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SPECIMEN LAYOUT FOR THE TITLE PAGE

THE MEANING OF BEING
AS A NURSE INVOLVED IN
THE WORK OF DEATH INVESTIGATION

A North American view and
its implications to practice in England

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of Doctor of Philosophy

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ABSTRACT

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The meaning of Being as a nurse involved in the work of death investigation.

Keywords: Being, hermeneutics, Heidegger, nurse, forensic, death investigation, coroner, North America, England.

This research study explored the meaning of “Being” (i.e. Heidegger’s four philosophical concepts of Being-in the-world, fore-structures, time and space) as a nurse involved in the work of death investigation in the USA. The objectives were to: reveal the hidden meaning of Being; transfer the findings into an English context by examining what nurses could offer beyond their current role boundaries in an area not currently practised to the extent that nurses make to other medical specialities; and finally put forward developments that would need to take place to ensure such proposals were successful in making an effective difference to health care.

In the USA there are two systems of death investigation, the Coronial and Medical Examiner system. The Coroner is an elected county or state position with varied educational and professional requirements. Some Coroner positions have been filled by registered nurses as they have put themselves forward successfully for election. In contrast, the Medical Examiner is an appointed county or state position who must be a licensed physician and a qualified pathologist or forensic pathologist in most cases. Within the Medical Examiner systems death investigators may also be appointed of which some have been filled by registered nurses.

It was under the interpretive paradigm that a Heideggerian hermeneutic study was undertaken. Snowball sampling was instigated to reach a hidden population and collect qualitative data by means of unstructured interviews, non-participant observations, interrogation of historical records and the keeping of a personal reflective diary. The seven phase analysis process underpinned by the hermeneutic circle was developed to enable a synopsis of the shared meaning of Being to be revealed through the presentation of paradigm cases that encompass stories and themes.

Of the 22 nurses found to be working as either death investigators or Coroners in the USA who fulfilled the inclusion criteria, 17 nurses from 11 States in the USA consented to take part. Fore-structures concerning age (average 37), gender (82% were women) and professional experience (majority came from an adult nursing background with emergency department or critical care experience) are discussed.

Overall participants were interviewed for a total of 78 hours in 11 States, five of which were also observed in practice for a total of 142 hours in 3 States, giving a total of 220 hours of interview and observational data. The interpretive analysis revealed the three major paradigms of: the authentic and inauthentic reality of Being (the death investigator nurse in action); the everydayness and averageness of Being (community outreach) and the publicness of Being (mass fatality care).

This study reveals knowledge concerning the meaning of Being as a nurse involved in the work of death investigation in the USA. Aspects of this illuminated landscape have propositioned for the advancement of nursing clinical practice to replace and further develop the current coroner's officer and soon to be implemented medical examiner officer role in England and Wales. Hence recommendations are made for practice development and further research in England.

Warning*: This study contains images of the dead, with images of both the external surface of the body and internal organs. If having read this warning, you choose to read the rest of this study you do so at your own free and informed choice.*

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DEDICATION

I wish to dedicate this study to my husband, Professor Dr Guy N Rutty MBE, Home Office Forensic Pathologist and Divisional Head of the East Midlands Forensic Pathology Unit at the University of Leicester who serves the public with devotion, integrity, empathy, advocacy and patience. He is a role model for any aspiring professional wishing to develop or expand their role into the world of death investigation. An encourager of practice development, research progression and education, Guy is both innovative and yet realistic in the advances he contributes to scientific knowledge.

Guy has gained respect and admiration both at home and abroad for not only his day to day work, but his work in the field of mass fatalities being the principle pathology adviser to the Home Office. He has assisted the United Nations International Criminal Tribunal and the International Commission on Missing Persons for the Former Yugoslavia concerning war crime investigations of mass graves found in Bosnia and Serbia and also in the identification and repatriation of bodies following the Tsunami in Sri Lanka.

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GLOSSARY OF TERMS

The following forensic nursing and medico-legal role terms as defined overleaf are relevant to this study:

Terminology	USA	UK
Forensic Nursing	According to the International Association of Forensic Nurses (2001), Forensic Nursing is the application of the forensic aspects of health care combined with the biopsychosocial education of the registered nurse in the scientific investigation and treatment of trauma, and/or death of victims and perpetrators of violence, criminal activity, and traumatic accidents. The forensic nurse provides direct services to individual clients, consultation services to nursing, medical and law-related agencies, as well as providing expert court testimony in areas dealing with questioned death investigative process, adequacy of	The Royal College of Nursing Forensic Nursing Forum (2005) state that forensic nursing is the caring of mentally disordered offenders and victims of abuse. Mullen (2005) provides more detail in his definition that forensic nursing involves the assessment and treatment of those who are both mentally disordered and whose behaviour has led, or could lead, to offending.

Terminology	USA	UK
	service delivery, and specialised diagnoses of specific conditions related to nursing. Forensic Nursing roles are also subsumed within other specialist roles including: The clinical forensic nurse specialist; sexual assault nurse examiners; legal nurse consultants; nurse educators and researchers; forensic psychiatric nursing; correctional nursing; nurse attorneys; paediatric nursing (child abuse/neglect); forensic gerontology nursing; any nurse specialising in the application of clinical or community based nursing practice involving victims of crime and/or catastrophic accidents.	

Terminology	USA	UK
Forensic Nurse Examiner	This overall term is defined as the application of the nursing process to public or legal proceedings. This includes the application of forensic aspects of health care to the scientific investigation of trauma, and/or death of victims and perpetrators of abuse, violence, criminal activity and traumatic accidents.	No equivalent
Clinical forensic nurse specialist	An individual specifically educated at the graduate level (master of science in nursing) in a clinical nurse specialist program in forensic nursing at a regionally accredited institution of higher learning.	No equivalent
Sexual Assault Nurse Examiner (SANE)	A registered nurse who has advanced education in forensic examination of sexual assault victims.	The equivalent is known as the Forensic Nurse Examiner (Sexual Assault), a registered nurse who has advanced

Terminology	USA	UK
		education in forensic examination of sexual assault victims who works under the guidance of a clinical forensic physician.
Custody Nurse	No equivalent	The application of clinical nursing practice to the assessment and monitoring of detainees in police stations. This includes data collection, promotion of safety, health intervention, evaluation and health promotion, as well as the proper collection, processing and preservation of forensic evidence when necessary. Custody nurses are involved too in assessing fitness for detention and fitness for interview in partnership with medical staffing.

Terminology	USA	UK
Death Scene Nurse Examiner	The application of clinical nursing practice to the assessment and care of the deceased at scenes under the direction of the forensic medical examiner or the coroner depending on which State the nurse is practising. This would include the verification of death, identification of previously unrecognised or unidentified injuries, as well as the proper collection, processing and preservation of forensic evidence in order to provide future expert court testimony.	No equivalent
Police Surgeon / Police Medical Officer	A physician hired by the police department whose responsibility it is to respond to the scene or hospital to provide and immediate interpretation of medico-legal	Known as the Police Surgeon/Forensic Medical Examiner, a doctor contracted by a police force whose responsibility it is to respond to the scene or hospital to provide an

Terminology	USA	UK
	injuries, collect forensic evidence and provide expert court testimony.	immediate interpretation of medico-legal injuries, collect forensic evidence and provide expert court testimony.
Forensic Pathologist	Pathology is the branch of medicine that deals with the causes of disease and the reaction of body tissues and fluids to disease and injury. A forensic pathologist is a doctor with speciality training in pathology and subspecialty training in forensic pathology (the part of pathology dealing with legal matters) who provides a forensic examination on the deceased, collection of evidentiary material and documentation for court presentation under the direction of the Coroner or Medical Examiner.	Pathology is the branch of medicine that deals with the causes of disease and the reaction of body tissues and fluids to disease and injury. A forensic pathologist is a doctor with speciality training in pathology and subspecialty training in forensic pathology (the part of pathology dealing with legal matters) who is contracted to a police force to provide a forensic examination on the deceased, collection of evidentiary material and documentation for court presentation under the direction of Her Majesty's Coroner

Terminology	USA	UK
Clinical Forensic Physician	A medical doctor employed by a healthcare institution, skilled in forensic techniques and whose responsibility is to provide a forensic examination, collection of evidentiary material and documentation for courtroom presentation	A medical doctor employed by a healthcare institution skilled in forensic techniques and whose responsibility is to provide a forensic examination, collection of evidentiary material and documentation for courtroom presentation pertaining in particular to sexual assault.
The Coroner or Medical Examiner	A **coroner** is generally, an elected medico-legal death investigation officer (may or may not have medical training). A **medical examiner** is an appointed medico-legal death investigation officer, generally a forensic pathologist or physician	**Her Majesty's Coroner** (England, Wales & Northern Ireland) is a registered medical practitioner or a lawyer (lawyers only in Northern Ireland), who has held a general qualification in their field for a minimum of five years. The purpose is to investigate into the causes of sudden or unexpected deaths

Terminology	USA	UK
		The Procurator Fiscal's (Scotland) main concern is to establish whether there has been any criminality or negligence associated with the death, rather than establishing the medical cause of it. He cannot issue a death certificate, as in the Coroners system, but instead the "Fiscal Certificate" or death certificate is issued either by the police surgeon or the pathologist.

AUTHOR DECLARATION

1. During the period of registered study in which this thesis was prepared the author has not been registered for any other academic award or qualification

2. The material included in this thesis has not been submitted wholly or in part for any academic award or qualification other than that for which it is now submitted

3. The programme of advanced study of which this thesis is part has consisted of
    a. Supervised tutorials – all of which were undertaken at the University of Bradford
    b. Education in the use of Nudist and Endnote computer software
    c. Attendance at relevant professional and research conferences

4. Guidance for the structure of this thesis was provided by the University of Bradford Research Degree Regulations (2010) and a text by Phillips and Pugh (1998) and Allison and Race (2004).

5. All images remain the copyright of the author. Any image not the copyright of the author has had the source referenced. All images comply with the current NMC (2008) Code: Standards of conduct, performance and ethics for nurses and midwives.

Jane E Rutty

CHAPTER ONE

INTRODUCTION

1.1 INTRODUCTION

Beginning any project or study is never straightforward and effortless. Instead it necessitates many forms of preparation. Steinbeck's discussion on preparing for a trip or expedition sounds much like preparing to research (Cohen et al 2000). The beginning of this expedition will now be revealed in this introductory chapter by firstly providing a personal reflection on nursing and death investigation. The overall research question along with its significance and importance will then be identified along with a summary of the focus and underlying framework of the study. Finally an outline of the study chapters will be summarised.

1.2 PERSONAL REFLECTION

This study reflects the journey I made on my first visit to the Lauterbrunnen Valley, a municipality of the Interlaken (district) of the Berneses Oberland, Switzerland. I was and still am a keen walker, but until then had only ever hiked up mountains in Scotland and the Lake District. My good friend told me about his experiences in visiting Lauterbrunnen, but said that I would never really understand how breathtaking it was unless I had seen it and experienced it for myself. As a result, I ventured with my good friend (now husband) to Lauterbrunnen to see for myself.

According to the Swiss Tourist Board (2010), Lauterbrunnen is considered to be one of the most spectacular glacial valleys in Europe, surrounded by the unspoilt natural beauty of the magnificent Swiss Alps with the most famous feature being the cascading 300 metre high Staubbach waterfall. They were not wrong. On arrival for the first time you see that Lauterbrunnen is nestled at the foot of the Eiger, Monch and Jungfrau mountains, in a spectacular walled valley. It is the imagined 'real Switzerland' of cow bells, wild

flowers, crystal clear streams and stunning waterfalls. The village itself nestles a couple of traditional restaurants serving cheese fondue as its speciality and rose wine. Central to the village is the church that rings its bells every morning echoing around the valley for miles. However, this is only half the story as there is more within the initial landscape to see and experience. One can take a monumental number of photographs, but it remains difficult to know the true experience of such an adventure. Instead, it is the holistic combination of photographs, personal stories, feelings, observations, guide books and maps etc that confirm the experience as it reminds previous tourists of their own journey and locals of the meaning of this experience of being-in-the-world.

Photograph 1: Rutty JE (1993) Lauterbrunnen Valley, Switzerland

This trip and many visits since have parallels to the journey I have encountered on this research study. The aim of each trip when visiting Lauterbrunnum was to walk to each mountain top within that valley. However on my first visit, I looked up from Lauterbrunum and saw the mountain top and thought "great, that's no bigger than the mountains in the Lake District!" (see photograph 1). Similarly, as the Literature Search began I thought or

believed that I knew everything, but quickly learnt that in fact I knew very little as there was much knowledge that seemed to be hidden and untapped.

Photograph 2: Rutty GN (1993) Lauterbrunnen Valley, Switzerland:

I began walking up the Jungfrau mountain one very early morning, well prepared after collating the relevant background information of which path to take and what equipment to bring with me. I then reached what I thought was the mountain top and felt on cloud nine, only to discover and see another mountain ahead (see photograph 2). No problem, I thought. A quick cup of tea from my flask, a rub of my aching knees and I will be on my

way. A simile to this study is to when the Data Collection began in earnest as it was here that I began to reveal that hidden knowledge.

When I reached the top of this mountain I was very tired and even more tired when I saw there was yet a snow capped peak to climb before I finished. The air was now thin and it took me twice a long to cover any distance than it had done up until now, just like the long period of Data Analysis and the search for “shared meanings of Being”.

Photograph 3: Rutty GN (1993) Glacier at the top of the Jungfrau, Switzerland:

It was then that I reached the ultimate peak. It was breathtaking. I was shivering. Yes it was very cold, but so exciting. I now had a 360^0 degree view of Lauterbrunnen and beyond. It was magnificent landscape to view. The whole experience had been unimaginable up until this point, but now it all made sense. I was enlightened. So my friend and I sat and gazed, had hot soup and bread rolls in a local café (well the only café in fact) in our fleeces, leg warmers and woolly hats. It was heaven. We met hikers from

all over the world that had taken a similar journey and others who had walked the length of the glacier from Italy (see photograph 3). The meaning of Being as experienced by my friend in Lauterbrunnen had been interpreted and could by verified by others. Just like the findings of this research.

It was now time to walk back down the mountain. Yes, it was an easier hike, but it allowed plenty of time to reflect on the journey experienced and to consider how to interpret and explain such an experience of Being to others. This was now the real beginning in designing implications for nursing practice and recommendations for future research.

This study then will take you on a journey, not to Lauterbrunnen on this occasion, but to the meaning of Being as a nurse involved in the work of death investigation, an American landscape. This is a unique role for nurses in that it does not exist in the United Kingdom or Europe. In addition this landscape has never been viewed in its totality before. This study's journey provides meaning to this world of nursing by exploration, discovery and innovation through the steps of the research process. The beginning of this journey will now be revealed in exploring my credibility as a researcher.

1.3 MY CREDIBILITY AS A RESEARCHER

To gain credibility as a researcher one must provide information concerning one's background and previous experience in coming to the study to enable my credibility to be judged in relation to intellectual rigour, professional integrity and methodological competence.

Resembling members of any other professional discipline, nurses have established and identified roles in areas throughout their practice, in the clinical area, education, management and research. The concept of the term "role" alludes to

> "... performed behaviours or behaviours perceived as acceptable, relative to a given situation" (Brook and Kleine-Kratct, 1983, 51).

Presently, the most widely accepted statement of the term role in nursing is by Henderson who proclaimed that:

> *"The unique function of the nurse is to assist the individual; sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he would perform unaided if he had the recovery strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible. This aspect of her work, she initiates and controls; of this she is the master. She also, as a member of a team, helps others as they in turn help her, to plan and carry out the total program whether it be for the improvement of health, or recovery from illness, or support in death. Nursing should never be seen as anything less than essential to the human race"* (Henderson, 1966, 15).

Following Henderson (1966), it has been stated that the elements of the nurse's role encompass that of a co-ordinator, counsellor, caregiver, educator, collaborator, patient advocate, change agent, and consultant (Doheny and others, 1982). However, the particular roles that nurses perform are determined by reciprocal validation between the

nurse, the multidisciplinary team and the consumers of health care. It is noted though that consumers tend to view nurses in terms of personal qualities, rather than role skills. Nevertheless, harmonious roles within a system such as health care can reduce uncertainty, ambiguity and tension (Leddy and Pepper, 1993).

My interest in nursing and death investigation began with my MSc in Nursing with the Royal College of Nursing Institute (London) when I explored the contributory role of the nurse in the Coroner's Enquiry from the Coroners' and Forensic Pathologists' perspective in England and Wales (Rutty 2000). It quickly became clear, that to believe if nurses practicing in England perform their work correctly that they will never be involved in any Coronial matter was a naive assumption to make. Especially when, the study had shown that the nurse's role extends to after a patient's life has ended and at times when necessary to the Coroner's enquiry (Rutty 2000).

It was at this time that I uncovered, quite by accident, that nurses were working as Coroners and Death Investigators in the USA, the one area of medicine (pathology) that nurses were not aligned to in the United Kingdom. However, there was no research or evidence internationally to show what such a role means in reality or what contributions to health care the nurses were making. It became very important to me to discover what this nursing service meant in its everydayness and whether the nursing service offered in the USA could benefit the multidisciplinary death investigation team and general public healthcare in England.

1.4 RESEARCH QUESTION

Hence the overall research question for this study is:

- What is the meaning of Being as a nurse involved in the work of death investigation in the USA?

1.4.1 Concept clarification

In the USA, the Coroner is an elected county or state position. The requirements for such a position depend on which county or state the Coroner sits. This varies tremendously throughout the country with regards to residency, age, term of office and educational and professional requirements. A deputy or deputies may also be appointed by the Coroner. Some Coroner and Deputy Coroner positions have been filled by registered nurses.

The Medical Examiner in the USA is an appointed county or state position. The requirements for such a position in all cases is that they must be a licensed physician and a qualified pathologist or forensic pathologists in most cases, but the term of office varies throughout the country. A deputy or deputies may also be appointed. Within such teams death investigators may also be appointed by the Medical Examiner. Some death investigator roles have been filled by registered nurses.

The concept “as a nurse involved in the work of death investigation in the USA” is now clarified for this study so as to ensure that the context of the following chapters is recognisable. Nurses in the USA have the opportunity to work within

either the Coroners or Medical Examiners systems. However, the titles of such nurses varies from one jurisdiction to another depending on the role and preference designated by the chief medical examiner or coroner. These titles have evolved as existing roles are filled by nurses or as new roles are developed for nurses in the forensic investigation of death. Examples of this can be seen where the State requirement for elected or appointed officials have the title of coroner or deputy. However, in other States the forensic nurse has replaced the non-forensic physician and hence holds the title of district medical examiner serving under the authority of the state medical examiner. Among other titles assumed by nurse investigators in medical examiner systems are field investigator, field agent, forensic investigator, forensic nurse investigator, medical investigator, medico-legal investigator, medico-legal death investigator and forensic nurse death investigator. Where nurses fill a supervisory role, titles may include chief investigator, senior investigator, or coordinator of the investigative team. For this study the term "nurse involved in the work of death investigation" encompasses all of these titles. However, individual titles may be used at times to assist in specific discussions.

1.5 RESEARCH AIMS

In order to answer the research question, the following research aims will be completed:

1. Critically interpret what prior experiences and/or understandings were bought by nurses concerning the meaning of Being as a nurse who became involved in the work of death investigation in the USA;

2. Critically interpret what current experiences and/or understandings nurses articulate as the meaning of Being as a nurse involved in the work of death investigation in the USA;
3. Bearing in mind that making a difference in health care is one of the prime concerns of nursing within England, critically examine if there is need for registered nurses to expand their role into the realms of death investigation and if so what nurses would be recommended to offer beyond their current role boundaries.

1.6 SIGNIFICANCE OF THE RESEARCH QUESTION

The overall research question is significant, as it will enable the creation of new knowledge, through original research that will interpret nursing procedures and practices in the USA. This will give structure and meaning to the everyday life of nurses working within the realms of death investigation: an area never researched before. Such findings will provide an insight into services that are being provided by nurses in the USA and suggest new ways of working to release the untapped potential for nursing within England. This in turn may expand and advance the boundaries of the nursing profession in England into a new speciality of practice in an area that up until now has never been considered for nursing, only medicine.

This study provides a modest attempt at portraying the meaning of Being as a nurse working within the realms of death investigation. It is justified because its revelations and discovery add to and enrich the profile of nursing work, not only in the research community, but also in the health, social and legal sectors. Because the meaning of Being as a nurse involved in the work of death investigation in the USA is uncovered in

this research, Coroners in collaboration with nursing in England can begin to develop their service to the general public, a service to be provided at the most difficult time in the lives of the general public from a multi-disciplinary perspective.

1.7 IMPORTANCE OF THE RESEARCH QUESTION

Exploring the meaning of Being as a nurse involved in the work of death investigation is worthy of exploration and investigation when the contributions to nursing theory and practice are realised. It is only over the last 100 years that an organised approach to nursing has appealed. Nursing is still poorly understood and because it is poorly understood it is poorly valued. It seems pertinent therefore, as many issues such as gender, education and developments in health care to name just a few, are constantly changing and influencing nursing as it strives to maintain a professional role in today's society that the following contributions that this study intends to make to nursing theory and practice are based on Blanchfield's (1978) criteria required for a true profession that being a: body of knowledge, regulating council; client benefit; code of conduct; advancement of knowledge; autonomy and equality. The contributions this research study will make therefore are that:

1. The body of research–based knowledge for nursing will be expanded through the interpretation of the meaning of Being as a nurse involved in the work of death investigation in the USA, which will enable
2. Professional standards for nursing in education and clinical practice to be developed in England thereby advancing the present nursing role. This in turn will
3. Ensure that the patient's legal rights for an expedient death investigation when necessary can be upheld, thus

4. Ensuring that the public is protected. It is hoped too that the acquired new knowledge will go towards enhancing patient and family multi-disciplinary health care at perhaps the most difficult and emotional time in peoples' lives. Additionally, this study will make contributions by
5. Enabling the nursing profession to keep up-to-date with advancing new knowledge and practice in order to maintain competence and professional development. Finally, the results of the study will contribute to the nursing profession by
6. Promoting autonomy and esteem for nurses by increasing role harmony within the multidisciplinary team, with the provision of a congruent realisation of the particular role that nurses could have in England within the realms of death investigation, rather than in the shadow of medical practice and the powerful patriarchal system of the Victorian era from which it derives its origins.

In addition, the process of seeking meaning within the told stories of Being made by nurses working within the realms of death investigation enriches those who share the stories of their experience, enhancing the tellers' abilities to provide testimonies with the potential to benefit others in similar circumstances. Equally, the narration of their experience provides them with a beginning, on a personal level, at exploring the meaning of Being as a nurse involved in the work of death investigation as well as the potential for further meaning and practice development.

1.8 FOCUS

Nursing work is ever changing. Nursing boundaries are on the move. This study is about nurses, nursing work and the different and sometimes competing frameworks that nurses call upon to name and perform that work. Because nursing work so frequently intersects with medical work, this study is also, inevitably, about doctors, and about the complex relationships between nurses and doctors and between nursing and medicine, particularly as nursing plays a major part in all medical specialities except pathology at this time.

The focus of this study also relates to the coronial aspect of death investigation, but not criminal investigation. It is about the investigation of who, when, how, where and why someone has died in order to enable a death certificate to be completed and how nursing does in the USA and could in England move into and contribute to this scenario of care.

1.9 FRAMEWORK

With knowledge surrounding health care increasing and sometimes even exploding, nursing is forced to adapt its cultural, social, political and ethical frameworks. However, this is not negativity that needs to be overcome, but a challenge to be part of the evolution, while the essence of nursing remains.

This research study though will lack a starting point without a definition of the role of the nurse of some kind. A sensible appraisal of what the nurse does is needed as a springboard to debate and investigate what nursing work should aim to be doing and what the priorities should be (Salvage 1992). It seems most appropriate and most useful for this research study to utilise Henderson’s (1966) definition of nursing as a starting point

and basis to research into the meaning of Being as a nurse involved in the work of death investigation in the USA.

Role theory is a conceptual framework that defines how individuals behave in social situations and how these behaviours are perceived by external observers (Brooks et al 2007). To promote role harmony in any profession or occupation there are three aspects to any role that need to be realised and have been described as: role prescription, role description and role expectation (Berlo 1960). Role prescription pertains to a complete and unambiguous account of the behaviours that ought to be carried out by individuals in a specified role. Role description, in contrast, is concerned with illustrating in detail the behaviours that are being performed in reality. Lastly, role expectations are related to the perceptions that people have about such behaviours. An ideal role is when there is congruence among role prescription, description and expectation, but when there are differences communication breakdowns occur (Berlo, 1960). Such tensions have a potential to instigate role conflict, role overlap and role ambiguity (McKenna et al 2003). In turn this can lead to lower productivity, tension, anxiety, dissatisfaction and withdrawal from the group (Chang and Hancock 2003).

Since Berlo (1960) role theory has developed into the five major theoretical perspectives of functionalism, symbolic interactionism, structuralism, organisational and cognitive (Hardy and Conway 1988). It is these frameworks for role harmony and theory that will be used to support this study when researching into what it means to be a nurse involved in the work of death investigation in the USA, and what they bring to such work to make a difference to health care. These frameworks will also be utilised to examine what nurses

could offer beyond their current role boundaries to the work of death investigation in England.

The Department of Health authored publications such as: *Make a Difference (1999a); The NHS Plan (2000 & 2001); The NHS Improvement Plan (2004); The NHS in England: Operating Framework for 2007-08 (2006); Modernising Nursing Careers (2006b); Towards a Framework for Post-registration Nursing Careers (2007), Framing the Nursing and Midwifery Contribution: Driving up the Quality of Care (2008); Equity and Excellence: Liberating the NHS (2010) and; Front Line Care authored by the Prime Minister's Commission on the Future of Nursing and Midwifery in England (2010)* are as a whole not only about recognising the value of nursing, but about raising the quality of patient care and improving the health of people. The context of care is changing with regards to: people's health and social needs; technology; expectations; the NHS; and nursing roles. It is this framework of strengthening nursing in the new NHS that will underpin this study by suggesting new ways of working in developing nursing roles and improving services.

1.10 OUTLINE OF THE STUDY

Chapter two, the literature review, follows this introductory chapter and reviews the literature on role of the nurse in health care, the purpose of the Coroner and relevant death investigation frameworks from around the world. This is followed by an analysis of the emerging forensic nursing role in England compared to those within the USA. Through this construct, a proposal is made to explore the meaning of Being as a nurse involved in the work of death investigation through the personal stories and observations of nurses' in this role.

Chapter three presents the study design from a philosophical perspective and the data collection and analysis methods respectively. The journey to a qualitative method and the narrowing of the road to Heidegger's hermeneutic philosophy is justified. This is accomplished by first discussing Habermas' three major sciences and applying the interpretive philosophical perspective from an ontological and epistemological perspective.

Chapter four critically puts forward the issues of data collection and analysis. This begins with applying Heidegger's hermeneutic philosophy to research methods and introducing the underpinning framework of the hermeneutic circle. The matters of sampling, instrumentation, protection of participants, methods of analysis and trustworthiness is then submitted and justified. Finally a description on how the findings will be reported in chapter five is summarised.

Chapter five, the research findings and discussion, provides the meaning of Being through paradigms that incorporate themes and stories of the participants' horizons who were interviewed and observed for this study. Such paradigms that then formed "shared meanings of Being" as a nurse involved in the work of death investigation in the USA are discussed fully with the current literature.

Chapter six, the conclusion, returns to the initial research question in regard to the findings and as a result of this process, delineates implications for theory, policy and practice for nursing within the realms of death investigation in England. The areas presented for review and consideration are contributions to knowledge, conclusions about the research question, including the recommendations for practice development,

strengths and limitations of this research study, and finally recommendations for future research studies.

It will be proposed that the meaning of Being as a nurse involved in the work of death investigation in the USA presented in this study informs and adds to the body of knowledge offering a unique insight into the potential expanding and advancing role of the nurse within this speciality in England.

1.11 CHAPTER SUMMARY

In summary, this first chapter has provided an overview of the research topic area concerning the significance of the study and the purpose of conducting it. The research is justified, the methodology is briefly described and the study outlined. On these foundations, the study can proceed with a detailed description of the research, beginning with a thorough exploratory examination of twenty years of literature on nursing and death investigation, both in Britain and the USA in particular. It is an area that has not been fully investigated or documented as will be now revealed, but an area of great importance to the nursing profession, multidisciplinary team and general public.

The word nursing over the years has been used to describe a very wide range of activities undertaken by many different people. These include informal carers and a variety of assistants and support workers, as well as those professionals within the family of nursing (Royal College of Nursing, 1992). This research study is concerned with professional nursing, that is, the practice of those people who hold a statutory nursing qualification with the Nursing and Midwifery Council in the United Kingdom or the American Nurses Association. Additionally, the terms “nursing”, “nurse” and “registered nurse” are used

generally and unintentionally interchangeable to encompass nursing, midwifery and specialist community public health nursing. Supplementary to this, to promote clarity and avoid inappropriate phraseology, the convention that nurses are female and patients are male, except where the context dictates otherwise, has been adopted throughout this research study. Finally all names have been changed to ensure confidentiality and anonymity of participants, the multi-disciplinary team and general public.

Having provided an overview of the key concepts involved in this study, chapter two provides a more detailed appraisal of the literature regarding the general role of the nurse and the coroner, along with a discussion concerning the various death investigation frameworks from around world to set the scene. The term forensic nursing is then defined along with an analysis of nursing work within the realms of death investigation with particular reference to England and the USA.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

Qualitative researchers historically were encouraged to commence their studies without a literature review, because it was asserted that an involved review would invalidate the qualitative study by directing the researcher on a particular course (Glaser 1992). The opposite view was held by Morse (1994) who cautioned researchers against this by describing this process as a possible senseless attempt to "re-invent the wheel", when an explanation or solution to the research question may perhaps already exist.

With this is mind, the following literature review has been conducted to generate a picture of what is known and not known about the meaning of Being as a nurse working within the realms of death investigation. It will discuss whether present research findings are relevant and applicable for use in health care practice in England and consequently whether or not there is a need for conducting a research study on this topic. The aim of this chapter is to illustrate the importance and significance of the research question for not only the nursing profession but also the multi-disciplinary team in health care and the coronial service, those outside the health care system who contribute to the Coronial service with particular reference to the legal sector and those families who become involved in the death investigation process.

The chapter will begin by setting the scene for this study by examining the general role of the nurse from a historical perspective through to the current position in health care. Following will be an evaluation of the philosophical and political issues surrounding the expansion and advancement of nursing practice interrelated to the changes in medical policy, health service delivery and workforce planning. A discussion will then ensue on the development and purpose of death investigation frameworks practiced in England,

Wales, Scotland and Northern Ireland. The question as to whether the coronial service in England and Wales is in need of reform will also be debated. To set the research study in motion the comparison to other death investigation frameworks being practised around the world will be discussed and the term "forensic nursing" will be defined along with an analysis of the emerging new nursing roles contributing to the coronial service in England and Wales today. A comparison will subsequently be made to other countries from around the globe. This chapter will draw to a close by suggesting that there is a potential gap in the provision of nursing care within the field of death investigation in England. This is especially pertinent following *The Coroners and Justice Act* (2009) which:

> *"…aims to deliver ore effective, transparent and responsive justice and coroner services for victims, witnesses, bereaved families and the wider public".*

2.2 THE ROLE OF THE NURSE IN HEALTH CARE HISTORICALLY.

The word "nurse" originated from the Latin word "nutrire", that is "to nourish" (Taylor et al 1989). The Western version of nursing has a long history and can be traced to as far back as the Middle Ages, between the 5th and 15th centuries (Goward, 1992). In the mid 19th century, most nursing care was carried out at home as part of women's unpaid domestic duties. Hospital patients, who were mostly destitute, were attended by women in religious orders or laywomen trained informally on the job. However, they also had a reputation for drunkenness and immoral conduct. This sad state of affairs had evolved for three centuries as nursing passed into its "dark ages" in England.

Since the Reformation in the 16th century and the suppression of monasteries, the quality of nursing and hospitals had suffered in all the Protestant European countries but most

severely in England. When Henry VIII established the Church of England in 1534, he seized over 600 charitable institutions and suppressed all religious orders. This seizure of church properties had a direct negative effect on women and nursing. Women lost political and administrative control of nursing operations. Inexperienced civil administrators took over from religious professionals who were steeped in a culture of care that had evolved since the beginning of the Christian church. As a consequence, women lost their voice in both hospital administration and nursing management (Donahue 1985), leading the whole medical system to begin a downward spiral of mismanagement, crowding, filth and infection. It was these conditions that prompted Florence Nighingale's avocation (Dossey 2000).

Nursing has its modern origins from later on in the 19th century and the early 20th century, when during the Crimean War of 1854-56 there was a need to care for wounded soldiers abroad. It was Florence Nightingale (1820-1910), a British nurse, who fulfilled this role when she organised a group of women to deliver care under her supervision and that of the war surgeons in Scutaria, Turkey (Meleis 1997, Buckenham and McGrath 1983). Here her primary goal was the army's establishment of preventive measures that would keep British soldiers healthy and not just merely tending to their wounds and sickness. She coped with conditions of crowding, inadequate sanitation and shortage of basic necessities. On July 28th 1856, Florence Nightingale left for England as an international heroine at the age of 36 (Dossey 2000).

It was in the last half of the 19th century, that the changing social conditions of that time supported the development of a more sophisticated system of health care and one that consequently created a place for the trained nurse. It was Florence Nightingale on her

return from the Crimean War who founded in 1860 one of the first nursing schools in the world, the Nightingale School and Home for Nurses at St. Thomas' Hospital in London (Goward 1992).

Nightingale's book (1860) "*Notes on Nursing*" was to become the best known of all her works and yet it has a modern message. Many of the concepts that she suggested e.g. the healing value of colour, light, music, pets, relaxation etc, are today integrated with traditional medicine and nursing and referred to as alternative therapies or complementary therapies. Her great accomplishment was to establish a theoretical framework for nursing practice where none had existed.

Perhaps, the largest achievement in nursing history since Nightingale's reforms has been The Nurses, Midwives and Health Visitors Act of 1979 (amended in 1992, 1997 and 2002), which set up the framework for the United Kingdom Central Council, the National Boards and the Professional Register for Nursing Midwifery and Health Visiting. Both the Council and Boards were dissolved in 2002 and replaced by the Nursing and Midwifery Council.

2.3 THE ROLE OF THE NURSE IN HEALTH CARE TODAY

The term role is a term drawn from the language of the theatre to describe the set of expectations associated with a person's position in a social organisation. Stable role definitions enable social organisations to function effectively. When parts are well known, well practiced, and agreed on by everyone in the cast, smooth performances result (Scheibe 1995). More prescriptively, Smith (1984) defines roles as the behaviours set for and expected of all people who perform particular functions. The role concept informs the

role holder of appropriate attire, duties, language, obligations, privileges and rights. From a theoretical viewpoint there are five major perspectives of role theory: The five major theoretical perspectives of role theory are: functional, symbolic, structural, organisational and cognitive (Biddle 1986).

Functional role theory sets out society as being a structure with interrelated parts and examines role development as shared social norms for a given social position. More simply, this theory is about how through unspoken consensus some behaviours are considered appropriate while others are believed to be inappropriate. Influential theorists include the English philosopher Spencer (1820-1903), French sociologist Durkheim (1858-1917), English social anthropologist Brown (1881-1955), Polish anthropologist Malinowski (1884-1942) and American sociologist Parsons (1902-1979). Symbolic Interactionist role theory examines role development as the outcome of individual interpretation of responses of behaviour. This theory was developed by American Pragmatism and the work of Mead (1863-1931) and Cooley (1864-1929). This approach is often used by qualitative researchers who use participant observation in order to access meanings. In this theory roles are perceived as relationships between what a person does and what others do around them (Lambert and Lambert 1981). Structural role theory was introduced by Park and Linton in the 1920s (Clifford 1996). They theorised that roles are linked to structural positions. In other words roles are viewed as serving functional pre-requisites of the social system. This relationship between the role and social structure may change as the institutions of society evolve. Overall, it emphasises the influence of society rather than the individual role utilising mathematical models. Organisational role theory very simply examines role development in organisations. Cognitive role theory can be summarised as the relationship between expectations and behaviours.

If we take nursing into consideration, it has been suggested that:

> *"Everyone thinks they know what a nurse is. She is a young woman who wears a distinctive uniform and a crisp white cap and works in a hospital looking after sick people. Everyone, too thinks they know what a nurse does: she carries out the doctor's orders so that illness can be cured and she helps the sick person through this painful process with comforts drawn from her reserves of compassion and common sense - mopping the fevered brow here, offering a word of reassurance there"* (Salvage 1992 p1).

Over 100 years ago a man's definition of a nurse, according to Nightingale, was not dissimilar to this when she found that:

> *"Yet no man, not even a doctor, ever gives any other definition of what a nurse should be than this - "devoted and obedient". This definition would do just as well for a porter. It might even do for a horse"* (Nightingale 1860 p200).

A very witty, but very significant statement, yet despite these perhaps very outdated views of the nurse's role, the disadvantage for nursing in defining a general role is that the exact meaning or description of nursing which includes all its activities is difficult. However, Donaldson and Crawley forcefully stated that:

> *"...the very survival of the profession may be a risk unless the discipline is defined* (1978 p14).

Yet those that have been suggested are so diverse, as discussed in McKenna's (1993) review, that this in turn reflects the quandary of its nature (Styles 1982). For instance, Sarvimaki (1988) believes that the moral art, involving practical activity and communicative interaction is the central essence of nursing. Where as, the scientific framework of positivism that underpins nursing practice is debated for by Smith (1981). Another perspective is that nursing is principally interested in helping others to maximise their function within varying states of health (Hall 1980), while some authors stress the unique "caring" aspects of nursing (Raya 1990, Van Maanen 1990). Others summarise nursing as a helping discipline that focuses on interpersonal interactions and a holistic approach (Chinn and Jacob 1987). Various scholars continue to debate also that nursing is both a science and an art, with science meaning an intellectual activity relating to knowledge and art as being skilful practice (Peplau 1988).

It is not surprising to have such an ongoing diverse and various debate, as all professions should discuss what the essential characteristics are that distinguish themselves apart from others. The importance of identifying the independent nature of nursing and its contribution to health care is emphasised by Chin and Jacobs (1987) as being vital to acquiring autonomy.

Nevertheless, a partial cause of this ongoing debate may be related to how few of the major nursing theories, such as needs theory, interaction theory and systems theory, have specifically focused on the role of the nurse. Theories in this context can be described as proposals which give a reasonable explanation to an event (Pearson and Vaughan, 1994), or as Chin and Jacobs (1991) define as being a systematic abstraction

of reality that serves some purpose and which describes, controls and predicts the events that are of concern to the particular discipline. However, role functions can be inferred from the theorists' perspectives on nursing.

In needs theories for instance, the role of the nurse is about alleviating or meeting patient and/or nursing-related needs, which infer according to Meleis (1997) the roles of problem solver, performer of nursing problem related activities, knowledge giver and temporary self-care agent.

Interaction theories in contrast, are chiefly concerned with the process of nursing in the context of a nurse-patient relationship. Inferred roles by Meleis (1997) are that of goal attainer, nurturer, helper or meaning finder. A model of nursing which is quite explicit regarding the nursing role under the umbrella of interaction theory is by Peplau, who suggests that the nurse moves between the six different roles of teacher, surrogate, resource person, counsellor, leader, and technical expert (Cameron-Traub, 1994).

A competitive view are systems theories where the emphasis is on the interaction of the parts that form the whole. Each part can and should be studied separately, but functionally what is most important is the interaction of the parts and the eventual output or end result (Pearson and Vaughan 1994), which suggests that the function of the nurse is to produce suitable outcomes for the patient consistent with the given theory. The biomedical model can be encompassed under this theory, along with nursing theorists such as Johnson's behavioural system model for nursing (1980), Levine's conservation principles of nursing (1967), Rogers' science of unitary human beings (1970) and Roy's adaptation model of nursing (1987). Roles suggested by Meleis (1997) in this view may

include that of external manipulator, controller, conservator, healer (without touch) or pace setter. However, contemporary theoretical views of nursing is the new model of people centre care and the four domains of informed and empowered individuals, families and communities; competent and responsive health practitioners; efficient and benevolent health care organisations; and supportive and humanitarian health care systems. This theory calls for a paradigm shift in health care systems away from the biomedical model of systems theory (Holzenier 2008).

Despite these many contrasting and competitive views on nursing, one of the areas of agreement among the various schools of thought is that nursing theories offer a beginning articulation of what nursing is and what roles nurses play. However, nursing is a complex activity that varies considerably according to the place in which it is practised. Defining what nursing is has always been found to be difficult, since its whole essence is its adaptability to both varying needs and varying settings.

A definition of nursing adopted by the International Council of Nurses in 1960 and presently, the most widely accepted statement of the term role in nursing is by Henderson who proclaimed that:

> *"The unique function of the nurse is to assist the individual; sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he would perform unaided if he had the recovery strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible. This aspect of her work, she initiates and controls; of this she is the master"* (Henderson, 1966, 15).

However, this is only the first part of Henderson's definition and only one part of nursing, and it is unfortunate that it is often used as if it were the full definition. Henderson continues:

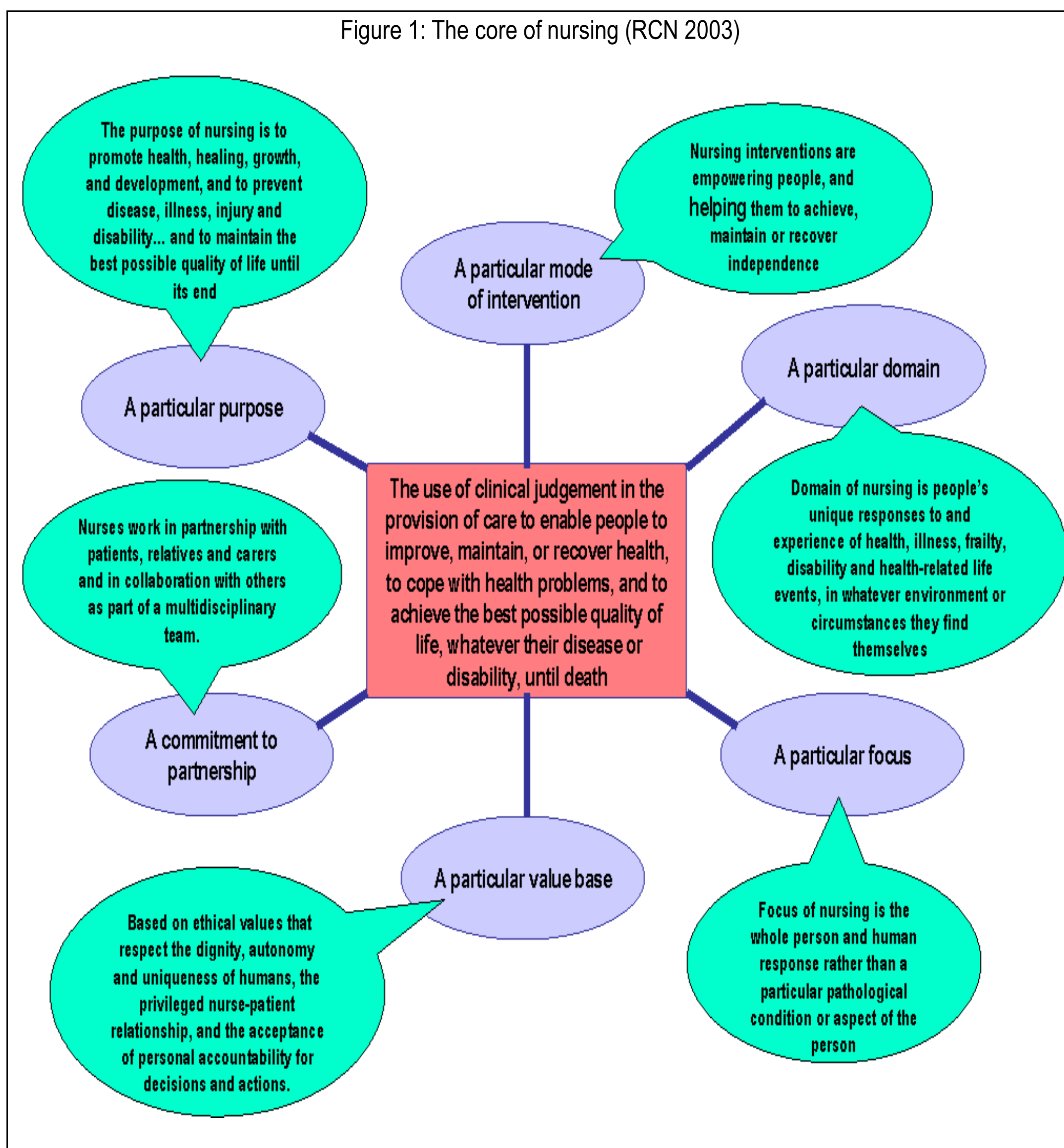
> "*In addition, she helps the patient to carry out the therapeutic plan as initatied by the physician",* [and] *"She also, as a member of a team, helps others as they in turn help her, to plan and carry out the total program whether it be for the improvement of health, or recovery from illness, or support in death".*

Henderson's (1966) definition of nursing of over forty years ago contains many elements that constitute the substantive nature of nursing today and is recognised all over the world as capturing the essence of what nurses do. Health promotion for example is a key component of her definition. Also, not only are the caring aspects of nursing acknowledged, but it additionally admits that all people will not recover from disease or injury. Finally, it defines the nurse's role as assisting those people to achieve established goals. Independence is truly a Western belief which Henderson stresses by helping the patient to gain independence, but this may not be of benefit to all cultures in our society today. Thus it is essential that nurses ascertain the personal values of each patient. These beliefs are reflected in the statement by the Royal College of Nursing (1992) who state that nursing helps people, as individuals, families and communities to achieve and maintain good health by supporting, assisting and caring for people during illness or when their health is threatened. It enhances people's ability to cope with the effects of illness and disability and ensures, as far as possible, that death is dignified and free from pain. A short time ago though the RCN in 2003, after a four month consultation exercise that

attracted 160,000 responses, the highest number of responses in the history of the RCN, redefined the core of nursing as:

> *"The use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death".*

Figure 1: The core of nursing (RCN 2003)



This core definition applies to all nurses, despite some parts of the definition being shared with other healthcare professions, as it is the uniqueness of nursing that lies in their combination. The RCN though have taken this core definition further by describing in detail six defining characteristics that relate to: purpose, mode of intervention, domain, focus, value base and partnership working (Figure 1).

It can be seen then that nursing has spent many centuries with an outward lack of a common agreement on the definition of the role of the nurse. This in turn, has up until now limited the discussion on role to general issues rather than focusing on specifics and particular roles, despite nursing forming the largest single group of health care workers in the country.

However, nurses have established and identified particular and specific roles in areas throughout their practice, in the clinical area, education, management and research, which would be too numerous to name and discuss. It is difficult then to devise a definition of the role of the nurse which is not so broad as to be almost meaningless, as nurses work in such a wide variety of fields from the largely preventative, advisory work of public health nursing at one end of the scale to the highly technical, curatively orientated field of intensive care nursing at the other end. Consequently the advantage of the RCN (2003) definition is that it has the potential to unite nurses across specialities, but also to explain their differences and is a useful tool to use to explain nursing value.

With the continuing debate about the role of the nurse in current healthcare and the suggestion that it is difficult to encapsulate, it has been put forward that nurses should stop trying to define what nursing is and concentrate instead on what it is meant to

achieve (Pearcy 2008). The Royal College of Nursing took this further in 2009 and suggested ways in which nursing could achieve such outcomes. This was described as providing individualised patient care that is safe and effective within a context and culture that enables person centred care to be sustained by all members of the health care team. The Royal College of Nursing (2010) has continued to consult and respond to emerging healthcare reforms. The implications of this are that the contribution and role of nursing will continue to be scrutinised.

This research study though will lack a starting point without a definition of the role of the nurse of some kind. A sensible appraisal of what the nurse does is needed as a spring board to debate and investigate what nursing work should aim to be doing and what the priorities should be (Salvage 1985). Consequently, after reviewing the literature, it seems most appropriate and most useful for this research study to utilise the RCN's 2003 definition of the nursing role as a starting point.

2.4 EXPANDING AND ADVANCING NURSING PRACTICE

The setting within which contemporary nursing works, seems to be continuously changing with the introductions of new concepts and innovations like: the nurse practitioner, specialist practitioner, advanced practitioner, the unscheduled care clinician and the surgeon's assistant. These concepts all increase the nursing role outside what historically were traditionally and established defined limits. However, this is not to state that this is a bad thing. Since the publication of the documents, "*Junior Doctors: The New Deal*" (NHS Management Executive 1991) and "The Scope of Professional Practice" (UKCC 1992), the issues related to the "expanding role of the nurse" have been at the forefront of both

the nursing and medical literature for the last twenty years. It seems that nurses today are being requested to accomplish more and more.

The phrase "role extension" historically pertains to nurses carrying out tasks or duties not covered in their pre-registration education, most of which, traditionally, were associated with acute medical-technical interventions customarily carried out by doctors (Wright 1995). From personal experience, this has been attending to tasks such as giving intravenous drugs, suturing, electrocardiographs and defibrillation. Ensuing guidance on role extension, was published by the Department of Health and Social Services (DHSS) as early as 1977. This document determined the legal and ethical implications for health authorities and professionals, and the power to carry out these activities was granted to the employing body on the basis of a certificate of competence for the nurse. These competency certificates were frequently approved by doctors, who ironically did not require certification or official training themselves.

Albeit this further certification and training, there was more often than not, no probability if a nurse changed jobs that training in one health authority would be recognisable and acceptable within another. The known extended role training had to be repeated, disregarding the nurse's previous level and years of experience.

Anxieties were brought up in 1989 by Tingle and Salvage, concerning the distrust of the entire scheme, the variegated training and certification and the extent to which nurses were equipped for the legal, professional and personal implications. The extended role was moreover condemned for suppressing practice (Carlisle 1992) and for its accent on a task orientated approach to training (Trevelyan 1993).

Scope (UKCC 1992) was a reply to the rising reproaches of the DHSS' view on the extended role of the nurse in 1989 and:

> *"... considers that the terms "extended" or "extending" roles which have been associated with this system are no longer suitable since they limit, rather than extend, the parameters of practice. As a result, many practitioners have been prevented from fulfilling their potential for the benefit of patients. The Council also believes that a concentration of "activities" can detract from the importance of holistic nursing care"* (UKCC 1992 p7).

This document was meant to free professional nursing practice from former rules that had restricted and confined the activities that post-registration nurses could assume. At the same time and to harmonise with this shift, the UKCC revised the Code of Professional Conduct (1992). Notably and in apt in this discussion is clause four, which formerly stated:

> *"As a registered nurse, midwife or health visitor, you are personally accountable for your practice and, in the exercise of your professional accountability, shall acknowledge any limitations of competence and refuse in such cases to accept delegated functions without first having received instruction in regard to those functions and having been assessed as competent" (UKCC 1984),*

which was revised to:

"As a registered nurse, midwife or health visitor, you are personally accountable for your practice and, in the exercise of your professional accountability, must acknowledge any limitations in your knowledge and competence and decline any duties or responsibilities unless able to perform them in a safe and skilled manner" (UKCC 1992a).

Extended role activities at this time were believed to be subsumed in the common requirements of nursing responsibilities. The judgement respecting whether or not a nurse had the required competency to carry out such duties as summarised in the Scope document (UKCC 1992) was now placed with the nurse, instead of the employer (Figure 2).

Figure 2: The Scope of Professional Practice (UKCC 1992b) states that:

The registered nurse, midwife or health visitor:

1. must be satisfied that each aspect of practice is directed to meeting the needs and serving the interests of patient or client;
2. must endeavour always to achieve, maintain and develop knowledge, skill and competence to respond to those needs and interests;
3. must honestly acknowledge any limits of personal knowledge and skill and take steps to remedy any relevant deficits in order effectively and appropriately to meet the needs of patients and clients;
4. must ensure that any enlargement or adjustment of the scope of personal professional practice must be achieved without compromising or fragmenting existing aspects of professional practice or care and that requirements of the Council's Code of Professional Practice are satisfied though the whole areas of practice;
5. must recognise and honour the direct or indirect personal accountability borne for all aspects of professional practice; and
6. must, in serving the interests of patients and clients and the wider interests of society, avoid inappropriate delegation to others which compromises those interests.

Nevertheless, whilst the nurse was lawfully required to adapt to modern and advanced practices, the employer was also required to supply authentication of training and retraining. Role expansion then in relation to Scope (UKCC 1992b) was:

> *"... is not merely about extending the list of techniques that nurses, midwives and health visitors have at their disposal, but neither is it necessarily against such extension. It is about enhancing care of the needy person in social context, and accepting new responsibilities if they represent a means to that end"* (Hunt and Wainwright 1996 pXVI).

An inference maybe, that nursing practice as a result should be guided by patients' needs and not by medical delegation. However, previous to this new measure, the New Deal document, a quality initiative, was published (NHSME 1991). This document had two essential components. The initial component pertained to new working arrangements, which comprised of placing limits on contracted hours of duty for junior doctors, and the instigation of both full and partial shifts. The secondary component corresponded with structures that develop the best utilisation of junior doctors competencies by ensuring that they carry out activities relevant to their medical training, and by improving their work conditions generally (Moyse 1994).

Within the agreement settled between the government and the medical profession in 1991, junior doctors were to be contracted to work for no more than 72 hours per week by the end of 1994 or be truly working for less than 56 hours per week by the 31st December 1996 (Moyse, 1994). The goal of this document was to introduce junior doctors, into working environments that were a great deal more pertinent, relevant and appropriate to

the twentieth century. However, the British Medical Association in August 2001 stated that almost half (48%) of the United Kingdom's junior doctors were working more than 56 hours per week, or without adequate rest according to latest Department of Health figures. As from 1st August 2001, this became illegal for newly qualified junior doctors. The same limit applied to all other doctors from August 2003. This in turn has had a direct impact on the expansion and advancement of nursing practice such as the loss of patient contact and care through the movement away from the bedside and the consequent delegation of nursing work to healthcare assistants (Spilsbury and Meyer 2005, Pearcey 2008).

2.5 IMPLICATIONS AND EFFECTS ON NURSING IN EXPANDING THEIR ROLES

Historically, nurses have centred their practice on a caring nursing model, while alternatively, physicians have aimed their practice around curing and the medical model. This is not to say though that physicians do not care. Presently, according to Castledine (1995), there are three schools of nursing thought in the UK. The first accepts that nursing practice is unique and free of medicine. The second school assumes that nursing is intimately associated to and subservient to medical practice. Consequently, as medicine evolves, it assigns particular duties to nurses. The third school, is the conception that caring and curing are not incompatible notions, merely parts of the same continuum. These three schools of thought will be applied as a framework to reflect on the implications and effects of *Scope* (UKCC 1992b), *New Deal* (NHSME 1991), *Modernising Nursing Careers* (DoH 2006), the *Prime Minister's Commission on the Future of Nursing and Midwifery* (2010) and *The Nursing Roadmap for Quality: A signposting map for nursing* (2010) documents on the expanding role in nursing.

2.5.1 Nursing practice is unique and free of medicine.

Concerning knowledge, this position deems that medical knowledge, aside its application to medical practice, is not a alternative for the nursing knowledge that is fundamental to nursing practice. Those who accept that medical knowledge is an alternative for nursing knowledge, illustrate an unfamiliarity and naiveté of nursing care with an attempt to withhold society from knowledgeable nursing services.

A powerful opinion by some members of the nursing profession, is that to venture to influence professionally prepared nurses that they ought to seize medical duties and perform at an inferior level in the medical domain, portrays an unbelievable human and intellectual waste. This school retains that, the nursing profession does not exist to secure delegated or transferred tasks from any other profession, especially medicine and particularly that it should not be the right of any other health professionals, to determine what nurses must practice (Nuckolls 1990).

Along with this, is a convincing reaction that the transformation away from the task orientated approach feasibly may be reversed, as nurses acquire increasingly more tasks handed down by junior doctors. Some conclude there could be a restoration to a task orientated scenario inasmuch as nurses discontinue caring for the patient holistically, but merely in the confines of delegated tasks. Nurses as a result, could simply be engaging in duties that doctors do not want to do, but many nurses do not enjoy acquiring the more technical aspects of a doctor's traditional duties, such as venepuncture, preferring

to care for, rather than cure, patients. This school accepts that nurses who secure doctors' duties are not being independent, moreover are pursuing somebody else's policy.

This school likewise understands that the purpose of expanding the scope of professional nursing practice is to evolve and advance the scope of nursing care and not the drift into medicine. Nursing consequently needs to ascertain its individual parameters or be conscious of the implications when advancing current and new competencies. A conflicting view to this is that, nursing has become too tunnel visioned in its progress, consequently growing further impregnable to the shifts that have transpired in health care and hence, nurses have forfeited responsibility of particular domains of health care like: nutrition, aspects of theatre work and needs assessment. This rigid approach maybe damaging to patient care, as doctors encounter nurses unwilling and disinclined to acquire specific skills, leading possibly to a new class of health care technicians being created (Castledine 1993).

Ultimately, within this view, for the scope of nursing practice to advance, it must be for the virtue of the patient and nursing care. It is the nursing profession itself who should be endeavouring to reshape nursing's position in the health care sector.

2.5.2 Nursing is intimately associated to and subservient to medical practice.

A conception postulated by some doctors is that an assortment of menial activities and/or some of the doctors' more routine duties, are capable of merely being designated as nursing responsibilities. Accordingly, there has been a prejudice for nurses, to develop their role by assuming accountability for many spheres of patients' management which have been reassigned from and by medical colleagues, considered to be "repetitive tasks" or "so called drudgery" (Pearcey 2008). This is a view supported by Allen's (2002) study in which consultant doctors claimed that nurses could be given the work that doctors did not want to do.

Shirley Giles in 1993 forewarned the nursing profession concerning this particular point, when she voiced her anxiety that the New Deal, could bounce back on the nursing profession and likewise reported a worry from a number of delegates at the Royal College of Nursing Congress, that the decline in junior doctors' hours was converting nurses and midwives into mini doctors. By way of illustration, one could examine the controversial role of the vein-stripping surgeon's assistant in Oxford, who happened to be a nurse (Shepherd 1993) and compare this to developments in current theatre practice with the instigation of the First Assistant to Surgeon role, and question whether this is the way forward. Is this nursing, or is this the genesis of the physician's assistant? The debate about nurses as doctors' handmaidens, or at the other extreme as mini-doctors, is commonly an issue for discussion and is not something new (Stilwell 1988) and is continually debated today more than twenty years later.

