UNIVERSITY OF NAIROBI

COLLEGE OF HEALTH SCIENCES

SCHOOL OF NURSING SCIENCES

DOCTORS' AND NURSES' EXPERIENCES OF ETHICAL CHALLENGES IN END OF LIFE DECISIONS IN CRITICAL CARE UNIT AT KENYATTA NATIONAL HOSPITAL

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H56/11105/2018

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF THE DEGREE OF MASTER OF SCIENCE IN NURSING (CRITICAL CARE) OF THE UNIVERSITY OF NAIROBI.

OCTOBER, 2020

DECLARATION

I, **Priscilla Kagendo Mwirigi; H56/11105/2018** declare that this research project titled "Doctors and Nurses Experiences on Ethical Challenges in the end of life decisions in critical care unit at Kenyatta national hospital" is my own original work and that it has not been submitted for any other award or Master's degree in any other institution of learning.

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CERTIFICATE OF APPROVAL

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DEDICATION

I dedicate this research project to the almighty God for his sufficient Grace and gift of good health.

I also dedicate it to my family for their patience, endurance and understanding during my absentia.

To the nurses and doctors who tirelessly care for the critically ill patients

ACKNOWLEDGEMENT

First I acknowledge the almighty God for enabling me to study this far. I would like to thank my supervisors' Dr Wagoro and Dr Wakasiaka for their dedication and commitment in the supervision of this study. I would also want to acknowledge the KNH administration for allowing me to conduct the study in the institution. I appreciate Critical care nurses and doctors who participated in the study for their time. To my fellow students who gave me moral support during this study period.

LIST OF ABBREVIATIONS

CCN: Critical Care Nursing

CCU: Critical Care Unit

DNR: Do Not Resuscitate

EOL: End of Life

ERC: Ethics and Research committee

ICU: Intensive Care Unit

KNH: Kenyatta National Hospital

UoN: University of Nairobi

DEFINITION OF TERMS

Critical care unit (CCU) - is a specific area within the health institutions, that admits patients with unstable dynamic physiological state, under the care of nursing and medical professionals, and contains monitoring tools and equipment needed to offer intensive care. For the purpose of this study, Critical care units include; main critical care unit in the first floor, neural critical care unit in level four, cardiac critical care unit, medical critical care unit in level seven and level eight of KNH.

Critically ill patient- is any patient who has a life-threatening illness, or is hemodynamic ally unstable requiring any immediate form of organ support such as intubation or ventilation and can either be semi-comatose, sedated, or involuntary, admitted in the critical care unit (CCU).

Ethical Decision making- Trying to distinguish right from wrong in situations with unclear guidelines. Either, it is a process whereby the patients and clinicians cooperate in decision making and choose care plans, tests, and treatments based on scientific evidence that even out the risks and desired results with client values and preferences. This is done when clinicians have to choose between conflicting ethical principles.

End of life care- is the health care provided to an individual who is critically ill, in the final days or hours of their lives (terminal stage), with a fatal condition that has turned out to be incurable, advanced and progressive or acutely ill clients.

Ethical decisions- Are moral decisions made in regard to patient care, being responsible, fair, trusted demonstrating respect and caring for an **i**ndividual**.** Ethical decisions involves Choosing the best alternative for achieving best results or outcomes, and Complying with individual and social values, moral and regulations. Ethical decisions are guided by ethical principles that govern critical care practices; Autonomy, veracity, beneficence, non-maleficence, justice, fidelity and confidentiality Barrett et al (2019).

Ethical challenges-A conflict of values between individuals or within individuals concerning which possible options should be chosen. Experience is a situation where a nurse or a doctor undergoes an ethical challenge where he or she is required to make an ethical decision. In this study Common areas felt with ethical challenges are obtaining informed consent, truth-telling, and patient confidentiality, withdrawal and withholding treatment.

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ABSTRACT

Background: Many nurses and doctors often experience ethical problems around decision making at the end of life. Lack of guiding policies in the unit on how to deal with ethical issues contributes to stress, tension, burnout, conflicts and feelings of guilt among the clinicians, which contribute negatively to the health of the clinicians and care of the patient. It was necessary to explore the experiences of nurses and doctors on these ethical challenges in end of life care so that steps can be taken to help them cope positively.

Objective: To explore nurses' and doctors' experiences regarding ethical challenges in end of life care in KNH CCU.

Methodology: This was a qualitative study utilizing a descriptive phenomenological approach. Nurses and doctors working in KNH CCU during the study period and were willing to participate by giving informed consent, were interviewed. Purposeful sampling method was used to recruit eighteen participants who were interviewed until data saturation. An audio recording was used to store data from interviews. Data collection took three weeks. Data analysis was guided by transcendental phenomenological data analysis process using N-VIVO software. Clustering of themes took place where the researcher clustered themes that were common from the study findings.

Results: There were five major themes identified: Definition of ethical challenges, Encounter of ethical challenges; Experience on decisions in end of life care and decisions arrived at when faced by an ethical challenge.

Conclusions: Ethical challenges are a reality at KNH CCU. The nurses and doctors providing care at KNH CCU find themselves in a dilemma when faced with ethical challenges.

Recommendations: An ethical committee from KNH mandated to handle ethical challenges should be set up. Need for guidelines, protocols or policies documenting exactly what should be done should a health care provider encounter ethical challenges.

CHAPTER ONE: INTRODUCTION

1.1 Background information

Ethical challenges cause job strain and burn-out syndrome among health care workers. This eventually affects the quality of patient care (Moon, & Kim 2015; Mealer & Moss 2016). Nurses and Doctors, who work in Critical Care Units (CCUs,) encounter ethically complex and morally distressing situations in their practice, yet they are expected to make quick ethical choices in patient care. Karnik & Kanekar 2016; Molewijk et al (2015) reported that ethical challenges emerge because clients are incapable of making decisions. There is scarce knowledge concerning how medical care workers respond to ethical problems in end of life care decision making. McLeod, 2016 and Haddad,(2019) found that adaptations in the fields of medicine, raised cost of living, and a difference between what clinicians know and patient knowledge about treatment are the reasons for ethical challenges in health care. Open discussion, collaborative decision making and consistency in practice are measures to reduce ethical challenges, especially in withdrawing treatment.

Despite there being institutional structures and procedures to follow in ethical challenges, nurses and doctors are sometimes overwhelmed by feelings of despair and powerlessness (Thomas & McCullough 2014). This is especially in critical care units where rapid decision making is essential to save a life. Additionally, time delay makes the decisions made not count as they encounter ethical issues (Rushton & Stutzer, 2015). Ethical decisions also involve moral decisions made in regard to patient care. Carla and Orquidee (2014) and Wagoro and Duma (2017) define ethical decision making as the procedure of examining and picking among options, achieving the best results or outcomes in compliance with ethical principles. Ethical choices

produce and maintain trust, express caring, fairness, respect, and responsibility for patients. Haddad & Geige 2019; Antonio and Sofia, (2016) found that in making ethical choices, the critical care nurses and doctors perceive and eliminate unethical alternatives and choose the finest moral alternatives in patient plan of care. Through appropriate and adequate knowledge in ethical decision-making, nurses and doctors in CCU are able to make ethical decisions in situations where there are no clear guidelines.

Jensen et al, (2019) found out that, doctors' time and again viewed the conditions for CCU ethical decision making more favorable as opposed to nurses. In relation to CCUs with average or good ethical decision-making conditions, CCUs with poor conditions for ethical decision making had the largest discrepancies among nurses and physicians especially in end-of-life decisions, physician leadership, and interdisciplinary reflection. Service providers are frequently challenged during end-of-life decision making. This includes issues for managing costs that endanger the well-being of patients, illegal, incompetent, or unethical practices of peers, and violation of patient privacy and confidentiality (Jared and Jensen et al., 2019).

The CCU is one of the sections within the healthcare center where members of the family suffer. Globally, one of the biggest challenges facing healthcare workers concerning making decisions for end life is predictive doubts and ascertains the time to start terminal life dialogues and support with members of the family (Sameera and Amar, 2016). Moreover Gavin et al (2016) found the majority of physicians and nurses worldwide demonstrate fear of giving up too soon, withdrawing all hope, and coming up with wrong choices. Due to a lack of appropriate communication to family members from doctors, families become worried and depressed.

According to Moon, & Kim, 2015, 66.7% of members of the family who have patients in the CCU showed signs of depression or anxiety. According to the Anxiety and Depression Association of America (2018), members of the family expressed signs of depression or anxiety. Professional guidelines are needed to avoid disputes, controversial issues, and empowerments of caregivers in terminal care choices

Research by Sandra et al., (2017) indicated that professional guidelines are needed to avoid disputes, controversial issues and empowerments of caregivers in terminal care choice-making. In African countries, the majority of healthcare workers will honor an advance directive such as "do not resuscitate order", thus withholding life-sustaining therapy (Lucinda et al., 2017).For instance, president Nelson Mandela's long hospitalization sparked the end of life discussions, about life supportive management, that could not be withdrawn as the law in the country criminalizes assisted dying. The constitution of Kenya (2010) considers life sacred, thus ethical challenges regarding end of life care are considered as major challenges among healthcare providers working especially in a critical care unit (Gitonga and Wambua, 2017). Even with the intensity of ethical challenges encountered in CCU, not much information has been written about the contribution of nurses and doctors concerning them (Mutinda and Wagoro, 2017). This research aims to explore the ethical challenges faced by nurses and doctors working in CCUs in their everyday practice.

1.2 Statement of the problem

Nurses and Doctors working in the critical care unit face varying experiences and perceptions on ethical challenges and decision making (Douglas, 2018, Kathleen, 2018; Mutinda & Wagoro,

2017). Ethical challenges are a source of stress among nurses and doctors working in the critical care unit and they require interventions because decisions made might affect the outcome of patient care (Perrin, 2019). An ethical challenge occurs when an ethical principle conflicts with a value (Barrett et al., 2019). Critically ill patients present with complex illnesses that require the use of sophisticated technology and rapid decision making by nurses and doctors in order to deliver timely quality health care. Downar et al., (2016) argue that taking away measures that help sustain life is a very dormant issue in the CCU, yet it entails a sophisticated sense of balance between ethical, health, and legal deliberations.

According to Kamik, (2016) no complete guidelines to aid in ensuring medical professionals make appropriate ethical decisions and so this calls for training. Kathleen, (2018) recommended that nurses and physicians take part in ethical discourse to support and understand the moral load shouldered by other individuals. Moreira & Fernandes (2012), Reitinger & Heimerl (2014) emphasized that the primary approaches to address these ethical issues are to share views, experiences, and feelings on moral challenges during group dialogues and explore ways of overcoming them, because a shared problem is half solved. In Kenya, sadly no research has been conducted on ethical challenges among doctors and nurses dealing with terminal care among acutely ill patients. Also the law does not allow euthanasia as life is sacred according to the Kenyan constitution 2010.

The researcher noted that there are no policies or legal guidelines that govern ethical decision making in our country on areas such as withdrawal and withholding mechanical ventilation or offering minimal support to patients with the unrecoverable condition, such as brain stem death

despite positive caloric reflex tests. Advance directives by relatives like DO NOT RESUSCITATE ORDER were sometimes not adhered to in clinical settings. Sometimes, no one is comfortable to document it down and disclose to the family. It is difficult to obtain informed consent from critically ill patients who are on mechanical ventilation and are unconscious. During the researcher's experience in CCU KNH, the researcher noted that, doctors and nurses do not have discussions to share experiences on ethical challenges that they encounter. The researcher noted that there are no communication structures or platforms where both nurses and doctors come together for ethical discussions, which are meant to allow health care professionals to reflect on their routine choices. In some cases where patients were terminally ill, many health care providers (doctors and nurses) were actively resuscitating the patient knowing very well that nothing much was expected.

The researcher also noted that even for those patients who had a brain stem death, there was no law or even policy governing the doctors to comfortably minimize ventilator settings and even extubate the patients, to create a bed for acute critically ill patient with a recoverable condition awaiting a bed in CCU. While working in the pediatric intensive care unit (PICU), the researcher noted that there was a critically ill child on mechanical ventilation and in a status quo. For this situation, disclosure to the mother of this child was a challenge to both the doctors and the nurses. It's for this reason that the researcher explores the experiences and perceptions of doctors and nurses towards ethical challenges in end of life care.

1.3 Justification

Ethical challenges are common phenomena among nurses and doctors in the critical care unit, therefore the decision made might affect the outcome of the patient care (Perrin, 2019). Antonio &Sofia (2016) noted that nurses and doctors encounter ethical challenges because they are the majority, usually at the forefront giving critical care and spend more time with the patients. Ethical challenges are encountered daily and the speed needed to come up with choices always stops critical care nurses and doctors from developing an understanding of the patient's feelings, desires and values (Antonio & Sofia 2016).

