The Lived Experience of Acute Care Nurses, Following Possible Exposure to HIV/AIDS In The Working Environment:

A Phenomenological Research Proposal.

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Signed: A J Brownlee Dated: 6-8-98

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ABSTRACT

The following paper takes the form of a research proposal that seeks to examine the lived experience of acute care nurses following possible exposure to the HIV/AIDS virus in their working environment.

The paper explores the characteristics of qualitative research and offers the phenomenological research design of Helen Streubert as the base methodology for the study. The paper justifies the choice of design by giving account of it's suitability to the study of the acute care nurses' lived experience when potentially exposed to HIV/AIDS. A detailed explanation of Streubert's design is offered along with a description of the method that would be followed in order to obtain the study's objectives.

A preliminary literature review is offered in an attempt to explain some of the effects that potential exposure to HIV/AIDS has on nurses. The paper offers some insight as to the transmissibility of HIV/AIDS and details some common fears, attitudes and coping mechanisms which nurses possess when confronted with the HIV/AIDS issue. The psychology behind nurses' fears and attitudes is explored along with the need for nurse managers to consider such psychology before attempting to change nurses attitudes and values. It is surmised that an understanding of nurses fears, attitudes and coping mechanisms in relation to HIV/AIDS, will give some insight as to the lived experience of acute care nurses following possible exposure to the HIV/AIDS virus in the working environment.

The paper briefly examines some of the advances that have been made in the areas of information, counselling and health agency policy in relation to nurses and possible HIV/AIDS exposure. The paper also seeks to explain how these topics can effect the lived experience of nurses following the possibility of exposure to HIV/AIDS. The need for comprehensive educational programs by nurse managers and educators, which give consideration to the education, counselling and policy requirements of acute care nurses, is highlighted in order to assist such acute care nurses through their lived experience. Further justification of the need for the proposed study is highlighted by the fact that there is very little literature available, which deals with nurses' lived experience, following possible exposure to HIV/AIDS in their working environment.

The paper offers some suggestions, based on the preliminary literature review, as to what the possible findings of this research may be. It is hoped that defining and explaining the lived experience of nurses, following possible exposure to HIV/AIDS in the working environment, by utilising a phenomenological study of this type, would result in a better understanding of what the nurses' lived experience entails. This understanding may therefore assist acute care nurses to have their needs met more effectively, following a period of possible exposure to HIV/AIDS at work.

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CHAPTER ONE: BACKGROUND

1.1 Introduction to the Study Topic

Acquired Immune Deficiency Syndrome (AIDS) was first detected in Australia in the early 1980's, and the cause was traced to the Human Immunodeficiency Virus (HIV) in 1983. By 1984 there were enough people suffering with AIDS in Sydney to require health authorities dedicate a number of hospital beds to be used specifically for AIDS patients. In 1987, 523 people were registered as AIDS sufferers, and 290 of these people had died. By 1994, 5737 people had been diagnosed to have AIDS, and 4014 people had died from AIDS. Globally, there is an estimated 16 million adults and 1 million children who are carriers of HIV, and the World Health Organisation estimates that approximately 4 million people have AIDS (Sinclair 1995, 27).

The transmission of HIV/AIDS in the working environment can occur in a number of ways. Where health care professionals are concerned, the needlestick injury is the most common form of cross infection of the HIV/AIDS virus from patient to nurse (Boland 1990, 43). Needlestick injuries actually account for one third of all work related injuries among health professionals. Other common sources of exposure to HIV/AIDS are blood or body fluid splashes to the eyes and mouth (Shultz, Harris & Shultz 1994, 23).

The chances of acute care nurses contracting AIDS from an infected patient is however very small. For example, the risk to nurses of contracting AIDS from an infected piece of invasive equipment, such as a needle, that has punctured their skin is estimated to be in the vicinity of 1 in 200 to 300 (Spechko 1991, 26). The chances of seroconverting (testing positive to HIV antibodies) is even less if the nurse has only

had exposure to blood or body fluids through the eyes, mouth or open cuts and wounds (Gingrich 1990, 18). In fact, there has not been any evidence that exposure to blood or a body fluid on unbroken skin has caused seroconversion to the HIV/AIDS virus. Nevertheless, the risks of acquiring AIDS from patients can be quite frightening to nurses and cause them much anxiety (Spechko 1991, 26-28).

Over the past few years, nursing and medical literature has been inundated with a plethora of information relating to the diagnosis and treatment of individuals with AIDS. Health care workers have been concerned about the transmission of AIDS from patients to themselves, and there has been much documentation as to the routes of transmission of the AIDS virus (Dickerson 1989, 26). There has also been documentation regarding concerns about the possibility that nurses who carry the HIV/AIDS virus may be able to transmit the virus to their patients (Parker 1992, 56). Unfortunately however, there is very little information available about nurses' feelings, attitudes, preconceptions and coping mechanisms following possible exposure to AIDS.

1.1.1 Study Purpose and Study Question

The problem of this study is to explore the lived experience of the acute care nurse, following possible exposure to the Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) in the working environment.

1.1.2 Research Question To Ask Participants

Please describe a situation where you have come into contact with the blood of a patient who may be a carrier of the HIV/AIDS virus. Please describe and explain all your thoughts and feelings surrounding the situation, until you have nothing further you can say about the event.

1.1.3 Study Ramifications

The proposed qualitative research study would seek to identify and describe nurses' thoughts and feelings, following possible exposure to HIV/AIDS, with the aim of assisting nurses and nurse managers to understand this situation. The presupposition underlying the study is that of an understanding of these thoughts and feelings would help to ensure that nurses who have encountered exposure to potential blood borne pathogens have their needs met. Furthermore, it is thought that an understanding of this lived experience would assist with the development and expansion of professional protocol and codes of practice that would better prevent such exposure, or support nurses who find themselves in this situation. It is also hoped that this study would increase people's awareness of the suffering that AIDS can cause, to patient family and nurse. In turn, this awareness may stimulate further phenomenological research, and lessen the impact that AIDS can bring. The importance of this study is reinforced by an apparent lack of available literature, regarding nurses' lived experience after possible exposure to HIV/AIDS in the working environment.

1.1.4 Rationale for Selection of Research Design

The proposed research topic would be studied using the qualitative research design of phenomenology. Qualitative research does not typically contain "hypotheses, dependent and independent variables, large or randomised samples, statistical analysis, conceptual frameworks, or scaled instruments", as seen with quantitative research. Qualitative research is not intended to "predict or control" a situation (LoBiondo-Wood & Harber 1994, 482-483). Qualitative research intensely explores unique circumstances and conditions in "naturalistic settings" in order to obtain data of "practises, behaviours, beliefs, and attitudes of individuals or groups as they normally function in real life" (Polit & Hungler 1995, 196). The focus of qualitative research is to "describe or explain phenomena or culture", and to do this in a way that will disclose the "richness" of the data. In view of the importance that society places on empirical inquiry, the qualitative researcher is challenged to convey data that is 'rich' and 'full' and yet depicted with objective enumeration (LoBindo-Wood & Harber 1994, 482-483).

