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Balinese nurses' experience of patient death

Viewed in the light of their cultural background

Balinesiska sjuksköterskors upplevelse av patienters död

Ur ljuset av deras kulturella bakgrund

Abstract

Background: Nursing is a profession in which one will face death in different circumstances, and how the nurse will be affected by the death of their patient may vary with the nurses' cultural and religious background. Bali-Hinduism is the most practised religion on Bali in Indonesia, permeating the inhabitants' day-to-day life.

Aim: The purpose of this study was to explore Balinese nurses' experiences of the death of a patient in their care, in the light of their cultural surroundings and background.

Method: Semi-structured interviews analysed with qualitative content analysis. The material was organized in themes and subthemes. The participants were one male and three female nurses from a private hospital in Denpasar, Indonesia.

Results: The results showed that the Balinese nurses were leaning rather heavily on their religious beliefs in their daily work, and that their cultural situations greatly affect their way of coping with patients' deaths. Three major themes emerged during the analysis: cultural and religious aspects, emotional reactions to patients' deaths, and factors that aid coping.

Discussion: Many of the ideas the nurses expressed could be further understood when learning more about Balinese culture and Bali-Hinduism, for example the notion that the physical health of a person is closely related to the will and intention of that person. Similar to Parse's view of the human being, the Balinese perceive the human being as a versatile and complex being, connected to and affected by various aspects such as background, culture, surroundings, religious context, education, family and other human beings. The results were discussed in comparison to recent research on the subject and to Parse's theory of humanbecoming.

Keywords: Death, Bali, culture, nursing, experiences, Bali-Hinduism

Sammanfattning

Bakgrund: Att arbeta som sjuksköterska innebär att möta döden i olika situationer, och hur sjuksköterskan reagerar på sin patients bortgång varierar med sjuksköterskans kulturella och religiösa bakgrund. Denna studie fokuserar på den balinesiska sjuksköterskans upplevelser och undersöker vad för slags copingstrategier hon använder. Bali-Hinduism är den mest utbredda religionen på Bali i Indonesien, och genomsyrar invånarnas vardag.

Syfte: Studiens syfte var att undersöka balinesiska sjuksköterskors upplevelser av patienters död, i ljuset av deras kulturella omgivning och bakgrund.

Metod: Semistrukturerade intervjuer som analyserades med kvalitativ innehållsanalys. Resultaten diskuterades i jämförelse med aktuell forskning och Parses teori om humanbecoming.

Resultat: Resultatet visar att balinesiska sjuksköterskor förlitar sig på religionen i hög grad i det dagliga arbetet, och att deras kulturella sammanhang kraftigt påverkar deras sätt att handskas med patienters död. Tre teman framträdde under analysen: kulturella och religiösa aspekter, sjuksköterskan och döden och faktorer som stödjer coping.

Diskussion: Många av de tankar som de balinesiska sjuksköterskorna uttryckte kunde förstås djupare vid inhämtning av mer kunskap om den balinesiska kulturen och Bali-Hinduism, exempelvis föreställningen att en persons fysiska hälsa är nära sammankopplad med hennes vilja och intention. I likhet med Parses syn på människan, ser balineserna människan som en föränderlig och komplex varelse som är ansluten till och påverkas av olika faktorer såsom bakgrund, kultur, omgivning, religiös kontext, utbildning, familj och andra människor.

Nyckelord: Död, Bali, kultur, vårdvetenskap, upplevelser, Bali-Hinduism

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Introduction

During one of the clinical placements during nursing school, the author experienced the death of a few patients in her care. Two died during cardiopulmonary rescue (CPR) and two other patients died under other circumstances. These experiences created resonance on a personal level and opened questions within the author about how nurses in general cope with their emotions after patient deaths.

Nurses all over the world will be faced with patients' death during different circumstances. Some patients die peacefully while other patients' deaths are more dramatic. Sometimes the medical team will be able to save the patient but not always, every so often patients are already dead upon arriving to the hospital. There are certainly several implications for the family of the patient and others left behind, but what are the consequences for the nurse afterwards? Is it possible to continue working throughout your shift after a patient died even though you put your highest effort into saving them? How does it feel to lose a patient whom you might have known well?

Not only the unexpected death of a patient, but the expected death may have emotional consequences depending on different factors such as the nurse's personality, her experience and approach towards death. This subject is not only valid in the context of Western nursing practice, but all over the world. In this study I intend to explore the experiences of nurses in Bali, in the light of their cultural context. Considering the Balinese culture, questions arise such as what implications the cultural and religious environment have to the nurses' coping strategies and views of death.

Background

A basic overview of Indonesia and Bali

Indonesia is the fourth most populated state in the world with its 256 million citizens who are spread over approximately 17 500 islands. The cultural and ethnic diversity is wide and according to United Nations Indonesia has more than hundred ethnic groups (Broderick, 2015). Indonesia in general has the world's largest population of Muslims, whereas Bali is mainly Hindu.

Indonesia was a Dutch colony for 450 years but was liberated in 1946. The most recent history of Indonesia has been one of communistic dictatorship and military regimes until the Asian economic crisis in the late 1990s, when the president was forced to resign. Since then there have been several democratic elections and financially the country is now one of the most stable in Southeast Asia, though since the financial collapse the country has been ridden with many economic crises (Shields & Hartari, 2006).

According to the World Health Organisation (2014) the most common causes of death in Indonesia were, in descending order, cardiovascular diseases, maternal, perinatal, nutritional and communicable conditions, cancer, diabetes, chronic respiratory diseases, injuries and other non-communicable diseases. The people who live in the cities have a lifestyle similar to Westerners' and those who populate the rural areas make their living mostly on farming and tourism.