Downar et al., (2016) argue that taking away measures that help sustain life is a very dormant issue in the CCU, yet it entails a sophisticated sense of balance between ethical, health, and legal deliberations. No research has been done on ethical challenges among doctors and nurses dealing with terminal care among acutely ill patients. Also the law does not allow euthanasia as life is sacred according to the Kenyan constitution 2010. Nonetheless, according to Kamik, (2016), a handful of healthcare givers possess specific knowledge and education meant for pulling out life-sustaining strategies, and there are no complete guidelines to aid in ensuring medical professionals offer the best quality of care to families and patients, and so this calls for training. Researchers also noted that there is no policy or legal guidelines that govern ethical decision making in our country on areas such as Withdrawal and withholding mechanical ventilation to patients with unrecoverable conditions, such as brain stem death with positive caloric reflex tests. Advance directives by relatives like DO NOT RESUSCITATE ORDER are sometimes not adhered to in clinical settings. Sometimes, no one is comfortable to document it down and

disclose to the family. It is difficult to obtain informed consent from critically ill patients who are on mechanical ventilation and are unconscious.

The current inquiry, therefore, endeavors to discover nurses and doctors experiences and perceptions with regard to ethical challenges in end of life decisions among critically ill patients in CCU at KNH. This will be critical in helping develop evidence-based recommendations and protocols in addressing such ethical challenges in the future.

1.4 Value of the study

Empirical evidence shows that doctors and nurses experience ethical challenges in deciding treatment plans to prolong life artificially (Cheon et al., 2015). In seeking the ethical challenges experienced by nurses and doctors, it is expected that the emotional, physical and social challenges woulds be gotten from the study. Secondly, the situations that often trigger ethical challenges and how the clinical team experiences it would be known. Thirdly, how ethical challenges experienced by nurses and doctors compare in their different roles of patient care were established.

Research done by Sandra et al. (2017) and Anke et al (2015) indicated that professional guidelines are needed on processes of making decisions that concern therapeutic care in terminal life conditions. Additionally, this enhances decisions made as well as empowering caregivers in coming up with terminal life choices. From the expected study findings, the expected recommendations were to formulate ways to address ethical challenges. The study recommendations if implemented would aid in solving disputes, conflicts, tension and stress that

often are a result of unresolved ethical challenges. Importantly, the expected conclusions from the study could be used by other scholars to do studies on ethical challenges. Lastly, the study was expected to add research knowledge that will be used in the development of the curriculum taught on ethical challenges in nursing and medical school.

1.5 Research questions

The researcher sought to respond to the following study questions:

1. What were the ethical challenges that nurses and doctors experience in CCU, KNH?
2. How were the ethical challenges experienced by nurses and doctors in CCU, KNH?
3. What was the comparison between the ethical challenges experienced by nurses and doctors in CCU, KNH?

1.6 Broad objectives

To explore nurses and doctors experiences regarding ethical challenges in end of life care in CCU, KNH.

1.7 Specific objectives

1. To describe the ethical challenges that nurses and doctors experience in CCU, KNH.
2. To describe how ethical challenges are experienced by nurses and doctors in CCU, KNH.
3. To compare the ethical challenges experienced by nurses and doctors in CCU, KNH.

1.8 Study assumptions

The current study assumed that:

- The participants had an interest in providing information and that the administration of KNH and CCU was supportive and allowed the study to be conducted.
- The respondents gave truthful and accurate information regarding ethical challenges surrounding end of life support

1.9 Scope of the study

This research focused on the experiences of doctors and nurses on ethical challenges regarding terminal life care in CCU, KNH. Doctors and nurses working in CCU, KNH were the target group.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

The chapter focused on ethical challenges in the Critical Care unit, the effects of ethical challenges among nurses and doctors and the comparison of ethical challenges between nurses and doctors. Sources of literature review were from internet sources. They were focusing on ethical challenges, practices regarding ethical challenges, and types of ethical challenges in CCU.

2.2 Ethical challenges in the critical care unit

Ethical challenges are legible decisions made in regard to patient care. Morals are those that should be done and those that should not; ought and ought not of actions and behaviors. Religious and culture determine the moral decisions of people in societies. Ethical challenges results due to actions that make the bearer of actions ponder whether it was right or wrong .They occur when ethical principle conflicts with a value. Ethics is defined as an evaluation of actions based on particular defined regulations. Ethical decisions involve deciding the best option that achieves positive results and complies with known norms and values (Barrett et al., 2019).

Ethical decisions are guided by ethical principles that govern critical care practices; autonomy, veracity, beneficence, non-maleficence, justice, fidelity and confidentiality. Doctors and Nurses employed in CCUs are often faced with various ethical challenges associated with the care of patients on life support machines whose care in some cases may be futile or of no benefit to the patients themselves (Douglas, 2018). These ethical challenges arise from patient care and in their

professional practice as critical care and other healthcare personnel attending to very sick patients on life support machines, sometimes with very poor prognosis but with very hopeful relatives (Rui and Donghao, 2016).

Ethical challenges which doctors and nurses are exposed to, challenge their ethical competence and may cause a lot of work-related distress and burnout (Downer et al., 2016). Nurses encounter ethical challenges when they find themselves in states where they are unable to practice what is deemed right for the practice, and end up experiencing moral anguish. Some nurses are bold enough to talk about it; others do not (Anker et al., 2015). Further, Douglas (2018) indicates that when patients keep relying on life-supportive measures; neither recovering nor dying with hopes idealistically high amongst relatives, makes doctors and nurses have a difficult situation in telling the truth about the patients' prognosis to the relatives, resulting to ethical conflict.

According to Melissa et al (2016) death in an ICU is in most cases considered a demoralizing encounter for healthcare workers, their families and their patients. Chiarchiaro et al, (2017) adds that on-going treatments for sustaining life with no medical enhancement is a major challenge to critical health care personnel and exposes patients to much pain as well as denies them together with their family members' honest prognostic information, palliative care, as well as lessen families' time to prepare for mourning and patient's time to be ready for death. However, in their study, Somayeh and Headiest (2016) found that, prolonged existence with poor quality of life in terminally ill patients has been a major problem for health care professionals, particularly nurses and doctors as they need to ascertain the effectiveness and inefficacy of medications.

2.3 Types of ethical challenges in end of life care in CCU

Nurses working in CCUs experience ethical challenges day in day out be it, concerning helping a family or patient address their own moral issues or professional ethics. This lesson as narrated by *Russell (2019)* touches on a few of the most commonly moral challenges in critical care nursing: palliative care, withdrawal of care, attorney's medical power, and advanced directives, euthanasia, do not resuscitate orders(DNR), and futile treatment. Also obtaining consent from the critically ill unconscious or semiconscious patient is a challenge to doctors and nurses because the illness incapacitates the patient. Hence the next of kin to an unconscious patient are often approached for informed consent, of which the authenticity of the relationship could be questionable. In addition, the critical care nurse or doctor is not sure whether the next of kin caused the injury since the patient is not able to talk at that moment these results to dilemma. The researcher noted in clinical practice that the next of kin is the person written on the file of the patient of which he or she could be the person who actually caused the assault.

For instance let's say Patient J has suffered damage to his lungs and can no longer breathe on his own. He will be attached to a ventilator for the rest of his life, and he needs to be revived several times a month. However, Patient J is awake and oriented the majority of the time. During one oriented period, he asks to be made a do-not-resuscitate (DNR) patient, implying that if his heart stops again, he doesn't want to be brought back. Patient J's sister doesn't agree with this and tells the hospital her brother isn't competent. She threatens to sue if the hospital allows her brother to become a DNR patient. She wants everything done to keep him alive. The cycle of Patient J's heart-stopping and being revived continues for several months. Finally, the hospital is able to assemble an ethics committee to determine that Patient J is competent and able to make his own decisions. He chooses to become a DNR patient and dies peacefully within a few days.

2.3.1 Palliative care and withdrawing care

Russell (2019) continues to explain that, in Patient J's situation, once he became a DNR, he didn't remove his ventilator; he chose palliative care. Palliative care is defined as pain management to a patient till transition to death takes place. The patient is sustained with meal and fluid but nothing considered a life-saving measure, such as cardiopulmonary resuscitation, dialysis, or surgery, unless surgery is to relieve pain and not aimed at curing the patient.

Had Patient J decided that he wanted to remove the ventilator that was keeping him alive, he would have been withdrawing care? This is seen a lot in patients who are brain dead, but their heart is still beating. In this case, all life-saving components, such as the ventilator and any medications, would be stopped, and the patient would be allowed to pass away. Patient J's scenario is all too common in the ICU. When a patient is dying, one family member might want everything done to keep the patient alive, while other family members (or the patient himself or herself) might want a peaceful death. This is when the attorney's medical authority or advance directive is very useful. If the patient has neither, then the hospital ethics committee must determine what the appropriate action is.

2.3.2 Advance directives

An advance directive is a statement that is written by the patient and signed by two witnesses (not family members) that details how the patient would like to be cared for should he or she become terminally ill or unable to make decisions, in which case this record chooses someone to come up with medical choices for the patient. In many countries, advance directives are

renowned in one form or another. For instance, in the USA, advance directives are recognized by legislative act in all fifty states. Advance directives can be considered legally binding if they are set up as per the outlines set forth by relevant law. Doctors and nurses use this statement to determine what the patient's wishes are and make sure they are followed. Advance directives are two-folded: Attorney's medical power and living wills. With the living wills, a person's wishes are made known through written notes; however, on his own, he or she cannot pick a person to act on or make such decisions or act on his behalf. On the other hand, the power of the Attorney general appoints a person but doesn't allocate property following a person's death.

2.3.3 Withholding or withdrawal of life-sustaining treatments

Once it is agreed that a particular intervention is not appropriate because the patient refuses it or it proves ineffective, it may be withdrawn (Breen et al, 2017). The moral issue in Withholding/withdrawal of an intervention is to ensure patient comfort. Studies have shown that the most prevalent conflicts in critical care ethical challenges are to do with Withdrawing life-sustaining equipment (Breen et al, 2017).

2.3.4 Euthanasia

It is derived from Greek words *EU* and *Thanatos* which means a peaceful death. It is a way of transiting to death without pain. It is carried out in a manner that does not withhold medication or overdosing drugs (Friedman, 2014). Euthanasia though legalized in some countries like Holland may pose challenges to the critical care nurses and doctors since it conflicts with the duty to save a life

2.3.5 Do-Not-Resuscitate (DNR) orders

If Cardio Pulmonary Resuscitation does not have demonstrable benefits, the patient or family desire for the intervention is irrelevant. The patient through their proxy may also want to exercise their "right to die" for instance, in the USA the society for the right to die receives more than 100,000 requests each month for living wills since June 1990 (Wesley, 2016). The critical care nurses and doctors may face ethical challenges in case relatives demand resuscitation to be done on a patient who had given a DNR order before becoming incompetent.

2.3.6 Living will

This is a written notice where the patient describes all medical interventions that are to be done on them when they are unable to make the decision. "Durable power of attorney" (DPAHC) is a tool used by a health representative of the patient that legalizes medical decisions for any patient when they cannot decide (Dominic, 2016). Clients are becoming increasingly informed of their rights and critical care nurses and doctors as well as other healthcare providers who do not use the documents that have the patient's wishes regarding life-sustaining care e.g. the 1durable power of Attorney may face lawsuits by either the patient or relatives (Laura, 2015).The critical care nurses and doctors have a responsibility to ensure decisions are made in the patient's best interests which may generate conflicts with the proxy if he makes life-threatening decisions. Researchers have shown that most of the ethical challenges in end- of - life care centered mostly on advance directives (Ormond, 2017).

2.3.7 Futile treatment

Nurses and doctors working in CCU are confronted with life-saving treatment decisions that are centered on inappropriate use of antibiotics, artificial nutrition, mechanical ventilation which may be of little benefit to the patient as well as burdensome to both the nurses, doctors and the patient (Teresa, 2018).The dilemma arises as to when some of these therapies should be stopped and who is to decide.

2.3.8 Allocation of scarce medical resources

This may affect the nurses and doctors directly or indirectly. Critical care Nurses and doctors Managers have a right to make ethical decisions using the required guidelines of the hospital and unit. They have a role in safeguarding human rights provided that nurses and doctors ensure provision of adequate treatment within the available resources and that there is no impartiality. This goes in line with the principle of justice.

