TITLE

Torn between dual roles: the experiences of nurse-family members when a loved one is hospitalised in a critical condition.

ABSTRACT

Aims and objectives. To understand and interpret the experiences of Nurse-Family Members when a family member or loved one is hospitalised in a critical condition.

Background. Having a family member hospitalised with a critical illness is a traumatic stressor, often with long term sequelae. Providing holistic care for family members who are also nurses makes the provision of care more complex because of their professional expertise; yet few studies have explored this issue.

Design. In this descriptive study, qualitative data were collected using a questionnaire and analysed using Van Manen's (1990) six step approach.

Methods. Twenty Nurse-Family Members completed an online questionnaire in June 2013. Qualitative findings from 19 participants were included in the analysis. The phenomenological analysis approach described by van Manen (1990) was used to describe and interpret Nurse-Family Member experiences.

Results. Nurse-Family Members experience significant dual role conflicts between their personal and professional personas due to their specialised knowledge, need for watchfulness, and competing expectations. Our findings describe how dual role conflicts developed and were managed, and reveal the resultant emotional toll and psychological distress as Nurse-Family Members struggled to resolve these conflicts.

Conclusions. Nurse-Family Members require a different type of care than general public family members, yet their unique needs are often unmet, leading to increased anxiety and distress that could potentially be minimised. An increased awareness and emphasis on the Nurse-Family Member experience can ensure health-care professionals are better placed to provide appropriate and targeted care to minimise distressing dual role conflicts.

Relevance to clinical practice. There is a need for targeted and specialised communication appropriate to each nurse-family members' needs and level of understanding, and to clarify expectations in order to ensure nurse-family members' professional knowledge and skills are recognised and respected without being exploited.

Keywords: dual role, nurse-family member, nursing, role conflicts, qualitative data analysis

What does this research contribute to the wider global community?

- Nurse-family members experience the hospitalisation of a critically ill loved one differently to general public family members.
- Nurse-Family Members experience significant dual role conflicts as a result of their specialised knowledge and experience
- An enhanced understanding of the unique Nurse-Family Member experience can facilitate appropriate and targeted care to minimise anxiety and distress resulting from dual role conflicts

INTRODUCTION

Having a family member (FM) or loved one hospitalised in a critical condition is a significant, traumatic stressor (Hughes *et al.* 2005, Stayt 2007). These admissions are often unexpected, leaving FMs little time to prepare for the resulting emotional onslaught (McNamara 2007, Vandall-Walker *et al.* 2007). The impact on FMs is often severe and

ongoing, including intense emotional distress (Engstrom & Soderberg 2004, Agard & Harder 2007), and even post-traumatic stress disorder (Azoulay *et al.* 2005).

For many years, health-care professionals (HCPs) have focused most of their attention on the critically ill patient, with little regard for how FMs were coping with the admission (Chien *et al.* 2006, Eggenberger & Nelms 2007). HCPs now recognise a more holistic approach is necessary to support distressed families alongside their critically ill loved ones (Agard & Harder 2007, Eggenberger & Nelms 2007, Maxwell *et al.* 2007). By providing appropriate and timely care, HCPs could significantly reduce FMs' fear and anxiety and avoid escalation into emotional and psychological crisis.

Background

In order to provide effective support for FMs of critically ill patients, HCPs first need to understand FMs experiences, challenges and needs. Molter (1979) undertook the first published study into the needs of relatives of critically ill patients and many researchers have since explored this issue in depth with general-public-FMs (Holden *et al.* 2002, Engstrom & Soderberg 2004, Alvarez & Kirby 2006, Agard & Harder 2007, Eggenberger & Nelms 2007). However, when the FM of a critically ill patient is *also* a nurse (Nurse-FM), factors exist that make the plan of care more complex. Similar to general-public-FMs, Nurse-FMs have been shown to experience anxiety, uncertainty, fear, anger and distress when a FM is hospitalised (Duke & Connor 2008, Salmond 2011,Cichelli & McLeod 2012). However we are now beginning to understand that Nurse-FMs are different from other health-care consumers, and experience unique stressors and challenges because of their dual role (Salmond 2011). Anecdotally, many nurses have discussed the ongoing distress experienced after their loved one received sub-optimal care in hospital. Yet, scant detail of the experiences, challenges and

needs of Nurse-FMs and the subsequent provision of care to this particular group has been found in the literature.

Nurse-FMs appear to want/need a different type of care than general-public-FMs. A qualitative systematic review of the limited literature available reported that Nurse-FMs' specialised knowledge can significantly increase fear and anxiety during hospitalisation of a loved one (Giles & Hall 2014). This review found the dual roles of Nurse-FMs are inextricably linked and recommended that HCPs consider both roles in order to provide appropriate care. In other words, provide usual care for the *FM-self*, alongside specialised care for the *nurse-self*. We currently have very little evidence about how HCPs can enhance the provision of effective care to this particular group of health-care consumers (Salmond 2011). To address this deficit, HCPs first need to recognise and understand the unique experiences, challenges and needs of Nurse-FMs.