Balinese Hinduism and health

The Balinese Hindu views of health and illness are closely integrated with their religious beliefs and are therefore important to address. The official name of the Hindu branch that is practised on Bali is Agama Hindu or Hindu Dharma. Hinduism in built on the idea that everything in the world is in some way organised and that the universe is not random. Nature will descend into chaos if left undisturbed, but as there are chaotic forces, there are also organising forces that counterbalance the chaos. Order – dharma - is considered positive, and disorder - adharma - negative (Eiseman, 1990). As the world needs to exist in balance between order and disorder, so does the individual, and the individual must orientate his or her karma towards the inner order. If a person's karma – their actions – is in line with their dharma, they contribute to their environment and promote harmony. Each person has their own inner dharma that constitutes the appropriate way to live for that person, and this coincides in some ways with how the Hindus are organised in castes. The caste system is not as pronounced in Bali as it has been in for example India, but manifests itself in some respects.

An example of Balinese religious view on health could be if a child falls ill, it may be because the mother was too emotional around the baby, and therefore her breast milk affected the baby in some way. Children and adults may become sick because of "fright", or because of being surprised (Wikan, 1989a). Health and illness also depends on how the family is protected from the external forces that seek to inflict disorder and chaos in their life. The presence of a family temple near the house, and the daily offerings and ceremonies the Balinese diligently conducts will protect them from illness or injury. There are several ways in which people can protect themselves from disease, but there are at the same time a wide variety of issues that can outbalance the efforts that are made to stay healthy and prosperous. Examples of these issues are the way the natural forces of dharma and adharma are at work in a person's life. For instance, one can be protected thanks to a family temple, but the illness or misfortune of a neighbour or family member can counterbalance the efforts to stay healthy. Negative feelings such as jealousy towards the family can also affect the effectiveness of the family temple.

End of life care – cultural and religious implications

Hinduism agrees with the concept of palliative care, but beyond that there are a number of conditions to consider when caring for the dying Hindu. For instance, the person making decisions is often a family elder or eldest son in the family. As opposed to the western ideal of individuality, family and community are very important, and family members will many times be present in the end of the patient's life, performing ceremonies, chanting and singing (Thrane, 2010). The nurse does not have to participate in such gatherings, but may be helpful by allowing private time and space for ceremonies and also help them to find the materials they need. It is important to include the family in the care of the patient, since decisions are made in a different way than a western nurse is used to. Thrane advises that to better understand the needs of the patient and the family, simple steps such as asking the family for advice before acting are very efficient.

Hindus believe in reincarnation and karma as the guidance for life, and this may affect their final time and choices of treatment. Karma is defined by your thoughts and actions through life, but is also a combination of the present, past and future as a combination of karma accumulated from your past life, karma that is saved for the future and karma of this life. Since the Hindu belief is that natural death will come in due time, many elder Hindus will abstain from aggressive medical interventions (Thrane, 2010). Some want to deal with old quarrels and make apologies where needed as a way reconciliate in the end of life, facing reincarnation. These circumstances allow the person to prepare for death and being born again. The better your karma is, the better your place in the next life will be. According to Hindu beliefs you can be reborn as a plant, an insect, an animal or a human being on different steps of the social ladder. Have you lived your life well and prepared properly for death, you have a higher chance for a beneficial reincarnation.

Another way of approaching death with a clean mind is to avoid medications such as sedatives and morphine, which may impact the level of consciousness. To approach this particular issue, Thrane (2010) recommends nurses to educate patients about different types of pain medications, as there are many substances that will not cause dizziness or sedation.

Health care in Indonesia

Over sixty per cent of the Indonesian Health care is public, and the rest is privately financed. A study by Barber, Gertler and Harimurti (2007) summarizes the access to Health Care in Indonesia and states among other things that although the government in the 1980s made a sizeable effort to provide health care for all its citizens, the results are not satisfying. For example, in 1994 there were only 50 nurses and 26 midwifes per 100 000 people. Few of these nurses and midwives hold

a degree and their role is unstable as there is no consistent definition of their professions (Hennessy, Hicks, Hilan & Kawonal, 2006a).

The access to health care for the individual is also limited due to financial reasons as well individually as nationally. The national instability in the economy has provided difficulties and delayed the attempts to develop a functioning health care system. As a patient in one of the public hospitals you need to pay for your hospital bed, food, medicines and nursing care, for instance. As of 2006, a third of Indonesia's population was considered below the World Bank poverty line; therefore the expense of hospital care constitutes an obstacle to the poor people's access to health care (Hennessy et al., 2006b). In line with this, other research shows that the poor were less frequent in their use of the health care system, while the financially stable population were more likely to seek medical attention (Barber et al., 2007). This leaves the poor population heavily exposed, combined with the fact that the infectious diseases Indonesian health care struggle with (malaria, dengue haemorrhagic fever, typhoid and tuberculosis among others) are increased by poverty. Malnutrition among children is another condition that naturally affects the poor to a higher extent. Primary health care is sometimes difficult to access due to the fact that many Indonesians on the countryside are scattered all over mountains and valleys, while the health care centre is located in the more populated areas (Shields & Hartari, 2006). Infrastructure poses another obstacle, since safe transportation is not always available due to heavy raining and earthquakes.

Nursing education in Indonesia

Nursing education in Indonesia offer diploma, undergraduate and post graduate level. Higher nursing education is five years, and the curriculum is national though not always consistent. Many universities offer nursing education at doctoral level and there are vast opportunities for Indonesian students to study abroad (Shields & Hartari, 2006). Four of these years are spent in an academic setting, and the last year consists of clinical practice. Studies, however, have shown that only 39 percent of nurses have diplomas and 60 percent have only an education level equivalent to high school. One reason of this is that the compliance to the curriculum is not well monitored and combined with the lack of a job description and a national organisation this results in a vast variety in nurses quality of education (Rochmawati, Retno Rahayu & Kumara, 2014). Another problem is the absence of a national organisational authority for nurses and midwives, and therefore there are no structured standards for the nurse's competence. Safety for patients is compromised with, for example nurses with only secondary school competence may perform complicated nursing tasks and midwifery (Hennessy et al., 2006a).