Phenomenology is a qualitative research method "whose purpose is to describe particular phenomena, or the appearance of things, as lived experience". The pivotal element of phenomenology is the study of people in their normal lifestyle. The lived experience involves the perceptions of reality and truthfulness that is experienced by the people that are being studied. In addition, this lived experience is what "gives meaning to each individuals perception of a particular phenomenon and is influenced by everything that is internal and external to the individual". Therefore, phenomenology becomes a form of consciousness as well as being a form of qualitative research methodology (Streubert & Carpenter 1995, 30-31). Crabtree & Miller (1992,

24) further define this method of research by stating that phenomenology simply asks the question, "What is it like to have a certain experience"?

The phenomenological approach to qualitative research is a particularly useful approach in the environment of nursing (Streubert & Carpenter 1995, 34). Rose, Beeby & Parker (1995, 1128) also view phenomenology as being a crucial form of research in the development of nursing knowledge and theory. It is suggested by Streubert & Carpenter (1995, 34) that the reason phenomenological research maintains such value in the nursing environment is due to its alignment with the philosophical underpinning's of 'holism' in the nursing profession. The view that; the philosophy of the research method must be given consideration when selecting the research design, is also shared by such writers as Koch (1995, 827).

Nursing has traditionally viewed patient/clients as being unique human entities, who possess physical, mental, and spiritual needs. Nursing advocates the 'holistic' approach to the care of people, and therefore nurses seek to accommodate all of their patient/client's needs in the delivery of care. This philosophical view of holism is "rooted in the nursing experience" and is not assigned to nurses from outside the profession (Streubert & Carpenter 1995, 34).

Just as nurses do not care for only one component of a patient/client's being, so too is it inconsistent to study people by dividing them into pieces. Therefore phenomenology is a suitable method of inquiry in nursing as it is philosophically grounded in the concept of holism and in the study of individual's experiences. As phenomenology is

so closely aligned with nursing principles, it also becomes useful for nurse education and administration (Streubert & Carpenter 1995, 34-35).

A researcher who is interested in a phenomenological study will assume that there is an *essence* that can be fathomed from a situation through a process of learning and rationalisation (Polit & Hungler 1995, 197). Whilst reviewing the work of Hersserl, an early pioneer of phenomenology, Koch (1995, 828) defines essences as being "the ultimate structures of consciousness". Streubert (1991, 119) believes that "essences...represent the basic units of common understanding of any phenomena". She hopes that a discernment of the essences of a situation will result in an awareness of what has been experienced. According to Beck (1994, 255) a by-product of the search for essences is that the researcher will focus on the essential components of the situation without delving into surrounding issues.

There are many different approaches to phenomenological research and different researchers may choose differing phenomenological designs. From the inception of phenomenological research there have been distinctions among each design. This becomes obvious when one considers the distinctions between "Husserlian transcendental phenomenology and Hideggerian hermeneutic phenomenology" of such pioneers of phenomenology as Husserl and Heidegger. Husserl believed that phenomenology should concentrate on the life experience, whereas Heidegger believed that phenomenology involved the consideration of how people develop understanding in different situations (Koch 1995, 827). Therefore, "method choice should be guided by the appropriateness of the method to the phenomenon of interest" (Streubert & Carpenter 1995, 36).

CHAPTER TWO: RESEARCH DESIGN & METHOD

2.1 Research Design

The proposed phenomenological research design is based on that of Helen Streubert. Streubert states that her phenomenological research design is an amalgamation of other phenomenological approaches that were compiled by such researchers as "Speigelberg (1960)...Colaizzi (1978), Paterson & Zderad (1976), Oiler (1982) and Van Manen (1984)" (Streubert 1991, 121). Streubert (1991, 121) states that this amalgamation of phenomenological research designs was an attempt to build the "strongest method to investigate clinical experience with the distinct plan to formulate theory". Streuberts phenomenological research design includes the following stages:

> "(1) Explicating a personal description of the phenomenon of interest, (2) bracketing the researcher's presuppositions, (3) interviewing participants in settings unfamiliar to the researcher, (4) careful reading of the transcripts of the interviews to obtain a general sense of the essences of the experience, (5) reviewing the transcripts to uncover essences, (6) apprehending essential relationships, (7) developing a formalised description of the phenomenon, (8) returning to the participants to validate the description, (9) reviewing the relevant literature, and (10) distributing the findings to the nursing community" (Streubert 1991, 121).

The selected design is a valuable and credible selection for the topic as is fulfils the selection criteria of being "valid, workable and manageable" in relation to the study's requirements (Kumar 1993, 6). The phenomenological research design is particularly applicable to the research problem of; 'exploring the lived experience of uncertainty, of the acute care nurse, following possible exposure to HIV/AIDS, as it meets the three criteria outlined by Streubert & Carpenter (1995, 35) for selection of the phenomenological method.

Firstly, a preliminary literature review utilising the Cumulative Index to Nursing & Allied Health Literature (CINAHL) database, with a reference range between 1981 and December 1996, reveals that there is much information written about nurses feelings and attitudes to AIDS and feelings towards patients with AIDS, however there is little information available about nurses' lived experience following possible exposure to AIDS. This fact reveals that there is a need for further understanding regarding this phenomenon, which is the first requirement for choosing phenomenological inquiry (Streubert & Carpenter 1995, 35). Any information that is available about nurses feelings after possible exposure to HIV/AIDS certainly needs to be expanded upon. This is another factor involved in the selection of phenomenological inquiry (Streubert & Carpenter 1995, 35).

Secondly, phenomenological research primarily studies the essence of a phenomenon by examining the lived experience of people in their natural environment (Rose, Beeby & Parker 1995, 1123). Phenomenology is also seen to be compatible with environments, such as nursing, where knowledge of human behaviour is important (Rose et al 1994, 1123). Therefore phenomenology best suits the research problem as it positively answers the question: Will the study of the lived experience offer the best understanding of the phenomenon of interest? The phenomenological approach collects data from personal conversing with people, and is therefore the ideal choice of research design, to convey the 'richness' of the collected data (Streubert & Carpenter 1995, 35).