Aims

The aim of this study was to understand and interpret the experiences of Nurse-Family Members when a family member or loved one is hospitalised in a critical condition

METHODS

Design

This study aimed to obtain preliminary findings to guide future research, and to develop recommendations to potentially improve the experiences of Nurse-FMs. A descriptive approach was used to address the study aim. We collected both quantitative and qualitative data using an online questionnaire (QA). This article presents the qualitative findings.

Descriptive designs are useful for preliminary research, for conducting an initial exploration of a particular issue (Taylor et al., 2011) and for documenting the prevalence, nature,

intensity and meaning of a particular issue (Polit and Beck, 2010). A descriptive approach can be justified for this research in light of the scant attention Nurse-FM experiences have been given in the literature.

Participants

Participants were required to be ≥18 years, living in South Australia, and currently registered with the relevant authority as a registered nurse. Participants needed to have experienced a loved one being hospitalised with a critical illness. No time limits were imposed because these experiences are often intense and remembered in detail many years later (Salmond 2011). Participants were recruited through snowball sampling among the principal researcher's professional contacts and via email from one university's academic mailing list. Twenty participants registered their interest in the study by emailing the principal researcher. This number was deemed adequate based on Guest, Bunce and Johnson's (2006, p. 76) recommendations that data saturation in qualitative research is likely to be achieved after twelve interviews.

Data Collection

The researchers developed an online QA using the extant literature to guide initial question formulation. An expert panel of three academic registered nurses with previous experience/expertise in the dual role of the Nurse-FM reviewed the QA via email for internal validity and their critical feedback was incorporated into the final QA. The final QA comprised 12 demographic questions, and 16 closed-response questions with space to write rationales. The QA also contained three open-ended questions to allow a more complete disclosure of experiences, attitudes and beliefs. A copy of the QA is included as Figure 1.

In June 2013, participants (n = 20) who registered their interest in the study were emailed an online link to the anonymous QA (Survey Monkey) on two separate occasions, two weeks

apart (in order to meet the first aim of this study). All twenty participants completed the first QA. The principal researcher exported the QA responses into a Excel document. Responses included in the qualitative analysis were from open-ended questions 29, 30, 31 and any rationales written in response to questions 10 and 13 – 28. One participant provided scant (<one line) responses to the open-ended questions and rationale responses; their responses were subsequently excluded from the qualitative analysis. The remaining 19 participants wrote detailed rationales for one or more of the closed-response questions. In addition, 13 participants answered all three open-ended questions, and four participants answered two of three open-ended questions.

Many participants were passionate about sharing their experiences, which were vivid in their memories after many years. For example, Catherine wrote, *'it obviously affected me as I remember it very clearly from 20 years ago.'* The time taken to complete the QA ranged from ten to 125 minutes, with an average of 34 minutes. Some Nurse-FMs wrote multiple pages, and one participant phoned the principal researcher to stress the importance of addressing what she saw as significant deficits in support for Nurse-FMs.

Ethical considerations

The relevant University Social and Behavioural Research Ethics Committee granted approval for the study (project number 6013). Informed consent was promoted by using a detailed information sheet and participants were informed that by submitting the online QA they were consenting to the study. The use of an online QA ensured anonymity and confidentiality.

Data analysis and rigour

Data analysis was performed within the guiding framework of third-generation hermeneutic phenomenology (Gadamer 1975) to develop interpretive accounts that accurately reflected each participant's feelings, thoughts and actions relating to the lived experience. Van

Manen's (1990) six step hermeneutic phenomenological method was used to describe the Nurse-FM experience of having a loved one hospitalised with a critical illness and was the key framework for data analysis.

Van Manen's (1990, p 31) framework includes lived space, lived relation, lived body and lived time of participants. The first step, *turning to the nature of the lived experience,* involved considering the research questions, as previously outlined in the data collection section. During step two, *investigating the experience as we live it, rather than as we conceptualise it,* we read the participants' own words written on the questionnaire to describe their lived experience and we noted similarities and differences between them. We read participant responses at least three times for an essence of the whole. During the third step, *reflecting on the essential themes that characterises the phenomenon,* we considered the words in each transcript by cutting and pasting quotes from participants, and highlighting key words and phrases into a series of tables in a Microsoft Word document. Step four, *describing the phenomenon through the art of writing and rewriting,* was undertaken by extracting and tabulating the words of participants into concepts which were then grouped first into key words (links) and then into themes. This search for themes became a coding process as the researchers separately and together interacted with the data, asking the interrogative quintet 'who, what, when, where and why?' (Dey 1993, p. 83). The fifth step, *maintaining a strong and oriented relation to the phenomena,* involved discussions between the researchers about their pre-conceived judgements and experiences and the similarities and differences between these and the data. During the final step, *balancing the research context by considering the parts and the whole,* the researchers dialogued, examining the data in coded and tabulated context as part of a *fusion of horizons* (Gadamer, 1975). This dialogue between meaningful words, phrases and concepts, and questioning each section of the text

(van Manen, 1990) led to the development of four themes that were interconnected and reflective of Nurse-FM meanings.