However, the conviction prevails within this school of thinking that role expansion is eventually and ultimately connected to gains in medical technology. Nevertheless, it is emerging that there has been insufficient consideration regarding this issue. So much so that some authors conclude that there is something disquieting and alarming about the manner in which the profession is receiving the additional tasks that nurses are presently being urged to incorporate in their role, for instance: patient history taking, phlebotomy and writing discharge letters. Some authors have described this disposition of various members of the profession as “excitement and joy” (Ashworth and Morrison 1996). Ashworth and Morrison (1996) suggest that this excitement is possibly unsuitable to how the true and factual circumstances should be perceived, that is, an overdue and intelligent explanation.

The role of the nurse it seems is becoming more and more technical. Considering technical aptitude is accepted as a superior ranking in society according to Ashworth and Morrison (1996), nurses are prone to judge the expansion on this route as an advancement for the profession. There is a suspicion, as a result, that there may be a prioritising of technical skills, in contrast to the personal expertise and attributes that are true components of the nurses’ role, by nurses themselves (Ashworth and Morrison, 1996). Nurses who have gained suitable educational and accomplished competency are able to decide their repertoire of caring as well as technological skills. Since this poses a motivating set of circumstances for nurses to enrich their job fulfilment and patient care, it additionally, but contrary to this, has the capability to take advantage of

nursing and to decrease recognised expectations of care. It is subsequently, for nurses to influence the pending consequence.

2.5.3 Caring and curing are not incompatible notions, merely parts of the same continuum.

Every expansion of the nurse's role must be grounded on a solid foundation of wisdom, enlightenment and comprehension. The nurse's role therefore is required to be seen and understood and not as an assorted accumulation of adhoc tasks (Dimond 1996). Therefore, it appears foreign to this school, to establish disjointed and inconsistent confines on the scope of the nurse's permitted role, inasmuch as it is inclined to convert the nurse as an unnecessary subservient to medical practitioners, frequently in domains where it is not clear who has the greater aptness. For instance, confinements in the nursing role may mean that while caring for the needs of the patient the nurse has to discontinue, embarrassingly, but nevertheless as a matter of course and direct the care/intervention to a higher authority, the junior doctor!

This school retains, that every clinical profession will uncover that it is increasingly unavoidable to operate as multidisciplinary units. The progression in the direction of multidisciplinary education will result in a colossal overlap of knowledge among them. In addition, it was envisaged by Christman (1995) that as professions begin to merge there would be a reduction in the total numbers of professions and that the principal control would be related to the position of scientific and clinical knowledge. Since this time there has been a paradigm shift in nursing theory from positivism to postmodernism and now towards

neomodernism (Whall and Hicks 2009). These paradigm shifts are affecting the nature of nursing education, practice and research.

According to Ashworth and Morrison (1996), the roles of the different professionals inside the health care team lack a logical boundary, harmonised to the effective care of the patient, instead roles are founded on the demands of hierarchical ranking and authority. They suggest, that what needs to be attained, is a health care team composed of a collection of health care professionals, individually being certain and in respect of their personal role and the roles of their colleagues. Equally, there is a necessity to reflect on the way in which roles overlay and the acceptance that this is not fundamentally a wrong development.

> *"An illustration of this in mechanistic terms is the pattern of slating that can be seen on a roof. The slates are not laid side by side, but overlap to a considerable degree in order to ensure that the building is waterproof. So it needs to be with the roles of health care professionals. The overlap in skills and roles ensures continuity of service delivery"* (Keighley 1993 p285).

A synopsis then, is that this view, reinforces, encourages and advocates a multidisciplinary approach to patient care. Aside these three schools of thinking, the implications and effects on nursing can be illustrated by the expansion, growth and transformations in the nurses' roles throughout the preceding years. A descriptive survey, by Land et al (1996), who were assigned to explore the extent of such initiatives, allied with the Scope document (UKCC 1992), in fifty

eight trusts in the West Midlands, reported that the evidence and indications suggest that practice has grown in two evidently divergent ways: technical skills based development and expanded practice through a holistic care model. It could be generalised from these findings that the third school of thought had not at this time set forth fully, but remained in the early stages of development. However, in 2010 McBride identified that nurses and physicians still do not understand what strengths each brings to the health care arena despite interdisciplinary education. Perhaps the growing evidence on interdisciplinary research underscores the need for increased clarity regarding what nursing as a discipline brings to the table (Banks-Wallace et al 2008).

While doctors and nurses are certainly not the only figures in the healthcare team, there is no doubt that the status of medicine and the sheer size of nursing continue to ensure that any successful model of service delivery relies upon the effective collaboration of these two professional groups.

2.6 EXPANDING NURSING ROLES AND THE WAY FORWARD.

The Scope (UKCC 1992, updated NMC 2002, amended 2008) document bestows nurses more independence, autonomy and liberty to expand their roles than ever before, while heightening their understanding of personal accountability. The continuing and persisting discussions within the literature, regarding the expanding nursing role, is feasibly owing to the undervaluing of nursing accomplishments. Research offers, that this is due to a deficiency in information and understanding among doctors respecting the scope and nature of nursing (Dowling et al 1995) and also the known problems and difficulties in describing the caring aspects of nursing work in a manner that will not be discharged as

insignificant and unimportant (Davies 1995). Therefore, principles and standards are required to make explicit the behaviours expected of each member of the healthcare team, thereby reducing any misunderstandings based on unchallenged or unspoken assumptions (Manley 2010).

A response to this predicament, implied by Read (1995), is perhaps for nurses and pre-registration house officers to be educated simultaneously concerning the ventures of a collection of tasks, for instance: venepuncture, cannulation, giving intravenous drugs, electrocardiogram recording, catheterisation and about requirements for requesting such as radiological or pathological investigations. A response that can clearly be seen within the third school of thought of caring and curing as compatible notions. A current example of this is the multi-professional education of student nurses and medical students initiative at the University of Southampton (and various other universities) who are learning together both academically and in practice (DoH & CAIPE 2002). Nevertheless, it must be recognised that nursing is not merely about advancing technical skills, but also the therapeutic component of nursing, such as "presencing" skills as described by Benner (1984) and Tolley (1994).

At the same time, but very much in contrast, it has been asserted, within the nursing literature, that the *Scope of Professional Practice* document (UKCC 1992, updated NMC 2002) and *The Code* (NMC 2008) supplies barely more than broad principles or guidelines to ground changes and expansions within the nurse's role (Castledine 1995). Authors such as Pearcey (2008) believe that, its broadness sanctions for an extensive interpretation of what is acceptable and permitted in the evolution and expansion of nursing work, although with the primary accent and importance being on the good of the

patient. Consequently, for the nursing profession to move forward within this regard, more research is necessary associated with the expanding roles of the nurse both before and after innovations are introduced. Nurses need to be explicit about what their clinical roles are particularly as their roles remain hard to define (Pearcey 2008)

Succeeding the instigation of the Scope and New Deal documents, the nursing and medical literature has been broaching questions such as: how is the nurse's role developing, as an expansion of nursing practice or is the doctor's assistant being created? Or perhaps more importantly, when nurses take on new roles how can the profession ensure it remains a nursing role as opposed to a doctor's assistant? These questions have created a lack in clarity as to where the role of the doctor ends and the nursing role begins. The New Deal document (NHSME 1992) it seems has had severe implications by confusing and clouding the issues surrounding the expansion of nurses' roles. A statement made more than forty years ago said that nurses who function as physician's assistants have neither expanded or extended their role, they have instead changed it (Mereness 1970).

To maintain the ventures accomplished in role expansion, nursing needs to continue to discuss, investigate and resolve, what the profession desires nursing to be and how the profession wishes to practice nursing in the future. By way of illustration, this type of work has previously been published following the "Heathrow Debate" (DoH 1993). This was a consultation of professional nursing leaders who examined the challenges facing the nursing profession in the twenty first century. Further work in this area has been through the *Prime Minister's Commission on the Future of Nursing and Midwifery* (2010) which sets out a way forward for the future of the professions in regards to: health quality,

compassionate care; health and wellbeing; caring for people with long term conditions; promoting innovation; nurses and midwives leading services; and careers in nursing and midwifery.

Cynics would declare that the *Scope* document (UKCC 1992, updated NMC 2002 and NMC 2008) was inaugurated to remove the pressure from exhausted and overworked junior doctors and to ease a lessening of junior doctors' responsibilities succeeding the New Deal (NHSME 1991). If this was so, it does not appear to have accomplished its purpose in the early years, inasmuch as it was released in the British Medical Journal, that at least 8000 junior hospital doctors in Britain (nearly a quarter of the total) were still working longer hours than they should be (Beecham 1997). In 2006, despite agreements that were reached in May 2000 between the European Parliament and the Council of Ministers concerning junior doctors and the European Working Time Directive, almost half of the 39,000 junior doctors working in the NHS were still working outside the New Deal hours limits (BMA 2006). In 2010 97% of doctors are working within the directive (BBC 2010), but an independent review has found that advanced nursing roles are diluting opportunities for junior doctors training (Santry 2010).

It can be contended, on the authority of Russell (1991), that a great deal of the change that has transpired in nursing has been "change by drift", that is, changes that have simply come to pass, as opposed to changes that have been the outcome of action planning.

The *Scope* document (UKCC 1992 updated NMC 2002, NMC 2008) is of interest and concern to the nursing profession, in view of the fact that it questions the extent and range

of practice and in this manner the capacity to deliver effective care. It equips nurses with the professional right set of circumstances to judge and evaluate the needs of patients in their care and when required, to set in motion the essential discussions, education and interprofessional agreements for nurses to expand their role.

The issue of modern and advanced nursing roles has established the focus for innovations. While nurses become set up to perform their roles in a beneficial, confident and innovative manner, the growth, strengthening and expansion of their competence and authority takes place. This produces practitioners who are inclined to question the beliefs and obstructions relating to patient focused care, whose expectation is to transform, evolve and expand practice as a process of effectuating excellence and meeting client needs. Additionally and along with these beliefs is that, there is little justification for expanding nurses' roles unless there are real gains in the quality of patient care or advance of the practice and understanding of nursing (MacAlister and Chiam 1995). A view still held today (DoH 2010).

To summarise, the expansion of nursing practice, needs to be directed by patients' needs and not to medical delegation. Additionally, role expansion should be experience led as well as academically and evidence based led, if it is to be responsive to patients' changing patterns of needs and values (Hunt and Wainwright 1996). The Scope document opened the door for further expansion and development in nursing and midwifery, but the profession continues to seek specific illustrations and examples of how they can expand their practice. Land and others' (1996) research study indicated the problem is not so much the way nurses are tackling the issue, but rather that activities associated with the scope of professional practice are not easily defined. Again,

resources are a problem, and lack of funding is holding back creative contributions from nurses. Despite the considerable concern, however, the professions have seen enormous opportunities in the expansion of the nursing role.

2.7 CURRENT EXPANDING AND ADVANCING DEVELOPMENTS IN NURSING.

The UKCC announced a review of the *Scope of Professional Practice* (UKCC 1992) document, which was updated and published by the NMC in 2002. Also being reviewed were the *Guidelines for Professional Practice* (UKCC 1996) which again were updated and published by the NMC in 2002. *The Code of Professional Conduct for Nursing Midwifery and Health Visiting* (UKCC 1992b) was reviewed and published by the Nursing and Midwifery Council in 2002 following the close of the UKCC. In 2008 the NMC amended and merged these three documents into *The Code: Standards of conduct, performance and ethics for nurses and midwives*. Review is an essential process in fast-changing times; it is important that these documents are seen to be relevant and appropriate.

During and following these developments, the number of tasks undertaken by nurses today has increased. This is related to a number of factors, ranging from resource issues, such as the need to reduce junior doctors' hours as previously discussed to the fact that nurses are being entrusted with wider responsibility in recognition of their roles as independent nurse practitioners. The government's published strategy for nursing, midwifery and health visiting, contained in the document *Making a Difference* (DoH 1999a), is notable for its proactive stance on nurses taking on more advanced and independent activities. The previous labour government wanted nurses to expand and advance their role to make better use of their knowledge and skills. This was reiterated in

the document *Liberating the Public Health Talents of Community Practitioners and Health Visitors* (DoH 2003). An example of this was making it easier for the profession to prescribe medicines and being able to register with the NMC as extended, independent and supplementary prescribers. Other examples include nurses now undertaking activities such as advanced assessment techniques, advanced interventions and verification of non-suspicious deaths. There are nurse-led minor illness and minor injury units where nurses carry out a variety of unscheduled activities. There are even nurses providing holistic surgical lists such as carpel-tunnel surgery attending the patient from admission to discharge and follow up.

Many see role expansion and advancement as presenting an exciting opportunity to develop new specialisms. However, expanding and advancing the nursing role has been controversial, and there has been disagreement within the nursing profession as to what approach should be taken. This has been exacerbated by not only the perpetually increasing expansion of clinical nursing roles, but also the delegation of nursing work to health care assistants (Spilsbury and Meyer 2005; McKenna et al 2006; Pearcey 2008).

Historically there has been no national standard or catalogue of expanded roles, and practices differ from region to region and even within hospitals (Standing Medical Advisory Committee and Standing Nursing and Midwifery Advisory Committee 1989). The debate is still an intense one nearly twenty years later. Nevertheless, active attempts are being made to address this issue as exampled by the new initiative of National Benchmarking, a result of the Essence of Care document (Department of Health 2001a, updated 2003). Recent developments such as NHS direct, walk in centres and the emergence of digital health and on-line services mean that patients are accessing primary

care services in an increasing variety of ways. The Educating and Training the Future Workforce Health Professional Workforce for England (2001c) documentation predicted that this is a trend that is likely to continue over the next two decades with particular reference to nurse-led services.

With the Department of Health publications *Modernising Nursing Careers* (2006b) and *Front Line Care* (2010), proposals have come from the NMC (2007) to regulate advanced nurse practitioners so as to enhance public protection. In response to this the Royal College of Nursing (2010) has reviewed and updated its guidance on the role, domains and competencies of advanced nurse practitioners in the UK that can be applied in all health care settings and within all specialities. In summary they put forward that:

> *"the advanced nurse practitioner offers a complementary source of care to that offered by the medical practitioners and other health care professionals. Advanced nurse practitioners augment the care that a team can deliver, and can also act as primary care providers in their own right"* (p4).

However, with the on-going NMC review on the advanced nurse practitioner there remains a lack of explicit description in turn limiting the development of the role (RCN 2010). In light of this the RCN (2010) have recommended to the NMC that they 1) set standards for advanced nurse practitioner practice 2) make provision for the regulation of advanced nurse practitioner practice and 3) provide standards to advanced nurse practitioner education.

Today, with a society that is more complex and diverse than ever before, there is clear evidence that the nursing profession have continued to adapt in meeting the needs of their patients, clients and the general public as the focus of the National Health Service changes to one of being patient-led (DoH 2005). Examples include further developments in a variety of: acute settings of the clinical nurse specialist, nurse consultants and modern matrons; in primary care of the community matron, nurses in primary care becoming partners in general practice, nurse-led primary care practices; and across the National Health Service the development of the entrepreneurial nurse (DoH 2006c).

However, there is another quiet and covert example of where nursing is expanding and advancing "outside" the traditional boundaries of health care as was suggested by Dr Mike Green, Emeritus Professor in Forensic Pathology at the University of Sheffield in 1993 (personal communication). He believes that nursing staff, in general are becoming increasingly more involved in legal processes in particular with relevance to their observations, records and recall of events. Internationally, nurses have expanded and advanced their role more extensively and for many years within aspects of the legal profession with the ultimate example of the ability of nurses to be coroners, sexual assault examiners and forensic nurse examiners in the USA (Cumming 1995; O'Connor 1995; Sullivan 1995; Davis 1994; Staunton 1994; Teylor 1994; Sounder and Trojanowski 1992; Descheneaus 1991; Schramm 1991). In addition there have been advances around the globe with nurses becoming death investigators very recently in South Africa, India and the Philippines to tighten up the historical relaxed investigation process; sexual assault examiners in Japan, Finland[1] and England (Rutty 2001c); and custody care nurses in

[1] Personal Communication – Virginia Lynch (Founder of the IAFN) (2000) International Association of Forensic Nursing 8th annual scientific assembly, Canada

England (Rutty 2001d) and the outback of Australia[2] both of which were instigated in order to reduce deaths in custody, but with Australia having a particular focus on the Aboriginal population. While it seems there have been many advances around the world regarding the nurses role within the medico-legal context, this study asks, why has there been this major boundary shift and role advancement in providing nursing services within the "death investigation system" in particularly in the USA and not in England? It is important therefore to present firstly an historical development of the Coronial service to position this debate in context.

2.8 THE HISTORICAL DEVELOPMENT OF THE CORONER IN ENGLAND AND WALES

Few people give much thought to what needs to be done when a person dies until they are directly involved. Relatives of the deceased require a permanent legal record of their death which allows them to proceed with the funeral and put the deceased affairs in order. For health professionals there are implications for both the management of individual cases and for future clinical practice. Information on the causes of death is invaluable for assessing the health of the nation and planning of health services. Essential to all these processes is the medical certificate of the cause of death, more commonly known as the Death Certificate. If the treating physician is unable to complete the Death Certificate, then the death is investigated by Her Majesty's Coroner in order to find the relevant information.

Historically, the Coroner is one of the oldest judicial positions of the English legal system. Indeed, as long ago as Saxon times (5th century) there is evidence of the existence of a

[2] Consultancy work in implementing custody nursing in the Outback of Australia – Jane Rutty (2001) Department of Health, New South Wales Australia

Coroner at least in name (Gee and Mason 1990). It was not until soon after the Norman Conquest in 1066 that the power of the Coroner was reinforced, as officials whose purpose it was to enquire in to sudden unexpected deaths, with the primary duty of determining whether the deceased was English or Norman.

The establishment of the office though is commonly assigned to over 100 years later during King Richard's reign (1189-1199) in the publication of the Articles of Eyre in 1194, an Eyre denoting a periodical circuit of justices. King Richard placed in office during this time some of his Knights as "Custos plactitorum Coronae" which translates as "Keeper of the pleas of the Crown". This title across the centuries has transformed into "Crowner" and now to "Coroner" (Dorries 1999).

Taking charge of the records and financial concerns of the Crown, especially in accordance to the deaths of the Monarch's subjects, were the responsibilities of the original Coroners. It was the neighbours' responsibility though to inform the Coroner if an unnatural death had occurred. If treachery was found the local villagers would be fined on account that they had forsaken in their requirement to preserve the King's peace and the offenders additionally would have their possessions seized before being brought to the gallows and hanged. The Coroner would nonetheless still procure a justification to extract a penalty from those involved, even if the death was accidental (Dorries 1999).

For the Monarchy, death was a remunerative and gainful enterprise. However, the Coroners were before long a reason for unrest amidst the peasantry. Following the death of King Richard, his brother John was crowned King. It was during King John's reign (1199-1216) and in the Magna Carta of 1215, that the people insisted on being allowed

from that day on to elect the Coroner, assuring equitableness. This practice was maintained until the Victorian era of 1888, when the election of Coroners by the people was abolished by Parliament. Instead, their appointments were made by the local authority, who were themselves the elected representatives of the people (Dorries 1999; Knapman and Powers 1985).

In London in the late 16th century when the plague was threatened again, wise women called "Searchers" had the task of deciding and recording the cause of death. Their records formed the basis of the "Bills of Mortality" which were published weekly. These reports were much in demand by wealthy Londoners warning them of the approach of the Plague.

In England and Wales, the Births and Registration Act of 1836 was introduced making death registration compulsory to prove death legally and improved mortality data, but it was not the requirement that doctors gave the cause of death. As a consequence bizarre and inconsistent causes were often reported. For example, it was recorded in April 1849 that an 18 year old youth in Wales had died of the "King's evil", and other causes of death given in that period were "Decay of nature", "Decline", "Water in the head" and "Weakness". In 1874 following concern that anomalies such as, the possibility of poison, violence or criminal neglect were escaping the notice of officials, the Death Registration Act was passed. This required that a treating physician sign a certificate indicating the cause of death. It was during this period that William Farr, credited by many as the father of modern epidemiology produced weekly returns of death in London City which were used by Dr John Snow in linking the source of a major cholera epidemic to foul water.

This finding and their subsequent conclusions pre-empted the germ theory of disease by twenty years.

In recent years information derived from death certificates and collated by the Office of Population and Census Surveys for as it is now called the Office for National Statistics has been used to investigate a number of health problems. For example in December 1952, in London, daily mortality rates were seen to increase sharply with the onset of smog and remained high afterwards. The public and government concern eventually led to the passing of the Clean Air Act in 1956.

The Coroner has survived a long and eventful history including the near extinction of the position in the 17th and 18th centuries. The office of Coroner has regained a position of importance in the English legal system in the last 100 years as the principal route for the investigation of sudden death (Gee and Mason 1990).

2.9 THE PURPOSE OF HM CORONER TODAY IN ENGLAND AND WALES

Today, the Coroner in England and Wales is a registered medical practitioner or a lawyer, who has held a general qualification within section 71 of the Courts and Legal Services Act 1990 for a minimum of five years (The Coroners Act 1988; The Courts and Legal Services Act 1990). The appointment is still made by the local authority to a geographical district known now as a jurisdiction. However, the Coroner is an independent Judicial Officer, responsible only to the Crown and cannot be dismissed by anyone other than the Lord Chancellor.

Currently, whenever a person dies, the law requires the death to be registered. In order for this to be effected there are two strict and rigid essential conditions that must be satisfied: a valid certificate supplying the cause of death must be completed and signed by a registered medical practitioner who attended the deceased during his last illness; and the cause of death must be shown to be entirely natural and prove satisfactory to the Registrar of Deaths in accordance with the *Registration of Births and Deaths Regulations* (1987). From 2012 following the implementation of the new coronial section of the *Coroner and Justice Act* (2009) a Medical Examiner (new position) will also be required to be involved in the death certification process. It is in all other cases that the death must be referred to the Coroner.

FIGURE 3: DEATHS, WHICH MUST BE REPORTED TO HM CORONER

A. Where there is reasonable cause to suspect a person has died a violent or unnatural death;
B. Where there is reasonable cause to suspect a person has died a sudden death of which the cause is unknown;
C. The person has died in prison or in such place or under such circumstances as to require an inquest.

Those causes of death which should be reported to the Coroner include: abortions; accidents and injuries; acute alcoholism; anaesthetics and operations; crime or suspected crime; drugs; ill-treatment; industrial diseases; infant deaths if in any way obscure; pensioners where death might be connected with a pensionable disability; persons in legal custody; poisoning; septicaemias if originating from an injury; and stillbirths where there may have been a possibility or suspicion that the child may have been born alive.

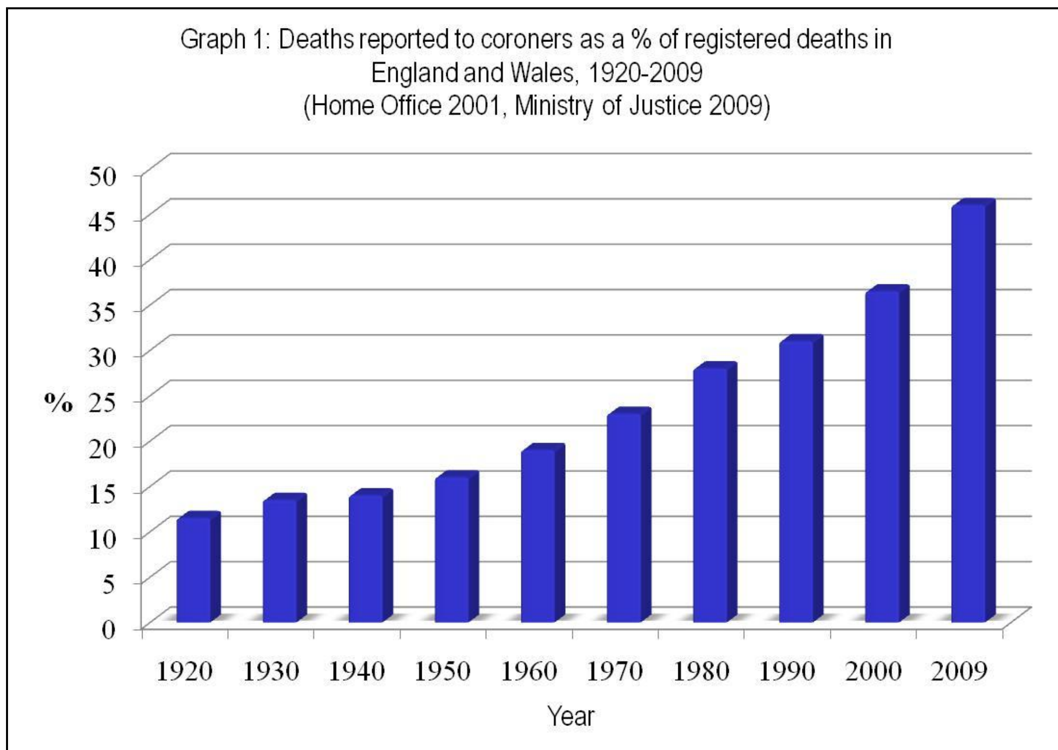
(Dimond, 1995; Coroners Act, 1988, The Coroners and Justice Act 2009)

The purpose of the Coroner is still to investigate into the causes of sudden or unexpected deaths (those of which have to be reported to the Coroner are summarised in Figure 3). If the death is violent, accidental or there are suspicious circumstances, the police will also have to be informed (The Coroners Act 1988, The Coroners and Justice Act 2009).

The other purpose of the Coroner is to enquire into the finding of Treasure Trove, that is, gold or silver coins or articles found hidden in the earth or other private place and for which an owner cannot be found (The Coroners Act 1988, The Corners and Justice Act 2009). However, discussion of this aspect of the Coroners' duties is outside the remit of this study.

In England and Wales, 234,800 deaths were reported to coroners in 2009, giving the proportion of all registered deaths reported to coroners being 46% (Ministry of Justice 2008), a rise of 32,800 and 9% respectively from the figures quoted for 2000 (Home Office 2001). In many cases preliminary explorations with the deceased's General Practitioner or Police Surgeon will indicate that the death was caused by natural causes and therefore no more additional investigations are needed. Nevertheless, the figures show that the long-term trend in the number of deaths reported to coroners continues upwards (see Graph 1). The Home Office believe that this long-term upward trend is probably due in part to the growing use since the 1980s of deputising services by general practitioners. In these cases the doctor attending at or after death cannot legally give a medical certificate showing the cause of death. With regard to the deaths informed to the Coroner, a total of 108,360 cases needed further investigation by way of an autopsy examination in 2009, but this has fallen by 46% compared to the year 2000 (Ministry of Justice 2010, Home Office 2001). This is due to the initial pilot studies of the new medical

examiner resulting in fewer deaths needing to be reported to the Coroner (Furness 2009) following the changes to death certification (The Coroners and Justice Act 2009) and the overall national decrease in violence resulting in death (Ministry of Justice 2009). This proportion has been declining since the 1970s when it was about 88%. In other words 21.5% of all deaths have a coronial autopsy.



2.9.1 The autopsy

The autopsy, from the Greek word "autopsia" meaning "seeing with one's own eyes", is a medical examination of a body after death, with the basic purpose of determining, among other things, the ultimate cause of death (Petrakis 1995). The relatives have no right to refuse an autopsy when requested by the Coroner, but they do have a right to have a doctor of their own choice present, at their own expense (The Coroners Rules 1984).

The autopsy is carried out following the Coroner's consent and direction, by a fully registered medical practitioner (The Coroners Act 1988, The Coroners and Justice Act 2009). When the circumstances surrounding the death are considered to be suspicious a Home Office approved forensic pathologist is usually directed by the Coroner following the request of the police to perform the autopsy. The autopsy examination will uncover a natural cause of death in the majority of cases, however a Coroner's Inquest will be required by law for about 12% of cases which remain to be investigated as an unnatural cause of death (Dorries 1999). Additionally, an Inquest can be conducted at the discretion of the Coroner if he considers it desirable to allay suspicion or public disquiet (Burton, Chambers and Gill 1985).

2.9.2 The coroner's inquest

The Coroner's Inquest in England and Wales is an enquiry not a trial, in other words inquisitorial as opposed to accusatorial, that is confined to discovering who the deceased person was, and how, when and where that person came to their death, together with information needed by the Registrar of Deaths, to enable the death to be registered (HMSO 1996, The Coroners and Justice Act 2009). Therefore, there are no parties, indictments, prosecutions, defences, trials, legal aid or award of costs, and no enforceable judgements or orders can be made.

Witnesses to the death are likely to be asked to provide a statement and may well be called to give evidence at the Inquest which is usually held in public, with witnesses being examined under oath by the Coroner and other interested parties in the Coroner's Court. However, witnesses are not obliged to answer questions

if this may incriminate themselves (The Coroners Rules 1984), as the motive of the Inquest is not to ascertain any criminal liability against any named person, or any question of civil liability, as a trial would. On the contrary, the intent of the Inquest is to purely establish the facts. Nevertheless, it ought to be realised that the facts exposed in the evidence could provide possible foundations for an action of civil damages.

The inquest may proceed without a jury unless the circumstances of the death indicate that there may be a continuing risk to the health and safety of the public (The Coroners Act 1988, The Coroners and Justice Act 2009). In other cases, Coroners have a discretion to hold jury inquests if they choose. As in previous years, the overwhelming majority of inquests in 2000 were held without juries with juries only being involved in 3% of inquests (less than 2% in 2007). The number of inquests held with juries in 2000 was around 820, similar to 1999 compared to 540 in 2007. Additionally around 980 inquests in the year 2000 and 930 in 2007 were adjourned by the coroner and not resumed, somewhat comparable with the level generally prevailing in recent years (Home Office 2001, Ministry of Justice 2008).

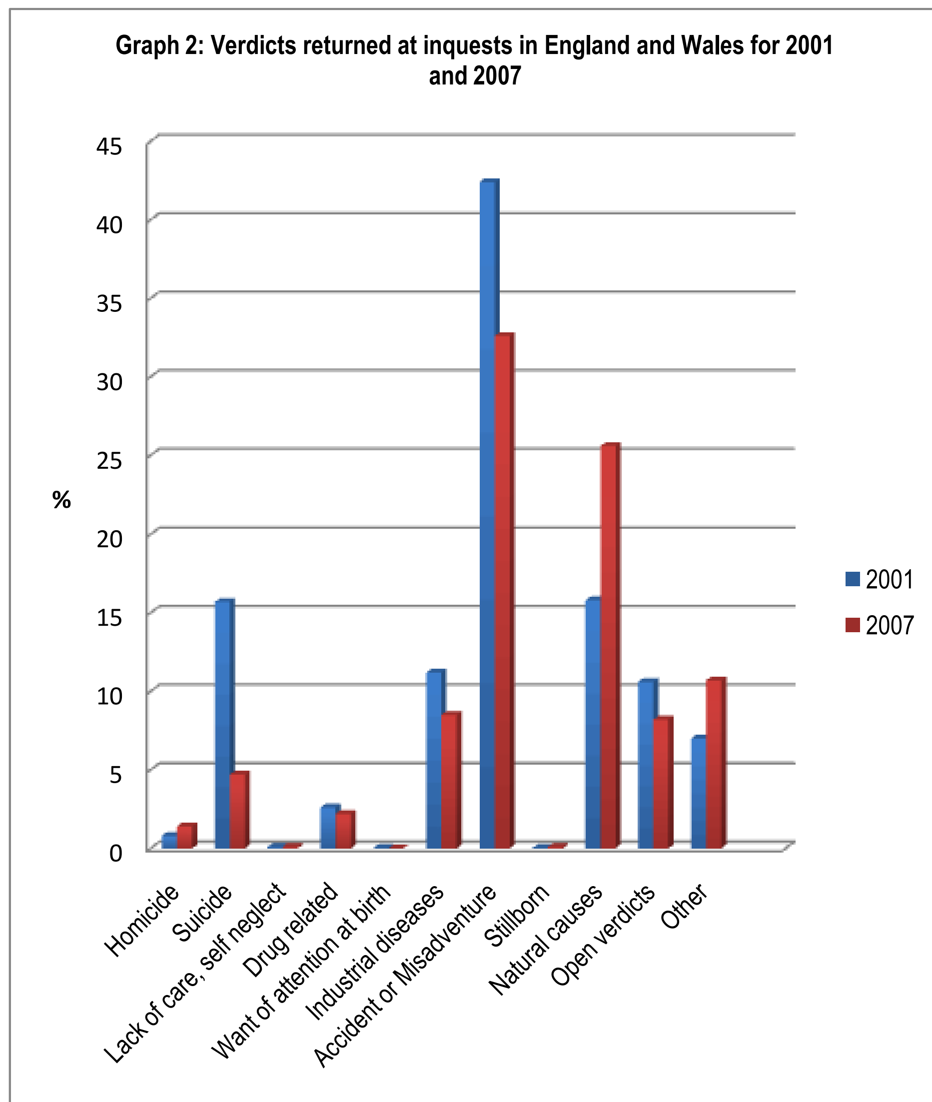
Inquests were held on 24,900 (12%) deaths reported to coroners in 2000, the highest since 1970 and 30,800 (13.2%) in 2007. This proportion was declining until the early 1990s, but the trend has reversed and the proportion of such deaths has been creeping slowly upwards in recent years (Home Office 2001, Ministry of Justice 2008).

As well as defining the actual cause of death, there are a suggested range of verdicts that can be delivered at the end of a Coroner's enquiry (The Coroners Rules, section 4, form 22, 1984). Decisions range from unlawful killing, clearly indicating wrongdoing to natural causes, want of attention at birth, industrial disease and drug dependency or abuse. However, some verdicts can also have an additional finding that the cause of death was aggravated by lack of care. When this is so, it can reflect on those accountable and/or responsible for the deceased's care. Possible other verdicts include suicide and accident or misadventure (Montgomery 1997). Finally, an open verdict would translate that the means have not been found as to how the cause of death arose (Dorries 1999). Verdicts are returned in nearly all coroners' inquests (Home Office 2001). The exceptions are those inquest adjourned by the coroner which he or she later decides not to resume, and are mainly inquests into deaths by unlawful killing and deaths by dangerous driving or careless driving when under the influence of alcohol or drugs in which court proceedings have been instituted. This avoids the need for two tribunals to consider the same evidence (Home Office 2001).

Verdicts were returned at over 27,360 inquests in 2007, that is 4,200 more than in 2000, which reflects the upturn in inquests held. The largest rise was in verdicts of natural causes, up from 3,642 in 2000 to 7,011 in 2007, a percentage increase of 9.8%. The largest decrease was seen in the category of suicide, from 3,626 in 2000 to 3,007 in 2007, a percentage difference of 11%.

As in previous years the most common verdicts in 2007 were death by accident or misadventure (32.6%) and natural causes (25.6). The proportion of verdicts of

death from industrial diseases has decreased to 8.5% in 2007 from 11% in 2000. Verdicts of death from drugs (dependence on, or no-dependent abuse of drugs) also decreased, from 3% in 2001 to 2.2% in 2007. Homicide on the other hand saw a slight increase of 0.6% from 2000 to 2007, giving a total of 1.4% of the total verdicts returned (Home Office 2001; Ministry of Justice 2007, see graph 2).



In summary, it can be seen that the Coroner's enquiry begins when a registered medical practitioner is unable to ascertain that the cause of a person's death was natural and so the case is consequently referred to the Coroner. Many investigations may be

commenced which may lead to an Inquest if necessary. The enquiry is complete when the cause of death is known and the information for registration of death has been gathered and completed.

Although the original purpose of the Coroner may have become obscured in the mists of history, logic has provided over time a procedure that ensures a fail-safe system so that the registration of every death can be subject to scrutiny and investigation for possible criminal involvement (Burton, Chambers and Gill 1985).

2.10 DEATH INVESTIGATION FRAMEWORK IN SCOTLAND

Entirely distinct from the rest of the United Kingdom is the Scottish legal system of the Procurator Fiscal. It developed separately, unaffected by the Norman Conquest with its roots instead lying deep in Roman and European Law rather than Anglo-Saxon principles. In fact, the development of Scottish Law was independent of England until the 1707 Act of Union. This act made provision for the retention of a separate legal system. The office of the Procurator Fiscal was formally recognised as one of service to the Crown in 1746 and became financially independent a century later. Nevertheless, matters of State emanating from Westminster has brought Scottish and English Law closer together. However, great administrative differences remain, particularly the need for corroboration, such that no person may be convicted on the testimony of a single witness.

As in many other European countries, criminal law in Scotland is administered by a public Prosecutor. The prime holder of this office is the Lord Advocate, who with the Solicitor General and Advocates Depute (collectively known as the Crown Council), prosecutes on behalf of the Crown for the High Court of Judiciary. These officials preside at Edinburgh

but sit on a regular Circuit of the major Scottish towns. In each Sheriff Dom the Lord Advocate appoints a Procurator Fiscal. The Fiscal prosecutes in the lower courts, but also investigates any death reported to him (see Figure 4; Green & Green 1992).

FIGURE 4: DEATHS UNDER MEDICAL CARE IN SCOTLAND: OFFICIAL GUIDANCE.

It is the duty of the procurator Fiscal to enquire into deaths which fall into the following categories, which are not to be regarded as exhaustive, viz:

- Deaths which occur unexpectedly having regard to the clinical condition of the deceased prior to this receiving medical care
- Deaths which are clinically unexplained
- Deaths seemingly attributable to a therapeutic or diagnostic hazard
- Deaths which are apparently associated with lack of medical care
- Deaths which occur during the actual administration of general or local anaesthetic

The forensic pathologist and/or the independent specialist adviser will require to direct his attention ot the following points, viz:

- Whether the patient was properly and sufficiently examined before the procedure
- Whether all due precautions were observed in the performance of the procedure and the selection and administration of any anaesthetic or medication
- Whether there were any factors present which could have been discovered indicating that the procedure would be attended with special risk to life.

(Dorries 1999)

The main concern of the Procurator Fiscal is to establish whether there has been any criminality or negligence associated with the death, rather than establishing the medical cause of it. He cannot issue a death certificate, as in the Coroners system, but instead

the “Fiscal Certificate” or death certificate is issued either by the police surgeon or the pathologist. The Fiscal does not hold inquests. Instead, he takes informal, unsworn statements from those involved. Nevertheless, these may be used as a basis for a fatal accident inquiry or subsequent court proceedings.

Deaths are reported to the Fiscal by the Registrar, who has a statutory duty to report certain types of death as stated in the Rules for Procurators Fiscal (HMSO, 1985). The categories are similar to those laid down in England and Wales (Coroners Act, 1988). However, in contrast the Fiscal does not have a dedicated equivalent of the Coroner’s Officer. Instead the police carry out the initial investigations on his behalf. After these have been completed, the Fiscal can take one of two courses of action. If he is satisfied that the death is natural, he may require a doctor to examine the body externally and issue a “View and Grant” certificate. If the cause of death is not known, or is thought to be unnatural, he must apply to the Sherrif for an authority for an autopsy. After the autopsy, the certified cause of death is given by the pathologist. If the death was found to be unnatural, then the Fiscal must report the circumstances to the Crown Office. If the Lord Advocate, acting through the Crown Counsel, feels that no further investigation is necessary, the matter will be closed. However, in cases where a criminal act or negligence may be a factor, a fatal accident inquiry is held.

Fatal accident inquiries are regulated by the Fatal Accident and Sudden Death Enquiry (Scotland Act 1976). They are held in public, just like inquests in England and Wales, but must be advertised by law. No jury is used and no verdict is returned. Instead, the Sherrif’s “determination” is the formal conclusion of the proceedings. Again, unlike the

Coroners system in England and Wales that is non-accusatorial, blame may be apportioned or deficient safety procedures highlighted.

In Scotland, all evidence must be corroborated, so whenever a death may be the subject of litigation, two doctors carry out the autopsy together. The autopsy rate in Scotland is much lower when compared to the rest of the United Kingdom, but this is due to the use of the "View and Grant" certificate system. The disadvantage of such a system though is the adverse effect on the accuracy of mortality statistics. The prime example statistically being that Scotland has the highest coronary artery disease rate in Europe (Rutty et al 2001).

2.11 DEATH INVESTIGATION FRAMEWORK IN NORTHERN IRELAND

In Northern Ireland there is a Coroner system that differs from that in England in a number of important respects. The Northern Ireland coroners must be practising solicitors. The Coroner in Greater Belfast is currently a full time appointment. The other six Coroners are part-time appointments. Section 7 of the Coroner's Act (Northern Ireland) 1959 states that:

> *"Every medical practitioner, registrar of deaths or funeral director and every occupier of a house or mobile dwelling and every person in charge of an institution or premises in which a deceased person was residing, who has reason to believe that the deceased died, either directly or indirectly, as a result of violence or misadventure or by any unfair means, or as a result of negligence or misconduct or malpractice on the part of others, or form any cause other than natural illness or disease for which he has been seen and treated by a registered*

medical practitioner within 28 days prior to his death, or in such circumstances as may require investigation (including death as the result of the administration of an anaesthetic), shall immediately notify the Coroner within whose district the body of such deceased person is of the facts and circumstances relating to the death".

This section places a duty on a number of people, including doctors, to report such deaths to the Coroner. Section 8 of the Act provides for the involvement of the local police in the investigation of circumstances of such deaths. The Government provides a full time forensic pathology service to assist the Coroners in their investigations.

2.12 THE CORONER SERVICE: A RELIC IN NEED OF REFORM

In 1999, it was suggested by Derrick Pounder, Professor of forensic medicine at the University of Dundee, that the coroner service in England and Wales was a relic in need of reform particularly so when considering the implication of the Human Rights Act (2000). Pounder (1999) believed that the coroner's investigation is an enforceable intrusion by the state into what would otherwise be a private family matter, the death of a loved one. Striking the balance between the reasonable needs of the state to investigate and the rights of the next of kin to privacy and religious ritual is not easy, with present evidence suggesting that this is not done well in England and Wales. Among the rights in the European convention are the right to respect for privacy and family life (article 8), and freedom of thought, conscience, and religion (article 9). The new act provides in clause 6(1) that:

> "it is unlawful for a public authority to act in a way which is incompatible with a convention right".

This provided a starting point for questioning some current practices in the coroner service. According to the Home Office (2001) survey, 201,246 deaths, representing a third of all deaths in England and Wales, were reported to the coroner in 2000. This has risen to 234,500 in 2007. The highest annual total to date (Ministry of Justice 2008). This continues the long term trend as one compares such statistics to 1970 when the number was 130,000, 20% of all deaths. The increase is largely accounted for by natural deaths voluntarily referred to the coroner by a doctor. Referrals by doctors now represent 60% of the coroner's caseload (Ashely and Devis 1992). To direct such a large number of natural deaths in to the medicolegal investigative system was considered by Pounder (1999) to be both intrusive, for the families concerned, and costly (Pounder 1999). However, since the Shipman murders there has been more concern about the proper process and also in part a growing use over the last twenty years of the general practitioner deputising service which has probably led to greater referrals (Ministry of Justice 2008).

Of the 234,500 deaths reported, 47% were subject to post mortem examinations under the legal authority of the coroner in 2007 showing a decrease of 21% since 2000. However, among the 148 coroner districts the percentage dissected varied from 43% to 100%. On these figures, it was suggested that not all coroner districts can be striking an appropriate balance between the needs of the state and the rights of the next of kin. The prevalence of these legally enforced autopsies was considered to be of legitimate concern to everyone (O'Sullivan 1993; National Funerals College 1998), but of particular concern to religious and ethnic minorities that do not approve of postmortem dissections (Rutty 2000; Sheikh 1998). Pounder (1999) believed that it was difficult to justify the current number of autopsies that were performed without the consent of the next of kin. In fact,

they occur in more than one in five of all deaths in England and Wales which also has financial implications. The two main costs within the £66 million budget for the coroner service are mortuary services and fees to pathologists (Ministry of Justice 2007) showed an overall increase in expenditure since 1999 of £20.8 million. Reducing the autopsy rate could offer substantial savings.

The public inquest was another area of concern for Pounder (1999) as he believed it necessarily conflicts with the right to privacy. In 2007 an average of 13.2% of reported deaths came to inquest, but the figures again vary from 6% to 28% across the 148 coroner districts (Ministry of Justice 2008). There were 30,841 inquests in 2007, with witness and juror expenses amounting to more than £2 million. It could be argued that many are unnecessary, and serve only to increase the distress caused to the family, particularly when the death is by suicide. Other areas of concern included the circumstances surrounding such deaths being often poorly understood by the investigating coroner's officer who is either a police officer or a lay person (Macdonald 1999), a critical finding for this study.

Bearing in mind the previous arguments put forward, this research study was timely in its early stages with the Home Office review being under way to investigate whether England and Wales should continue within the Coroners system or instead implement the Medical Examiners framework as exampled in the United States of America when investigating death or in fact to implement something completely different. The Home Office chose to remain with the Coroners system (The Coroners and Justice Act 2009).

2.13 OTHER DEATH INVESTIGATION FRAMEWORKS FROM AROUND THE WORLD

Following research into the practices of North America, Canada, Australia, New Zealand, Western Europe (including Southern Ireland), Malaysia, Japan and South Africa, the death investigation frameworks that are practiced for the investigation of unnatural and certain other deaths can be summarised into broadly three types of methods, those being. the generic criminal investigation and judicial system; the medical examiner system; and the coronial system.

2.13.1 The generic criminal investigation and judicial system

Occasionally known as “civilian” systems, the generic criminal investigation and judicial system is mainly found in most European Union countries where an official is responsible for investigating crime and prosecutions. A prime example is in France where the “procureur” also investigates death. In most countries judicial involvement comes from the examining magistracy who also takes responsibility in directing the investigation. Similarly, as exampled by Finland, approaches based on forensic pathology services can also found in central and north-east European countries.

In all such countries who follow this particular system, there is an requirement for the authorities to undertake autopsies that have not been consented for by the next of kin, despite the fact that they usually only take place where there has been a doubt concerning a crime surrounding the death. In these cases, forensic autopsy specialists carry out the autopsy, with several countries insisting that two doctors participate. In contrast, medico-legal autopsies in Germany necessitate a

court order and the consent of relatives. Nevertheless, if consent is not available then there is power to continue with the autopsy. The law in Germany makes a distinction among an external examination of the body, which is called a "post mortem" examination and an internal examination which is known as an "autopsy".

In countries following this system of death investigation public judicial hearings into death are quite rare, except when investigations may lead to criminal prosecutions, or if the decision not to prosecute is challenged in court. Procedures concerning deaths in prison or detention do not typically have any special procedures either. Furthermore, self inflicted death or deaths from road traffic accidents would also not typically have any special procedures unless of course a prosecution is involved. Despite the fact that in some countries there are powers to investigate and autopsy deaths from certain defined communicable diseases, this system does not routinely relate to deaths that are regarded to be natural but instead where the causative disease is not known.

In summary, deaths that are suspicious in a criminal sense are the prime concern within this system of investigation. It is concerned with dealing with deaths where the specific disease is unknown as opposed to where the cause is natural. Furthermore, this system tends to have high rates of consented autopsies and include for the most part public examinations where there are prosecutions only.

2.13.2 The medical examiner system

In 1877, the first medical examiner system was established in the state of Massachusetts, requiring that the coroner be supplanted by a physician known as a medical examiner. Using the system established in Massachusetts as a model, New York City developed an improved medical examiner system in 1915. Maryland soon followed in New York City's footsteps and in 1939 developed the first state wide medical examiner system in the USA (Inguito et al 2001). The medical examiner systems came about due to the high homicide rates and the general feeling by the public that politically elected coroners were dishonest, crooked and deficient in technical expertise, particular as the coroner could come from any professional or lay background.

The medical examiner system which replaced many of the coroners systems in the United States is unique in that it is directed by forensic pathologists who establish the cause of death, but who in the main do not enquire into the circumstances of that death. Within this system, forensic pathologists provide services to the police and criminal investigations services and undertake in-house autopsies and other scientific investigation services. Many Medical Examiners employ specialist forensic investigators, not medically qualified but educated to degree standard, who manage cases and visit death scenes, such as the forensic nurse examiner the first of which was in New York City.

Medical examiners in the USA are public officials appointed by the state, city or county. Their investigations are administrative not judicial but their determinations like those of any other public official, may be contested through

the courts. The responsibility for death investigation currently in the USA is not with the federal government, but with individual states who can also be assigned to individual cities and counties. Today, State Medical Examiners can be found in 22 states, coroner systems in 11 states and a combination of the two in 18 states. Similarly, Canada too has medical examiner systems but in only four of its provinces (of which there are 12 in total).

To discover the cause of death whether by disease or injury is the function of the medical examiner. However, they do not investigate into the circumstances of individual deaths. Judicial inquests take place in a few US states, but they are infrequent and the decision whether to convene one may be made by the District Attorney, the elected official of the city or the county administration. It is interesting too, that in Canadian Medical Examiner jurisdictions, inquests are held by the mainstream judiciary and are rather more common than in the USA. Nevertheless, when inquests do take place they are presided by a judge from the state, city or county bench. Medical Examiners can and do though make contributions to epidemiological and preventative health literature.

2.13.3 The coronial system outside the UK

Exported by early emigrants who settled in other countries from England is the coronial system. These countries are now known as those within the Commonwealth and the USA. The Coroner system was brought to the United States during the early 1600s where the first recorded autopsy was performed in Massachusetts in 1647 (Inguito et al 2001). Elected coroners within the USA today tend to be sited where the state, county or city has not been replaced by

Medical Examiners. Many of the coroners tend to be either doctors, nurses or lawyers who have been elected. However, the laws governing election do not impose any qualification as such and so a plumber for example could be elected as coroner as exampled in South Carolina (USA) in the 1980s.

Coroners' enquiries into deaths are more likely to take place in private rather than by public inquest as it is in England and Wales. However, traumatic cases do tend to be published generally.

Two features that make the coroner systems distinctive in Commonwealth countries and the USA are that:

A it is a specialist investigation service concerned only with the investigation of deaths. However, in Victoria and New South Wales, Australia, the coroner also investigates fires;

B as well as finding the medical or injury cause of individual deaths it undertakes judicial style inquiries into their circumstances which is unlike the medical examiner's system.

Today, coroners are appointed rather than elected in most Commonwealth countries and the USA, and must be a doctor or lawyer for the most part. British Columbia in Canada is an exception to this rule as lay people can be appointed here. Slightly differently again is Quebec in Canada, where the service uses doctors for much of its work but lawyers to conduct the inquests. In Australia death investigation is the responsibility of the individual states and in Canada of the provinces. Both Australia and Canada have made very substantial reforms to

the coroner's system compared to most other countries in recent decades with statutes and structures being implemented throughout the 1990s, in comparison to some states in the USA such as South Carolina who are still following coroner's rules from the 1860s.

Despite the many variations within the coroner's system around the world, the common development has been the advancement of a single coroner service for a state or province rather than multiple locally appointed judicial style city and county coroners who hold a substantial amount of public inquests. Instead, coroners today are involved in providing:

- Objectives, procedures and standards set centrally for the service as a whole;
- A chief coroner in charge, supported by a headquarters organisation and staff;
- Training and quality control processes;
- A service to the deceased and to the family as opposed to a public act, but also in ensuring that it is a private and administrative rather than a public process;
- Public inquests that are held on a much smaller scale than in the past and that such inquests are discretionary in that they are chosen for their prediction of revealing general risks or systems weaknesses and producing recommendations to enhance public safety (HMSO 2003).

So far this chapter has presented the many variations of death investigation processes from different parts of the world. The literature has shown us in certain instances that nurses are playing an important role in such investigations. The next section will

therefore begin by critically analysing what is meant by forensic nursing as a lead into the role of the nurse and death investigation.

2.14 FORENSIC NURSING DEFINED

The term "forensic" derives from the Latin word *forensics, a public debate or forum*, once referred to the Roman market place where lawyers orated in ancient times, and is now used to describe debates in courts of law. Simply stated, forensic means "pertaining to the law". Therefore, a sub-discipline of science that practices its speciality within the arena of law is practicing the principal of forensic science. Anywhere the world of law and the world of medicine interface, a medicolegal or forensic case occurs, establishing the entity of forensic medicine.

Clinical forensic practice derives from the broader field of forensic medicine which was recognised as a speciality early in the 19th century. In fact the use of medical testimony in law cases predates by more than 1000 years the first systematic presentation of the subject by Italian Fortunatus Fidelis in 1598. A sub-speciality of public health, clinical forensic practice is defined as the

> *"application of clinical and scientific knowledge to questions of law and the civil or criminal investigation of survivors of traumatic injury and/or patient treatment involving court related issues"* (Iyer et al 2006 p808).

Both the survivors and instigator of liability-related injuries require consideration of forensic clinicians, a role different from that of a forensic pathologist, who is solely concerned with the scientific investigation of death.

From personal experience there seems to be a misconception in England that forensic nursing only means mental health/psychiatric nursing within institutional care units and prisons. This is not the case. In fact women have been practicing forensic type services as early as the 13th century when they were involved in examinations to confirm the virginity of women who were marrying into royalty or evaluations of sexual assault victims. Nevertheless, the 1990s has seen a significant paradigm shift from considering forensic nursing as only within the mental health arena as today it actually involves within England, custody nursing and sexual assault nurse examiners. Additionally, some nurses have changed their careers and are now working as coroners' officers, forensic anthropologists and lawyers (Rutty 2006).

To date within England forensic nursing for the adult branch nurse is a very small, yet a developing new sub-specialism for the profession (Rutty 2001). Custody nursing was developed, piloted and implemented with Kent Constabulary in 2000, the Metropolitan Constabulary in 2001 and Leicestershire Constabulary in 2002 and is now being considered and implemented by other police forces including the Nottinghamshire and Derbyshire forces. The Sexual Assault Nurse Examiner was developed in 2001, piloted in Greater Manchester Constabulary under the guidance of the Home Office and is now practiced in London and Preston. All nurses working within Accident and Emergency units throughout the country have always examined the victims of trauma, but to date the role is unrecognised. Additionally, many registered nurses are making a major contribution to the coronial system and are respected by coroners and forensic pathologists throughout England and Wales for their work (Rutty 2000). Despite these tentative and innovative developments, few members of other professions allied to the

medico-legal system including nursing at present acknowledge these roles, discuss it or analyse it to any great extent. Instead forensic nursing with the exception of forensic psychiatric nursing remains somewhat unrecognised in the United Kingdom. However, a new document by the Home Office (2002) entitled *Vulnerable Individuals* and the *Safeguarding Vulnerable Groups Act* (2006) passed as a result of the *Bichard Inquiry* (Home Office 2004) arising from the Soham murders in 2002 has begun to recognise the needs of the public concerning child protection, domestic violence and elderly abuse.

In contrast, there are advanced developments throughout the world typified by the United States of America (USA) that are widely accepted and grounded in evidence based practice. Forensic nursing in the USA originally defined its role in the field of death investigation as a medical examiner's investigator (Lynch 1991). The term forensic nursing in the USA was officially coined in 1992 when about 70 nurses gathered in Minneapolis for what was billed as the first national convention for sexual assault nurses. The USA recognised many years ago due to a short fall in medical staffing that nurses could support many areas of medico-legal work. To date their principle roles include the forensic nurse death scene examiner, custody nurse, sexual assault nurse examiner, the clinical forensic nurse examiner in hospital emergency rooms and the nurse coroner. They have a national education programme, national practice standards, quality assurance and an association in the form of the International Association of Forensic Nurses. Interestingly in the USA, often it is the forensic nurse who has the principle role rather than the forensic medical practitioner, although the two work in partnership for the

benefit of crime investigation and reduction, death investigation and health care (Lynch 1997).

Forensic mental health nursing has a long history within the United Kingdom and is recognised in its own right as a nursing specialism. However, the literature demonstrates that the discipline of forensic nursing internationally is an umbrella term that encompasses not only forensic mental health nursing, but also nurses working within the arena of death investigation, sexual assault, legal nurse consulting and clinical forensic nursing (Lynch 1997, see figure 5).

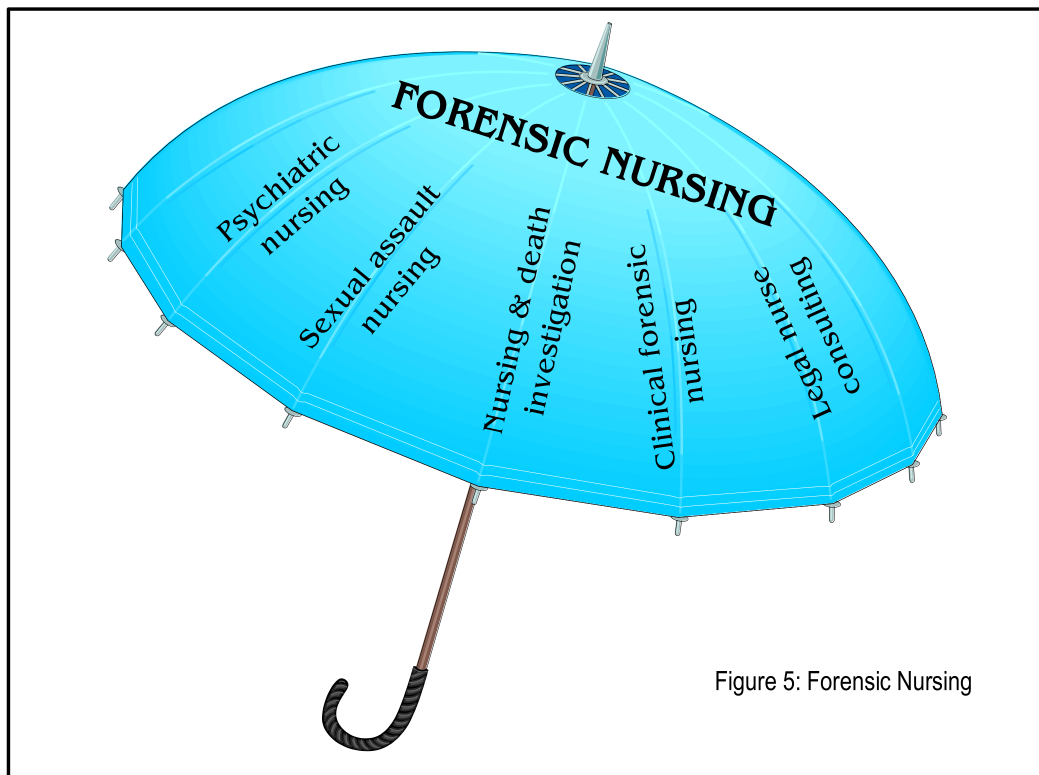


Figure 5: Forensic Nursing

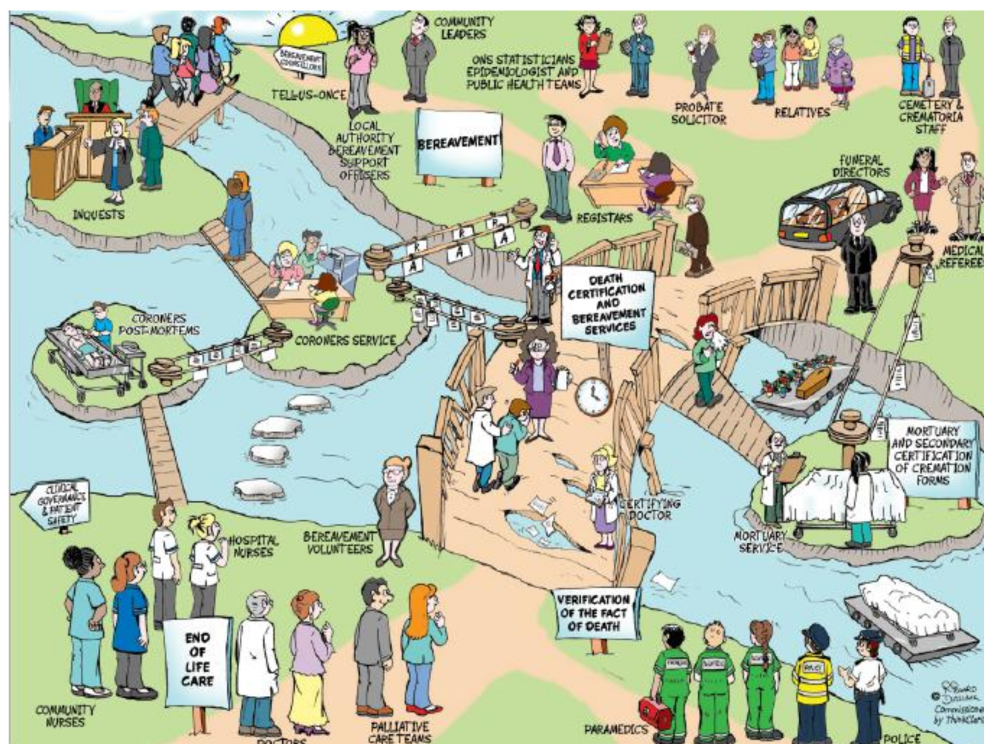
2.15 DEATH INVESTIGATION AND FORENSIC NURSING IN THE UK.