Finally, the researcher should always give consideration to a research design that takes account of accessible resources, the available time required to complete the research,

the consumers of the research, and the researcher's capabilities (Streubert & Carpenter 1995, 35). The researcher affirms that the resources and time necessary to implement the proposed research would both be available should the research be carried out. The research findings would be distributed to the nursing community, and therefore nurses would constitute the major 'audience'. This fact supports the selection of phenomenological inquiry, as it has already been established that the philosophy of phenomenological research is compatible with the holistic philosophy of nursing (Streubert & Carpenter 1995, 35; Rose et al 1994, 1123). The researcher also affirms that his inherent style and abilities would accommodate the traits of the phenomenological research design.

2.1.1 Site and Sample Population

Phenomenological research most frequently utilises "*purposeful sampling*" when selecting the sample group for study (Streubert & Carpenter 191995, 43). The proposed research study would incorporate the purposeful sampling technique. Purposeful sampling operates under the assumption that the researcher has significant understanding and discernment, relating to the research problem, to choose the sample size and group that would best represent the situation under study. The researcher may choose as many participants as he/she can, or he/she may only choose the respondents who most typically understand or represent the phenomenon of interest (Polit & Hungler 1995, 235).

It is imperative that subjects are chosen who have actually experienced the phenomenon in order that they may be able to share their experiences and perceptions (LoBiondo-Wood & Harber 1994, 496-497). Researchers must also ensure that the participants are ready to describe their lived experience. Therefore the researcher may need to be creative when it comes to recruiting, and approach prospective participants in a positive manner (Burns & Grove 1997, 72 & 312).

The phenomenological researcher must decide on how many respondents would be necessary to portray the lived experience of the issue under study. Streubert (1991, 121) states that a review of phenomenological studies has revealed that researchers have used sample sizes ranging from 1 to more than 400, however the typical number of respondents are between 4 to 7. Streubert (1991, 121) advises that phenomenological researchers must continue to interview more subjects until *saturation* of data occurs. Saturation is a point at which no new themes are being

displayed in the data, and the themes that are being uncovered during data collection are becoming repetitive (LoBiondo-Wood & Harber 1994, 497).

Although this form of sample selection has been criticised as not being externally validated in its applicability, it does offer the researcher some distinct advantages over other sample selection techniques. Often, a purposive sample of people may be used to examine and evaluate a recently designed research instrument. The researcher may also choose a purposive sample if he/she values the information and opinions that are retained by experts in the topic under investigation (Polit & Hungler 1995, 235). The researcher suggests that nurses who have potentially been exposed to the HIV/AIDS virus would be in a unique position to discuss their lived experience, and would be considered experts in this area.

It is proposed that the phenomenological study would be carried out in the Intensive Care Unit (ICU) and Accident and Emergency (A&E) ward, of a major public hospital in Sydney Australia, after permission has been obtained from the hospital's ethics committee. Expected sample size would be of approximately 6 acute care nurses who agree to participate in the study, and who have come into contact with the blood or body fluid of a patient who has the potential for carrying the HIV/AIDS virus. The exact number of participants would be amended during the study in order to fulfil the saturation requirement. It is expected that a major Sydney public hospital would have a sufficient number of possible participants, given the size and nature of patient/client turnover, to fulfil the study's needs.

In order to prevent participant coercion and any violation of nurses' privacy the researcher would recruit study respondents by placing a written invitation in the hospital's newspaper or newsletter. The researcher would also position posters in the ICU and A&E wards, with similar information printed on them, in order to assist the recruitment process. The invitations would contain a brief explanation of the need for the study, and the manner in which data would be collected, processed and distributed. These invitations would ask the possible respondents to contact the researcher by telephone. The researcher's name and telephone number would be displayed on the advertisements.

Any acute care nurses who have reported an incident that involved possible exposure to the blood or body fluids, of a patient with the potential to be carrying the AIDS virus, would be eligible for the study. The names of any acute care nursing staff who fit this criterion, and volunteer their services, would be placed on a confidential list in order to attain the number of possible respondents. Such nursing staff would also be given the opportunity to participate anonymously, and all participants will be given assurance that their identity would not be revealed. The researcher will choose approximately six consenting participants, who have most recently reported exposure to the blood or body fluids of a patient who is potentially infected with HIV/AIDS. Indeed, saturation may occur with a smaller number of respondents, and the six consenting nurses may not all have to be interviewed. More subjects would be selected if added participants are required to fulfil the saturation requirement. Respondents would be informed that written consent will be obtained at a pre-interview visit.

As mentioned earlier, it is expected that a major Sydney public hospital would have a sufficient number of possible participants, given the size and nature of patient/client turnover, to fulfil the study's requirement of approximately six respondents. As the study is dealing with the lived experience of nurses who have been *potentially* exposed to HIV/AIDS contaminated blood; any report of blood or body fluid exposure carries this potential. This, in turn, automatically establishes the beginnings of the nurses' lived experience. Therefore all acute care nurses who report blood or body fluid exposure are potential study respondents.

Should the situation arise where there is not enough respondents to fulfil the study's needs, it is proposed that the study would be extended to acute care nurses in other hospitals. Respondents would be recruited from other hospitals by placing the proposed advertisement in a major nursing journal, which is widely circulated. For practical purposes, the selection of respondents can be restricted to hospitals in the Sydney area.

2.1.2 Researchers Role

Data is usually collected in a narrative format and revolves around the researcher's perceptions, as they converse with the participants in the study. The qualitative researcher typically interacts closely with the participants of the study, in order to learn how the individual perceives the situation under study, and what their thoughts and feelings are concerning the problem. In this way, the researcher becomes the 'instrument' for collecting data (Polit & Hungler 1995, 196).

2.1.3 Research Method

According to Streubert's phenomenological research method, the first step that is taken by the researcher is to explain a "personal description of the phenomenon of interest" (Streubert 1991, 121). The writer's personal situation of being potentially exposed to the HIV/AIDS virus happened as a student nurse, when he experienced a blood splash in the eye. This occurred when a new born baby's umbilical cord ruptured as an obstetrician applied manual tension on it, in an attempt to deliver the mother's placenta.

The blood from the umbilical cord splashed into the writer's right eye, and missed the faces of the doctor, the mother, and the baby. The writer quickly irrigated his eye with saline, and was then told to put on a new hospital gown and assist with the next delivery. At the end of the shift, the charge nurse recommended that the writer fill out a Hospital Incident Form, and then ask the Infection Control Nurse for information as to the correct procedure to be followed after exposure to another person's blood.

At no stage was there any formal or informal counselling offered from any staff member, including the Infection Control Nurse, nor any information given as to how AIDS could be transmitted. The writer was then asked to have blood collected for a baseline HIV/AIDS test, and to return in three months for a follow-up test.