Throughout this interpretative research we maintained a decision trail in order to establish rigour and trustworthiness (Koch 1994). A sample of decisions made while analysing data are included in Table 1, which depicts theme development. Nurse-FM quotes were included throughout this paper to describe their experiences and to allow other researchers to evaluate transferability of findings (Lincoln & Guba 1985).

RESULTS

Participants were between 24 and 56 years of age, predominantly female (95%), with 1 to 40 years of professional experience. Participant characteristics are presented in Table 2, along with information about their relationship with the patient and their Nurse-FM status at the time of hospitalisation.

The Themes

Nurse-Family Members experienced significant dual role conflicts between their personal and professional personas due to their specialised knowledge, a need to watch over their loved one and competing expectations. As Nurse-FMs struggled to manage and resolve these dual role conflicts, the resultant emotional toll led to increased anxiety and distress. Figure 2 presents a model of the interconnected themes that describe and interpret the experience of Nurse-FMs when a loved one was hospitalised.

Dual role conflicts

Dual role conflicts between the *nurse-self* and the *family-member-self* emerged as the core, overarching theme that represented the overall experience of Nurse-FMs. They identified as being/feeling *different* to general public FMs due to their unique dual role, with most Nurse-

FMs agreeing they required a different type of support than general-public-FMs. Despite wanting a different type of care, many Nurse-FMs experienced a conflict between wanting to hide or wanting to reveal their RN-status. For example, 15 Nurse-FMs reported their RN-status was known to staff; however, only eight actually *wanted* their RN-status known (refer to Table 2). Consequently, internal conflicts arose for many participants. Some wanted to remain anonymous to avoid being treated 'differently' or being judged by staff. Others were happy for their RN-status to be known if it did not negatively affect patient care.

Some Nurse-FMs who initially withheld their RN-status later disclosed it to legitimise their concerns. For example, Amy wrote, *'they were not responding to what I believed was the medical reason for the emergency...I felt staff would give me more credit for understanding the situation and listen to me regarding my medical concerns.'* Other Nurse-FMs disclosed their RN-status immediately to ensure the best possible patient care was provided or in order to obtain specialised information and access. Others however were reluctant to accept special treatment when it was offered. When their status *was* known, some Nurse-FMs believed more emphasis was placed on their RN-status than on their family member role.

> *I didn't mind they knew I was a registered nurse but during a family meeting I was asked if I was and of course I said I was, and after that the staff would always say "oh are you the nurse?…[It] made me feel that I was often the topic of conversation at handover when I was actually there as a sister and medical and legal guardian. (Kristen)*

Specialised knowledge

Wanting acknowledgement of specialised knowledge

Many Nurse-FMs believed their specialised knowledge made them *different* to general-public-FMs, and wanted their knowledge acknowledged and respected by staff. For example,

Molly *'wanted to be afforded respect for my knowledge, not just another distressed mum.'* While Julie pointed out, *'We like more information and want to be included when possible. Respecting the increased amount of knowledge that we have vs the general public is important.'* Some Nurse-FMs went further to say they were often best placed to notice clinical deterioration, and stressed the importance of respecting Nurse-FMs' opinions.

> *Family members who are nurses have a knowledge base beyond that of other family members…Family spend more time with the patient than any doctor and will see subtle changes before anyone. (Gladys)*

Dual role conflicts arose when Nurse-FMs were torn between wanting their specialised knowledge acknowledged by staff, and wanting to keep their RN-status private for fear of being treated differently or having their nursing skills taken advantage of.

> *...the experience of the dual role is mixed…you want to be acknowledged for having knowledge and [be] treated accordingly [but] you don't want to be taken for granted in the role and [be] expected to fill out forms or undertake other nursing duties which can happen. You also want staff to not be afraid of your knowledge. (Simon)*

Other Nurse-FMs were happy for their RN-status to be known so they could perform nursing interventions without staff worrying, or be listened to when they identified errors in care.

Wanting specialised communication

Nurse-FMs highlighted the need for specialised communication that took into consideration previous knowledge and skills. Hannah highlighted that, *'we should be given more time for explanation because we need more depth and have more questions than most other people who would simply accept what was going on and the treatment offered.'* In particular, Nurse-

FMs wanted comprehensive answers to their questions, rather than what Gladys referred to as *'pointless answers to my questions. I needed to know the truth and they needed to know that I had some knowledge of what was going on.'*

Rather than expecting all Nurse-FMs to have a similar knowledge base, participants highlighted the importance of determining individual levels of understanding and emotional status, and tailoring communication accordingly.