The belief that nurses who perform their everyday work correctly will never be involved in any coronial matter is a naïve assumption to make. As already presented, Green (1993) suggested that nursing staff in general are becoming increasingly more involved in legal

processes in particular with relevance to their observations, records and recall of events. In contrast internationally, nurses have embraced their role more extensively within aspects of the legal profession with the ultimate example of the ability of nurses to be coroners in the USA. Sadly, within England and Wales this role of the nurse has to date been poorly addressed, with many nurses themselves not considering this as an area that they should be involved in. Additionally, except for previous research by Rutty (2000), there are no peer reviewed published articles within the nursing or medical literature to date that evaluate or reflect on nursing practice in the United Kingdom within this area.

It seems that the final service to our patients and family care has not been considered in-depth. Death investigation is an area of great upheaval in people's lives and can be very confusing (see cartoon 1), yet one which the nursing profession seems to have forgotten in the United Kingdom.

Cartoon 1



(Taken from Furness 2009)

The Department of Health and Social Security in 1977 stated that no matter what changes occur regarding the nurse's professional role, the essence of the profession will always be about caring for people. Henderson in 1966 also referred to care when she said that nursing would never be seen as anything less than essential to the human race. The Royal College of Nursing in 2003 even stated that nursing is based on a combination of professional knowledge and skills, with the desire to care for others. It is with these beliefs in mind and the foresight regarding the contributions that forensic nursing already makes and could make to death investigation that previous research was completed by Rutty (2000). This work suggests that the nursing profession in England and Wales has a great deal to offer the Coroner's enquiry. These roles will now be discussed in turn.

2.16 THE EMERGING FORENSIC NURSE IN ENGLAND AND WALES

According to Home Office forensic pathologists and Coroners in England and Wales, nurses of all specialities as part of their everyday work are contributing in some way to death investigation (Rutty 2000). In other words, every nurse is a forensic nurse. Such roles can be split into those that contribute covertly to the Coroner's enquiry to those that are more directly involved.

2.16.1 Nursing roles that contribute covertly to the Coroner's Enquiry

Nurses contribute regularly to Coroners' enquiries, but in the majority of cases will never be aware of their input (Rutty and Rutty 2000). Such indirect nursing roles include those of record keeping and nursing policy in particular. Coroners and forensic pathologists, to aid in death investigations, commonly read records from all nursing specialities. This includes notes and care plans, observation charts and scribbled notes. They are perceived as being extremely valuable and

depicted as being a way to obtain a feel of a situation that extends beyond the pure facts presently evident, a perspective that medical notes are unable to provide. The successful use of nursing records is due to the fact that nurses have such great intimacy and closeness with their patients. Hence, they are more able than other professions to understand, empathise and present patient views holistically. Nursing records are conceptually part of a large and sometimes complicated jigsaw puzzle during a Coroner's enquiry. It is often the nursing data that enables a full picture of events to be seen when used simultaneously with other data, as one forensic pathologists stated quite bluntly:

> *"The old saying in forensic pathology is, if you want to know what should have happened read the medical notes, but if you want to know what really happened read the nursing records"* (Rutty 1998 p66).

Nursing records are perceived as an honest, descriptive indication as to the circumstances leading up to and surrounding patient death. Consequently, they make a vital contribution to an investigation. Interestingly though, computerised records are not well favoured as there is a fear that a valuable nursing tool is being lost by the inability to record unusual events.

Another essential role is described as the importance of all nurses acquiring a working knowledge about the Coroner's Enquiry (Rutty 2000). Gaining such knowledge enables nurses to perform their role when required to a higher standard concerning death investigation, in turn promoting family care of the deceased patient. Such a role can be performed by any nurse in any nursing

environment, from the trauma centre to the community arena. This may be simply about having the knowledge to advise families about organ transplantation or by explaining why their loved one needs an autopsy or even by providing information on death certification.

Knowledge gaps can cause nurses to have a professional image that lacks confidence (Benner 1984), by presenting themselves to families and other professions as being confused and unprepared. This in turn causes relatives and friends of the family to become frustrated and upset. More importantly, fear of the unknown is a powerful factor as it can exaggerate beliefs that maybe untrue and so anything that can be done to alleviate this situation can only be beneficial. Learning and spreading knowledge about the correct practices and procedures of the Coroner's enquiry is the answer, as many nurses see the Coroner as this dreadful person in the background who is going to make life very difficult. There is a degree of suspicion too that Coroners are there to point the finger of blame (Rutty 1998).

Nursing policies and standards are designed to clarify what constitutes acceptable practice and guards against risk by incorporating suitable safeguards (Grimshaw et al 1995). They provide a benchmark against which quality may be assessed by describing either a minimum level required for safe and effective practice, or a level of excellence, thereby encouraging best practice (Waller et al 2009). Today Clinical Governance, the framework by which quality is governed in the NHS, specifies the setting of standards as a key component of quality improvement. Standards are defined by the DoH (2004): as a means of

describing the level of quality. The performance of organisations can be measured against this level of quality. In other words, standards provide a benchmark against which quality can be measured (Waller et al 2009). Developing and strengthening nursing policy is a role particularly important to Coroners who come from a legal professional background (Rutty 2000). Nursing polices provide them with something concrete to fall back on and to compare the actions of nurses in clinical practice with, whereas Coroners from a medical background tend to rely on their own past experience. Developing and reviewing nursing policy should happen irrespective of a Coroner's enquiry. However being able to clarify and justify nurse practice decisions through strong evidence to not only the Coroner, but the bereaved family too, assists tremendously with their understanding of their loved one's death.

2.16.2 Nursing roles that contribute directly to the Coroner's Enquiry

There is a potential that nurses, again from any speciality, can be involved directly in a Coroner's enquiry. This is as a resource provider, communicator, supporter, through presencing, as an evidence giver or through the role of stewardship (Rutty 2000).

As part of a multi-disciplinary team in health care, be it in the community or the acute sector, the nurse need not attempt to deal with issues surrounding patient death by herself. She can however act after the death of a patient as a resource provider to relatives by sharing knowledge with them concerning the coronial process. For example, if the death is to be investigated by the Coroner or even the police, she can assist relatives by directing them to other relevant

professionals such as bereavement counsellors and coroners' officers who can help them further. This role is seen to occur after a patient has died, but before relatives have left the ward/unit in a hospital environment. The nursing literature would agree that this is not just a role that occurs in relation to the Coroner's enquiry, as bereaved relatives will look to the nurse to provide all kinds of information. However, the guidance that nurses can provide to grieving family members and friends may prove invaluable in helping them to comply with unfamiliar procedures at a difficult time in their lives (Davis 1994, Urpeth 2010).

A parallel role is that of communicator (Rutty 2000). This role not only embraces initial communication between bereaved relatives and the multi-disciplinary team, but also builds upon relationships developed during the patient's stay within the health care environment. Nurses have a major role here in promoting communication between all multi-disciplinary team members and relatives. Coroners and forensic pathologists perceive that it is the nurse who "knows" the patient and relatives. Therefore the nurse is important as the first contact with the family. Good management at this stage will prevent and avoid possible problems later. As Kyle (1995) said, without frequent and direct communication by nurses to all concerned, good multi-disciplinary team working cannot always be guaranteed.

Benner (1984) suggested that nurses are often educated to believe that they are most effective when doing something practical for a patient. Several nurses in her study, however, noted the essential importance and value of just being with a patient, otherwise known as presencing. This led to her belief that nursing theory

must be shaped by real world experiences (Thompson 2005). Benner stated that:

> *"this ability to presence oneself, to be with a patient in a way that acknowledges shared humanity, is the base of nursing as a caring practice… To presence oneself with another means understanding and being with someone" (Benner and Wrubel 1989 p13).*

Similar to this, Coroners believe too that if an enquiry is held the role of the nurse and presencing is perceived as becoming important (Rutty 2000). Presencing is described as the presence of a nurse known to the relatives during the Coroner's Inquest in court. It is believed that presencing can have a tremendous calming effect on relatives at this difficult time in their lives. It is a way of being with others by way of concern and companionship.

Following the death of a patient, the continuing caring relationship that nurses have with relatives cannot be underestimated and should not be ignored (Rutty 2000). The role of stewardship concerns care, support, counselling and validations of feelings for families e.g. bereaved relatives seeking assurance from a familiar nurse that an autopsy is considered standard procedure in death investigation. Davis (1994) has previously suggested that families involved in a coroner's enquiry may suddenly feel pushed aside or helpless, particularly if they were involved in care decisions while their loved one was alive. Stewardship is concerned with extending the caring relationship that nurses have with relatives,

by continuing the role of patient advocacy to the Coroner's enquiry. Stewardship is about caring, and being concerned.

Coroners and forensic pathologists in England and Wales believe that it is not only the continuing nurse-relative interaction that is important, but also the nurse-nurse relationship. The role of supporter encompasses supporting, comforting and reassuring other colleagues (Rutty 2000). It is a role that is of great value to the profession as a whole. However, there is a tendency for nurses to be very much left on their own when involved in a coroner's enquiry as one described a regular scenario in his court:

> *"I sympathise with nurses, because on the occasions when they [nurses] do come along it's obvious that they're very upset, they're concerned, they feel very lonely and they feel unloved at that particular time. The witness box is a very, very lonely place. Just to have somebody hold your hand and be with you in the Coroner's court can only be a good thing" (Rutty 1998).*

Senior nursing colleagues better serve the role of supporter, within the context of the Coroner's enquiry. This role can be compared to supportive styles of leadership in nursing. Handy (1993) suggests that in organisations such as health care, support produces subordinate satisfaction, lower staff turnover and grievance rates and less inter-group conflict.

A final role where nurses are contributing directly to the Coroner's enquiry in England and Wales, relate to that of evidence gatherer and giver. As an evidence gatherer this is a role that nurses do not always take on as a priority. For instance, when a body is brought to the Accident and Emergency Department, the last thing most staff think about is the recovery, labelling and storage of exhibits for coroners' investigations. Yet nurses in such departments, hospital wards, laboratories or GP practices may at some point work with a police exhibits officer who requires samples, X-rays or patient's notes. If a victim is pronounced dead on arrival to hospital, how the body is handled can make a difference to any subsequent investigation (Rutty 2000b).

The nurse gives evidence either in the form of written or verbal evidence. Unfortunately, this is an area where nurses are not performing to their best ability compared to their role of record keeping within the health care arena (Rutty 2000). When nurses are required to give evidence regarding their witness to fact, firstly they write a statement, which in some Hospital and Community Trusts are then formerly submitted to their manager/name nurse, who forward this on to the Coroner. No more may be required from the nurse. However, in some cases, nurses will be needed to give evidence verbally in a Coroner's Inquest in the Coroner's Court where they will answer questions related to the case. Many nurses though, have minimal or no training or education in preparing written statements, simply because there is little on offer to them (Rutty and Rutty 2000). Similarly, the art of verbal evidence giving and dealing with cross examination by nurses in court is not highly valued by Coroners and forensic pathologists, often being perceived instead as confused and unprepared (Rutty 2000). Further

research has not investigated this area since this time, but it has been suggested that employers should be more aware of the support that employees need. The NHS should copy the good practice of the police service and other professions and prepare staff for this type of duty by providing them with information in advance, support on the day of the inquest and support afterwards if necessary (First 2007). Despite these views, the nurse as evidence gatherer and giver makes a major contribution to the Coroner's enquiry and one that is predicted to develop through experience and education, but more importantly one that is required more and more.

2.16.3 Future nursing roles that could contribute to the coroners' enquiry

Two future nursing roles have been proffered and debated by the Coroners and Forensic Pathologists of England and Wales (Rutty 2000), based on their perceptions as to how they believe the every day nurse may advance in this area of death investigation. "Verifying the fact of death" as opposed to certifying the cause of death, remained purely by law at this time within the domain of medical practitioners. Coroners were open-minded and ready to consider that this could be a role for nurses, but forensic pathologists and police surgeons are deeply divided. This was disappointing when the fact of death was already being verified by other non-medical staff such as paramedics in some areas of the United Kingdom. On a positive note, some hospitals are now educating nurses in the verification of death. This means in reality, that some nurses can now perform last offices and transfer the deceased to the mortuary without a doctor needing to attend to confirm patient death. Following Rutty's (2000) research a more recent expanded role of the nurse was implemented by the custody nurses from Kent

Constabulary in January 2001 who have implemented the verifying the fact of death successfully within the custody suites of police stations and at death scenes within the community. So far, this has shown to be cost effective and less time consuming for the police force when compared to previous arrangements with police surgeons (Personal communication, Karen Swinson, Custody Nurse Manager, Kent Police Constabulary, May 2001). Another example is the increasing number of senior community nurses who are trained to verify expected death among terminally ill patients to fill gaps left in GP out-of-hours services. Audit figures from 2007 show that 68% of end-of-life patients who died in the community were verified by community nurses (News 2008). Anecdotal evidence also suggest that paramedics are not only verifying death in the community, but assessing whether such deaths are suspicious or not as they expand their roles into that of the police surgeon and in doing so cut costs incurred by the police constabulary concerned. Despite these developments particularly in nursing, the situation in which it would be appropriate or inappropriate for the nurse to verify death has not as yet been clearly defined nationally for all areas of nursing practice.

The second future nursing role proffered is that of nurses as expert witnesses. This concept is on the whole embraced positively by Coroners and forensic pathologists (Rutty 2000). Although all grades of nurses may qualify either as an ordinary or professional witness, the step up to an expert witness where opinions are provided concerning nursing practice are currently considered as a role relevant only to senior nurses and a role that would be utilised in the Coroner's enquiry only occasionally at present. Despite its current rarity even today, it is an

anticipated role that will expand for the nurse in the future particularly with the onslaught of the advanced nurse practitioner, the nurse consultant and nurse led health care services.

In summary, forensic nursing roles within the realm of death investigation remain in the United Kingdom haphazard, with no national framework for practice and consequently are not reviewed. Yet the nursing profession in most other general areas of practice is developing, progressing and advancing at an expeditious speed. Additionally when the nurses' role in the United Kingdom is compared to the USA, it can be labelled as almost pre-historic concerning death investigation. The question now though is, why did this role expansion take place in the USA and what services are nurses providing?

2.17 DEATH INVESTIGATION AND FORENSIC NURSING IN THE USA

Nurses have served as field death investigators for Canadian medical examiners since the 1970s when nurses in Alberta began to receive training, a trend that moved across the Canadian provinces and into the United States. In fact, the theoretical model of forensic nursing evolved from the role of the police surgeon, sometimes known as the forensic medical examiner, in the United Kingdom and other European countries, as no such posts existed within the USA or Canada. Hence, historically in the USA particularly, because of a lack of communication and coordination, a gap had existed between clinical practitioners, criminal justice system employees and forensic science operatives. Previously, this gap was either left open, or filled by physicians and nurses lacking forensic training, resulting in the misinterpretation of and/or omission of valuable forensic evidence. The failure of physicians and nurses to recognise the legal issues surrounding

patient care is believed by Lynch (1998) to have robbed victims of the support and in some cases the evidence needed to validate their victimisation. In order to understand the foundation upon which forensic nursing was built in the USA, it is necessary to examine the history of clinical forensic medicine, or "living forensics" as it is labelled sometimes today.

Living forensics is a field of inquiry that was brought to the attention of clinical nursing by Harry C McNamara, Chief Medical Examiner for Ulster County, New York. Although the concept of clinical forensic medicine and its applications to the living was new to the USA, it had been widely practiced in the United Kingdom and other parts of the world for the past two hundred years. In 1987 McNamara defined clinical forensic medicine as

> *"the application of clinical medicine to victims of trauma involving the proper processing of forensic evidence"* (p2).

This concept stresses the importance of the health care team being sensitive to the legal issues surrounding their patients. It was believed that the resources available for help from law enforcement and the courts, as well as from the community and social service organisations must include health care services. No longer could healthcare providers work in isolation from the legal issues previously delegated to law enforcement. Instead it was felt that it was the responsibility of healthcare professionals to maintain a high index of suspicion and to protect victims. It is also held that it was their responsibility to provide the necessary leadership in routinely identifying, treating, and properly referring victims of child, elder and spouse abuse to appropriate authorities.

The practice arena included registered nurses and nurse practitioners, physicians, physicians' assistants, paramedics and emergency medical technicians. It also included community service professionals (such as police offices, court officials and attorneys), interacting with victims. These professionals were expected to be able to recognise the problems in the existing system and alert other trained personnel to potential solutions. To this end, it was believed necessary to establish and train professionals in the philosophy of living forensics, beginning with emergency interventions.

In tandem with these beliefs was the recognition of an epidemic of violence and its associated trauma that has resulted as a critical healthcare problem throughout the world, not just in the USA. In 1985, the U.S. Surgeon General's Workshop on Violence and Public Health focused on sexual assault, physical assault, homicide and spouse abuse. Victims from these scenarios constituted the target population already identified by emerging forensic nurses who were tenaciously maintaining a holistic view of intervention strategies.

Since then, the Joint Commission on Accreditation of Healthcare Organisations (JCAHO) had issued standards for emergency rooms and ambulatory services addressing all forms of abuse including: child abuse, sexual assault, domestic violence, and elder abuse. Meetings were convened between staff members of the American Medical Association, the American Hospital Association, and the Education Development Center, Inc. to develop model protocols, educational materials, and training programs that would assist healthcare providers to comply with the JCAHO standards.

Lynch (1998) considered that the many cases of death that occurred in the clinical setting fell within the jurisdiction of the medical examiner or coroner and believed it to be vital that clinicians were skilled in the documentation and preservation of evidence related to those cases. Nurses, particularly emergency room nurses, were often the first to come in contact with the victim and the evidence before the police were even notified that a crime had been committed. Additionally, with the advent of advised pre-hospital (paramedic) care, many trauma patients bypassed the emergency room entirely and were admitted directly to surgery or intensive care. This represented an opportunity for nurses to make a significant contribution to public health and safety as nursing had embraced the continuum of the life cycle – caring for individuals at the time of death as well as the moment of birth. In fact, the events which immediately preceded and occurred at the time of death become crucial factors in the medicolegal investigation of death.

The focus of forensic nursing was clearly identified as a vital intervention by healthcare in advocacy and administration to victims of violent crime – the survivors, the deceased and the families of both. The wide range of components that defined this focus may have appeared confusing to those without knowledge of the forensic sciences. Yet it was the body of knowledge in its entirety that provided its strength. The identified problems in USA society were great and multifaceted and required education and expertise that was equally diversified. In truth, the combined efforts of forensic science, medicine, law, nursing and public health were required to deal with the complex problems of violence.

Forensic nursing today in the USA provides healthcare responses to the sequelae of criminal and interpersonal violence. Nurses according to Lynch (1998) were being challenged to share a mutual responsibility with the legal system, in order to augment

available resources for individuals with liability related injuries, crime victims and prevention of injury or death by early detection of potentially abusive situations are critical steps to stem the effects of human violence. The responsibility of the forensic nurse in legal issues brings this new specialist in line with the concept of the nurse investigator, providing continuity of care from the acute care setting and/or crime scenes to courts of law.

Forensic nursing within the field of death investigation as a discrete discipline, was recognised with the first formal paper delivered on the subject at the American Academy of Forensic Sciences (AAFS) annual meeting in New Orleans, in February 1986 (Lynch 1986) following its innovation in Canada during the 1970s. However, despite this innovation of nearly 30 years ago in the USA and more than forty years ago in Canada there is a lack of research concerning the nurse's role and death investigation. In fact, all published papers are discussion papers which is understandable with the sub-speciality being so young compared to other traditional specialities, but then again there has been no published research carried out in order to promote knowledge and move the forensic nurse forward despite enormous achievements in such a short period of time.

2.18 A FUTURE NURSING WORKFORCE NEED OUTSIDE THE BOUNDARIES OF TRADITIONAL HEALTH CARE

After reviewing the literature it would appear that there maybe a potential area of health care for patients, clients and families in England that has either been missed or forgotten by the nursing profession. Countries such as the USA, Canada, Finland, India and the Philippines are providing a nursing service within the death investigation process. This chapter also earlier showed that 234,800 deaths were reported to the Coroner in the year

2009, that is 46% of all deaths in England and Wales (Ministry of Justice 2010). It must be realised that this also means 234,800 bereaved families involved in coronial enquiries and death investigation. Perhaps expanding and advancing the nursing role within this area may provide valuable nursing care that is currently not delivered, a gap in health care provision, but what does it mean or could it mean potentially to be a registered nurse working within the realms of death investigation?

2.19 CHAPTER SUMMARY

Henderson (1966) believed that part of the nurse's role is not only to assist our patients to a peaceful death, but to also support all patients in death. Davies (1994) took this one step further by suggesting that the role of patient advocacy goes beyond death. Rutty (2000) has shown that nurses are contributing on a regular basis to the Coroner's enquiry and death investigation, be it in a hit and miss way in England and Wales particularly when compared to other expanding and advancing nursing roles.

If nursing is to continue in successfully developing and advancing in England and Wales, it must be complimentary to medicine as it evolves in response to society's changing demands. Medicine has always had a working relationship with nursing, except in pathology and up until recently forensic medicine. It may now be time to extend the interdisciplinary support and assistance to include the forensic pathologist and forensic nurse as a co-operative team.

Forensic practice in nursing is not new to England and Wales, particularly when we consider mental health nursing. However, other branches of nursing involvement in forensic practice could be a new expanded and advanced role for the nurse of this

century. It is making a difference to health care already in areas that are not always traditionally part of the National Health Service, such as child protection, custody care and sexual assault, but very importantly it is also beginning to make a difference to the legal arena. Nursing has always been diverse. Nursing has always been about caring. Nursing has always been needed by the most vulnerable groups in our society. Perhaps there is a need for a new forensic nurse practitioner working within the realms of death investigation.

It is time therefore for nursing to take the lead in building multi-disciplinary partnerships in clinical practice, education and research, but it is imperative that the underlying intention of upholding and promoting patient advocacy and family health care remains. After all, caring is the central concern and essence of nursing.

Reviewing the literature on nursing and death investigation provided a rationale for exploring the meaning of such work. While the evidence pointed to the issues of the role of the nurse generally and the effects of expanding roles with medicine and the way forward, followed by an analysis of death investigation frameworks worldwide, nursing was then considered within this realm. Consequently, I have suggested that there is "hidden" evidence as to the meaning of such nursing work currently being practised in the USA. This then led to the overall research question and aims for this study as detailed in Chapter One, Section 1.4 and 1.5. The next chapter will discuss how the study design was therefore chosen from a philosophical perspective to answer the question "what is the meaning of Being as a nurse involved in the work of death investigation in the USA?"

CHAPTER THREE

STUDY DESIGN: THE JUSTIFICATION

3.1 INTRODUCTION

The research study that does not explain its underlying philosophy, can lose its meaning. Philosophy offers congruence and purpose and supplies a framework from which to imagine and consider, to understand and realise and to create and perform (Hartman, 1997). The intention of this chapter is to put forward an abstract discussion of the philosophical basis informing this research study namely the interpretive paradigm and Heidegger's Hermeneutic methodology, so that meaning can be achieved and maintained.

The drive to the interpretive paradigm and Heidegger's hermeneutics was not an easy one. Reaching this decision was the result of personal knowledge development, beginning innocently in conventional empirical thinking and the belief that only pure science is the way forward in progressing knowledge. However, continuing in a period of systematic self dispute from not only the aspect of the reliability and validity of research processes on offer, but then also the influence of underlying politics and morality at its centre, it was the work of Benner (1984) and her use of hermeneutics in nursing research that provided me with the confidence and strength to continue being faithful to interpretism and the work of Heidegger. The following chapter puts forward these critical reflections, its underpinning discourse and justification for this decision.

Following a brief discussion on philosophy in general terms along with Habermas' three sciences (1972), this chapter will begin by describing and justifying the use of the interpretive paradigm in informing this research study and the consequential hermeneutic approach within which the study is being undertaken. Heidegger's hermeneutics will then

be justified in its application to this study by critically discussing the ontological and epistemological issues.

3.2 PHILOSOPHY.

Philosophy derives form the Greek work philein meaning “to love” and the word sophia meaning “wisdom” (Moody, 1990) and has been defined by Sarter (1988) as a study into the nature of reality via rational or intuitive thought, the goal being wisdom. Similarly, but perhaps more explicitly and simply, it is described as:

> *“the study of problems which are ultimate, abstract and very general. These problems are concerned with the nature of existence, knowledge, morality, reason and human purpose” (Teichman and Evans 1995 p1).*

Philosophies attempt to see reality as a whole. They analyse the nature and findings of different branches of knowledge, examine the assumptions on which they rest, the problems to which they give rise to and seek to establish a coherent view of the whole sphere of experience. Philosophy as a whole is split into separate subject divisions, the principle being: metaphysics, axiology, epistemology and logic (appendix 4). More simply, it can be explained as the study of: beings or their being; right and wrong; knowledge; and valid reasoning. In simple terms it is: what is; how we should act; how we know; and how to reason. It is a reflective discipline that uses the rational process of philosophic inquiry to investigate issues of significance to humankind (Harper and Hartman 1997).

The development of scientific knowledge is influenced by philosophical viewpoints, which provide ontological perspectives that guides epistemology and methodology (Newman 1992). The assumptions that describe reality are known as ontology and the assumptions that underpin knowledge and truth are known as epistemology. The methodology determines the methods to be used in a research study and consequently should reflect back to the philosophy underlying that study. The advantage of considering the philosophical beliefs underpinning a research study, is that the beliefs and values can be clarified, giving purpose and direction to the focus of the study. Ontological, together with epistemological and methodological claims, are what differentiate paradigms.

A paradigm, in contrast to philosophy, is a way of looking at the world, a general perspective. The word "paradigm" derives from the Greek "paradeigma", meaning "pattern" (Moody 1990). It presents a set of philosophical assumptions about the world that are interrelated in a way that helps break down the complexity of the real world (Khun, 1970). At present, there are three major paradigms utilised in nursing research based on Habermas' three major sciences: the positivist (or empirical-analytic), the interpretive (or historical-hermeneutic) and the critical theory (or social action) approaches (Allen et al 1986).

3.3 HABERMAS' THREE MAJOR SCIENCES

Jürgen Habermas (1929-), a philosopher in post World War II Germany, believed that the ideal of National Socialism a German political movement that began in 1920 (commonly known as Nazism, ending in the creation of the Third Reich, the one-party German state commanded by the dictator Adolf Hitler from 1933 to 1945) and the consequent Nuremberg Trials from 1945 to 1949 had failed morally and politically. This belief was

reinforced to Habermas when as a graduate student at the age of 24 interested in Heidegger's work and a set of republished lectures by Heidegger originating from 1935. Habermas in response to these republished lectures ignited a national debate by writing a letter to the Frankfurt General Newspaper in 1953 publicly questioning Heidegger concerning his reference to the "inner truth and greatness" of National Socialism (Heidegger 1959 p199) and the signs of sympathy with Nazi ideology in Heidegger's work. It was Heidegger's non-response to this question that led Habermas to believe that the German philosophical tradition was failing in its discourse due to the political pressure to both not understand or criticise National Socialism. This negative experience between philosophy and politics led Habermas to look further afield and to Anglo-American thought and their pragmatic and democratic traditions on a range of issues including violations of civil liberties, German reunification, intervention in Kosovo and the invasion of Iraq.

Habermas defended his philosophical beliefs in his work "*Knowledge and Human Interests*" (1972). The origins of this theory lie in an historical tracing of epistemological ideas, particularly from the European philosophers Husserl, Kant, Hegel through to Marx and Freud. Habermas' own ideas on the three major sciences of positivism, interpretism and critical theory are profoundly influenced by the writings of these philosophers.

3.3.1 Positivist paradigm

Being predominantly connected with the French philosopher Comte (1789-1857, the 19th century observed the materialization of the positivist philosophy of science. A group identified as the Vienna Circle advanced and expanded this philosophy further in the 1920s when it grew to be known as logical positivism. The principle that the lone technique to achieve true knowledge was through the collecting of

data via sensory experience was put forward by logical positivists (Meleis 1991). Logical positivists, later acknowledged as logical empiricism, stimulated a new confidence in the power of science to solve problems of significance to humankind. In addition, it became synonymous with the "scientific method" and the "received view" of what was believed to be valid as knowledge. It was not until the 1960s that this position of science influenced philosophical thinking and fashioned the development of both medicine and nursing as scientific disciplines.

This paradigm is based on an epistemology, which conceptualises knowledge as independent of the knower, thus it is independent of context (Holloway and Fulbrook 2001) and the world is believed to operate in accordance with laws that are discoverable (Burns and Grove 1997). The only valid knowledge is scientific knowledge according to positivist philosophy. Empiricist philosophy, which contributes to this paradigm, directs researchers to seek understanding through measurement and quantification of empirical data using an objective stance (Fealy 1994). More recently the emphasis on empirical data has been widened to include "evidence" which may encompass self-report data, therefore subjectivity can be used within this paradigm for example in the use of self-report ratings of variables (Schumacher and Gortner 1992, Parahoo 1997).

Quantitative research is the research approach enlightened within the paradigm of positivism. Such research considers a desire to generalise findings and to identify cause and effect relationships (Parahoo 1997). By testing hypotheses and developing theory through deduction, it looks to account for the world through the frequent application of experimental designs being utilised in the research process.

Prediction and control of nature are understood to be the desired outcomes of quantitative research (Burns and Grove 1997). Then again, positivist research's mission for universal laws has been said to have weakened with qualifying statements currently being made with reference to the precise and detailed circumstances in which the laws that preside over nature apply (Schumacher and Gortner 1992).

The generalisability of findings being the foremost advantage of this approach means that quantitative research has a great deal to offer nursing (Norbeck 1987; Carr 1994). On the other hand, when applied to the study of multifaceted phenomena it reduces them to measurable parts. This is contradictory to the concept of holism which is central to nursing practice and may therefore be criticised for representing an incomplete view of the complexity associated with human beings (Munhall 1989).

The presupposition that the methodological procedures of science might be directly utilised to nursing situations arrives from the positivists' viewpoint that the results of nursing research can be framed in terms of generalisable laws and that humankind can be handled as objects of the natural world (Parker 1994). However, it is the complexity of the central topic under investigation, humankind, that is the major obstacle in conducting nursing research studies using this paradigm, as:

> *"Each human is unique in personality, social environment, mental capacities, values, lifestyle and health status" (Polit and Hungler 1993 p17).*

This was reflected in the Literature Review (Chapter 2) when it was determined that the forensic nursing role is a complex activity which varies considerably according to the place in which it is practiced. Consequently, positivism has not been widely utilised with forensic nursing and as a result there has been insufficient experimental research to evaluate clinical practices (Rutty 2000).

The positivist paradigm was therefore abandoned for this study as its aim is to test theories (deduction) with the ability to replicate any findings. This study, "the meaning of Being as a nurse involved in the work of death investigation in the USA", is not about testing hypotheses, but takes a more broad exploratory nature to its investigation from a holistic contextual view. A positivist study would need to compartmentalise the phenomena under enquiry which in turn would misplace the ability to view the research participants as a whole system of meaning and consequent understanding. This study believes in the notion that properties of a system are made up of unified wholes that are greater than the simple sum of their individual parts. This is an idea first summarised by Aristotle and named as holism. More importantly, holism is congruent to today's nursing in that the profession recognises the emotional, mental, spiritual and physical elements of each individual and attempts to treat the whole person in its context. With this study looking for the "meaning of Being" in an aspect of nursing, it seems appropriate that this positivist paradigm is rejected.

3.3.2 Interpretive paradigm

Included into this paradigm is an epistemology of relativism. As a result reality is viewed as subjective, socially constructed through interaction and founded on the

meaning people attach to it (Sarantakos 1993). Truth is held to be the interpretation of phenomena, context-dependent, dynamic and evolving as opposed to the objective nature of truth which is rejected (Holloway and Fulbrook 2001). The Individuals are perceived as interpreters of their experience and creators of themselves by their existential choices (Munhall 1989).

Qualitative research informed by this paradigm involves modes of inquiry concerned with understanding human beings and their transactions with themselves and their surroundings (Benoliel 1985). No attempt is made to manipulate and control and reality is explored from the emic perspective. Understanding is sought through the examination of everyday experience in naturalistic settings (Morse and Field 1996). In contrast to the need for research detachment central to the quantitative paradigm, the qualitative approach sees the researcher and participant as inter-related and this is said to expand and deepen understanding of the participants' experience. Qualitative research is criticised because of the inability to generalise its findings (Miles and Huberman 1994), but research carried out within this paradigm does not seek to generalise rather it aims to enhance understanding (Haase and Myers 1988).

Nevertheless, the interpretative approach, has developed because of dissatisfaction with the positivist's approach in the study of humanism. This approach is directed towards providing interpretative accounts of phenomena rather than law-like generalisations (Wilkes 1994) and is an approach consistent with the aims of this study. The interpretative approach will be critically discussed in more detail in section 3.3.4.

3.3.3 Critical theory paradigm

The critical theory paradigm shares a number of characteristics with the interpretive paradigm including a belief that individuals construct their own reality. In spite of this, dissimilar to the preceding paradigms critical theory seeks to deconstruct established knowledge as a result of its rejection of a unitary truth. It furthermore seeks to explain social order and as a result endeavours to become the vehicle that challenges the status quo (Fay 1993). For this reason it has an emancipatory mission that is not conducive to this study's aim. In addition, the critical theory paradigm, research methodology, and practice are all deemed political rather than neutral and subsequently have an effect on numerous processes within society. Undertaking research with people rather than on them is highlighted in methodologies enlightened by this critical theory approach for example action research (Stevens and Hall 1992). While this study's findings may possibly point towards a need for change, its objective is to describe the meaning of Being as a nurse involved in the work of death investigation rather than aiming to effect social changes as critical theory does.

The critical theory approach goes beyond the interpretative and positivist approaches by totally integrating theory and practice. It seeks to identify and criticise disjunctions, incongruities, and contradictions in people's life experiences (Wilkes 1994). However, a significant failing is that it accepts the male world-view as the social norm and assumes it as a frame of reference for all research (Hartman 1997). Despite this failing, critical theory also includes feminist theory. Given that the majority of nurses are women, feminist theory possibly could be regarded as a suitable underpinning for this study. However, feminist theory

functions on the supposition that women are oppressed (Holloway and Wheeller 1996). Even as the literature points towards the continuation of oppression in nursing, founding the study on this hypothesis would, it was thought, inflict a prejudice before allowing the phenomena of concern to come into sight unencumbered to any individual theory and so for this reason it was rejected.

3.3.4 Justification for choosing the interpretive paradigm

The interpretive paradigm and qualitative research is a systematic and yet subjective approach used to describe life experiences and give them meaning (Silva and Rothbart 1984). It is conducted to generate knowledge concerned with meaning and discovery in order to promote understanding (Burns and Grove 1993), the aim of this study. Research under this paradigm is complex and broad, focusing on understanding the whole, which is consistent with the holistic philosophy of nursing (Leininger 1985). Very importantly though, this paradigm is particularly valuable as it facilitates research to not only explore new perspectives (horizons) on known areas and ideas, but when little is known about an area of study it can also reveal processes that go beyond surface appearances (Strauss and Corbin 1990).

The philosophical paradigm chosen to inform this research study is the interpretive paradigm as it seeks to gain a deep understanding of “the meaning of Being as a nurse involved in the work of death investigation in the USA” rather than looking for universal truths. The assumptions held in this paradigm provide clear justification for its choice in that it has enabled the inclusion of suppositions that:

- There are multiple constructed interpretations of reality due to the fact that despite us all living within one universe, our experiences and interpretations of being and meaning can be very different, historically dependent and rooted in language. This became particularly important as a British nurse researching into the meaning of Being as a nurse involved in the work of death investigation in the USA. It is the philosophical perspective of the interpretive paradigm that can provide the means of enabling people to relay their own "experiences of" this nursing role. Allowing the researcher into their world, via this paradigm, permits the researcher to interpret experiences at first hand, with the aim of discovering meaning and promoting understanding. The researcher and research participant are viewed as sharing common practices, skills, interpretation and everyday practical understanding by virtue of their common professional culture and language;
- The researcher and participant are both changed by the research process as it is recognised as being impossible for the researcher to be completely detached from the research subjects and endeavour in isolation to rigidly defined variables. This is believed by those who follow the classical paradigm of positivism to be a disadvantage in that researcher bias becomes unavoidable. However, the interpretive paradigm sees this as an advantage in that it recognises the importance of the researcher's openness concerning their own pre-judgements, values and beliefs being brought throughout the research process to assist in its interpretation of meaning. This is imperative belief for this research study with the knowledge that not only are two differing cultures being brought to the research process, but two death investigation and nursing systems steeped in historical development;

- Description and understanding can be more useful and interesting than attempts to establish cause and effect relationships in that it deals with value-laden questions, can explore novel areas of research holistically and examine phenomena comprehensively. As the Literature Review (Chapter 2) has already concluded there is little knowledge available presently with respect to nursing work and death investigation. The philosophical perspective of positivism would require the researcher to hypothesise such a role with the intention of generating generalisable laws, but with such sparse knowledge to assist the hypothesis stage, this is impractical. Instead, there is a need to "tap" into nurses' experiences in the USA and interpret such experiences to eventually enable realistic application within England.

In summary and as previously discussed, interpretivism is based on a more humanistic philosophy being conducive to the work of nursing in comparison to pure positivism and thus also provides a source for an extensive diversity of qualitative research methodologies such as grounded theory, ethnography, phenomenology and hermeneutics.

3.4 THE INTERPRETIVE PARADIGM AND METHODOLOGY

Methodology within the interpretive paradigm is the method of interpretation of texts, and secondly of the whole social, historical, and psychological world. The problems were familiar to Vico (1668-1744) an Italian philosopher of history and raised in connection with biblical criticism by Schleiermacher (1768-1834). Under the title of "verstehen" the method of interpretation was contrasted with the objective scientific method by Weber (1864-1920) and Dilthey (1833-1911). Its inevitable subjectivity is the topic of the major

writings of Gadamar (1900-2002). This is now presented, considered and justified from the three standpoints of ontology, epistemology and methodology.

In philosophy, ontology is the study of being or existence. It addresses the nature of reality, in other words, what can be known about reality. Essentially an ontological discussion tries to decide what things there are in the world (Powers and Knapp 1995). It was first accorded a central role by the 18th century German rationalist Christian Wolff (1679-1754), who distinguished ontology from the other branches of metaphysics (Capaldi 1997).

Within the interpretive paradigm, philosophers link the act of interpretation with being, by claiming that interpretation is the activity that enables us to experience the world. For these thinkers, everything that exists in the world exists for people through acts of interpretation and understanding (Thompson 1990).

Epistemological questions arise once the ontological question about the nature of reality has been assumed. Epistemology seeks to answer the question of how one can come to know about that which exists. This includes the nature of the relationship between the knower and what is to be known. According to Kneller (1971) the generally accepted ways of knowing identified by epistemologists relate to revealed, intuitive, rational, empirical and authoritative knowledge. Revealed knowledge is believed to have come from God, examples of which can be found in the Bible for instance. Intuitive knowledge on the other hand is knowledge that is considered to be known within a person, sometimes referred to as insight, but this knowledge that can only be gained through experience. In other words, intuitive knowledge is not something that can necessarily be

taught, but something that can be gained over time through repeated experience. In nursing, intuitive knowledge is often referred to as experiential knowledge. In contrast, rational knowledge is based on reason using the principles of logic with empirical knowledge being gained through the use of observation and use of the senses as exampled by hypothesis testing and experiments. Finally, authoritative knowledge is believed to be true based on faith as it is guaranteed by respected authorities considered to be reliable in their field of study.

Nursing on the other hand, while recognising the accepted framework of epistemology, tends to follow the structure put forward by Carper (1978) of empirics, aesthetics, personal knowledge and ethics. Empirics referred to as the science of nursing where knowledge is organised into general laws and theories in order to describe, explain and predict phenomena. A different knowledge position is that of aesthetics characterised as the art of nursing where rather than the use of laws there is recognition of perception and empathy in practice. Personal knowledge is distinct once more with the focus being on the importance of the interpersonal process, in knowing the "self", knowing the "other" in order to make every effort to develop an authentic personal relationship between nurse and patient/client. The final belief is that of ethics. The term ethics in this sense centres on the significance of obligation and what needs to be carried out in practice through the use of value and belief systems within society. Crucially, Carper (1978) distinguished these four fundamental patterns of knowing as not being mutually exclusive, but interdependent. In other words, there is interaction among the four constituent parts leading to the holistic approach of theory development, a fundamental deliberation central to the nursing profession, rather than only studying the constituent parts.

Issues concerning methodology follow on from the ontological and epistemological assumptions made. In other words, once it has been decided how one can come to know about the things that are in the world, then methodological questions ask how one can go about finding that knowledge, that is, what approach should be taken. According to Swanson and Chenitz (1982 p242):

> *"No one methodological stance, in and of itself, leads to scientific discovery and theoretical breakthroughs. Therefore, in order to make any discoveries that are relevant to nursing practice, we must encourage the use of a variety of scientific approaches. Qualitative research is a systematic study of the world of everyday experience".*

In summary all interpretive enquiries watch, listen, ask, record and examine. The methodological opportunities available for researchers within the interpretive paradigm include ethnography, grounded theory, and phenomenology along with hermeneutics to name a few.

3.4.1 The rejection of ethnography justified

Originating in the discipline of anthropology, ethnography provides the researcher with the means to investigate into cultures and worlds different to their own. It is naturalistic in nature using observation, interviews and description as a means of data collection. Ethnographical research focuses on the "lifeways" of a particular culture or subculture, using in-depth procedures such as observation. The aim is to examine what the world is like for people who have shared beliefs, customs, practices and social behaviours that are different to our own accepted culture.

Illustrations of such studies are extensive and varied with the example of Kendrick et al's (2007) study into the "*Perceptions of depression among young African American men*" and Turbull et al's research on "*An outside perspective of the lifeworld of ICU*" (Turnbull et al 2005).

Ethnography, all the same, would not be suitable for this study as although the emphasis is on the meaning of Being a nurse involved in the work of death investigation in the USA, it is not about focussing on the community of nurse death investigators from the view point of discovering shared culturally specific beliefs and practices, but on the subject of interpretation of human behaviour, structures of society and how people function within these structures. It was felt therefore that ethnography would be too limiting and controlling in researching the socio-cultural facets alone.

3.4.2 The rejection of grounded theory justified.

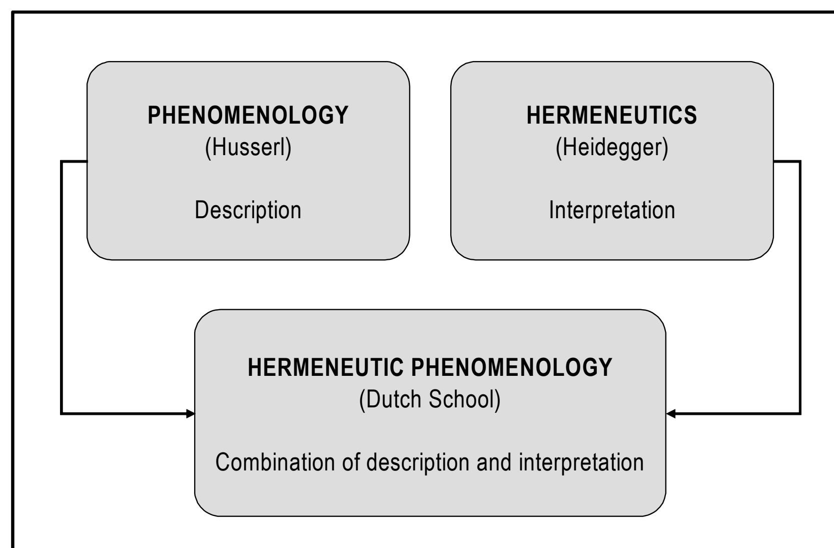
Grounded theory developed by Glaser (1930-)and Struass (1916-1996) in 1967 calls attention to the generation of a theory from data collection (Glaser and Strauss 1999). This is an approach that collects and analyses qualitative data with the aim of developing theories and theoretical propositions grounded in real-world observations using the constant comparison method. It aims to describe not only what is happening as with other interpretive methodologies, but unlike others to also progress knowledge development further through proposition development making it possible for theories to be formed through induction (Bryant and Charmaz 2007).

Grounded theory though was rejected as this study is not about generating a new theory concerning nurses as death investigators, but about seeking to understand behaviours through shared meaning principles. In other words, hermeneutics will activate the ability to gain a reality through negotiated meaning so that a non-mediated understanding of what is true can be exposed and made known (Schwandt 2000).

3.4.3 The rejection of phenomenology justified

An alternative option to consider was phenomenology, but there is much disagreement concerning the interpretation of phenomenology due perhaps to the term having been used so widely across the world especially as it is well known and accepted that there are many schools of phenomenology involving a number of development phases. For this study the terms for phenomenology, hermeneutics and hermeneutic phenomenology will be used an indicated below in figure 6.

Figure 6 – Terminology of phenomenology and hermeneutics



In addition to this the language used in phenomenology is often quite confusing and has led to some misinterpretations by nurse researchers as criticised by Crotty and Paley (Crotty 1996b, Paley 1997, Paley 1998). Their critiques resulted in the request for greater rigour in justifying the methodology chosen and a clear application in its methods.

In simple terms hermeneutics includes the German phase which began with Husserl (1859-1938), the French phase and the main figure of Sartre (1905-1980) and the Dutch phase.

The German phase of phenomenology as a research approach is considered to be rooted in the philosophical writings of the German philosopher Husserl (1977) who was influenced by the descriptive psychology of the Italian philosopher and psychiatrist Brentano (1838-1917) (2006). Based on the investigation of phenomena (that is, things as apprehended by consciousness) rather than on the existence of anything outside of human consciousness, Husserl introduced the concept of the "lived experience" as the natural world in which we live. He put forward that the "lived experience" is not readily available to us all as it is always made up of what we take for granted and therefore fail to explore. He believed that the aim of phenomenology is to return to the familiar and re-examine what we believe we already know and understand by reflectively bringing into awareness what has been taken for granted. This type of research always asks about the nature of human experience. In other words "what is it like?" The main emphasis of Husserl's phenomenology is to enable the researcher to describe

experiences as perceived and interpreted by the participant. It aims to describe human experience fully, but in a very broad and descriptive way.

The French phase sees Sartre's phenomenology disagree with Husserl who put forward that consciousness for the most part is deliberate. Instead Sartre advocated that consciousness is always an intentional activity aimed at the world. Husserl also believed that consciousness incorporated perception, thoughts and ideas, but Sartre developed this further and challenged that it also incorporated desires, wishes, emotions, moods, impulses and imagination to question the world as it is. Sartre went on to argue that because of this we are always aware of possible options and alternatives giving us the freedom to imagine the world in a different way (Reisman 2007). Sartre has received much criticism for this philosophy (sometimes named as existentialism) by various religious groups due to his denial that the universe has any intrinsic meaning or purpose and the stance that individuals need to take responsibility for their own actions in order to have an effect on their own futures rather than relying on faith. This has not been helped by the inconsistencies he portrayed in his philosophy concerning the two views of rationalism (reasoning as a basis of action) and phenomenology, which in turn has led his philosophy to have countless differing interpretations by ensuing scholars (Whitford 1982).

The Dutch phenomenology of the Utrecht School, consisted of a range of phenomenological orientated psychologists, educators, paediatricians, sociologists, criminologists, psychiatrists and anthropologists. It was after the misery of World War II and the post war turmoil that Dutch phenomenology came

together, heavily influenced by French existentialism, and turned to the future of young people (Levering and Van Manen 2002). Humanism (the concern with the needs, wellbeing and interests of people) and personalism (the belief that only persons are real in the ontological sense, have value and free will) became the motivation that focused mostly on the notion of combining both description (Husserlian beliefs) and interpretations (Heideggerian beliefs) often referred to as hermeneutic phenomenology (Cohen et al 2000).

A point to consider though is that Dutch philosophy has been heavily influenced by theology throughout its history and is considered by some to be shaped by religious doctrine to the disadvantage of science. This stance is coupled with very few scholars and philosophers who give the opposite view (McAllister 1997). Nevertheless, as subsections of phenomenology, the Dutch phase of thought was famous for its phenomenological psychology and criminal phenomenology in particular (Kockelmans 1987, Giorgi 1986). However, developments in phenomenology as inspired by the Dutch school have since moved into two contemporary camps with the work of van Manen's hermeneutic phenomenology being said to be influenced by the Utrecht School (Netherlands) and Giorgi's empirical phenomenological psychology from the Duquesne School (USA) (Holloway and Wheeler 1996).

Despite the differing phases of thought in phenomenology, the broad goal in each remains the same in that phenomenology is about gaining knowledge about a phenomena. Its concern is to understand the way people exist in the world, the significance of everyday things and events, the phenomenon "as it is" and the

"lived experience". However, phenomenology was rejected as it only enables the researcher to focus upon very broad description, whereas hermeneutics (as will be discussed later in section 3.5 through to 3.6) makes it possible to give attention to taken for granted practices and common meanings through the process of interpretation.

In addition the notion of bracketing in phenomenology is required so that the researcher is separated from the experiences under exploration, a stance not conducive to this study. Instead hermeneutics recognises the importance of the researcher's experiences rather than it being a hindrance and the consequent altruistic effect on trustworthiness. It was felt to be important to be able to acknowledge to the research process my own experiences in the world of death investigation as it is considered impossible to separate our knowledge from our lived experiences and thus to shed (bracket) our past experiences. Instead it is these experiences that make possible the understanding of the experiences of others. This study believes in the value and worth of acknowledging experience and rejects the use of bracketing so as to promote understanding of any prejudices that may be held and hence avoid the distortion or repression of any findings (Grondin 2003).

> *"For whomever pronounces himself or herself free of prejudices is all the more blindly exposed to their power. Prejudices will exercise their underground domination all the more strongly, and potentially distortingly, when denied or repressed" (Grondin 1990 p54).*

3.4.4 The justification for hermeneutics

The interpretivists link the act of interpretation with conditions of knowledge. They maintain that everything in the world that can be known is known by people through acts of interpretation. Interpretation is presented as a broad human activity, as the way of having access to the world or the way in which reality can be apprehended (Thompson 1995). Reiteration by Leininger (1985) stressed that knowledge of people consists of more than what can be seen, sensed and measured. The goal of hermeneutics consequently is to understand practices and skills by looking for patterns, commonalties and meanings in order to present practical knowledge (Moody 1990). In other words, hermeneutics is a process of revealing phenomena so that they seem familiar and comprehensible (Leonard, 1989).

The use of hermeneutics as an underlying philosophy for this study is justified from the standpoint that it will enable the interpretation of human behaviour, structures of society and how people function within these structures through shared meaning principles. In addition hermeneutics will make it possible to give attention to taken for granted practices and common meanings through the process of interpretation, a perspective that other philosophies as previously discussed do not embrace. This will enable a non-mediated understanding of what is true to be exposed and made known. Hermeneutics also recognises the importance of the researcher's experience rather than it being a hindrance which in turn increases trustworthiness in its findings. This again is a view conducive to this study compared to other philosophies that encourage the use of bracketing.

3.5 HERMENEUTICS AND WESTERN WORLD HISTORY

To understand hermeneutics one needs to look at the etymology to see when it entered language, from what source and how the form and meaning of hermeneutics has changed over time. The word hermeneutics derived from the Greek word for *interpreter.* This is related to the Greek God Hermes who served other gods as a bearer of messages to mortals. Hermes was believed to play tricks on those he was supposed to give messages to, often changing the messages and influencing therefore the interpretation of such messages. The Greek word thus has the meaning of one who makes the meaning clear.

3.5.1 Hermeneutics in Ancient Greece and Rome

Scholars in antiquity (8th century BC to 5th century AD) expected a text to be coherent, consistent in grammar, approach and viewpoint, and they amended difficult to understand or corrupt readings to act in accordance with their classification of rules. Nevertheless, the original focus was to restore the authentic versions of scriptures that were prone to numerous errors from hand copying.

Aristotle's (384-322 BC), a student of Plato (427-347 BC) and teacher of Alexander the Great (356-323 BC), treatise "De Interpretatitione" is the earliest work that looks at the relationship between logic and linguistics (Whitaker 1996). His theory of interpretation was that words are symbols or signs of affections or impressions of the soul, with the written word being a sign of the words spoken.

3.5.2 Early Biblical and Medieval hermeneutics.

Hermeneutics during Early Biblical times (0-500s) and the Medieval period (400-1400s) as a general science of text interpretation can be traced back to two sources. Firstly, the ancient Greek rhetoricians study of literature, which came to fruition in Alexandria (founded 332 BC) and secondly the Midrashic (from the Hebrew word meaning extensive interpretation of Biblical texts that were first written down in the 2nd century forming the Tanakh, Hebrew Bible) and Patristic traditions (early Christian writings of the 1st and 2nd centuries). Both were contemporary with Hellenistic culture which marked the unification of the Greek world that shared a common culture based on that of the 5th and 4th century BC Athens. It was the early Jewish Rabbis and Church Fathers who sought deeper meanings rather than just the text at its face value, but also to the detriment used allegorical writings to attempt to explain meanings which at times led to the loss of the literal meaning. The Patristic writers (100-700) were interpreters of early Christian writers using exegesis. In other words, they used interpretation and understanding of a text on the basis of the text itself rather than perhaps in relation to the relevance of contemporary society (Kaiser and Silva 1994, Copeland 1991).

3.5.3 Hermeneutics during the Renaissance and Enlightenment periods.

It was the Renaissance period (1400s-1600s) that encouraged the development of modern interests, values and beliefs and the revival of learning based on the times of ancient Greece and Rome without the previous controls of Medieval times. This resulted in a large number of investigations and studies of natural events, art and literature to a degree never known before. For example,

European explorers (the most famous being Christopher Columbus) began to search for new trading routes and map unknown territories. Concerning hermeneutics it was the Renaissance period in the 1400s that saw a new humanist perspective to knowledge development come into view. This position incorporated the use of historical and critical methodology in analysing texts. This is exampled particularly through the work of Lorenzo Valla, an Italian humanist who proved in 1440 that the “Donation of Constantine” (752) was a forgery through the fundamental analysis of the evidence within the text itself (Bowersock 2007). Hermeneutics thus expanded from its medieval role by explaining the correct analysis of the Bible.

The Enlightenment period (1600s-1700s) saw the emergence of Protestant exegetes who interpreted scripture in response to historical and social forces. This was to enable any difficult to understand scriptural passages or passages that were contradictory in nature to be clarified by comparing them to current Christian practices.

3.5.4 Modern Hermeneutics

Modern Hermeneutics generally considered to be during the 1700s-2000s began with Schleiermacher (1768-1834), a German philosopher, who explored the nature of understanding in relation to all human texts and modes of communication rather that just deciphering sacred texts as had been carried out previously. Instead, he defined hermeneutics as the art of avoiding misunderstanding. This was a fundamental shift of the meaning of altruistic interpretation in that it was now not only about understanding the exact meaning

of words, but also the meaning in relation to the speaker or writer of such words (Bowie 1998).

Dilthey (1833-1911), a German philosopher inspired by the works of Schleiermacher, broadened hermeneutics further by propositioning that interpretations involves a “mediated” understanding that can only be attained by placing the human expressions made in their historical contexts. He believed that understanding was not about reconstruction, or reforming what has been expressed in a more understandable way, but of communicating clearly and accurately what has been expressed in the text (Wilson 1989).

Heidegger (1889-1976), a highly influential German philosopher, shifted the focus of hermeneutics from interpretation to existential understanding. In other words, the belief that individual human beings create the meanings and essence of their own lives are therefore responsible for what they make of themselves. However, to know what to make of oneself is considered one of the hardest philosophical questions since Ancient Greece and Rome (Long 2001). In direct contrast to Dilthey, Heiddeger put forward this stance as an action against rationalism and empiricism, with his focus being on “non-mediated” understanding rather than “mediated” and so considered a more true way to being-in-the-world rather than just simply as a way of knowing. Heidegger also suggested that knowledge is a procedure in which individuals passively perceive things, from mental representations of them and it is from this that statements of reality can then be formed (Urden 1989). He believed that from birth onwards we interact with others in our culture and what is said to us shapes our understanding of the world and

the meanings we give to it. Advocates of this approach believe that interpretation of text and/or expression will reveal its social context in which they were formed and hence provide the reader with the means to share the experience.