Most of the developing countries e.g. Kenya lack adequate resources in the critical care areas to include dialysis machines, staff, beds, disposable material, personal protective equipments etc. Application of justice under these circumstances may pose a dilemma to the critical care nurses and doctors. The priorities determined by the professionals in the CCU to give a certain preference to some patients over others whom they consider more deserving may be questioned in the name of justice if the patients suffer neglect as a result. Therefore; allocation of resources can lead to a dilemma when the decision made does not lead to better patient outcomes and in situations where resources are scarce.

2.4 Experiences on Ethical challenges

Weygand et al. (2015) posit that intensive care patient's service with possibly recoverable states who can gain from increased in-depth observation and invasive care as compared to when it can safely be offered in high dependency areas or general wards. ICU ought to have defined operational guidelines on a consultant to consultant referral, multidisciplinary care, and good communication where necessary (Majuta, 2016). The critical care unit (CCU) is a famous area to pass away (Sumaira et al., 2017). Moreover, frequent moral disputes amongst shareholders take place in the CCU (Merve et al., 2018), and can manifest with burnouts, conflicts, disagreements, and mass turnover among health caregivers. Nonetheless, the clinicians employed in CCU ought to be qualified and competent in almost all areas for moral choice making.

According to Moon and Kim, (2015) the root causes of disputes are end-of-life matters such as the lack of respect for the independence of the patient, as well as behavioral matters, like poor communication amid nurses and physicians or verbal abuse. However, Connolly, et al (2016) urges the CCU physicians to be thoughtful about conflicts arising out of behaviors to ensure the sharing of choices that pertain to terminal life care. According to Melissa et al, (2016) moral disputes are greatly related to the burnout syndrome and job strain among caregivers, and as a result, may compromise the quality of medical treatment. In addition Zakaria, (2016) suggests that dealing with ethical clashes in a proper manner should be taken as a more comprehensive and vital area in order to enhance the quality of life.

2.5 Effects of ethical challenges by nurses and doctors

According to Braus et al (2016), admission to a CCU is distressing to the care givers, the patients and their members of the family. Members of the families are thought not to get the much-needed attention as their preferences and needs are inaccurately and erroneously analyzed by medical care workers. Terminal life care in CCU by the health care team is often ineffective and inadequate due to the absence of good communication amid caregivers and patients, absence of psychosocial and emotional support, absence of family-patient centered care and inadequate resources (Shorofi et al, 2016). In a survey done by Devlin et al (2018) on clinical guidelines and practices family support in the patient-oriented ICU in the USA, CCU doctors and nurses were incapable of delivering treatment as per the wishes of the patient. Considering the primary duty of nurses and doctors in terminal life decision making, patient care as well as their increased role in families and patients' attitudes, the surrounding moral issues, counseling and support services on healthcare futility are crucial for such team members (Somayeh and Hedayat 2016).

Gavin et al (2016) in his study on "Avoid cardiopulmonary resuscitation choices", nurses working in CCU will continue giving care to the patients as required but will stop active treatment if advised to do so by the doctors or physicians they are working with. In the same study, the majority of the nurses were resuscitating patients minimally in cases where there were -do not resuscitate directives, only less than half obeyed the directive of Do Not Resuscitate order. Health care practitioners in the CCUs should come up with appropriate and accurate choices without delay when patients possess little physiologic reserve and in situations where there is a high degree of uncertainty and stress (Geoffrey and Cristina, 2015). Decisions meant for disease diagnosis in CCU areas always put patients to the treatment approaches that can be correct if not damaging. Decisions related to diagnoses crowd our practice at each time; but the

plans that people's minds employ to come up with these judgments are possibly the element of health care that we have little knowledge of (Mark, 2016).

2.6 Comparison between nurses and doctors experiences on ethical challenges

When there is a demand from the patient and his members of the family to discontinue the treatment, nurses and doctors always carry it on even among states and nations with laws that provides for the right of the patient to reject therapy (Sandra et al, 2018). Interns expect nurses to fulfill their "orders" while nurses themselves have many expectations that physicians know what to do and have all the answers whenever a problem springs up (Geoffrey and Cristina 2015). Financial constraints, the absence of leadership protocols and guidelines that control inter-professional cooperation, planned performance focused on patient throughput at the expense of measures of strengthening the team, gaps in professional education, as well as lack of staffing that increase workload may play a part in disputes (Pablo et al, 2018).

The wider cultural, social, political, and legal background can contribute to disputes, improving expectations and perceptions, including conventional hierarchies, cultural values, gender roles, or ethical norms. All the aforementioned factors can have a bearing on the disputes, frustrations, and misunderstandings that are faced routinely as doctors and nurses collaborate in the intensive care units (American Sentinel University, 2015). Misunderstandings in the CCUs are primary concerns, where inter- and intra-team disputes altogether take place among families, all professional groups, and patients (Wujtewicz et al, 2015). Frequent fights happen amid doctors and nurses, with those involving family members, nursing teams and between CCU personnel coming second.

In conflicts and meetings involving health care team, where various members of healthcare facility hold divergent attitudes and opinions concerning prolongation of treatment meant to sustain life, the consultant's opinion that active cure ought to be furthered comes first, even if the rest of group members including nurses see this cure to be ineffective (American Sentinel University,2015). According to a study done by Sumaira et al, (2017) on the views of nurses and physician about decision making that concerns end-life-care in the CCU, the authoritarian attitude which is exhibited by consultants is a hindrance which limits the delivery of quality terminal life care to clients in the CCU.

The root causes of fights and misunderstandings are perceived to be improper approach towards patient treatment, poor quality of information offered, as well as unsatisfactory means of communication (Maryam and Nahid, 2016). According to Devlin et al (2018), the conflicts between physician and nurse in the ICU include animosity or mistrust, non-transparent or unclear processes for making decisions, and lack of respect. CCU disputes can have far-reaching negative effects for all health care members, including wider society, patients, families, doctors, and nurses (Nadeem et al, 2018). An interview of patients together with their members of the family, by Debra et al, (2015) found that communication skills are important in ensuring good quality of ICU medication.

2.7 Challenges in end of life care ethical decisions

Patients' management at the terminal life shall entail ethically challenging matters such as pulling out and preservation of interventions, and life-sustaining treatment, health futility, and physicians

assisted suicide (Sandra et al 2018). The terminal care choices to prolong life are weighed on the grounds of quality of life following this advanced therapy, patient-focused care, and have to be considered together with the common process of decision making (Robert et al, 2017). Such emerging technologies and medical treatments are escalating the number of individuals in the look for prolonged care. With the increased older population as well as the analysis of the projected rise in this populace, it is hard if not impossible to offer long-term advanced treatment and care to the population (American College of Healthcare Executives, 2019).

Everyone must know that patients are humans and thus consider making plans and getting information for terminal life care priorities (Sameera and Amar, 2016). In the case of unsuccessful cures, patients together with their families can morally weigh the alternative for safe and comfortable care (Geoffrey and Cristina, 2015). Professionals in the healthcare centers are working hard towards the tough task of educating the patient the value of refusing treatment because in some incidences can cause harm or may not completely benefit them (Sameera & Amar, 2016).

According to a study by Eva and Venke (2015) on "ethical challenges in critical care unit among nurses and doctors", established that the common ethical challenges experienced by nurses were terminal life matters; if there need to be an age limit for coronary surgery; conditions in which it's more damaging than beneficial to carry on treatment; and allocation of resources with regard to better staffing. Braus et al (2016) established that nurses are faced with various ethical challenges in the critical care unit, and when they are faced with such ethical challenges, they tend to utilize agreements as their common criteria for guiding decisions as opposed to the needs

and well-being of patients. In their study, Creutzfeldt et al (2015) death in the CCU always take place following an exacerbation of a recurring life-limiting disease or serious illness that threatens life which results in intensive medication. In many instances, people admitted in the CCU pass away following the withdrawal or preservation of life-sustaining measures.

According to (Silen, 2018), one significant challenge facing doctors and nurses in the critical care unit is concerning EOL choice-making, Patient prognosis, establishing when to initiate EOL support and discussions with family members, as well as prognostic uncertainty. This concurs with Carson et al (2016) that the majority of the Nurses and physicians worldwide express fear and are afraid of not providing psychological support and make the wrong decision or neglect care of the patient and this is a major source of ethical challenges. Further, Hinkle et al, (2015) states it's hard for the health care professionals and members of the family all together to relinquish curative care, which could be mainly because medical care workers feel poorly trained to ascertain how and when to launch these EOL dialogues.

2.8 Theoretical framework

The *Travelbee*'s *Human-to-Human relationships* theory (1971) is a theory used because it explains the relationship between nurse –patient, their communication and cooperation. Cooperation and communication are useful ways to minimize ethical problems in the care. The theory of *Human-to-Human relationship* was selected because the nurse, the doctor and the patient are unique human being and cooperate with each other in the planning care. Both parties are involved in an interaction, which makes it possible for them to have a relationship with each other

The purpose of theory is to assist an individual and his/her family to decrease their suffering and help them to find the meanings of ethical situations. The nurse or doctor knows that the patient is thinking, acting, feeling and experiencing and then structures; interventions to use available knowledge and understanding to be aware and recognize the uniqueness of this human being as a patient and also meet the patient's needs. The nurse and the doctor should access similarities and differences between him/herself in order to identify any requirement of the ill person and family as they interact.

According to the *Travelbee's Human-to-Human relationships* theory (1971) the nurse and the doctor should have a common understanding between himself/herself and the patient in a meeting and also have an understanding of what they are communicating about. Human, communication, meaning of life, suffering and human relationships are important concepts in the theory (Sarvimäki & Stenbock-Hult, 2008). In this theory it is important that the nurse and the doctor understands and cares about another person's suffering and the interactions between them are also discussed. In addition this interaction between them includes any contact during communication verbally or non-verbally. Every individual is unique and experiences suffering differently. Most patients have difficulties to communicate their suffering and it is not always possible to communicate this with someone else. That's why nurses and doctors working in CCU need communication technique as a method to assist the patient to create a comprehensive picture of himself or herself and his or her illness. They also need communication technique to identify patients' needs and finally assist them during the decision-making process.

Human to-Human relationship is a series of experiences between a nurse, the doctor and a sick person. The human being is always in the process of changing, and this process is not time dependent. In addition this process does not happen immediately, whereas it builds up day by day in interaction between the health care personnel the ill person and family members. The health care personnel should assist individuals to maintain hope and avoid hopelessness by being available and willing to help for example by listening to the ill persons, their discomfort or feelings of disabilities and well-being contribute to health. The researcher adapted this theory because in CCU, the nurses, the doctors, the patients and the family interact often. The researcher also indicates that critically ill patients' needs in the end-of-life care cannot be met independently and they have difficulties to communicate their needs due to their critical illness.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Study design

The study was qualitative study utilizing descriptive phenomenology to explore nurses' and doctors experiences on ethical challenges regarding end of life care through interviews.

3.2 Phenomenology

Descriptive phenomenology is a qualitative research that describes lived experiences of study participants in their natural settings (Morrow, Rodriguez, & King, 2015, Sihre, 2019; Shosha, 2014). It was developed in the 20th century by philosophers such as Husserl, and Sartre, with the purpose of exploring the essence, meaning, and structure of an individual or group of people's life experiences about a certain concept (Annelie et al, 2019). Phenomenology yields qualitative data. It provides room to explore individuals' experiences and perceptions in their natural settings without predetermined criteria (Rubin and Belkany, 2017). For this study, transcendental phenomenology was used. It focused on describing individual experiences. Individual perceptions and challenges vary and so an in-depth individual interview produces rich information regarding nurses 'and doctors' perceptions of ethical challenges. The researcher, therefore, explored in detail, the ethical challenges encountered by doctors and nurses in clinical practices when offering end of life care.

3.3 Study site

The current research work was carried in the main CCU/KNH, situated at tower block on the first floor. The hospital has a capacity of 21 beds with full equipment, and it admits clients

nationwide from the wards and theatres and through accident and emergency department. KNH is situated along the capital city of Nairobi along the hospital road in the upper hill. The hospital was established in 1901, it has a bed capacity of 1800. Besides the main CCU, the hospital also has other satellite CCUs namely; neonatal CCU, pediatric CCU, neurological CCU, medical and cardiology CCU (data was gotten from the KNH administration office on 21st January, 2020 by the researcher). The main CCU admits all patients who require critical care except neonates who go to NICU. Sixty (60) percent of patients admitted in the main CCU have brain injuries, other conditions include severe sepsis, post-cardiac surgical patients, multiple organ failure, motor neural defects, and Obstetrics emergencies.

The researcher while on clinical practice in CCU noted that due to increased demands of hospital beds, the neonates were also being admitted to CCU especially when there was no space in NICU and in PICU. KNH provided a good study site since it is the largest referral hospital in East and Central Africa. The Critical Care Unit has a bed capacity of 21 beds, the largest bed capacity in the region of Africa. The nurses and doctors working in the hospital thus have a lot of experience in dealing with a lot of patients and thus are faced with ethical challenges on a daily basis. Being a teaching hospital, the nurses and doctors were more willing to participate in the study after the informed consent process. The study findings would thus be useful for the nurses and doctors by informing them of the existing gaps in ethical challenges and recommending suggestions to decrease the time spent in making ethical decisions.

