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Professional tears: developing emotional intelligence around death and dying in emergency work

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Aims and objectives. This paper explores how emergency nurses manage the emotional impact of death and dying in emergency work and presents a model for developing expertise in end-of-life care delivery.

Background. Care of the dying, the deceased and the bereaved is largely conducted by nurses and nowhere is this more demanding than at the front door of the hospital, the Emergency Department. Whilst some nurses find end-of-life care a rewarding aspect of their role, others avoid opportunities to develop a relationship with the dying and bereaved because of the intense and exhausting nature of the associated emotional labour.

Design. Qualitative study using unstructured observations of practice and semistructured interviews.

Methods. Observation was conducted in a large Emergency Department over 12 months. We also conducted 28 in-depth interviews with emergency staff, patients with terminal illnesses and their relatives.

Results. Emergency nurses develop expertise in end-of-life care giving by progressing through three stages of development: (1) investment of the self in the nurse–patient relationship, (2) management of emotional labour and (3) development of emotional intelligence. Barriers that prevent the transition to expertise contribute to occupational stress and can lead to burnout and withdrawal from practice.

Conclusions. Despite the emotional impact of emergency deaths, nurses who invest their therapeutic self into the nurse–patient relationship are able to manage the emotional labour of caring for the dying and their relatives through the development of emotional intelligence. They find reward in end-of-life care that ultimately creates a more positive experience for patients and their relatives.

Relevance to clinical practice. The emergency nurse caring for the dying patient is placed in a unique and privileged position to make a considerable impact on the care of the patient and the experience for their family. This model can build awareness in managing the emotive aspects involved in care delivery and develop fundamental skills of nursing patients near the end of life.

Key words: accident and emergency, emergency department, emotional aspects, end-of-life care, nurse–patient relationship, nursing care

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Introduction

Despite the intentions of the end-of-life care strategy in the UK (Department of Health 2008) to provide quality care, little attention has been given to support emergency nurses who deal with death and dying on a daily basis. Drawing on findings from a qualitative study that explored nursing care of patients who attend an Emergency Department (ED) at the

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end of life, this paper focuses on the professional developmental processes involved in effectively managing the critical aspects of death, dying and bereavement. Previously, the authors have defined distinct trajectories of end-of-life care in the ED (Bailey *et al.* 2011). This paper goes further to describe how nurses manage the emotional aspects of death, dying and bereavement in emergency work. Whilst deaths in the ED can provoke discomfort, the most concerning aspects of the end of life for emergency nurses is the care of the dying and bereaved, many of whom experience less than ideal care in the ED (Bailey *et al.* 2011). Emergency nurses are trained in their role for resuscitation and develop coping mechanisms to objectify the suddenly deceased (Bailey *et al.* 2011). By removing individual aspects that resemble the patients' personhood, they are able to manage the tragedy of sudden and unexpected death. These coping mechanisms do not exist in the care of patients dying a slower, progressive death (Bailey *et al.* 2011). As a result of the lack of support and awareness, the emotional labour that accompanies nursing care of the dying and the bereaved can be intense and exhausting and can be seen to require a great deal of support and personal awareness and coping strategies. If not dealt with adequately, these issues can lead to occupational stress, ill-health and withdrawal from nursing practice (Bailey 2009). In an ageing population where people near the end of life are likely to be seen in the ED, attention to the development process of emergency nurses is fundamental to deliver quality end-of-life care.

Background

Major shifts in patterns of disease and treatment have affected the way nurses are now exposed to the dying process (Degner & Gow 1988). A combination of environmental and socio-economic factors has led to changes in how nurses now view death and dying and the way they cope with it on a daily basis. Care of the dying, the deceased and the bereaved is largely conducted by nurses and has been recognised as one of the most stressful aspects of nursing work (Vachon 1987, McWhan 1991, Copp 1999, Hopkinson *et al.* 2005). It presents both professional and personal challenges, and the negative impact it can have on care has been well documented (Vachon 1987, Stacciarini & Troccoli 2004, Glasberg *et al.* 2007, Wu 2007). Numerous studies identify the causes of stress for emergency nurses with patient suffering, family presence in the ED and death and dying featuring highly (Payne *et al.* 1998, Adeb-Saeedi 2002). Given the inability to change the demands of the job, it is necessary to explore the developmental process through which nurses can learn to manage the stressors involved in providing end-of-life-care in the ED.