Nurses and death

Working as a nurse in the hospital environment, death will be present in more or less pronounced ways. In the emergency room you fight death every day with advanced technical tools, in the palliative care death is ever present in the daily work, and for example in the orthopaedic ward patients may suffer heart arrest or other life-threatening conditions. An example of how death affect nurses can be read in an American study by Hinderer (2012), who investigated the nurses' feelings and ways of coping after a patients' death, whether death was expected or not. Nurses experienced a variety of emotions which range between guilt and stress to actual grief and long-term suffering in terms of reliving the death of their own relatives. The study also contains different ways of coping that nurses used to process the death of a patient. Some of them worked with the family of the deceased and this helped the family to address their grief, and the nurse gained comfort from their communication.

Problem statement

Working as a nurse in different parts of the health care system carries different meanings and may trigger emotional reactions within the nurse. This will affect her working environment, personal life and care for patients as well as her working situation and, possibly, her personal life. To further understand nurses' situation and the various aspects that may affect her, it is important to explore nurses' own experience. To further nuance understanding, it is valuable to recognize experiences of nurses from different cultural backgrounds, such as the lived experience of Balinese nurses.

Aim

The purpose of this study was to explore Balinese nurses' experiences of the death of a patient in their care, in the light of their cultural surroundings and background. The specifics of death in this study are not defined, but covers variations such as strokes, haemorrhages, respiratory failure and acute heart failure. The subject raises questions as how the nurse deal with the emotional consequences, and what factors that help him or her to cope.

Theoretical framework

Rosemarie Rizzo Parses' theory of human becoming will be used as the theoretical background in discussing the data collected, as this theory is appropriate for understanding a person's

development affected by many aspects in his or her life. The concept of the human being, which is part of the metaparadigm of nursing, is the focus of this study.

Since Parses' theory views the human as a becoming creation in a symbiosis with the environment and with other individuals, it is fitting to apply on the experience of the nurse in her own health process and process of becoming (Parse, 1999). The patients she meet and the experiences she gain will be a part of her reality and will have different meaning depending on the nurse's impression and values. Therefore, Parse's theory will not be used in the way of viewing the patient's becoming, but to understand the nurse's own becoming as an individual.

To try and understand a person, it is impossible and inadvisable to ignore her surroundings and relationships, as every aspect of a person's life will affect her and her view on life. In the same way, the person herself will influence her surroundings and the universe to the extent that separating a person from her environment will never show the whole picture (McLeod-Sordjan, 2013). Consequently, a nurse is not only the words that describe her profession, but is also a product of her upbringing, environment and relationships. A nurse's formal role cannot fully be separated from her personal worldview. As a result of this point of view, a nurse will be affected in different ways by the patients she meet and the current circumstances.

The human becoming theory views the human being as coexisting with the universe in a manner that is impossible to separate, and the human herself is greater than her individual parts (Parse, 1999; McLeod-Sordjan, 2013). The person and her environment (fellow humans, her surroundings, relationships and the entire universe as a whole) take part of a continuous exchange of energy and will affect one another in a rhythmic way. Parse considers the individual as an open being with the ability to freely choose her path and bear the responsibilities of her choices. She is also able to freely choose meaning in situations, and the meanings chosen will be drawn from the individual's own values and priorities, as well as her previous experiences and way of living (Hansen-Ketchum, 2004). These experiences and beliefs are both known and unknown to the persons themselves, a concept that offers an explanation to why we do not always understand our own reactions and feelings.

In order to understand the human becoming theory, it is important to grasp the idea that health is not just the opposite of illness, but is a cocreating and ever changing process that moves with the rhythmical patterns of relationships. The process of healing from physical and mental injury is in a similar way a unique development that only the person experiencing it can properly understand. A person's lived experience of health may vary from day to day, as people continually create their own reality (Parse, 2008).

One of Parse's principles of cotranscending cast a light on energies that are released in the relations (Parse, 1999). The energies both give the possibility to look at the reality with new eyes, but also give the power to distance ourselves from unpleasant or unwanted aspects of life. This principle may illuminate nurse's coping strategies when facing death.

Method

Data collection

This study was conducted using a qualitative study design with data collected from semi-structured interviews (Danielson, 2012). The semi-structured interview technique has the advantage of following a pre-set pattern of the interview guide, but is also open to flexibility in focusing on open questions. This method allows participants and interviewer to address and further investigate issues they feel are important. Interviews were conducted face to face, and after obtaining the participants' consent, they were digitally recorded to simplify the processing.

The interview guide (appendix 1) to the interviews contained questions such as how a regular day at work is structured, and whether the nurses could remember and relay a situation when a patient died in their care. Follow-up questions revolved around nurses' feelings and coping strategies after such an event. The interviews generated almost 5 000 words in total and were conducted in English, although English is neither the interviewer nor the participants' first language. The interviews lasted for about 30 minutes each.

Participants

Four participants were recruited from the private hospital Manuaba General hospital in the city of Denpasar, which is the capital of Bali. The head nurse was contacted and after getting information on the study, the nurses in the staff who were interested in participating received further information on the study. The number of persons who were asked to participate was unknown to the author.

The participants were three women and one man, who all worked both in the emergency unit and in the polyclinic. Three of the nurses had attended nursing school for three years, and one for five years. The nurses' ages were between 22 and 25 (median: 23,5 years). Years in clinical practice varied between six weeks to three years (median: 2 years) and years in nursing training varied from three years to five (median: 3 years). No participants dropped out of the study.

Data analysis

The interviews were recorded and before the data was analysed, the interviewer listened to the recording several times. The interviews were transcribed verbatim before commencing the analysis (Denscombe, 2009). Data was analysed using a qualitative content analysis to extract keywords, which were condensed and organised in themes and subthemes, then compared to the nursing theory described above. An example of keywords was "sadness – want to die"; this keyword was sorted into the subtheme "nurse-family relationship" which were placed in the theme "cultural and religious aspects" (appendix 3). To make understanding easier, statements have been transformed to a more correct use of English, since English was not the participants' first language. To ensure that analysis was correctly executed, the transcriptions of the interviews were sent to the supervisor of this project.