3.4 Study population

The study population comprised of all nurses and doctors offering services in the CCUs in KNH. They are generally the main health care practitioners, have rich source of information and are also involved in decision making at end of life care. They are the main providers of direct care to patients and take long hours with patients in CCU hence are subjected to ethical challenges. According to the human resource records of the hospital (gotten on January, 2020) there were one hundred and ten (110) nurses and fifty (50) doctors who worked and manned the CCU unit.

3.5 Sample size determination

Sample size was determined by saturation of data as recommended in phenomenological qualitative research (Ahmed, 2016; Shire et al, 2019, Rodriguez, & King, 2015). In this study, sampling was done until saturation was achieved and it ceased when no new information was discovered and no new data was generated. Following that the researcher was able to get a sample size of 18 participants. Data saturation is the point when no new information is obtained (Sandra et al, 2017).

3.6 Sampling technique

Purposive sampling

The researcher utilized purposive sampling method to identify study participants (nurses and doctors) who were actively giving care to patient, and had rich source of information on ethical challenges. . The researcher explained to the ward manager about the study title, objectives and methodology, thereafter explained to the nurses at report giving and taking time and to individual nurses as the researcher met them. Saturation reached after 18 participants were interviewed.

Purposive sampling is a non-probability sampling method where subjects are selected based on the characteristics of a population and the objectives of the study. The characteristics included the ages of the participants, gender, number of years of CCU experience and specialization. The guide lines for sampling in qualitative research studies propose a sample size of between 5 to 20 participants (Gentles et al, 2015) because the intention of qualitative research is not generalization but reaching saturation.

3.7 Inclusion /exclusion criteria

3.7.1 Inclusion criteria

The investigator recruited participants who had experience of ethical decisions and were willing to share their thoughts and experiences (Moser and Korstjens, 2018).

- Nurses and doctors who were working in KNH CCU during study period and were willing to participate by giving informed consent.
- All nurses and doctors who had worked for more than one year in KNH CCU to be able to share their lived experiences in ethical decisions and were willing to participate in the study by signing an informed consent.

3.7.2 Exclusion criteria

- Nurses and doctors who had worked for more than one year in KNH CCU but were on leave during study period
- Nurses and doctors who refused to consent for the study
- Nurses and doctors who were working in KNH CCU and were willing to participate but were on quarantine due to Covid-19

3.8 Recruitment processes

3.8.1 Recruitment of nurses

After all approvals by ethics and research committee and the KNH hospital to collect data were received, the researcher then visited the CCU daily at 7.30 am. The time was selected because it was report taking and giving time for the nurses in the morning shift. Approximately fifteen to twenty nurses reported to CCU each morning for duty, with four doctors also reporting for duty in the morning. The researcher explained to the ward manager and also to the nurses in general about the study. The researcher then met with the individual prospective participant. The objectives and procedure of the research was explained to the individual's nurse and the ward managers. They were also informed by the researcher the intention to carry out the study. Willing participant was asked by the researcher on the most appropriate time for interview bearing in mind that CCU is a busy unit with critically ill patients who require medical care. The researcher was taking mobile phone contacts of the nurses who were scheduled for an interview, together with their preferred dates and time for the scheduled interviews. The researcher continued with recruitment process each morning after nurses' hand over the morning report till data saturation.

3.8.2 Recruitment of doctors

The recruitment process of doctors was the same as nurses, the only difference being in the time to recruit the doctors. The researcher used the time after doctors ward round from 10 am to recruit them. The time was selected because it was at this time that doctors had finished ward rounds and were informed of the study and asked to participate in the study. A meeting was held with the individual doctors afterward round report was over and the objectives and procedure of

the research was explained to the individual doctor. They were informed verbally by the researcher the intention to carry out the study. Willing participant was asked by the researcher on the most appropriate time for interview bearing in mind that CCU is a busy unit with critically ill patients and emergency procedures such as resuscitation. The researcher continued with recruitment process each morning after doctors round until data saturation reached.

3.9 Data collection

3.9.1 Data collection tools

An in-depth interview study guide (Appendix III) was used to collect data from participants. The tool was researcher developed and subjected to peer review and expert opinion sought for accuracy and validity. This tool was used for qualitative data collection during interviews with the nurses and doctors. The interview guide (Appendix III) was constructed to answer the research questions and objectives. It contained six questions open-ended with the respective prompts to facilitate understanding of the participant. The interview guide took approximately 30 -40 minutes to administer to each participant, the time was within the guideline of MOH on duration of physical meeting.

It was used by the researcher to obtain information regarding nurses and doctors experiences on ethical challenges. The nurses and doctors explained ethical challenges they experience when offering terminal life care, among acutely ill patients in CCU. They also described their practices in addressing ethical challenges arising during the end of life support in CCU, KNH and the situations in which they felt challenged in making decisions regarding end of life care.

3.9.2 Data collection method

In-depth interviews were conducted by the researcher, one nurse or doctor per interview, during

a convenient time for the participant. Interviews were conducted in an environment approved by the Ministry of Health within CCU and in a convenient location to the participants. They were conducted face to face. Interviews were audio-recorded using a tape recorder with the participants consent. Audio recording was done to ensure correctness of information. Each participant was interviewed once. Data collection continued until saturation reached. Interviewing was considered because it was a valuable method for exploring the construction of meanings from participants in their natural settings (Alshenqeeti, 2014). Also Interviews allowed study participants to speak in their own voices and express feelings as well as thoughts. After signing a consent form, the participant was then interviewed. The participant was probed through the use of follow up questions. Every participant was interviewed and audio recording was done by the researcher using a tape recorder throughout the interview process.

Interviews were conducted in English at the participant's convenient place and time, ensuring privacy, freedom from distraction. An interview was lasting for 30 to 40 minutes; however time varied according to the individual participant and the occurrence of emergency procedures. The Participants were then assigned an identity to avoid identification. After each interview was documented, transcription was done by trained and qualified personnel. The process involves putting each recorded interview audio on the website and text was automatically generated from the recorded audio to text. Any personal identifying information on the recording was de-identified during transcription to ensure participants confidentiality. The researcher then compiled notes as soon as the interview was done and transcription followed. A qualified trained transcriber who had experience did transcription through repeated careful listening to audio records, familiarizing with data and paying attention to what the participant said then typed what had been audio recorded. Verbatim transcription was done whereby the principal investigator captured each verbal sound in an audio recording into a text format transferring everything on an

audio file exactly the way it was delivered, including the pauses, non-verbal utterances and even silence and got meaning of words used in different language.

3.9.3 Field Notes

Field notes were generated during the interviews. The notes were paraphrased statements, direct quotations and personal comments made by the participants. According to Julia and Jana (2017),Deggu and cruz (2018), field notes are widely recommended in qualitative research as a means of documenting needed contextual information. They are also facts used as valuable sources of data to understand what the participant was not able to express orally. The researcher read interview transcripts several times; made detailed notes and interpretations with each reading. From the comprehensive notes developed from the initial readings, the researcher constructed short clear and understandable information; they did not form part of the data. The notes were intended to be read as evidence that gave meaning and aided in the understanding of the phenomenon under study. The notes also help the researcher to remember any forgotten information or refer.

3.9.4 Trustworthiness

This is the accuracy and truthfulness of research findings. All data was tested to ensure there was no internal conflict or inconsistencies. The researcher used her two research supervisors, who went through the audio records and the transcripts to check and verify the transcripts to see whether what the participants said is what was recorded. Also transcription was done by qualified personnel. The researcher employed an Interview guide to gather the data. The

Recorded interviews and verbatim transcripts were discussed and shared with the research supervisors throughout the research process as part of audit trials.

The reliability of the interview guide was done by pretesting interview guide on nurses in medical CCU. The medical CCU was used because it admits patients with medical life-threatening conditions, while in the main CCU patients with all conditions, both surgical and medical are admitted. Nurses who consented participated in the interview. Pretesting was done through audio recording and transcription was done by qualified personnel. The two research supervisors went through the recordings and transcription for verification of pretests. Throughout data collection, the researcher was taking notes for referring.

3.9.5 Credibility

Piloting the interview schedule before the commencement of data collection ensures that the questions elicit the much-needed details. DeVault (2019) recommends examining referential adequacy as a means to analyze preliminary interpretations and findings against the uncooked information, and debriefing of peers to offer an outside check on the study procedure that might hence improve credibility. In this research, peer-reviewing was done by supervisors prepared at both doctoral and masters level.

The recorded interviews and verbatim transcripts were discussed and shared with the research supervisors throughout the research process as part of audit trials. Where the participant used a different language such as Kiswahili then the researcher would get the meaning.

3.10 Data management and analysis

Data management and analysis was guided by Colaizzi's seven steps of descriptive phenomenological data analysis process (Morrow, Rodriguez, and King 2015). Sources of data included demographic questionnaires, interview transcripts, field notes and literature review

In the first step the researcher familiarized with the data, by replaying and listening through all the audio- recorded interviews several times. Verbatim transcription by a trained and qualified transcriber together with the researcher followed up independently. The transcriber was trained on qualitative research process. An independent transcription was done to verify consistency of data in the transcripts as one of the verification processes to enhance trustworthiness. The researcher removed all identified information from the transcript and replaced with text identification label where letter P represented the participant and the transcript was represented by a number in order to protect the participant identity. In the second step the researcher identified significant statements in the recordings that are of direct relevance to the phenomenon under investigation which was experiences in end of life care. Clustering of themes then took place where the researcher clustered the identified meanings into themes that were common across all the transcriptions. The transcribed data was kept in a safe place only accessible to the researcher

3.11 Dissemination plan

The research findings will be disseminated to University of Nairobi School of nursing sciences. Study findings will also be presented to CCU nurses and doctors, and KNH research department. Copies of study findings will be given to KNH-UON ethics and research committee, presented in conferences and published in journal.

3.12 Ethical considerations

The four fundamental ethical principles were upheld based on the philosophical standards of Non-maleficence, beneficence, respect for autonomy, and justice guided in applying for ethical approval by encouraging researcher to anticipate the ethical tensions and challenges which would arise during the study (Wagoro & Bhatt, 2012; Wagoro and Duma, 2018).

Ethical approval was obtained from Kenyatta national hospital-university of Nairobi Ethics and Review committee (KNH-UoN ERC),approval number (p107/02/2020).The researcher also obtained permission from KNH to conduct the study in the institution, study registration number;-Anesthesia CCU /127/2020

3.12.1 Beneficence

The researcher observed the welfare of the research participant at heart. Participants were informed that there was no individual benefit such as financial payments. But the study results could be used to institute measures that would benefit the critical care, clinical team, with regards to making ethical decisions. They also would benefit if the findings of the study are implemented so that they are able to make ethical decisions inappropriate way.

3.12.2 Non-maleficence

The principle of non-maleficence ensures that the researcher does not purposely cause harm to the participants they were well handled and not neglected and in case the participants felt some psychological or social discomfort during the completion of the questionnaire, they were allowed to stop. The research was conducted under the guidelines of the KNH-UON ERC & KNH administration for protection of participants from any harm.

3.12.3 Autonomy and informed consent

Study participants were given an opportunity to understand the information about the study and make voluntary choices. A consent form (see appendix I) was used to obtain written informed consent. Also, participants had the right to withdraw from the study at any time without repercussion, right to ask questions, and refuse to disclose information. The respondents were offered time and chance to weigh if they would or not take part in the study.

3.12.4 Justice

In the current research, the investigator treated all the participants fairly, justly, and equitably. Confidentiality was maintained throughout the study to ensure that there was no intrusive to participants' lives. Inclusion and exclusion criteria, as well as the sampling method and recruitment procedures, were fair to all nurses and doctors there was no discrimination when selecting participants. The respondents had the right to demand that any information disclosed be maintained in stringent confidence; and that all participants' consents were respected.

3.12.5 Confidentiality

All the completed questionnaires were anonym zed by the use of coding and stored on an. encrypted device, of which only the researcher accessed. The participant was asked to use a signature identifiable only by them. No identifiable of participants in any publications and reports coming out of this study.

CHAPTER FOUR: FINDINGS

4.1 Introduction

The study was on the nurses and doctors experiences on ethical challenges in end of life situations in critical care unit at Kenyatta National Hospital. The study participants were taken through the consenting process. The primary prerequisite was geared towards improving the quality of care on patients in CCU; also improve on the management in policy making and develop guidelines on ethical challenges in regards to end of life experiences. The information gathered was treated with confidentiality and used mainly for the purposes of the study.