During the three-month window period, between the baseline HIV/AIDS test and the follow up test, the writer experienced feelings of uncertainty as to the possibility of contracting AIDS. Although the writer understood that the chances of contracting AIDS under such circumstances were almost inconsiderable, he could not overlook the

possibility. Therefore the writer experienced three months of anxiety, uncertainty, and doubt. The writer remembers a constant uneasy feeling of concern and apprehension that tended to preoccupy his thoughts and cause him to retract socially. The foreboding possibility of contracting HIV/AIDS and the resulting ramifications, to both the writer's personal life and his relationships with friends and loved ones, was a source of constant worry and distress. The writer unconsciously committed himself to work and study in an attempt to try to forget the situation until the final test result was finalised.

As the writer now recalls this event in the beginning of his career, and remembers the feelings of uncertainty that were experienced until the final HIV/AIDS test was known to be negative, he realises that much concern could have been relieved if the situation was handled differently. Information about the HIV/AIDS virus, its transmission, and its treatment would have alleviated much anxiety. A full knowledge and understanding of standards or protocol, as to the procedure to be followed after possible exposure to blood borne pathogens, would have given direction and comfort. Some form of counselling or debriefing would have also assisted to relieve the feelings of uncertainty. Most importantly, an understanding and reinforcement of safe working practices (ie the wearing of protective glasses) may have prevented the situation happening.

The second stage in Streubert's phenomenological research method, and possibly the most important step, is to "bracket the researcher's presuppositions" (Streubert 1991, 121). Given the writer's personal experience, it can be seen that the writer's preconceived thoughts, feelings and understandings of HIV/AIDS, all effect the lived experience after possible exposure to the HIV/AIDS virus. There is also a real danger

that such issues may impinge on the collection and analysis processes of the phenomenological study. Therefore, the bracketing process becomes imperative.

Bracketing involves the process of identifying the researcher's preconceived ideas and beliefs about the problem under study, and then removing them from consciousness. "Bracketing requires the researcher to remain neutral with respect to belief or disbelief in the existence of the phenomenon" (Streubert & Carpenter 1995, 33). The crux of the bracketing process is to prevent the researcher's pre existing beliefs from impinging on the collection and interpretation of the essence of the phenomenon. Without the bracketing process, the data that is compiled will not capture the 'purity' of the phenomenon (Streubert 1991, 120).

The bracketing process also increases the study's validity. The bracketing process helps to eliminate "researcher bias" thus increasing the research "credibility" (Rose et al 1995, 1126). This 'reduction' process is "motivated by the wish to avoid the possibility of error" Beck 1994, 255).

2.1.4 Data Collection

The next phase in Streubert's method involves interviewing participants in unfamiliar surroundings (Streubert 1991, 121). It is suggested that utilising a setting that is not familiar to the researcher would increase the researcher's listening, and assist the participant to feel comfortable during the interview. It is postulated that increasing the participant's comfort would promote easy disclosure of their feelings and perceptions (Streubert 1991, 122).

Data collection methods may vary according to the researcher's preferences. Researchers may utilise tape recordings and written notes however the *interview* is the primary manner of data collection (Streubert 1991, 122). In this way, the "researcher becomes the tool of data collection" (Streubert & Carpenter 1995, 37). The writer would utilise written notes and tape recordings during the interviews. Data from interviews would be formulated into transcripts (Streubert 1991, 122).

Before the interview takes place, the writer would contact the people in the sample group in order to arouse their interest and to give them time to ponder the study question. It is suggested that this pre-interview visit would "produce richer descriptions" (Streubert 1991, 122). Written material may be given to the participants in order to highten their understanding of the study question. The pre-interview visit also allows the researcher to develop a rapport with individual respondents (Sorrell & Redmond 1995, 1120).

Ethical considerations such as "informed consent and permission to tape record" would be gathered during the initial contact by the researcher (Streubert 1991, 122).

As mentioned earlier, respondents would be asked to fill out a written consent form. Often, researchers do not know what sensitive issues might arise during the interview and therefore the researcher should always allow for the participants' privacy. This being the case, the writer would also utilise a coding system for respondents, to assist in preventing their identity from being disclosed. Subjects would be informed that they can withdraw from the study at their discretion, without any retribution, at any time. Sometimes the interview process is emotional or even painful for participants, particularly if the issue is a sensitive one, and therefore the researcher accommodate the possible need for social support. Empathy and objectivity would be maintained at all times (Holloway & Wheeler 1995, 226-227; Streubert & Carpenter 1995, 44-45).

The researcher would utilise known interviewing skills to facilitate data collection. Researchers must have an understanding of the mechanics of an interview and must possess certain interviewing skills. Researchers must be aware of interview techniques such as being alert, nodding appropriately, sitting close to the participant and continuing eye contact. The researcher must also be able to discern the obvious and hidden meanings displayed during the interview and must be able to respond to such meanings (Sorrell & Redmond 1995, 1118).

Verbal and non-verbal probes may be helpful to assist the researcher to acquire more detailed responses and ensure that the respondent understands what is being asked of him/her (Burns & Grove 1997, 355). Silent pauses may create a relaxed pace and may stimulate elaboration of detail, and reflection may also generate new data (Sorrell & Redmond 1995, 1121). Researchers must use open ended questions to facilitate the richness of data (Sorrell & Redmond 1995, 1118). The interview would end when

saturation takes place and there is no new data being demonstrated (Streubert 1991, 122).

2.1.5 Data Analysis

Streubert's phenomenological research method involves a consolidation of four steps of data analysis. The first step involves the reading of the interview transcripts in order to begin to discern the general essences or common pieces of information that are being displayed (Streubert 1991, 122). The interview transcripts would be read whilst the researcher is listening to the tape-recorded interviews, as this will confirm accuracy and allow the researcher to reflect on data and become engrossed in the data. Burns & Grove (1997, 533) suggest that the researcher should listen to the tape recordings immediately following the interviews. The researcher should also take note of such details as individual respondents' voice tone.

The second step in Streubert's method of data analysis involves the identification and retrieval of the important statements from the collection of transcriptions. Any words that do not assist in the isolation of the main focus of a sentence are removed. The researcher would place significant statements on index cards and then interpret significant meanings from the index cards (Streubert 1991, 122). The researcher would begin to develop an intuitive understanding of how ideas relate and can use this information to develop initial assumptions (Burns & Grove 1997, 535). As this process is carried out, Streubert states that the researcher would begin to realise that some cards would display more than one theme. This fact reveals that some themes and essences have critical relationships to each other (Streubert 1991, 122).