> *It needs to be understood that knowledge is helpful but when it is a family member a lot of that disappears or is out of context…it shouldn't be taken for granted you know what is going on…ask if they understand and expand if necessary. (Catherine)*

Watchfulness

Keeping watch and advocating

Most Nurse-FMs felt compelled to watch over and advocate for their FM, fearful that care would deteriorate in their absence. Some Nurse-FMs avoided complaining about poor care because they were afraid their loved one would be treated poorly as a result, and many worried about being labelled *difficult* and were careful to avoid offending staff when reporting care omissions. Those who did formally report poor care were disappointed their complaint was not acted upon, and one Nurse-FM shared her distress when trying unsuccessfully to advocate for her husband.

> *The weeks during his stay when his care was appalling were very difficult as I did not want to be 'over reacting' but could not tolerate what was happening. When expressing my concern to people I was labelled as 'anxious' and 'stressed' — both true and real but hardly the reason for*

expecting my husband to be kept clean, dry and warm, let alone covered and dignified in front of strangers… (Gladys)

Stepping in

When care was perceived to be very poor, or when errors/omissions were noted, many Nurse-FMs went beyond watchfulness and verbal advocacy, to intervening on the patient's behalf. Some Nurse-FMs described themselves as having to be 'difficult' in order for staff to take their concerns seriously and act on them. Others wrote about having to 'pull rank' in order for the patient to receive adequate care.

It was only after my intervention that [my mother] received morphine for her pain...In the end having to pull rank and play the 'I'm a registered nurse who works in an ED' on the poor nurse on the late shift so my [mum] could finally get some pain relief. This I did not like doing, as I just wanted to be the daughter and be there for my mum. (Alicia)

Some Nurse-FMs wrote about having to step in on numerous occasions to ensure their FM received adequate nursing care, believing their specialised knowledge and skills prevented significant deterioration in the patient's condition.

Many times I had to be there to request basic care, notice when he was deteriorating and feed and keep him clean...Thankfully my own abilities possibly saved him from deteriorating further...I was not prepared to sit back and watch the appalling care my husband received...[he] would not have made the progress he has without the input my knowledge added....He had to have someone to keep him safe. (Gladys)

Some Nurse-FMs went further to report their FM could have died if they had failed to intervene. For example, Molly wrote, *'My daughter nearly died due to incompetence and I picked the error up. [The] intern was writing out discharge meds [and] ordered Amoxicillin…I reminded the intern that my daughter was HIGHLY allergic to penicillin.'*

Competing expectations

Expectations placed on self

Most participants wrote about the high expectations they placed on themselves because of their dual role. Some Nurse-FMs actively nursed both their own FM and other patients in the vicinity. Other Nurse-FMs described the obligation they felt to provide this care, and the added pressure they felt to maintain control, lest everything '*fall apart'* (*Cheryl*).

Family member expectations

Nurse-FMs also felt under considerable pressure from the patient and other family members to play a particular role. For example, some patients were comforted by the Nurse-FMs' *nurse-status* and wanted them to provide hygiene care, and assist with meals and mobility. Other family members expected Nurse-FMs to translate complex terminology, and make decisions on their behalf — often placing undue pressure on the Nurse-FM and increasing their anxiety levels.

> *I was more anxious and worried than other family members and this was reinforced when they tended to rely on me to make decisions for them all...Other family members relied on me but I did not want to be in control or responsible for decisions. (Hannah)*

Some Nurse-FMs like Emma reported increased levels of anxiety as a result of family members wanting constant reassurance in the face of what they knew to be a poor prognosis; *'I knew survival was not likely, that it was 'only a matter of time.' It was stressful because my*

other family members wanted reassurance, and odds, which put a great deal of pressure on me.'

Staff expectations

Nurse-FMs felt pressured by staff to undertake tasks that would not be expected from a general-public FM. Some Nurse-FMs were afraid they would be asked to perform advanced skills such as CPR and struggled between wanting to stay with their loved one and leaving to avoid staff. Others, like Molly, reported that *'the nurses relied on me to provide most of the care, which I found exhausting',* and many Nurse-FMs reported feeling distressed at being taken for granted and not being allowed to 'just' be a family member.

> *When I visited they hardly came near my father and I felt they were leaving me to attend to the care. In the end I was distant to [my father] as I felt all care was being left to me…I wanted to be me and not a nurse...It was difficult to see what was happening with my knowledge and wanting to 'hide' as my [father] was dying, but having to keep him in bed, make sure the IV wasn't pulled out etc. Not my job!!! The topic of me doing the care should have been discussed. Some people may want to do it, others not. (Catherine)*

Emotional toll

Specialised knowledge amplifying emotions

Most Nurse-FMs wrote about the impact of their specialised knowledge on their emotional state. Some, like Grace, were unsure if their knowledge was beneficial or detrimental: *'… I don't know if I would have preferred to have been worried because of what I did know, or worried because of what I didn't know.'* However most participants believed their dual role amplified their emotions, increasing their anxiety levels.