4.2 Demographic information of participants

The study population comprised of nurses and doctors offering services in the CCUs in KNH who generally are the main health care providers,they have rich source of information and also make decisions in end of life care. They are front line care givers to patients and take long hours with patients in CCU. A total of 18 key informants were interviewed among them 13 critical care nurses and 5 doctors; by gender 3 males and 13 females. They had 3 years to 10+ years. The minimum age was 28 years and a maximum of 47 years.

4.2.1 Socio-demographic characteristics of the participants

Participant	Gender	Age (years)	Years of experience in CCU	Designation & Qualification
Participant 1	Female	45	13	Critical care nurse
Participant 2	Female	37	10	CCC manager / Critical care nurse
Participant 3	Male	42	14	Patient care nurse
Participant 4	Female	36	5	Registrar - anesthesia
Participant 5	Male	35	6	Resident anesthesiologist
Participant 6	Female	46	21	CCU Manager-Nurse
Participant 7	Female	30	4	Critical care nurse
Participant 8	Male	45	15	Critical care nurse
Participant 9	Female	33	5	Critical care nurse
Participant 10	Female	40	15	CCC Manager
Participant 11	Female	35	6	Critical care nurse
Participant 12	Female	30	5	Doctor - Anesthesia
Participant 13	Female	36	8	Critical care nurse
Participant 14	Female	45	18	Critical care nurse
Participant 15	Female	47	22	Critical care nurse
Participant 16	Female	28	4	Critical care nurse
Participant 17	Male	38	2	Doctor - Anesthesia
Participant 18	Male	40	3	Doctor - Anesthesia

4.3 Ethical challenges that nurses and doctors experience at CCU KNH

An ethical challenge is when a clinician has to choose between conflicting ethical principles on the best alternative for achieving best results; when a health care provider is caught in between the best practice and the humane stimuli. When the nurse or the doctor in CCU is not sure whether to continue or to stop giving medical care and support, hence the confusion faced when

one is not able to decide on a situation. The study finding articulated a number of ethical challenges such as; use of mechanical ventilation in CCU (withdrawal or withholding mechanical ventilation); social cultural and religious beliefs among some of the patients; the DNR (Do Not Resuscitate) order; when relatives of the patient and the medical team disagree in principle on what is best for the patient.

Nurses and doctors were able to define ethical challenges and shared the experiences they encountered. Five themes were identified as explained below

Theme 1: Conflict between practice and human stimuli

The nurses and doctors interviewed stated that ethical challenges are those challenges which occur especially in the critical care unit as patients experience their end of life; and as a health care practitioner you are caught in between on the best practice and the humane stimuli. These are times when the health care practitioner is not sure whether to continue or to stop giving medical care and support. The study participants noted that ethical challenge is the confusion faced when one is not able to decide on a situation.

The conflicting ideologies between the relatives of the patient and the medical team when both parties disagree in principle on what is best for the patient noting a case in point when caloric test turns positive and has been confirmed and the patients relatives insist that the patient should continue with life support

The study participants reported that at times due to the fact that there are no guiding tools or documents on ethical challenges even when a patient has been put on minimal support do they continue giving antibiotics and IV fluids or which medications should be given. Other challenges noted were for instance who should be admitted into ICU or not; at what point should support be

withdrawn; when to or not to resuscitate a critically ill patient depending on the prognosis; knowing whom to admit into ICU or not

Examples of the excerpt from the participants for this theme are given below

P11"In my own understanding ethical challenge is whereby you are in a dilemma between the nursing ethics and the medical ethics and what you find on the ground and you are not able to make a decisive decision"

P1"A patient have been done caloric test which turns positive and has been confirmed by another different physician or a neurosurgeon and still you find that the relatives says that the patient should be put on life support".

P13"Yes I encounter ethical challenge like for instance how do you deal with a patient who had brain stem death who you have been given the "do not resuscitate order" by either the doctor or the patients"

Theme 2: Encountering ethical challenges

All the study participants interviewed indicated that they have encountered ethical challenges in their day to day service within the critical care unit.

The nurses and doctors interviewed were further asked how they felt about ethical challenges and they noted that ethical challenges drain those involved in providing end of care services to the patience since there are no guiding policies. The challenge being fear from legal authorities in

cases where as a medical practitioner you withhold help which might land you into trouble since there are no protocols in what to do especially in end of life experiences. There is confusion experienced and those interviewed wished that there had policies or guidelines directing them on what to do when faced with ethical challenges

The study participants reported that the experience is stressful; frustrating and very demoralizing and as medical professionals they don't feel motivated to work at all and that one is not able to make appropriate decision on a patient. There is a feeling that one is not achieving their goals in the unit of providing care especially in instances where a patient has brain injury or brain death and the situation is very dire in that the patient is not benefitting from ICU so you feel bad since the patient won't heal

On particular ethical challenges experienced by nurses and doctors, they mentioned that Sometimes relatives want the machine switched off. Another ethical challenge is when the guardian to a patient refuses to sign the consent form in a case where the patient needs an urgent operation and especially for children and critically ill patients who cannot sign for themselves. There was a lady who had a caesarian section and developed post-partum hemorrhage but her relatives refused her to be transfused sighting their religious beliefs.

It was reported that for patients in critical care unit and have brain death the health provider is challenged on whether to stop the medication; whether to resuscitate or not and whether to continue with the high supportive mechanical ventilation or not. The 'Do Not Resuscitate' order sometimes is very challenging from a human perspective as well as from a medical professional since from a human point of view you want to safe life but you find an order to 'do not resuscitate'. Again there is conflict of interest where a patient who really needs ventilator support misses the opportunity for a patient who won't benefit from the same due to influence. A case in

point was a patient who tested positive for caloric test and confirmed by senior consultants yet the relatives insisted that the patient should be put on life support.

Examples of the excerpt from the participants for this theme are given below

P12 "I wish that I could have a clear legal arrangement concerning end of life care so that sometimes you could re-escalate the ventilation management and the support that you are giving or maybe have a guideline that is in place so that no one is victimized on certain decisions concerning end of life care management"

P3 "So because of that so at times we are really, really challenged so the best you can do is to just allow the patient to take the natural course I might understand as a care giver, it is so challenging to continue giving care yet I know that the prognosis is poor"

P11 "The ethical challenge which I can remember a Seventh Day lady, who had given birth through caesarian section; and her relatives said they don't want her to be transfused and she had PPH"

P1 "A patient have been done caloric test which turns positive and has been confirmed by another different physician or a neurosurgeon and still you find that the relatives says that the patient should be put on life support"

Theme 3: Experience of ethical challenges

The nurses and doctors interviewed stated that in all of their ethical challenges in end of life experiences in the critical care unit they raised concern with the relevant authorities. They pointed out that they hold discussions and forums with their fellow colleagues. The participants felt that they need guidelines and protocols because these discussions have been there for long and still no tangible documentation which should be followed in situations of ethical challenges in critical care unit. The discussions are held by the nurses, doctors, in-charges of the unit, consultants, counselors, patients and relatives especially the family where they discuss on way forward.

Some of the diagnosis of the patient's whom the participant's encountered with ethical challenges included:- Brain-stem death, spinal cord injury, severe head injury, anemia, brain hemorrhage; trauma patients; multiple injuries; brain damage; PPH; post operative or post abortion complications; cancer; cardiac (heart) issues; brain death; massive hemorrhage (CVA); hypothermic- multiple organ failure; intussusceptions; sickle-cell disease

Examples of the excerpt from the participants for this theme are given below

P1 "This has gone on for a very long time but we need a guiding protocol on what to do in case because most of the time we find that we discus within ourselves but if we have something which is guiding us we can benefit more"

P5 "Yes I did because we had a talk with the unit consultant, and other colleagues in the unit and we had to seat down with the family and discuss about the benefits and the risk that would be involved in case we do not administer the anesthesia or do the operation and the benefits the child would have after the operation"

Theme 4: Impact on decisions in end of life care

Generally, the nurses and doctors noted that the medical heath care practitioners caring for patient during their end of life experiences feel de-motivated and psychologically traumatized. They also feel discouraged and very low emotionally mainly because they don't know what steps to taken when faced by an ethical challenge.

There is fear of victimization in case a health care practitioner fails to do that which is expected of him or her as a medical professional purely because there is no standard operating procedure to be followed. Again the health care professional fears to be sued because of the outcome so sometimes one is forced to do that which is not medically beneficial to the patient due to the fear of victimization regardless of the knowledge which one has; you follow what is legally accepted. It is difficult and tricky and one feels frustrated and discouraged when you lose a patient and wish there was anything you could have done to save that life.

There is a feeling of defeat especially when at the end of the day the patient's prognosis is pointing to an obvious outcome of end of life and yet as a health care provider you are required to continue giving critical care and ventilator support so when the prognosis is poor you feel that you are not achieving. It is a tight situation because as a medical professional you have to strike a balance by respecting the right of the patient as well as what is professionally acceptable. Mainly

the study participants indicated that what would help them was to have a standard operating procedure which can guide them anytime they are faced with end of life ethical challenge.

On how the nurses and doctors motivate themselves, they mentioned that they get motivated through the debriefing sessions which are held within the unit with the facilitation of the counselors attached to the critical care unit. In these meetings they have the opportunity to discuss the ethical challenges they face as a team. They also reported that in these forums they have the opportunity to share with their colleagues their experiences while the unit counselors help them deal with the psychological trauma

From a human perspective the participants felt that as long as their conscious is clear in that irrespective of the outcome they did their best then that motivates them to continue with their assigned duties in the critical care unit. Some of the study participants felt that it is appointed at one point to die and therefore their faith helps calm their nerves.

Examples of the excerpt from the participants for this theme are given below

P14 "If we had guidelines on what to do or we have steps to follow it would be better but now sometimes you feel very low very discouraged because you don't know what you are supposed to do at that time"

P16 "Actually you really feel bad because after the whole process of caring for this patient finally you come and find a 'do not resuscitate order' so when that time comes when you don't need to resuscitate and you have to leave this patient rest peacefully I really felt so bad because I was like I can give this patient another chance"

P9 "Yes because you allow a patient to die without doing anything and then after thinking you resuscitate this patient will continue suffering, so you allow the patient to go but still we need a clear guidance in that the management should come up with a tool to deal with those critical patients"

P11 "I motivate myself through debriefs when we talk with the counselor because sometimes you feel so discouraged but through debriefing you are able to lay down the burden that is on your shoulder as you talk with the counselor and share and you get encouraged"

Theme 5: Decisions arrived at when faced by an ethical challenge

Most of the study participants interviewed mentioned that they usually consult widely with the other medical health practitioners such as the doctors, nurses, the in-charges, managers, team leaders, consultants as well as the counselors attached to Critical care unit.

They consult with the seniors in the unit and particularly those who have been in the unit for long and also for the doctors to give an okay on the DNR [do not resuscitate] order and in so doing the nurse feels supported. However the study participants maintained that though they consult their colleagues in the critical care unit, ethical challenges more often than not remains a challenge since there are no guidelines or laid down procedures which can be followed.

Again the participants noted that sometimes they are required to resuscitate patients regardless of their medical status even where there is no hope that the patient will recover, at least to prolong their life. In situations where the condition of the patient may not change, a family conference is organized and after discussing with the family members or the caregivers a consensus is

collectively reached at to minimize support especially for those patients who have brain death to stop resuscitation.

In general the study participants maintained that as a unit they should come up with certain policies and guidelines. Counseling with the relatives and caregivers on the patient's condition on the possible outcome in regard to how beneficial will it be by admitting the patient into the CCU. A participant pointed out that at KNH there is no policy guiding on ethical challenges and also the Kenyan Constitution does not support certain procedures practiced in other Countries like "Do Not Resuscitate" order or other measures to discontinue support to the patient. Kenyatta National Hospital should in principal come up with a policy to guide the medical practitioners on procedures or a standard operating procedure which should be followed in the critical care on issues pertaining to ethical challenges. The Kenyan government also should come up with a law in our health institutions to guide on ethical challenges to avoid medical legal issues and therefore have a legal document on the same.

For patients who are conscious they need to be involved and talked to on their medical status even as their relatives are brought on board. Also it is important to give the patients in critical care unit their very best and do whatever it takes to save a life because each life is precious and equally important irrespective of their illnesses. The relatives to the patients should be brought on board and be briefed on the medical condition of their patient through medical conferences with the doctors and the nurses so that they understand their patient better and in so doing lay their anxieties on whatever outcome.