The third step in data analysis involves the isolation and elaboration of the themes that are critically related. This process then leads to the final step of data analysis; the evolution of an exhaustive description of the study's phenomenon (Streubert 1991,

122). The exhaustive description takes the form of a written document which identifies and explains the meaning of the phenomenon without any contamination or researcher bias (Streubert & Carpenter 1995, 42).

2.1.6 Study Validation

According to Streubert's phenomenological research method, the next step in the research process involves returning to the study respondents in order to validate the written material. This process is imperative, as it is crucial to determine if the information is accurate. If the participants do not agree that the information accurately portrays the phenomenon, the researcher must repeat the data collection and analysis process and return again to the participants for validation. Further validity can be gained by interviewing several sample groups from differing backgrounds, ages, and cultures, as this will reduce the chances of misrepresentation (Streubert 1991, 121-122). Validation of written material can also be gained by giving examples of subjects' responses in the form of direct quotes (Burns & Grove 1997, 72).

2.1.7 Pilot Literature Review & Distribution of Findings

The final two steps in Streubert's phenomenological research method are the literature review and the distribution of the study's findings. A literature review would allow the researcher to understand how the study results fit into the general body of nursing knowledge (Streubert 1991, 121-123). A postponement of the literature review until the data is analysed would prevent the researcher from being biased by the literature (Streubert & Carpenter 1995, 40). The "researchers description...should only include what is seen in the situation and not what is read in the literature" (Burns & Grove 1997, 118-119). The literature review may further validate the phenomenological study's findings, or it may also serve to point out further topics of study that relate to the research question (Streubert 1991, 123).

The distribution of the study's findings to the nursing community is also important, as it allows the nursing community to utilise such findings. Sharing the information that is gained would add to the nursing profession's body of knowledge and augment theory production (Streubert 1991, 123). Burns & Grove (1997, 635-636) highlight the need to distribute the study's findings by stating; "the greatest impact on nursing practice can be achieved by communicating nursing research findings to a variety of audiences". In this way, the distribution of findings would fulfil the purpose of the study. It is proposed that the findings would take the form of a bound document, and a copy would be given to Avondale College's Wahroonga campus on the grounds of the Sydney Adventist Hospital.

2.1.8 Possible Study Limitations

As the study would recruit participants from a major public hospital in Sydney Australia, it is not wise to assume that it would be representative of nurses from other cities or from nurses in the rural community. Nurses in this study may be influenced by certain unknown variables that are unique to Sydney or unique to the individual hospital. Major Sydney hospitals are mainly situated in the central areas of the city, therefore the study may not be representative of patients and nurses from the outer suburbs.

Another possible limitation of the study may be a difficulty in recruiting participants. Due to the sensitivity of the study's topic, the researcher may find that nurses are not willing to become involved. The researcher may be challenged to convince respondents that their identity will not be revealed and may have to consider more innovative recruitment processes.

As mentioned earlier, phenomenological research carries the risk of observer bias during the interpretation and development of essential essences. Therefore if the bracketing process is not carried out meticulously, the resulting material may be influenced by the researcher.

CHAPTER THREE: LITERATURE REVIEW

3.1 Introduction to Literature Review

As mentioned earlier, a preliminary literature review revealed that minimal studies exist to elaborate on the lived experience of acute care nurses, or nurses in general, who have been potentially exposed to the HIV/AIDS virus through contamination with patients' blood or body fluids. There is however, considerable information regarding nurses' fears and attitudes toward HIV/AIDS and their fears and attitudes associated with caring for patients with AIDS. Some literature details the psychology behind such fears and also the coping mechanisms that nurses may utilise. Much information exists as to the management of health-care workers who have been exposed to patients' blood and body fluids. There is also ample literature available regarding such topics as Universal Precaution policies and suggested educational programs. It is surmised that investigation of the above mentioned topics will give some insight as to the lived experience of acute care nurses, who may have potentially come into contact with blood borne pathogens, in the working environment.

3.1.1 Nurses Fears and Reactions Following Possible Exposure

Reutter & Northcott (1995, 493) interviewed 13 nurses who had been potentially exposed to the HIV/AIDS virus through contamination with patients' blood or body fluids, by means of a grounded theory study. Although the study mainly highlights coping mechanisms, the authors reported that nurses explained their initial reactions were that of fear, anxiety, dread and guilt. The participants in Reuter & Northcott's study explained a profound loss of control, associated with not knowing whether they would seroconvert, and this lead to depression. Terror was another common feeling associated with the situation, and a feeling of guilt arise from the realisation that blame may be attributed to them, if they had incurred the exposure by not following proper hospital procedures (Reutter & Northcott 1995, 496).

Fear seems to be the universal reaction to any situation involving possible exposure to HIV/AIDS (Cochrane 1994, 5; Moorehouse 1993, 29; Stephany 1994, 80). Nurses feel that they have become a "walking time bomb" (Moorehouse 1993, 33). Stephany (1994, 80) reinforces this phenomenon with her personal account of 'fear' and 'paranoia' in caring for AIDS patients, after being exposed to the HIV/AIDS virus from a needle stick injury. Stephany (1994, 80) states; "I felt frightened and embarrassed: frightened of acquiring such a dreadful disease and embarrassed to be such a squeamish nurse". Whether good or bad, Stephany (1994, 80) stated that "denial" was the coping mechanism that gave her most comfort.

Following exposure to another person's blood, professional nurses may begin to think irrationally. This phenomenon takes place even though the nurse may know that his/her reasoning is unjustified (Anonymous 1990, 50; Cochrane 1994, 5). Long

standing belief systems may be challenged as nurses struggle to come to terms with the situation (Cochrane 1994, 5). Nurses may presume that they have became HIV positive even when without any evidence to support the assumption (Moorehouse 1993, 31). Nurses may demand to know the HIV status of the patient who has potentially infected them even though this request may be ethically wrong or even impossible (Cochrane 1994, 5; Moorhouse 1993, 29).

Following exposure to a patient's blood, nurses may react with extreme worry or be extremely composed. Stephany (1992, 104) recounts how she calmly carried on with her duties after receiving a needlestick. Stevens & Hall (1996, 43) report how one nurse "fell apart" during the window period of uncertainty, as the nurse recounts that she "was a wreck". This nurse stated that the needlestick was "the worst thing that ever happened to me in my whole life" (Stevens & Hall 1996, 43).

Another nurse, who wished to remain anonymous, recalled all of his/her concerns of possible life changes should he/she become HIV positive. The nurse felt that he/she would not be able to acquire life insurance, or a house loan, and his/her roommates would wish to leave. The nurse had concerns that he/she would not be able to find a sexual partner or he/she would have to continually use condoms in any sexual relationships. The nurse also had concerns about loosing his/her employment (Anonymous 1990, 50). The nurse stated that he/she began to "wish I had kept quiet" and also began to feel "very much alone" (Anonymous 1990, 50).