> *Just that situation of being emotionally involved, and trying to make decisions on behalf of the family…[It was] very difficult to be professional and play RN professional role...The knowledge and experience is still there — but the emotion is stronger I think — that's what I found difficult. Regardless of my knowledge it was very hard to be on the other side of the care...I was not scared by the ventilators, could help with suction etc. but it was my dad on that bed and it scared the hell out of me. (Hannah)*

Emotion versus intellect

Many Nurse-FMs wrote about the burden of their dual role. They reported that their *FM-self* was extremely fragile, and that it was difficult (and in many cases impossible) to switch off their *nurse-self,* further exacerbating internal conflicts. They stressed the importance of staff recognising both the FM-self and the nurse-self in order to provide effective care and support.

> *It is the opinion of everyone else that nurses who are family members should know all about what is going on. Yet people forget that we are human too and when it is your family it is different, often you can't shut off as easily from the emotions as you do when you are at work. We also need that medical jargon conversation as that satisfies the working nurse in us and the knowledge side. Once that side is sorted we can then…be the support for the family member who is sick. (Alicia)*

Dual role conflicts were reported by most participants. Some Nurse-FMs like Sharon were relieved when permitted by staff to just be a family member, *'She* [*the RN*] *would tell me it was OK to take off my "nurse's hat" and just be a daughter — this usually ended up with me having a bit of a cry — quite cathartic.'* Sharon went on to write *'You can take the girl out of nursing but not the nurse out of the girl,'* indicating that the dual role is more complex than

electing to be either one or the other. These dual roles were *inextricably intertwined* or *consciously separated* depending on the severity of the admission. For example, when her son was hospitalised Cheryl allowed her FM-self to dominate, sharing that *'I think this was one of the times when my mother hat over ruled my nursing hat. He was so sick that I was constantly worried about the outcome.'* Whereas Gladys saw her two roles as inextricably intertwined, *'I am an RN. It is who and what I am.'*

Most participants agreed Nurse-FMs required a different level of care than general-public-FMs, stressing that their specialised knowledge should be acknowledged and respected, and that additional and specialised communication is often necessary in order to reduce anxiety.

As a result of their emotionally charged experiences, many Nurse-FMs wrote about how they had/would change their practice in order to provide an enhanced level of care and empathy to all FMs, but particularly to Nurse-FMs. Some Nurse-FMs believed they were already providing an excellent level of care, but now appreciated the additional stressors impacting Nurse-FMs, and focused on tailoring care and information to individual preferences and needs.

DISCUSSION

This study explored Nurse-FM experiences when a loved was hospitalised with a critical illness. While some of their experiences were similar to those reported for general-public-FMs, our study highlighted several unique challenges faced by Nurse-FMs. For example, general-public-FMs have been reported as feeling useful and involved when able to provide care to their hospitalised loved ones (Mitchell & Chaboyer 2010). In contrast, Nurse-FMs in this study felt taken advantage of when asked or expected to provide (at times advanced) nursing care. In addition, because of their specialised knowledge many Nurse-FMs reported significant levels of distress when their FM received what they identified as poor care. This is

consistent with previous research (Salmond 2011, Giles & Hall 2014) that has identified Nurse-FMs' experiences as being different to those of general-public-FMs.

Also consistent with previous research (Salmond 2011, Giles & Hall 2014) were the significant dual role conflicts identified between the *nurse-self* and the *FM-self* experienced by all Nurse-FMs in this study. As a result, they felt under constant pressure to watch over their loved ones and protect them from 'poor care'. Competing expectations from self, family members and staff also took a considerable emotional toll, further increasing Nurse-FMs' distress as they struggled to find a balance between *being there* as a FM to support their loved one, and using their professional persona to ensure the best possible standard of care was delivered to the patient. Unique to this study was an insight into the fact that some Nurse-FMs (more than a quarter in this study) wanted to hide their RN-status, and the impact this had on further role conflicts. Nurse-FMs were often torn between not wanting their RN-status known and disclosing their status in order to 'pull rank' when patient care was compromised, or when they wanted access to information in order to reduce their anxiety.

Very little attention has been given in the literature to the dual role experiences of Nurse-FMs in the critical admission context. However, studies into the related phenomenon of 'double duty caregiving' (where nurses care for elderly relatives in the home), have reported similar experiences to Nurse-FMs in this study. Direct comparisons between the experiences of double duty caregivers (DDCGs) and Nurse-FMs of critically ill hospitalised patients must be undertaken with caution due to the unexpected nature of the critical admission versus the more chronic nature of care provided by DDCGs. However these experiences are similar enough to justify a comparison in order to increase our understanding of the unique challenges faced by Nurse-FMs.