Ethical considerations

To ensure that this study is in line with the ethical principles of research, several measures have been taken. This is important both for the sake of the participants, but also for scientific research in general (Kjellström, 2012).

In preparation of this study a relative to the author, situated in Bali, has contacted the Manuaba General Hospital, in the interest of this study. Prior to the interviews, participants received a written introductory letter (appendix 2) that explained the extent and purpose of this study, and that they were in no way obligated to partake, as their involvement was fully voluntary. They were informed that they at any time could choose to discontinue the interview and withdraw the information, as Kjellström (2012) describes, considering qualitative interviews. Participants were guaranteed anonymity and after obtaining their oral consent, interviews were conducted. To guarantee the anonymity of the nurses, all of them will henceforth be addressed as "her" or "she", since one of the nurses was male.

In case the interviews stirred emotions and memories in the participants, I offered the possibility for the nurses to contact me if they need to, along with my contact details.

The participants were also offered the possibility to contact me to change or withdraw a statement should they wish to. They have the option of reading their transcribed interviews if they like. A copy of the finished product will be sent to all participants.

The ethical committee at Ersta Sköndal University College approved of this study in January 26th 2016.

Results

When analysing data, the content could be organised into themes and subthemes. Three themes emerged: cultural and religious aspects, emotional reactions to patients' deaths, and factors that aid coping being the largest theme. In these themes, several subthemes surfaced describing different aspects of the themes.

Cultural and religious aspects

This theme describes how the nurses relates to the patients and describes how they help patients with religious issues. The theme also contains how the nurses viewed their experiences of obligation toward their patients, and what that obligation consists of. Nurses expressed the importance of cultural and religious awareness when facing the dying patient. To help the patient come to terms with their condition and keep the patient feeling safe was considered of high significance as to help the patient to be relaxed. Nurses recognised the patient's need to achieve acceptance in preparation for death. One nurse said:

> If the patient has religious needs we can facilitate a spiritual guidance in line with the patient's own beliefs, to help them accept their condition, trying to tell the patient that everyone will die eventually. It's just about time.

Nurse-patient relationship

This subtheme illustrates the balance of dependence in the nurse-patient relationship. Nurses recognised their responsibility to answer to the patient's needs, as patients are relying on the nurses to care for them in the best way they can.

Nurses expressed the need to keep up appearances when experiencing grief or sadness, as to be able to care for their patient in the way they were obligated to. The trust-responsibility element of the relationship between a patient and the nurse was underlined, and also argued for to keep the patient feeling safe and comforted. One of the nurses said:

> If we feel sadness because another patient has died, we still have to smile and we have to do the best for the next patient. Because the patient trusts us, so we have to do the best.

As specific ways to care for the dying patient, four factors were relayed as the nurses' responsibility: biology, psychology, sociology and spiritual. These responsibilities could not be

defined; therefore the meanings are hard to interpret. These were themes they worked on in their education and which were considered nurses' main duties, and could be used as a tool to get a good overview of the patient's needs and planning the care. The nurses considered psychology the most important:

> I think the most important is psychology, yes. Biology, we can collaborate with the doctor or the physiotherapist or any other profession, but for psychology we as nurses can do more.

Nurse-family relationship

Nurses considered the relationship and the caring for the patient's family as an important part of their work. As all the nurses at least once mentioned the family of the patient, this subtheme also communicates that the nurse relates to the patient's family regardless of their presence or absence. When asked what was important to consider when treating the dying patient, besides the medical issues, nurses stressed the relationship with the patient's family. They saw the family's need for support and education as highly valuable in their care for the dying patient. They recognised the families' need for knowing what had happened when their family member had passed and considered working with families as a natural part of their work. One nurse said:

> His family will be sad. We educated the family, we told them what happened. And we give them support.

Another nurse said:

> Maybe, I think… I will give the support for the family.

Sometimes nurses had to support families to ensure the health of family members of the deceased. In one case where an elderly man died suddenly of a non-haemorrhagic stroke, the nurse needed to especially support his wife who as a reaction to her husband's death also wanted to die. The support given consisted of personal encouragement and religious aspects. The religious part considered the Balinese Hindu notion that a person's spirit may be delayed from ascending to heaven if the death of that person is surrounded by too much, or any, grief. She described her experience like this:

In her grief she wanted to follow the patient, she wanted to die. So I have to support her, tell her to keep fighting. I support the family so they will not be too sad, so the spirit of the deceased can move on and not follow the family.

Another nurse used her own and the family's shared religious beliefs to support them when there was no obvious medical explanation to their child's discomfort. In the interview she made it clear that the medical aspect of treatment is the number one priority, but that the spiritual part of nursing care served as a complement when finding comfort and solutions in medicine was difficult. In this particular case, the nurse gently advised the child's parents to in prayer communicate with and hopefully appease the external forces that might be working around the child. She described the situation like this:

In Balinese culture we always trust there is someone that we can't see… that maybe is disturbing him. So we suggest to them to go and pray and tell them "I think, we don't know, but maybe you can ask permission with the spirit and ask them not to disturb your child and take care of him".

Emotional reactions to patients' deaths

This theme summarizes the nurses' emotional reaction to their patients' deaths and how they remembered the situations. Their narratives were very detailed when describing the patient and the medical situation, even though some of the events took place a few years back. There were even recollections of what medicines the patient was given in particular situations.

Participants expressed a range of emotions related to the event of a patient in their care dying but did not always verbalise their emotions. The emotions of some situations were conveyed through gestures and facial expressions. One nurse's facial expressions seemed to convey grief while her words were not especially emotional:

I felt different after my patient died, I think that you will look back on a day and know that it changed you…

Some expressed feelings of regret and inadequacy, some expressed fear when faced with patients in a bad condition or already dead:

> Once, the patient was dead on arrival when he came in the ambulance, and it was so scary for me.