The end-of-life care strategy (Department of Health 2008) aimed to improve the quality of end-of-life care for all adults in a place of their choice. Part of the strategy focused on the training and education of healthcare professionals to care for the dying in a variety of clinical settings. The strategy highlighted that end-of-life care needed to be embedded in the undergraduate nursing curriculum, staff induction programmes, continuing professional development and in appraisal systems. Quality markers have been developed to provide a measure for local standards of end-of-life care (Department of Health 2009). Based on the structures and processes of care, the quality markers aim to achieve the best possible outcomes for people who are approaching the end of life, their families and those caring for them. They identify a framework to achieving quality end-of-life care in different clinical environments which is useful in developing training programmes at both undergraduate and postgraduate levels. However, there is a fundamental need to understand how nurses learn to manage the emotional aspects of their role prior to engaging them in this learning opportunity. This paper addresses this gap in knowledge.

Methods

Drawing on ethnographic methods, a qualitative study was conducted in a large UK ED to explore end-of-life care delivery. The findings presented in this paper relate to how nurses manage the emotional impact of end-of-life care in the emergency environment. Adopting the 'participant as observer' role (Gold 1958), over 900 hours of unstructured observations were conducted over 12 months in all areas of the ED to observe accurately the 'backstage' as well as the 'front stage' behaviours of emergency staff (Goffman 1959). The observation period provided a platform on which natural interviews occurred amongst the emergency staff, informal conversations that take place with the objective of eliciting data (Murphy & Dingwall 2003) which provided a considerable amount of highly insightful data. In addition, in-depth interviews were conducted three months after the start of the observation and carried out with emergency staff (n = 10 nurses, two doctors, one student nurse, two Emergency Department Assistants) recruited at the ED, patients who had experienced an ED admission within six months (n = 6) and their relatives (n = 7) recruited at the Specialist Palliative Care Unit (SPCU). The study was given favourable ethical approval (reference: 06/Q2403/171). All participants gave their permission for the interviews to be digitally recorded. All interviews were transcribed, coded in Nvivo7 and analysed thematically alongside the observational data and

cases. No patients or relatives refused to be interviewed; however, patient attrition was high owing to patient deterioration and death (Bailey 2009).

Results and discussion

Irrespective of their condition, prognosis or extent of symptoms, the patients evaluated their experience of care in the ED largely on the basis of the level of attention they received and the relationship they had with those providing their care. The findings emphasise the significance the emergency nurse has in providing meaningful quality end-of-life care that is supportive to patients and relatives. Whilst some emergency nurses are seen as experts in providing end-of-life care, they contrast markedly with others who avoided getting involved in this aspect of ED work altogether.

Three developmental stages emerged from the data analysis. Presented as a three-stage model, it can be used to show how nurses learn to develop expertise in end-of-life care in the ED (see Fig. 1). Progression through these three stages generally seems to occur through learning from multiple patient and relative encounters. The way individual nurses respond to these challenges seems to determine whether they develop appropriate skills and learn to manage the potentially harmful effects of regular exposure to death and dying. Each stage is discussed with supporting evidence from the observational and interview data.

Stage 1: Investment of the therapeutic self in the nurse–patient relationship

The art of caring is professionally embodied in a 'therapeutic alliance' that develops between the nurse and the patient and is referred to as the nurse–patient relationship (Fortinash & Worret 2004). The findings reveal that the investment of the therapeutic self into this relationship can have a positive impact on the patient experience. During the interviews, the nurses expressed the value of the 'therapeutic self' as intrinsic to 'knowing the patient' and recognising their individual needs.

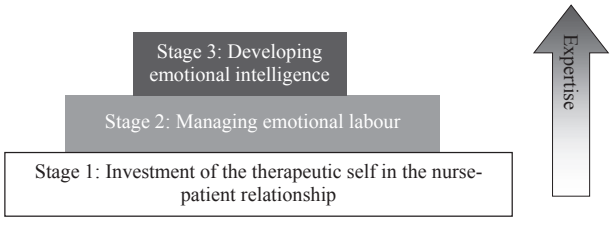

Figure 1 Developmental model.