Examples of the excerpt from the participants for this theme are given below

P11 "Yes because every day you are faced with different challenges, the patients are different, the relatives are different and the issues are different so every time you are faced with an ethical challenge you consult widely either with the doctors or the consultants or with the nurses"

P15 "Yes at times we sit down and we share and discuss but at the end of it all it still remains a challenge because there is no written policy on whatdo"

P12 "we usually decide to do a family conference and after we discuss with the family we agree collectively and decide that we have agreed so that we are able to minimize the kind of support we are giving especially for those patients who have brain death so that we do not have to continue resuscitating and that bed can be given to another patient who needs it more"

P11"the relatives should be briefed by going for the medical conferences with the nurse and the doctor so that they understand their patient better and from their they are able to lay their anxiety; and to know the way foreword to know where they are headed to"

P5 "Sometimes they may end up becoming medical legal issues, so there should have a laid down policies, which are supposed to be followed in case such happen or specific challenges arise within the unit"

4.4 How ethical challenges are experienced by nurses and doctors

When relatives of the patient and the medical team both parties disagree in principle on what is best for the patient noting a case in point when caloric test turns positive and has been confirmed

and the patients relatives insist that the patient should continue with life support. When your professionalism as a health care practitioner is challenged because the patients have their own rights to demand a service yet what the patient wants is not professional. When a patient has brain injury or brain death and the situation is very dire and therefore the nurse or the doctor attending to such a patient feels that such a patient is not benefitting from CCU. Other instances are at what point should support be withdrawn; when to or not to resuscitate a critically ill patient depending on the prognosis; when religious beliefs outweigh professionalism and a case in point is when relatives decline to blood transfusion. Majority of those interviewed stated that they don't have any protocol or anything which they can follow when faced with ethical challenges for instance for patients who have tested positive on caloric test what procedures should be followed, so there is need for a guiding protocol or operating standard procedure on the same.

4.5 Comparison of the ethical challenges experienced by nurses and doctors

The study results show that both nurses and doctors are faced with same ethical challenges. All participants experienced ethical challenges around decision making at the end of life. The main dilemma for both nurses and doctors was witnessing suffering which aggravated a moral obligation to reduce that suffering. Another concern witnessed by both the nurses and doctors was the uncertainty about the best course of action for the patient and family. Theme 2 on the ethical challenges experienced was reported by both the nurses and doctors interviewed. However, the key difference between the nurses and doctors interviewed was that while the doctors make the decisions the nurses have to live with these decisions like the DNR (Do not Resuscitate) order. Observed differences between nurses and doctors were a function of the professional role played by each rather than differences in ethical reasoning or moral motivation.

Competing values, religious beliefs, scare resources, and challenged decision making were some of the emerging themes across the board. Although the nurses stay long hours with the patients at the critical care unit the doctors have a deeper level of training in ethics issues.

The nurses as compared to doctors face ethical challenges in their daily practice as they are required to provide autonomous and collaborative care to the patients in the critical care unit. The nurses spend more time with the patients in CCU as compared to the doctors.

Theme 5 on the decisions arrived at when faced by an ethical challenge both the nurses and doctors reported the aspect of consultation within the unit. The preference to ask for ethics consultations to address ethical issues was found to be significantly associated with the degree to which ethical issues have deepened, and the level of experience acquired while dealing with ethical issues. There is need for the nurses and doctors to engage in moral discussion to understand and support the ethical burden carried by the other.

CHAPTER 5: DISCUSION AND RECOMMENDATIONS

5.1 Introduction

In this chapter the conclusions derived from the findings of this study on the experiences of doctors and nurses on ethical challenges in end of life situations in critical care unit at the Kenyatta National Hospital are described. Some limitations have been identified. The conclusions were based on the purpose, research questions and results of the study. The implications of these findings and the resultant recommendations are also explained. Recommendations were based on the conclusions and purpose of the study.

The study was an exploratory, expressive and contextual qualitative study. The researcher adopted a phenomenological approach to achieve the objectives of the study. Unstructured, open, qualitative interviews were conducted with five doctors and thirteen nurses offering services in the CCUs in KNH who were purposively selected as participants. The interviews were conducted in English and tape-recorded, then transcribed and analyzed. The researcher enlisted the help of an independent co-coder and both derived themes from the findings of the study. The co-coder and the researcher then held a consensus meeting to clarify discrepancies and identify similarities. Themes and categories that emerged from the data were augmented with literature review from other studies conducted elsewhere. Trustworthiness of the data was assured and ethical considerations respected (Lincoln & Guba 1985:36). The findings and recommendations described below are based on the experiences of the eighteen participants, the research question, the objectives and the themes emerging from the data analysis.

The research question to be answered was:

"What are the ethical challenges that nurses and doctors experience and how are these ethical challenges experienced by nurses and doctors in CCU, KNH"

In responding to this question, the study achieved the following objectives:

- To describe the ethical challenges that nurses and doctors experience in CCU, KNH
- To describe how ethical challenges are experienced by nurses and doctors in CCU, KNH
- To compare the ethical challenges experienced by nurses and doctors in CCU, KNH

5.2 Summary of the data

Eighteen key informant interviews were conducted with the health care providers who comprised of five doctors and thirteen critical care nurses attached to the critical care unit, KNH. These health care providers had served at the critical care unit for 3 years to 10+ years while their ages were 28 years and 47 years.

Five themes emerged and the findings were discussed according to the themes that emerged from the data:

Theme 1: Definition of ethical challenges

Theme 2: Encounter of ethical challenges

Theme 3: How nurses and doctors experiences ethical challenges

Theme 4: Impact on decisions in end of life care

Theme 5: Decisions arrived at when faced by an ethical challenge

Theme 1: Definition of ethical challenges in one's own words was verbalized by the health care providers as a dilemma between the nursing ethics and the medical ethics. An ethical challenge occurs when an ethical principle conflicts with a value (Barrett et al., 2019). They noted that

Ethical challenge was a state of confusion or conflicting ideologies which was attributed to several factors. Again Barrett et al (2019); highlight that ethical decisions are guided by ethical principles that govern critical care practices; autonomy, veracity, beneficence, non-maleficence, justice, fidelity and confidentiality. The patient therefore has a right to beneficence, justice and confidentiality even as the other stakeholders make decision on behalf of the patient who mostly is not in a position to defend him or herself. The constitution of Kenya (2010) considers life sacred, thus ethical challenges regarding end of life care are considered as major challenges among healthcare providers working especially in a critical care unit (Gitonga and Wambua, 2017). Even with the intensity of ethical challenges encountered in CCU, not much information has been written about the contribution of nurses and doctors concerning them (Mutinda and Wagoro, 2017).

When patients experience end of life, the health care provider is torn between whether to stop giving care and support and allow the patient transit into the next world. The study participants sighted instances when caloric test turns positive and has been confirmed and yet the patients' relatives insist that the patient should continue with life support. Another situation was when the patient is on minimal support do they continue giving antibiotics and IV fluids or which medications should be given and therefore posing an ethical challenge on withdrawal and withholding treatment. Nurses and Doctors working in the critical care unit face varying experiences and perceptions on ethical challenges and decision making (Douglas, 2018, Kathleen, 2018; Mutinda & Wagoro, 2017).

Majority of those interviewed felt challenged on 'at what point should patient support' be withdrawn. The 'do not resuscitate' order was discussed with mixed reactions with some

participants expressing that it is not right to withhold support while others maintained that in cases where the prognosis is poor especially patients with brain stem death the support should be withdrawn. When the health care provider finds a "no not resuscitate" order they feel powerless. Downar et al., (2016) argue that taking away measures that help sustain life is a very dormant issue in the CCU, yet it entails a sophisticated sense of balance between ethical, health, and legal deliberations.

Other ethical challenges mentioned were obtaining informed consent where relatives or caretakers are supposed to sign on behalf of the patient but they have a different opinion and yet the patient needs urgent surgery. Cultural and religious beliefs were reported to affect health care support in end of life experience with participants noting that some social norms don't allow blood transfusion and patients in critical care unit have lost their lives when relatives and caregivers refused to consent on transfusion or take long to decide. Financial constraints were mentioned where a patient loses life due to delay while waiting for required tests like CT scans; MRIs and other requirements. Additionally, time delay makes the decisions made not count as they encounter ethical issues (Rushton, & Stutzer, 2015).

Theme 2: All the study participants interviewed indicated that they have encountered ethical challenges while providing services in the critical care unit in end of life experiences. The nurses and doctors interviewed noted that ethical challenges drain those involved in providing end of life care services to the patience since there are no guiding policies or protocols. They also reported that the experience is stressful; frustrating and very demoralizing and as medical professionals they don't feel motivated to work at all and hence not able to make appropriate decision on a patient. Ethical challenges cause job strain and burn-out syndrome among

healthcare workers. This eventually affects the quality of patient care (Moon, & Kim 2015; Mealer & Moss 2016). The participants pointed out that they find themselves in a fix on what to do and what not to do in regard to the welfare of the patients and therefore feel limited and depressed at the same time when they lose a patient.

From the study several specific ethical challenges encountered during end of life experiences in the critical care unit were mentioned. For instance the relatives of the patient sometimes demand the machine switched off as such withdrawing mechanical support to the patient. The guardians or relatives other times refuse to sign the consent form on behalf of the patient who needs urgent operation or on behalf of the children who by law cannot sign for themselves. There was mention of a case where a certain lady after undergoing a caesarian section developed post-partum hemorrhage but her relatives because of their religious beliefs refused any blood transfusion on her.

Other cases are situations where the patient has brain death and the health care provider negotiates whether to withhold and withdraw medication; whether to resuscitate or not; or whether to continue with the high supportive mechanical ventilation or not. A participant shared an experience where there was a ‘do not resuscitate’ order yet there was that urge to save a life but as the nurse attending to that patient your hands are tied and the experience was very frustrating. Ethical decisions involve moral decisions made in regard to patient care in an attempt to achieve the best results for the benefit of the patient. Carla and Orquidee (2014) and Wagoro and Duma (2017) define ethical decision making as the procedure of examining and picking among options, achieving the best results or outcomes in compliance with ethical principles. Socio-cultural and religious affiliations also pose an ethical challenge especially where religious beliefs contradict with medical regulations and ethical principles. Parents play a role in ethical

challenges when they deny their children an opportunity to live by objecting to anesthesia where urgent surgery was needed. McLeod, 2016 and Haddad,(2019) found that advances in medicine, increasing economic stress, rise of patient self-determination and differing values between health care workers and patients are among many factors contributing to the frequency and complexity of ethical challenges in healthcare.

Theme 3: The study divulged that after experiencing ethical challenges the nurses and doctors interviewed raised concern with their other health care practitioners and other relevant authorities. In so doing, they are able to create an enabling environment where they are able to share their experiences. They hold discussions and forums with fellow colleagues mainly the nurses, doctors, consultants, in-charge of the unit, and the counsellors attached to the critical care unit. In other instances they also involve the patients and relatives to discuss way forward. Through these forums the health care providers attending to patients in the critical care unit are able to come up with preferred ethical choices and alternatives on best practices.

These ethical choices are intended to guide on how best to manage the patients in expressing care, maintaining trust, and respecting the values of the patients. These discussions help in decision-making and therefore the nurses and doctors in the critical care unit are able to make ethical decisions in situations where there are no clear guidelines. Haddad & Geige 2019; Antonio and Sofia, (2016) found that in making ethical choices, the critical care nurses and doctors perceive and eliminate unethical alternatives and choose the finest moral alternatives in patient plan of care.

The study finding listed some of the diagnosis of the patient's whom the participant's encountered with ethical challenges which included; Brain-stem death, spinal cord injury, severe

head injury, anemia, brain hemorrhage; trauma patients; multiple injuries; brain damage; PPH; post-operative or post abortion complications; cancer; cardiac (heart) issues; brain death; massive hemorrhage (CVA); hypothermic- multiple organ failure; intussusceptions including sickle-cell disease.

Theme 4: Ethical challenges are a source of stress among nurses and doctors working in the critical care unit and they require interventions because decisions made might affect the outcome of patient care (Perrin, 2019). The findings of this study revealed that the nurses and doctors caring for patients in the critical care unit experience a number of psychological traumas like stress; they feel discouraged and very low emotionally. Some study participants reported fear of victimization due to the fact that there are no guidelines to be followed when faced with ethical challenges in case one fails to achieve the expected standards. The nurses and doctors interviewed felt that the situation is tricky and frustrating when a life is lost and as a health care provider serving in the critical care unit one wonders what more could have been done to save such a life. Despite there being institutional structures and procedures to follow in ethical challenges, nurses and doctors are sometimes overwhelmed by feelings of despair and powerlessness (Thomas & McCullough 2014)

Others felt demoralized when they encountered a ‘do not resuscitate’ order and therefore had to let the patient rest in peace though they would have wished such a patient could have been given another chance. It is a tight situation because as a medical professional you have to strike a balance by respecting the right of the patient as well as what is professionally acceptable. In African countries, the majority of healthcare workers will honor an advance directive such as "do

not resuscitate order", thus withholding life-sustaining therapy (Lucinda et al., 2017). For instance, President Nelson Mandela's long hospitalization sparked the end of life discussions, about life supportive management, that could not be withdrawn as the law in the country criminalizes assisted dying.