Desperation and frustration was also conveyed. One of the nurses told a story about a patient with very bad injuries, and she remembered how her feelings of desperation and helplessness turned her to prayer:

> I didn't know what to do because the patient was in such bad condition, so I just prayed…

Another nurse talked about her feelings of inadequacy after a patient's death. She talked a while about how a lack of medical equipment or knowledge can make you feel frustrated when taking care of a dying patient. These feelings seemed difficult to verbalise, she searched for words for a while before she said:

> I felt this regret, regret like I can do better, do more…

Another nurse had been experiencing grief and guilt as a well-known patient of hers passed away when she wasn't present. This patient had been in her care for a long time and she had built a deep relationship with the patient and his family. Her facial expression was troubled when she said:

> The family was like my second family, and he was like my second grandfather. So I asked myself "why wasn't I beside him when he died?"

After discussing her emotions considering a patient's death, one nurse concluded:

> You know, we can be sad and this feeling can follow us for a while, but we have to move on and get a new feeling with a new day.

Factors that aid coping

The nurses described different areas of their work and life that helped them cope when they experienced emotional distress. One said that their ability of coping with feelings after a patient's death was depending on how the patient had died, and that she experienced this to be true for

both nurses and patients. If the patient had passed unexpectedly there was a higher likeliness of chock, but when death was expected, the family, the patient and the nurse could easier accept death.

> I think it depends on the patient, if he dies suddenly there is more sadness for the family, compared to the patient with cancer when they have a chance to accept the condition step by step. I see many people getting hysterical when suddenly the patient dies. They… they are in denial.

Religion

Leaning on religion seemed to be a strong factor when coping with difficult feelings. Nurses mentioned fate as a reason to a patient's death, and upon asked how much their spiritual life took place in their day they gave it some importance. One nurse described their communal prayer like this:

> Before we start the day we pray in the temple. Before we go to work… we need God to help us in our project.

Another way, in which religion was a part of their job, nurses mentioned for example consulting with religious leaders to find out when cremation of the dead body was preferable, according to Balinese Hindu beliefs. Different days are good, better and bad for doing certain things in the Balinese culture. To know which days are good or bad, one needs to consult someone who can interpret the Balinese calendar, which has a complicated set of rules and therefore most often need to be deciphered by a priest or another religious leader.

Seeking support in friends

When answering questions about coping with their emotions and whether talking about feelings was accepted, many of the participants described their confiding in friends as an important factor and they considered it normal to talk about their feelings to their friends, and generally felt better afterwards. One nurse answered:

> I think we tell our friends what we feel and then my friend can help me find a solution and support me, to tell me it's ok if I am sad…

Another nurse said:

> My reactions… when this patient was dead, I spent time with my nurse friend.

The patient's family as a coping factor

Nurses thought that the presence of the family in the end of life was of great value to the patient. Some had experiences with a very present, active and considering family and this helped the nurse in her coping as well. Another had experiences of an absent family of a disappointed breast cancer patient, and expressed her issues with this:

> I think if the medical part is well managed, but the family is unsupportive, then the patient's situation is not very good. The family has a responsibility towards the patent. She [the patient] told me this, and I agree with her. It's not just medical.

One of the nurses illustrated a situation where a patient's family actively gave their permission and blessing for the patient to die. The patient had suffered many strokes with heavy sequelae leaving the patient on bed rest and fed with a nasogastric tube for several months. When the patient unexpectedly took a turn for the worse, the family was there for him, and the nurse experienced it as encouragement for herself.

> The family is kind to me; they were like a second family to me so when I felt guilt for not being there when he died, there was some comfort in visiting his grave.

Nurses working in teams

All the nurses had experience from being a part of a team, which constituted working together and praying together at the hospital's communal temple every morning before starting the shift. When describing different situations when patients had died, the participants included the teamwork they experienced in their accounts. A nurse related feeling stronger and more knowledgeable in their teams:

> (After a patient died) …my friend called the leader team, so the leader team came home to the family and informed them. That day I felt sad, but afterwards we talk and pray together in our team and after that we were stronger.

Working in teams was also useful to quickly assemble the course of action during an emergency, when the nurse felt overwhelmed and uncertain:

> I just asked: what could I do with our team, with our doctor to help him?

Professional approach and following procedure

This subtheme illustrates how the nurses were aware of their responsibilities, and how they would stifle their emotions until they had finished their duties and assignments for the day. Emotional reactions did not stop them from continuing working that day. When asked if they had any emotional reactions that followed them during the rest of the day, nurses almost immediately mentioned having to move on to the next patient. This gave the impression that their emotional state was secondary to the needs of their next patient, as if focusing on their own emotions was somehow selfish. They were well aware that they had more responsibilities at work and had to give their other patients their attention as well, as one nurse described it:

> I felt regret, but I had another responsibility, another patient. So I thought, "if this patient died, maybe it is the way", and I moved on to my next patient.

Another nurse recalled a similar situation:

> When this patient died, I talked to my friend, but I had another responsibility. I worked with my team and then I was not too sad.

In the nurses' duties, the task of caring for the body was included and this procedure contained the duty to sit with the body for a couple of hours after confirmed death as to make sure there was no more life signs. Another part of this assignment was to tie the patient's thumbs and big toes together, as a way to keep the body and spirit "together" and in the position of prayer until cremation. It was evident that in the caring for the body, nurses implemented the religious and cultural traditions of the patient to a high extent, and described the ritual for the dead body:

> First we remove the IV and the catheters so that the patient is clean from all medical equipment. After doing that we clean the body with water, then we close the ears and nose with cotton and tie the chin.

Nurses viewed the importance of their acting professionally and correctly as important, and also as a way to justify their actions to themselves and as a way to know how to behave themselves in various situations. One nurse remembered a difficult situation when a patient died, but was certain that she had followed procedure properly and therefore she knew she had done her best:

> … if the patient is in bad condition we must call the doctor, and after doing that, I started CPR. I performed CPR until I was tired and then I checked the EKG to see the situation. Afterwards I felt I could do better but I know I did the right procedure for the patient. Maybe this was the way for him… and I did the best for him.