Gademer (1990-2002), a German philosopher and student of Heidegger believed hermeneutics to be the heir to the older tradition of practical philosophy. He believed that understanding is possible by being completely situated within the horizon of praxis (that is, the application of a skill rather than a theory alone) and in the same way as Heidegger that the historical character to every understanding is the principle of hermeneutics. More simply, Gadamer puts forward the notion that understanding is always temporary in nature and must therefore belong to the field of praxis (Grondin 1994). Gadamer argues (1976) that it is precisely through the interplay between one's existing cognitions or values and the elements of other cultures or new theories that one develops knowledge. He went on to describe hermeneutic understanding as being represented by a hermeneutic circle, as a portrayed interpretation that is never perfected. Instead it is always tentative, ongoing and liable to re-examination. Leonard (1989) expanded these thoughts even further by suggesting that hermeneutic science stems from the realisation that there is no Archimedean point, in other words, no beginning or ending. That is, no objective knowing, because all knowledge emanates from persons already in the world.

Ricoeur (1913-2005), a French philosopher, extended the idea of hermeneutics as textual analysis to any human situation, which then is to be "read" as a text to reveal the substance of life experiences. The interpreter therefore looks for the

leading metaphor that recaptures the meaning of a social situation. Ricoeur developed "hermeneutics of suspicion" based on Heidegger's concepts and the influences of Gadamer. He hypothesised this to be a method of interpretation which assumes the surface meaning of a text is an effort to conceal the political interests that are provided by such text. The purpose of interpretation under this belief is to suspect the credibility of text that is considered to be superficial in nature and to explore instead what is below the surface in order to reveal a more authentic dimension of meaning. Ricoeur therefore believed that discourse can both reveal and conceal something about the nature of being (Bourgeois and Shalow 1990).

3.5.5 Contemporary hermeneutics

Today, Habermas (1929-), a German theorist in the tradition of critical theory and American pragmatism is known for his criticism of what he considers old fashioned hermeneutic philosophies especially of those by Gadamer because of the missing dimension of critical theory. Habermas believes that knowledge is a product of our society which is often mystified and reified. One can overcome this, he claims, through the use of critical reflection within "critical hermeneutics" by studying the three generic domains of human interest, namely, the technical, practical and emancipatory interests (that is, the positivist, interpretive and critical theory methods) (Thompson 1984). In the company of Habermas is Ortiz-Oses (1943-), a Spanish philosopher and student of Gadamer. Ortiz-Oses, who is inspired by Jung (1875-1961) a Swiss psychiatrist and founder of analytical psychology, developed Symbolic Hermeneutics as the Mediterranean response to northern Europe hermeneutics.

3.5.6 The justification for Heidegger's hermeneutics

In summary, this historical development has provided researchers with six modern definitions of hermeneutics:

- Theory of biblical exegesis
- General philosophical methodology, the Enlightenment form
- Science of all linguistic understanding
- Hermeneutics as methodological foundation of humanities
- Phenomenology of existence and of existential understanding
- Systems of interpretations used by man to read the meaning behind myths and symbols.

Hermeneutics as put forward by Heidegger grew out of both the history of hermeneutics along with the consenting and opposing agreements he had with Husserl's phenomenology. For example Husserl was interested in the understanding of the lived experience, a stance that many nurse researchers mistakenly concentrate on when claiming to underpin their research from Heideggarian hermeneutics when really they are coming from the Dutch school of thinking and hermeneutic phenomenology (Caelli 2001). Heidegger though developed this idea of the lived experience further to Husserl by incorporating three distinct notions to claim that hermeneutics is the process by which:

- *"the basic structures of Being… are made known";*
- *"the working out of the conditions on which the possibility of any ontological investigation begins";* and
- "*an interpretation of Dasein's being"* (with "Dasein" being the German word for "being there") (Heidegger 1962 p37-38).

In other words, as Cohen (2000) explains, hermeneutics is the attempt to understand:

- the phenomena (experience) of the world as they are presented to us (similarly to Husserl);
- how it is we go about understanding the world as it is presented to us; and
- "Being" itself.

These philosophical stances are relevant in the underpinning of this study as it will not only provide an underpinning theoretical framework for the data collection and analysis, but will embrace the exploration of the ontological as well as the epistemological nature of the meaning of Being as a nurse involved in the work of death investigation, that is, a more holistic view of meaning and everydayness. Nurses' current everydayness, or common ways of being (because they are those experiences to which one pays the least reflective attention to) will be enabled to be illuminated.

This study also believes in line with hermeneutics that research in this philosophy can provide knowledge which is useful beyond its immediate context. However, while no interpretive scholar would attempt to suggest that the information

generated is generalisable in the sense that a positivist study would be, there is no doubt that it can illuminate vitally important areas of practice that are taken for granted, but relevant to others working or wishing to develop such work in similar areas (Hartman 1997), in this case nursing and death investigation. Heidegger's hermeneutic philosophy will now be discussed in more detail.

3.6 HEIDEGGER'S HERMENEUTIC PHILOSOPHY

Martin Heidegger (1889-1976) was a German philosopher interested in ontology, metaphysics, Greek philosophy, technology, art, language, poetry and thinking. He was influenced by Plato, Aristotle, Kant, Hegel, Nietzsche, Dilthey, Brentano, and Husserl and was best known for his work *Being and Time* (Heidegger 1962). He is also known to have inspired the work of Sartre, Gadamer and Ricoeur to name a few.

After studying theology at the University of Freiburg in 1909 and following the publication of Being and Time in 1927 Heidegger was appointed Professor of Philosophy in 1928 after Husserl (his teacher and a phenomenologist) retired. It was in 1933 when Adolf Hitler came to power that Heidegger was elected as Rector of the University and joined the Nazi Party. Husserl since his retirement had continued his research at Freiburg, but he was eventually barred from the university because of his Jewish heritage. Heidegger's year as Rector was not an easy one. So much so he resigned in 1934, but remained a university academic and member of the Nazi Party until the end of World War II. However, it was between 1945 and 1951 that he was prohibited from teaching under the de-Nazification rules of the Allied authorities. He was though reappointed again as professor in 1951 until 1967 and continued to write until his death in 1976.

It was uncomplicated and logical at first choosing Heidegger's hermeneutic philosophy to underpin this study especially after reading Being and Time (Heidegger 1962). However, this all changed on learning of his relationship and sympathy with Nazism. In the early stages of this research this was a difficult hurdle to overcome as one struggled with the controversy of a clear philosophy being presented on the one hand and some unsavoury political values and beliefs there were being offered up on the other, values and beliefs that have no place in nursing. It all seemed to be so contradictory. This was not helped on learning that Heidegger had been criticised publicly for not renouncing Nazism or for condemning the Holocaust (Holmes 1996). This had led to some critics to abandon his philosophy altogether. Others condemned his politics, but interestingly declared this has had no influence on his philosophy (Crotty 1996). Uneasiness, worry and doubt coupled with a declining personal confidence began to seep into the previous self-assured position of this study.

Despite lengthy study of other interpretive philosophies though, the draw to Heidegger's hermeneutics remained. With the support from skilled supervision during this dilemma and on continued critical reading and self reflection a mature understanding was attained. It became clear that although Heidegger did not turn away from Nazism, it seems he was intensely dissatisfied with its official philosophy and ideology particularly concerning its racial principles which he never agreed to. Heidegger may have made the mistake of not examining the influence that politics may have had on his philosophy, but this study believes that Heidegger's philosophy concerning knowledge development as a distinct entity was in fact sound. Critics of Heidegger's philosophy include Ayer (1910-1989) a British philosopher of logical positivism and Russell (1872-1970) another British philosopher and rationalist who claimed his work was subjective, uninteresting and

difficult to follow. However, the German philosopher Gadamer (1900-2002) and French philosopher Derrida (1930-2004) have been sympathetic to Heidegger's work regardless of his life choices (Gadamer 1976; Derrida 1981). With this in mind Heidegger's philosophy will now be critically discussed in detail to underpin this study by exploring his four philosophical concepts of: being in the world, fore-structures, time and space.

3.6.1 Being in the world

Heidegger argues that the most important thing is that the world exists. His philosophy is that we are born into an already existing world and that through a shared social existence, and by way of a shared language, we come to be. It is our existence that determines what we can come to know and that an understanding of the person cannot occur in isolation from the person's world (Walters 1995). However, it is philosophised that people are immersed in the world, that the world is taken for granted, creating hidden experience and thus hidden knowledge. Heidegger addresses this difficulty through the importance of revealing the significance and nature of the world (Reed and Ground 1997).

Heidegger believed there were many ways for us to be-in-the-world, but that the most significant way was in being aware of one's own Being (Mackey 2005). In other words, the ability to think and wonder about one's own Being and existence. Heidegger refers to human existence as Dasein, or being-there and the human condition as being in and of the world, rather than subjects in a world of objects, a positivist's perspective (Reed 1994). Although phenomenology can search for Being in all phenomena, ontological searches in the human sciences use the human being as an entity through whom to understand Being. Heidegger felt that

Being could be located and described within the questioning human. For Heidegger, the Dasein of the inquirer was the beginning point of the discovery of Being within an entity. Dasein or "There-Being", therefore, denotes a human means of explicating the nature of Being. The notion of Dasein contains three elements representing the past, present and future of a person, that is, attunement, articulation and potential. Attunement is described as the way in which one meets with experience. Articulation is defined as the way in which one has the experience. Where as potential is asserted as being the experience where one's goals lead (Reed and Ground, 1997).

The concept of Dasein informed the theoretical framework of this research, because the "There-Being" of nurses reflected some of the nature of the Beingness within the phenomenon. It was decided to use the term "authentic genuineness" to equate with Heidegger's concept of Dasein. The reason for substituting the phrase "authentic genuineness" for Dasein was that the phrase "authentic genuineness" would have more user-friendly relevance for English speaking, pragmatically orientated individuals, such as nurses from the USA, as well as for the community of people for whom the findings of this research were likely to be most helpful.

3.6.2 Fore-structures

According to Heidegger (1962) fore-structure is the building block for the process of interpretation. In other words, he believed in prior awareness in the sense that fore-structure is what is understood or known in advance of interpretation. Altruistic meaning then is when the phenomena in the world under study has

been revealed in its totality, what is "there" and "already there". Heidegger described this further by introducing the concept of the "circle of understanding" or hermeneutic circle (Munhall 1986 p 87):

> *"This circle of understanding is not an orbit in which any random kind of knowledge may move; it is the essential fore-structure of Dasein itself" (Heidegger 1962 p195).*

He believed that it is pre-conceptions that can demonstrate any prejudice or distorted account of Being. It is important therefore to determine if there are any such prejudices and to evaluate their legitimacy when undertaking research in this philosophy. This is where one can see the influence on Ricoeur's development of the "hermeneutics of suspicion" as previously discussed. Heidegger stressed the worthiness of the hermeneutic circle is to enter the circle at the beginning of a study of enquiry by acknowledging any presuppositions (they may be provisional at this stage) and then before a final conclusion is reached on the study to return to the starting point with the benefit of a deeper understanding. This in turn can then cause the next conclusions to be more insightful and so on around the circle until a final conclusion in time is met. For example, the problems in the process of interpretation arise when one element (instance in a text or experience) can only be understood in terms of the meanings of other elements (or even the whole text or whole experience) and yet understanding the whole text (or experience) is dependent upon the understanding of the original element of that text (or experience). In other words, light dawns gradually over the whole, a belief of the holism of meaning.

Along with the concepts of being-in-the world and fore-structures is time and space. According to Heidegger (1962) we live out our experiences within the total context of our lives, that is, the time and space of our existence from our birth until our death.

3.6.3 Time

Time today can mean so many different things to different people depending on the context in which it is being experienced. This becomes more apparent when looking at the philosophical perspectives of time. Time is defined in two distinct perspectives. The realist's view time as something that can be measured and part of the fundamental structure of the universe where events occur in sequence. A good example is Greenwich Mean Time, a positivist view. On the other hand, time from the Kant tradition is a measuring system used by humans, but it is not objective in nature. An example would be perhaps when we say that "we have no time to do something" or "time went so fast", an interpretive view. The interpretive view has been regularly experienced during certain phases of this study.

How humans understand time in their everyday lives is based on temporality, that is, how one connects with the world in relation to measured time. Heidegger (1962) refers to this temporality as "datability". He put forward that datability is referred to in three perspectives that are interrelated that is: things happening now; something that has not yet happened, but is to happen then (not-yet now); and things that happened previously or on a previous occasion (no-longer now)

(Mulhall 1996). In other words Dasien is orientated to the concerns of the present with the future and past experiences considered as phenomena. The awareness though of the past, present and future are as one, in the present (Mackey 2005). Heidegger (1962) points out then that the datability of events although based on measured time is not exclusively based on the positivist view of time, but the interpretist's existential view. The existential view is that "now" will vary according to what one is doing. For example, indicating the value of something at a given moment in time (small time interval) such as when watching Johnny Wilkinson's successful opportunistic drop kick in a rugby final or the hours engaged in chatting to one's sister on the phone. In essence time is periodic and spanned. The existence of Dasein then in relation to time is not only objective, but ontological and interpretive in nature, as time is not only periodical based on world time, but it can also be stretched. In other words, how one experiences movement rather than a duration. The word "pace" may suit the purpose in explaining the concept or "stretch" more simply.

Heidegger believed that interpretations cannot take place unless time is taken into consideration. Heidegger's philosophy concerning time it that it is a sequence of self-contained units, a series of "nows" that emerge from the future, present themselves to the individual and disappear into the past. Dasien then is concerned with the present. Future and past events are regarded as phenomena which either will be or were the focus of its present concern (Mulhall 1996). However these three entities of everyday time are considered to be tightly interwoven. In other words, temporality as the awareness of time through the

experience of being in time (Heidegger 1962) allows past, present and future to be experienced as a unity. Put more simply this means that:

> *"…what is experienced in the present is coherent with what was experienced in the past and is expected to be experienced in the future, such that awareness of then is as one, in the present" (Mackey 2005 p183).*

For Heidegger, time is both objective and subjective. It is objective in the sense of the use of world time and subjective in the ontological sense.

3.6.4 Space

The term space has two opposing definitions according to science in that space is considered to be either part of the fundamental structure of the universe or part of a fundamental abstract mathematical conceptual framework. In contrast, the philosophical two sided argument is on the one hand that space is an ontological entity itself or a conceptual framework we use to reflect about the world.

Heidegger (1962) believes that existence is not only temporal as discussed above under time, but spatial in nature, that is being-in-the-world. He put forward that all objects in the world belong somewhere, "the there". In other words, Dasein understands space as near and far, close and distant in relation to the related object's practical purpose. For example, the notion of travelling to a destination as being so near and yet so far or a distant relative may in fact live close by. This is explained further as "the there" meaning that humans are

always either bringing something close to them ("here") or experiencing it as being remote ("yonder"). Heidegger is saying that space is not about distance that is measurable, but about what "matters to a person". Heidegger refers to this as "care" sometimes translated in the literature as "concern" (Mackey 2005).

Heidegger (1962) also discussed the concept of "horizon" and how being-in-the-world is dependent on this too. The horizon can be clarified as an interior with an enclosure and a boundary, that indicates within that space what can be seen from a past, present and future perspective. It is the horizon that enables being-in-the-world to be located in both time and space. He believed that what is in the foreground or background of horizon depends on the unique location of being-in-the-world. More simply perhaps is that horizon is about our perspective or point of view. However, one's horizon can change as new perspectives become visible. For example one uses the concept horizon in our everydayness of language when we relate to for example "broadening our horizons". It is not possible though to ignore and leave one's horizon, instead horizon is dynamic continually transient, developing and reforming. An illustrative example of this can be seen in the movie "The Truman Show", a film based on what is considered to be the normal life of a happily married man with a good job. However, he is being televised 24 hours a day unaware that his entire life is a constructed reality soap opera. The point of the story is that Truman is being-in-the-world within the horizons of the world that was created for him, but accepted as reality by him. It is only when a studio light falls from the sky that his perspective on being-in-the-world begins to change. His horizon (perspective) on his being-in-the-world begins to change. To cut a long story short, Truman

decides to travel to "broaden his horizons" only to hit a wall painted sky while sailing into the horizon, the edge of the show's studio set (boundary) Truman discovers a door labelled exit, bows out of the show and walks through the door changing the perspective of his horizon. In reality though one cannot touch horizon as Truman did as to us horizon is not physical, but a conceptual perspective of our aspirations that we predict and strive towards. Instead, the horizon can never be reached, it is always just out of our control. Horizon is believed by Heidegger to expand and contract as it accompanies us through life. Horizon then is not about the limits of understanding, but about possibilities and being-in-the-world in relation to fore-futures, space and time (Heidegger 1962).

3.7 CHAPTER SUMMARY

The effects of the political climate on nursing research cannot be disregarded and may in fact be a limitation of this research study. Unfortunately, it is the search for solid facts and figures such as cost effectiveness, accountability and performance indicators that is the contemporary philosophy of a market economy. The necessity for nursing to justify practice and protect its positions could possibly entice a resurgence or reinforcement of the positivists' paradigm as a foundation for nursing knowledge, particularly moreover with the endeavour to intensify the scientific ranking of nursing in its battle to form its own unique body of knowledge (Playle, 1995). This is a usefulness that cannot be abandoned, but that could unjustly disregard the importance of research studies utilising the interpretive paradigm and Heidegger's hermeneutic philosophy. The interpretive paradigm addresses and develops understanding of human experience that is person centred and holistic in nature, enabling this research study to gain rich knowledge and insight about nurses involved in the work of death investigation, which the positivistic

paradigm has been unable to yield. In summary, this research study is based on Heideggerian hermeneutics. The goal is to discover meaning and achieve understanding with the focus being on interpretation and meaning. The study aims to accurately describe and interpret participants' meanings and practices, through the identification, description and interpretation of common practices, which in turn will enable important and hidden aspects of practical knowledge to be revealed. However, it is recognised that the use of Heideggerian hermeneutics is always open to change and criticism and that it acknowledges that the development of knowledge is never complete.

This chapter justified a hermeneutic investigation under the interpretive paradigm, with the intent of illuminating and enhancing hidden knowledge. This is justified since it is the strength of this philosophy that positively facilitates intimacy and provides a means of uncovering information that can contribute to remarkable, intellectual and wise understanding. The study design has been presented, discussed and analysed form ontological, epistemological and methodological aspects in an abstract form. Chapter Four provides a detailed description of the data collection and analysis methods, underpinned by the hermeneutic philosophy of Heidegger, with the intention of supporting the decisions made throughout this chapter.

CHAPTER FOUR

STUDY DESIGN: APPLIED TO METHODS

4.1 INTRODUCTION

This research study is qualitative in nature and is involved with gaining meaning and understanding of Being from nurses involved in the work of death investigation in the USA under the umbrella of the interpretive paradigm and Heidegger's hermeneutic philosophy. The justification of using Heidegger's hermeneutic philosophy is that it embraces the exploration of the ontological as well as the epistemological of the subject under study, enabling a more holistic view of meaning and everydayness. Nurses' current everydayness or common ways of being will therefore be illuminated.

The aim of this chapter is to provide a detailed description and critical discussion of the actual plan used for accomplishing this study, so that the reader can fully follow the research process carried out. Supplementary to this, the intention of this chapter is to enable future replication of this study and to demonstrate the study's relevance to other situations. As a result, the issues addressed are in relation to the procedures of data collection, sampling, protection of participants, analysis and finally timing which will be alluded to throughout. The chapter will begin by applying Heidegger's hermeneutic philosophy to the research methods based on his four philosophical concepts of: being-in-the-world, fore-structures, time and space.

4.2 HEIDEGGER'S HERMENEUTIC PHILOSOPHY APPLIED TO METHODS.

Many nurse researchers have used Heidegger's hermeneutic philosophy to guide their methods of research. However, there has been concern in the published literature that some nurse researchers are confusing philosophy with method and have therefore been criticised for the processes of their research (Paley 1988). This has not been helped with the many differing interpretations of how methods under Heidegger's philosophy,

Husserl's phenomenology and the Dutch school's hermeneutic phenomenology should be executed. The most obvious being the inclusion of the concept of the "lived experience" into Heideggerian research when this is in fact a Husserlian concept from the rationalist theories of the French philosopher Descartes (1596-1650), not Heidegger (Paley 1988). Another example is Crotty's (1996) criticism of Benner (1994) who claimed to be following Heidegger's hermeneutic philosophy. However, when studying her work it can be seen to be underpinned not only by Heidegger's philosophy, but also that of the French existential phenomenologist Merleau-Ponty (1908-1961) (1962). Here, one must note that Merleau-Ponty although influenced by Sartre and Heidegger was also strongly persuaded by Husserl's phenomenology.

Nevertheless, Heidegger does not offer research methods that should be employed under his hermeneutic philosophy as his philosophy was written at a theoretical level and not intended for applied research. Hence there is no step by step formula to follow for data collection and analysis. Instead one has to return to the interpretivists to discover that studies under this paradigm are principally concerned with matters of knowing and being by watching, listening, asking, recording and examining. This study believed therefore that it was important to return to Heidegger's four philosophical concepts of Being-in-the-world, fore-structures, time and space to acquire guidance on how the research process should proceed with trustworthiness in order to prevent methods to be mistakenly chosen that are not in line with Heidegger.

Heidegger's (1962) philosophy described **Being-in-the-world** in that we are born into an already existing world and that through a shared social existence, and by way of language we come to be. Our existence determines what we come to know and therefore

understanding of the person cannot occur in isolation from the person's world. In other words the object and the person are inseparable, a holistic phenomenon (as discussed in section 3.6.1). This therefore suggests that the researcher should engage in both descriptive and interpretive activities as Heidegger's approach emphasises the rich description to be found in everyday living, and the interpretive basics of all understanding. In addition, it is important therefore for the researcher to accept and value the descriptions given by the participants as their reality, which is their understanding of the phenomenon (Koch 1999) as it is their horizon being studied. For trustworthy interpretation to take place therefore the researcher must:

- begin by engaging with the phenomenon as soon as the researcher becomes aware of it;
- continue this engagement by becoming immersed in the data collected by listening and reading participants descriptions; and
- finally to look for the fore-structures and thematic meanings held within the data to go beyond meaning rather than only relying on the literal meaning of the participant's words (Mackey 2005).

As previously discussed in section 3.6.2 **fore-structure** according to Heidegger (1962) is what is understood or known about a phenomenon in advance of interpretation. In other words, prior awareness or anticipation of meaning (Mackey 2005). He described this further with the introduction of the "circle of understanding" otherwise known as the hermeneutic circle (Munhall 1986). He believed that the acknowledgement of pre-conceptions can assist in demonstrating any prejudice or distorted account of Being. This therefore suggests that the research should enter the hermeneutic circle at the beginning of the study by acknowledging any presuppositions and to then return to these

presuppositions again at the end of the study having gained deeper insight of the phenomena, providing a holistic view of meaning.

As previously discussed in section 3.6.3, Heidegger (1962) put forward that **time** is how one connects with the world in relation to measured time, that is, temporality or as he put it "datability". Datability encompasses the three interrelated perspectives of past, present and future with Dasien being orientated to the present based on our future and past experiences. It is important therefore in a hermeneutic study that the philosophical conceptualisation of time as temporal is reflected in the research process and in its discussion of the findings (Mackey 2005). This is done by being alert to those things which stand out in the participants descriptions, which situate their experience in time in order to enhance understanding of the experience of time and consequently the nature of Being.

Concerning **space**, Heidegger (1962) deliberates as previously discussed in section 3.6.4, that existence is not only temporal but spatial in nature too. That is, all objects in the world belong somewhere, not in a measured sense though, but with regards to what "matters to a person". Heidegger referred to this as care (or concern). Heidegger also put forward the concept of "horizon", our perspective or point of view. So, it is essential the researcher when describing phenomena situates the participants experience in space, so as to promote understanding of meaning. For example, is the description being experienced in the foreground or background of the participant's horizon?

Based on the guidance offered up by Heidegger's (1962) philosophy above the following methods utilised for this study will now be critically discussed and presented in detail

concerning: the hermeneutic circle, sampling, instrumentation, protection of participants, analysis (including how the findings will be presented) and trustworthiness.

4.3 THE HERMENEUTIC CIRCLE

Heidegger's hermeneutic circle refers to the interaction and relationship between our self-understanding and our understanding of the world. He uses the notion of the hermeneutic circle to symbolise the experience of moving between the two interrelated elements of parts and the whole of Being. This idea of an expanding circle of understanding replaces the image that understanding is linear, a more positivist viewpoint. Instead holistic understanding is circular in the sense that it continually refers back to itself, examining its assumptions, reviewing progress and recognising the success in its continual developments from parts to whole, as to understand the whole is to understand all of its constituent parts and vice versa. The best simple example is that of a jigsaw puzzle, where the individual jigsaw pieces (parts) are interdependent to each other in making a picture (whole). In others words the idea of holism is more than the sum of its parts, but an integral whole. Another example can be seen below with the play on individual letters as parts and words as a whole in promoting understanding (McDonald 2007).

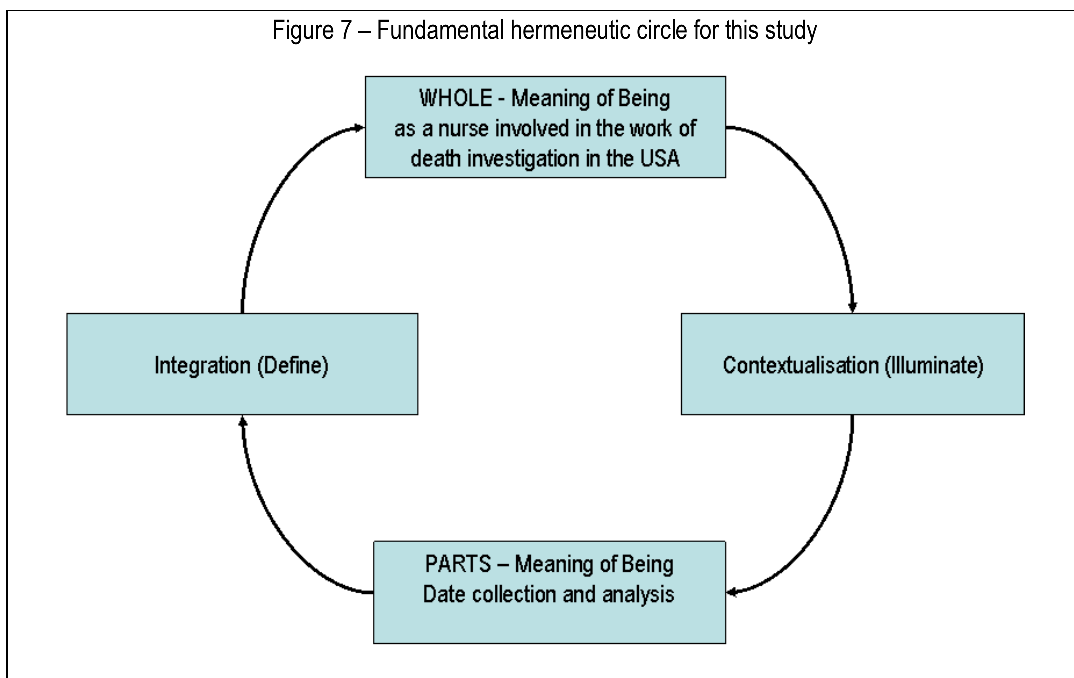
THE PAOMNNEHAL PWEOR OF THE HMUAN MNID. Aoccdrnig to a rscheearch at Cmabrigde Uinervtisy, it deosn't mttaer in waht oredr the ltteers in a wrod are, the olny iprmoatnt tihng is taht the frist and lsat ltteer be in the rghit pclae. The rset can be a taotl mses and you can sitll raed it wouthit porbelm. Tihs is bcuseae the huamn mnid deos not raed ervey lteter by istlef, but the wrod as a wlohe.

Here we see that a word cannot be understood by analysing the letter alone, but also that sentences cannot be interpreted by analysing the meaning of words alone. The fact that one understands a sentence is because it is part of a larger whole that is interpreted by means of the context in which it is found. It is this underpinning framework of the hermeneutic circle and holism that has been used to inform and undertake all elements of the research process for this study. Crotty (1998) defined the hermeneutic circle as an attempt for the researcher to understand:

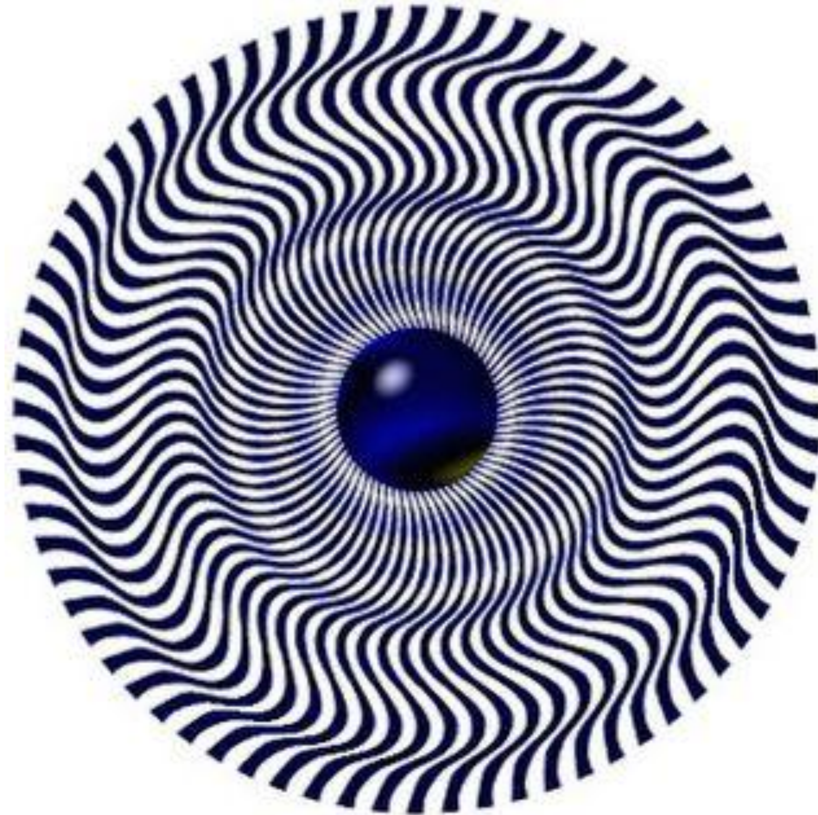
> "…the whole through grasping its parts, and comprehending the meaning of the parts divining the whole" (p92).

In other words, the process involves examination of the parts, by defining each component before it is then integrated into the whole. The fundamental hermeneutic circle for this study is based on the work of Bontekoe (2000) (see figure 7).

Figure 7 – Fundamental hermeneutic circle for this study



This is symbolised further in Heideggerian terms as a horizon of experience and understanding of Being that is in need of interpretation due to hidden knowledge, liking to an iceberg that can be seen above, but not below the water when sailing. For example, on first impression to the observer when viewing the pictorial circle below (McDonald



2007) what should be a stationary circle appears to be moving, almost spinning and to be three dimensional in nature. However, one soon learns this is in fact only a perception as when we draw on our other experiences and understandings it contradicts this conclusion.

In other words, optical illusions can occur when there is conflicting data. Just like experiences can be misunderstood if the relevant data is unavailable or explained incorrectly to us. The idea of the hermeneutic circle then is to promote agreed communal understanding and meaning and to prevent misunderstandings through trustworthy data collection and analysis. This was undertaken by the continual re-examining of all aspects of the research process until a settled consensus of meaning of Being as a nurse involved

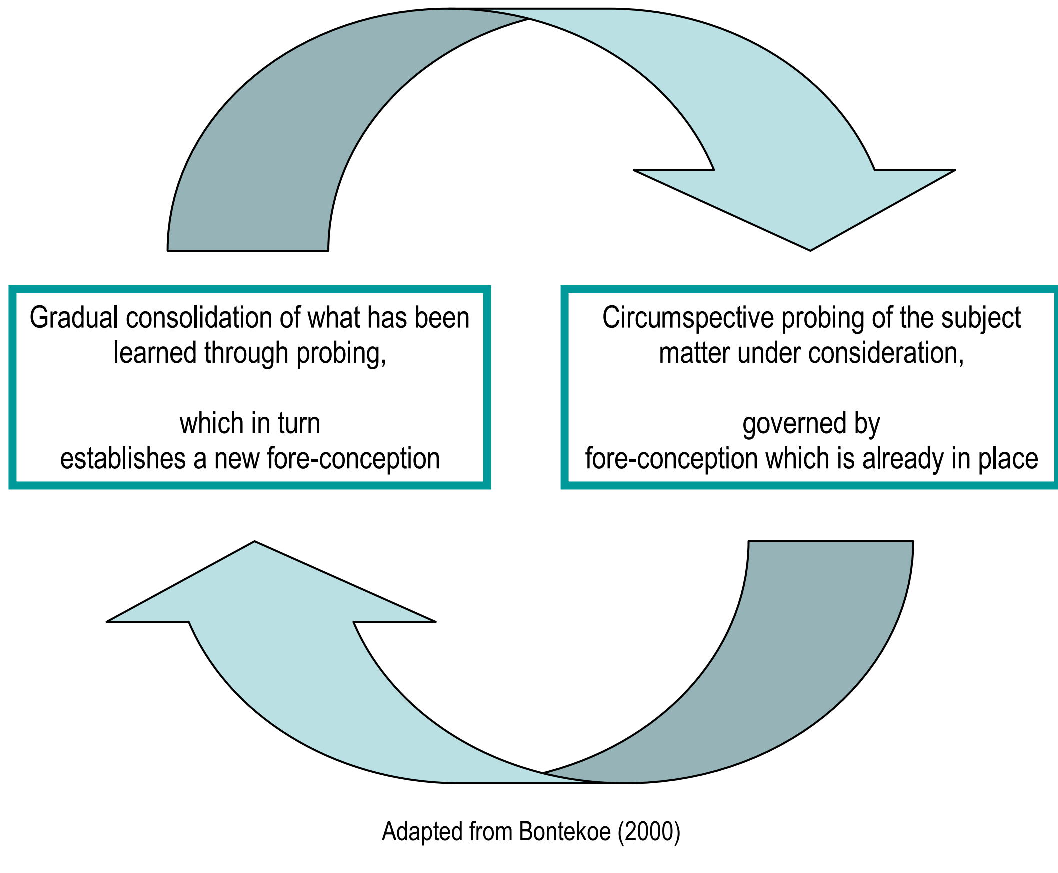
in the work of death investigation in the USA had been achieved by the participants and me the researcher.

The beginning of the hermeneutic circle under Heidegger's philosophy is the expectation to acknowledge any assumptions (that is pre-existing beliefs and knowledge) that may influence the data collection and consequent data analysis. This is in direct contrast to Husserl's phenomenology that requires the researcher to bracket their own pre-conceptions about the subject under study. These assumptions will therefore be presented at the beginning of the Findings and Discussion Chapter in section 5.2 in order to contextualise the findings being presented.

In summary, the meaning of Being according to Heidegger lies hidden in the depths of our experiences which cannot be retrieved and clearly explained in a single instance or in research terms in one episode of data collection or analysis. Instead, in order to view the meaning of Being more clearly Heidegger suggests that the analytical exploration of hidden meanings (forays), for example the iceberg section above the water, should be approached gradually on a successive number of occasions over time using the hermeneutic circle. These forays can also, as an act of interpretation, begin to be explained and illuminated based on the implied pre-understandings already uncovered (Bontekoe 2000). For example, the idea that the past can only be understood in the light of the present and the present can only be understood in the light of the past. Heidegger's hermeneutic circle provided clear defined circular and continual successive stages to assist in uncovering the meaning of Being which in turn has been applied throughout the research process for this study, utilising the following framework (see figure 8).

Figure 8

Underlying framework for uncovering the hidden meaning of Being
was used repeatedly throughout the research process

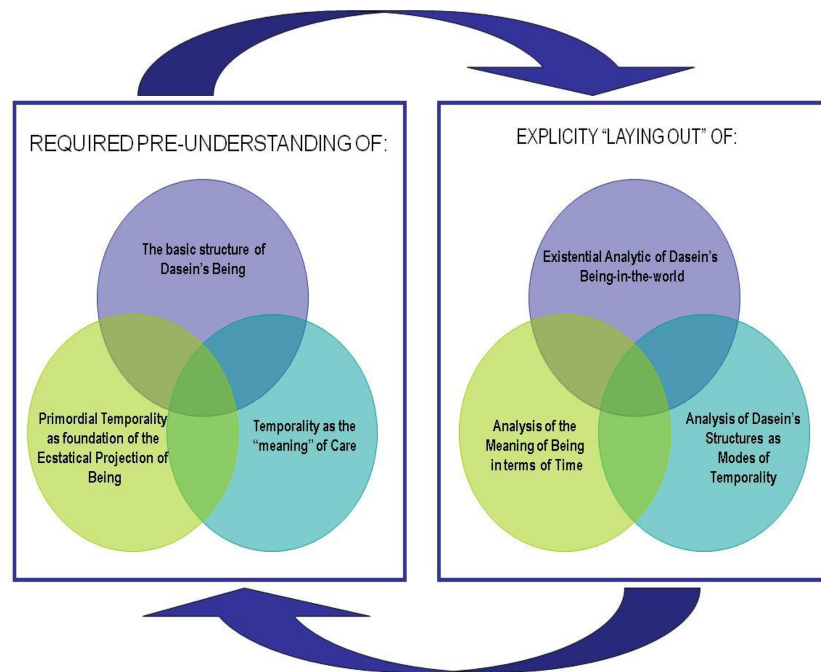


Adapted from Bontekoe (2000)

As well as underpinning the study with the above framework of circular and continual successive stages to uncover the hidden meaning of Being, a representation of Being was developed based on Heidegger's work to provide clarity for the data collection and analysis process (see figure 9).

Figure 9

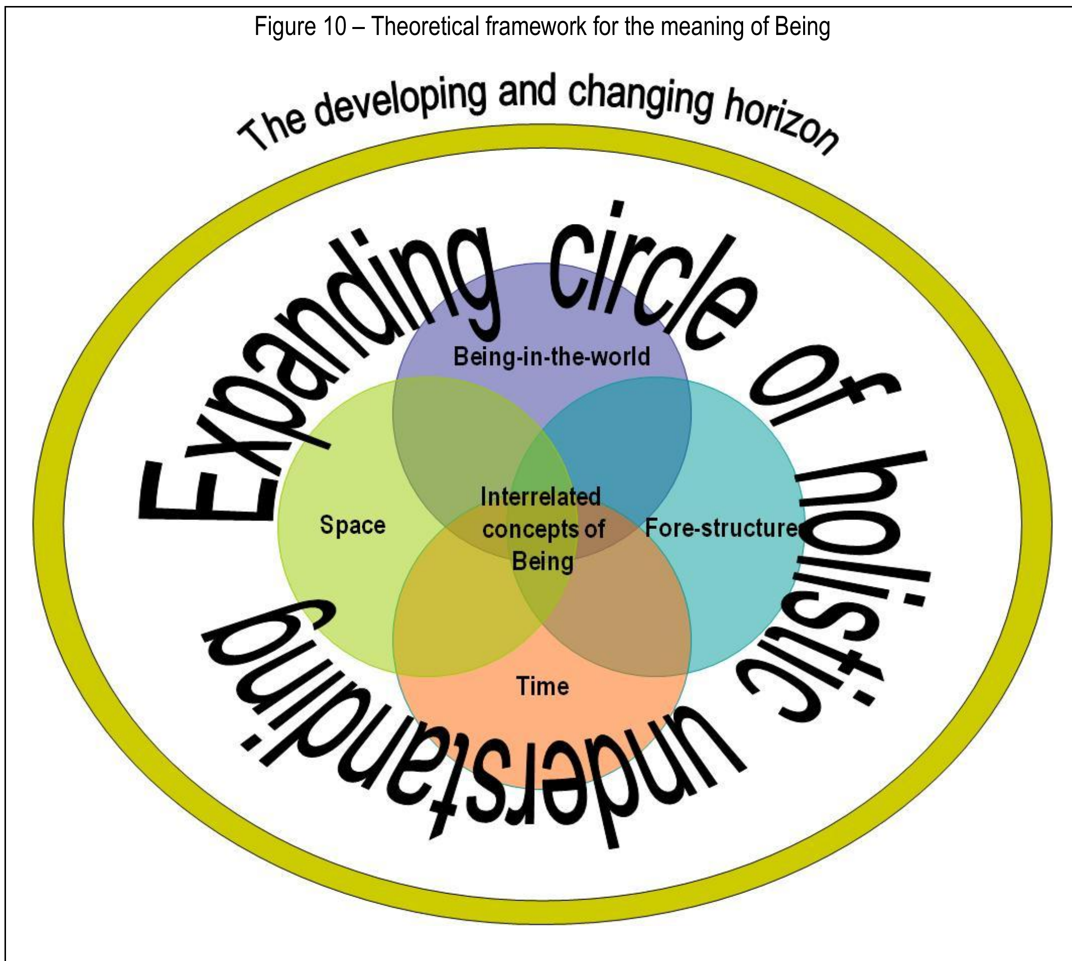
Heidegger's Circular Structure of Being and Time that informed the data collection procedures and interpretive analysis.



Adapted from Bontekoe (2000)

The study recognised that there was a need to develop a more simplistic overall theoretical framework for the meaning of Being where one sees the horizon constantly developing and changing dependent upon the four concepts Being-in-the-world, fore-structures, time and space that could be applied to the research process. It is this model illustrated overleaf (figure 10) that provided the backdrop for exploring the meaning of Being as a nurse involved in the work of death investigation in the USA. It is now with this in mind, that the detail of the methods used will be critically presented.

Figure 10 – Theoretical framework for the meaning of Being



4.4 SAMPLING

A sample is a subset of the population of interest. For this study the population consisted of those nurses who were involved in the work of death investigation in the USA. However, to ensure that a homogeneous sample was gathered, an inclusion criteria for potential participants was drawn up (see appendix 5) to ensure that the data gathered would reveal the meaning of Being to the nurses under study.

Despite having clear criteria for potential participants to be included, finding such a population was difficult as there was not (and still is not) any definitive list or register as such that can be utilised to find nurses who are involved in the work of death

investigation. Coroner and death investigator societies and State Boards were contacted as well as the International Association of Forensic Nurses in a quest to find such individuals, to no avail as the name of the person was needed first to confirm that such a person existed in that role. No other records were available to interrogate as either no records were kept as to where nurse coroners/death investigators were located or which coroners/death investigators were in fact nurses as such information was deemed as confidential and not for public use. The only information available was which death investigation systems were being used per state (see picture below) and county. In other words, a hidden and hard to reach population had been stumbled across. Therefore a different tactic had to be instigated.

Bureau of Justice Statistics (2007)

On return to the literature and the World Wide Web, it was noted where some such nurses might be located and practising as coroners or death investigators. It was decided therefore that the most appropriate action was to instigate the snowball sampling technique (Vogt 1999). Nurses identified were as a result contacted in the first instance and approached to participate provided they met the inclusion criteria. Further potential participants were selected by means of nominations or referrals from the previously chosen participants, who then in turn nominated other individuals until no new relevant referrals were made. This means that a non-random sampling method was used as an informal method to seek out the target population.

It was recognised nonetheless, that the snowball sampling technique does have its difficulties as it can produce problems of representativeness and bias as participants nominate other potential participants from their own social network leading to some networks not being tapped into. To counteract this, the decision was made that it was very important if possible that nurses working within such roles should be sought from a range of States within the USA so as to avoid a slanted interpretation of the meaning of Being.

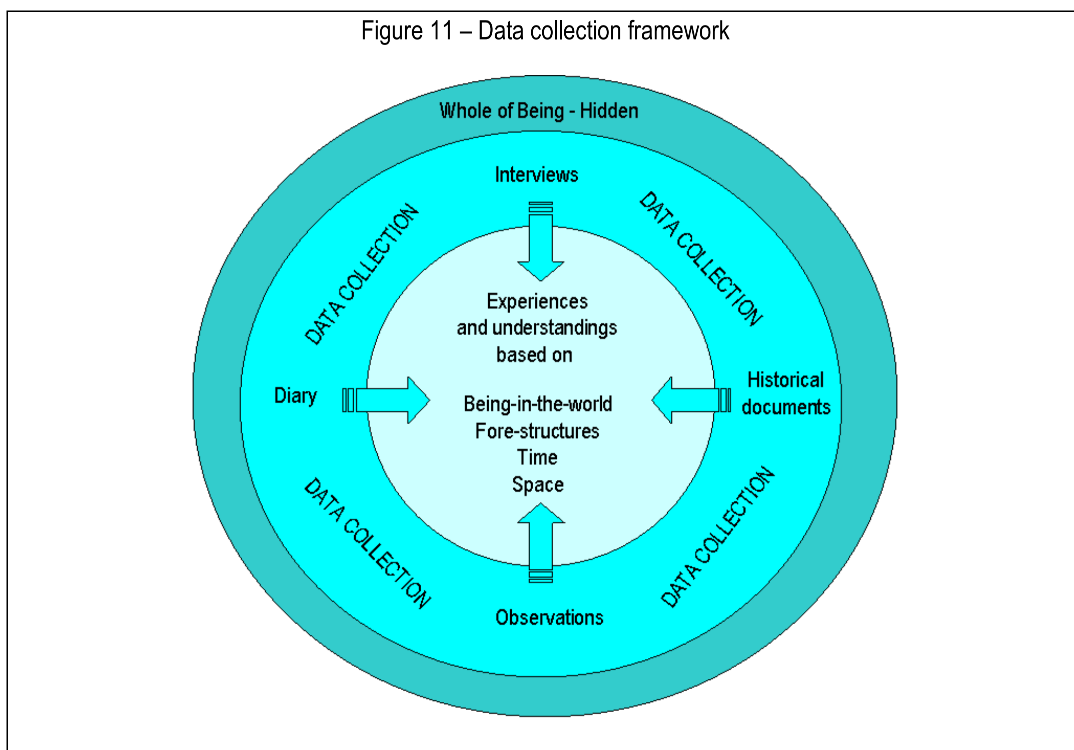
The size of the sample to be included within this study was not identified numerically, but based on the belief that the sample size is considered adequate when no new information is forthcoming from participants. This is not in relation to saturation though as theoretical saturation is not sought in hermeneutic studies as it is the temporality of truth that is recognised. Nevertheless, it was anticipated that the sample would not be large in size (positivists view the need for large samples to enable generalisation), but somewhere between six and twenty five. This decision was justified as if the sample becomes too

large in interpretive research the richness and depth of meanings extrapolated from participants are more likely to be lost (Holloway and Wheeler 1996).

4.5 INSTRUMENTATION

The collection of data through the use of non-participant observations, unstructured interviews, historical documents and a reflective diary were techniques used for this study as it correlates well within a hermeneutic philosophy (see figure 11 below).

Figure 11 – Data collection framework



The observation and interview technique were chosen so as to encourage participants to describe the phenomena of interest as openly and in as much detail as possible. The advantage of such methods is that they illuminate previously hidden knowledge, with the positive ability of being able to look at familiar situations with fresh eyes. In other words from an ontological standpoint at taken for granted experiences of the world in order to explore the meaning of Being as a nurse involved in the work of death investigation in the

USA. The gathering of data from historical documents and the keeping of a reflective diary by me was justified as it not only assisted in providing the context and factual evidence of the experiences and understandings described and presented by participants, but also assisted in making available a means of corroboration to enhance trustworthiness.

4.5.1 Unstructured non-participant observation and field notes

The unstructured non-participant observation schedule was developed following completion of the literature review (see appendix 6). While this schedule was guided by the overall research question the aim of the observational method of data collection was to collect information that was related to contexts, experiences and structures. It was also deemed important, as the study is exploring the meaning of Being, to be alert for descriptions of: Being-in-the-world, fore-structures, time and space.

A time restriction for the participants was set for observational periods in that they were equivalent to one nursing shift, be this at day time or when on call at night or the weekend. Nevertheless, this entailed anything from two to twenty one observational appointments per participant dependent on their availability. Arrangements concerning the set up of such appointments were made in advance when the study was discussed with potential participants and formal consent took place for those participants wishing to be involved (see appendix 9 and section 4.6 for further details). Details numerically on the total number of observations made is discussed in section 5.3 of the Findings and Discussion chapter.

It was anticipated in advance that non-participant observation techniques can give the impression to participants that the researcher is very removed, disconnected and uncaring from the situation at hand especially as by profession I as the researcher am a registered nurse observing nursing. Normally, if one were researching in the United Kingdom and assistance was required, then obviously the observation would be immediately stopped and help would be given within determined role boundaries. However, researching nursing experience in the USA was a different matter as here my nurse registration was not recognised and I was also uninsured. To prevent these potential thoughts and or perspectives to interfere with the data collection, the meaning therefore of non-participant observation was reinforced in detail so that there were clear lines of responsibility concerning "nursing" care. This is discussed in more detail in section 4.6.

Various positioning approaches as the observer were utilised depending on the activity being undertaken by the nurse. For example, when nurses were involved in communicating with relatives in an office setting, single positioning was used, where I stayed in one location for a period of time to observe the experience. Furthermore, mobile positioning was also employed so that participants could be followed throughout a period of time or activity, for example when nurses were required to travel to a destination. Finally multiple positioning was incorporated too as part of the data collection so that behaviours could be observed from a number of different angles or locations. For instance, when nurses were attending death scenes.

Fields notes using the schedule were recorded during and after observation periods and included daily records of people, events, conversations and notes concerning my endeavour to interpret and understand the data through synthesis. In other words, the attempt to gain a unified holistic meaning of Being made up from the combination the different observations made was also recorded.

The observational schedules were transcribed word for word, on to a Personal Computer with a Microsoft ® Word/Version 6.0 package. Once completed the observational schedules were reviewed again to check for omitted words or misunderstandings and consequently corrections were made. These were then returned to the participant for verification. The transcriptions were then saved to both the hard drive and a compact disc. A paper copy and the compact disc of the transcriptions along with the original schedules were locked in a filing cabinet and a pass word assigned to my personal computer.

4.5.2 Unstructured interview

The unstructured interview guide was developed following completion of the literature review (see appendix 7), resulting in two main questions that were asked:

- What prior experiences and/or understandings bought you here in becoming a nurse involved in the work of death investigation?
- What have been and are your experiences and/or understandings as a nurse involved in the work of death investigation?

The two questions were developed in order that the four concepts of being-in-the-world, fore-structures, time and space could be unearthed in turn providing a contextual perspective of the experiences and understandings being described and presented. In addition this enabled there to be flexibility in enabling participants to follow their own thoughts and describe their perspectives on Being, with minimal direction and control by me. Furthermore this ensured that similar types of data from individual participants could be collected in relevance to the overall study.

No time restriction was set for the interviews undertaken, only that the participants were informed prior to the interview taking place that it was anticipated that at least three interviews over time would be undertaken at around one hour each. It was their decision as to what day and time the interview should start. However, if participants wished to talk for longer or less than one hour then they were assured that this would not be a problem providing that they remained comfortable. This was to ensure that participants were still able to plan their working day without too much interruption. It was also the participants' decision concerning the location of the interview as long as they were able to guarantee that there would be no distractions or interruptions, with the exception of an emergency. At least one interview with every participant was face-to-face. However, some interviews due to the distances involved in meeting with participants over a period of time were conducted by telephone. Results regarding this are presented in the Findings and Discussion Chapter.

Participants were made aware prior to interviewing that the interviews would be tape recorded and consent was sought from them for this. Traditional tape-recording equipment was used for face-to-face interviews, so as to alleviate the feelings of intimidation and obtrusiveness on behalf of the participant and produce less clutter. A voice activated recorder was used to tape the interviews that were undertaken via telephone set on speaker phone.

The recorded interviews were then transcribed via a Sanyon Memo-Scriber TRC7050A, word for word, on to a Personal Computer with a Microsoft ® Word/Version 6.0 package. Once completed the taped interviews were listened to again while reading the transcript to check for omitted words or misunderstandings and consequently corrections were made. These were then returned to the participant for verification. The transcriptions were then saved to both the hard drive and a compact disc. A paper copy and the compact disc of the transcriptions along with the original interview tapes were locked in a filing cabinet and a pass word assigned to my personal computer.

4.5.3 Historical documents

Historical documents such as records and statements authored by forensic medical examiners, nurse coroners, nurse death investigators, witnesses and the court (both lay and professional) were used to support and strengthen experiences and understandings presented by participants and to assist in presenting the subsequent findings from a more holistic viewpoint to enhance meaning. This was considered to be particular valuable when historical accounts of experiences and understandings were being communicated by participants.

Public data therefore was photocopied on site with permission from the coroner or forensic medical examiner and later transcribed word for word, on to a Personal Computer with a Microsoft ® Word/Version 6.0 package. Once completed the documents were reviewed again while reading the transcript to check for omitted words or misunderstandings and consequently corrections were made. The transcriptions were then saved to both the hard drive and a compact disc. A paper copy and the compact disc of the transcriptions along with the historical documents were locked in a filing cabinet and a pass word assigned to my personal computer.

4.5.4 Reflective diary

A critical reflective diary was kept throughout the study, including during and immediately after the data collection periods in addition to field notes made after interviews, observations and interrogation of historical documents. For instance entries were made following the first time I accompanied (as an observer) a nurse coroner out on a call at night and following an interview with a nurse death investigator recalling her first experience in managing the removal to a mortuary of a decomposing body found in the undergrowth. Such entries as with other data collection methods used were also transcribed and stored as previously discussed.

The reflective diary was not used solely as a data collection method, but also incorporated the recording of my personal strengths and weaknesses during the study in order to develop and implement actions plans to improve the research throughout the study period. Examples are my personal critical reflections

following meetings with my research supervisors, my sudden feelings and experiences of gestalt (holism!) and my self reminding of why I am researching this subject. This has helped tremendously to keep the study in perspective and to promote confidence in personal beliefs particularly when my periods of study were interrupted.

4.6 PROTECTION OF PARTICIPANTS

It was recognised early on in the development of the proposal for this study that it would require the intimate engagement with not only nurses, but the multi-disciplinary team and general public, a well known characteristic of qualitative research. With this in mind the ethical principles reflected in this study are founded on the four principles approach to biomedical ethics as outlined by Beauchamp and Childress (1994), those being the respect for autonomy, non-maleficence, beneficence and justice along with the challenges of gaining approval for the study, informed consent, confidentiality, anonymity, USA law pertaining to nursing practice, the Nursing and Midwifery Council's Code of Professional Conduct (2004) and issues surrounding the communication of secrets.

4.6.1 Gaining approval for the study

Gaining approval to collect data, analyse and present the findings from this study was an extensive and on-going process, especially with it occurring in a country outside the UK and the complication of snowballing as a sampling technique. This entailed the gathering of approval from the relevant Heads of Department (Chief Coroners or Forensic Medical Examiners) to undertake the research in their jurisdiction where nurses had been identified as practising as coroners or death investigators. Once approval was granted based on the fact that I could

not understandably practice as a registered nurse but only as a researcher, this enabled nurses (potential participants) to then be approached to take part in the study by being interviewed and observed in their everyday practice. In addition it permitted historical records of nurse coroners and nurse death investigators to be interrogated and reviewed to assist in providing context and factual corroboration for the eventual experiences and understandings presented by the participants.

4.6.2 Informed consent and gaining access

Autonomy derives from the Greek for self and rule. It pertains to the ability of people to choose freely for themselves and direct their own lives (Seedhouse 1988). This can be compromised for participants in research studies who may be either influenced by the actual or lack of information given by the researcher. Thus participants have the right to full disclosure, so that the right of self-determination can be honoured. It is only when this has been ascertained that participants can be fully informed about the research, hence enabling informed consent to take place (Polit and Hungler 1993, Lyon and Walker 1997).

Informed consent though is an ongoing process within the philosophy of hermeneutics with its focus being on the meanings and interpretations of participants' experiences, as ideas within this interpretive paradigm are based and developed on the data collected and not by testing hypothesis. This is recognised especially when interviewing participants as it can deeply affect some people who do not just reveal their experiences and thoughts to the researcher, but sometimes become aware of hidden feelings themselves for the first time, bringing into play the principles of non-maleficence and beneficence. For this

reason, it was paramount that when interviewing participants in particular that the interview not only ended on a happy note, but that support was also available from both myself and the Head of Department to work through any issues that were felt by the participant to be affecting and deviating from their normal state of health in relation to their physical, mental and social well-being.

The sample was initially contacted by telephone at departmental level to gain consent for data collection from the Chief Coroner or Forensic Medical Examiner, depending on the death investigative system being practised (see appendix 8 and 9). It was at this time that eligibility for inclusion was verified, the study explained and potential participants put forward by me via the use of a leaflet explaining the study and informing them of my contact details should they wish to take part (appendix 8). Such potential participants were then contacted and again eligibility for inclusion verified and the study explained. If a potential participant expressed an interest in taking part, then informed consent was gained.

The participant was consented by: informing them about the study in detail regarding its purpose and procedures for data collection; discussing the risks and benefits to them in taking part; stating how confidentiality and anonymity would be maintained and discussing voluntary participation and the right to withdraw from the study at any time (see appendix 8 and 9). These discussions also included my role in particular as a non-participant observer. Special efforts were made to ensure that participants understood that consenting to take part in the study also meant that I as a nurse researcher from the UK would be observing (not

practising) in unfamiliar surroundings and so their leadership and guidance concerning health and safety would be vital.

With regards to all of the above, participants were told they could refuse to discuss any issues, terminate any part of the data collection process at any time or withdraw from the study overall for any reason without any resultant detrimental effect to themselves or their death investigation team. A consent form was signed by them and I to this effect (see appendix 9).

4.6.3 Confidentiality and anonymity

With regards to confidentiality and anonymity in particular, all collected data were kept in a locked filing cabinet. Participants' names were not attached to tape recordings, schedules, field notes, transcriptions or saved computer folders, but a participant number assigned instead. Data was accessible only to me and the relevant participant (not the department).

There was however one area that was identified where it would be deemed necessary to breach confidentiality and anonymity of participants, that is my witnessing of unsafe practice during the data collection and analysis process. This entailed the necessary need to inform participants prior to their consent that if I witnessed practice believed to be detrimental to clients (that is, the deceased, family and/or friends of the deceased) or member of the multi-disciplinary team then my advocacy as a registered nurse from the UK would take precedence over the research study. Guidelines had therefore been agreed in advance with the relevant Heads of Departments involved in the study (see appendix 10 to enable

me to take action without going outside my own professional nursing boundaries and that of USA or State law. The prime and most obvious example being of my not having a USA nursing license to practice. This was so Heads of Departments and participants were clear of my role in the UK as a registered nurse) and my role for this study as a researcher (non-practising nurse) in the USA.