The patient perspective embedded in these findings reveals that the core quality that underpins care delivery is the therapeutic self in the nurse–patient relationship. The 'therapeutic milieu' that is created during the nurse–patient interaction to which Scholes (2006) refers has a positive impact on the patient and their relative. Patients valued the 'closeness' that the therapeutic self-offered. They identified good care with 'presence' at the end of life and the value that a nurse 'being with' someone during this time can have. Interestingly, the patients and relatives who recalled poor experiences of care in the ED acknowledged this was a result of the lack of a close nurse–patient relationship, highlighting that absence of stage 1 in care delivery can result in poor patient satisfaction:

> If they let you know that they really did care if you will be alright or not. But they don't. All they are there for is to earn a few bob[money] and go home. That's all they are bothered about. (Joe, patient)

Joe, a 67-year-old man with terminal lung cancer, was interviewed at the SPCU three weeks after his ED admission. As he reflected on his 'care' in the ED, neither Joe nor his wife Rose could identify one particular nurse who had cared for him during his ED stay and he described feeling 'stuck in a corner and left'. Patients seem to view nursing care not necessarily by what is done but more to do with how it is done. Joe described the emergency nurses as task focused rather than patient focused which was reiterated by some of the staff nurses as they reflected on their colleagues. Jane discussed the importance of personality in the nursing role and suggested that the characteristics of some nurses were more suitable when it came to providing end-of-life care to patients and being empathetic to relatives:

> I think some people are better at it than others. Just because of the person that they are, their personality, the way that they are, their outlook. Some people are more tuned in to deal with that sort of thing than others I think. (Jane, SN)

In the ED, much attention is given to the technical aspects of care and not necessarily the aspects of care that both the patients and the nurses in the study highlighted as essential to nursing the patient at the end of life. This supports the work of Scholes (2006) who looked at the development of expertise in nurses working in intensive care units. McCormack and McCance (2006) have argued that there is a need to move beyond a focus on technical competence which requires nurses to engage in authentic humanistic caring practices. Both McCormack and McCance (2006) and Scholes (2006) interpretations resonate with the concepts raised in this study in the ED where the complexity of delivering care is shaped around the development of the nurse–patient relationship.

As the nurses recalled positive experiences of end-of-life care, they described not only the emotional closeness but also a physical 'closeness' which they experienced with either the patient or their relative resonating with the healing relationship to which Benner refers. They spoke about the value of providing comfort and communication through touch. During the interviews, many of them described how they felt an unusual closeness to the patient or the relative and the patients perceived as fundamental nursing care:

> We knew she was going to die at some point and I do not know why I did it but before I left I bent down and kissed her on the forehead. I have not got a clue why I did it but that really stuck with her partner. She said if only all of the nursing care we had received was as a nice as yours. But I have not got a clue why I did it, I just did. I do not know why because I do not normally go round kissing patients. I did not even know them very well. I had not been with them all that long. It was automatic. It just seemed right and her partner really, really appreciated it and wrote a really nice letter. It just seemed right at the time. (John, SN)

Many of the nurses referred to these automatic responses as 'intimate'. In the literature, intimacy is intrinsically related to the therapeutic nurse–patient relationship (Kadner 1994). Muetzel (1988) described this level of engagement as 'being there', nurses connecting with patients physically, psychologically and spiritually. Kadner (1994) further adds that intimacy involves 'self-disclosure of personal information with the expectation of understanding and acceptance', characteristics described by the patients during the interviews when asked what made a good nurse.

During the observations, touch was frequently provided as a means of comfort. The placing of a hand on a patient's hand or on a relative's shoulder replacing verbal communication, but was only observed as a practice amongst nurses. Other acts such as the holding of a patient's hand, combing of their hair, rubbing of their feet, not usually seen as professional were approached as acceptable as a form of comfort care during the 'intimate' time that a patient dies.