The study revealed that what would help the health care providers attached to the critical care unit was to have a standard operating procedure which can guide them anytime they are faced with end of life ethical challenges. Nurses and Doctors, who work in Critical Care Units (CCUs,) encounter ethically complex and morally distressing situations in their practice, yet they are expected to make quick ethical choices in patient care. The disadvantage is that the patients due to the fact that mostly they are unconscious are not able to make any decisions concerning their conditions hence depend either on the health care providers or their relatives to make the decisions. Karnik & Kanekar 2016; Molewijk et al (2015) reported that ethical challenges emerge because clients are incapable of making decisions.

Though the nurses and doctors experience ethical challenges they reported that they motivate themselves by way of holding forums with fellow colleagues in the critical care unit. These forums are debriefing sessions which provide both professional and psychological support to the nurses and doctors serving in the critical care unit as they deliberate on the ethical challenges encountered. The counselors attached to the critical care unit facilitate the psychological support while the medical professionals discuss ethical challenges with other consultants and senior colleagues attached to the critical care unit. Another motivation mentioned was allowing the patient some dignity in that even if they don’t recover but transcend to the next world, they

experience a dignified death and this allows those patients who have suffered for long to rest peacefully.

Despite of the ethical challenges experienced; the nurses and doctors interviewed maintained that from a humane respective they give their best as they serve in the critical care unit and therefore as they observe patients experience end of life journey their conscious is clear. For the study participants who believe in God noted that it is appointed for one to die at one point in time so their faith in God helps them calm their nerves when their patients at the critical care unit experiencing end of life transit into the next world.

Theme 5: Service providers are frequently challenged during end-of-life decision making. This includes issues for managing costs that endanger the well-being of patients, illegal, incompetent, or unethical practices of peers, and violation of patient privacy and confidentiality (Jared and Jensen et al., 2019). The study found that the nurses and doctors interviewed usually consult widely with the other medical health practitioners; the doctors, nurses, the in-charges, managers, team leaders, consultants as well as the counselors attached to Critical care unit. They consult with their seniors and especially those who have served in the critical care unit for long.

There are times when a medical conference is organized to discuss particular situations with the relatives of the patients in the critical care unit to chart way forward especially for those patients with brain death so that they collectively agree to withdraw support like resuscitation. Moreover Gavin et al (2016) found the majority of physicians and nurses worldwide demonstrate fear of giving up too soon, withdrawing all hope, and coming up with wrong choices.

The CCU is one of the sections within the healthcare center where members of the family suffer.

The relatives of the patients in the critical care unit are usually depressed and anxious wondering whether their kin will pull through or whether there is any hope. The study participants suggested that it is important to counsel and brief the relatives and caregivers of the patients admitted at the critical care unit on the possible outcome in retrospect to the prognosis of the patient. By chance that the patient at the critical care unit is conscious he or she should be updated on their prognosis as well as the management of their case. According to Moon, & Kim, 2015, 66.7% of members of the family who have patients in the CCU showed signs of depression or anxiety. Also;According to the Anxiety and Depression Association of America (2018), members of the family expressed signs of depression or anxiety.

Globally, one of the biggest challenges facing healthcare workers concerning making decisions for end life is predictive doubts and ascertains the time to start terminal life dialogues and support with members of the family (Sameera and Amar, 2016). The study findings showed that currently there are no protocols or guidelines stating which procedures to be followed during ethical challenges. In light of this, the study team reported that it is of paramount importance to have or documentations, guidelines, protocols or laid down procedures which can be followed considering that there are no standard operating procedures in place on ethical challenges. Professional guidelines are needed to avoid disputes, controversial issues, and empowerments of caregivers in terminal care choices. Research by Sandra et al., (2017) indicated that professional guidelines are needed to avoid disputes, controversial issues and empowerments of caregivers in terminal care choice-making. In this regard also the study participants felt that there is need to set up an ethical committee mandated to be meeting either monthly or quarterly to discuss on the best practices in end of life experiences in regard to ethical challenges.

According to Kamik, (2016) no complete guidelines to aid in ensuring medical professionals make appropriate ethical decisions and so this calls for training. Kathleen, (2018) recommended that nurses and physicians take part in ethical discourse to support and understand the moral load shouldered by other individuals. Moreira & Fernandes (2012), Reitinger & Heimerl (2014) emphasized that the primary approaches to address these ethical issues are to share views, experiences, and feelings on moral challenges during group dialogues and explore ways of overcoming them, because a shared problem is half solved. In Kenya, sadly no research has been conducted on ethical challenges among doctors and nurses dealing with terminal care among acutely ill patients. Also the law does not allow euthanasia as life is sacred according to the Kenyan constitution 2010

5.3 Limitations

Certain limitations were identified in the study: setting for interviews; participants' effect; and data collection and analysis.

5.3.1 Setting for interviews

The setting was found to be inappropriate, having interferences. There were a lot of interruptions during interviews, since interviews were conducted at the participants' workplace during work hours. This happened despite all efforts taken to reduce interruptions such as knocks on the door by colleagues. There was also a lot of noise outside the interview room from patients and colleagues attending to emergencies.

5.3.2 Participants' effect

Because the data collection was in the form of unstructured interviews and the participants knew the researcher, the participants could have withheld some of their personal in-depth experiences.

5.3.3 Data collection and analysis

A few limitations in the data collection were identified

- The study was carried out during a very difficult time when the medical care providers were busy handling the Covid-19 patients at the Kenyatta National hospital. It was therefore very challenging for the nurses and doctors who participated in the study to spare their limited time to respond to the research questions. The number of the study participants was greatly affected as some of the frontline health providers were on quarantine. In this regards only five doctors participated in the study though the researcher would have wished to have more doctors participate in the study
- Data collection was time-consuming for the researcher
- The nature of qualitative study relied on the researcher's judgments' of data collection; the researcher was the main data collection instrument for the unstructured interviews however, the possibility of bias was minimized by the assistance of an expert co-coder

5.4 Recommendations

The researcher makes the following recommendations on the experiences of doctors and nurses on ethical challenges in end of life situations in critical care unit at Kenyatta National Hospital

- Decisions on end of life experiences are complex and challenging and therefore there isneed for guidelines; protocols or policies documenting exactly what should be done should a health care provider encounter ethical challenges while providing support to patients in the critical care unit. These policies and guiding protocols should be made accessible to the critical care nurses and doctors.
- An ethical committee from KNH mandated to handle ethical challenges should be set up. Admission and discharge protocols should be adhered to by the nurses and doctors to avoid admission of patients with poor prognosis.

- More involvement between the health care practitioners working in CCU and the relatives of the patient on disclosure especially where the prognosis is poor to avoid conflicts.
- More discussions on how to obtain informed consent from critically ill patients who are on mechanical ventilation and are unconscious
- Counseling and support guidelines should be developed to empower the nurses and doctors involved in supporting patients in their end of life experiences in the critical care unit
- The administrators should provide opportunities for communication to help staff reduce moral distress and generate creative strategies for dealing with ethical challenges.
- There is need for more research on ethical challenges among nurses and doctors dealing with acutely ill patient and training on end of life care decision.

	2019		2020			
Activity/ Month	Jul – Sep	Oct –Dec	Jan -Mar	Apr - Jun	Jul – Sep	Oct – Nov
Topic identification,						
Concept development,						
proposal writing						
Ethical review and Approval.						
Data collection, data entry, coding						
Data analysis and Report writing						
Presentation of report & defense of dissertation						
Submission of Dissertation						

Gantt chart: July 2019 –November 2020

STUDY BUDGET PROSAL AND BUDGET JUSTIFICATION

Components	List of Measure	Duration /Number	Cost (KShs)	Total (KShs)
Personnel				
Literature search and internet Services				10000
Transcribing fee				25000
Printing				
Consent form	1	2	10	20
Interview guide	1	2	10	20
Final report	1	80	10	800
Photocopying				
Consent form	20	2	3	120
interview guide	20	2	3	120
Final report	9	85	3	2295
Final report binding	10	1	500	1500
Other costs				
ERC fees				5000
Records access fee				500
Tape recorder				5000
Publication fee				70000
TOTAL				**120375**

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APPENDIX I: CONSENT FORM

TITLE: DOCTORS AND NURSES EXPERIENCES OF ETHICAL CHALLENGES IN END LIFE DECISIONS IN CRITICAL CARE UNIT AT KENYATTA NATIONAL HOSPITAL.
PRINCIPAL INVESTIGATOR: PRISCILLA KAGENDO MWIRIGI

Introduction

I am Priscilla Kagendo Mwirigi, a student undertaking a master degree in nursing (critical care) of the University of Nairobi. I am carrying out a study to explore the experiences of doctors and nurses on ethical challenges in end of life decisions in the critical care unit at Kenyatta national hospital. This interview will be tape-recorded for purposes of reference and also so that I can pay full attention to you during the interview.

Your identity will not be revealed in any way and the information given will be handled with Confidentiality. The purpose of this consent is to give you the information you require, to help you decide whether or not to participate in the study.

Participant Information

You are invited to participate in this study because you are a qualified nurse or doctor currently working in the critical care unit. The main objective of this study is to explore the experiences of ethical challenges in end of life care among doctors and nurses working in the critical care unit at Kenyatta national hospital. The specific objectives are to explore ethical challenges facing doctors and nurses working in CCU at KNH.

Study Procedure

If you agree to participate in this study you will be interviewed by the principal investigator in a private room where there will be silence, freedom, and comfort. The interview will take about 30-40, minutes and you will be voice recorded for purposes of reference and also to enable the interviewer to pay full attention to the process.

Risks

There will be no risks associated with your participation in this study since there will be no recording of personal identification data.

Benefits

No individual benefits or even compensation. However, the hospital management will use the study results as interventions for adequate decision making when doctors and nurses are faced with an ethical challenge.

Voluntary participation and withdrawal

You will have free will to decide whether to participate in the research.

Participation is absolutely voluntary and that you have a right to end participation, in case you change your initial mind and decide to withdraw. There will be no penalties following your withdrawal.

Confidentiality

The principal investigator has an obligation to protect your information from unauthorized access, use, disclosure, modification, loss or theft. This ensures the trust relationship between the investigator and the participant and to the integrity of the research study. You will not be identified, all information was kept under lock and key and electronic information was under a password.

Contact persons

Principal investigator contacts: Priscilla Kagendo 0722 698808

Ethics and research secretariat, telephone: 726300-9 Ext 44355

Email: uonknh-erc@uonbi.ac.ke

If you have any questions or concerns about this study feel free to contact us directly.

Confirmation of consent; Are you willing to participate in this study?

Yes..................No...............If yes please sign.................

Principal investigator.................................Time................Date................

Demographic profile of the informants

Informant code....................

☐ Choose the appropriate

1. How old are you____________________
2. What is your gender?

Male________________

Female _____________________

3. What position do you hold in CCU?

Managerial______________

Patient care nurse or doctor ___________________

4. What is your specialty in ICU?

Critical care or anaesthesia _______________________________

5. What is your experience in CCU?

2-3 years ________________

3-5 years _____________________

6-10 years ________________

More than 10 years __________________

APPENDIX II (A): LETTER TO KNH-UoN ERC

LETTER SEEKING PERMISSION FROM KNH-UON ETHICS REVIEW COMMITTEE TO CONDUCT A RESEARCH STUDY

Priscilla Kagendo Mwirigi
School of Nursing Sciences
University of Nairobi
P.O. Box 30197 - 00100 Nairobi

To The Chairman
KNH-UoN Ethics Review Committee
Po Box 20723
Nairobi

Dear Sir/Madam

RE: AUTHORITY TO CONDUCT A RESEARCH STUDY IN KNH CRITICAL CARE UNIT.

My name is Priscilla Kagendo Mwirigi, a master of science in nursing student at the University of Nairobi. I am kindly seeking approval to conduct a study on nurse's and doctors' experiences on ethical challenges in end of life decisions in the critical care unit at KNH CCU. The study findings will be used to improve the provision of quality critical care to the critically ill patients admitted in KNH CCU.

I hereby present my research proposal document for your guidance. Your support will be highly appreciated. Thanking you in advance.