4.6.4 Secrets

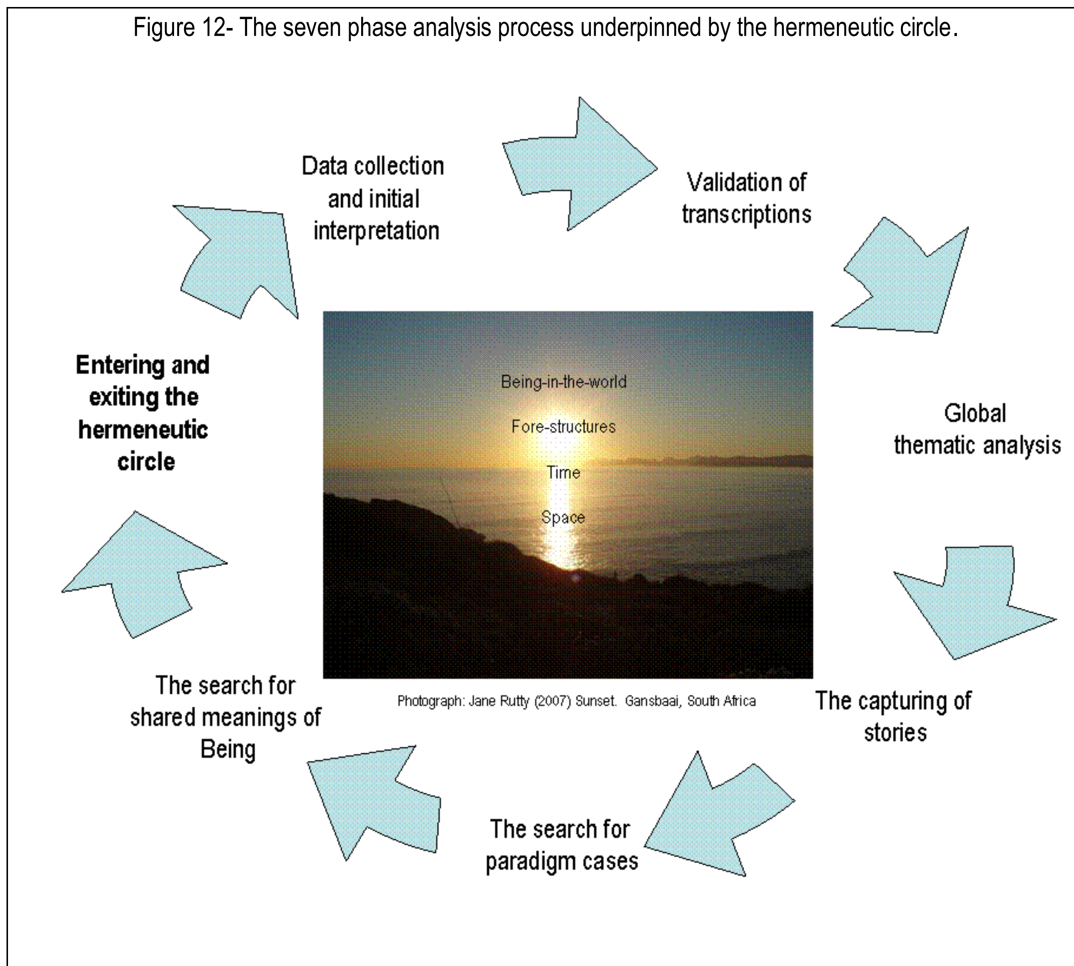
All participants were discouraged from revealing any secrets during the data collection and analysis process unless participants were able to give informed consent for such data to be included in the study. The prospect of participants communicating secrets or an “off the record” remark was considered to be beneficial as it implied that a trusting relationship had been developed between the researcher (me) and the participant. However, this was discouraged from the outset and should have such instances occurred (which they did not) then the participant would have been gently encouraged to refer the matter to the appropriate person.

4.7 METHODS OF ANALYSIS

The goal of hermeneutics is to enable the participants who took part in a study to not only enable the future reader of the study findings to understand their meaning of Being, but to also make sure that they have not been misunderstood. It not about extracting theoretical terms or higher order concepts, but about discovering meaning and understanding (Benner 1985). However, there is very little in the published literature that supplies and details, replicable and applicable descriptions of analysis methods for use within nursing research under Heidegger’s hermeneutic philosophy. Exceptions concerning this

interpretive process include the works of, for example, Benner, Tanner and Chesla (1996) and Leonard (1994). With this in mind, a step by step phase approach for analysis was developed and applied to this study following Heidegger's hermeneutic philosophy and recommendations from the literature (figure 12).

Figure 12- The seven phase analysis process underpinned by the hermeneutic circle.



The following critical explanations are presented in linear fashion for ease of reading. However, the analysis method is in fact circular in motion in that it repeats on itself throughout the process, a recommendation of Heidegger that one should repeatedly reflect and return to both the participants' and researcher's fore-structures as previously discussed. In addition it is considered to be interrelated in nature as it is the analysis of parts of Being that illuminates the whole of Being. The seven phase analysis process

method used supported by the hermeneutic circle for this study will now be illustrated in how one explored the meaning of Being as a nurse involved in the work of death investigation in the USA.

This study believed too that it was important to ensure that Heidegger's four philosophical concepts of not only fore-structures, but Being-in-the-world, time and space remained alerted to throughout the analysis process. Ensuring that the philosophical concepts underpinned the analysis provided confidence that Heidegger's philosophy was being followed and that other philosophies did not become integrated mistakenly, in turn promoting an authentic method.

4.7.1 Phase 1 – Entering the hermeneutic circle

On entering the hermeneutic circle, my own experience and knowledge were acknowledged regarding the world of death investigation in order to remain conducive to Heidegger's philosophy of the rejection of bracketing as previously discussed in Chapter 3. Heidegger valued the critical reflection on one's own acquired related experiences as it is these experiences that make possible the understanding of the experiences of others. In addition this study held that it assists in the illumination of any prejudices that may influence the findings. However, it was not only my own previous experiences and knowledge that was being bought to the study that was considered, but also the understanding of others (not participants) who had published on the subject under exploration. This can be seen clearly in Chapter 2, the Literature Review. Therefore these fore-structures, as Heidegger (1962) describes them, are presented in section 5.2

at the beginning the Findings and Discussion Chapter, in order to set the scene and returned to throughout the discursive process.

4.7.2 Phase 2 - Data collection and initial interpretation.

Phase two enabled all initial interpretations made by me of the data collected to be validated by the participant involved. This involved all participants checking any interpretations I had made immediately after, for example the interview or observation period. These interpretations were then validated by the participants by comparing their own perspective and changes were made as necessary. The advantage of this method is that participants felt they owned the interpretations that had been initially made by me and solidified the beginnings of a trusting relationship between researcher (me) and participants.

4.7.3 Phase 3 – Validation of transcriptions

As described in section 4.5 concerning instrumentation and transcription, all data collected was transcribed as soon as possible. Once completed the transcripts were reviewed again to check for omitted words or misunderstandings and consequently corrections were made. These were then returned to the participants for verification. Again, this effort to establish the truthfulness of data was not only about enhancing trustworthiness (as discussed in more detail in section 4.8), but about maintaining the research/participant positive relationship.

4.7.4 Phase 4 – Global thematic analysis

This phase involved the reading of all transcriptions several times in order to gain an initial global view of participants' horizons concerning the overall research

question, viewed as the beginnings of becoming immersed in the data. On the re-reading of transcripts, themes that consistently emerged were identified and provided the ability to develop the beginning of an interpretive plan. All the transcriptions were then read for the third time from the perspective of the first interpretive plan and even more themes added if necessary. What were felt to be missing data or in need of further clarification was logged and further exploration was sought from previous participants, for example by being re-interviewed or questioned regarding historical documents. Alternatively, if past participants were unable to close the gap, then this also guided the data collection process for subsequent participants. This additional data was then also subjected to analysis and added to the interpretive plan. Phase 3 of the analysis became complete when no new participants were consented into the study due to there being no new themes emerging and categories were able to be formed from the themes, which in turn provided the basis of the study's findings. This phase illustrates the process of both data collection and interpretation occurring at the same time.

4.7.5 Phase 5 – The capturing of stories

Following on from the global thematic analysis, phase 4 leads on to the capturing of stories to capture meaning, viewed as becoming totally immersed in the data. Meaning being that when one read the story, the meaning is believed to be true as it can be applied to other circumstances or experiences of the reader. This was achieved by sharing such stories with the study participants and gaining their validation. However, before validation could occur interpretive writing of the stories needed to take place. It began by making summaries of the central concerns within the data along with the relevant excerpt, resulting in the

beginning of a participant's story. These early writings enabled the forming of interpretation to begin. As interpretations emerged they were revised through regular revisions by returning to original transcripts as necessary. It was here that the initiation of paradigm cases began to come into view.

4.7.6 Phase 6 – The search for paradigm cases

Paradigm cases are forms of narrative analysis, not case studies (Leonard 1989) in that although analytical in nature, it looks at stories from the outside in and after the fact. Phase 6 then, named as the search for paradigm cases, involved the exploration for strong instances of particular patterns of meaning within stories. These were then compared to current theory and/or to critical discussions about clinical practice within the published literature to promote understanding and explanation of the stories when presenting the findings underpinned by the four concepts of Heidegger's Being: Being-in-the-world, fore-structures, time and space.

4.7.7 Phase 7 – The search for shared meanings of Being

It was phase 7 that focused on looking for shared meanings or central concerns that were extrapolated across stories and paradigms in order to develop summaries. It was these summaries (not theories as in grounded theory) that were then used to provide a synopsis of the meaning of Being as a nurse involved in the work of death investigation in the USA as presented in section 5.5 of the Findings and Discussion (chapter 5). The synopses were disseminated to all participants who took part in the study for final verification (for further detail regarding the criteria see section 4.8.1 on trustworthiness and credibility).

In summary, the interpretive framework technique used for this study was thematic in nature as it correlated well within a hermeneutic philosophy (see figure 13 below). It has been shown that the interpretive process of analysis undertook continual interpretive writing that took place in parallel with data collection through unstructured interviews, non-participant observations, interrogation of historical documents and the keeping of a personal reflective diary.

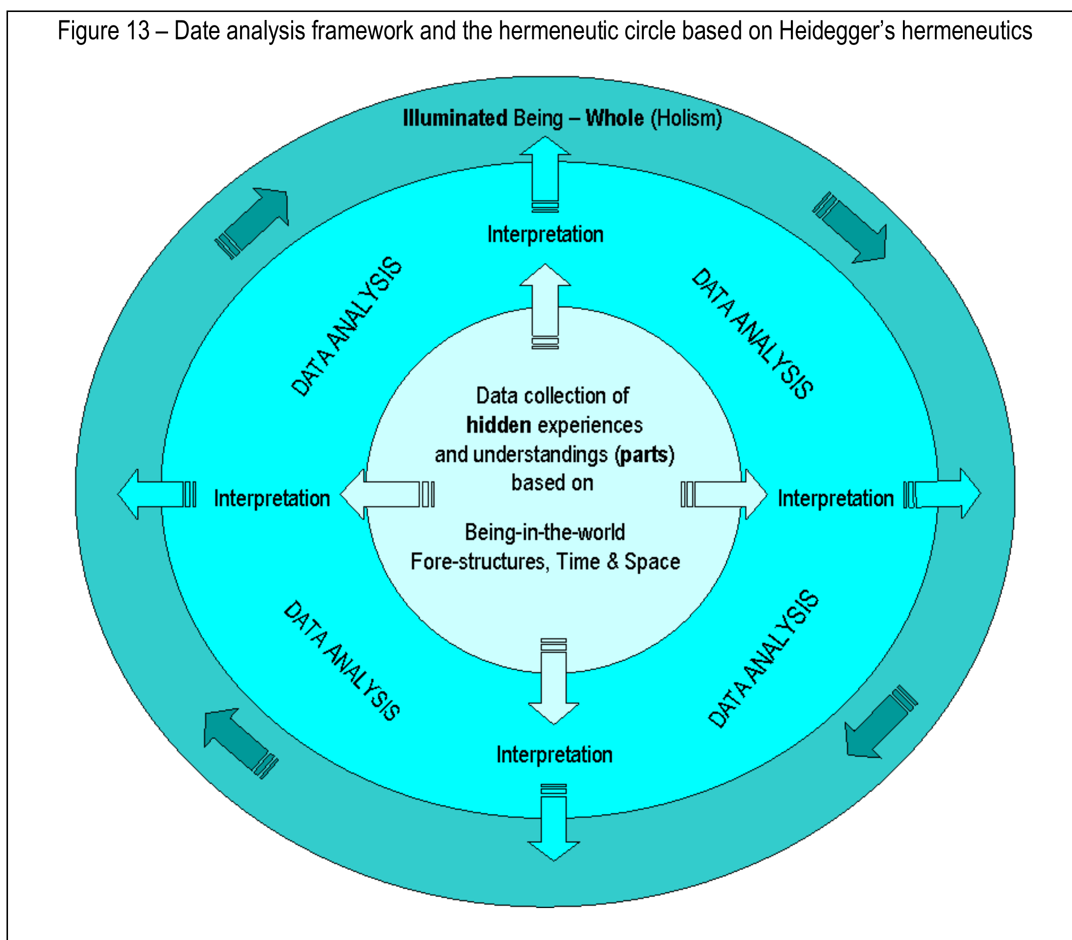


Figure 13 – Date analysis framework and the hermeneutic circle based on Heidegger's hermeneutics

4.8 TRUSTWORTHINESS

It has been argued by Wheeler (1992) that issues concerning validity and reliability are different when dealing with qualitative data and so the terms should be known as trustworthiness and rigour, respectively: trustworthiness existing when the findings of a

qualitative study represent reality; rigour is shown by establishing trustworthiness (Holloway and Wheeler, 1996).

The essential purpose of trustworthiness and rigour is to ascertain if the data collected and analysed represents the true phenomena under study. In other words, the qualitative data via unstructured interviews, non-participant observation, interrogation of historical records and my reflective diary, represent through interpretation the true state of the meaning of Being as a nurse involved in the work of death investigation in the USA. It is paramount therefore, that these issues of trustworthiness and rigour are critically discussed and applied to this study. The criteria for establishing trustworthiness and rigour according to Guba and Lincoln (1989), Robson (1993) and Koch (1994) relate to credibility, transferability, dependability and confirmability underpinned by a decision trail (Whitehead 2004) which will now be presented.

4.8.1- Credibility

Credibility is used to evaluate the quality of data and refers to the confidence in the truth of such data. With this in mind, credibility has been ensured by providing clear detail regarding the inclusion criteria for potential study participants (see appendix 5) and by illustrating truthfully those participants who took part during the Findings and Discussion Chapter (see chapter 5, section 5.3). Credibility has been enhanced further through the acknowledgement of my own assumptions (that is pre-existing beliefs and knowledge) that may have influenced the data collection and consequent data analysis and interpretation as recommended at the beginning of Heidegger's hermeneutic circle. This too is presented critically in section 5.2 (see chapter 5). To demonstrate that the study

findings do in fact represent truth, Robson's (1993) recommendations on improving creditability has also been addressed concerning: prolonged involvement, persistent observation, triangulation, and member checks.

Prolonged involvement and persistent observation or engagement is upheld through the time spent in data collection processes in gaining trust and knowledge about the participants under study and by guaranteeing that there had been no misunderstandings concerning the meaning of Being as a nurse involved in the work of death investigation in the USA. This is clearly evidenced when reflecting back on the methods of analysis (section 4.7) and the research study timetable.

Triangulation is recommended to be used in qualitative research to further the probability that the findings presented are credible. This is evidenced in this study through the use of multiple methods of data collection, that is, unstructured interviews, non-participant observations, interrogation of historical documents and the keeping of a personal reflective diary. This has enabled data collected to be checked against each other for accuracy. Examples include the exercise of comparing historical records with unstructured interviews and the use of measuring up the accuracy of non-participant observations with my personal reflective diary.

The criteria of **member checking** have been fulfilled as the findings were verified by all participants who took part in the study. It was intentional that all participants took part in comparing the study's findings with their own perspective

of the meaning of Being. All participants therefore were asked at each stage of the analysis process to confirm that their descriptions and understandings of the meaning of Being as a nurse involved in the work of death investigation in the USA had been interpreted truthfully with regards to the following criteria that they were able to:

- recognise their own understandings and meanings within the interpretations presented to them;
- make known to me any omissions or misunderstandings that were present in the interpretations and hence in need for additional data or correction.

To be refreshed on this information in detail refer back to the methods of analysis in section 4.7.

4.8.2 Transferability

Transferability in qualitative research relates to generalisability or how the findings from the sample can be transferred to the rest of the population. Generalisability in qualitative research in different to that of quantitative research as it is not about being able calculate the distribution of a phenomena statistically, but about the ability to understand the phenomena. With the addition of providing details concerning justification for decisions made in both chapters 3 (study design) and 4 (this chapter), the study has been careful to ensure that the context when describing the meaning of Being within chapter 5 (the Findings and Discussion chapter) is unambiguous. The inclusion of Heidegger's four concepts of Being-in-the-world, fore-structures, time and space has fulfilled this criteria by ensuring that there is no confusion as to where and who the data is transferable.

A summarised Research Decision Trail taken from the justified critical discussions of Chapters 3 and 4 can be viewed in appendix 11.

4.8.3 – Dependability

The stability of data over time and over conditions is referred to in qualitative research as dependability and is reliant on credibility as if credibility is established then the study is also considered to be dependable. A way of assuring this is through stepwise replication (Polit and Hungler 1993). Repeated interviews and observations therefore took place to ensure that the data produced was similar in nature and that interpretations made by me were validated by participants. A summarised Research Decision Trail taken from the justified critical discussions of Chapters 3 and 4 can be viewed in appendix 11 to follow the research process.

4.8.4 - Confirmability

To persuade others that the research data is trustable, qualitative researchers use the criteria of confirmability. Confirmability is about demonstrating and confirming that the data collected in a research study is linked to the interpretations and conclusions presented, evidenced through the use of an audit trail. An audit trial therefore was produced (see appendix 14) to enable the examination of early intentions of the study, study processes, development of data collection instruments, collected raw data, analysed data and formation of findings. The audit trial is referred to in more relevant detail in Chapter 5, the Findings and Discussion.

In summary, a number of processes were put into place to assure trustworthiness, namely credibility, transferability, dependability and confirmability. Credibility has been achieved through the accurate description of participants. Transferability has been accomplished in the sense that detailed context has been provided when critically discussing the findings. The gain of dependability is evidenced through the inclusion of a summarised research decision trail and finally confirmability with the production of an audit trial.

4.9 REPORTING THE FINDINGS

In qualitative research it is usual that the findings and discussion sections are integrated as is in this study, being divided into three main sections. The first section focuses on acknowledging my own assumptions that may have influenced the research findings, followed on by descriptive statistics concerning the data collection and participants who were included. The third section critically discusses and presents through paradigm cases the interpretive findings and finally the fourth section puts forward a synopsis of the shared meanings of Being.

4.10 CHAPTER SUMMARY

The actual steps of collecting the data are specific to each and every research study and dependent on the research design. Without high quality data collection methods, the accuracy and robustness of research conclusions are easily misinterpreted and challenged. However, this chapter has discussed in detail and justified the application of Heidegger's hermeneutic philosophy, the hermeneutic circle, sampling, instrumentation, protection of participants, methods of analysis and trustworthiness in exploring the phenomenon.

Chapter Five (findings and discussion) provides a detailed, critical interpretation and discussion on "the meaning of Being as a nurse involved in the work of death investigation in the USA" through the use of paradigm cases based on the methods presented throughout this chapter.

CHAPTER FIVE

RESEARCH FINDINGS AND DISCUSSION

5.1 INTRODUCTION

The findings from a qualitative study are unique to that study. Hence, it is not the intent to generalise the findings from this study to a larger population, as a hermeneutic enquiry is not reducible to formal theory or to abstract variables used to predict and control. Instead research under Heidegger's hermeneutic philosophy is about understanding and explaining the phenomena through the temporality of truth and formal discussion underpinned by the four concepts of Being-in-the-world, fore-structures, time and space. It is also recognised that understanding the meaning of a phenomenon in a particular situation is useful for understanding similar phenomena in similar situations (Leonard 1989) and therefore knowledge is considered as being transferable in nature.

This chapter will be launched by providing the reader with an overview of my own personal horizon (assumptions and prejudices) as it changed and developed throughout the research process framed by Heidegger's hermeneutic circle as previously presented (chapter 4, section 4.3, figure 8). Subsequently, the relevant descriptive statistics concerning the sample who participated in the study will set the scene for the findings and discussion. The findings and discussion will then be critically presented using paradigm cases and stories to illustrate the themes illuminated in relation to the meaning of Being, endorsed by an audit trail. Finally, a synopsis of the shared meaning of Being will be submitted concerning "the meaning of Being as a nurse involved in the work of death investigation in the USA".

5.2 CHANGING PERSONAL HORIZON

This study followed Heidegger's hermeneutic philosophy and therefore held that it was vital that my own personal changing and developing horizon should be acknowledged so

that my own fore-structures (assumptions and prejudices) that may have influenced the research process were acknowledged. It is rare to see researchers in the published literature providing such reflective information (Koch 1994), but it is crucial to do so under Heidegger's hermeneutic philosophy to maintain credibility as a researcher. Therefore a reflective presentation will now follow through the circumspective probing of each phase of the research process and my fore-structure that was already in place when first coming to the study. Then, based on the consolidation of what I have learnt as the study progressed illuminate my new fore-structure (horizon).

To gain credibility as a researcher one must provide information concerning one's background and previous experience in coming to the study. Chapter one (the introduction) of this study has already provided the reader with a summary of my background to enable my credibility to be judged in relation to intellectual rigour, professional integrity and methodological competence (see section 1.2 and 1.3). In addition, as previously mentioned in Chapter 3, section 4.5.4 concerning instrumentation and data collection a personal reflective diary was kept throughout the study not only data collection purposes, but to provide the gateway to reflect on my own experiences and prejudices throughout the research process that may have influenced my horizon. This will now be drawn upon to inform the following discussion.

5.2.1 Formulating the research question

My interest in nursing and death investigation began early in my nursing career when I became aware in practice that as soon as the word "Coroner" was mentioned, multi-disciplinary practitioners seemed to me (my assumption and

prejudice) to worry and sometimes even panic, including myself. However, I wondered why were we worried and what were we panicking about?

It was not until some years later, I had the opportunity to study for my MSc with the Royal College of Nursing Institute (London) where I critically analysed the extended, expanded, specialist and advanced role of the nurse from a philosophical, theoretical and practical view point. This broadened my horizons to areas of critical debate I had never really applied to my practice before which was a good thing, but it also led to the niggling personal reflections resurfacing about the Coroner. It was at that moment that I now wanted to know why nurses had expanded and advanced their roles in all specialities related to medicine except pathology. A pattern seemed to me to be emerging in that it seemed that the area of death investigation had either been forgotten by nurses or that such knowledge concerning their contribution was hidden. This in turn led to me exploring the contributory role of the nurse in the Coroner's Enquiry from the Coroners' and Forensic Pathologists' perspective in England and Wales (Rutty 2000). The findings showed that to believe if nurses perform their work correctly they will never be involved in any Coronial matter, was a naive assumption to make. Especially when, the study had shown that the nurse's role may extend to after a patient's life has ended and at times when necessary to the Coroner's enquiry, albeit covert in nature.

It was not long after this revelation when speaking at an international conference in Europe regarding the findings of that study (Rutty 2000) that I uncovered quite by accident, that nurses were working as Coroners and Death Investigators in the

USA. What a discovery! My horizon became suddenly expanded! It was as if a huge hole had been blown in to what I believed to be a comfortable space! The capacity of possibilities concerning nursing and death investigation would now never be the same again in my eyes.

The beginning of this study made it possible for me to critically explore and reflect on the expanded and advanced role of the nurse concerning the coroner, pathology and death investigation particularly in the USA. However, there was no research or evidence published internationally to explain, describe or justify it. It was this lack of illuminated experience, literature, theories and ideas that I believed was constricting and stopping the progress of research in this area. It therefore became imperative to me to discover more about this nursing service and whether such a nursing service offered in the USA could benefit the multidisciplinary death investigation team and general public concerning healthcare in England. Had nursing in England missed a valuable opportunity, an undiscovered potential?

Due to the lack of knowledge available on the subject it was considered essential therefore to explore the entirety of the phenomena rather than focus on specific concepts and to capture the context to enable transferability to England, if applicable. The overall research question went through many developments until it dawned on me that what was needed was a clear understanding of meaning through the exploration of Being so that gathered interpretations could be presented holistically, in line with the fundamental beliefs of nursing.

To justify such a research question I needed to acknowledge if the question was important enough with practical applications and whether nurses, the multi-disciplinary team and the wider general public would benefit from the knowledge produced. Also, could this research question potentially help to improve nursing practice and the findings contribute to nursing theory? My initial perspective on this was yes, as it had numerous potential applications not just at home, but abroad too in that an area of nursing would be illuminated enabling research and practice development to progress with the underlying intention to always promote the well-being of the general public. My current horizon (new fore-structure) concerning the research question and the consolidation of what I have finally learned can be seen in more detail in Chapter Six, The Conclusion. However, before you visit that section it is time to step back, reflect on my personal horizon concerning the research process.

5.2.2 Research design

The research design of this study went through many developments under the guidance of my study supervisor. It was obvious from the beginning that it would be interpretative in nature, but values and beliefs in the background of my horizon did come forward with a vengeance on many an occasion. It was particularly in the early stages that confidence was often lost as to the credibility of the design chosen as one became faced with researchers aligned to the positivist paradigm of knowledge generation particularly from the medical and coronial professions.

In essence, after studying various interpretive designs on offer, this study first aligned itself to Husserl's phenomenology. However, I was not entirely content

with my choice, as I found it difficult to justify to colleagues, not due to my lack of knowledge on the subject, but because it just did not fit the research question. It was that jigsaw puzzle again. The wrong piece had been put in the box.

My study design journey then progressed into Heidegger's hermeneutics. Here it felt extremely comfortable and content, but positivists were providing doubt in my stance when chatting at informal research meetings or national and international conferences concerning the lack of validity and reliability and the impossible ability to generalise. Fellow researchers from the medical profession even warned me "to take heed". It was also at this time that I learnt about Heidegger's affiliations with Nazism. This sent my perspectives concerning the research design into chaos.

Hard to believe, but it was then that both chaos and complexity theory took hold of my concentration as I studied the works of Byrne (1998), Peak and Frame (1994), Cowan et al (1999) and Kauffman (1995). In other words, the theory that a change in something seemingly harmless and innocent, such as the flap of butterfly wings, may in fact cause unexpected larger changes in the future, such as a tornado. Now I had not only changed design, but changed paradigm. However, it quickly became known to me that, while I found this theory absolutely fascinating (I had always adored mathematics at school) it was not going to aid in answering the study's research question at any level. So I returned in high spirits back to Heidegger's hermeneutics in the knowledge, conviction and confidence that the design chosen despite his affiliations was indeed justified. This was evidenced to my delight in my ability to provide entertaining discussion to the

shortcomings of positivism and virtues of the interpretive paradigm in relation to this study. More importantly, elevated confidence had been gained through the consolidation of my learning concerning the research design in the knowledge that the philosophy chosen would shape my methods in a logical manner so as to uncover the meaning of Being. More detailed critical discussion on the justifications for the research design chosen can be viewed in Chapter Three, the Study Design – The Justification.

5.2.3 Data collection and analysis

This phase of the data collection and analysis process involved sampling, instrumentation, protection of participants, methods of analysis and trustworthiness all of which are detailed in Chapter Four, the Study Design – Applied to Methods, sections 4.4-5.2.3. However, concerning my changing personal horizon it is relevant here to reflect particularly on the unstructured interviews and the positive effect an incident had on ethics, analysis and trustworthiness.

The start of the data collection saw the first unstructured interviews being undertaken. It was immediately after completing the very first interview that I noted in my personal reflective diary that I needed to be more aware of my non-verbal communications with the participant. While non-verbal communication can be a positive interaction as it encourages the participant to continue with their explanations and descriptions, it could also be harmful ethically. For example, one participant in the interview said:

> *"I'm sure Susan* [name changed] *said the same thing about that yesterday when you went out on that "decomp"* [decomposed body] *case with her?"*

I was suddenly taken by surprise. It would have been so easy to nod and agree. However, I immediately became alerted that this would be an easy way to breach confidentiality and instead reminded the participant gently that I would not be able to convey to her what other participants had shared with me. At first the interviewee was taken aback, but it then had a positive effect on the interview as the participant expressed feeling more relaxed in the knowledge that their interview would in fact remain confidential.

On personal reflection, I recorded this critical incident as despite having piloted my interview technique to ensure my ability in using effective communication techniques the issue of the possibility of breaching confidentiality through non-verbal communication had not been experienced. A conscious effort therefore was made to ensure that an occurrence such as this would not take me by surprise again. It was important therefore to refocus my performance as an interviewer by drawing on my clinical experience and being more attentive to all of my non-verbal communications. Even more so I wanted to ensure facial expressions did not give away not only agreement or disagreement, but revelations or the mundane.

I had mistakenly assumed having been involved throughout my career interviewing patients and families this was indeed an experience I would have

been able to manage successfully as I had done so time and time again in practice. However, I had not come across this before in any of my own research. Nevertheless, I concluded that this incident, although quite fleeting, had indeed confirmed my integrity, credibility and trust to the participant concerned and became a positive learning experience for me to take forward and apply throughout the data collection process. So much so, that when interrogating the data I actively looked for (but did not find) possible mistaken breaches of confidentiality to ensure that there had been no influence on the data collection and consequent trustworthiness.

5.2.4 Summary

In summary, this section has enabled a small glimpse into my own personal changing and developing horizon through the integration of some parts of my personal reflective diary concerning the research question, research design and data collection.

My initial horizon was acknowledged by providing a reflection on my own initial fore-structures (assumptions and prejudices) concerning nursing and death investigation. Such fore-structures that were in place can also be seen at the beginning of this study in the critical discussions that took place particularly in chapters one and two.

Continual circumspective probing has taken place throughout the research process as analysed and synthesised through chapters three and four and the reflective presentations above.

It is this chapter in the presentation of the interpretive findings that one will be able to view a new fore-structure that I have established through the consolidation of both the analysis and personal learning concerning “the meaning of Being as a nurse involved in the work of death investigation in the USA”. This will be illustrated through the following analytical discussions of the study sample and interpretive findings (sections 5.3 and 5.4).

5.3 THE STUDY SAMPLE

The total population of nurses according to the International Association of Nurses (2007) recorded as working in practice as death investigators or coroners in the USA was 98. However, this figure relies on those who are members only and therefore does not take into account those who may be practising who were not members. However, whilst this seemed like a good lead, the association did not record or identify which State such nurses were actually practising in at the time of this study. The term practising also related to those nurses who were academics or researchers and not necessarily in clinical practice. In addition, contact details of such nurses were unable to be released due to confidentiality rules and regulations.

The total population of nurses registered as a diplomat practising as a nurse coroner or death investigator was also not recorded by the American Board of Medicolegal Death Investigators for public view at the time of this study. It is however possible to search the on-line database for such individuals, but unfortunately one needs to know the name of the individual in the first place.

As presented in Chapter Four (instrumentation and methods of analysis, sections 4.5 and 4.7) it was therefore necessary to search for this population using information gained through snowball sampling, published literature and the world wide web during the study period (see appendix 12). This entailed searching through 50 States and some 3,141 counties. The results were disappointing with little published within the literature or the World Wide Web (see appendix 2). On contacting potential participants, and requesting their assistance in referrals, it was noted that nurses often expressed their own frustration at not being able to find other nurses working in similar positions to them. This is still echoed as one views such frustrations openly on the World Wide Web as staff interested in this role attempt to make contacts. Nevertheless, some nurses were able to refer me to other potential participants and subsequently, the sample for this study based on the inclusion criteria (appendix 5) was drawn from a population of 15 USA States, that is 30% of 50 States where nurse death investigators and/or nurse coroners were found to be employed.

These 15 States produced a total population of 27 nurse death investigators/nurse coroners employed in practice of which 22 fulfilled the study's inclusion criteria. A total of 20 nurses consented to take part in the study, but one withdrew due to illness, and two withdrew as they left their position shortly after the study started. This left a total of 17 (77%) participants over 11 States. The details of participants have been tabled in appendix 12, but a summary can be viewed in table 1.

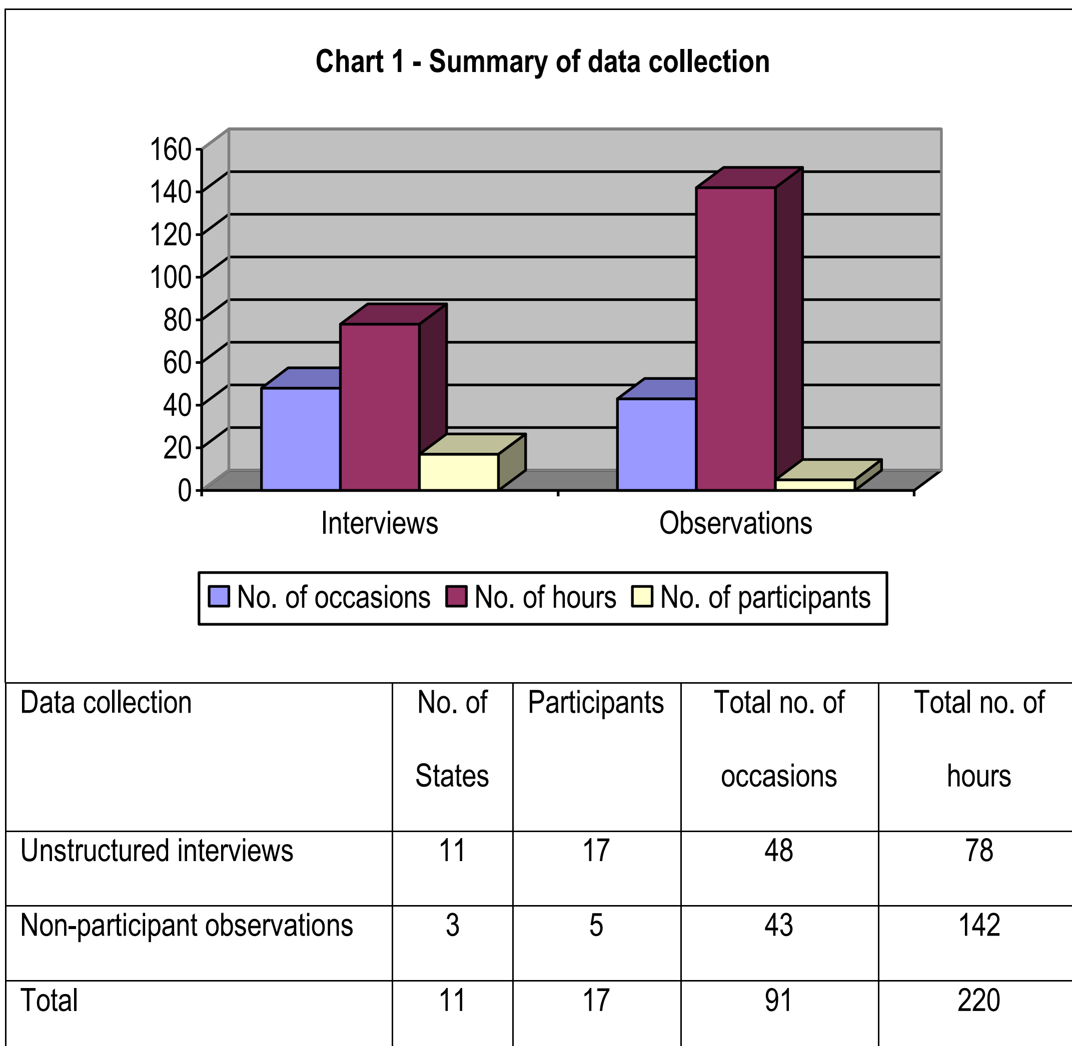
Table 1 - Details of the participants (*n* = 17)

Age, median (range)	37.1 (25-52)
Men/women	3/14
Prominent nursing background on entry (UK equivalent):	
Adult nursing	11 (64.7%)
Childrens nursing	2 (11.8%)
Mental health nursing	4 (23.5%)
Learning disability nursing	0 (0%)
Years of experience (full-time equivalent) as a licensed registered nurse, mean (range)	12.6 (4-26)
Years of experience (full-time equivalent) in current post as a nurse coroner or death investigator, mean (range)	5.5 (3-10)

The average age of those nurses that took part was 37.1 with an age range of 25 to 52, the majority being women reflecting the gender division in traditional nursing. The majority of participants came to the position from an adult nursing background with emergency department or critical care experience (64.7% *n* = 11). A smaller number came from childrens and mental health nursing (11.8% *N* = 2 and 23.5% 4 respectively). The range in years of nursing experience was quite wide from 4 to 26 years, the average being 12.7, of which an average of 5.5 years had been as a nurse coroner or death investigator (ranging from 3 to 10 years).

Chart 1 shows that all 17 participants were interviewed at least twice, with 14 who were interviewed three times, which gave a total of 48 interviews that were undertaken

altogether. Twenty seven of the interviews took place over approximately one and a half hours and eleven lasted for more than two hours, giving a total of 78 hours over the whole sample. Non-participant observations of five participants took place on 2 to 17 occasions per participant, each occasion averaging a minimum of 3.5 hours. This gave a combined total of 142 hours. In summary the data collection of unstructured interviews and non-participant observations in 11 and 3 States respectively, took place over a total of 91 occasions and 220 hours (see appendix 13).



Data collection	No. of States	Participants	Total no. of occasions	Total no. of hours
Unstructured interviews	11	17	48	78
Non-participant observations	3	5	43	142
Total	11	17	91	220

5.4 INTERPRETIVE FINDINGS AND DISCUSSION

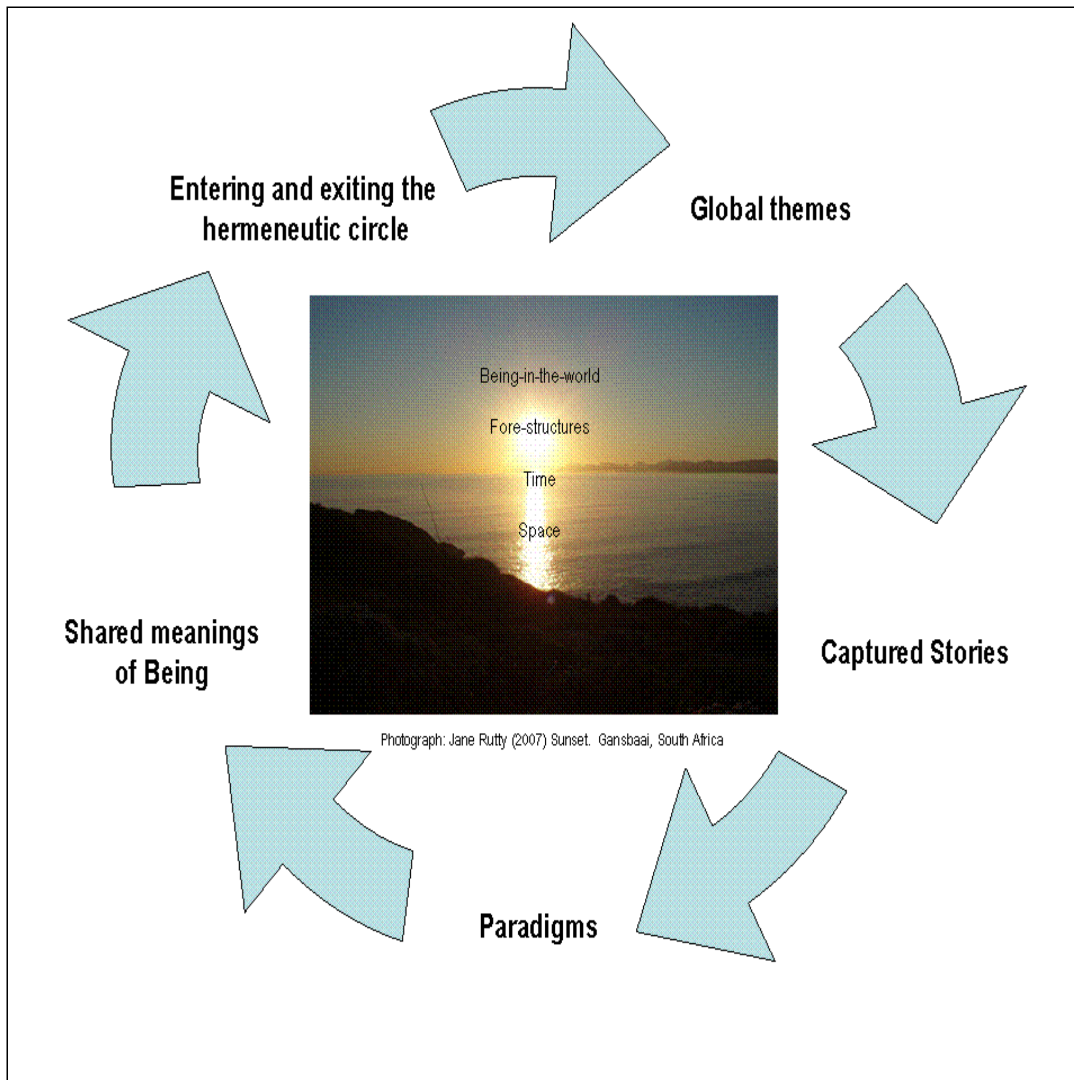
In the USA there are about 2,000 medical examiners and coroners' offices (of which approximately 98 are nurses, that is 4.9%), providing death investigation services for a population of 281,421,906 (USA Census 2000) covering a landmass of 3,794,066 miles^2.

To set the interpretive findings into context, it is important to recognise that in the USA, regardless of the title, authority and jurisdiction the work of death investigation remains the same as the UK. It is about expecting the unexpected and trying to make sense of the senseless. For all of them, no day is typical and no case is routine. They investigate everything from homicides and suicides to drug overdoses, car accidents and occupational injuries. At the end of the day, their role is to determine a cause and manner of death. The questions that they need to answer are in the USA:

- Who was the person?
- What happened?
- When did the person die?
- Where the "what" happened and where the person died?
- Why did it happen?
- How did it happen?

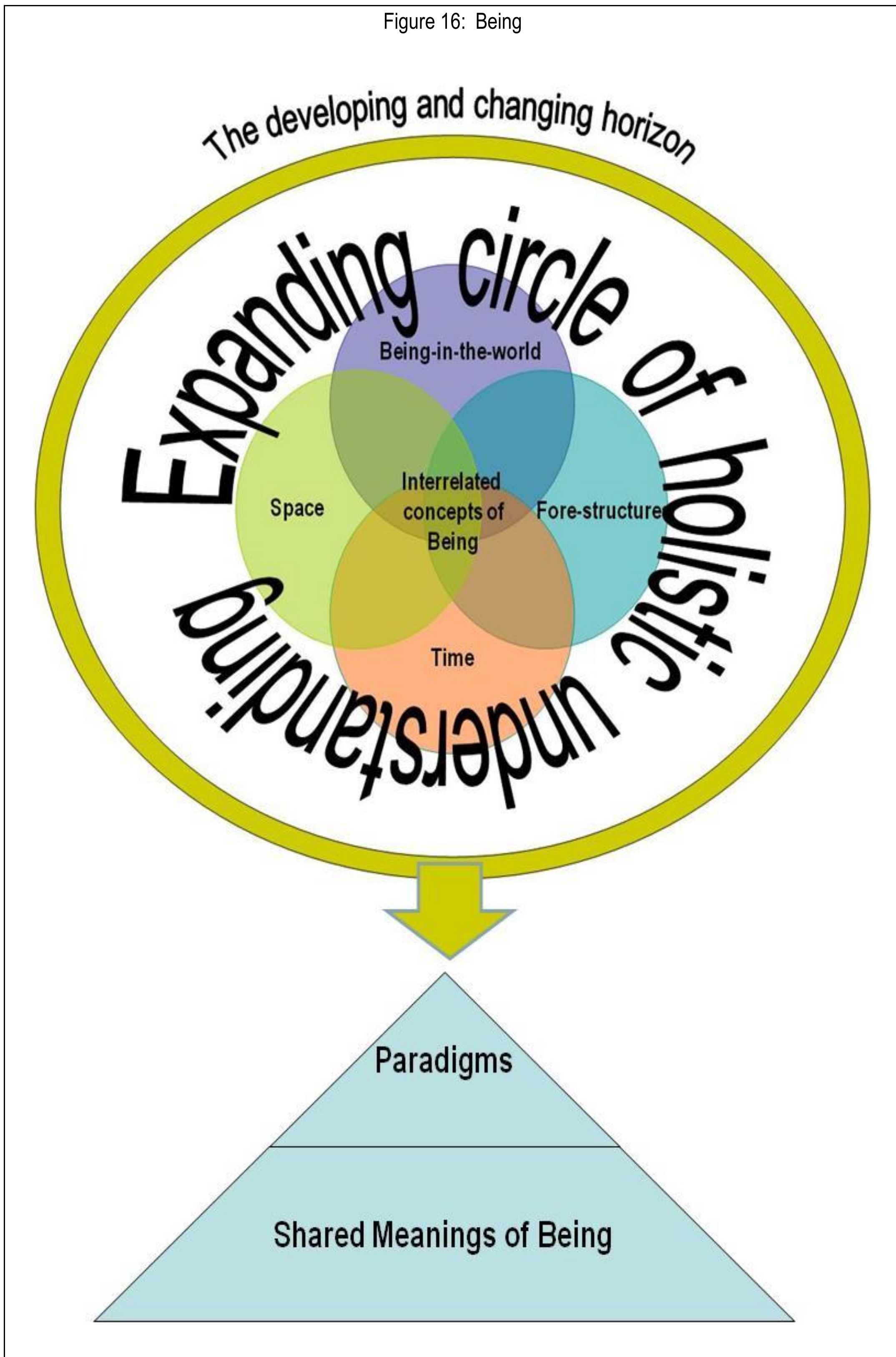
The interpretive findings within the above context will now be critically discussed and presented using the framework adapted from Heidegger's hermeneutic circle as presented in Figure 15.

Figure 15 – Overall framework for presenting the interpretive findings



Paradigms will be analytically examined in turn with the incorporation of the relevant themes and captured stories underpinned by Heidegger's four interrelated concepts of Being that is: Being-in-the-World, Fore-structures, Time and Space. Finally, the shared meanings of Being as a nurse involved in the work of death investigation in the USA will be presented and summarised in order to illuminate the circle of holistic understanding (see figure 16)

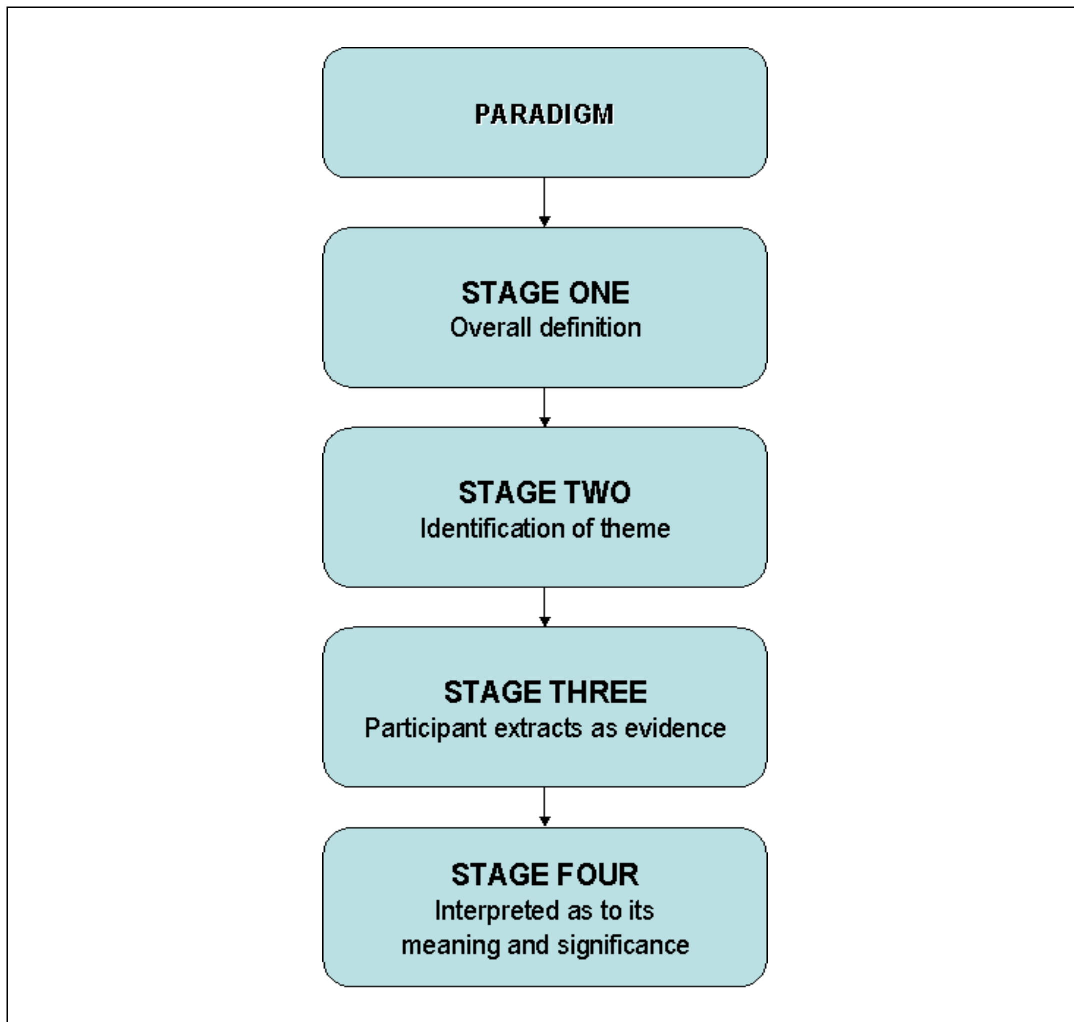
Figure 16: Being



In order to provide further transparency as to how the final written text has been constructed for each paradigm, a structure has been developed to underpin the interpretive findings and discussion. Such transparency demonstrates the management of my own perception concerning the difference between noting physically what has been seen or heard through observations, interviews, historical documents and my reflective diary and then interpreting what this means and why it is significant. This can be seen when reviewing the seven phase data analysis utilised in this study, of: entering the hermeneutic circle; data collection and initial interpretation; validation of transcriptions; global thematic analysis; the capturing of stories; the search for paradigm cases and the final phase in the search for shared meanings of Being.

It is fundamental therefore in following Heidegger's hermeneutic philosophy and applied research methods that the interpretation and discussion of each paradigm begins with an overall definition, identification of themes, followed by extracts of evidence from the data collection (e.g. a participant's view, comment, observation or captured story) which is then critically discussed, interpreted as to its meaning and significance (see figure 17).

Figure 17 Structure in presentation of each paradigm



The interpretive analysis illuminated the following three paradigms:

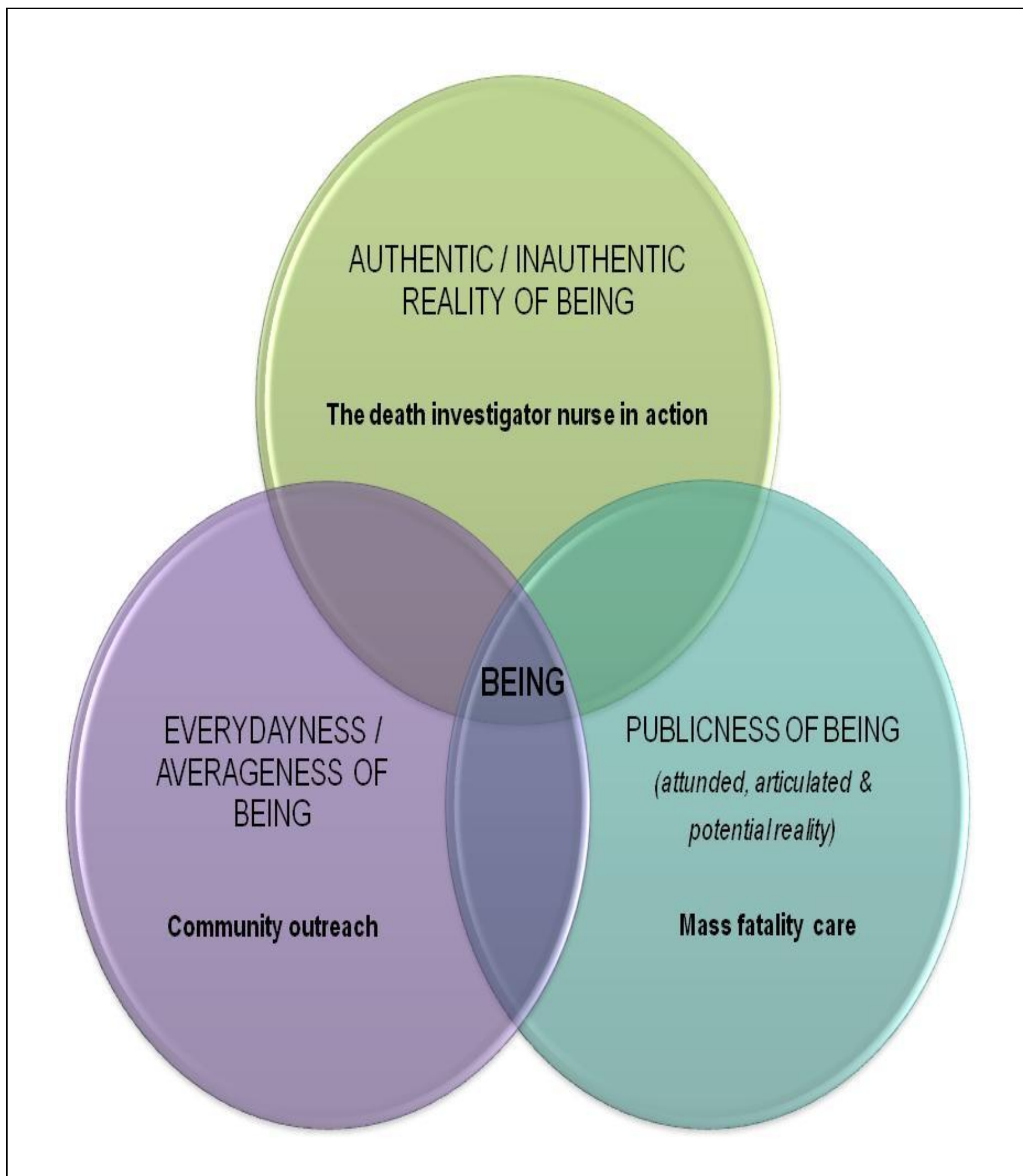
A. the authentic reality of Being: the death investigator nurse in action

B. The everydayness of Being: community outreach

C. The attuned, articulated and potential reality of Being: mass fatality care.

For an overview of this horizon, see figure 18 and table 2. To enhance confirmability of the interpretive findings an audit trail can be viewed in appendix 14. These paradigms will now be critically discussed in turn.

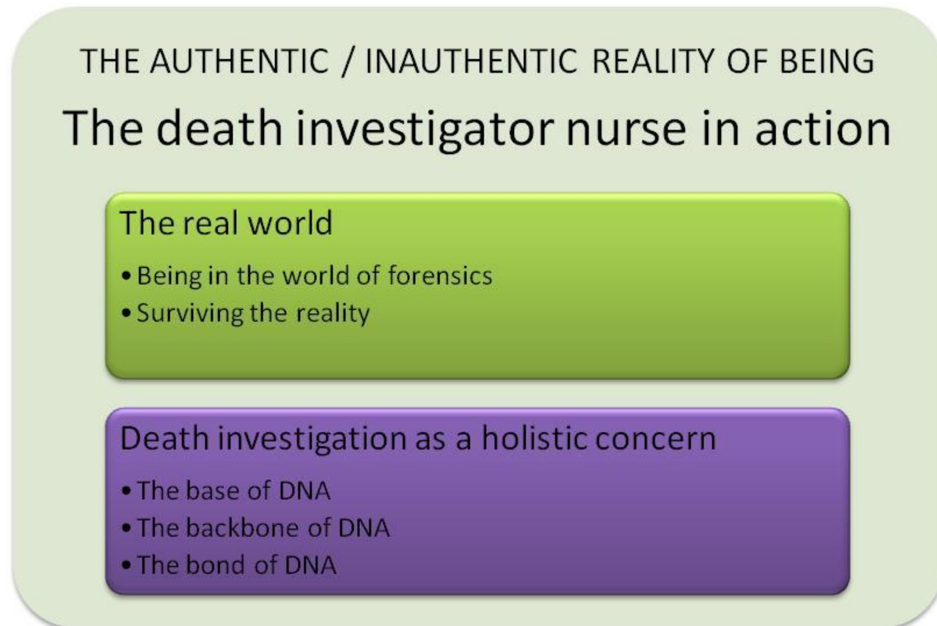
Figure 18: The meaning of Being as a nurse involved in the work of death investigation in the USA



PARADIGM	GLOBAL THEMES	MICRO THEMES
A. The authentic / inauthentic reality of Being: The Death investigator Nurse in Action	A1 The real world	i. Being in the world of forensics ii. Surviving the reality
	A2 Death investigation as a holistic concern	i. The base of DNA ii. The backbone of DNA iii. The bond of DNA
B. The everydayness / averageness of Being: Community outreach	B1 Family support and resolution	i. Human identification and family notification ii. Survivor grief resolution
	B2 Community and society public health care	i. Benefiting the living through the dead ii. Media management and public openness
C. Publicness of Being *(The attuned, articulated and potential reality of Being):* Mass fatality care	C1 Mass fatality disaster preparedness	i. Capability exercising ii. Multi-disciplinary training and practice development
	C2 Mass fatality disaster response	i. Identification of and return of human remains ii. The illumination of unnoticed crime iii. Psychological health

5.4.1 PARADIGM A

The authentic and inauthentic reality of Being: The nurse death investigator in action.



According to Heidegger Dasien (concern or authentic genuineness) exists in two separate forms, that is, authenticity or inauthenticity (Steiner 1978). An authentic existence is when individuals come to realise who they are and come to terms with the idea that every individual is a unique person. It is when a person realises that their own fate, future or destiny is reliant upon themselves to accomplish, that their concern with the world shifts from worrying how they should be behaving in order to fit in with the rest of their society to becoming concerned with fulfilling their own genuine capacity to grow in the world (potential) (Warnock 1970). In contrast, an inauthentic existence is described by Heidegger as individuals whilst striving for their own genuine capacity to grow in the world begin to embrace the norms, beliefs, intolerances or injustices of the world leading to them being unable to differentiate themselves from society as being individual (Heidegger 1962). The notion of authenticity has been taken up by scholars such as Benner

(1984), Benner and Wrubel (1989) and Parse (1987) who have explored some possibilities of choices in nursing practice, as nurses decide courses of action in their day to day work.