Whilst the nurses could see the value in investing the therapeutic self into the relationship, they were concerned about the implications of their acts. Kadner (1994) proposes that the professional relationship is skewed as intimacy is associated with a personal relationship and not a professional one:

> Sometimes they [the relatives] have given me a kiss as they have left on numerous occasions and I have thought – is that very professional? But then I have thought no she is a little elderly lady if she just wants a kiss and cuddle, then I think that is acceptable. It is such an intimate time anyway. (Annette, SN)

As Errser (1991) warns 'the effective use of such opportunities in a way that at the very least does not do more harm than good requires tremendous skill on the part of the nurses'. They also worried that 'getting too close' was problematic and some distanced themselves from dying patients owing to the emotional impact the death would have on them.

Stage 2: Managing emotional labour in emergency work

Benner *et al.* (1999) describe the emotional labour that accompanies a crisis in the ED as 'very demanding, requires sensitivity and attunement to one's own and other people's responses in the situation'. The concept of emotional labour is most commonly associated with Hochschild (1983) who defined emotional labour as 'the induction or suppression of feeling to sustain an outward appearance that produces in others a sense of being cared for in a convivial, safe place'. Emotional labour in nursing has been particularly associated with distressing situations whilst caring for terminally ill patients (James 1992), patients in pain and experiencing loss (Smith 1992) or patients transitioning from active treatment into palliative care (Kelly 2000). Identifying and managing emotional labour having invested the therapeutic self into a relationship with the dying patient or bereaved relative is the second stage of the model. Not all nurses are able to progress to this stage because of the distancing behaviours they adopt to protect them from grief; however, this can be more stressful for the nurse over a prolonged period of time.

Emergency nurses are frequently with patients and their relatives at critical moments. Although they may be short, these periods are often intense and emotionally demanding:

> I think it is more the emotional side of what happens. You just think [about the loss of life] and because the family told me so much personal stuff [information], you just feel for them so much. You are putting yourself in their shoes so much that it makes you emotional. It was just so rotten. (Annette, SN)

McMillen (2008) observed comparable findings amongst intensive care nurses who got emotionally involved when caring for dying patients they had looked after over time, similar to Annette. Several other nurses revealed the emotional impact of caring for patients near the end of life and their relatives. Catherine's comment demonstrates the emotional impact that this type of work can have leading her to consider leaving emergency nursing:

> This is why part of me wants to leave [emergency nursing] because you are drilled into and you are battered emotionally. You can do what you can and you will cry for these people or you will ponder

over them and wake up in the middle of the night thinking I cannot believe what happened and you will be cut down. (Catherine, SN)

Hochschild (1983) argues that emotional life is socially controlled. When nurses do not feel as they think they ought to feel in a particular situation they engage in emotional labour to manage, control or alter their emotional status to correspond with what they believe is appropriate. Managing emotional labour is the second stage in the model and is essential for nurses to develop the ability to manage the boundaries of intimacy and distance. Nurses in the study who were unable to manage the emotional labour associated with end-of-life care frequently developed distancing behaviours as a coping mechanism when confronted with a dying patient or their relatives in an attempt to avoid their own grief:

I know it is their way of coping with dealing with death. It is the same when it comes to actually caring for the dying some of my colleagues would rather not be in there, they say they find it boring. They find it distressing and their way of coping is just not to go there and have as little contact as possible leave it to somebody else who can. I have seen gambling all the way through from the really bad jokes again just a coping mechanism to people who just cannot cope with it emotionally themselves and just reduce to tears. (John, SN)

Others have argued that the emotional aspect of nursing is something to be embraced to provide quality care to patients. Von Dietz and Orb (2000) propose that it is important for nurses to experience compassion, because it affects their decision making and actions, which in turn contributes to excellence in practice. Henderson (2001) has also argued that emotional involvement displayed by nurses contributes to the quality of care stating that the emotional engagement by nurses is perceived as a requirement to achieve excellence. Despite this, James (1992) warns that emotional labour is 'skilled, demanding, work', and certainly in the ED, CB witnessed how it was often intense and as identified by our study findings, over time this could be exhausting. If nurses were not supported to reach the final stage of the model, they were at risk of developing ineffective and potentially harmful coping mechanisms that could lead to stress, ill-health and withdrawal from practice:

You just feel emotionally drained sometimes. I've been there myself and I know what its like and it's like a smack in the face every time. It reminds me every time…perhaps that's why I ended up having six weeks off with stress related problems. (John, SN)

Amongst the participant group in the study period, three nurses identified that they were considering leaving emergency nursing, one of them was considering leaving nursing all together. Whilst more research needs to be done into this, it is interesting that during their interviews, each of them recalled bad experiences with patients who were dying in the ED and felt overwhelmed by the emotional impact of their professional role on their personal life. Whilst they had developed from the first stage of the model and had invested their self into the nurse–patient relationship, they were unable to manage the emotional impact that this relationship brought with it.

Stage 3: Developing emotional intelligence

The third and final stage of the model is the development of emotional intelligence in providing end-of-life care. By recognising emotional labour, nurses can develop emotional intelligence to solve problems, facilitate learning and manage change (Huy 1999). Goleman (2001) identifies four main components of emotional intelligence, self-awareness, self-management, social awareness and relationship management, which are used to describe this stage of development.

The components that Goleman (2001) describes allow the nurse to recognise others and regulate their own emotions using their intuition to guide their decisions. Self-awareness is central for nurses to develop an emotional intelligence in their care of the dying and bereaved. It allows the nurse to reflect on past experiences, core values and identify strengths and weaknesses in their practice. Self-management involves the control of such emotions in response to a fast-changing environment. In the study period, there was a clear divide between staff who demonstrated aspects of self-control in situations which were volatile or potentially emotional and those who did not, which surprisingly was not synonymous with the years they had worked in ED but how they had progressed along the stages of the model. Social awareness relates to the ability to sense and understand another person's emotions and react appropriately understanding social networks. One nurse displayed a deep social awareness for a family of a dying man during one observation. Despite the pressures of the four targets, a Department of Health initiative to admit or discharge patients within four hours of ED admission, she prioritised a private bed space stating that 'the family needed precious time with their dying father'. The final concept to manage relationships is the ability to manage conflicts as well as to inspire, motivate and develop others: a fundamental role of the expert in practice.

During the interviews, nurses at this stage of the model spoke about the importance of 'knowing their patients' and their 'gut instincts' in relation to individual care delivery. Goleman (2001) indicates that the emotional competencies involved in emotional intelligence are learned capabilities but must be worked on and developed to achieve performance. McQueen

(2004) argues further that the management of emotions is required in successful interactions so that professionals show an understanding of their patients and their colleagues which consequently influences the feelings of those around them.

McQueen (2004) questions whether educational programmes prepare nurses adequately to be 'self-aware' and to provide psychological support in the course of their work. Henderson (2001) also declares that nurses feel inadequately prepared for the social, interpersonal and emotional demands of their roles. The study findings certainly support the notions made by McQueen (2004) and Henderson (2001). Evans and Allen (2002) add that emotional intelligence is generally overlooked in the nursing curricula; yet they state that 'the nurse's ability to manage their own emotions and to understand those of their patient's is an asset in providing care'. Learning the tacit aspects of managing emotions and understanding those of patient's is an asset in providing care (Evans & Allen 2002). Building a close nurse–patient relationship, whilst maintaining professional boundaries is challenging during highly sensitive, emotionally charged and often intimate moments. Whilst educators recognise that death anxiety and personal attitudes involved in end-of-life care giving are shaped during the preregistration education (Kurz & Hayes 2006), there are no curricular requirements to include these fundamental aspects of professional development into nursing programmes. As Dickinson *et al.* (2007) suggests, nurses need to recognise and confront their own reactions to death before they can help their patients do so. Being able to do this in a safe and supportive environment will not only benefit them, but also ultimately result in a better experience for the patient. Making emotions explicit in the curriculum is an essential requirement to educate the emotionally intelligent practitioner (Freshwater & Stickley 2004) and as this paper illustrates, it is a fundamental process in developing expert practice. The findings in this study support the previous literature that emotionally intelligent individuals are able to recognise and use their own and others' emotional states to solve problems in the ED, to accomplish patient goals and overcome adversity in their practice.