Similarities between the dual roles of Nurse-FMs and DDCGs include increased anxiety due to specialised knowledge (Scott *et al.*2006, Cicchelli & McLeod 2012, Manthorpe *et al.* 2012,), blurring and eroding of boundaries between the personal and professional self (Manthorpe *et al.* 2012, Ward-Griffin 2004, Ward-Griffin *et al.* 2005, Ward-Griffin *et al.* 2011), and competing expectations leading to dual role conflicts (Ross *et al.* 1994, Ward-Griffin 2004, Ward-Griffin *et al.* 2005, Ward-Griffin *et al.* 2011, Cicchelli & McLeod 2012, Manthorpe *et al.* 2012). Similar to the DDCGs in the study by Cichelli & McLeod (2012), Nurse-FMs in our study stressed the importance of clarifying expectations to ensure their professional knowledge and skills were recognised and respected without being exploited.

Other similarities between DDCGs and Nurse-FMs included the obligation to constantly negotiate boundaries between their professional and personal caregiving roles (Ward-Griffin 2004). Both Nurse-FMs and DCCGs often used their connections in order to gain special privileges or to ensure a better level of care (Ward-Griffin *et al.* 2005). However, both groups were sometimes reluctant to use their status in this way to avoid being seen as difficult.

The phenomenon of role conflict and its distressing consequences have been recognised by role theorists for decades (Getzels & Guba 1954, Greenhaus & Beutell 1985, Biddle 1986). Yet it is only more recently that we are beginning to explore role conflict specifically in relation to Nurse-FMs. The effects of role conflict and a constant blurring of boundaries on DDCGs were examined by Ward-Griffin *et al.* (2009), when they tested a double duty caregiving scale. These researchers found that an increased degree of blurring between DDCGs' professional and personal roles negatively impacted their well-being and mental health. Given the similarities between DDCGs and Nurse-FMs experiences it is likely that this negative impact would apply equally to Nurse-FMs, warranting further exploration.

Limitations

Purposive sampling from one geographical region and the small sample limits transferability of findings to Nurse-FMs with similar backgrounds. Further, the majority of participants were female therefore the male perspective is not fully represented. The study relied on cross-sectional, self-reported data which can potentially restrict participant responses. However, the use of open-ended questions and space to provide rationales for closed-questions allowed participants to share their experiences without time or word restrictions. In addition, the use of an anonymous online QA allowed participants to be more open about their experiences than they may have been in a face-to-face interview.

CONCLUSIONS

This study adds valuable insights into an important issue which has received very little attention. Nurse-FMs are different to general-public-FMs yet their unique needs are often unmet, leading to increased anxiety and distress that could potentially be minimised. Findings from this study both echo and build upon previous research in the area. Unique to this study was an insight into how the Nurse-FM experience affected future practice and it was evident that an increased awareness facilitated an enhanced level of care when caring for not only Nurse-FMs but all FMs. A raised awareness around this issue could potentially increase the quality of care HCPs provide to Nurse-FMs.

RELEVANCE TO CLINICAL PRACTICE

There is a need to explore this phenomenon on a wider scale to gain a better understanding of the scope of this issue and to determine how and to what extent Nurse-FMs are affected by their experience. Current research has examined the phenomenon from the Nurse-FMs' perspective only, so it would be useful to explore the HCP perspective in order to provide a balanced account.

This study reinforces the need to recognise and acknowledge Nurse-FMs' unique experiences and needs. An increased awareness and understanding of this issue will ensure HCPs are able to offer adequate support which in turn could help minimise the significant stressors experienced by this unique group of health-care consumers.

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Conflict of interest

No conflict of interest has been declared by the author.

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Table 1: Example of theme development during analysis.

Participant quotes (including pseudonym)	Concept	Key words	Subtheme	Theme
… [the] nurse spoke to me like a colleague … in a respectful supportive manner (Marie). Nurses need more information as they have a greater understanding (Joan). Knowledgebase [for nurses] is different - but - in times of stress may need more reassurance as the worst has been seen (Molly). …[more] explanation to other family members who are nurses. They have some knowledge already and being informed would alleviate fears (Alicia). The more you know the more fearful [you are] I think (Hannah). Family members who are nurses have a knowledge base beyond that of other family members. Questions must be answered fully, tests explained and ordered when required. … family members who are nurses will expect the care to be given and will not make excuses or be thankful for poor care (Gladys). We have an increased knowledge about medical things so need to be treated as such (Sarah). I'm not saying that they (nurse family members) should receive special treatment but their knowledge should be acknowledged and respected. (Cheryl). Would not assume someone had more of an understanding simply because he/she is a nurse. Some people know more than others, or know different things …really does depend on the individual (Emma).	Language-communication with a Nurse-FM; knowledge	Knowledgebase Collegial communication Being informed. Respecting knowledge. Acknowledging previous knowledge Varied knowledge bases.	Specialised knowledge - requiring specialised communication	Toll of The Dual Role