Yours Faithfully,

Priscilla Kagendo Mwirigi,
MSCN student UON
Reg. No H56/11105/2018

APPENDIX II (B): LETTER TO KNH-RESEARCH AND PROGRAMME

LETTER SEEKING AUTHORIZATION TO FROM KNH-RESEARCH AND PROGRAMME TO CONDUCT A RESEARCH STUDY DURING COVID 19 PANDEMIC

PRISCILLA KAGENDO MWIRIGI UON SCHOOL OF NURSING SCIENCES
P.O. BOX 30197- 00100 NAIROBI. CONTACT +254722698808
JUNE 8TH 2020

TO
THE HOD
KNH RESEARCH AND PROGRAMMES
PO BOX 20723
NAIROBI

Dear sir/madam

RE: AUTHORITY TO CONDUCT A RESEARCH STUDY IN KNH CRITICAL CARE UNIT IN COMPLIANCE WITH THE COVID 19 PREVENTION MEASURES.

My name is Priscilla Kagendo Mwirigi, a nurse working at KNH CCU, but currently a student at the University of Nairobi undertaking a course on Master of Science in nursing (critical care nursing). I am kindly seeking approval to conduct a study on nurses and doctors experiences on ethical challenges in end of life decisions in the critical care unit at KNH CCU.

It is a qualitative study utilizing a descriptive phenomenological approach, whereby nurses and doctors working in critical care unit of KNH during study period will be interviewed. Purposive sampling method will be used to recruit participants. An interview guide tool will be used during interview schedule and audio recording and transcription will be done.

Preventive measures to COVID 19 disease will be adhered to during data collection period. The Principle investigator is the one to collect data, there is no research assistance. I will use PPE provided by the hospital to all the staff since I am one of the staff of KNH. Will also be washing hands with soap under running water, no handshaking, and will keep a one meter distance during data collection, between the researcher and the participant. I will also use hand sanitizers.

The study findings will be used to improve the provision of quality critical care to the critically ill patients admitted in KNH CCU.
I hereby attach my research proposal Ethics approval letter and a copy of abstract of the proposal for your guidance. Your support will be highly appreciated. Thanking you in advance. Kind regards.

Yours Faithfully,
Priscilla Kagendo Mwirigi, MSCN student UON. Reg.N0 1156/11105/2018

APPENDIX III: INTERVIEW GUIDE

Question	Prompts
a) What do you understand by the term ethical challenges as pertains your practice in the critical Care unit? b) In your practice are there instances when you encountered ethical challenges as you offered end of life care?	• How would you define ethical challenges in your own words? • Do you encounter ethical challenges provision of end of life care? • What do you feel about ethical challenges? • Which particular ethical challenge have you ever encountered? • What made you feel that it was an Ethical challenge?
c) Please tell me some of your interventions when faced by an ethical challenge in CCU	
d) Please tell me your experiences of ethical challenges that you have encountered during your practice as a Critical care practitioner.	• Can you remember the diagnoses of those patients whom you encountered an ethical challenge? • Did you ever raise any concerns with your fellow health care practitioners?
e) Does ethical challenge in end of life care decisions have any impact on you as a Critical care practitioner?	• How does it make you feel when faced by an ethical challenge? • How do you motivate yourself when you encounter an ethical challenge in provision of end of life care?
f) In your opinion what decisions do you think should be arrived to when a nurse or a doctor is faced by an ethical challenge?	• What decisions do you make when faced by an ethical challenge? • What do you think should be done in case of an ethical challenge or how should it be managed.

Thank you very much for willing and consenting to be part of this study and for your time.

APPENDIX IV: LETTER OF APPROVAL FROM KNH-UON ERC.

UNIVERSITY OF NAIROBI
COLLEGE OF HEALTH SCIENCES
P O BOX 19676 Code 00202
Telegrams: varsity
Tel:(254-020) 2726300 Ext 44355

KNH-UON ERC
Email: uonknh_erc@uonbi.ac.ke
Website: http://www.erc.uonbi.ac.ke
Facebook: https://www.facebook.com/uonknh.erc
Twitter: @UONKNH_ERC https://twitter.com/UONKNH_ERC

KENYATTA NATIONAL HOSPITAL
P O BOX 20723 Code 00202
Tel: 726300-9
Fax: 725272
Telegrams: MEDSUP, Nairobi

Ref: KNH-ERC/A/163

4th June 2020

Priscilla Kagendo Mwirigi
Reg. No. H56/11105/2018
School of Nursing Sciences
College of Health Sciences
University of Nairobi

Dear Priscilla

RESEARCH PROPOSAL – DOCTORS' AND NURSES' EXPERIENCES OF ETHICAL CHALLENGES IN END OF LIFE DECISIONS IN CRITICAL CARE UNIT AT KENYATTA NATIONAL HOSPITAL (P107/02/2020)

This is to inform you that the KNH- UoN Ethics & Research Committee (KNH- UoN ERC) has reviewed and **approved** your above research proposal. The approval period is 4th June 2020 – 3rd June 2021.

This approval is subject to compliance with the following requirements:

a. Only approved documents (informed consents, study instruments, advertising materials etc) will be used.
b. All changes (amendments, deviations, violations etc.) are submitted for review and approval by KNH-UoN ERC before implementation.
c. Death and life threatening problems and serious adverse events (SAEs) or unexpected adverse events whether related or unrelated to the study must be reported to the KNH-UoN ERC within 72 hours of notification.
d. Any changes, anticipated or otherwise that may increase the risks or affect safety or welfare of study participants and others or affect the integrity of the research must be reported to KNH- UoN ERC within 72 hours.
e. Clearance for export of biological specimens must be obtained from KNH- UoN ERC for each batch of shipment.
f. Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. (*Attach a comprehensive progress report to support the renewal*).
g. Submission of an *executive summary* report within 90 days upon completion of the study.
This information will form part of the data base that will be consulted in future when processing related research studies so as to minimize chances of study duplication and/ or plagiarism.

For more details consult the KNH- UoN ERC website**http://www.erc.uonbi.ac.ke**

Yours sincerely,

PROF. M. L. CHINDIA
SECRETARY, KNH-UoN ERC

c.c. The Principal, College of Health Sciences, UoN
The Director, CS, KNH
The Chairperson, KNH- UoN ERC
The Assistant Director, Health Information, KNH
The Director, School of Nursing Sciences, UoN
Supervisors: Miriam C.A. Wagoro, School of Nursing Sciences, UoN
Dr. Sabina Wakasiaka, School of Nursing Sciences, UoN

Protect to discover

APPENDIX V: STUDY REGISTRATION CERTIFICATE

KNH/R&P/FORM/01

KENYATTA NATIONAL HOSPITAL
P.O. Box 20723-00202 Nairobi

Tel.: 2726300/2726450/2726565
Research & Programs: Ext. 44705
Fax: 2725272
Email: knhresearch@gmail.com

Study Registration Certificate

1. Name of the Principal Investigator/Researcher
   PRISCILLA KAGENDO MWIRIGI
2. Email address: priscillakagendo@gmail.com Tel No. 0722698808
3. Contact person (if different from PI) Dr Miriam Wagoro
4. Email address: carole@uonbi.ac.ke Tel No. 0722737356
   0722737356
5. Study Title
   Doctors and Nurses experiences of ethical challenges in end of life decisions in critical care unit at Kenyatta national hospital
6. Department where the study will be conducted Kritical care unit (Main)
   (Please attach copy of Abstract)
7. Endorsed by Research Coordinator of the KNH Department where the study will be conducted.

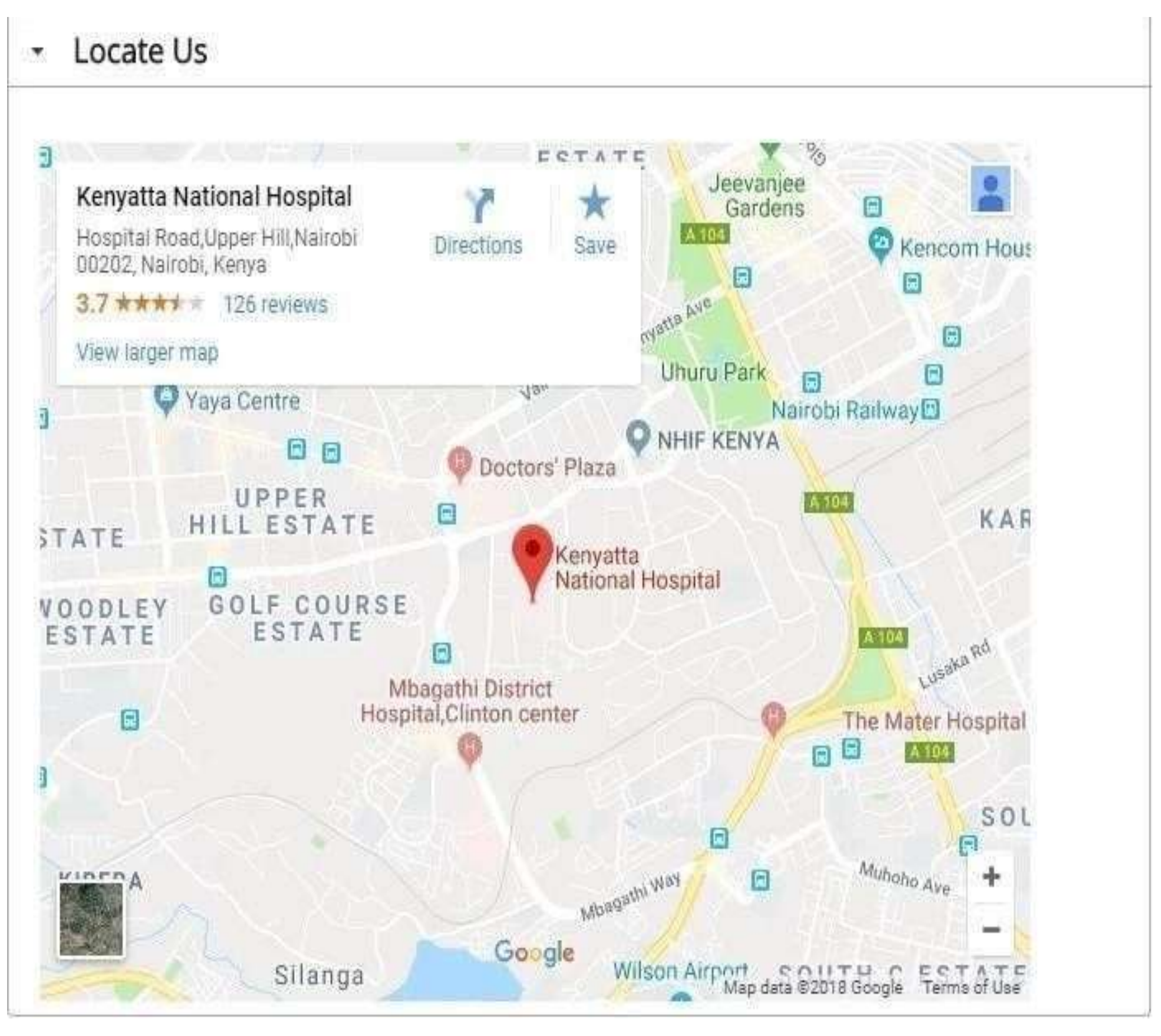
   Name: .... Signature .... Date ....
8. Endorsed by KNH Head of Department where study will be conducted.

   Name: Dr K. Monanyi Signature [signature] Date 11/06/2020.
9. KNH UoN Ethics Research Committee approved study number (P107/02/2020)
   (Please attach copy of ERC approval)
10. I Priscilla Kagendo Mwirigi commit to submit a report of my study findings to the Department where the study will be conducted and to the Department of Research and Programs.

    Signature [signature] Date 11/06/2020
11. Study Registration number (Dept/Number/Year) Anaesthesia/ccu/127/2020
    (To be completed by Research and Programs Department)
12. Research and Program Stamp [stamp: KENYATTA NATIONAL HOSPITAL, 12 JUN 2020]

All studies conducted at Kenyatta National Hospital **must** be registered with the Department of Research and Programs and investigators **must commit** to share results with the hospital.

APPENDIX VI: KENYATTA NATIONAL HOSPITAL MAP



APPENDIX VII: PICTURE OF KENYATTA NATIONAL HOSPITAL

APPENDIX VIII: TURNITIN ORIGINALITY REPORT

Doctors' And Nurses' Experiences of Ethical Challenges in End of Life Decisions in Critical Care Unit at Kenyatta National Hospital

ORIGINALITY REPORT

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6	Submitted to Mancosa	Student Paper	
7	journals.sagepub.com	Internet Source	<1%
8	Submitted to University of Nairobi	Student Paper	<1%

Lead Supervisor's Signature: *AtienoMCW* Date 30th October, 2020

Director's Signature *AtienoMCW* Date 30th October, 2020