Barriers to transition

Transition along the stages of the model is challenging owing to several obstacles: environmental constraints of the ED, willingness to develop the nurse–patient relationship and coping mechanisms adopted in response to anxieties around death. Without adequate educational support, nurses are unable to overcome these barriers and are prone to occupational stress and burnout, which can result in ill-health and withdrawal from practice.

Environmental constraints

Observing the patient journey through the ED reveals difficulties in developing the therapeutic relationship. During the observations, the ratio of staff to patients constantly changed owing to the unpredictability of emergency presentations. As patients moved through the ED system, they moved to different areas of the department as their condition stabilised or in some cases deteriorated. This meant that their care was handed over to other nurses as they waited for an admission bed or for further treatment. During the interviews, the nurses expressed the main reason for not developing a therapeutic relationship was associated with the resources of the ED and nature of the emergency environment. Many of the nurses both in the interviews and during the fieldwork frequently became frustrated when they were unable to provide the kind of care they wished to give.

For the emergency nurse meeting a patient or relative for the first time, there is little time to develop rapport and relationship. Time and information are limited in the ED, and the staff frequently reported that relationships had to be formed quickly. Anthony captured the importance of developing a relationship with the patient and relatives:

> We are human, we are dealing with death and the thing about are department specifically is you have to form contacts with people and establish a relationship almost intimately over two minutes. It is not like on the ward where patients may be there for weeks and you get to know all the relatives and the names. You have got to bond with the patient or the patients relatives instantly so that they know they can turn to you and trust you and rely on you. (Anthony, SN)

As technology advances, emergency nursing continues to change. Some predict that the development of monitoring equipment, telemedicine and electronic surveillance means that nurses will be called on to monitor patients from a distance rather than face to face (Scholes 2006). According to Benner, this change in practice reduces the valuable nurse–patient interaction, which nurses rely on to develop the intuitive skills, which are necessary for this model. Whilst advances in technology offer opportunity, they cannot account for the importance of 'being with' a dying patient or supporting a family in their crisis when a patient dies.

Willingness to invest into the relationship

Despite the apparent benefits of the therapeutic nurse–patient relationship, not all patients were able to or even willing to invest in the nurse–patient relationship owing to embarrassment, denial around death or anger. The forming of therapeutic relationships under such circumstances is clearly a complex challenge, and Muetzel (1988) argues that the ability of the nurse to partake in such a therapeutic relationship is

dependent on the nurse having developed as a person, both personally and professionally.

Malone (1996) notes that emergency staff have to quickly assess patients who are acutely ill and those who are not which can lead to the risk of stereotyping which may well form a further barrier to the formation of the relationship. Baillie (2005) further recognises that in the ED, patients who are embarrassed or regretful of their illness or state may prefer to distance themselves from the nurse during the ED attendance. Similarly, nurses may also prefer to set boundaries in the relationship with patients who are regular attendees and any others who are manipulative or abusive.

Coping mechanisms

Not all nurses could invest their self into the relationship. Many reported that this was as a result of personal anxieties over dying, fears of saying or doing the wrong thing, feeling unprepared and being unable to manage their own feelings in what they perceived to be an already fragile situation:

> I like the minor injuries side. I am not one who really likes the trauma side and that perhaps is quite interesting because I don't like death… I have to say because I fight shy and I do fight shy of going in the resuscitation room so I have not had that much experience [of caring for patients who have died in the ED]. (Margaret, SN)

Whilst Margaret was an experienced emergency nurse, she was unable to invest her therapeutic self into a relationship with her patients because of her fears around death and dying. Instead, she distanced herself from patients who were at the end of life, to the extent of avoiding working in areas where she knew they would be taken for care.