Table 2 Characteristic of Nurse-Family Members and information about Nurse-Family Member status

Pseudonym	Age	Gender	Nurse-FMs role in relation to the patient	FM admitted to Nurse-FMs own workplace	RN-status known to staff	How was Nurse-FM's RN-status known to staff?	Did Nurse-FM want RN-status known?
Marie	44	F	Daughter	No	Yes	FM told staff	Yes
Joan	44	F	Spouse/partner	No	Yes	FM told staff	Unsure
Julie	28	F	Daughter-in-law	No	Yes	FM told staff	Yes
Cheryl	50	F	Mother	No	Yes	FM told staff	Yes
Amy	52	F	Sibling	No	Yes	Nurse-FM told staff	Yes
Leanne	53	F	Sibling	No	Yes	Nurse-FM told staff	Yes
Hannah	56	F	Daughter	No	Yes	Nurse-FM told staff, staff guessed	Unsure
Catherine	32	F	Daughter	Yes	Yes	Known to staff, own workplace	No
Alicia	27	F	Daughter	Yes	Yes	Known to staff, own workplace	Unsure
Sarah	27	F	Sibling	Yes	Yes	Known to staff, own workplace	Yes
Molly	37	F	Mother	No	Yes	Known to staff, past workplace	Yes
Michelle	51	F	Daughter-in-law	No	Unsure	Known to staff?, past workplace	Unsure
Emma	24	F	Granddaughter	No	Yes	Known to staff	No
Gladys	52	F	Spouse/Partner	No	Yes	Known to staff	Yes
Grace	40	F	Niece	No	Unsure	Staff may have guessed	Unsure
Kristen	50	F	Sibling	Yes	Yes	Staff guessed and asked	No
Simon	56	M	Sibling	No	Unsure	Staff may have guessed	No
Sharon	45	F	Daughter	No	Yes	Staff guessed	Unsure
Abigail	45	F	Daughter	No	No	Not applicable	No

Questionnaire – Experiences of the Family Member who is also a Registered Nurse

When answering the questions, please think of an occasion (that stands out to you most) when one of your family members or loved one was admitted to hospital in a critical condition.

BACKGROUND INFORMATION

1. Non-Identifying Pseudonym (ie John Smith).
2. Your age at the time of hospitalisation of your family member / loved one
3. Your gender
    a) Female
    b) Male
4. What is your clinical area of expertise ie Intensive care Nurse
5. How many years were you qualified as a Registered Nurse at the time of your family member's hospitalisation?
6. Was your family member admitted to your own workplace (ward or unit)?
    a) Yes
    b) No
7. What was your relationship to the family member loved one admitted to hospital?
    a) Spouse/partner
    b) Parent
    c) Child
    d) Sibling
    e) Other – Please state
8. At any time during the hospitalisation did staff know that you were a registered Nurse?
    a) Yes
    b) No
    c) Unsure
9. Did you want staff to know that you were a registered nurse?
    a) Yes
    b) No
    c) Unsure
10. In relation to question 9 - Why / Why not?
11. If staff did know you were a registered nurse, how did they find out?
    a) I told them
    b) It was my own workplace and I was known to staff
    c) My family member told staff
    d) Other – Please state
12. If staff did not know you were a registered nurse, why not?
    a. I wanted to be treated like a member of the general public
    b. There was no time to tell them
    c. I did not want staff to feel / act differently because of my RN status
    d. Other – Please state

YOUR EXPERIENCES OF THE DUAL ROLE OF THE FAMILY MEMBER WHO IS ALSO A NURSE

When answering the following questions, please indicate how much you agree or disagree with each statement by placing a tick in the relevant box. If you would like to provide a reason for your answer, you can provide this in the comments section under each question.

13. During the hospitalisation I found it easy to identify when my family member was receiving 'good' care

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

Comments:

14. I experienced increased fear and anxiety about my family member's condition during their hospitalisation because of my nursing knowledge (ie I knew all the things that could go or were going wrong)

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

Comments:

15. I felt the need to 'watch over' the patient to make sure the care they received was adequate

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

Comments

16. I experienced decreased fear and anxiety about my family member's condition because of my nursing knowledge (ie I was familiar with the sights and sounds and environment)

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

Comments:

17. I felt the need to act as an advocate/spokesperson for my hospitalised family member

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

Comments:

18. I was given special access to areas of the hospital that members of the general public do not have access to because of my RN status

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

Comments:

19. My family member received extra / special care and attention during their admission because of my status as a Registered Nurse

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

Comments:

20. I was given special care and attention during my family member's admission because of my status as a Registered Nurse

