The Unexpected Death of a Child and The Experience of Emergency Service Personnel

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Contribution to Emergency Nursing Practice

- The experience of dealing with unexpected pediatric death after unsuccessful resuscitations has a profound effect on emergency health care providers, personally and professionally.
- There is a pressing need for continuing ongoing education on pediatric end-of-life issues.
- Follow-up services would help with the grief emergency health care providers experience after the unexpected death of a child.

Abstract

Introduction: In 2013, 55,000 infants and children, aged 0 to 14, died in the United States. Nearly 7,000 of those deaths were attributed to traumatic causes. A child's death significantly affects emergency service personnel (ESP) caring for children and families. This study explores the lived experience of ESP involved in unsuccessful pediatric resuscitation efforts and how this experience affects them professionally and personally.

Methods: A phenomenologic approach guided this study. Using an open-ended format, an interview was conducted with a purposive sample of ESP who experienced unexpected pediatric death. Eight ESP participated in semistructured, face-to-face interviews, ranging in length from 35 to 75 minutes. The research question asked: "What is it like for you when a child dies after an unsuccessful resuscitation attempt?" Data were analyzed using thematic analysis.

Results: Van Manen's 4 existentials guided this study, and 10 subthemes emerged that included: "what if," "dying before my eyes," "team," "what if it was were my child?/being a parent," "the environment," "being trapped," "wounded healer," "education," "anger," and "coping."

Discussion: This study explores the experience of ESP involved in unsuccessful pediatric resuscitation that resulted in unexpected pediatric death and ESP's perceptions of this experience: thoughts of loss, a sense of anger, and a lack of preparation to cope with unexpected pediatric death and the unknowns of life.

Key words: Pediatric; Death; Emergency Service Personnel (ESP); Experience

Pediatric trauma and death can take a toll on health care providers. In one urban emergency center in southeast Texas, ED personnel treated two young children's near drownings—both requiring intubation—on consecutive days. On the third day, they unsuccessfully treated a young child who drowned. It was a breaking point for many ED staff. Hearing the parents grieve over the loss of their child stilled the usually frenetic emergency room. The next day, one nurse indicated the depth of impact, asking, "How am I supposed to be a nurse, do this job, then go home and be a mom?"

Trauma is defined as exposure to—experiencing, witnessing, or being confronted with—events involving actual or threatened serious injury or death or threats to individuals' physical integrity.[1] Emergency Service Personnel (ESP) who care for children in emergency centers may be exposed to pediatric trauma such as acute illness (eg, septic shock), life-threatening events (eg, choking, drowning), physical abuse, and death. In these circumstances, not only do ESP engage in resuscitative efforts, they also support the children's families.[2–4]

In 2013, 55,000 infants and children aged 0 to 14 died in the United States.[5] Of these deaths, 7,000 were attributed to traumatic causes.[5] Nearly 75% of pediatric deaths occur in hospitals, often in pediatric intensive care units and emergency centers.[6]

The emotional toll of experiencing a child's trauma or death may increase ESP's personal levels of trauma, anxiety, and stress, affecting performance of workplace duties and personal lives, particularly if they have not received training or preparation for coping with pediatric death.[7,8] Emergency centers are the site of an unrelenting influx of traumas, crises,

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J Emerg Nurs ■.
0099-1767

http://dx.doi.org/10.1016/j.jen.2017.06.002

and patients. Although extant literature focuses on the effects of a child's death on families,[9–11] few studies have addressed the experiences of ESP who have been involved with unexpected pediatric deaths after unsuccessful resuscitations.

Purpose

This hermeneutic phenomenologic study explores the personal experience of ESP who have experienced unexpected pediatric death after unsuccessful resuscitation in emergency care settings. It provides ESP a voice and allows them to express their perspectives and the personal and professional effects of this experience. The research question is: "What is it like for emergency service personnel when a child dies after an unsuccessful resuscitative effort?" Having ESP articulate their experiences can lead to an understanding of their feelings and the effects of pediatric death on ESP.

Methods

STUDY DESIGN

Van Manens's (1990) hermeneutic phenomenologic approach provides a structure to understand ESP's lifeworld and the meaning of their "lived" experience of unsuccessful resuscitative efforts and the unexpected death of a child. Hermeneutic phenomenology aims to "uncover the structure, the internal meaning structures of lived experiences" (van Manen, 1990, p 10). Van Manen identified four structures, or "existentials," that comprise a person's lifeworld— lived time, lived other, lived space, and lived body—that guide the interpretive process.[12]

SAMPLING AND RECRUITMENT

The University Medical Center Institutional Review Board approved this study, and participants were recruited via flyers and in-services at a level-1 trauma center and a local Emergency Nurses Association meeting. Inclusion criteria included ESP working in emergency centers and ESP who had experienced the unexpected death of a child after an unsuccessful resuscitative effort. Exclusionary criterion was for ESP who had not experienced the phenomenon under study. Eight respondents met inclusionary criteria and agreed to participate. The small sample size is appropriate to a hermeneutic study, which has as its goal understanding the phenomenon from the perspective of each participant, rather than generalizing findings.

DATA GATHERING

After providing informed consent, participants were interviewed at a time and place convenient for them in a face-to-face, semistructured format, ranging from 35 to 75 minutes. Interviews were informal and conversational, providing comfort, as the discussion focused on traumatic experiences. Interview questions included, "What is it like for you when a child dies after an unsuccessful resuscitative effort?"; "Tell me more about an unsuccessful resuscitative effort in which a child died that has stayed with you?"; and the probe question, "Can you tell me more?" Interviews were audio-recorded and transcribed verbatim, pseudonyms assigned, and interviews coded to ensure confidentiality. The researcher maintained a journal throughout the study to record personal reflections, biases, and assumptions. Field notes recorded during and immediately after interviews documented nonverbal observations during interviews (Table 1).

TABLE 1
Demographic information

Pseudonym	Role	Ethnicity	Age
Elizabeth	Registered Nurse	Caucasian	40
Michelle	Physician	Indian	32
Sally	Registered Nurse	Caucasian	30
Avaril	Physician	Indian	39
Sarah	Registered Nurse	Caucasian	29
Larry	Respiratory Therapist	Middle Eastern	36
Vanessa	Physician	Asian	36
David	Physician	Hispanic	35

DATA ANALYSIS

Using van Manen's (1990) methodology, interview data were thematically analyzed to derive an understanding of each participant's lifeworld. Reading, writing, and reflection on phrases that described the lived time, other, space, or body of the lived experience were significant components of the interpretive process. Themes and subthemes emerged from these readings. Consistent with van Manen's (1990) philosophical assumptions, and used throughout the study, were Madison's[13] principles for establishing rigor.

Results

THEMATIC FINDINGS

This hermeneutic phenomenologic study gave voice to 8 ESP members from various professional and ethnic backgrounds and revealed participants' lived experiences and lifeworlds. Findings are addressed using the existentials—lived time, lived other, lived space, and lived body—as a framework.[12] In the following