Senior staff nurse Ellen described how some of her colleagues avoided getting involved with relatives:

> There are some people that avoid it [speaking to the relatives] at all costs. Not necessarily the junior people, some senior people I know would prefer not to be involved with families at all. Whether they have had a bad experience themselves or they can't deal with other people's emotions I don't know. But they are not the most calm of personality themselves. I would say, not the most empathic of my colleagues. (Ellen, SSR)

Ellen acknowledged that not all of her staff team are able to carry out the tasks involved in end-of-life care in the ED. She remarked that they are unable to deal with other people's emotions and their own personality traits do not produce a calm environment for patients, their relatives or for the rest of the staff team. Having interviewed some of the staff that Ellen referred to, they revealed their anxieties around caring for the dying and bereaved justifying their behaviour by a lack of educational support. Lucy had worked in ED for three years but was not comfortable with investing into a therapeutic relationship with dying patients or bereaved relatives:

> I have never had to do it [talk to the relatives] and I cannot ask for help now. I just avoid it. (Lucy, SN)

Whilst Lucy was more than competent in assisting in resuscitation attempts which we observed in the study, she would move to other patients as soon as the decision was made to stop or withdraw active treatment. In this case, people like Ellen would speak to the relatives and in her interview she described how she would prefer to do this than volunteering one of the staff nurses, unless she was confident in their ability to manage their own emotions and care for the relatives.

Conclusion

This research study has explored the multifaceted and complex process of end-of-life care delivery in the ED. The findings show that nurses who invest their therapeutic self into the nurse–patient relationship and are able to manage emotional labour are able to develop an emotional intelligence in caring for the dying and bereaved. Despite the emotional impact the emergency death can have, they find reward in caring for the dying and their relatives ultimately creating a more positive experience for both the patient and the nurse. There are three distinct stages that the nurse goes through to develop the level most associated with expertise in caring for the patient at the end of life in the ED. The nurse first has to invest the therapeutic self into the nurse–patient relationship to develop the intuitive skills associated with recognising deterioration and the individual needs of the patient as death nears. However, if inappropriately managed, the emotional labour involved can be exhausting. To manage this, the nurse has to develop skills of emotional intelligence. It is at this level that the patient and nurse have a mutual relationship and understanding of dying process, preparedness for death and openness.

The research illustrates that whilst therapeutic intimacy is required to develop intuition in the care of the dying associated with caring excellence, the emergency environment and nature of emergency presentations constrain the development of such a relationship. Similarly, the inner anxieties and concerns of the nurse can act as a barrier to developing this relationship and act as a barrier to developing expertise in end-of-life care.

Targets set out in the NHS Plan (2000), NHS end-of-life care programme (2005), end-of-life care strategy (2008) aim to improve training and provide support for healthcare professionals caring for the dying and the bereaved. However, they do not address the emotional aspects of support-

ive and palliative care delivery. This paper addresses a previously neglected area of emergency nursing and proposes a theoretical model in response to the emotionally demanding aspects of end-of-life care. In the absence of existing evidence, this model offers emergency nurses and educators an insight into how nurses develop expertise in caring for the dying and bereaved. It does, however, require the co-operation of curriculum developers and educators to provide and reinforce the learning opportunity. Professional development activities designed to address these issues we argue will need to address the very complex underlying factors, which our research has uncovered. Like so many areas of professional competence, healthcare workers in this area need a great deal of support and training to help them re-evaluate and change aspects of their professional practice, which may have been strongly developed as a result of previous experiences.

Relevance to clinical practice

There have been changes in the way that practitioners are exposed to the dying process. As the population ages, more people are dying for a longer period of time and for many, comorbidities can complicate their end-of-life status and decision making. Despite attempts to keep end-of-life care in the community (Department of Health 2006), it is highly likely that throughout their illness, they will require emergency care. The document 'Improving patient experience in Accident and Emergency departments' (Department of Health 2003) makes reference to 'building patient relationships' in the ED as 'building trust, understanding how patients may be feeling and respecting patient's privacy and dignity' (Department of Health 2003). This model provides an insight into how emergency nurses can manage the emotional labour that accompanies their work. It provides an awareness of the importance of recognising and regulating emotions in the light of overcoming inadequacies in the social, interpersonal and emotional demands of the nurse's roles in end-of-life care. It can be used to address some of the barriers raised through continuing professional development. Whilst it has been acknowledged that not all patients and not all nurses will want to or even be able to develop a intimate nurse–patient relationship, it has been recognised that it is the quality of the nurse–patient relationship that plays a key role in influencing the experience of end-of-life care for both the patient and the nurse.

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Contributions

Study design: CB; data collection and analysis: CB; manuscript preparation: CB, RM, DP.

Conflict of interest

None.

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