Education

When asked if their education had prepared them for the probable event of a patient dying, answers were inconsistent. One nurse felt the education was not enough, however the necessary knowledge and experience had been gained through working in the clinical setting. Other nurses had studied palliative care in the shape of seminars and semi-formal lectures, and considered themselves prepared enough for entering the clinical world. One nurse commented on studying to be a nurse as something that changed them as a person, and that being more knowledgeable felt good to them. Knowledge was empowering to the nurses, as they felt they had a responsibility to share their knowledge so that it benefited others. One nurse felt that her education was an asset to her in her personal life too:

> I can help people, and I can help my family too, if they don't know about health… I know many kinds of diseases, health programs and the importance of personal hygiene for nurses…

Discussion

Methodological considerations

Limitations and advantages

The design has the advantage of allowing participants to focus on and explain their feelings on a certain subject. In a similar way, the interviewer has the ability to ask follow-up questions about subjects that seemed interesting. This method gives the flexibility needed to develop an understanding for a person's story, although these interviews lacked in time. While the interviews

were short, they were very rich with information, and the nurses were eager to provide a lot of details and gave very thoughtful answers. There are a number of limitations to this study, mostly due to the small size of the study and due to linguistic and cultural barriers such as the fact that English were neither the interviewer's nor the participants' first language. The decision to not use an interpreter has most certainly affected the results. Cultural barriers may have affected the results since it is not certain that the Balinese notion and the Swedish notion of a concept means the same thing.

Since only four nurses were interviewed, the results will not be considered complete, as the results may have varied if more nurses had been interviewed. The nurses needed to return to their nursing tasks after finishing the interviews; this may have affected the depths of their answers, due to feeling pressured for time. The young age of the nurses may also have affected results, as the number of years in clinical practice may affect how nurses view their experiences, as well as it limits the numbers of encounters with death. A possible advantage considering the nurses' young age may be that the experiences they relayed were rather recent in their working life.

As all the interviews and the analyzing process was conducted by one person, the ideas are based on one person's interpretation and understanding of the material. The raw material has been viewed by Vera Dahlqvist (supervisor) and Magdalena Kegel, PhD (relative to the author and situated in Bali).

Preconceptions

According to Henricson (2012), a personal preconception consists of the author's previous earlier experiences and expectations considering the subject. Before making this field study on Bali, the author has never before been to Asia, despite having relatives who live there. The author's idea of what the Indonesian countryside and the Balinese lifestyle were like was completely based of the narratives of my relatives, from media and Swedish elementary school. The inexperience considering Asia in general and Bali in particular has proved to be a limitation to the understanding, as there has been some trouble understanding some concepts of the Balinese culture. However, there have been many opportunities to deepen the understanding since the author spent two months in Bali, living in a rural village amongst the locals. Discussing Balinese culture and Bali-Hinduism with neighbors and my relatives has also widened the understanding.

The experiences that lead the author to this subject are from the different clinical placements in nursing school when the author have been participating in performing CPR on two patients who did not survive. The author's emotional reactions following these events awoke the interest

in how others felt and how they coped. It is possible that the author's own experiences with patients' death has colored the view of the Balinese nurses' experiences.

Results discussion

The results of this study touches upon different aspects of the nursing profession related to patients' deaths. The findings that relates to the Balinese culture and nurses' experiences and emotions related to patients' deaths will be addressed. The nurses' relationship with the family will be discussed in the light of Parse's human becoming theory.

Cultural and religious aspects

When approaching the Balinese religion and culture, one needs to be aware of that there are no simple ways to describe certain phenomenon, since there are many different ideas of how and why things are. The Balinese culture and the Swedish culture are vastly different. This has become evident to the author when doing research and attempting to understand the culture.

In this study's results, one nurse recalls a situation when after a patient's death, she helped the family not to feel too much sadness, in order to help " the spirit of the deceased" to move on and "not follow the family". This statement was surprising and needed further explanation. Upon doing more research, another explanation rose to why you should not let yourself feel and express grief, the reason being that sadness and sorrow can interfere with the spirit's ascendance to heaven (Wikan, 1989a).

There is an idea in the Balinese culture that one shouldn't feel and express too many emotions in the ordinary day-to-day life either, since this opens opportunities for chaotic and unbalancing forces to enter the life of that person. These forces might make you fall ill or get bad luck. This can be connected to the nurses' stories about having to smile for the next patient after something bad had happened, both as a way of wanting to show respect, but also something deep ingrained in their cultural knowledge, that smiling is equal to wishing good health for the other person. Wikan (1989b) explains the Balinese notion that mental and physical health is closely related to the will and intention of the individual. A happy face will make a happy body and spirit and a person with good intentions will be healthier and have better karma. Therefore, a Balinese person might smile and laugh though experiencing grief or pain, since the intention to smile and be happy will help bring you health. Smiling and making jokes at a funeral is therefore not disrespectful, but an effort to bring forth health and prosperity for the bereaved. The subtheme "professional approach and following procedure", mentions the nurses' way of moving on from an emotionally charged situation to a new patient. This may also have a basis in their religion as a

way of showing the next patient respect and to protect themselves from outer forces. Another way of viewing this is the idea of karma and how selflessness and other good deeds will give you good karma, and affects you positively in the next life (Eiseman, 1990).

According to Wikan (1989b), the Balinese believe that a person is an entirety of soul, mind and body, connecting all aspects of a person. This idea is quite similar to Parse's view of the human being (Hansen-Ketchum, 2004), in which the person is considered a being of many connecting features. The human becoming theory also heavily stresses the way that the person is integrated with their surroundings, background and cultural beliefs. This way, the Balinese view of a human being agrees with Parse's theory in that the human being is indivisible and consists of multiple characteristics that are dependant on inner and outer forces.