Other nurses were quite positive about the situation of possible exposure to HIV/AIDS. Fasshinder (1992, 112) published an article which did not concentrate on

the negatives associated with possible exposure, but utilised the situation to reinforce the importance of Universal Precautions. Carlisle (1993, 56-57) discussed the situation of Joy Bath who overcame her difficulties and negative emotions, when informed about her seroconversion after exposure to a HIV positive patient, and continued her work as a missionary nurse. Carlisle (1993, 57) did however state that Joy Bath was hurt by people who "jump to the same false conclusions" as to how she contracted HIV/AIDS.

3.1.2 Psychology Behind Fears

Fears and anxieties are a normal stress response when associated with the HIV/AIDS virus (Meisenhelder & LaCharite 1989, 29-30). In the usual stress response; "anxiety occurs when the threat is not clearly identified, and fear occurs when the threat is identified" (Meisenhelder & LaCharite 1989, 29). In the case of HIV, fear of contraction sets up a discernment of the terrible outcome of 'full blown' AIDS. The obvious stimulus in this stress response is the potential exposure to the HIV/AIDS virus, whether justified or not, leading toward a threat to self and then a fear of contagion. Feelings of fear and anxiety become the inevitable outcome of this stress response even though there may not be any rational basis for such emotions (Meisenhelder & LaCharite 1989, 29-31).

The fear and anxiety associated with potential exposure to HIV/AIDS is a natural and normal human response to a perceived threat to self. Many nursing researchers have concluded that fear and anxiety is in fact unavoidable in situations that are dealing with the HIV/AIDS virus (Steele & Melby 1995, 880). Fear of HIV/AIDS is not limited to lay people but is universally felt by nurses and other health care professionals (Stanford 1988, 47). Potential exposure to the HIV/AIDS will usually cause the nurse to respond in a negative manner. Potential exposure will also stimulate the nurse to unconsciously develop negative attitudes, which are often irrational and unjustified and are based on previous experiences and values (Akinsanya 1992, 63; Boland 1990, 40).

Nurse's attitudes, not unlike the general population's attitudes, assist the nurse to rationalise a situation or cope with a difficult problem. Attitude formulation is a normal role in life as it provides the matrix for people to respond negatively or

positively to stimuli from each individual's environment (Hewitt 1993, 145-149). Negative attitudes associated with potential exposure to the HIV/AIDS virus are a natural defence mechanism which nurses utilise to avoid the uncomfortable situation of possible infection (Last & Blanchard 1982 cited by Boland 1990, 40).

It is also important to note that the crux of nursing is all about patient care. Nurses are carers, and although they have to maintain a certain degree of professional detachment, they cannot cease to retain their humanness. "Sympathy" is an essential part of the nurse's practice, and often nurses develop a close relationship to patients and their families (Steele & Melby 1995, 880). Nurses may become a role model to families as they are trying to come to terms with the illness of their loved one (Hicken 1990 cited by walker 1992, 60). In turn, families develop many expectations of nurses, and often nurses feel stressed and unable to cope (Sullivan & Mills 1990, 13). The physical and emotional distress, that is associated with AIDS care, will leave a lasting impression on nurses and can cause them to develop fears and anxieties toward the virus (Bloomfield et al 1991 cited by Steele & Melby 1995, 880).

3.1.3 Types of Fears

The negative fears and attitudes that are experienced following possible exposure to the HIV/AIDS virus are a result of many complex issues that involve individual nurse's lives. Fear is a complicated emotion that is influenced by many variables, whether such variables are justified or not (Huerta & Oddi 1992, 224). Fears are closely associated with personal "prejudices... and mythologies" and are "inextricably woven into the fabric of our value systems" (Kerr 1991, 26). Even nurses who work with AIDS patients continuously may still conceal fears. It has been proven that as nurses care for more AIDS patients, they develop more negative attitudes (Anonymous 1992, 22).

Firstly, the fear of acquiring a potentially fatal disease, that has no known cure, is of utmost importance to nurses (Hewitt 1993, 144). As well as the virus's fatal outcome, the virus does not respect age, sex or social class (Steele & Melby 1995, 879). This fear of contagion is often heightened by a attitude of hostility toward the ever-increasing numbers of AIDS sufferers. Although it is proven that there is only a very small risk of acquiring HIV/AIDS from occupational exposure, the resulting fear can cause the nurse to think and act irrationally and may eventually subtract from the nurse's ability to deliver high quality nursing care (Hewitt 1993, 144).

Nurses fear of the transmissibility of HIV/AIDS has been illustrated by nurses leaving their job, being unwilling to supply nursing care to AIDS patients, supplying token care to such patients, and putting AIDS patients in isolation rooms without justification (Flaskerud 1991, 237). Nurses have been reported to have nightmares concerning the issue of HIV/AIDS and anxieties have manifest themselves through acute and chronic

episodes of physical and emotional ill-health (Bloomfield et al 1987 cited by Steele & Melby 1995, 880). Anger and hostility toward fellow colleagues, a reduction in productiveness, and an unwillingness to follow institutional objectives has also been witnessed amongst nurses who harbour deep seeded anxiety concerning HIV/AIDS (Boland 1990, 40).

The distress associated with the possibility of exposure to the HIV/AIDS virus is generally associated with a fear of the unknown. The unpredictable nature of the HIV/AIDS virus and the uncertainty of the outcome may cause nurses to view the virus irrationally. Nurses can become distrustful of the most empirical data available about the virus. The mystery personifies the unknown, embellishes the fear, and increases the nurses belief in the transmissibility of the disease (Meisenbelder & LaCharite (1989, 33). The nurse's previous experiences may also augment such fears (Boland 1990, 40).

Unresolved fears of death play a major role in the lived experience of acute care nurses following possible exposure to the HIV/AIDS virus (Cohen, Hurley & McGriff 1988, 34; Meisenbelder & LaCharite 1989, 33). This fact is particularly prevalent in western society where death is seen as a terrible and even nonsensical outcome (Sontag 1977 cited by Meisenbelder & LaCharite 1989, 33). Death is usually 'denied' in western countries and scientific interventions are employed to prolong life at all cost. A lethal and irremediable disease harbours all the terror of death itself. Therefore HIV/AIDS is to be avoided like death itself (Meisenbelder & LaCharite 1989, 33).

Many people view death as a punishment for something that the individual has done. Moralistic emphasis is given to the unexplainable or unrestrained death of an individual. Some nurses feel that people with AIDS have brought the disease upon themselves and therefore they are deserving of the outcome of the disease (Meisenbelder & LaCharite 1989, 33).