This paradigm “the authentic and inauthentic reality of Being” focuses on “the nurse death investigator in action” with regards to their genuine existence within their world to fulfil their own potential. It is about nurses moving in to a world that historically has been considered a non-traditional role for nurses and yet by going against the norm they have developed a holistic service in the care of the deceased, relatives of the deceased and the general public and become accepted as part of the team. The following discussion will illuminate the landscape of this paradigm by critically presenting the themes disclosed by participants, that is: the real world; and death investigation as a holistic concern.

5.4.1.1 Theme A1 The real world

To think and talk about death is considered by many to be morbid. Perhaps we assume that such an event will not happen to us for a long time and therefore it is considered gloomy to be involved in such discussions. The exception perhaps is those of us who have come through a life threatening experience and survived. The hard truth is that we will in fact die at some point as death is indiscriminate and certain for us all. Nevertheless, we tend generally not to dwell on the matter only think about it on occasion when we hear sad news be it near to home or in the media.

Television and crime novels in contrast have almost one could argue glamorised the investigation of death, especially non-accidental death. Examples include the CBS drama “Quincy” along with the more recent popular “CSI – Crime Scene Investigation”, the BBC drama “Silent Witness” and crime novels by Patricia Cornwell, to name only a few. Even the ITV drama “Inspector Morse” unveiled multiple murders each week in total contradiction to UK Home Office statistics. All such fictional stories are based around teams of forensic practitioners who are generally portrayed as gallantly uncovering the truth behind horrific murders.

Between these two worlds of morbidity and glamorisation participants in this study illuminated the theme “the real world”. It depicts a practical understanding and acceptance of the actual nature of their meaning of Being as a nurse involved in the work of death investigation rather than the gruesome or romantic view they voiced as often being put forward by the media. These examples of authentic and inauthentic realism can be seen more clearly as we examine the micro-themes of “Being in the world of forensics” and “Surviving the reality.”

Micro theme A1.i Being in the world of forensics.

Heidegger believes that Being-in-the-world is about the idea that the world is here, now and everywhere around us. In addition we are completely immersed in it. This though does not mean “in” as tea might be in a cup or laundry in a washing machine. Instead it refers to being in

space and time. In other words it can be described as not only circumstantial, but a world that is taken for granted, creating hidden experience and thus hidden knowledge. Heidegger addressed this difficulty through the importance of revealing the significance and nature of the world (Reed and Ground 1997). Next is a story captured through the interviewing and observation of a nurse coroner of Being in the world of forensics which has taken into account fore-structures, time and space so as to reveal hidden experience and knowledge.

> Anna a mechanical engineer and registered nurse is married to Alan who is described as a house husband. They have two young school aged children whom they home school. They live outside a state city in the country. Anna's professional nursing background is intensive/emergency care nursing. She has worked full-time at the local county hospital for the previous ten years.
>
> The coroner in Anna's county was an elected position. This meant that anyone, according to state rules could put themselves forward as a candidate for a four year tenure. Having experience or professional qualifications in medicine or law was not a requirement. The general public would then vote on who they wished to be their coroner based upon the election campaign that individual put forward. The current coroner at that time was a former Sheriff who would not be running for re-election.

Anna loved her job as a nurse, but became more and more frustrated at the lack of "concern" the county coroner at the time seemed to have for the deceased and their relatives when visiting the hospital emergency department. Concern is explained in this story as a possible way of Being-in-the-world of forensics. In other words, the potential had been missed in making "care" visible.

> *"I just knew I could do a better job. I knew I had so much I could give. I knew my nursing background could make a difference to families. I knew I had to try".*

Anna was already showing signs at this stage of what Heidegger describes as "Primordial moodness" one of the three basic structures of Dasien (Being in the world). Anna was beginning to become tuned to this world of forensics. Her horizon was beginning to change as new light began to dawn over her current fore-structures.

She had been watching how the coroner talked to families, what he did when he viewed the deceased and how medical records assisted him with his investigation. According to Anna based on past experiences and future potential it was time to stand. Anna put herself forward for election.

> *"Like I said when I became coroner I didn't know the term forensic nurse. I just… the reason I prompted me*

to go into it… I was sitting in the ER one night and I saw a man, a coroner interact with a family. It's kinda… I thought I could do better than that. I mean I was appalled and so found out who was retiring and jumped into the political circle and ran for coroner".

Anna describes herself as being thrown into the political arena. Her landscape was changing. Her view of the world was changing.

Anna's campaign included speaking about her previous nurse education in anatomy and physiology, pharmacology, growth and development, assessment skills and interviewing to name only a few. Anna was the only person with a medical background running. She did not find the campaign easy being out almost every night of the week talking and giving speeches to various civic and professional groups.

"It was interesting. Like I said I'm an introvert, so giving speeches was tough".

Anna, a virtual unknown when she entered the coroner's race, won. She was the only woman among five candidates who won the Republican nomination for the candidacy and went on to defeat the former Sheriff. In the general election she defeated the local Democrat. Anna became the Chief County Coroner in the deep south of USA for a community of

around 300,000 residents and additional tourists at that time.

This though was only the start for Anna. Being-in-the-world of forensics would now change Anna's horizon. Her fore-structures would transform, time (the present) would change based upon past experiences and "nows" to emerge from the future; space would alter as what was considered remote or near (space) before would adjust. Anna's horizon of Being-in-the-world would develop and reform as new possibilities in the world of nursing became apparent. An example of this changing view can be seen in the following story.

Anna (the nurse coroner) and I (observer) were travelling to her office at 2pm following a morning of me observing her working by assisting the local forensic pathologist who was undertaking an autopsy in the local mortuary. The day was now very hot. The local car radio in her unmarked police car was letting us know that the temperature was a high of 93.5°F (34°C), but it felt much hotter because of the high humidity. It felt good to walk finally into her air conditioned office. However, we were only indoors for two minutes, when her beeper sounded.

She made the call to the dispatcher (police control) to hear that some neighbours had reported to the local sheriff's department a foul smell that had been steadily getting worse over the last two days in the

apartment next to theirs. It was time to face the high temperatures and humidity again.

On arrival to the apartment, we were met by the blue flashing lights of police cars, two local police officers, a detective, and a police sergeant who was on an educational sabbatical with an interest in "bugs" (insects). Anna waved to the police officers standing in the front garden to the building wearing face masks. I was not at that immediate point sure why they were wearing face masks, but it was on entering the building that the disagreeable smell hit me. Anna was mask free and unconcerned.

> *"Smells like a "decomp" to me" she said, "I think the neighbours are right".*

Her intention was not to be flippant or to be viewed as being unconcerned, but to relay to the police officers present using their communicative culture that she suspected a decomposed body.

Inauthenticity in the business of working with other teams was coming into view.

The neighbours had called the sheriff's department, because they had recognised the smell as someone had

died unnoticed for some time in that apartment seven months previously.

We climbed the stairs to the apartment and opened the front door. The smell to me was now torturous. Anna told me that if I take a deep breath in through my nose, the smell would become bearable. I did and it did. She was right. She squeezed my arm and waited until I was ready to walk with her again.

We walked through to the back of the apartment to the bedroom where a man was indeed deceased accompanied by a mass of flies and maggots. It was a very sad and lonely scene. Anna pronounced him dead. He was extremely swollen all over his body with what looked liked haematemesis down the side of the bed and floor. Decomposition can be confused by police officers and lay members of the public as signs of violence or trauma (Shepherd 2003), but Anna was able to allay their fears of suspicion immediately preventing a long and expensive police murder investigation.

The body was assessed, samples taken, "tagged" and "bagged" by Anna. She was extremely respectful to the deceased in relation to his privacy and talked to him quietly about what would happen to him at each stage. The body was transferred to the mortuary for further detailed investigation. Anna then ensured the

apartment was secure and we travelled to the mortuary.

On arrival to the mortuary, Anna knew everyone and they all were pleased to see her too. Some said "Hi Anna" others said "Hi Chief". The forensic pathologist, investigating police officer and Anna worked together to identify the deceased.

Once he was identified, Anna immediately notified the family in person at their home. The resulting investigation found that Dwane (the deceased) had probably been dead for about a week. He was a "hobo" (vagrant) who had been given special housing to try and help him get "back on his feet" having suffered for years with alcoholism. His family lived only blocks (streets) away from his apartment, but they never visited according to neighbours.

Dwane as originally suspected by Anna was ultimately found to have died naturally from a gastro-intestinal bleed precipitated by alcoholism. A death certificate was drawn up to that effect. The family were again notified in person this time at her office and offered time to discuss anything and everything surrounding Dwane's death from practicalities, health promotion and psychological care. They were invited to contact the coroner's office whenever they felt the need to talk or to resolve any issues they felt unclear or uncertain about.

Anna though went one step further than this. She then put into place with special housing for all residents to be visited on a regular basis to try and avoid such a sad situation happening again. It may not save someone's life, but she hoped it would promote their dignity, after all everyone deserves a good death.

This story shows that Anna was applying all her nursing skills to provide not only a coronial service as dictated by law, but a holistic coronial service using her authenticity as a nurse to advance the potential of this role on her own initiative but at the same time fitting in to this new world of forensics (inauthenticity).

> *"I'm always, knowing that in our state that anybody can run for coroner, but I'm always a little surprised we don't have more nurses running, because it's a great mesh, with all our background".*

It was on the way back to the Coroner's office again that a late afternoon summer thunderstorm popped out of nowhere. The heaving downpour gave some light relief to the heat and the day, but it was only short lived as the storm left as quickly as it arrived. Anna's bleeper sounded again. The dispatch informed Anna of a suspected suicide. It was time to face the heat of the day again.

This story was not like something from a police drama you might watch on television. It was a typical day for Anna and her deputies. Duties include responding to the scene of an accident or suspicious death, collaborating with detectives and forensic teams, pronouncing death, examining the body, taking tissue/blood samples, taking pictures of the body and the scene (see photograph 5), keeping meticulous records, arranging for the body to the taken to the morgue or coroner's office for autopsy, talking with relatives, health and safety, and concluding evidence enabling a death certificate to be completed.

Photograph 5: Nurse coroner attending scene

It cannot be described as a glamorous landscape of being in the world. Nevertheless, all participants believed that being a death investigator nurse was, as one participant aptly described:

"…probably the most rewarding nursing position that I've ever had. I think it's also the most exciting nursing position I've ever had. The most fun that I've ever had. You know my friends will say "how's work?" Well, what can I say, "We're busy, it's great." I mean how do you answer that question? But I really enjoy what I do and I think we do a great service. I think nurses have a gift for this and being a nurse coroner is kinda like being on the edge, you know we are really on the edge of nursing. We're kind of coming into our own time here. It's sort of exciting to be on the edge, but at the same time it can be sort of nerve racking".

Anna held her position as Chief Coroner for 18 years having been re-elected three times during this period, overseeing more than 1000 death investigations per year, before she resigned to make a lifestyle change with her family into farming.

Micro theme A1.ii Surviving the reality

The reality is that nurses involved in the work of death investigation feel constantly watched by their professional colleagues within the world of forensics and the public. They believe that any mistakes they make will not only have a direct impact on them personally, but the whole profession of nursing. The example being in that the perception will be not that Anna (nurse coroner) made a mistake, but that it was a nurse

who was not able to do the job. They believe they are walking a very fine line where there is no room for carelessness. Instead diligence is the requirement to prevent a fall in the "up hill battle" for recognition.

> *"I'm always planning as there are so many stumbling blocks. Sometime it can be overwhelming, bit I forge ahead. I mean… I just think we're right there… we are looking at the frontier of nursing. We're the pioneers. Yeah, that's it… we're the pioneers".*

Being in the world of death investigation is one view, but surviving the reality is a stark contrast. At times the reality can be difficult to handle as nurses as death investigators are dealing with sad and intense situations all the time. Participants claimed they forgot most cases after a while, but that there were always some that they will always remember. At the time such cases were quite difficult and felt unmanageable to cope with.

> *"I give my staff what I think if very good time off, because sometimes we have to deal with very emotional case loads which are sometimes very unique situations with abnormal and dysfunctional families. So I give my staff time to go home and get back onto a right frame of life".*

Participants are aware that regular exposure to violent deaths, such as stabbings and shootings and child cases can lead to anxiety during such

an exposure and shortly afterwards and if not addressed could indeed lead to traumatic stress. Traumatic stress being described as an acute emotional condition associated with reactive anxiety (Gates and Gillespie 2008). The majority had such experiences in their fore-structures of Being as a nurse from an emergency or critical care experience. Nevertheless, all participants felt that positive thinking and collegial humour promoted their coping abilities as they realised that others were living through the same experience and that they were not alone. To them this was a comforting thought.

Humour is defined as the quality of being amusing or comical (Oxford Dictionaries 2006). One could argue that it is one of the most important, but often underused skills for coping with anxiety and UFOs (Un-Foreseen Occurrences). It can assist in providing a perspective and the feeling of being in control in times of stress and unpleasantness. Participants described the experience of humour and laughter at work as a way of encouraging calm in the workplace. They all knew that there would be days when they would feel angry, annoyed, frustrated, upset, even disturbed, but humour relieved such tensions. The relief may have on some occasions only have been brief, but it offered immediate uplifting feelings of hopefulness, light heartedness and relaxation. An example of collegial humour was found on one participant's office notice board. It was a copy of a short article she had written for the International Association of Forensic Nursing's newsletter (2000) in trying to encourage more nurses to consider becoming death investigators.

Top Ten Reasons To Be A Nurse Death Investigator:

10 You get to rise a 2am, venture into freezing temperatures, and stay up until after the sun rises. (Remember, mom always said the early bird gets the worm)
9 You get to see your friends' expressions when you explain to them what you really do
8 You will get to go to homes and businesses your mother never allowed you to talk about, much less visit
7 You get to drive into neighbourhoods our mother said she better not catch you within a mile of
6 You get to continue to interact with physicians. (Remember mom said, as a nurse, you might get to marry one)
5 You get to obtain a new wardrobe that includes bio-suits, thermal underwear, fireman boots, and hard hats
4 You will realise that your mom's diversity training did not include crack houses, adult book stores, and the jail
3 You get to experience smells that your mother was sure could only be produced after allowing eggs to rot
2 You get to play in traffic during rush hour on a regular basis, even though your mother taught you better
1 You get to use your nursing education beyond your wildest dreams!

It was Cousins (1979) who first described in the medical literature the potential therapeutic effects of humour and laughter whilst experiencing chronic illness first hand. He believed that negative emotions were having a negative impact on his health and therefore theorised that the opposite theory must be true, that positive emotions would have a positive impact. This has been reconfirmed by McCreaddie and Wiggins (2007) in their comprehensive literature review from 1980-2007.

Goodheart (1994) and Wooten (1996) also held that humour and laughter can release emotional tension or uncomfortable emotions and be effective in providing self-care tools to cope with stress leading to a positive attitude in turn affording a sense of perspective (A further

example of this is presented in section 5.4.3.2). Selye (1974) pointed out though that stress is not dependent on an external event only, but also on the person's perception of the event and the meaning they give to it. All participants explained that whenever they felt stressed, that yes humour and laughter did help each other momentarily, but it was the thank you notes and cards from families that was the real reliever and the ultimate reward for having to experience such stress. The majority of participants actually stored the notes and cards of thanks they received and used them as a personal therapeutic at times of high stress. An example of how a simple thank you from families can promote the ability to cope was described by one participant:

> *"I remember spending three days in an autopsy room taking photos of different types of injuries. For weeks afterwards I compiled the photos into a slide show for one of my courses. Because I spent so much time looking at them, the photos – especially those of children started to disturb me. I found I wasn't sleeping at night… and yet a day or so later in the lobby of a restaurant one night, a woman recognised me and hugged me and told me what a good job I had done in informing her of her loved one's death. That is the reward for me. It's a confirmation that we did the best we could under the worst conditions. It tells you, you are doing something right. At the end of the day whether it's a good one [day] or a bad one, we're*

here to represent the deceased and the families and make sure they get a fair investigation".

In summary, participants cannot control the events that have precipitated a death; however they have learnt how to manage their perspective of such events and their consequent emotional response through collegial humour and personal therapeutic rewards. Nurses involved in the work of death investigation focus on the positive aspects of their job by finding answers for and dealing sensitively with grieving families rather than the sometimes unpleasant paths they take to arrive at their conclusions. There is a fascination that is appealing to such nurses who feel they can make a difference in a world of sadness that everyone will experience one day when they hear of death. The theme "the real world" confirmed that nurses involved in the work of death investigation will care for you and your family in your time of need no matter who you are, where you are, what state you are in or at what time they find you after your death. They believe that they are your advocate and will listen intently to you:

"I wonder if he {or she} is trying to tell us something".

They are ready and waiting 24 hours a day, every day of the year. This is their real world and how they survive the reality.

5.4.1.2 Theme A2 Death investigation as a holistic concern.

In direct contrast to atomism, Holism, the theory that unified wholes are greater than the simple sum of their parts, is not a new concept to nursing. Instead there is a belief that we are all holistic beings with physical, emotional, psychological, social and spiritual domains. Holism as a theory holds that any parts of a whole cannot exist or be understood in isolation only in relations to the whole (Wilkes 1994).

The nursing process, an adapted form of problem solving theory, is a process used in the western world to deliver nursing care holistically to patients and clients supported and underpinned by nursing philosophies, theories and/or models (Aggleton and Chalmers 2000). Consequently it can take many different theoretical forms in how the nurse views their patients, the environment, health and the purpose of nursing. Examples include systems theory, stress/adaptation theory, caring theory, and growth and development theory to name only a few as previously discussed in chapter two. However, its focus always remains the same regardless to which theory is being followed in that the process of nursing is about improving the patient's/client's health needs holistically. The advantage though of theoretical underpinnings to the process of nursing is that it enables the nursing profession to further develop their practice and to provide measured quality health care.

It was in 2002 that a State Board of Nursing in the USA threatened not to renew the active licenses of nurses who were practicing as death

investigators or coroners, despite the publication of the "Scope and Standards of Forensic Nursing Practice" by the American Nurses Association in 1992. It was not that nursing had nothing to offer death investigation, but there was a lack of clear conceptualisation of nursing within this speciality in comparison for example to medicine and the role of the forensic medical examiner and forensic pathologist. In addition there was no standard definition of a death investigator nationally within the USA at that time, making it extremely difficult to delineate differences between Forensic Nurse Death Investigators and Non-nursing Death Investigators. As a consequence, according to participants, it was becoming difficult to convince some State Boards of Nursing (and others who historically controlled death investigation) that nursing was taking place.

> *"They* [State Boards of Nursing] *don't necessarily understand what we're doing, but from our perspective we're nursing. We're providing a holistic approach to death investigation. We investigate death, but as a nurse we get to look at what else as a public servant we can do for our population such as dealing with families at times of grief, prevention of preventable deaths and promotion of health. It's kinda hard to explain and put it into words".*

Nurses had not convincingly provided such boards with a clear view of this landscape. In other words, their internal boundaries of meaning

needed explaining. Their authentic genuineness could not be seen as others in society seemed to believe they were just doing other people's roles, not nursing, the inauthentic view. The problem according to participants was the lack of a clear theoretical underpinning concerning their role as being different to others. This was especially important to them as gaps in the system were filled by not only nurses, but hospital physicians, emergency medical technicians and paramedics as well as lay people.

> *"There are people who are not nurses that do a great job in this area* [death investigation]*, but it's our holistic approach that makes us unique to death investigation. We are nursing, but nursing in a non-traditional environment. I don't know why no one thought of it before now".*

As suggested in the introduction (chapter one, section 1.9) of this study to promote role harmony in any profession or occupation there are three aspects to any role that need to be realised and have been described by Berlo (1960) as role prescription, role description and role expectation. Role prescription pertains to a complete and unambiguous account of the behaviours that ought to be carried out by individuals in a specified role. Role description, in contrast, is concerned with illustrating in detail the behaviours that are being performed in reality. Lastly, role expectations are related to the perceptions that people have about such behaviours. An ideal role is when there is congruence among role prescription,

description and expectation, but when there are differences communication breakdowns can occur. Such tensions have a potential to instigate role conflict, overlap and ambiguity (McKenna et al 2003). The fore-structured examples of such incongruence in this instance were State boards. Nurses as death investigators therefore needed to clarify their authenticity and inauthenticity in order to promote their potentiality. As a result, they returned to their foundations of holistic nursing care and the nursing process in an attempt to underpin their practice theoretically.

Nursing as a concept can be interpreted and understood from a variety of different views, e.g. as an entity, a disposition or an evolutionary phenomenon (Rodgers 1989). If viewed as an entity that is as a measure of constancy, then there would be little change or movement in its beliefs, values and practice activities since its inception. In contrast, nursing can be considered as a dispositional concept in that it is consistent with ethical theory which obligates and inspires right action to serve the good. Finally, nursing can be conceptualised as an evolving phenomenon. In other words the main thrust of the development of nursing knowledge comes from perceptions, expectations and aspirations of members of the profession including both practitioners and academics. It is also linked with the complementary role development of other professions, but remains differentiated by its unique approach to practice and its significant contributions to human concerns. To wait for a definitive nursing theory or revolutionary changes in societal expectations of nursing may decrease the likelihood that nursing will achieve its potential

for actualization. An evolutionary view of the concept of nursing can stimulate optimal development (Cameron-Traub 1994).

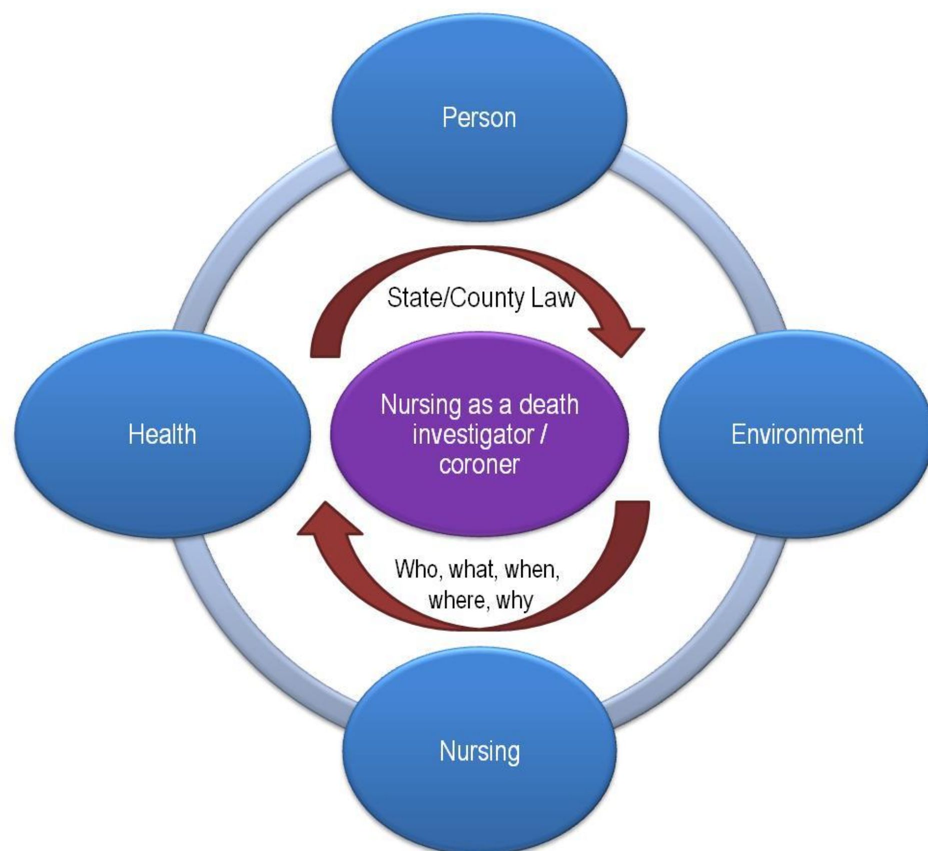
The four concepts generally considered central to the discipline of nursing are: the person, environment, nursing and health. In addition the concerns for nursing should be made clear through a clear description of the antecedents to practice; process in practice; and consequences of practice (Cameron-Traub 1994). However, participants of this study put forward that an underpinning nursing theoretical model had not been developed by nurses working within this field to underpin the process of nursing as a death investigator or coroner. They admitted to be drawing on previous knowledge and skills in their application to working outside traditional nursing boundaries.

> *"We may not have our own model of nursing for death investigation, but we are the bridge between medicine and the law… enforcement folk. In this office* [coroner's office] *we use the four recognised world concepts of nursing to try and describe what we're all about. It's sort of our little vision. We see ourselves* [nurse coroners] *in this office… in this set up as being sort of a… the spoke in the wheel… This is the place* [coroner's office] *where it all comes together… medicine, police, family, scientists. We as nurses are not more important than anyone else who is part of the investigation, but just sort of like… we're*

where everything synapses… where everything comes together to know the who, when, what, where and the whys".

Participants in this study concluded that the:

- **person** was thought of in terms of the deceased, the family, the next of kin, witnesses, other agency officials and the community.
- The **environment** may include any location where the deceased has been found or a death has occurred and includes the internal and external (societal behaviours and laws) influences on the scene of death.



- **Nursing** is the process of investigative interaction in the application of the nursing process to legal proceedings in the investigation of

death (i.e. who, what, when, where, why and how), care of the family and/or survivors and care of the community and/or society.

- The concept of **health** relates to benefiting the living through the dead which may include survivor grief resolution or public health education.

Participants believed it was important for nurse death investigators to consciously apply the nursing process to their practice in order to ensure that the expertise gained through their nursing education and experience benefits not only the investigation, but survivors and the community at large. All participants believed that the nursing process approach to death investigation actually should be viewed as

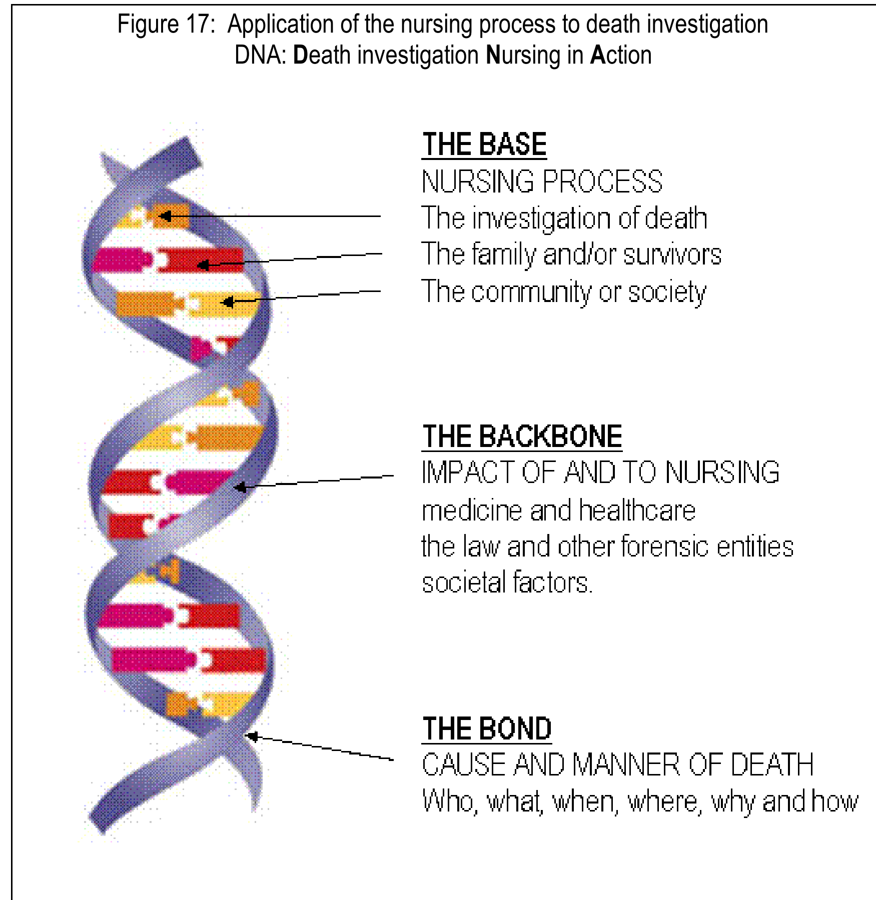
> *"… three separate components that curve and rotate in an interrelated and dynamic manner just like a DNA helix"*

The notion is that when there is any change in one area, it will impact on the overall whole. This was interpreted for this study as being "Death investigation Nursing in Action" (DNA), in other words, the interacting application of the nursing process to death investigation. It entails three entities (components), that is, the base, the backbone and the bond (see figure 17).

The **base** of the DNA, the nursing process comprises of three components related to: the investigation of the death; the family and/or

survivors; and the community or society, in the assessment, planning, implementing and evaluation of care.

Figure 17: Application of the nursing process to death investigation
DNA: **D**eath investigation **N**ursing in **A**ction



In addition, these interrelated components exist along side a supporting structure, the "**backbone**" consisting of medicine, law enforcement, forensic teams and society at large. The "base" and "backbone" interact, influence and impact on each other through a fluid, but safe environment as professional boundaries blur and merge in the care of the deceased, family and society.

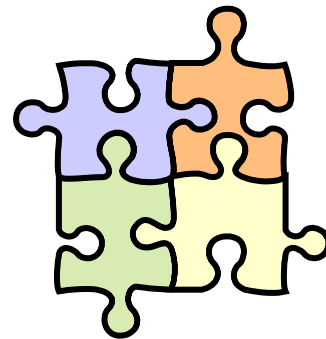
The "**bond**" of the DNA brings together the base and backbone in deliberate co-existence to answer the underlying pragmatic question in

determining a cause and manner of death by answering the questions, who, what, when, where, why and how.

The nursing process conceptualised through the concepts of the base, bond and backbone of DNA will now be discussed in more detail.

Micro them A2.i. The Base of DNA

The base of DNA, the nursing process involves the phases of assessment, planning, implementation and evaluation. As a nurse involved in the work of death investigation, the process is just the same as nurses who work in other specialties, but rather than it being applied in a linear or circular fashion some of the steps are performed simultaneously. Each step also contains multiple meanings or components which when pieced together provide a whole picture. This provides the nursing investigator with new insight, just like a jigsaw puzzle does when all the pieces are fully put together. One participant described this as being:



"A historian turning multiple stories into answers".

It is about being a leader, clinician, researcher, educator and manager.

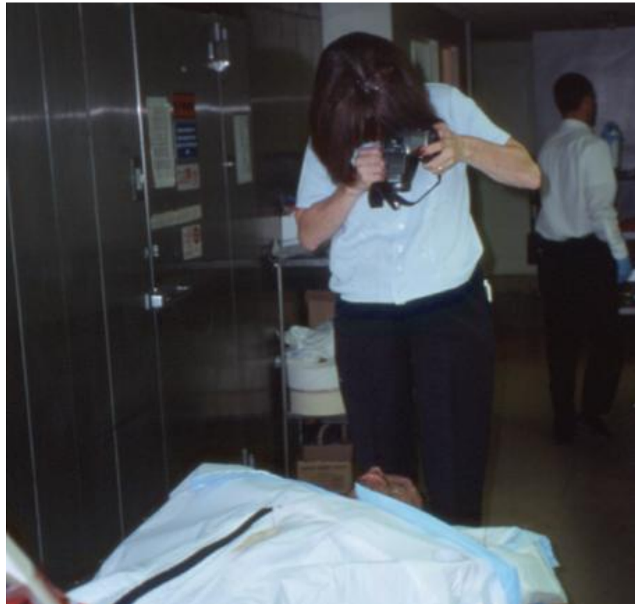
The investigation of death in action by nurses following in-depth observation is interpreted as the nursing process being divided into three parts, the investigation of death, the family and/or survivors and the community or society, examples of which will now be presented.

The investigation of death

The investigation of death involves three critical components, that is, medical/social history, examination of the body and scene investigation.

Assessment of the deceased is set in motion when the nurse coroner/death investigator is first notified of the death and enters the immediate environment where the death occurred. Before even reaching the body, an enormous amount of data is assessed just by observing the environment. For example, how warm or cold is the atmosphere, listing medication found on the kitchen table, an appointment card for the local physiotherapist or counsellor, or blood splatter. As the nurse begins to move through the house or apartment they will assess not only where the body is, but the position it is in. Examples include, a body found slumped on the toilet, lying in bed, or on the floor reaching for an emergency call button. They also make a record of the state of inanimate objects such as whether the lights are switched on or off. On reaching the body, it is then assessed for body temperature, lividity and rigor mortis; skin colour and integrity; wounds, traumas and scars; approximate weight and height to name only a few. Assessment data will also be gathered from the deceased's family, friends, healthcare providers such as the attending or

personal physician, medical records and the autopsy should it be later performed (see photograph 6).



Photograph 6: Rutty JE Nurse coroner performing photography in the mortuary

The ensuing **plan** will depend on the findings of the assessment as to whether the death is suspected as being natural or unnatural. However, planning is about developing further investigation into the circumstances of death. Planning options include the deceased being transported either to a funeral home or to the local morgue until further investigations are completed. During this stage, it is very possible that further assessment data may be noted and so the plan would be altered as needed or a new plan devised altogether. In other words, the planning process is forever developing and possibly changing as the assessment process remains constant. An example during this study was through Betty's story

> *"I remember one case of an elderly man who had died in a car accident. He had received a tremendous amount of trauma.*

The family believed he must have been badly assaulted by someone prior to the accident to have received so many injuries, making it a possible suspicious case. However, it was on detailed investigation that this was not so, as witnesses observed him (the driver) being slumped over the steering wheel wearing no seat belt, the car mounting the pavement and the man being projected through the car windscreen. That must have been hard to watch. The autopsy later showed he had died of natural causes, a myocardial infarction. The plan therefore changed from suspicious to non-suspicious death".

It can be seen therefore that planning occurs simultaneously with assessment during the ongoing investigation. **Implementation** was described and observed as following through with a plan. At this stage the notification of death is carried out, survivors at the scene are assessed and referred for counselling if necessary, and personal property is secured (see photograph 7). The plan to follow through a suspicious or natural cause of death for example, or the plan to change and implement a different interview technique with relatives once abuse is suspected, or it may involve the implementation of public health education following a cluster of young drug addicts dying from drug overdose.

Photograph 7: Rutty JE Nurse Coroner securing property following a suicide.

Evaluation involves concerning the investigation, the review of the interpretation of laboratory tests, medical records being compared to autopsy reports, further discussions with detectives and the family are reconsidered and findings implemented as appropriate. Finally the evaluation process is completed when the investigation is over having answered the questions of who, what, when, where, why and how. In addition, peer review is undertaken to establish if all aspects of the nursing process were competent and proficient so as to advance and enhance future death investigations.

The family and/or survivors

The family orientated **assessment** is to determine the needs of the next-of-kin and what support they necessitate at that time. When a need is identified, **planning** for a successful resolution begins immediately. Planning also includes how to proceed with the investigation and how

and when to interact with the family of the deceased. Therefore this stage is more likely to be carried out in conjunction with the other steps of the nursing process, such as **implementation**, as the death investigator may only have a very short span of contact with the family. The **evaluation** process is completed when the investigation is over and when the family and/or survivors feel no further support is needed. Again a review of these of the nursing process takes place to promote future holistic family care.

<u>The community or society</u>

The nursing process in each investigation of death will also take place from a community or society perspective to ensure the health and safety of the wider population. This for example could include identifying community risk factors for accidental deaths, such as recurrent car accidents on the same stretch of road, multiple suicides from the same geographical point, or trends in child deaths. This in turn has lead to promotion of psychological care in schools, public health education concerning babies sleeping in unsafe bedding and road closures. Community and society public health care is presented in more detail under paradigm B in section 5.4.2.2.

Micro theme A2.ii. The Backbone of DNA

The backbone of the DNA relates to the interrelated nursing process being supported and influenced by multidisciplinary professionals such as medicine, law enforcement, forensic teams and society in the care of the

deceased, family and society. It is well known that professional boundaries in health care are becoming increasingly blurred as nurses move into areas that were once the domain of others. According to Dowling (1997), many problems are caused by the “in-between-ness” of nursing work in these new professional roles. Participants in this study echoed this problem in that they felt in their world that there seemed to be two views held particularly by forensic medical examiners concerning their roles as nurse death investigators/coroners.

The first view articulated by participants was that forensic medical examiners believed that nurses as death investigators were moving somewhat away from nursing and towards law enforcement, in other words, inauthenticity. It was relayed that caring and empathy were not appropriate within this environment. Instead they portrayed to nurses that it should be about arresting and charging a suspect. They had conveyed to some participants that appropriate death investigators should be individuals who were armed, certified police officers and therefore nurse death investigators must decide whether to maintain their major component of caring and empathy or become co-opted into the police culture (see photograph 8). This view came home when observing nurse coroners in action and noting that part of their attire involved a gun being kept in the car’s glove compartment. This piece of death investigator equipment seemed contradictory to the values and purpose of nursing, but explained by observed participants as being for self-protection and not to enforce the law.

Photograph 8: Rutty JE The nurse coroner and forensic pathologist

> *"I know it sounds crazy that nurses carry guns in their cars as part of the job, but this is for self protection not for law enforcement. After all, we usually go out alone and that could be day or night. Sometimes we ask law enforcement to back us up if going to a dodgy area, but sometimes even good areas can become dodgy".*

In steep contrast, the authentic view articulated by participants was that forensic medical examiners believed that nurses as death investigators were evolutional in their collaborate development with other complementary professions within the world of death investigation. This is how the participants also viewed their own landscape. All participants in this study were clear in their descriptions of meaning that although sometimes their role entailed some sleuthing in the investigation of death, this is where it ended. The investigation of criminal activity clearly lay

they believed with law enforcement agencies not death investigators. Participants believed that caring and empathy are important and are to be practised as an integral part of the process of death investigation as they as nurses have a unique and valuable contribution to make.

> *"We almost become a private investigator in a way… but only in that we want to answer the questions who, what, when, why and where. We have an approach to our work that is strictly unbiased and about fact finding… but beyond that we care for the people involved whoever they are… not just the victims either, but the perpetrators too".*

This assertion according to some participants had positively affected experienced police officers who were adopting some of the skills of a caring and empathic approach towards survivors of homicide victims (see photograph 9).

Photograph 9 Rutty JE Nurse coroner and deputy sheriff

The argument is that the philosophy of isolationism is no longer useful or efficient. There is a consistent belief among participants that science is moving towards more holistic solutions to problems. Caring and curing therefore are not incompatible notions, merely parts of the same continuum as previously discussed in chapter two (see photograph 10).

Photograph 10 Rutty JE Scene of suspicious death: Detective, sheriff, deputy sheriff, nurse coroner and forensic pathologist.

Micro theme A2.iii. The Bond of DNA

The Bond of DNA is the underlying framework to the work of death investigation in that the ultimate aim is to conclude the cause and manner of death by answering the pragmatic questions of who, what, when, where, why and how. This provides clear guidance in the application of the nursing process in the investigation of death, care of the family and/or survivors and the community or society within a multidisciplinary forensic team. Nursing as a death investigator is about an evolutional process of

nursing that encompasses a healthy degree of suspicion as they focus on the victim who has died as they develop collaboratively with other complementary professions. However, in addition they also assume a therapeutic stance for the family and secondary survivors.

5.4.1.3. Paradigm A summary

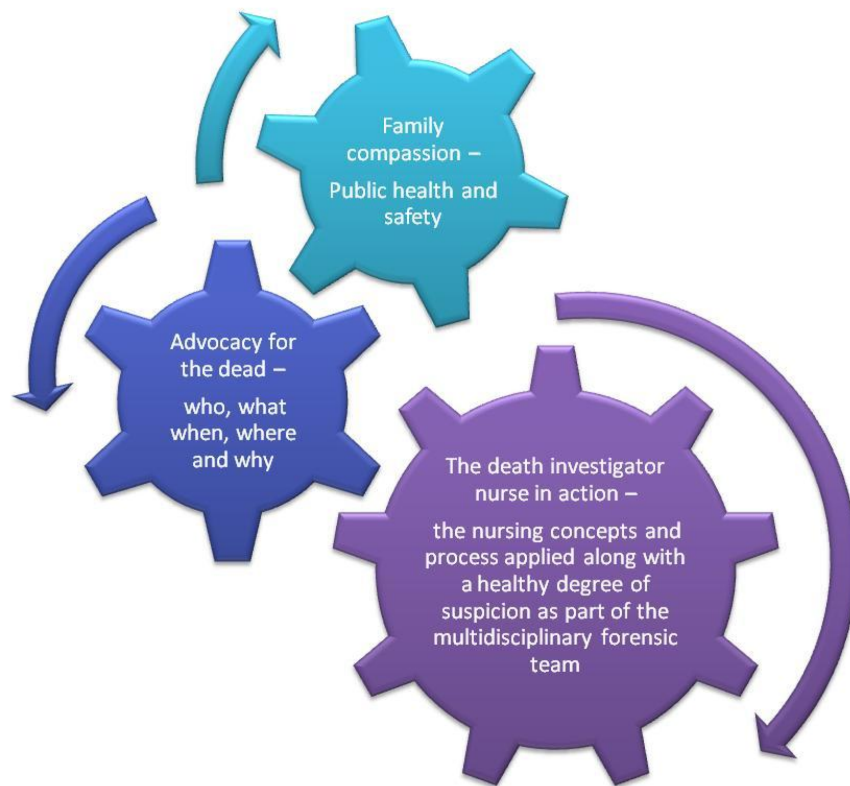
In summary, “the meaning of Being as a nurse involved in the work of death investigation” can be made clear through the testimonies and observations of participants relating to the real world and death investigation as a holistic concern.

The real world was enlightened as being the saddest and yet most rewarding nursing position participants had experienced, where they focused on the positive aspects of their work supported through collegial humour and fore-structured experiences in health care.

Death investigation as a holistic concern was embraced through the concept of DNA (Death investigation Nursing in Action) where the evolutional process of the nursing process is applied to conclude the cause and manner of death within a multidisciplinary and developing complementary forensic team.

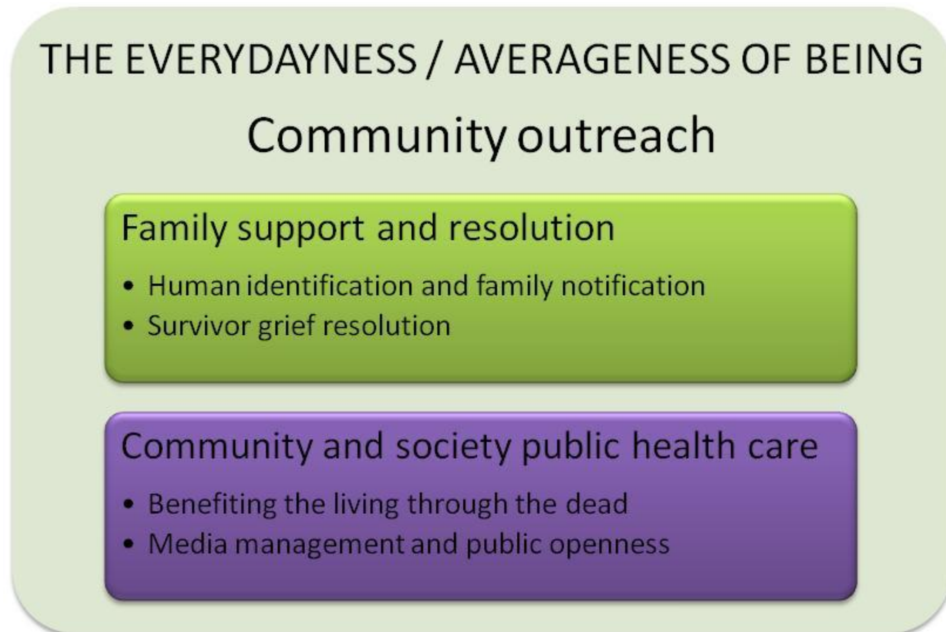
This study puts forward that “the authentic and inauthentic reality of Being” (the death investigator nurse in action) means one that is committed as part of the multidisciplinary forensic team to treating and

speaking for the dead with dignity in order to answer the questions who, what, when, where and why by staying on top of forensic and investigative techniques and using a healthy degree of suspicion whilst applying the nursing process. Along side this continuum is treating families with compassion and promoting the health and safety of the public at large.



PARADIGM B

The everydayness and averageness of Being: Community outreach



This paradigm of "the everydayness and averageness of Being – community outreach" came about through the themes and stories illuminated by participants concerning their "meaning of Being as a nurse involved in the work of death investigation in the USA". Heidegger put forward that Dasien is orientated to the concerns of the present with the future and past experiences considered as phenomenon which either will be or were the focus of its present concern (Mulhall 1996). He believed within this context that every Dasien has "everydayness" and "averageness" ways of being.

The "everydayness of Being" according to Heidegger (1962) is about us being immersed in getting on with the job in hand in our every day lives as opposed to spending large amounts of time deeply reflecting thoughtfully about our Being-in-the-World. In other words it is areas of our lives that we pay least reflective attention to. Heidegger put forward that this is how we live for the most part.

Everydayness is often disregarded or unseen by us as it is so close to us and so very familiar. Everydayness cannot be avoided as it is a habitual way of being with one another. The only difference one will experience in everydayness is variety. The “averageness” of Being according to Heidegger (1962) is when the individual no longer attempts to achieve and accepts a loss of differentiation.

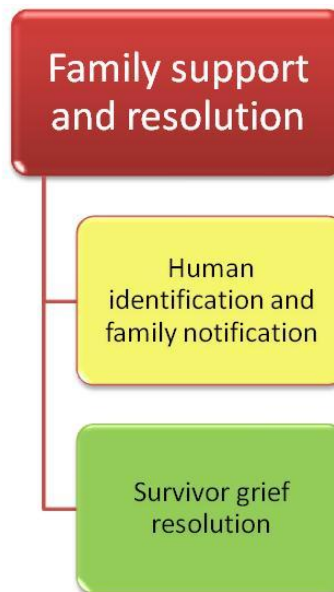
Community outreach is a method to disseminate ideas that are usually of an educational nature. It is also a way for individuals or groups to share their ideas and practices with other audiences such as business or the general public. More than this, it is about engagement and concern.

Such practices of engagement and concern were considered to be hidden from view because they constituted the everydayness and averageness of nurses involved in the work of death investigation. Therefore the following themes are discussed and presented through the incorporation of stories: family support and resolution; and community and society public health care.

5.4.2.1 Theme B1 – Family support and resolution

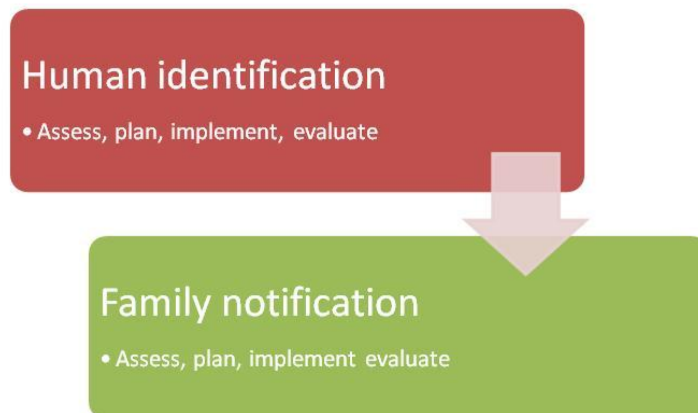
The advantage of being a nurse is that you have the clinical skills to identify physical findings and then the counselling skills to deal with the emotional aftermath, according to the participants. Nurses are also aware of the resources that are available to guide victims in the direction that they need to go to get as much healing as they can. This theme is about providing a community service and helping people to accept death as being part of life be it often in very tragic and/or horrific circumstances.

Participants believed that death is an intimate experience and considered it a privilege to participate and contribute to the support of the bereaved. Human consolation, participants held, is not the purpose of investigation, but nurses as investigators bring this support to the doorstep as they are experienced in reaching out to people and being able to provide on the spot grief counselling. At the same time they are able to interpret medical records in the way that police officers cannot. However, it will always be challenging and strenuous. Examples of this can be seen through the micro themes of human identification and family notification leading to the overall aim of survivor grief resolution.



Micro theme B1.i. Human identification and family notification

Identifying the dead is one of the main aims of the coroner / forensic medical examiner. It is not always possible though to do this visually due to injury, concealment or post mortem changes. The detailed examination of the dead for identification purposes is a task for a multidisciplinary specialist team such as the forensic pathologist, forensic odontologist, anthropologist, other experts and the death investigation nurse. Methods utilised range from morphological characteristics, fingerprints, identity from teeth, identification of the origin of tissue or samples, the individuality of cells, identification of DNA profiling, tattoos and body piercing, identity of decomposed or skeletonised remains and facial reconstruction from skulls. It is only after the deceased has been identified can the next of kin be notified.



Participants believe that the human identification and family notification procedure is underpinned by the nursing process. An assessment is made initially to collect the appropriate data in order to identify the deceased. A plan will then be developed to bring about the task of

identification such as fingerprinting, photography, x-rays etc which is implemented and evaluated. Assessment will be returned to if identification has been unsuccessful and the cycle begins again.

The task of family notification of death historically has been given to law enforcement and remains so in many states across the USA. However, some states have given this authority to death investigators. Once the deceased is identified then an assessment of the family notification location will be undertaken. Again a plan will be developed to guide how the notification will be undertaken, but this will change rapidly as each situation will require a different approach on implementation. For example, some nurse coroners will always jointly notify families in partnership with the local pastor should they know that the family belong to that particular church (see photo 11).

Photograph 11 Rutty JE Nurse Coroner and Pastor working together to notify a family

Finally evaluation will constantly guide the death investigation nurse as responses by families to their presence will not only vary but change for example from fear to curiosity, from quietness to hysteria, from denial to fainting.

Going to somebody's house to notify a family of a death was described as being part of everyday life be it an awful and very difficult thing to do and so very different to delivering such news in an emergency department where relatives usually are aware of injuries and the situation and are somewhat prepared for the worst. An example can be observed in Betty's story.

> Betty is a registered nurse who holds a criminal justice degree. She specialised in childrens nursing, emergency department nursing and was a legal nurse for some years in a lawyer's office. Now Betty works full-time as a deputy nurse coroner.
>
> It was on a Wednesday that friends of the deceased (Ronald) had informed Betty and the police that he was missing. They were worried about him as he was a heavy drinker and liked swimming in the local river particularly when intoxicated. Betty acted on this information and had visited the scene with the police where Ronald's friends had informed them was his favourite area for "taking a dip". On arrival they found a full set of clothes neatly arranged, but no

> identification on the side of the river bank. Betty ordered the river to be searched.
>
> On Thursday I was observing Betty, when she received a call from dispatch (police control) to inform her that a naked deceased black man had been found in the local river by tourists who were out boating for the day. The local water police were transporting him back to shore. The body was moved to the mortuary and identified after detailed investigation by the forensic pathologist to very possibly being Ronald, but there was some uncertainty. It was imperative that Ronald's identification and/or social security number could be found to confirm that the body was him. Once confirmed Betty would then need to track down Ronald's next of kin. Only then could any notification of relatives begin. Betty described this area of work as being like a private investigator. The first point of call would be his friends.

The underlying goal of all coronial/death investigations is to gather and document factual evidence to answer the fundamental questions of who, why, when, where and how a person died an unnatural death. Yet it is more than that for those investigators that are nurses. It is about providing a holistic service beyond these five questions. Betty's continuing story illuminates this horizon.

> We travelled to an extremely rundown area south of town to a Day Centre where Ronald and his friends

used to hang out. The Day Centre can only be described as a shack, a broken and filthy wooden building full of massive holes. Betty spoke to two people who were sitting outside the opening of the building, where there should have been a front door, on the street enjoying an ice lolly. They confessed they did not know anyone called Ronald, but if anyone did then "Blackie" would. They pointed to a shop on the street corner.

The street itself was littered with rubbish, unleashed dogs enjoying the sun and young people relaxing in stationary cars. It felt an intimidating place to be, but Betty was not troubled.

> *"It's because my car looks like a police car" she said. "There's no need to worry as they know I'm a nurse. They see me as a trusted investigator".*

This recognition by the public had come about as they compared the work of nurses as death investigation roles with other possible investigators such as plumbers and law enforcement. Betty story continues.

Betty had visited these streets and many like them before. The community were watching us intently wondering what the story was. We reached the shop on the street corner, another shack.

> The shop owner's name was George, but he was known locally as Blackie. He was an extremely well spoken Rastafarian who had lived in the community for more than thirty years. He was well respected by the community, so much so that he looked after a number of people's identification cards including Ronald's. George gave Betty Ronald's identification. She promised to return it to him if the dead man was found not to be the same person.
>
> Betty returned to her car and phoned into the fingerprint unit with the identification details. The dead man was confirmed as Ronald. The fingerprints on his identification card matched the fingerprints from the mortuary and those that were already on file due to his previous arrests and charges for petty crime. Betty jumped with glee! "I've got a hit! I know who he is!"

Betty was thrilled to have confirmed the identity of the deceased man. It was deeply clear though that the forensic response is not enough. Intervention in grief can be seen in the rest of this story as one witnesses the nurse's experience in public relations and being comfortable in relaying sensitive information to family members.

> Betty returned to the shop to see George. She knew she had to break the bad news to him as there was no other way of finding Ronald's next of kin. George was devastated to hear that the man in the water was

definitely Ronald. Betty spoke with him for some time softly and calmly. George knew where Ronald's brother lived, but not the address. He wanted to escort us there personally. He locked up his shop and asked us to follow his car.

As we drove towards the home of Ronald's brother we noticed that everybody and anyone who is walking along the sidewalk (pavement) is waving to George as he passes by. He waves back to them all. We eventually arrive. George knocked on the door. Ronald's brother answers from behind the door. George informs him who Betty and I are. Betty without delay identifies herself and asks to come in to his home to speak to him. The door is opened and we are met with the tearful faces of Felix (Ronald's brother) and Jeneka (Ronald's sister-in-law). We are invited in and George leaves offering his help should they need it any time.

Betty immediately makes eye contact and quietly establishes a rapport with the family by making sure everyone has a seat including ourselves. Betty notifies them surely but slowly of Ronald's death. She then waits for them to ask questions so as to not rush them. The conversation turns to how he died and she informs them of the circumstances and probable cause of death as accidental drowning. As the discussion moves on to more practicalities such as caskets and funerals, Felix and Jeneka break down. Betty immediately reaches out and hugs them both very quietly. Some

time later we are leaving the house having left them with some written information and letting them know that they can phone Betty at any time should they wish to talk with her again. They thank her for her generosity and kindness.

The task of notifying a family member of the death of a loved one can be unpleasant and requires compassion and respect. Hostility can also at times be often projected toward the one making the notification, complicating an already difficult task. This requires a balance of objectivity, empathy and compassion. On interviewing a death investigation nurse she recalled that human identification and family notification as being part of the job and that although a sad undertaking, but something they do almost every day. It is considered as being very rewarding to complete a case rather than being unable to identify the deceased or notify their family. Catrina tells her story.

"I don't normally think too much about identifying the dead and notifying the family as it's just part of the job. But now that you ask, one case always haunts me. I had to go and make notification by myself. It was an 18 year old boy who was a freshman in college who was driving back to his mom's house. I'm a mom too. He was coming home for the summer and he wasn't watching where he was going and he was hit by a train. His mom had dinner on the table waiting for him to walk in and instead it was me who knocked on the door. I think it was that

moment I just realised how I would impact somebody's life. I realised then that every time I go and knock on somebody's door I'm destroying them. I'm destroying their life by bringing them the fear that they fear the most. You cannot get away from the fact that there are times when you will hurt people. Compassion though is our saviour. We try to fix that hurt as much as we can and that's where my nursing experience comes in, as hopefully I can begin to help in easing the pain of that crisis".

With increasing frequency, the nurse is the one who tells the family that their loved one has died. In this area, nurses as death investigators have made a significant contribution as grief counsellors and crisis interveners. The principles and philosophies of nursing, focuses on the extended family, providing an empathic approach to tragic death. Such engagement and concern is not visible to death investigation nurses, only on self reflection does this come to the fore. This is because they felt they were only applying their nursing skills to the procedure of notification. Yet families time and time again were able to see this holistic service as they compared such services to non-nursing death investigators. This is visible more strongly through the micro-theme "survivor grief resolution". Nurses in this role possess the understanding of grief and loss incorporating caring and compassion with investigative techniques. It is not suggested that death investigation nurses can decrease grief or the development of complicated grief, but it is being put

forward that nurses in this role can minimise additional trauma to survivors as investigations are conducted.

Micro theme B1.ii. Survivor grief resolution

The psychological wounds inflicted on survivors often leave indelible marks. The reaction to the notification of death is frequently overwhelming. Such scenarios can lead to nightmares and flashbacks. In addition non-accidental death can also bring into the lives of ordinary people involvement with the medical examiner/coroner, police, district attorney, judicial system and the media. Death investigation nurses hold that they have a responsibility to try and minimise such emotional trauma, hence the micro theme "survivor grief resolution".

Bereaved families bond with death investigation nurses. Their relationship following family notification can stretch to months. For example, a family maybe having a bad day at home as they think about their child that died and suddenly decide they would like more information. Sometimes it maybe something the death investigation nurse has informed or confirmed to them on a number of occasions before or sometimes it is about something new or perhaps something they just do not understand. The key is knowing how much the family wants to know at that time so as not to interrupt the grieving process. This was described by participants as survivor grief resolution. An example of this can be in Daisy's sensitive story.

> *"I tell my families always, I have two rules. I will answer all the questions I can, but I will never tell them more than they want to know. Once you build up the relationship with the family you come to understand when they are ready for additional information".*

> Daisy remembered how she had cared for a family with two teenage children. She had to notify the parents that one of those children had died of an autoerotic asphyxiation (intentional restriction of oxygen to the brain for sexual arousal). The family were devote Christians.

Traumatic news that is also surrounded by social stigma had to be delivered. It is estimated that at least one such death occurs everyday in the USA (Sheleg and Ehrlich 2006). Culture and religion plays a very important part in understanding death, in defining its meaning, loss and coping mechanisms (Chattrjee 2007).

> The family did not ask any further questions at the time of notification and so Daisy decided to wait rather than forward further information to them herself. It was two days later that the mother (Hillary) called in to the office to see Daisy. She wanted Daisy to explain to her what an autoerotic asphyxiation death was. Knowing about the family's religious beliefs, Daisy did not want to tell her more than she was ready to hear and so suggested that

> Hillary led the conversation by asking questions. Hillary began tentatively with some questions and then went away to do some of her own research. Hillary would then return again when ready and ask further questions. This cycle continued by Daisy supporting the need for Hillary to ask and sometimes repeat questions as the trusting relationship built. It was imperative to Daisy throughout this cycle to reduce and prevent if at all possible any further emotional trauma. Time in its measured sense was not important.