Early pre-Hindu animistic cults, Buddhism and the fact that the beliefs may vary in the villages scattered over the island influence the Balinese culture (Suryani et al., 2011). It seems like a full understanding of Balinese culture is impossible to a foreigner, since the culture is so varied geographically. Because the beliefs vary geographically, research on Balinese culture have certain limitations. However there is an interesting body of knowledge about the culture. Wikan (1989b) explains the way the Balinese hide their emotions and try not to be too emotionally affected by life's events. In her study she relays a few situations where she was surprised by the fact that the Balinese seemed to make jokes and laugh when someone has died. To a Western person this may seem disrespectful and harmful to the grieving process, but the reality is quite the contrary.

Nurse-family relationship and the human becoming theory

The results in this theme show that nurses relate to the family of the patient in different ways and this affected the nurses to various extents. According to Parse's theory of human becoming, the human being cannot be separated from her environment and her surroundings, since all our relations will affect us (Hansen-Ketchum, 2004). Since separation from her surroundings is impossible, it is an assumption that a patient's family will be a part of the nurse's worldview.

Some of the nurses mentioned in this study that their experiences of caring for different patients varied in some correlation to the patient's family. The human becoming notion of the individual and her surroundings affecting one another in a dynamic and rhythmic way indicates that both the patient's family and the nurse will be changed by their meeting and being near each other. Sometimes these changes will be palpable to those involved, and sometimes not (Hansen-Ketchum, 2004). When applying the human becoming theory, one may argue that a nurse will also be affected by the fact that the patient's family is absent or non-existent. Since, according to the human becoming theory, all situations and individuals are unique and the only ones to

completely understand them are the persons within that relationship, there is no certain way of knowing what the nurse-family relationship looks like (Parse, 2009). However, one can be certain that all situations are different and not one is without effect on the nurse, whether the effect is manifest or latent. This is evident in the fact that the nurses mentioned the patient's family in nearly every case they relayed. Another part of this theme is the nurse's task to support the family, and how nurses used their religious and cultural knowledge to help the family of the patient. Parse's theory is applicable to this aspect as well; since the nurse's upbringing, personality and cultural background will affect her in the way she can meet the family in their time of need.

Furthermore, a study by Suryani, Lesmana and Tiliopoulos (2011) that evaluated interventions made to aid mentally ill people in Bali, offer an opinion on the matter of using the cultural and religious awareness when conducting modern medical interventions. The idea is that when approaching a culture as specific as the Balinese, the way to go is to combine medicine, traditional and community-based systems with a cultural-sensitive view. This indicates that to be able too meet the needs of the patient's family, nurses and health care practitioners should use a holistic approach.

Emotional reactions to patients' deaths

The fact that the nurses in this study experienced a variety of emotional reactions to their patients' deaths was not surprising. Their recollections of the situations were also very detailed, something that is common when nurses remember the first time a patient died, according to Kent, Anderson and Owens (2012). In their study they found that a high percentage of nurses with varying years in clinical practice could clearly remember their first patient death, with a surprising amount of details. This may explain that the Balinese nurses could describe their encounters with death in such an explicit way. The details of this first death tend to stay with the nurse through many years (Kent et al., 2012).

The results showed a number of negative feelings connected to the patient's death: grief, sadness, guilt, desperation and frustration among other things. If nurses are not allowed to express these feelings and are not supported by their organisation to deal with them there may be unwanted consequences (Houck, 2014). Houck further claims that nurses whose feelings are not dealt with in appropriate time are more likely to develop chronic grief, and are also more likely to experience compassion fatigue and therefore their patients may be affected. There is a risk that the nurses experience a decline in their ability to provide compassionate care. These nurses are also more likely to quit their jobs. Anderson, Kent & Owens, (2015) warns that not being able to

handle emotions and reactions may also lead nurses to use negative coping mechanisms such as distancing themselves from patients and avoid terminally ill patients.

None of the participants in this study expressed any positive emotions related to the patient's death. Some research has shown that sometimes nurses experience positive feelings in relation to a patient's death, such as relief, feeling glad that the patient wasn't suffering any more, pride in doing a valued work etcetera (Gama, Barbosa & Vieira, 2012).

Factors that aid coping

Religion

Some of the nurses mentioned religious practice as a way of coping with their work. Praying privately and together with the hospital staff was something that both helped them prepare for the day and helped them cope with their emotions in their work. A study by Johnston Taylor, Gober Park and Bacon Pfeiffer (2014) states that the faith was a strong personal coping factor for religious nurses. Deal (2010) offers another view of the nurse and religion, as a way to connect with the patient and create a fuller and deeper nurse-patient relationship.

Seeking support in friends

The nurses stated that seeking support from their friends was a way of coping with their reactions and emotions after a traumatic event. To seek support from friends is a common way to handle stress, and Morrissey (2005) mentions that nurses whom don't have proper, formal support from their organization tend to do this in higher extent. However, Morrissey concludes that one cannot assume that this way of coping is enough for the nurses to handle their emotions. Appropriate measures, she suggests, is to conduct staff debriefing meetings, discussion forums among other things.

The patient's family as a coping factor

It is evident in the results that some of the nurses took comfort in the presence of a patient's caring, welcoming family. One nurse even described them as her "second family". This connects to Parse's idea of a person's family being not only those whom she is connected to by blood, but also those whom she is in close physical and psychological vicinity to. Parse (2009) explains the family as an "…indivisible, unpredictable, ever-changing connectedness…" and this formulation gives weight to the possibility for a nurse to feel very close to a family that's not her own.

Education

One nurse in this study expressed a feeling of satisfaction and accomplishment connected to the education that she had received. One of the nurses felt that their education on death and the dying person was insufficient, while other nurses were content with their education. Being well educated and well equipped to do your job is very important. However, according to Cui, Shen, Ma and Zhao (2011), there seems to be a lack of education about death and the dying patient among nurses. Since the caring for the dying person and later the dead body can be a difficult experience it is important for nurses to be well prepared for this situation. The findings by Cui et al. further shows that nurses who have taken part of an end of life education program were more comfortable talking about such matters, and experienced less negative emotions when dealing with death.