As mentioned, many nurses who have difficulty in coming to terms with death and dying see AIDS as a "death sentence" (Cohen et al 1988, 34). This increases their anxiety about HIV/AIDS and caring for AIDS patients. Cohen et al (1988, 34-35) state that nurses unresolved feelings may even cause them to feel guilty when dealing with the issue of terminal illness. These feelings are worsened by the fact that the numbers of AIDS patients are growing and many sufferers are quite young. Nurses can also become burnt-out and feel hostile toward patients for dying on 'their shift' (Mount 1986 cited by Cohen et al 1988, 35).

When dealing with the issue of HIV/AIDS, nurses will also have fears for the safety of their family. The thought of a family member contracting an incurable and fatal disease will concern many nurses (Boland 1990, 41; Hewitt 1993, 145). Nurse's concerns for the health and well-being of their loved ones will often cause nurses to assess their options and even reconsider their occupation or their place of work (Hewitt 1993, 145). This fear is also extended to the social lives of the nurses and their families. The negative effects associated with contracting HIV/AIDS can impact on the family members' social interactions and may therefore impinge on their social acceptance (Laschinger & Goldenberg 1993, 448).

Many researchers also site prejudice toward homosexuals and intravenous drug users as being contributing factors that influence negative attitudes toward people with HIV/AIDS (Bennett 1992, 285). The AIDS issue is fraught with "social stigma" as many people attach a degree of blame to any members of society who engage in 'risky' behaviour (Cohen et al 1988, 35). Rebuking the person for contracting HIV/AIDS is a common notion in western culture, as many people view the virus as being a sexually transmitted disease that punishes the individual for sexual immorality. Nurses may fear the HIV/AIDS virus as it has the potential to make them "social outcasts" (Meisenbelder & LaCharite 1989, 33). Such irrationality is caused by a lack of knowledge and expertise in the areas of sexual conduct and substance usage (Flaskerud 1991, 242).

Homophobia ("the reluctance to interact with homosexual individuals") has been an issue that has received the attention of nurse researchers lately (Kemppainen, Dubbert & McWilliams 1996, 296-297). Nurses develop moralistic and cultural opinions about HIV/AIDS that effect how the disease is perceived (Flaskerud 1991, 240). Flaskerud (1991, 240) cites a study by Wallack (1989) to highlight this point; as approximately half of the doctors and nurses in Wallack's study harboured feelings of resentment toward homosexuals as they believed that HIV/AIDS was caused by homosexual behaviour, and now this disease is killing 'innocent' heterosexuals. In her study of a predominantly Christian nursing college, Wilkinson (1992, 71) concluded that "a negative attitude" towards homosexuals is sustained by a "sufficient number" of student nurses to be a major area requiring consideration by nursing lecturers and the health care system. Such negative beliefs are consistently uncovered in nursing research and are usually related to ignorance, through a lack of information (Akinsanya

& Rouse 1992, 404). This fatalistic attitude towards homosexual individuals also results in an unwillingness to care for AIDS sufferers (Swanson et al 1990, 345).

This manner of reasoning is somewhat contributable toward the media as nurses are not immune to its effects. Much of what is portrayed in the media is "hysterical reporting" (Cohen et al 1988, 33). Steele & Melby (1995, 882) state that in their study of nurses knowledge and beliefs about AIDS, nurses reported that they acquired most of their information from the media. Swanson, Chenitz, Zalar & Stoll (1990, 342) acknowledge television as one of the most powerful tools for influencing both nurse and public alike. Swanson et al (1990, 342) also acknowledge that many misconceptions exist regarding AIDS, and it's transmission, amongst nurses and the public. Laschinger & Goldenberg (1993, 448) state that nurses who rely on the media for information about HIV/AIDS were less willing to care for patients with HIV/AIDS. Obviously, quality information, which does not stereotype individuals, is urgently needed in the media.

3.1.4 Coping Mechanisms

Once a nurse recognises his/her personal fears and anxieties regarding the HIV/AIDS virus, the nurse usually utilises his/her personal coping mechanisms. If the nurse's personal coping mechanisms are inadequate, the potential exposure to the HIV/AIDS virus will present the nurse with some unique problems that may endanger the nurse's own mental integrity (Cohen, Hurley & McGriff 1988, 35). The ideal goal of all coping mechanisms is to balance the actual risk to the perceived risk, and therefore relieve the associated stress. Unfortunately however, this goal is not always achieved (Meisenhelder & LaCharite 1989, 31).

Nurses' personal coping mechanisms may adopt many forms (Cohen et al 1988, 35). Often, nurses will avoid the situation as much as possible or utilise unrealistic amounts of protective clothing, in an attempt to cope with potential risk of exposure. Nurses may also feel the need to verbalise their fears to others, in order to cope with the uncertainty of possible exposure (Meisenhelder & LaCharite 1989, 31). Sometimes nurses' fears cause them to refuse to care for AIDS patients (Akinsanya 1992, 63).

Reutter & Northcott (1995, 493) carried out a Grounded Theory study in order to examine nurses' coping methods during their period of uncertainty as to whether they had actually contracted HIV/AIDS following possible exposure. This study concluded that nurses coped by "minimising the effects of exposures" by promoting bleeding at the puncture site or dousing the affected area in bleach solution. Nurses coped by "reducing a sense of vulnerability" through evaluating whether harm had been done, evading stressful situations and deciding to test for HIV antibodies. Nurses coped through a system of "selective disclosure to others" so as to maintain professional

integrity and avoid criticism. Nurses also coped by "assigning meaning" to the event in order to assess its cause and its affect on the nurse's personal life. Reutter & Northcott (1995, 498) highlighted the fact that respondents of their study would avoid any situation that would "arouse fear" or would remind them of the possible contamination that they had experienced. This study is representative of the few studies that are available regarding this topic, that are available on the CINAHL database.

Cohen et al (1988, 35) state that any coping mechanism that will reduce stress will be a valuable resource to nurses who are troubled by possible exposure to HIV/AIDS. "Jogging, relaxation exercises, meditation, or diversionary activities" are all encouraged. Of course, combining such coping mechanisms with a supportive and friendly education and counselling program is the ideal way of confronting and relieving the fears and stresses of acute care nurses.

3.1.5 Changing Nurses Negative Attitudes and Values

All human beings, including nurses, have established values and attitudes that give meaning to life. Unfortunately, prejudism and myth are also values that are firmly established in the developing stages of human life. As mentioned previously, these attitudes, fears and values give meaning to an individual's actions and assist the individual to rationalise thought. Such instinctive values and attitudes also prevent the individual from psychological trauma and can be used as weapons to dominate others that do not have similar beliefs (Kerr 1991, 26).