This cycle can be compared to Heidegger's philosophy of time. Both Daisy and Hillary were experiencing a series of "nows" that emerged from the future (as Daisy explains Hillary's son's death) that then disappeared into the past becoming fore-structures. In other words, Daisy and Hillary are concerned with the present. It is not linear. It cannot be measured. Instead the present is experienced by what has been experienced in the past and what is expected in the future. Heidegger's concept of space explains this even further through the realisation as to what Hillary believed to be remote (yonder) in her world was in fact much nearer to her world (here) than she had ever imagined. It was this ontological realisation that Heidegger's horizon is not only continually reforming, but that its boundaries are very different based on the fore-structures of the viewer. Daisy's fore-structures were in fact in this example almost in opposition to Hillary's at the beginning of the relationship. It was only as mutual understanding of each other's fore-structures came into focus that

their horizons changed and new perspectives of Being-in-the-world became visible and recognisable.

A simpler way of explaining this using an analogy would be that of Hillary at the beginning of the relationship with Daisy having short-sightedness. This meant that she was unable to focus on the ideas that seemed so distant, so beyond her horizon to see. Her vision at this stage was blurred, just too unrecognisable to understand. It was Daisy's gentle and empathetic support that helped Hillary to slowly but surely to wear her prescription glasses at her own pace to refocus to see and to understand Daisy's horizon in turn providing new perspectives on how to help others. Daisy as a nurse was able to guide Hillary gently through the grieving process.

> She knew there would be a number of stages from the initial shock and grief in the first 24 hours, followed by a lengthy consultation that could and did last a number of months, until finally there was a tapering off from Daisy's support. Hillary is now a voluntary counsellor for families who have experienced a similar bereavement such as her family did in collaboration with the Coroner's office.

5.4.2.2 Theme B2 – Community and society public health care

Community and society public health care is not a new initiative to nursing. It is often defined as the science and art of preventing disease, prolonging life and promoting health through organised efforts of society. It relates to the overall health of a set population based on collated statistics in relation to many factors such as epidemiology, the environment, economy, crime, social behaviour and culture to name only a few.

The death investigation offices I observed and/or interviewed were all in agreement that community and society public health was a central theme to community outreach. Their main goals were to assist in increasing the quality and years of life and eliminating health inequalities. For them, it was about benefiting the living through the dead whilst at the same time being able to manage the media to ensure safe and meaningful public openness. These micro themes will now be presented in turn.

Micro theme B2.i. Benefiting the living through the dead

Death investigation nurses were found to be dedicated to benefiting the living through the dead through health prevention and promotion that is evidenced based.

> *"We learn so much that will benefit the living through the dead so that living members of society will have healthier, happier, longer, lives."*

Two nurse coroners (Theresa and Suzy) told their story in reducing the rates of sudden infant death in their county.

> Theresa and Suzy analysed the historical files of deceased babies under one year over a three month period and found that 68% were found dead when sleeping with an adult. The county was then mapped out to see if there were any clusters so as to enable the death investigation nurses to focus their educational efforts. The cluster was found to be in one of the poorest neighbourhoods where homes intermingled within an industrial area known locally as being socially economically trapped. A "Back to Sleep" campaign began (see letter and photograph 12). Parenting books were designed and a short radio and television Public Health Service Announcement was aired over 500 times in one month. The results were positive. Statistics showed that significantly less babies were dying as they slept alone in their own cots.

Dear Merchant,

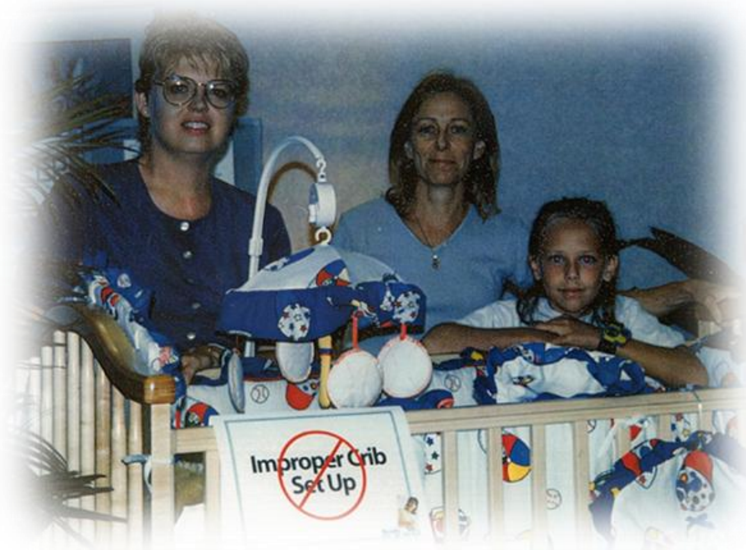
We are in desperate need of your help. There has been a significant increase in the number of Sudden Infant Death Syndrome (SIDS) cases in [illegible] SIDS is the diagnosis given for the sudden death of an infant under one year of age that remains unexplained after a complete investigation. SIDS is the leading cause of death in infants between one month and one year of age. African American children are two to three times more likely than white babies to die of SIDS. More boys are SIDS victims than girls.

October is Sudden Infant Death Syndrome Awareness Month and the Back to Sleep Campaign is being re-encouraged to educate parents and care givers that infants who are placed on their backs to sleep are less likely to die of SIDS. With your help we can educate the community regarding these risks. Parents and care givers need to know the following:

1. Babies should be placed on their back when sleeping
2. Babies should be placed in their own crib or bassinet
   Bed-sharing is discouraged and not recommended.
3. Babies should be placed on a firm mattress.
   Do not place pillows or stuffed animals in bed with an infant

As a task force dedicated to seeing our SIDS rate decline we need your assistance in getting this message out to parents and care givers. Your dedication to community enrichment is an opportunity to possibly save countless lives. Please set up floor displays that illustrate the above mentioned items. Store advertisements in print and on television should not display infants placed on the tummy, or cribs full of stuffed animals and thick quilts. While they are attractive in the nursery, they can be deadly. Display posters and literature that outline the safeguards in your baby supply area of your store. These items can be supplied to you free of charge from the National Institute of Child Health and Human Development. We would be happy to get you started with a supply of posters, stickers, pamphlets, and door hangers all getting the Back to Sleep message out.

Pampers brand diapers will be printing the Back to Sleep logo across the diaper-fastening strips of its newborn diapers, marking the first time ever that a diaper has delivered life-saving information straight to parents and care givers. These and other efforts greatly increase the number of people who directly receive the important message that placing the baby down to sleep on its back significantly reduces the risk of SIDS. We know that we can count on you to help us in this endeavor.



Photograph 12: Rutty JE Nurse coroner and "Back to Sleep" campaign.

Another example was Katie's (nurse coroner) educational programme for troubled high school teens (teenagers), "End Results".

Katie had found out through a retrospective survey that there was a higher proportion of teenagers dying due to drug and gun related deaths in her county compared to other counties in her state. This entailed a programme that enabled teens to consider how their decisions impact upon their future and what happens to people who make poor decisions through drugs and guns. The aim of the programme is to enable teens to learn how to make good decisions in order to shape their future in a positive way. After the teens tour the morgue and see a slide show, Katie explains how some young people die and describes the emotional scenes that take place when she has to tell a mother or father that their son or daughter is dead. At the end of the session, she hands out her business card and instructs the teens to write the name, address and telephone number of a loved one on the back. Then she directs them to put it into their wallets.

> *"If I find my card at your death scene, it will break my heart because I'll know you had the opportunity to learn but it will make one part of my job easier… I'll know where to find your mama".*

Shock tactics is not something new to be used in health promotion or public health. Such strategies have been found to be successful as long as the messages delivered are not contradictable. However, such

strategies can lead to warning fatigue, riskfactorphobia and the forbidden fruit effect which is clearly not in the public interest. The death investigation nurses aware of this did not therefore take on national health promotion targeted programmes, but targeted health promotion based on local death statistics as explained by Fran:

> *"As a nurse I get to look at what else as a public servant [*coroner*] we can do for our population as an independent. How best can we serve our population".*

Nurses had to question whether their audience already knew the answer or whether they has just chosen to ignore it. The nurses know that people make decisions based on what they feel to be important at that time in their lives. Through experience, the death investigation nurses were able to aim talks at the appropriate people using positive campaigns by ensuring they knew who they were trying to reach, how resistant that targeted group was expected to be to the message and what kind of message delivery would work best. This is an example of the everydayness of nursing as a death investigator applying their research skills to benefit public health.

Micro theme B2.ii. Media management and public openness.

As a nurse coroner or death investigation nurse it is highly likely that they will be expected to be an official spokesperson to the media for either factual information or expert opinions. Most death investigation nurses

have found that it has taken some time to be accepted by the media and the public. Johnny explains this more fully when he told his own story.

> Johnny was a nurse who had been working in the emergency department for more than 15 years. He had always wanted to be a Coroner, but had never got around to applying. However, this all changed when the then Chief Coroner was found to be stealing from the dead and hence his position was terminated. So Johnny took his chance, gained support from the local police and politicians and was successful in his application.
>
> > *"When I stepped in to office* [position of coroner]*, it was such a mess. The previous coroner had his office in his own home! There was stolen jewellery, wallets and all sorts of things everywhere. It was a lot to sort out. I think he was really quite unwell and things were just snowballing out of hand for him. It was a sad situation, and the public were not very forgiving.*
> >
> > *So I started and knew that especially as this is an elected position that the public would be watching me. It was a strange feeling, but I knew I would succeed. So I got my own office in the County Court House on government property. I felt it was so important particularly after what had been happening that the*

public got their confidence back. I wanted to be as open as I could to the public. I wanted somewhere that families could come to and talk to me about their loved ones who had died. For example about the autopsy and what the pathologist found. Things like that. So now, I spend a lot of time with families going over autopsy reports and explaining them, talking through self blame and things like that.

I can tell you after more than 15 years in a thankless job (the emergency department), I've had more thank yous in the last 15 months [big smile} *as coroner. That's nice in this business, its better than all the money in the world".*

Death investigation nurses have had to develop their skills quickly on how to not only manage the media, but at the same time ensure that public openness remains whilst at the same time avoiding public panic. This has involved becoming knowledgeable about the different types of news media and their audiences, the use of proactive media relations and being prepared for potential scenarios that the media will be interested in. Nurses have drawn on their leadership skills to develop key messages in order to answer the questions about the deceased (i.e. who, when, where, how and why?) through to issues surrounding public health care. It is a skill that has had to be gained by avoiding reactive

communications through leadership and the identification of potential situations in order to maintain credibility and competence.

> *"There was a time I hated going to the mail box to get the papers in the morning. But it's got better. They began to see the work that we do as nurses. It took some time to be accepted".*

Ongoing public information is important to prevent rumours and to provide information to the public about a particular incident. It is about governance in the sense that death investigation nurses practice by respecting the rights and interests of the general public.

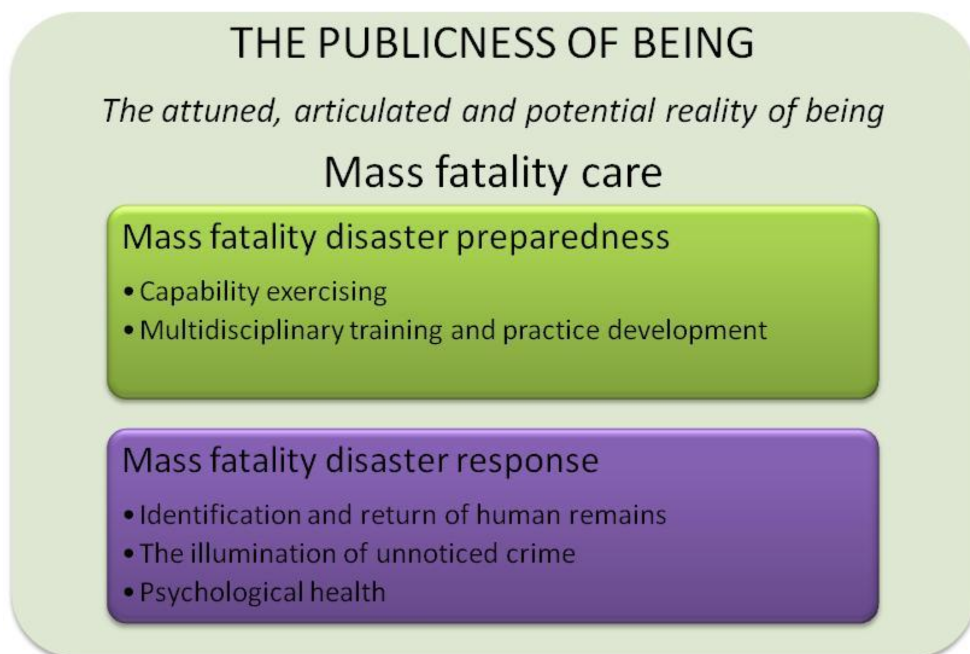
5.4.2.3 Paradigm B summary

Community outreach (the everydayness and averageness of Being) is about family support/resolution and community/society public health care. This paradigm has shown that nurses as death investigators are not only involved with the investigation of death, but the survivors of the deceased. Such nurses are bringing a holistic perspective to the care of the deceased and their grieving families and/or friends. They are considered to have a unique presence in that they demonstrate true contact and spiritual intimacy, assets to the core of nursing. It is an average, everyday story of their lives. While the nurses continue to maintain their excellence through governance and holistic applied care this paradigm by them is considered an everyday occurrence, their

everydayness and averageness of Being as a nurse involved in the work of death investigation.

5.4.3 PARADIGM C

The publicness of Being *(The attuned, articulated and potential reality of Being: mass fatality care).*



The paradigm the "Publicness of Being - mass fatality care" was put forward through the analysis of participants concerning their "meaning of Being as a nurse involved in the work of death investigation in the USA". Heidegger (1962) philosophised that Publicness is about relating to or concerning the people at large or all members of a community. In other words, it is the complete loss of self for a public image. In this mode, the individual conforms to preconceptions and opinions. The individual ceases to create and define a self, such as a fashion designer with one style that is repeated again and again with minor variations knowing it will keep their customers happy. In turn the individual becomes withdrawn from independence by steering clear of what might be

considered novel. The three elements within this mode are represented by the past, present and future of a person, that is, attunement, articulation and potential. Attunement is being responsive to something else through receptiveness and adjustment, a commitment to equilibrium and harmony through modification or fine-tuning in order to achieve accuracy or conform to a standard. Articulation is the ability to coherently express one thoughts, ideas and feelings clearly and effectively. Thirdly, potential is the capacity to develop and to succeed in becoming (Heidegger 1962), that is, the inherent capacity for coming into being. More simply, the current unfulfilled capacity to improve, develop and attain impressive achievements. The paradigm mass fatality care includes the themes of mass fatality disaster preparedness and mass fatality disaster response which will be discussed in turn underpinned by the three elements of publicness.

Both of the tragedies of September 11th and Hurricane Katrina undoubtedly had an effect on the development of forensic nursing particularly surrounding the developments of mass fatality and disaster nursing on a scale that was previously considered to be unimaginable in the USA. Death investigation nurses up until this time carried out on a daily basis the identification of the deceased and human remains, the determination of the cause of death and returning of the deceased or remains to the next of kin as part of the paradigms "the death investigation nurse in action" and "community outreach". However, such experiences on a mass scale had not been experienced first hand by them. Instead participants had gained fore-structures about this paradigm knowledge through the media

with the reporting of for example the truck bomb in Oklahoma City in 1995 that killed a total of 168 people.

Incidences of mass fatalities disasters, with 9/11 having been of particular significance to all participants in this study, had changed participants' horizons and consequential meaning of Being as a death investigation nurse. This was seen as being high on the agenda of participants and hence became a paradigm in its own right being a personal and professional life changing experience. In other words, it had altered their landscape of Being. This study was able to view this changing landscape in action through Heidegger's philosophy of Being and the interrelated concepts of Being-in-the-world, fore-structures, time and space. It is relevant therefore to now describe my own fore-structures in regards to this overall paradigm in advance of interpreting these themes by revealing what for me was "already there". This is important reflection so as to ensure that there are no prejudices or distortion of accounts of Being put forward by me when discussing the micro themes of mass fatality disaster preparedness and mass fatality disaster response (sections 5.4.3.1 and 5.4.3.2 respectively). This is my story:

> Prior to this research study I attended an international forensic nursing conference in Florida attended by 450 nurses two weeks after the September 11th 2001 (9/11) atrocities in the USA after four hijacked airliners crashed into the towers of the World Trade Centre in New York City, the Pentagon in Washington and a rural field in Pennsylvania.

Forensic nurses from New York City had attended the World Trade Centre to assist possible survivors. It became quite clear to them though that survivors would be very few. So instead, they began working as mortuary assistants to collect and process biological and evidentiary remains of the victims, many of whom were still missing and probably never to be found (McPeck 2002). They also, provided clinical care and support for about 2000 police officers, fire fighters and emergency workers who were at Ground Zero at any one time.

I had never up until that time attended a conference that was so quiet and still. The morning coffee queue was silent apart from only a few attendees who were whispering. My previous experiences of conferences had always been of the air buzzing with loud, happy networking and of friends greeting each other from around the world. Instead, you could almost touch the sadness.

The conference began with the passing of two resolutions one of which was the condemning of the terrorist attacks where aside from the 19 plane hijackers 2,974 people died (450 who were emergency responders) and 24 remain to this day as listed missing. In addition 1,100 people were treated

at hospitals in Manhattan during the first 48 hours.

Following these resolutions the first scheduled conference key note speaker was to be a sheriff's deputy/rescue-dog handler, but he was working at Ground Zero (known by those working on sight as "The Pile"), the sight of the collapsed twin towers of the World Trade Centre in New York.

The audience was quite tearful, emotional and despondent. You could have heard a pin drop. It was as if the whole conference was still in shock following this terrorist attack on their home soil and they were grieving. Everyone's vulnerability had been raised.

However, Sally Karioth of Florida State University in Tallahassee, a nurse, psychologist and grief expert in recent loss and trauma stepped in at the last minute to address the gathering. Sally is known as a very special public speaker who has a gift for evoking a wide range of emotions from her audience. It is a gift she has acquired from her varied experiences as a nurse, teacher, writer, talk show hostess and nationally renowned grief therapist. Her key talk was indeed moving, inspirational and sometime humorous, so much so that she turned the conference around full circle in that towards the end she made us all laugh very loudly for a very long time. She shared her slogan with us that "Life is not a dress rehearsal" and that "Everyday you should have at least one exquisite moment". Offering such respite was not only a release for everyone there present, but liberating. The conference buzz was back with determination. One now could

almost feel the conference buzz. It was as if the buzz was providing not only a release for the conference attendees, but it became a kick start for action in the development of mass fatality care by nurses involved in the work of death investigation in particular.

Sadly, it was not only September 11th that experienced mass fatalities, but some years later natural causes were responsible between 25th and 30 August 2005 when Hurricane Katrina devastated much of the north-central Gulf Coast. The hurricane caused what was considered the most severe loss of life of more than 1,836 people and property damage in New Orleans, Louisiana, when flooding caused the levee system to fail in more than 50 places flooding 80% of the city and neighbouring parishes (Knabb et al 2006). Two years later, Louisiana still had an estimated 500 unidentified bodies, an indication of the scale of the tragedy.

No country or group of individuals can completely avoid the experience of violence whether it be the devastation of an uncontrollable natural disaster, or intentional war or trauma.

> *"… we have a whole other realm that goes on in regard to disaster preparedness and response that comes into community preparation. I guess what I mean is… when you think about triaging in a mass disaster we can bring our nursing skills to that job. I'm used to disastrous settings having worked in ER for over 20 years, so I can take those skills and apply them to my role as a nurse coroner".*

Consequently all participants held that the themes of mass fatality disaster preparedness and response were essential to describing their "meaning of Being as a nurse involved in the work of death investigation in the USA". These will now be discussed in turn.

5.4.3.1 Theme C1 Mass fatality disaster preparedness

The interpretive findings of this study show that "Disaster preparedness" as a nurse involved in the work of death investigation in the USA is about being ready to respond to such incidences of fatalities. It is the act of practising and implanting the plan for dealing with a mass fatality event before such an event occurs in reality.

> *"Disaster preparedness comes as part of our community preparation strategy. Our nursing skills go along way into maintaining this strategy".*

Traditionally, initial responders to disasters are recognised as being local police, fire fighters and paramedics who are involved in the work of health and safety, search and rescue, medical care and evacuation. These professionals train and work on a daily basis to assist the public during catastrophic events. On the other hand, mass disasters have often meant an even wider multi-disciplinary team involvement such as pathologists, coroners, engineers and psychologists. Each County studied in the USA had disaster preparedness plans in place which

addressed the elements of response and pre-assigned responsibilities and actions to state agencies and organisations such as the Coroners' Association, Department of Health and Environmental Control, Funeral Directors' Association, Morticians' Association, Department of Public Safety, National Guard, Department of Mental Health, Federal Bureau of Investigation (Evidence Response Team), American Red Cross, Salvation Army, State Law Enforcement Division, Dental Identification Team, to name only a few.

From around the world one hears on a regular basis through the media about another mass disaster. Even closer to home, in the United Kingdom there have been incidences of large numbers of people being injured and killed due to natural disasters such as severe weather and man-made disasters such as train derailments (e.g. Paddington Rail Crash of 1999 that saw 31 deaths.

Such disasters can present overwhelming challenges to the multidisciplinary team of medicine, nursing, scientists, and law enforcement agencies, but it is hoped through capability exercising and multidisciplinary training and practice development that some of these potential challenges can be overcome in advance. This is evidenced through the ability of participants to be responsive and receptive (attunement), to communicate coherently (articulation) along with the capacity to learn and develop (potential) through the following two micro themes.

Micro theme C1.i. Capability exercising

Mass fatality disasters in both the USA and UK have called attention to the need for preparation and quick response by emergency management, law enforcement and healthcare/public health professionals. This is not considered something new for nursing internationally as historically nurses have been involved in caring for victims or war and disaster. For example, as early as the days of Florence Nightingale, nurses have been a vital clinical and humanitarian resource in times of emergency need.

Public and private sector leaders in the USA have come together to design more disaster-resilient communities. It has been found that all disasters are intensely local at first and that most communities are "on their own" often for as long as the first 72 hours (O'Leary 2004). This new awareness had led to the mandatory updating of strategies to improve disaster preparedness, particularly in light of the threat of terrorism. This has involved the mapping of countless organisations in local disaster preparedness and response through capability exercising by analysing, refining and rehearsing local disaster roles in the event of chemical, biological, radiological, nuclear or natural mass fatality events. This is turn has led to participants either leading or taking part in "table top" exercises or "live simulation" exercises. UK Resilience (2010) describes six activities under the umbrella of Integrated Emergency

Management: articulation, assessment, prevention and preparation, response and recovery.

Megan, a nurse coroner, told her story in being involved in a table top exercise to test theoretically their ability as a death investigation team to respond to a mass fatality.

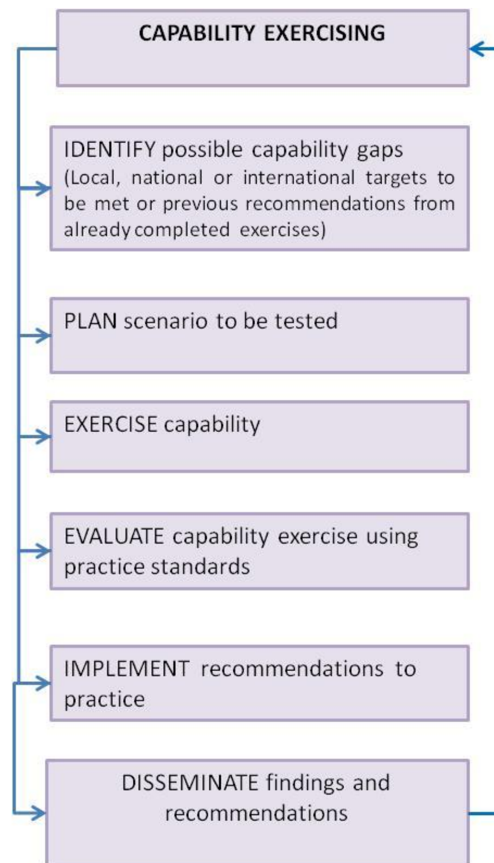
"It was good fun. It was great to be able to talk things through in a relaxed atmosphere. We learnt a lot about what procedures worked well and others that did not. That was the scary bit, but at least now we can correct that and feel better prepared".

Megan explained that the exercise was set up to find out how the local hospitals, public health and those involved in emergency management would manage the resources available to them.

"We found out that we didn't have appropriate plans in place to manage large volumes of fatalities. That was the scary bit I was telling you about earlier. I mean… we didn't have enough fridges for everyone [sufficient refrigeration storage for remains]. The good thing about the exercise though was that as a team we were then able to develop together plans… a mass fatality plan... which we then put into… action. What was great was how it [the exercise] included public health, the fire department, other coroners from around the State, forensic pathologist… all sorts of professionals actually. It was good to see how we all worked together. But then that was only in theory. I did meet a lot of new friends which I know that will make my job easier should such a disaster ever happen".

Megan carried on explaining as to how now that the team had a "mass fatality plan" in place that this would not be the end. It was intended that the new plan would also be exercised along with needs identified by team members, a never ending circle of trying to identify potential capability gaps.

All participants who took part in this study believed that capability exercising was essential so as to identity possible gaps in their service and procedures and to predict their response to such an event. Death investigation nurses as part of the multi-disciplinary team would plan scenarios to be tested, exercise that capability, evaluate the exercise overall and implement any recommendations they had found into their practice procedures as standards to be followed. Their overall findings and recommendations are then shared locally across the multidisciplinary teams through training programmes and nationally through forensic conferences, government department and other national organisations. This in turn has led to multi-disciplinary training and practice development.



Micro theme C1.ii. Multi-disciplinary training and practice development

Multidisciplinary training and practice development has been concerned with the preparation and management of mass fatalities including

administrative operations, site management, morgue operations, bioterrorism, protocols, mass burial guidelines and family assistance center operations by focusing on advance planning, preparation and response. The aim of such preparation is to ensure that the team is trained for heightened awareness, casualty management, decontamination and the use of defense equipment when there has been or possibly been chemical, biological, radiological or nuclear contamination.

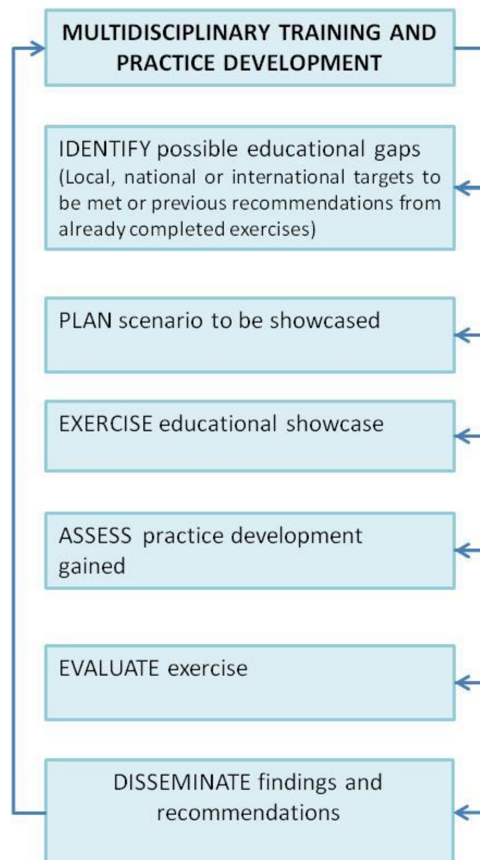
All participants interviewed believed that multi-disciplinary training and practice development was essential so as to identity possible educational gaps in their provision of service. Rob, a death investigation nurse, explained that:

> *"Its OK checking your capabilities as a team, but people need to learn the procedures for response first before you can even think about exercising them".*

Robert put forward how important it was as a death investigation nurse to be fully aware of the role the

medical examiner or coroner in such an incident, to be familiar with existing policies and procedures for response and how to recover, process and identify human remains.

Death investigation nurses as part of the multi-disciplinary team would plan scenarios to be showcased, showcase that scenario, assess what has been learnt by participants who took part in the training and finally evaluate the educational programme overall. This evaluation would then be used to inform future training.



An example of such training was described by a group of participants who had set up an internship for nurses who wanted to be death investigators or coroners. This two week programme was designed to provide registered nurses with a hands-on opportunity to learn about death investigation and mass fatality preparedness and response through lectures and observations of nurse coroners in action. Examples included simulation of mass suicide scenes and road traffic collisions (McLaughlin and Marrone 2002). This has evolved from disaster training

awareness through the sharing of personal experiences to competency-based instruction and performance assessment (Kennedy, Carson and Garr 2009).

5.4.3.2 Theme C2 Mass fatality disaster response

Mass fatality disaster response is about the ability to respond to such a situation, followed by the return to the former or better state of affairs that existed previously (Matheson and Hawley 2010). Death investigation nurses are considered as being capable to interact with police, physicians, grieving families and to collaborate with other professionals in forensic investigations (Lynch 2006), as one death investigation nurse suggested:

> *"Our skills in triage, organisational skills and identification skills all help in responding to a mass fatality disaster… Everything you learn as a nurse is invaluable in a situation like this [mass fatality disaster event] when you are needed to respond".*

In the event of any mass fatality incident, despite the cause, disaster victim identification must be undertaken to enable the return of human remains to the correct next of kin. The humanitarian and legal responsibility for this falls upon the forensic community. In mass fatality situations the expertise of many specialities are called upon to aid identification efforts and allow for the speedy return of recovered human remains to the relatives of the deceased.

The process of identification basically entails the comparison of pre-mortem data with post-mortem data as described in the theme "death investigation as a holistic concern". In addition, it is paramount to confirm that foul play has not taken place. For example, forensic specialists braced themselves for bodies recovered of people who did not drown but who were killed in the looting and other criminal activity that followed Hurricane Katrina and Rita. The stress that comes with these situations is often played out over and over again in the media adding to the family's distress even further according to participants. An example of this was the retransmission by Fox News of the live stories of 9/11 in 2001 some nine years later. Consequently participants put forward that mass fatality disaster response for nurses as death investigators in their horizon was about the identification of and return of human remains, the illumination of unnoticed crime and psychological health of the multi-disciplinary team and survivors of the deceased. These micro-themes will now be discussed in turn.

Micro theme C2.i. Identification of and return of human remains.

The identification of and return of human remains in a mass fatality disaster situation is no different to the theme of the "Death investigation nurse in action" but on a grander scale. It could also include the identification and re-burial of remains when for example a large number of gravesites are disturbed whether this is due to natural disasters such

as flooding or manmade disturbances. Some State Registered Nurses have even in these circumstances taken on the role of pathology assistant during the autopsy as described by Hammer et al (2006) when they assisted pathologists following the tragedy of September 11th in New York.

The death investigation nurse is experienced in gaining what is known as pre-mortem data in collaboration with the police in assisting with the identification of the dead. This she will apply to a mass fatality incident. It could include dental records, fingerprints or X-rays, information concerning tattoos, scars or even prosthesis. Records such as those from the military or immigration can also be proven useful in such investigations. However, the search for such items is always made much easier when the death investigation nurse is made aware of by the police, family or friends that a named person is missing. It is then a case of matching the post-mortem data assuming there is sufficient material with the pre-mortem data. When the processing is completed, the manner and cause of death are determined and the remains released to the family.

The vast majority of identifications are done visually by family or friends. Nevertheless, it is well documented that visually identification is not enough as family and friends can make mistakes when trauma causes distortion of features. The aim is to be able statistically confirm that the person has been correctly identified and that there is no possibility that

he or she is someone else. Sometimes though when no missing persons have been filed and the body found is beyond visual recognition it may be months, years or even never that the remains would be identified. Jamie gave an example of identifying and returning human remains. This was not in relation to a mass fatality disaster event, but all participants agreed that this was a typical story that could be readily applied as radiological methods of identification have been reported as being used (Nye et al 1996):

> *"One day a little old lady came out of her shack and dolls a battered old skull. Now we could never find the rest of the bones. We already knew of an eighty year old man called Jess who had disappeared from home a year ago. Nobody had a great picture of him when he was alive. So we couldn't recreate that picture. So you know, I'm sitting here and saying "Oh Lord, how are we ever positively going to identify this skull?" As it turned out I went and pulled the medical records of Jess and found that he had a CT scan pre-mortem, prior to his death during one of his hospitalisations. So we took the skull down to the radiologist. They CT scanned it and they matched them [the two scans] up. It was like a footprint, a fingerprint. So we positively identified him. And so you know that's just what we do and most people say well what difference does it make? It made a big difference. One, it's your family, because they have some*

closure as to what happened to their eighty year old relative and that yes he had died".

Mass fatality disaster events with high fatality rates will always present unique problems. Death investigation nurses recognised that the capacity to handle bodies and conduct death investigations will be extremely tough and demanding. It is the rapid identification of victims who have died that is the important issue, not only for the surviving family and friends, but also for law, insurance and relief agencies. Sometimes delays will occur in regards to death notification which can add to the trauma being experienced by bereaved families. This is often due to the lengthy process of recovering remains. This will be discussed further under the micro theme C2 iii.

Micro theme C2.ii. The illumination of unnoticed crime.

The scene of a mass fatality disaster maybe a crime scene in itself. However, violence is an important issue facing communities affected by natural disasters, such as the Tsunami and the Pakistani Earthquake, though the full extent of the problem has not been thoroughly studied.

Immediately following a mass fatality disaster, concerns about injuries, infectious diseases and the provision of basic needs takes precedence over the surveillance of violence. Studies of post-disaster violence rates are few and are mainly from the USA. There is evidence for example that child abuse and neglect increased in the six month period after

Hurricane Floyd hit North Carolina. The study confirmed a five fold increase in inflicted traumatic brain injury in children under the age of two compared to those counties not affected by the hurricane. Increases in intimate partner violence levels were also reported in the Philippines after Mount Pinatubo erupted, in Nicaragua after Hurricane Mitch, in the USA after the Loma Prieta earthquake and the eruption of Mount Saint Helens. Rape of women and children collecting water and firewood has also been reported in refugee camps in Guinea and Tanzania (WHO 2005). There is also evidence that deaths can result from looting or violent competition for shared survival resources including food, water and shelter.

All participants believed that the accurate determination of the cause of death is essential for a number of reasons as it may be used to exonerate the innocent when foul play is suspected, identify crimes of murder or provide evidence to identify public health and work related risks. Every death in a mass disaster must be treated as any other death investigation to ensure the advocacy of the deceased. This to them was an important theme to be identified as:

> *"We are the stable force in death investigation whether it be criminal or not representing the deceased and their families".*

Micro theme C2.iii. Psychological health

The majority of people in the western world can probably remember where they were and what they were doing at the time of the 9/11 attacks

in New York. Psychological effects following mass fatality incidents include fear, chaos and social disruption (Lacy and Benedek 2004) and if the incident is particularly devastating people including forensic workers can feel overwhelmed. This in turn can have a significant impact on the psychological health of both survivors and multi-disciplinary teams such as search and rescue workers deployed to the disaster manifesting as emotional and physical symptoms.

Mass panic among civilians can also lead people to behave with references only to ones self. Some for example will flee in a desire to escape where others will behave in the opposite way and freeze. Death investigation nurses recognised that such responses could be compared almost to the grieving process and their roles in survivor grief resolution. In exceptional circumstances this can take years. For example, it took more than four years for members of the Office of the Chief Medical Examiner of New York City to identify 2749 victims from the 9/11 attacks, through the examination of more than 20,000 physical remains (Brondolo et al 2008). For death investigation nurses therefore it was felt to be paramount that disaster preparedness included public education campaigns and that disaster response also focused on communicating openly with the public at large.

It may not be possible to improve the predictability of an event, but it is possible to improve the predictability of the individual's response to an event by providing some context to help organise the thoughts and

feelings individuals may have during and following high intensity stressful events (Brondolo et al 2008). Death investigation nurses who took part in this study have already taken this on board by instigating regular support group meetings to talk through difficult cases, following mass fatality exercises or to air potential worries. They found these debriefing exercises to be extremely useful in that they believed it enabled them to release their anxieties before such worries caused them severe emotional or physical strain. One nurse coroner explained:

> *"… I hate to use the words does it mess with your mind, but sometimes it can. That's the reason why I give them [death investigation nurses] days off so you can go home and hug your kids. You truly come to understand how brittle life is… I mean after working in here if you don't understand how short life can be then you're not seeing the whole picture. So that's… it kind of gives you more appreciation for your days. It gives you a driving force to know that life is not forever".*

5.4.3.3 Paradigm C summary

This study found that the participants' meaning of Being in "mass fatality care" was affected tremendously as fore-structures shifted due to external influences such as the media, leading to a dramatic change in the landscape of their previously viewed world. In other words, the idea that death investigation nurses are conforming to preconceptions and opinions, that is publicness. This correlates with Heidegger's philosophy

that Being is dependent on the interrelated concepts of Being-in-the-world, fore-structures, time and space. In other words, how one interprets the meaning of Being now maybe different from then and may even shift again in the future based on what we know presently.

Participants in this study though believed that disaster preparedness will enable them to respond appropriately, but evaluation of such responses will in turn inform all future capability exercising and multi-disciplinary training and practice development.

5.4.4. SHARED MEANINGS OF BEING

The discussion so far has been critically presented using paradigm cases and stories under the philosophy of hermeneutics to illustrate the themes illuminated in relation to "the meaning of Being as a nurse involved in the work of death investigation in the USA". This study was underpinned by the fundamental hermeneutic cycle put forward by Bonteko (2000, see figure 7, page 172) where the literature review provided the contextualisation with parts of the meaning of Being having been gathered through data collection and analysis. Careful

examination of the in-depth data looked for patterns and commonalities. From this, possible hypothesis have been developed that could lend themselves to be tested in order to generate theory. This section therefore will be taking these overall findings by providing not only a synopsis of those shared meanings, but a discussion on how nursing theory could potentially be developed inductively based on the initial literature review and research findings already presented so as to guide future professional practice. Consequently, these findings as a whole will now be integrated through interpretation and meaning.

5.4.4.1 In application to Heidegger's philosophy

Being according to Heidegger (1962) is underpinned by the four philosophical concepts of being-in-the world, fore-structures, time and space. Being in the world (Being-there, Dasien) is described as having five modes representing a choice of self and achievement, that is: authenticity, inauthenticity, everydayness, averageness and publicness.

Authenticity relates to the genuiness or truth of something, with **inauthenticity** resulting from business, preoccupation and excitement. This for example, was viewed through the paradigm of the "death investigator nurse in action". Here the horizon of the real world through the themes of Being in the world of forensics and surviving the reality could be seen and was described as being "on the edge". In addition the idea was brought forward that for nurses death investigation is a holistic concern in that they were committed as part of the multidisciplinary team to speaking for the dead in answering the questions who, what, when,

where and why through the application of nursing concepts and process along with a healthy degree of suspicion.

Everydayness represents a person who is no longer changing or making choices even though the individual might be different from others. **Averageness** takes hold when the individual no longer attempts to achieve differentiations, but accepts it instead. These modes were viewed for example through the paradigm of "community outreach" which involved family support and resolution through human identification and family notification and community and society public health care by benefitting the living through the dead along with media management and public openness underpinned by governance. In their everydayness and averageness, nurses are considered to have a unique presence in that they demonstrate true contact and spiritual intimacy.

Publicness relates to the concern for the people at large or all members of a community. It relates to the idea that the individual has complete loss of self for a public image by conforming to preconceptions and opinion, withdrawing from opinion. This is further represented through the three elements of the person's past, present and future, otherwise known as attunement, articulation and potential. An example of this was the description of fore-structures that had been influenced by the media. This was evidenced in this study for example through the paradigm of "mass fatality care" and the themes of mass fatality disaster preparedness and response which took into account: capability

exercising, multi-disciplinary training and practice development, identification of and return of human remains, the illumination of unnoticed crime and psychological health.

It is these five modes of **Being-in-the-world** that are encompassed by the concepts of fore-structures, time and space. **Fore-structures** according to Heidegger (1962) are about what is understood or known in advance of interpretation. This stance reveals holistically what is "there" and "already there". In other words, it can demonstrate any prejudice or distorted accounts of Being. Examples of this were described throughout the interpretive findings, one being the effect of the September 11th terrorist attacks.

Time is described by Heidegger (1962) as the "now" which will vary according to what one is doing, otherwise known as the existential view. Time though is objective and subjective and will depend on the pace or stretch of time. For example the belief to some of us that death will not happen to us for a long time, Anna's time to stand for coroner and time to discuss the death of a relative by taking the survivors through grief resolution.

Space according to Heidegger (1962) is about the here and the there. Space is dependent upon concern, a simile being what matters to a person. The horizon that one views in this concept is interior with a boundary that can be seen from the perspectives of the past, present and

future. The horizon though can never be reached as it expands and contracts as it accompanies us through life. The horizon in summary is about possibilities. It is about being in the world in relation to fore-structures, space and time. Examples of this can be viewed through all the paradigms put forward in this study as one sees nurses involved in the work of death investigation not only being in the world of forensics, but adapting and developing their nursing skills to provide a holistic death investigation underpinned by community outreach and public health.

In summary, Heidegger (1962) described the theory of Being, of human existence as a happening, a life unfolding between birth and death. Existence as a result is a temporal life with one's actions being nested in the contexts of the world through life stories. Hence all actions are rooted in meaningful contexts of the past and directed to some future end through the experiences of the now. It is these thoughts that can summarise the shared meanings of Being as a nurse involved in the work of death investigation in the USA in the now (see figure 18).

With this in mind, it is paramount that roles are considered when developing or contributing to nursing theory, as an ideal role is when there is congruence among role prescription, description and expectation, but when there are differences communication breakdowns can occur (Berlo 1960). Such tensions have a potential to instigate role conflict, role overlap and role ambiguity (McKenna et al 2003), a tension to be

avoided in order to promote success and acceptance in practice expansion, development and advancement.

Figure 18: The meaning of Being as a nurse involved in the work of death investigation in the USA

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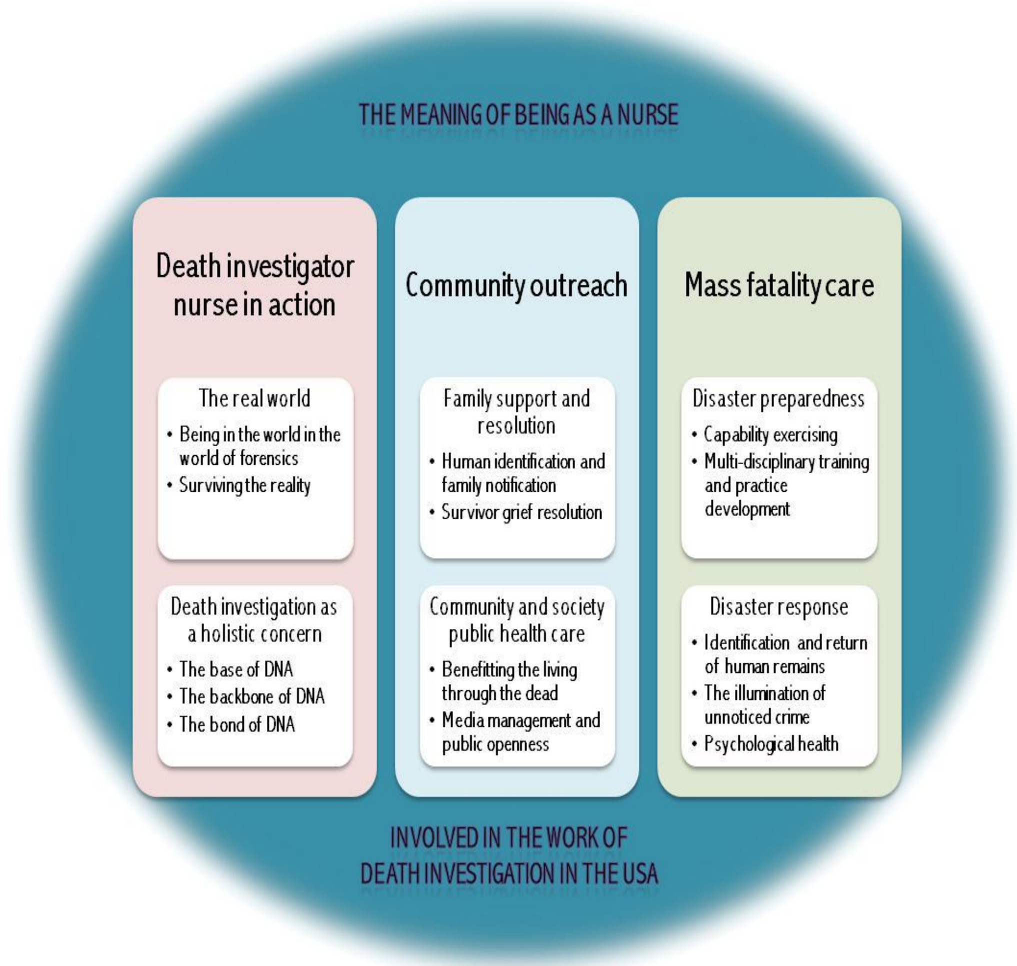


5.4.4.2 In application to role theory.

This study showed that a dynamic role in death investigation in the USA has evolved clinically within the nursing, medical, legal and community settings as a whole in response to death investigation, community

outreach and mass fatality care through practice development and application, research and public health. However, it has been noted that there has been a lack of clear conceptualisation of nursing within the work of death investigation in the USA despite its development and advancement in comparison for example to medicine and the role of the forensic medical examiner and forensic pathologists.

Nursing theory is a way of providing a body of knowledge that can support practice. Theories are used to describe, develop, disseminate concepts that can then be implemented into practice so as to guide nursing actions, predict possible practice outcomes and predict client response. The value of developing nursing theory is that it allows for public debate of: the philosophical assumptions made; the development of structural statements and hypotheses to guide nursing interventions and; systematic scrutiny of emerging protocols derived from a conceptual framework. In turn this can provide the opportunity to promote congruence in regards to role prescription, description and expectation.

5.4.4.3 Theory development

Nursing theory is based upon the assumptions put forward about the nature of nursing, the basis of nursing knowledge and how nursing is practised in the real world. This study through the investigation of "what is the meaning of Being as a nurse involved in the work of death investigation in the USA" is able now following the discussion of its findings though paradigms and stories to suggest how theory could be

developed in this area of nursing in relation to the antecedents to practice (theory assumptions), process in practice (universal concepts) and consequences of practice (propositions).

The nursing profession is based upon a specialised body of knowledge that has always been reflected by many different views and beliefs (see chapter 2, section 2.2). Despite these differences four concepts have emerged as being interrelated components of nursing, that is: heath, environment, person and nursing. Before these concepts are applied to the findings of this study, it is relevant to state the **theory assumptions** that have been made by the participants and me concerning the development of this framework:

1. The role of the nurse is ever changing as health care systems develop, progress and advance sometimes outside traditional boundaries such as the legal system;
2. Nurses as death investigators is a young speciality in the profession of nursing compared to other specialities;
3. There is inadequate awareness of the role of the nurse as a death investigator particularly by multi-disciplinary teams and the general public;
4. The death investigation nurse is currently poorly defined;
5. Nurses as death investigators have come into being (expanded their roles), because there was a need not met in the work of death investigation due to low staffing levels and high monetary costs of

forensic medical examiners in direct relation to the large geographical and population areas covered;

6. Nurses as coroners has come into being due to State election rules and the public's preferred vote;
7. The evolving role of nurses working within death investigation is relevant to the profession of nursing as they have the appropriate skills to apply and implement to this area of forensic work;
8. Altruism is the central element in the outcome of nurses involved in the work of death investigation in order to investigate the cause and manner of death;
9. All people such as the deceased, witnesses, perpetrators or victims have equal rights in regards to the law and family support/resolution and in so doing death investigation nurses are sensitive to cultural, spiritual and religious needs.

Once theory assumptions have been recognised it is relevant to then put forward the four concepts that are universally agreed upon: health, environment, person and nursing.

- The concept of **health** relates to benefiting the living through the dead by assisting the general public to reach optimal health through personal evidence based choices in regards to health prevention and promotion;
- The **environment** includes any locality where the deceased has been found or a death has occurred and includes the internal and

external (societal behaviours and laws) influences on the scene of death;

- **Person** is thought of in terms of the deceased, family, next of kin, witnesses, other agency officials and the community at large;
- **Nursing** is the process of investigative interaction in the application of the nursing process (assessment, planning, implementing and evaluation of care) to legal proceedings in the investigation of death (i.e. who, what, when, where, why and how) in determining the manner and cause of death, care of the family and/or survivors and care of the community and/or society. Here the nurse is the initiator in that the interpersonal process is either shared or initiated by the nurse.

Ideas for consideration usually follow the identification of assumptions, otherwise known in nursing theory as **propositions** underpinned by the four concepts of nursing. Propositions describe the linkages between concepts being descriptive, explanatory, predictive or prescriptive.

Hence, the following propositions are put forward based upon the findings of this study (i.e. the interrelated concepts of nursing and the three paradigms of the meaning of Being as a nurse involved in the work of death investigation in the USA) and the concepts of humanitarianism and perspective transformation:

- The nursing process within the death investigation process is an evolutional, holistic, skilled, intuitive concern applied to conclude the

manner and cause of death as an advocate of the deceased within an extraordinary multidisciplinary and developing complementary forensic team;

- Death investigation nurses have a unique presence in their demonstration of true contact, spiritual intimacy, empathy and empowerment in their care of victims, perpetrators, families, community and society through community outreach concerning family support and resolution and public health care that is evidence based;
- Mass fatality care to the death investigation nurse is about being fully prepared through governance and leadership to respond in the: identification and return of human remains; illumination of unnoticed crime and; psychological health as part of multidisciplinary relief agency teams.

It is envisaged that these three propositions will direct and lead death investigation nurses and nurse coroners in the USA to clarify their definition of nursing within this speciality and their objectives for practice and practice development. In other words, from a hermeneutic philosophical viewpoint, their meaning of Being-in-the-world based on what is already known (fore-structures), in the context of what is being put forward (time), along with the possibilities through innovation and advancement that could stretch the boundaries of potential (space).

5.4.4.4 Shared meanings of Being summary

Returning to Henderson's definition of nursing (chapter one, section 1.3) and the assumptions, concepts and propositions put forward above it is suggested that:

> The unique function of the nurse involved in the work of death investigation through perspective transformation is being an advocate for the deceased and holistically caring for their families and the public at large. This work is underpinned by the interpersonal process of investigative interaction and public health in the application of the nursing process to legal proceedings in determining the manner and cause of death. This aspect of her work she initiates and leads underpinned by governance as part of a multidisciplinary complementary forensic and relief agency teams. She also as a humanitarian has a unique presence in the demonstration of altruism, spiritual intimacy, empathy and empowerment in her concern for victims, perpetrators and witnesses being sensitive to their cultural, spiritual and religious needs. Nursing should never be seen as anything less than essential to the human race, even after death.

5.5 CHAPTER SUMMARY

This chapter began by providing an overview of my own changing personal horizon in regards to the research process in: formulating the research question; research design; along with the data collection and analysis methods. It then provided a description of the study sample to put the interpretive findings into context. Following this the interpretive findings were presented through critical discussion using participants' stories formulated and underpinned by unstructured interviews, observations and historical records under the paradigms of the death investigation nurse in action, community outreach and mass fatality care. Finally the shared meanings of Being as a nurse involved in the work of death investigation in the USA was suggested under Heidegger's (1960) four concepts of Being and five modes of Being-in-the-world. This in turn led to the theorising of how potentially the professional practice could be developed inductively framed by the hermeneutic cycle concluding in the shared meanings of Being.

CHAPTER SIX

CONCLUSION

6.1 INTRODUCTION

Nurses as death investigators or coroners in the USA are unique in that they do not exist in the United Kingdom or Europe. In addition this extended role has never been analysed in its entirety before. A journey therefore began, not to Lauterbrunnen on this occasion, but through what has been a most rewarding research journey in preparing, experiencing and reflecting on my own and others' horizons involving the meaning of Being as a nurse involved in the work of death investigation in the North American landscape. To conclude a research study such as this is difficult as it is very hard to let go, but it is indeed now time.

This is not the end of the journey though. Perhaps instead, this is the real beginning as implications and recommendations are made for clinical nursing practice and practice development in England as well as designing proposals for future research, this could be perceived as the plan for a returning expedition. My horizon I now know is unable to remain within a rigid boundary instead space is forever stretching and contracting as new ideas, innovations and experiences come into view.

It is proposed that the meaning of Being as a nurse involved in the work of death investigation in the USA presented in this study informs and adds to the body of knowledge offering a unique insight into the extending role of the nurse within this speciality and the potentiality for England. Before this potentiality is discussed it is appropriate and relevant to précis the previous chapters that have led to this conclusion.

6.2 PRÉCIS OF PREVIOUS CHAPTERS.

Chapter one, the introduction, provided an overview of the research topic, the significance of the study and the purpose of conducting it. The research was justified, the methodology was briefly described and the study outlined. On these foundations, the study was able to proceed with a detailed description of the current and underpinning research, in chapter two. The literature review began with an exploratory examination of twenty years of literature on nursing and death investigation, both in Britain and the USA. It was revealed to be an area that had not been fully investigated or documented, but an area of potential importance to the nursing profession, multidisciplinary team and general public providing a rationale for exploring the meaning of such work. The evidence pointed to the issues of the role of the nurse generally, the effects of expanding roles and the way forward. An analysis of death investigation frameworks worldwide was then presented with nursing being considered within this realm. Consequently, it was suggested that there was “hidden” evidence as to the meaning of such nursing work currently being practised in the USA which led to the overall research question and aims of this study being refined.

Chapters three and four, the research design in regards to its philosophical justification and applied methods defended a Heideggerian hermeneutic investigation under the interpretive paradigm, with the intent of illuminating and enhancing hidden knowledge. This was presented, discussed and analysed from the ontological, epistemological and methodological aspects in abstract form followed by a detailed description of the hermeneutic circle, sampling, instrumentation, protection of participants, methods of analysis and trustworthiness in exploring the phenomenon.

Chapter five, the findings and discussion, provided an overview of my own changing personal horizon in regards to the research process in formulating the research question, research design, along with the data collection and methods of analysis. A description of the study sample to put the interpretive findings into context was then put forward. Subsequent to this the interpretive findings were presented through critical discussion using participants' stories formulated and underpinned by unstructured interviews, observations and historical records framed by the paradigms of the death investigation nurse in action, community outreach and mass fatality care.

Finally the shared meanings of Being as a nurse involved in the work of death investigation in the USA was suggested under Heidegger's (1960) four concepts of Being and five modes of Being-in-the-world. This in turn led to the theorising of how potentially professional nursing practice could be developed inductively framed by the hermeneutic circle. It is relevant therefore following these findings to now suggest how they could be applied to England potentially by discussing the possible implications for clinical nursing practice and recommendations for practice development.

6.3 IMPLICATIONS FOR CLINICAL NURSING PRACTICE AND RECOMMENDATIONS FOR PRACTICE DEVELOPMENT IN ENGLAND.

In the USA there are about 2,000 medical examiners and coroners' offices providing death investigation services for a population of 281,421,906 (USA Census 2000) covering a landmass of 3,794,066 $miles^2$ (9,826,630 km^2). This is interpreted as each medical examiner/coroner covering an average population of 140,711. In comparison England has less than 200 coroners providing death investigation services for a population estimated to have been about 50,714,000 in 2006 (UK Census 2001) covering a

landmass of 50,346 miles^2 (130,395 km^2)), the population number each coroner is covering (245,694) is somewhat higher compared to their American colleagues. In other words, coroners in England compared to medical examiners and coroners in the USA are providing investigation services for a population that is on average 57% larger, but over a landmass that is 98.6% smaller.

One can immediately see why then in the first instance that nurses in the USA were utilised to overcome the shortage of forensic pathologists and forensic medical examiners within this speciality, as firstly a larger geographical area could be covered more logistically and secondly nurses were monetarily less expensive. However, as this study has shown it was not expected in the early developments of this role how nurses as a profession would expand and advance in regards to death investigation in the USA. Such nurses are now involved in the investigation of death, community outreach and mass fatality care as part of multidisciplinary forensic and relief agency teams. In consequence the findings of this study led to the theory that:

> The unique function of the nurse involved in the work of death investigation through perspective transformation is being an advocate for the deceased and holistically caring for their families and the public at large. The work is underpinned by the interpersonal process of investigative interaction and public health in the application of the nursing process to legal proceedings in determining the manner and cause of death. This aspect of her work she initiates and leads underpinned by governance as part of a multidisciplinary complementary

forensic and relief agency team. She also as a humanitarian has a unique presence in the demonstration of altruism, spiritual intimacy, empathy and empowerment in her concern for victims, perpetrators and witnesses being sensitive to their cultural, spiritual and religious needs. Nursing should never be seen as anything less than essential to the human race, even after death.

The question that remains to be answered is whether there is a need for registered nurses such as those in the USA to expand and advance their role into the realms of death investigation in England and if so what could they potentially offer beyond their current role boundaries?

The current system in England (and Wales) requires that for all deaths the doctor who attended the patient in their final illness should complete a Medical Certificate of Cause of Death (MCCD). It was suggested in the Shipman Inquiry (2003) that when a death occurs within hospital walls there are knowledgeable professionals who are fully aware of the procedures that need to be undertaken. In contrast, when a death occurs at home in the community there is no single professional authority that has overall accountability in assisting with such matters. Instead, depending on the nature of the death a range of professionals could possibly be called upon such as paramedics, forensic medical examiners (police surgeons), general practitioners, doctors from the deputising service, palliative care nurses or police officers to name only a few. On top of this quandary there are different procedures being utilised throughout the country which has led to confusion

about what is expected of such professionals. To add to this 30% of deaths which do not result in cremation are not necessarily scrutinised by a second medical doctor before the body is disposed of (buried). It was also recognised that many functions carried out by coroners, the majority of which came from a legal background, required them to make medical judgements and therefore recommended that the Coroner Service acquired medical, legal and investigative expertise. The Shipman Inquiry (2003) concluded that there should be a nationally agreed policy for dealing with deaths in the community with the prime responsibility being based with the Coronial Service in collaboration with the creation of the new Medical Examiner Service.