Clinical implications

This study is in line with modern nursing science. It is clear that nurses who face death in their work are affected by it and have need of several coping strategies. These strategies may be religious, cultural or personal in their character, but what the participants of the study seemed to have in common were the fact that they leaned on at least one coping strategy each. Besides stressing the fact that nurses are affected by patients' deaths in various estimates, the results of this study can offer a better understanding of culturally dependent nursing care. In the light of Rosemarie Rizzo Parse's theory of human becoming, it is apparent that a person can never fully be separated from their surroundings and background, and therefore nurses will carry their experiences and values with them to work. In a similar way, nurses are likely to use coping strategies that are familiar to them as a part of their own worldview.

This study can offer a better understanding of how nurses' backgrounds and personal views will colour their daily work and their experiences. This may be useful when forming guidelines for reflection or debriefing for care units or individuals, or when assembling a team. Nurses and other professionals from different backgrounds, cultures and worldviews will be able to see a problem, patient or situation in various lights.

Further research

To expand the subject and further explore the experience of Balinese nurses and patient death, additional research is needed. It would be of interest to compare the experiences of nurses working in private hospitals to nurses in public hospitals, to see whether differences in finances, structure and the hospital's environment affects nurses. To obtain a nuanced view of nursing on

Bali, there are many aspects to explore, for example how a western nurse experience the strong cultural views when working in Bali. Other ways to further understand Balinese nurses may be to interview nurses with longer time in clinical practice, nurses in palliative care or nurses working on the countryside. This study is limited in its reach and depth, and therefore additional research on the subject would be of interest both for the universal understanding of nursing and factors that affect coping when faced with death, but also for Balinese nurses to aid development in this area.

Conclusion

The results of this study illustrate that the interviewed Balinese nurses were leaning rather heavily on their religious beliefs in their daily work, and that their cultural situations greatly affected their way of coping with patients' deaths. Other aspects that coloured their experience were their education and years in clinical practice, as they gained necessary skills working in the field. Three themes emerged during the analysis: cultural and religious aspects, factors that aid coping and emotional reactions. Among factors that aid coping were seeking support in friends, the patient's family as a coping factor, working in teams with other nurses and professions, education and religious support. A large portion of the results could be explained further with a deeper knowledge of the Balinese culture, along Bali-Hinduism, which is the most practised religion on Bali.

Some of the results can be said to be universal amongst nurses, such as the emotional reactions after a patient's death and the need for support from the team and the nurses' friends. Other research will contribute to this fact, as well to the fact that one's time in clinical practise does matter to one's experiences. What is unique about this study and its results is the heavy emphasis on the cultural and religious aspects. There are several studies on this subject, considering religion as a coping factor for nurses, but since Bali-Hinduism is such a geographically limited religion, some of the study's findings are only applicable in this context.

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Appendix 1. Interview guide

Please tell me about an ordinary day at work?

Can you recall an event when a patient of yours died unexpectedly?

Please tell me about this event?

How did you feel after this event?

How did this event affect you for the rest of the day?

Has your education form prepared you for situations like this?

Yes → Can you describe how you were prepared in training? How has this helped you to deal with your reactions?

No → Would you have liked to have preparation during training, if so, in what way?

What do you feel is important when treating dying patients?

What do you think of when I say the word "dignity"?

Is there anything that you want to add besides what we've talked about?

Appendix 2. Letter to participants

To the participants in the study "Nurses experience of a patients unexpected death"

This study is aimed at Balinese nurses who have experienced one of their patients unexpectedly dying. The purpose of this minor field study is to explore the nurses' experiences of the unexpected death of a patient in their care. The subject raises questions such as how the nurse deal with the emotional consequences, and what factors that help him or her to cope. The study aims to enable further understanding of nurses' experience of patients' deaths.

This letter is a request whether you would like to participate.

If you wish to partake in this study you will be individually interviewed about your own experiences considering the subject. The interview is like an ordinary conversation, and will last about one hour. If you allow it, I will record the interview, which will make the processing easier. No names or other personal information will be written down; as to guarantee the participants full anonymity. Claudia Kegel will be conducting the interviews. The record of the interview will be stored on a USB data key. The data collected will be stored locked up and when all the interviews are finished and the material has been processed, the USB data key will be destroyed. The result of the study will be available in paper format and online through Ersta Sköndal University College library.

Your participation in this study is fully voluntary, and this means that you at any time can choose to interrupt the interview and withdraw what you have shared without any need for explanation. You choose what you want to share and you are in no way obligated to answer all of my questions if you do not wish to.

When the final product is finished in the end of May, you will receive a copy of my study to read if you like. The finished Bachelor's thesis will also be published online in Sweden.

The ethical research committee of the institution of health care science at Ersta Sköndal University College has approved of this study 2016-01-26.

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Appendix 3. Chart of keywords, subthemes and themes

Themes	Subthemes	Keywords
Cultural and religious aspects	Nurse-patient relationship	Do their best Spiritual guidance Health=entirety Psychology Relaxing-accepting Allowing death space Fate
	Nurse-family relationship	Family-acceptance Emotional support "Keep fighting!" Sadness-wants to die Family important Fate=comforting
Factors that aid coping	Religion	Praying Awareness of afterlife Religion completes medicine Visit grave Altruistic motives
	Seeking support in friends	Confide in friends Supported by friends
	The patient's family as a coping factor	Like second family Family – kind and comforting
	Education	Well educated = empowering Gained experience working Study palliative care Not enough education Nurse = empathy not sympathy

	Professional approach and following procedure	Privacy important Caring for the body Other responsibilities Follow procedure Do their best Keep up appearances
Emotional reactions		Unexpected=chock, frightening/expected = acceptance, peace Regret, inadequacy DOA-scary Guilt, sadness – because absent Smile though sad Sadness Desperation Different as a person Grief