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

Comments:

21. I was worried about being seen as 'difficult' or 'interfering' to the staff because of my RN status?

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

Comments:

22. I was worried about being critical or complaining to the staff about poor care?

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

Comments:

23. Looking back on my experience during hospitalisation of my family member, I think it would have been easier for me at the time to just be a family member with no nursing knowledge

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

Comments:

24. During the hospitalisation, I felt under pressure by other family members and or the patient to 'always be in control'

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

Comments:

25. During the hospitalisation I found it difficult to separate the dual roles of nurse and family member

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

Comments:

26. During the hospitalisation I felt like I had to hide my emotions from the patient / my other family members to avoid upsetting them

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

Comments:

27. During the hospitalisation, I felt under pressure by other family members and or the patient to be the 'font of all knowledge' (ie know everything that was going on, to be an information provider, answer questions etc)

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

Comments:

28. Family members who are also nurses require a different type of care than family members who are members of the general public

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

Comments: What is the reason for your answer to question 28?

29. What was it about your experience of being in the dual role of both a nurse and family member that you remember most?
30. Did you / would you make any changes to your future practice as a registered nurse following your experience as a Nurse-Family Member and if so what would they be?
31. Do you have any other comments about your dual role experience?

Thank you for your time in completing this questionnaire. We appreciate and value your input.

Questionnaire Key: Please note that space to write qualitative responses are not included here due to space limitations. Participants were provided with space online to write as little or as much as they desired. This article presents an analysis of the qualitative responses from questions 29, 30 and 31 and rationales provided for questions 10 and 13-28.

Figure 1 Questionnaire - Experiences of the Family Member who is also a Registered Nurse

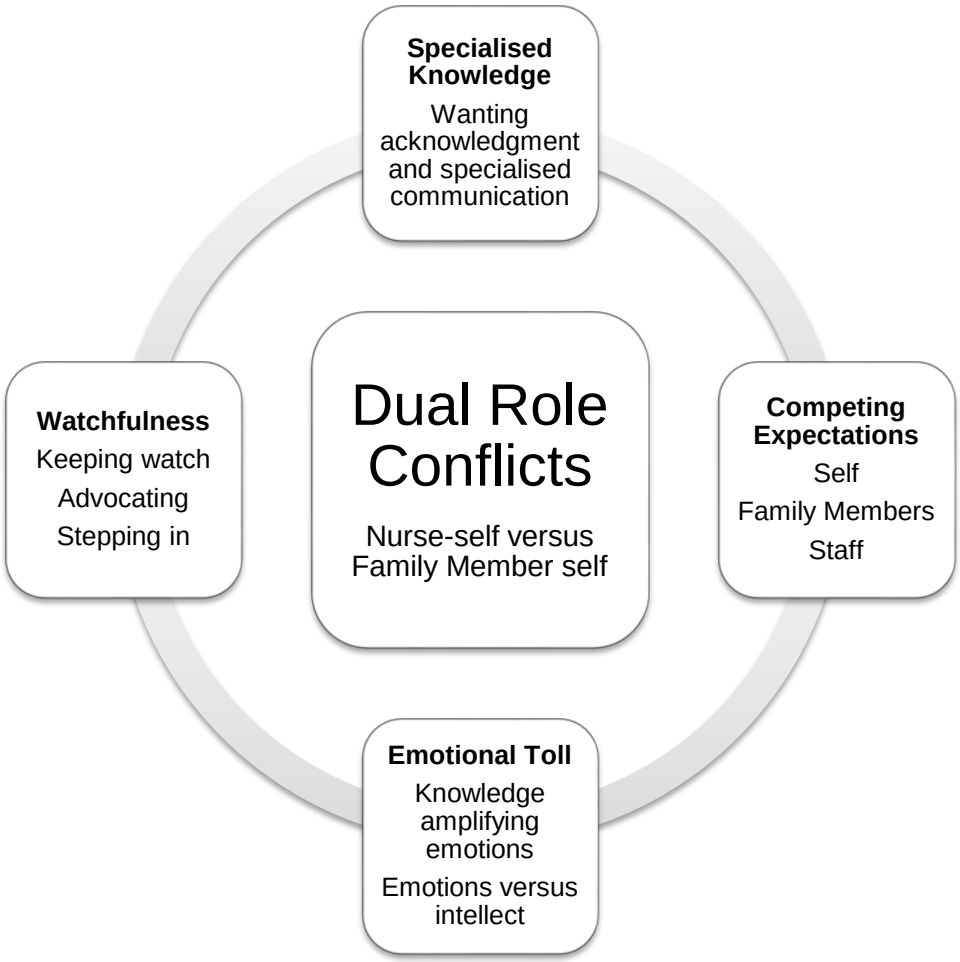

Figure 2 A model representing the experience of Nurse-Family Members who's loved one was hospitalised with a critical illness.