The Coroners and Justice Act (2009) is divided into four parts and looks at: coroners; criminal offences; criminal evident, investigation and procedures; and sentencing. Within this it sets out that the principle of the Medical Examiner is to safeguard against certifying deaths which should be investigated by the coroner. They will do this by assessing the stated cause of death. The service will be supported by a Medical Examiner Officer and Primary Care Trusts will be responsible for monitoring the performance of the Medical Examiner's Service against set standards. The report also recommended that the aim and purposes of the new Coroner Service should be to:

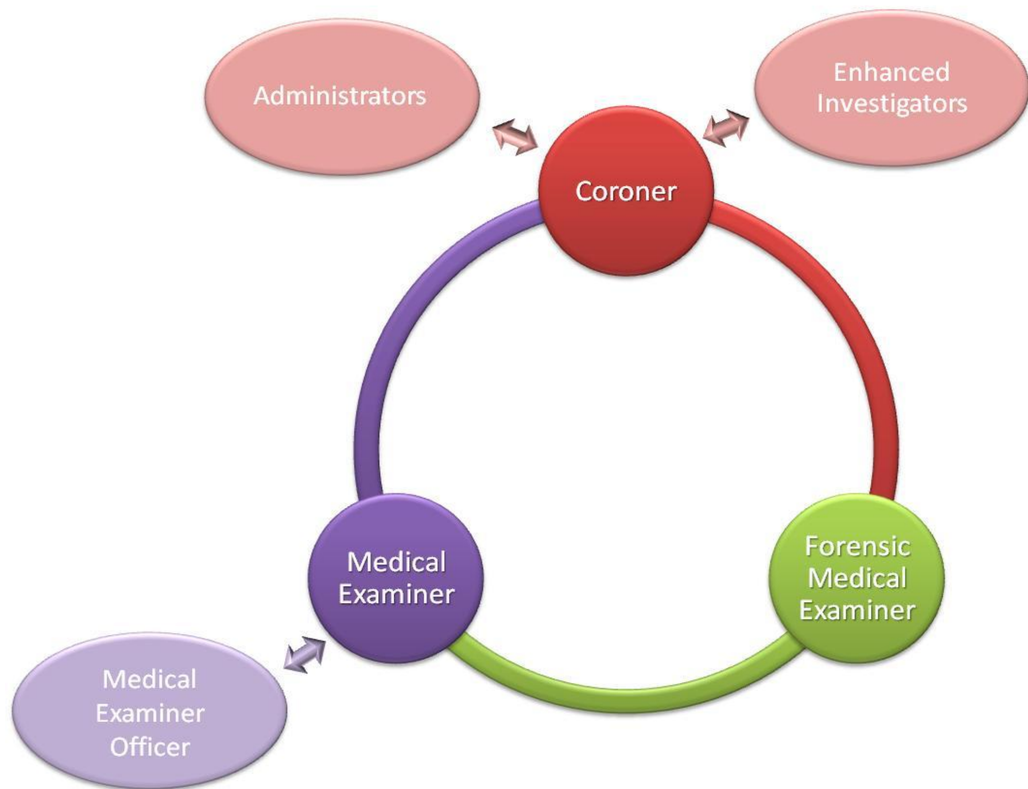
> *"provide an independent, cohesive system of death investigation and certification, readily accessible to and understood by the public. It should seek to establish the cause of every death and to record the formal details accurately, for the purposes of registration and the collection of mortality statistics. It should seek to meet the needs and expectations of the bereaved. Its procedures should be designed to detect cases of homicide, medical error and neglect. It should provide a thorough*

and open investigation of all deaths giving rise to public concern. It should ensure that the knowledge gained from death investigation is applied for the prevention of avoidable death and injury in the future" (para 19.13-19.14).

This was not a new concept as it was recognised by the Brodrick Committee in 1971 that the coroners' system was undergoing a shift away from crime towards a more medical and social function recommending that police officers should no longer be coroners' officers. Coroners' officers posts have now been civilianised, but the roles and responsibilities are variable depending on which jurisdiction in which it is being practiced, in turn leading to service quality inconsistencies. In addition, the majority of coroners' officers have no medical experience or education, despite coroners believing it is desirable to hold such attributes. Instead, according to the Shipman Inquiry (2003), many coroners' officers acquire medical knowledge by learning on the job and reading medical dictionaries.

Therefore it was envisaged too that the Coroners Service would replace coroners' officers with trained investigators who had enhanced roles along with administrators to perform more routine tasks. It is for that reason very interestingly to see that the aim of the Coroners and Justice Act (2009) is to:

"...deliver more effective, transparent and responsive justice and coroner services for victims, witnesses, bereaved families and the wider public".



The coronial reforms of this Act are due to be implemented by April 2012. The aims are to deliver an improved service for bereaved people; introduce national operational leadership and; ensure more effective investigations and inquests. The size and boundaries of coroners' areas are to be reviewed to ensure effective operation and coordination with other statutory services. The impact of these changes it is hoped will: provide a simpler process for bereaved families; enable doctors to have access to a medical examiner to discuss causes of death; reduce the amount of paperwork that funeral directors and registrars have to complete; and reduce the number of deaths needed to be reported to coroners. As this transitional phase develops, the debate continues on role boundaries between doctors and nurses and the advanced nurse practitioner. The medico-legal debate though adds another more challenging and complex argument. This study believes it is now an ideal opportunity to consider

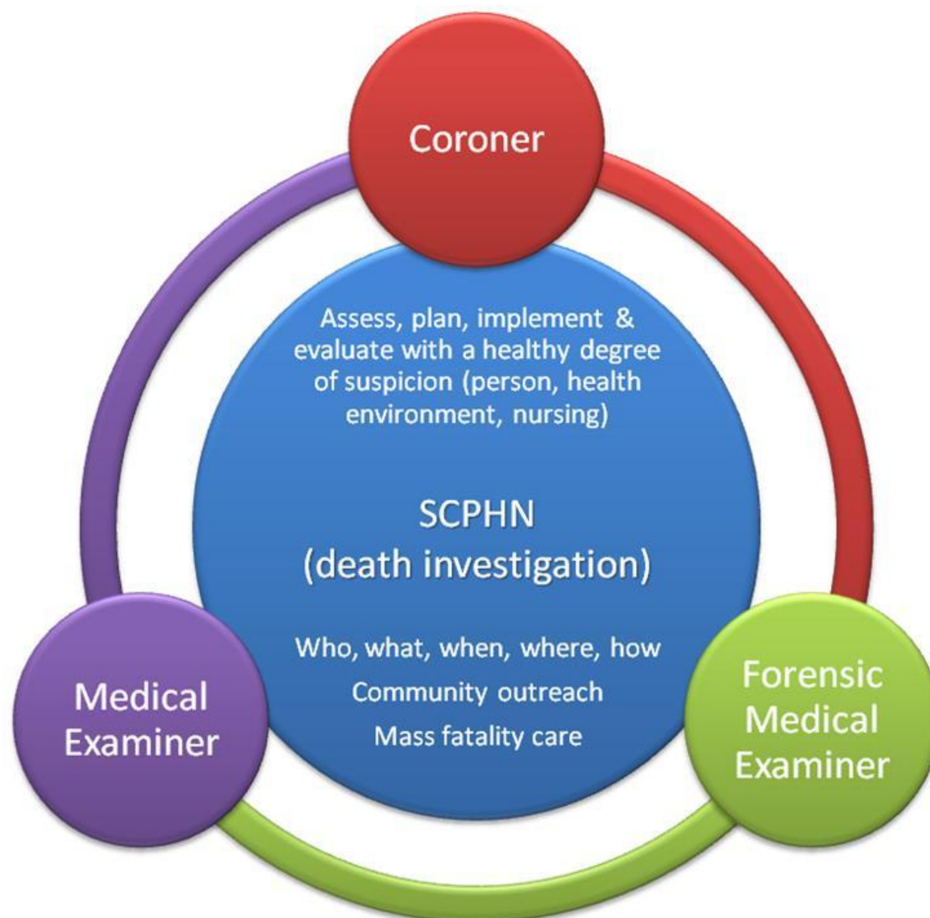
restructuring the coroners' office in England to include death investigation nurses who would work collaboratively with the Coroner, Forensic Medical Examiner and new Medical Examiner.

This study recommends that registered nurses are repositioned by expanding and advancing their role to bridge the gap between law and medicine within the coronial, forensic medical examiner and new medical examiner system. This would be a complementary role to that of the new coroners' administrators. Such nurses could offer services in regards to the investigation of death, community outreach and mass fatality care underpinned by holistic nursing care of families and bereaved people. It is believed such achievements would create firmer links between the coroner's office, forensic pathology, the new medical examiner (yet to be implemented), the forensic medical examiner, public health, healthcare generally (primary, secondary and tertiary), the legal system and the general public.

Such developments would need to be recognised by the Nursing and Midwifery Council (NMC) by creating a new field of practice, death investigation nursing, within the specialist community public health nurses registration. This is necessary to ensure there is a mechanism through which the NMC can exercise its main function of protecting the public (NMC 2004). It is envisaged that the death investigation nurse would replace the enhanced investigator and medical examiner officer (both yet to be implemented) in acting on behalf and in support of the coroner, forensic medical examiner and the new medical examiner (yet to be implemented).

The benefit of the death investigation nurse would be through the services of:

- Death investigation, that is the application of the nursing process to legal proceedings in investigating the who, what, when, where and how the person died;
- Community outreach, which would entail family support and resolution along with community and society public health. The priorities of this service would involve human identification and family notification; survivor grief resolution; public health care (benefiting the living through the dead) and media management;
- Mass fatality care that is: preparedness through capability exercising and multi-disciplinary training; and response through identification and return of human remains, illumination of unnoticed crime and psychological health.



The development and provision of a death investigation nurse with medical, legal and investigative expertise is expected by this study to create cost savings by simplifying the system of death certification, its contribution to public health and in the care of bereaved families. In turn much of the burden will be reduced on the coroner's office, the new medical examiner's service and forensic medical examiner workloads, providing a more cohesive, unified and consistent death investigation. It is recommended therefore that a steering group involving all the relevant stakeholders is set up to develop, implement, monitor, review and evaluate the death investigation nurse by establishing a pilot to test the proposed role. Stakeholders need to include the Nursing and Midwifery Council, Ministry of Justice, Home Office, Coroners' Society, Royal College of Nursing, National Policing Improvement Agency, Coroners' Officers Association, British Association of Forensic Medicine, Royal College of Pathologists, Strategic Health Authorities, Forensic Science Society and the International Association of Forensic Nursing on an advisory basis.

The steering group would be responsible for setting guidelines and strategies in regards to expertise, education and research in ensuring quality outcomes, promoting the avoidance of risk taking, improving communication processes and guaranteeing that there is no confusion as to the scope and definition of these innovative positions. It is envisaged the use of a supportive multidisciplinary steering group will assist towards preventing role stress and conflict and the feeling of isolation, a recognised outcome of new practitioner roles that are not supported by managers. Success would be measured against improvements to the death investigation process, community outreach and mass fatality care.

For such a role to be implemented it is recommended that a post-graduate curriculum proposal is developed in collaboration with the Nursing and Midwifery Council, Higher Education, The Coroners' Society, Coroners' Officers Association, Ministry of Justice, Department of Health, National Policing Improvement Agency, Royal College of Nursing, Royal College of Pathologists, Healthcare Workforce Deanery and Healthcare Trusts. Such a curriculum would be underpinned by the standards of proficiency for specialist community public health nurses that are grouped into the four domains of: search for health needs; stimulation of awareness of health needs; influence on policies affecting health and; facilitation of health-enhancing activities (NMC 2004). The following part-time curricula outline is suggested after considering the expanded versus the advanced nursing role, the needed consequent preparation within the field of death investigation and with nursing moving to an all graduate profession (see tables 2 and 3).

Table 2 - Part-time Curriculum Structure

Year	Semester 1	Semester 2	Award
1	The law and practice of the coroner (15) The nursing process as a holistic concern applied to death investigation (15)	Family support and resolution (15) Community and society public health care (15)	PG Cert
2	Research designs in public health (15) Strategic leadership and management in primary care (15)	Mass fatality care (15) Advanced forensic nursing science applied to death investigation (15)	PG Dip
3	Dissertation		MSc

Table 3 - Part-time Curriculum Outline: Aims

AWARD	AIMS
PG Cert Death investigation	1. Equip students with in depth knowledge, understanding and skills in regards to death certification, coronial law, ethics and modern death investigation techniques; 2. Critically analyse and discuss the use of theories and conceptual frameworks applied to death investigation nursing and how they can be further applied and developed to enhance services in death investigation; 3. Enable students to critically evaluate and apply contemporary community outreach agendas fostering positive values and attitudes associated with family support and resolution, health promotion and media management;
PG Dip Specialist Community Public Health Nursing (death investigation) with NMC registration	4. Foster critical analysis, evaluation and synthesis of the varying philosophical and research bases for professional practice; 5. Critically analyse the influence of strategic leadership and effective management on the social, political and economic context in relation to death investigation nursing and clinical governance; 6. Develop students' abilities and skills of critical analysis, synthesis and evaluation in advancing forensic nursing science within the field of death investigation in contribution to innovation, change and quality improvement.
MSc Specialist Community Public Health Nursing (advanced death investigation) with NMC registration	7. Enable students through the systematic, in-depth, exploration of a specific area of death investigation nursing to extend their knowledge, understanding and ability to contribute to the advancement of nursing knowledge and practice within the field of advanced nurse death investigation.

The next steps would be to run further pilots to test engagement with coroners, medical examiners and forensic medical examiners along with registrars, funeral directors, forensic pathologists and other stakeholders. Collaborative funding therefore from the Department of Health and Ministry of Justice would need to follow these initiatives in order to guarantee the drive and motivation for such achievements.

6.4 STRENGTHS AND LIMITATIONS OF THIS RESEARCH STUDY

The effects of the political climate on nursing research cannot be disregarded and may in fact be a limitation of this research study. Unfortunately, it is the search for solid facts and figures such as cost effectiveness, accountability and performance indicators that is the contemporary philosophy of a market economy. The necessity for nursing to justify practice and protect its positions could possibly entice a resurgence or reinforcement of the positivists' paradigm as a foundation for nursing knowledge, particularly moreover with the endeavour to intensify the scientific ranking of nursing in its battle to form its own unique body of knowledge (Playle 1995). This is a usefulness that cannot be abandoned, but that could unjustly disregard the importance of research studies utilising the interpretive paradigm and Heidegger's hermeneutic philosophy. The interpretive paradigm addresses and develops understanding of human experience that is person centred and holistic in nature, enabling this research study to gain rich knowledge and insight about nurses involved in the work of death investigation, which the positivistic paradigm has been unable to yield. Nevertheless, this research study is able to describe a number of strengths and limitations to not only put the findings into context, but to also assist other researchers in their decision making when developing similar proposals.

A major strength identified was the use of member checking, which was one of the methods used to evaluate the quality of data, credibility. The method involved the verification of findings by all the participants who took part in the study (see appendix 15). This was an intentional decision rather than using an external auditor so that all participants could compare the study's overall findings with their own perspective of the meaning of Being. In other words the interpretation of the data collected could be confirmed. Credibility in turn could then be upheld as there was confidence in the truth of

the data. The process entailed all participants being asked at each stage of the analysis procedure (the hermeneutic circle) to confirm that their descriptions and understandings of the meaning of Being as a nurse involved in the work of death investigation in the USA had been interpreted truthfully. The two criteria employed were that of ensuring participants recognised their own understandings and meanings with the interpretations put forward to them and that any omissions or misunderstandings were either corrected or additional data was collected.

The sampling technique and sample size could be identified as a limitation of this study. Finding the population of nurses working as death investigators in the USA was difficult as there was no definitive list or register that could be accessed and used. The snowball sampling technique was therefore instigated. Nurses who were initially identified through the literature, the World Wide Web (websites) or personally through international conferences were contacted in the first instance. Perhaps the use of social networking sites such as Facebook (www.facebook.com) would have increased uptake especially with the participants being international in nature. However it was decided not to use this method as it was felt that this may slant the sample to those participants who were more technological competent leading to the potential exclusion of those who did not have access to the World Wide Web. Instead, further potential participants were selected by means of nominations or referrals from the previously identified participants, who then in turn nominated other individuals until no new relevant referrals were made. It is recognised though that this method of sampling can produce problems in regards to representativeness and bias as participants nominate other potential participants from their own social groups leading perhaps to some groups not being tapped into. There was an attempt therefore to ensure that the sample represented a wide range of States

within the USA so as to avoid a slanted interpretation such as a west coast or mid state view.

Some researchers, particularly those from the positivist view, would argue that small samples will not enable generalisation of the findings to the larger population. The sample size for this study was not identified numerically at the beginning of this study as it relied instead on the belief that the sample size is considered adequate when no new information is forthcoming from participants. In hermeneutic terms it is the temporality of truth that is recognised rather than saturation which is used by other qualitative methodologies. This decision was justified as interpretive research relies upon the richness and depth of meanings which can be lost if large samples are employed. Having provided a précis of the findings and identified the overall strengths and limitations it is pertinent to put forward recommendations for future research based upon these premises.

6.5 RECOMMENDATIONS FOR FUTURE RESEARCH

The study aimed to accurately describe and interpret participants' meanings and practices, through the identification, description and interpretation of common practices, which in turn enabled important and hidden aspects of practical knowledge to be revealed. However, it is recognised that the use of Heideggerian hermeneutics is always open to change and criticism in that it acknowledges that the development of knowledge is never complete. This section therefore will attempt to identify unanswered questions and outstanding gaps in the evidence put forward by this study so as to direct future research. To date there remains an enormous research gap in relation to nurses working within the realms of death investigation as identified in chapter two, the literature review.

There are, in fact, only a limited number of discussion papers and short articles published. It is recommended therefore that the following research is undertaken.

Towards the end of this study other countries such as Canada, Finland, India, Korea and South Africa have now employed nurses as death investigators or nurse coroners. A repeat of this hermeneutic study into the meaning of Being may prove useful in illuminating further horizons from around the world into how nurses are developing, expanding and advancing their roles within the forensic multidisciplinary team. It is hoped that this will inform England further as to the potentiality of the development of the death investigation nurse.

A survey could be undertaken using the Delphi technique to gather consensus of opinion, attitudes and choice from specialist community public health nurses, coroners, coroners officers, forensic pathologists, forensic medical examiners and bereaved families as to the development of the death investigation nurse in England in providing a service as described by this study under the shared meanings of Being.

Based on the findings of the above survey and bearing in mind that making a difference in health care is one of the prime concerns of nursing within England it is suggested that a pilot study is instigated as to the potential public health service that nurses as death investigators could provide as part of the coronial, forensic medical examiner and new medical examiner team in regards to investigation, community outreach and mass fatality care as described in section 6.3. The pilot through the use of an action research design would take place within each of the nine regions of England to investigate the significance, feasibility and potentiality of such a role including recommendations as to

what nurses could offer beyond their current role boundaries through the use of an action research design.

Finally, a quantitative survey comparing family perceptions of the service offered by coronial teams versus coronial teams who have incorporated death investigation nurses could be initiated to explore the above developments and contributions that nurses are making to the services of public health and death investigations.

6.6 POSTDOCTORAL FIVE YEAR TIMETABLE

Following the suggested implications for nursing practice, recommendations for practice development, strengths and limitations of this study and consequent recommendations for future research as previously deliberated, a postdoctoral five year timetable is proposed (see table 4). This plan has been put together so as to not only further my own expertise in this area, but more importantly to disseminate and implement the findings of this study through publication, management of change and further research. It is intended though to be flexible so as to reflect the degree of innovation and complexity that the findings of this study have offered.

Table 4 – Post-doctoral five year timetable.

PHASE	2011	2012	2013	2014	2015
1	**Consultation** • Repeat hermeneutic study into the meaning of Being as a death investigation nurse in Korea and South Africa; • Survey (Delphi technique) to gather consensus.				
2	**Design and develop** Steering group formed to: • Develop death investigation nursing national clinical protocols in line with the Coroners and Justice Act (2009); • Develop standards and proficiencies for the new Specialist Community Public Health Nursing (death investigation) pathway with the Nursing and Midwifery Council (NMC); • Develop and validate post-graduate curriculum with the NMC, Higher Education, Healthcare Workforce Deanery, Ministry of Justice, Royal College of Pathologists and Coroners' Society.				
3		**Test, pilot, evaluate, refine** • As a pilot study using an action research design implement the death investigation nurse in nine regions (North-West, North-East, Yorkshire and Humberside, West Midlands, East Midlands, South West, South East, East Anglia and London) to investigate the significance, feasibility and potential; • Complete a quantitative comparative survey of all nine regions to examine bereaved families, coroners, medical examiners, forensic medical examiners, forensic pathologists, funeral directors registrars and death investigation nurses' perception of piloted service.			
4				**Planning, preparation and staged roll out.**	

6.7 CHAPTER SUMMARY

This study set out to explore the meaning of Being as a nurse involved in the work of death investigation in the USA. The three aims were to:

1. *Critically interpret what prior experiences and/or understandings were bought by nurses concerning the meaning of Being as a nurse who became involved in the work of death investigation in the USA.*
2. *Critically interpret what current experiences and/or understandings nurses articulate as the meaning of Being as a nurse involved in the work of death investigation in the USA*
3. *Bearing in mind that making a difference in health care is one of the prime concerns of nursing within England, critically examine if there is need for registered nurses to expand their role into the realms of death investigation and if so what nurses would be recommended to offer beyond their current role boundaries*

Aims one and two have been undertaken underpinned by Heidegger's hermeneutic philosophy by answering the overall research question and suggesting how nursing theory could be developed in regards to assumptions, universal concepts and propositions contributing to a new and innovative definition of nursing.

Health care and health policy are rapidly changing along with the role of the nurse, midwife and specialist community public health nurse. The document Front Line Care (2010) not only recognised the value of nursing, but also the importance of raising the quality of patient care and improving the health of people. Florence Nightingale (Cook 1914) once said:

“Unless we are making progress in our nursing every year, every month, every week, take my word for it, we are going back”.

This study has recognised an area of potential development and advancement in public health nursing that has up until now negated in England compared to our American colleagues. The third aim therefore was fulfilled by putting forward in this chapter the implications for clinical nursing practice and recommendations for practice development in expanding and advancing the nurses role into death investigation in England with the Department of Health and Ministry of Justice. Proposals for future research while recognising the strengths and limitations of this study were finally put forward to investigate and explore nurses working in similar positions around the world and to examine the multi-professional consensus, significance, feasibility and potential of such a development in England.

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ACTS

1194 Articles of Eyre

1215 Magna Carta

1276 Statute De Officio Coronatioris

1707 Act of Union

1836 Birth and Registration Act

1874 Death Registration Act

1956 Clear Air Act

1976 Fatal Accident and Sudden Death Enquiry, Scotland Act

1979 The Nurses, Midwives and Health Visitors Act

1984 The Coroners Act and The Coroners Rules

1987 Registration of Births and Death Regulations

1988 The Coroners Act and The Coroners Rules (amended)

1990 Courts and Legal Services Act

1992 Nurses, Midwives and Health Visitors Act (amended)

1997 Nurses, Midwives and Health Visitors Act (amended)

2000 Human Rights Act

2001 Health and Social Care Act

2002 National Health Service Reform and Health Care Professions Act

2002 Nurses, Midwives and Health Visitors Act (Professional Conduct) (Amendment) Rules

2003 Health and Social Care (Community Health and Standards) Act

2006 The National Health Service Act

2009 Coroners and Justice Act

APPENDICES

Appendix 1

SELECTED PERSONAL PUBLICATIONS, OFFICES HELD AND CONSULTANCY WORK ARISING FROM THIS STUDY

JOURNAL PAPERS

- RUTTY JE and Rutty GN (2000) Giving evidence: why and how. Nursing Times, August 10th 96(32):40-41
- Woodward H, RUTTY JE and Rutty GN (2001) A 51 year retrospective study of the trends of height, weight and body mass index at the time of death in those age 16-103. Journal of Clinical Forensic Medicine, 8(2): 66-73, June.
- BouHaidar R, RUTTY JE & Rutty GN (2004) Forensic web watch – forensic nursing. Journal of Clinical Forensic Medicine. 11:220-222
- Rutty JE (2006) Does England need a new genesis of forensic nursing. Forensic Science, Medicine and Pathology 2(3): 149-155
- Rutty JE (2006) Forensic nursing. Forensic Science, Medicine and Pathology 2(3): pp215

ABSTRACTS IN JOURNALS

- RUTTY JE (2002) Religious attitudes to death. Education in Pathology, July, No 119, pp17
- RUTTY JE (2002) Care of the deceased in Britain: Religious variations and what every Histopathologist needs to know. The Journal of Pathology Supplement, July

BOOK CHAPTERS

- RUTTY JE (2OO1) Care of the deceased in Britain: Religious variations and what every Histopathologist needs to know. In Rutty GN (editor) Update in Autopsy Practice, Springer-Verlag London Ltd, pp1-22
- RUTTY JE (2002) Care of the deceased in Britain: Religious variations and what every Histopathologist needs to know, part 2. IN Rutty GN (editor) Update in Autopsy Practice, Springer-Verlag London Ltd, pp1-16
- RUTTY JE (2003) Religious attitudes to death from a health care practice perspective. IN Encyclopaedia of Forensic and Legal Medicine. Elsevier, London
- RUTTY JE (2006) Forensic Nursing. IN Rutty GN (editor) Update in Autopsy Practice, Springer-Verlag London Ltd, pp1-13
- RUTTY JE (2006) Forensic medicine and nursing: Global perspectives Part II, England and Wales. IN Lynch V (editor) Forensic Nursing. Lippincott Williams and Wilkins, Greensburg USA, pp 606-609
- RUTTY JE (2010) Religious Attitudes to death and post mortem examinations. IN Burton JL and Rutty GN (editors) The Hospital Autopsy: A Manual of Fundamental Autopsy Practice. Hodder Arnold, London pp 39-58.

CONFERENCE INVITED KEY SPEAKER

- RUTTY JE (2000) A nurse in the witness box. Regional BMI Healthcare conference, Legal Issues. Sheffield Hallam University, 11 November.
- RUTTY JE (2000) Custody nursing: A forensic nursing innovation for England. South Carolina Hospital University. Charleston, South Carolina, 01 August.

- RUTTY JE. (2001) Forensic Nursing: The role of the nurse in death investigation. Fingerprint Branch, New Scotland Yard - 100 Years of Fingerprints at Scotland Yard, A Centennial Conference on Identification, London. 26 June – 29 June.
- RUTTY JE (2002) Religious variations: What every histopathologist needs to know. Royal College of Pathologists, London. 24 January.
- RUTTY JE (2004) The nurse as a death scene investigator. Forensic Science Society Conference, Derby. 23-25 April.
- RUTTY JE (2009) Nurses making a difference to healthcare in custody suites. National Sickle Cell Conference, Unit for Social Study of Thalassaemia and Sickle Cell (TASC Unit), De Montfort University. 10 June.

CONFERENCE PRESENTATIONS

- RUTTY JE (2000) Developing and assessing advanced nursing practice. European Regional Conference of the Commonwealth Nurses' Association (Guernsey), 17-19 March
- RUTTY JE, Woodward H and Rutty GN (2000) A 50 year retrospective study of height, weight and body mass index at the time of death in those aged 16-103. Royal College of Nursing Research Society Annual Conference (Sheffield), 13-15 April
- RUTTY JE (2001) Nursing care for detainees in police stations: A qualitative study explores the meaning of this pioneering role in England. International Council of Nursing Congress, Copenhagen, Denmark, 10-14 June.
- RUTTY JE (2001) Forensic Nursing: A concept analysis for the United Kingdom. International Association of Forensic Nursing 9th annual scientific assembly, Orlando, USA. 25 September – 02 October.

- RUTTY JE (2001) Death investigation: A hermeneutic study of the forensic nurse's role in South Carolina, USA. International Association of Forensic Nursing 9th annual scientific assembly, Orlando, USA. 25 September – 02 October.
- RUTTY JE (2001) Nursing care for detainees in police stations. A qualitative study explores the meaning of this pioneerinGNursing role in England. International Association of Forensic Nursing 9th annual scientific assembly, Orlando, USA. 25 September – 02 October.

CONFERENCE POSTER PRESENTATIONS

Woodward H, RUTTY JE and Rutty GN (2000) A 50 year retrospective study of height, weight and body mass index at the time of death in those aged 16-103. Pathological Society of Great Britain and Ireland Winter Meeting (London), 18-21 January.

RADIO INTERVIEW

RUTTY JE and Lynch V (2007) Forensic Nursing. BBC Radio Leicester

OFFICES CURRENTLY HELD

- Global Advisory Board Member, Journal of Forensic Nursing
- Board Member and Referee, Journal of Clinical Forensic Medicine
- Editorial Panel Member, Journal of Forensic Science, Medicine and Pathology (until 2009)
- Sentinel Reader for Evidence Based Nursing, McMaster University
- Founder & President, European Association of Forensic Nurse Practitioners (until 2009 – now UK Association of Forensic Nurse Practitioners).
- External Examiner, Graduate Diploma in Custody Nursing, Dundee University.

CONSULTANCY WORK

- 2003 - Home Office Review: Death certification and investigation in England, Wales and Northern Ireland
- 2005 - Leicester University Medical School and Leicestershire Constabulary re: Research and practice development of the forensic nurse examiner
- 2005 - Council for the Registration of Forensic Practitioners (Home Office) re: Registration of nurses
- 2008 - Lead Evaluator, Operation Torch – International, multidisciplinary mass fatality CBRN capability and educational response exercise in preparation for the 2012 Olympics (Chrystal Palace Stadium).
- 2010 - Author and developer, E-Learning Medical Examiner Project: Faith Considerations (Part 1 Abrahamic faiths, Part 2 Dharmic faiths, Part 3 Far Eastern faiths, Part 4 Other traditions), Department of Health and Royal College of Pathologists.

PROFILE CITATIONS

- Marquis Who's Who in Science and Engineering: 2002-2010, multiple editions.
- Marquis Who's Who in Medicine and Healthcare: 2002-2010, multiple editions.
- Marquis Who's Who in the World 2003-2010, multiple editions.
- Marquis International Who's Who of Professionals: 2004-2010, multiple editions.
- Dictionary of international biography: 2004-2010, multiple editions..
- The Cambridge Blue Book: International Biographical Centre, Cambridge, England. 2005-2010, multiple editions
- Madison Who's Who of Executives and Professionals: 2005-210, multiple editions.

RESULTS OF PEER-REVIEWED PUBLICATIONS REGARDING

NURSING AND DEATH INVESTIGATION IN THE USA

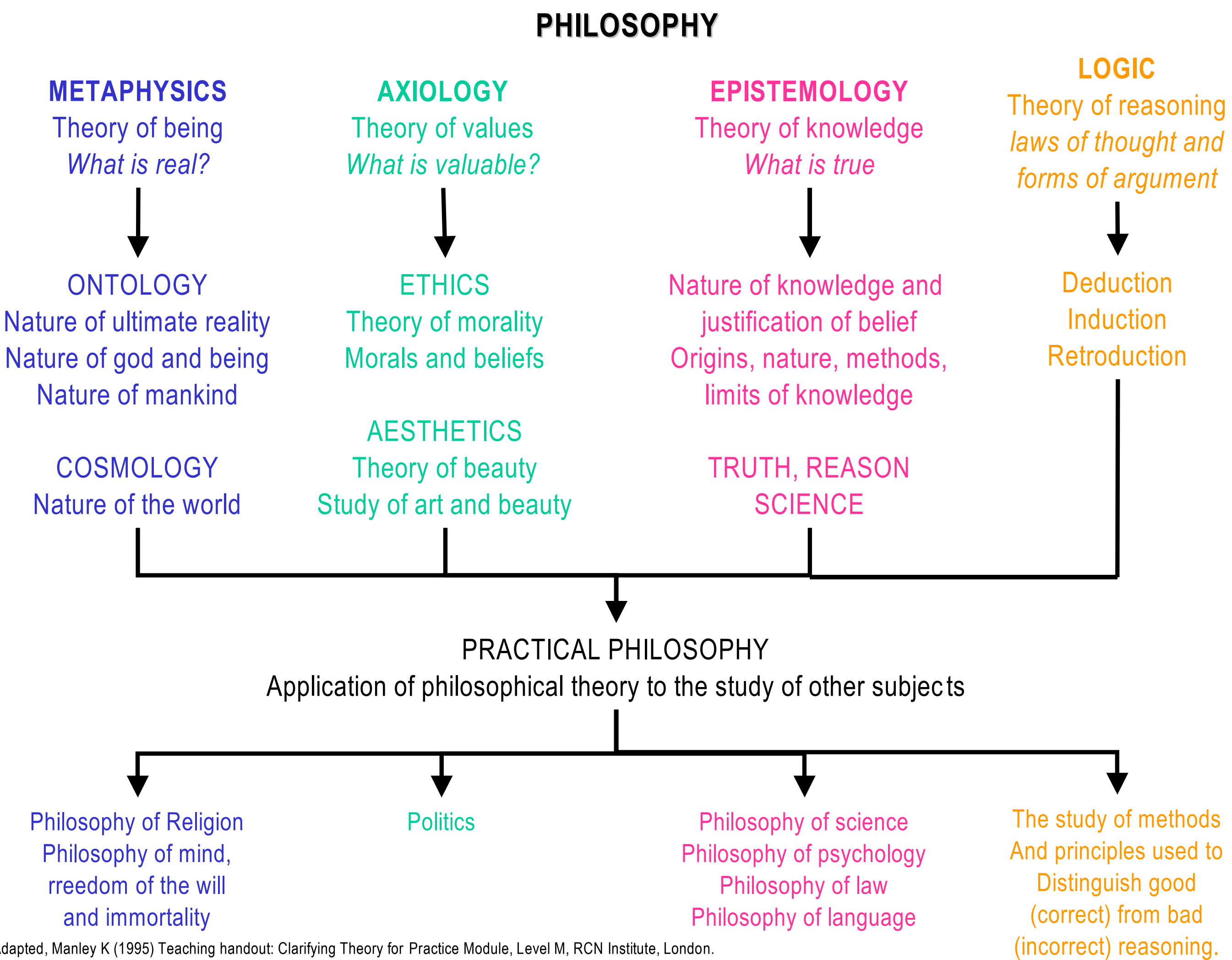
IN DATABASES CINAHL AND MEDLINE

FROM 1984 TO 2007

SEARCH TERMS	CINAHL		MEDLINE	
	Results	Relevant	Results	Relevant
Forensic nursing	808	4	128	0
Death investigation	14	1	125	0
Death investigator	2	2	11	0
Coroner	70	2	496	1
Medical examiner	81	0	1177	0

TYPES OF RELEVANT PEER REVIEWED PUBLICATIONS

REFERENCE	PAPER TYPE
Jezierski M (1994) Deputy coroner: A different kind of nursing. Journal of Emergency Nursing 20(5):425-6	Short article (Interview)
Bear ZGS (1995) Forensic nursing and death investigation: Will the vision be co-opted. Journal of Psychosocial Nursing and Mental Health Services 33(9):59-64	Discussion paper
Cumming MF (1995) The vision of a nurse-coroner: A "protector of the living through the investigation of death". Journal of Psychosocial Nursing and Mental Health Services 33(5):42-3	Discussion paper
Benak L (1996) First death investigator course for nurses held in Dade County. On The Edge 2(3):6	Short article
Cumming M (1996) Nurse-coroner to forensic consultant: one emergency nurse's experience. Journal of Emergency Nursing 22(6):494-497	Short article
Chewning S (2000) How to become a death investigator. On The Edge 6(4):6-7	Short article
Chewning S (2001) Nurses provide closure as death investigators. Nursing Spectrum (Southeast) 2(6):20.	Short article
Boock M (2003) Life, death and everything in between: RN takes on multiple roles as coroner in Ski Haven. Nursing Spectrum (West) 4(1):18-9	Short article
Lasseter S (2003) Harris County, TX, Medical Examiner's Office expands forensic nursing division. On The Edge 9(3):17	Short article



Adapted, Manley K (1995) Teaching handout: Clarifying Theory for Practice Module, Level M, RCN Institute, London.

PARTICIPANTS CRITERIA FOR INCLUSION

- Registered Nurse in the USA holding the National Council of Licensure Examination
- Member of the licensing authority where practicing in accordance with the National Council of State Boards of Nursing in the USA
- A Registered Diplomat with the American Board of Medicolegal Death Investigators for at least one year (D-ABMDI)
- Currently employed as a nurse coroner or nurse death investigator in the USA
- Acquired at least three years full-time equivalent experience in their current post as a nurse coroner or death investigator, that is 5,000 hours
- Has the responsibility to conduct scene investigation

UNSTRUCTURED NON-PARTICIPANT OBSERVATIONAL SCHEDULE.

Experiences/ understandings as a nurse involved in the work of death investigation

INTRODUCTION
Reiterate the purpose of the interview and how long it is expected to take
Confirm that all data will remain confidential and the value of the participant's contribution
The need for them to take part validating interpretations made of this interview
Inform participant that a summary of the final study findings will be forwarded if requested

BE ALERT TO PARTICIPANT/S DESCRIPTIONS OF:
Being-in-the-world; Fore-structures; Time; Space

Date:	
Location:	
Research participant/s number:	

Time	Field notes - Record of people, events and conversations (including observation position)	Interpretation notes

Appendix 7

UNSTRUCTURED INTERVIEW GUIDE

INTRODUCTION

Reiterate the purpose of the interview and how long it is expected to take

Confirm that all data will remain confidential and the value of the participant's contribution

The need for them to take part validating interpretations made of this interview

Inform participant that a summary of the final study findings will be forwarded if requested

BACKGROUND AND PRE-UNDERSTANDING

What prior experiences and/or understandings bought you to become a nurse involved in the work of death investigation?

CO-CONSTITUTION AND INTERPRETATION.

What have been and are your experiences and/or understandings as a nurse involved in the work of death investigation?

BE ALERT TO PARTICIPANT'S DESCRIPTIONS OF:

- Being-in-the-world
- Fore-structures
- Time
- Space

SUMMARY AND THANKS

SUMMARY OF RESULTS

A summary of the results of this research will be supplied to you electronically, at no cost to you, upon request on completion of the study.

HOW DO I FIND OUT MORE?

If you would like to know more about my research in general and/or would like to participate in my research then please feel free to contact me either by post, telephone or email.

CONTACT

Jane E Rutty
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Would you like to consider participating in research to explore what it means to be a nurse involved in the work of death investigation in the USA in order to examine what nurses in England could offer beyond their current role boundaries within this area of practice?

If your answer is "***YES***" then this leaflet tells you:

- What the purpose of the research is;
- The procedures for participating;
- Risks and benefits of participating;
- Issues surrounding compensation, confidentiality, voluntary participation and the right to withdraw; and
- How you can find out more.

SOURCE OF SUPPORT FOR THIS RESEARCH

This study is being undertaken to fulfill the requirements required for a PhD at the University of Bradford.

WHAT IS THE PURPOSE OF THE RESEARCH?

You are being asked if you would like to participate in this research to explore what it means to be a nurse involved in the work of death investigation in the USA. In England there are no such roles for nurses and so I am examining what nurses in England could offer beyond their current role boundaries within this area of practice.

WHAT ARE THE PROCEDURES FOR PARTICIPATING IN THE RESEARCH?

Should you choose to participate in this study you will be observed and interviewed in your clinical place of work.

The observations by me will be non-participant in nature over a number of working shifts varying from two to twenty one days. The observational data will be in the form of note taking.

The interviews conducted by me will be unstructured in nature. It is anticipated that at least two interviews will be undertaken, each of which will take around 45 to 90 minutes each. The interviews will be tape recorded.

On completion of the data collection and analysis you will be asked by me to review the findings to ensure that the analysis is a true reflection of your perceptions and experiences as to what it means to be a nurse involved in the work of death investigation.

These are the only requests that will be made of you.

On my visits to the USA I will acting as a nurse researcher from the UK and therefore will not be practicing as a registered nurse during data collection periods.

WHAT ARE THE RISKS AND BENEFITS OF PARTICIPATING IN THE RESEARCH?

There are no benefits to participating in this study, other that the knowledge that you may someday be helping others working or contemplating to work in the same situation as you in the USA. The results of the study may have constructive impact also on practice development in the USA and the UK.

COMPENSATION

You will not be compensated for participating in this study and participation in the project will require no monetary cost to you.

CONFIDENTIALITY

Your name will never appear on any research instruments, that is, observational schedules or otherwise. All written materials, tape recordings and consent forms will be stored in a locked filing cabinet in my office during the study period, but then destroyed on completion of the study. Any data stored electronically will be secured by password and deleted permanently on completion of the study.

Your identity along with the identities of your death investigation team and families/members of the public will not be incorporated in the data analysis, unless you and the relevant person give permission for such photographs to be taken and included as part of the study's findings.

VOLUNTARY PARTICIPATION AND THE RIGHT TO WITHDRAW

Your participation in this study is completely voluntary. You are free to withdraw your consent to participate at any time. The withdrawal form the study will not affect your relationship with me or your death investigation team.

[UoB Headed Paper]

UNIVERSITY OF BRADFORD

THE ROLE OF THE NURSING PROFESSION IN DEATH INVESTIGATION

CONSENT FORM

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SOURCE OF SUPPORT
This study is being undertaken to fulfil the requirements required for a PhD at the University of Bradford

PURPOSE
You are being asked to participate in this research to explore what it means to be a nurse involved in the work of death investigation in the USA in order to examine what nurses in England could offer beyond their current role boundaries within this area of practice.

PROCEDURES
If you choose to participate in this study you will be observed in clinical practice over a number of working shifts (varying from 2 to 21 days). The observations by me will be non-participant in nature. You will also be interviewed at least twice during this period. It is anticipated that each interview will take around 45 to 90 minutes and will be tape recorded and transcribed for analysis. On completion of the data collection and analysis you will be asked to review the findings to ensure that the analysis is a true reflection of your perceptions and experiences as to what it means to be a nurse involved in the work of death investigation. These are the only requests that will be made of you.

RISKS AND BENEFITS
There are no benefits to participating in this study, other than the knowledge that you may someday be helping others working or contemplating to work in the same situation as you here in the USA. The results of the study may have constructive impact also on practice development both here in the USA and the UK.

COMPENSATION
You will not be compensated for participating in this study and participation in the project will require no monetary cost to you.

CONFIDENTIALITY
Your name will never appear on any research instruments, that is, observational schedules or otherwise. All written materials, tape recordings and consent forms will be stored in a locked filing cabinet in the researcher's office during the study period, but then destroyed on completion of the study. Your identity along with the identities of your death investigation team and families/members of the public will not be incorporated in the data analysis, unless you and/or the relevant person gives permission for photographs to be included as part of the study's findings.

VOLUNTARY PARTICIPATION AND RIGHT TO WITHDRAW
Your participation in this study is completely voluntary. You are free to withdraw your consent to participate at any time. The withdrawal from the study will not affect your relationship with your death investigation team.

SUMMARY OF RESULTS
A summary of the results of this research will be supplied to you electronically, at no cost to you, upon request on completion of the study.

PARTICIPANT'S VOLUNTARY CONSENT
The study described above has been explained to me and I understand what is being requested of me and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research study. I understand that should I have any further questions the research or about participant's rights, I may call Jane Rutty or Professor Jeff Lucas as listed above.

	Jane E Rutty
____________________________	____________________________
Participant's name	Researcher's name
____________________________	____________________________
Participant's signature	Researcher's signature
____________________________	____________________________
Date	Date

[DMU Headed Paper]

DE MONTFORT UNIVERSITY

THE ROLE OF THE NURSING PROFESSION IN DEATH INVESTIGATION

CONSENT FORM

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SOURCE OF SUPPORT
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PURPOSE
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PROCEDURES
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RISKS AND BENEFITS
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COMPENSATION

You will not be compensated for participating in this study and participation in the project will require no monetary cost to you.

CONFIDENTIALITY

Your name will never appear on any research instruments, that is, observational schedules or otherwise. All written materials, tape recordings and consent forms will be stored in a locked filing cabinet in the researcher's office during the study period, but then destroyed on completion of the study. Your identity along with the identities of your death investigation team and families/members of the public will not be incorporated in the data analysis, unless you and/or the relevant person gives permission for photographs to be included as part of the study's findings.

VOLUNTARY PARTICIPATION AND RIGHT TO WITHDRAW

Your participation in this study is completely voluntary. You are free to withdraw your consent to participate at any time. The withdrawal from the study will not affect your relationship with your death investigation team.

SUMMARY OF RESULTS

A summary of the results of this research will be supplied to you electronically, at no cost to you, upon request on completion of the study.

PARTICIPANT'S VOLUNTARY CONSENT

The study described above has been explained to me and I understand what is being requested of me and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research study. I understand that should I have any further questions the research or about participant's rights, I may call Jane Rutty or Professor Jeff Lucas as listed above.

	Jane E Rutty
Participant's name	Researcher's name
Participant's signature	Researcher's signature
Date	Date

GUIDELINES TO DEAL WITH AND REPORT UNSAFE PRACTICE IN THE USA

As a registered nurse from the UK these are guidelines for me as a researcher in the USA to deal with and report unsafe practice (should it occur) when either observing, interviewing or reading written records as part of the study's data collection and analysis process.

These guidelines were written and agreed in conjunction with the relevant Heads of Department be they the Chief Coroner or Forensic Medical Examiner (dependent on the death investigation system in place in that State and/or County) involved in the research.

Should unsafe practice be bought to my attention:

1. The data collection process for the research study will be immediately halted
2. The health and safety of the individual (be it the research participant, deceased, client, member of the public or other professional) being compromised will then be ensured and if required emergency help will be called for
3. Concerns regarding the individual who was practicing unsafely (may be the research participant or other member of the multi-disciplinary team) will then be reminded of my professional responsibilities as a registered nurse from the UK researching (not practising) in the USA in that such concerns cannot be ignored and must be reported appropriately and support offered even if they did not request it
4. The individual's line manager will then be informed
5. Guidance and support will be sought from the Head of Department involved in the research study at that time (Chief Coroner or Forensic Medical Examiner) and my

research supervisor (back in the UK) as to the way forward in resolving the issue of unsafe practice bought to my attention and continuing with the data collection process for the research study

6. Written evidence to the appropriate manager or other relevant authority will be submitted if requested to do so
7. A full record of the incident will be recorded in my own Reflective Diary for personal development purposes only and not used as part of the data collection or analysis.

SUMMARISED RESEARCH DECISION TRAIL

(Transferability)

RESEARCH PROCESS	**RESEARCH DECISION TRAIL**
RESEARCH QUESTION What is the meaning of Being as a nurse involved in the work of death investigation in the USA?	Following a review of the literature from 1984 onwards led to this research question after demonstrating hidden knowledge in need of illumination about the phenomenon, as no other research had explored this perspective before. Therefore, this study has led to the generation of new knowledge.
STUDY DESIGN Heidegger's hermeneutic philosophy	A review of Habermas' three major sciences led to the justification for the interpretive paradigm. The potential relevancies, contributions and limitations of the various methodologies were considered such as ethnography, grounded theory and phenomenology before choosing hermeneutics. Hermeneutics was justified as being appropriate as its goal is to understand practices and skills by looking for patterns, commonalities and meanings so as to reveal phenomena that seems then to be familiar.

RESEARCH PROCESS	RESEARCH DECISION TRAIL
Cont…	Various hermeneutic philosophies were considered including historical, modern and contemporary, but Heidegger's work was justified as it embraced the exploration of the ontological as well as the epistemological nature of meaning of Being providing, a more holistic view in parallel to nursing.
SAMPLING Snowball sample of nurses as death investigators or coroners	The sample was a hidden population and so the snowballing technique was instigated. Disadvantages of this technique concerning representativeness were counteracted by including participants from a range of States within the USA. The size of the sample was not identified numerically, but based on the belief that sample size is considered adequate when no new information is forthcoming from participants. This is not in relation to saturation though as theoretical saturation is not sought in hermeneutic studies as it is the temporality of truth that is recognised. Nevertheless, it was anticipated that the sample would be somewhere between six and twenty five. This decision was justified as if the sample becomes too large in interpretive research the richness and depth of meanings extrapolated from

RESEARCH PROCESS	RESEARCH DECISION TRAIL
Cont…	participants are more likely to be lost.
INSTRUMENTATION Observations Interviews Historical documents Reflective diary	These methods of data collection were justified as they correlated well within a hermeneutic philosophy as they encourage the participants to describe openly the phenomena with the added bonus of being able to gather further information concerning context and factual evidence to enhance trustworthiness. In addition the study of participants through a multiple instrumentation approach on multiple occasions enabled issues/items to be revisited and new areas to be discussed that participants may have forgotten to put forward previously. The use of participant validation of all transcripts was to enhance the trustworthiness of the data collected.
PROTECTION OF PARTICIPANTS	The study believed in gaining approval, informed consent, confidentiality and anonymity founded on the principles of autonomy, non-maleficence, beneficence and justice and professional conduct requirements both in the UK and USA.

RESEARCH PROCESS	RESEARCH DECISION TRAIL
METHODS OF ANALYSIS	The seven phase analysis process underpinned by the hermeneutic circle was justified in that it fulfilled Heidegger's recommendation that one should repeatedly reflect and return to both the participants' and researcher's fore-structures (and not bracket). In addition it is interrelated in nature in that the analysis of parts of Being enabled the illumination of the whole of Being. The use of participant validation at all stages of the data collection and interpretation phases was justified to enhance trustworthiness. This was evidenced further through the production of an Audit Trail (appendix 14).
TRUSTWORTHINESS	Trustworthiness is justified as it was considered from the aspects of credibility regarding: prolonged involvement and persistent observation, triangulation and member checking. In addition the issue of transferability from the aspects of dependability and confirmability were supported.

RESEARCH PROCESS	RESEARCH DECISION TRAIL
PRESENTATION OF FINDINGS	As many quotations as possible were included to not only support the findings being presented, but to ensure that context of the meaning of Being was upheld.
CREDIBILITY OF THE RESEACHER (ME)	This study in its introduction has provided a summary of my background and experience so that readers can judge the credibility of the research in relation to intellectual rigour, professional integrity and methodological competence. The keeping of a reflective diary assisted in maintaining an honest view of me in relation to the development of my own horizon throughout the study which is acknowledged at the beginning of the Findings and Discussion chapter.

Appendix 12

STUDY POPULATION BASED ON SNOWBALL SAMPLING, PUBLISHED LITERATURE AND THE WORLD WIDE WEB OVER THE STUDY PERIOD.

KEY: ✓ = Yes

STATE		SYSTEM IN PLACE				NURSES FOUND IN PLACE AS	
		Centralised State Medical Examiner	County Coroner	County Medical Examiner	Mixed County Medical Examiner & Coroner	Death investigators	Coroners
PACIFIC WEST	Washington				✓	✓	✓
	Oregon	✓				✓	
	California				✓		
	Alaska	✓					
	Hawaii				✓		
WEST	Montana		✓				
	Idaho		✓				
	Wyoming		✓				
	Nevada		✓				✓
	Utah	✓					
	Arizona						
	New Mexico	✓					

STATE		SYSTEM IN PLACE				NURSES IN PLACE AS	
		Centralised State Medical Examiner	County Coroner	County Medical Examiner	Mixed County Medical Examiner & Coroner	Death investigators	Coroners
CENTRAL	North Dakota		✓				
	South Dakota		✓				
	Nebraska		✓				
	Colorado		✓			✓	
	Kansas		✓				
	Oklahoma	✓					
	Texas			✓		✓	
MID WEST	Minnesota				✓		✓
	Wisconsin				✓		✓
	Iowa			✓			
	Illinois				✓		
	Ohio				✓		
	Michigan			✓			
	Indiana		✓				

STATE		SYSTEM IN PLACE				NURSES IN PLACE AS	
		Centralised State Medical Examiner	County Coroner	County Medical Examiner	Mixed County Medical Examiner & Coroner	Death investigators	Coroners
MID SOUTH	Missouri				✓	✓	
	Arkansas		✓				
	Louisiana		✓			✓	
	Mississippi				✓		
	Tennessee			✓			
	Kentucky		✓				
NORTH EAST	Connecticut	✓				✓	
	Massachusetts	✓					
	Maine	✓					
	New Hampshire	✓					
	New York				✓	✓	
	Rhode Island	✓					
	Vermont	✓					

STATE		SYSTEM IN PLACE PER STATE				STATE HAS NURSES IN PLACE AS	
		Centralised State Medical Examiner	County Coroner	County Medical Examiner	Mixed County Medical Examiner & Coroner	Death investigators	Coroners
MID ATLANTIC	Delaware	✓				✓	
	Maryland	✓					
	New Jersey			✓			
	Pennsylvania	✓			✓		✓
	Virginia	✓					
	West Virginia	✓					
SOUTH EAST	Alabama				✓		
	Florida			✓		✓	
	Georgia				✓		
	North Carolina	✓					
	South Carolina			✓			✓
SUB TOTAL						**10**	**6**
OVERALL TOTAL						**15 States**	

NB: Washington State was found to have both nurse death investigators and nurse coroners in place. Therefore the true total number of States is 15

Appendix 13

SAMPLE IN DETAIL

REGION	STATE	PARTICIPANT	GENDER	AGE	YEARS AS REGISTERED NURSE	PREVIOUS AREA OF NURSING	YEARS AS CORONER / DEATH INVESTIGATOR	INTERVIEWS		OBSERVATIONS		OTHER	
								NO.	TOTAL HRS	NO.	TOTAL HRS	HIST DOCS	DIARY ENTRY
PACIFIC WEST	1	1	M	41	16	A	6	3	5	0	0	✓	✓
		2	F	27	5	A	3	2	3	0	0	✓	✓
WEST	2	3	M	45	20	A	6	2	3.5	0	0	✓	✓
		4	F	28	5	A	3	3	4.5	0	0	✓	✓
CENTRAL	3	5	F	38	13	A	3	2	3.5	0	0	✓	✓
	4	6	F	41	16	A	5	3	4.5	0	0	✓	✓
		7	M	42	17	A	7	3	4.5	0	0	✓	✓
MID WEST	5	8	F	32	7	A	5	3	5	0	0	✓	✓
MID SOUTH	6	9	F	45	20	A	8	3	4.5	0	0	✓	✓
NORTH EAST	7	10	F	42	18	A	10	3	4.5	0	0	✓	✓

REGION	STATE	PARTICIPANT	GENDER	AGE	YEARS AS REGISTERED NURSE	PREVIOUS AREA OF NURSING	YEARS AS CORONER / DEATH INVESTIGATOR	INTERVIEWS		OBSERVATIONS		OTHER	
								NO.	TOTAL HRS	NO.	TOTAL HRS	HIST DOCS	DIARY ENTRY
MID ATLANTIC	8	11	F	29	5	A	3	3	4.5	0	0	✓	✓
		12	F	31	6	A	3	3	5	0	0	✓	✓
SOUTH EAST	9	13	F	29	4	A	3	3	4.5	2	7	✓	✓
	10	14	F	45	20	A	7	3	4.5	2	7	✓	✓
	11	15	F	25	4	C	3	3	5.5	10	30.5	✓	✓
		16	F	39	14	A	10	3	5.5	12	38	✓	✓
		17	F	52	26	MH	9	3	6	17	59.5	✓	✓
TOTAL	11	17	M - 3 F - 14	NA	NA	A–15, C-1 MH–1, LD-0	NA	48 *(17 participants)*	78	43 *(5 participants)*	142	✓	✓
MEAN	NA	NA	NA	37.1	12.7	NA	5.5	2.8	4.6	NA	NA	NA	NA
RANGE	NA	NA	NA	25-52	4-26	NA	3-10	2-3	3-5.5	NA	NA	NA	NA

Appendix 14

AUDIT TRAIL EXAMPLE (CONFIRMABILITY)

PARADIGM B: The everydayness / averageness of Being – Community outreach

THEME B1: Family support and resolution

Micro theme i: Human identification and family notification

Participant No.	Interview No.			Observation No.	Diary Entry No.
	1	2	3		
1	√	na	√		57 69
2	√	na			58
3	√	√			59 66
4	na	√			60
5	na	√			72
6	√	√	√		62 73 79
7	√	√			64 70
8	√	na			61
9	√	na			80
10	√	na	√		77 85
11	√	√	√		76 87 88
12	√	na	√		75 83
13	√	√		2	10 12 - 9
14	√	√		1	11 29 - 28
15	√	√	√	4 9	19 22 38 - 13 14
16	√	√	√	3 5 10	16 33 51 - 34 36 47
17	√	√	√	2 3 8 12 15	1 7 49 - 3 4 40 51 54

MEMBER CHECKING FORM

Now that you have taken part in the data collection process by being interviewed and/or observed by me, one of the themes identified is that of "human identification and family notification. Below is an exert from one of those interviews along with my interpretation taking into account a number of interviews and observations from other participants. Please read the exert below, complete the attached form and return to me via email.

On interviewing a death investigation nurse she recalled that human identification and family notification as being part of the job and that although a sad undertaking, but something they do almost every day. It is considered as being very rewarding to complete a case rather than being unable to identify the deceased or notify their family. Catrina tells her story.

"I don't normally think too much about identifying the dead and notifying the family as it's just part of the job. But now that you ask, one case always haunts me. I had to go and make notification by myself. It was an 18 year old boy who was a freshman in college who was driving back to his mom's house. I'm a mom too. He was coming home for the summer and he wasn't watching where he was going and he was hit by a train. His mom had dinner on the table waiting for him to walk in and instead it was me who knocked on the door. I think it was that moment I just realised how I would impact somebody's life. I realised then that every time I go and knock on somebody's door I'm destroying them. I'm destroying their life by bringing them the fear that they fear the most. You cannot get away from the fact that there are times when you will hurt people. Compassion though is our saviour. We try to fix that hurt as much as we can and that's where my nursing experience comes in, as hopefully I can begin to help in easing the pain of that crisis".

With increasing frequency, the nurse is the one who tells the family that their loved one has died. In this area, nurses as death investigators have made a significant contribution as grief counsellors and crisis interveners. The principles and philosophies of nursing, focuses on the extended family, providing an empathic approach to tragic death. Such engagement and concern is not visible to death investigation nurses, only on self reflection does this come to the fore. This is because they felt they were only applying their nursing skills to the procedure of notification. Yet families time and time again were able to see this holistic service as they compared such services to non-nursing death investigators.

QUESTIONNAIRE

Now that you have read the interview exert and my interpretation (in the box on the previous page), please tick the following statements to confirm whether you agree or disagree

	Agree	Disagree
1. The interview exert is recognisable in my own clinical practice as a death investigation nurse / nurse coroner	☐	☐

If you agree with statement 1, go to statement 2

If you disagree with statement 1, please describe your reasoning for this decision as fully as possible below and then go to statement 2:

____

____

____

____

____

____

____

	Agree	Disagree
2. There are no omissions in the interpretation	☐	☐

If you agree with statement 2, go to statement 3

If you disagree with statement 2, please describe your reasoning for this decision as fully as possible below and then go to statement 3:

____

____

____

____

____

____

	Agree	Disagree
3. **There are no misunderstandings in the interpretation**	☐	☐

If you *agree with statement 3, go to question 4*

If you disagree with statement 3, please describe your reasoning for this decision as fully as possible below and then go to question 4:

____

____

____

____

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____

____

4. **Please describe any additional information from personal experience as a death investigation nurse / nurse coroner you deem worthy of being included within this theme of "human identification and family notification".**

____

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