responding to treatment. If successful, nurses then seek to ensure that relatives have a voice in what is happening. Nurses accomplish this task through voice enabling. They create a space and time for relatives to share their understanding as to what is happening and what is likely to happen. Nurses share their observations with relatives so that relatives can more effectively take part in discussions with physicians about treatment options and what is best for the patient.

Through emotional holding, nurses support families by prioritising time spent talking with family members. If families are not aware of the seriousness of the situation, then through creating time-space nurses try to bring about acceptance of what is happening. Nurses try to ensure that families spend as much time as possible at the patient's bedside and they bend rules, such as around visiting times, to ensure that this happens. They also negotiate with physicians and families to delay withdrawal of treatment so that any missing family members can be at the bedside. When death is imminent, they try to create a more peaceful environment around the dying patient. Nurses are concerned that relatives are told in a timely way that their loved one is dying; this is reinforced through bounded communication and the use of religious rituals. In bounded communication, nurses make sure that they only communicate with relatives in a way that has been predetermined by physicians, by reinforcing what physicians have said. In this way, nurses avoid dealing directly with questions that they consider to be within the domain of medicine, such as prognosis. Where nurses perceive the family to be religious, they may appeal to rituals such as references to religious texts in order to convey the seriousness of the situation. Comfort giving is focused on reducing the suffering of patients and their families, and focus on pain relief and other comfort

measures for patients. Comfort giving extends beyond death since nurses are very sensitive to the needs of the recently bereaved family.

Conclusion

Despite approaching this research project using different ideas of grounded theory, we generated a theory because, as a group, we engaged in negotiated re-orienting, whereby we reached consensus through open discussion at meetings and using classic GT as the overall methodology. The theory highlights the important role ICU nurses have in end-of-life care in bringing about consensus as to the patient's prognosis and re-orienting care from an emphasis on cure to one emphasising palliation. The theory demonstrates that nurses have a clearly articulated and complex role in end-of-life care in an area that is medically and technologically dominated.

References

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