Although nurses utilise their value system to define their 'personhood', nurses are constantly being asked to conform to institutional norms, or risk reproach from employers or peers. Nurses are placed in the situation where they are torn between their individuality and their sense of social conformity. This ambivalent situation is particularly relevant when nurses consider the issue of HIV/AIDS. Nurses are being asked by the health-care system to conform to the singular view of "homogeneity" in order to care for many AIDS patients. This line of reasoning, by the health care system, may be bordering on "oppression", as the system is asking nurses to confirm to a view that has been assumed to be 'true' (Kerr 1991, 26-27).

Whether the issue is 'homophobia' or not, nurses feel a strong need to retain the values that define their 'personhood'. Any threat to a belief system will bring on a powerful desire to protect and justify it. Sometimes the individual will even increase their support of their convictions in order to maintain their value system. Nurse managers would do well to consider these facts when they ask nurses to change their attitudes, no matter how necessary, toward HIV/AIDS (Kerr 1991, 26-27).

Psychologists have differing theories as to the best way of ensuring change in nurses' attitudes. Some believe that positive reinforcement, such as assigning nurses their requested shifts, will cause them to accept change. Others believe that the nurse manager must examine the nurse's motives and instigate a change in the nurse's motivation for retaining their beliefs and attitudes (Hewitt 1993, 145). Still others believe that attitudes are underpinned by emotional, behavioural and intellectual components, that all need to be considered, when promoting change (Baron 1989 cited by Hewitt 1993, 146).

Hewitt (1993, 146) introduces the concept of "dissonance", as developed by Festinger (1957) and states that this is a valuable factor to consider when instigating change in nurses attitudes. When utilising the factor of "dissonance", the nurse manager will explain and justify the opposing view that he/she wishes the nurse to adopt. The nurse then feels uncomfortable with his/her personal attitudes as they can see value in the opposing argument. The nurse will begin to seek additional information in order to re-establish a harmonious belief system. The crucial finale to this approach is that the nurse manager must supply adequate information and reasoning to convince the subordinate to change.

This approach is particularly applicable to the health-care system, as nurses need to be committed to caring for AIDS patients and understand that AIDS does not pose a significant threat to them. If nurses are empowered by their belief, and see credibility in the argument that they are not at significant risk, they will be more likely to

internalise the change in attitude. In turn the fear and anxiety associated with HIV/AIDS will be reduced (Hewitt 1993, 146-147).

There is little argument that nurses attitudes and beliefs must change if their fears and anxieties regarding HIV/AIDS are to be reduced, and the best way to change such attitudes is by permitting all nurses to be well informed (Boland 1990, 41; Demirbag & Ridenour 1995, 129; Meisenhelder & LaCharite 1989, 36; Robinson 1992, 62; Stanford 1988, 47). As mentioned earlier, nurse managers must consider each nurse's individual cultural and personal values, in areas such as death and sexual behaviour, before planning any education program (Kerr 1991, 26). It is vitally important that nurse managers isolate individual nurses needs and tailor educational programs that are personally and professionally relevant to the individuals concerned (Martin 1995, 109).

3.1.6 Health Agency Policy and the Lived Experience

In 1987, the National Institutes of Health, Centers for Disease Control (CDC), when dealing with the occupational hazard of nurses contracting HIV/AIDS through contact with patients' body fluids, developed the Universal Blood and Body Fluid Precautions or Universal Precautions. These recommendations were intended to provide safe working environments for health workers, and stipulate that nurses must use protective equipment when dealing with any patients' bodily fluids, maintain correct asepsis and sterilising techniques, and dispose of contaminated materials safely (Dickerson 1989, 27). Furthermore the CDC has recommended that Health care workers are trained in the correct application of Universal Precautions in their basic training, and that hospitals must have active infection control staff who supply further inservice and training in this area (Centers for Disease Control 1991, 38).

The CDC has also established a "comprehensive postexposure management program" and health care institutions can incorporate this into their official infection control policies for nurses to follow, should they experience potential exposure to bloodborne contaminants (Spechko 1991, 26). Such postexposure programs inform the nurse of the correct course of action following exposure and offer the nurse information and counselling (Fahey, Beekmann, Schmitt, Fedio & Henderson 1993, 405-412). Such postexposure programs still require refinement but they are very useful for nurses who find themselves in this situation (Fahey et al 1993, 411).

Hospital standards are also bound by the Occupational Health & Safety Act of 1983. Therefore hospitals have a duty of care to their employees and must have active protocols to minimise risk to nurses (WorkCover Authority of New South Wales

1994, 4). Many hospitals even have standards for the administration of the HIV antagonist drug zidovudine (AZT) to nurses post exposure to potentially contaminated blood or body fluids (Gingrich 1990, 18). Acute care nurses must be aware of the correct protocols and use them (Dickerson 1989, 28). The development of such policy, and the regulation of practices, is also beneficial for the employing agency. This becomes evident when one considers the multi-million dollar litigation figures that have been successfully claimed by employees (Anonymous 1995, 30).

The adoption and implementation of universal precautions in hospital policy has resulted in a massive reduction in the incidence of patient-to-nurse contamination of the HIV/AIDS virus and other blood borne pathogens (CDC 1998 cited by Kemppainen, St.Lawrence, Irizarry, Weidema, Benne, Fredericks & Wilson 1992, 111). Universal precautions have also allowed nurses who are carriers of the HIV/AIDS virus to continue working safely (Jackson & Russell 1991, 23). Such universal precautions are seen to be "adequate" by most professional bodies (Flaskerud 1991, 239). Therefore all health-care institutions are urged to train their staff in the correct use of universal precautions before they function in a patient care situation (Cohen et al 1988, 33).

Studies have shown however, that nurses sometimes do not report incidents involving contamination by blood or body fluids, and therefore decline routine blood testing for HIV/AIDS, as ignorance may prove to be a source of comfort. The decision to test is often associated with feelings of guilt and anxiety. Nurses will sometimes yield to testing after a period of emotional turmoil as to not knowing if they have contracted HIV/AIDS or not (Reutter & Northcott 1995, 499).

Even though there are successful prevention measures in place, nurses will often disregard universal precautions (Huerta & Oddi 1992, 227). Many nurses who work in hospitals are not wearing gloves when acquiring blood samples and are therefore placing themselves in a situation of unnecessary risk. Many nurses are still re-capping needles, regardless of their knowledge as to the associated risks (Steele & Melby 1995, 886). Sullivan & Mills (1990, 14) cite a study carried out by Dr Harvey Bartnof, "director of AIDS education at the University of California", where half of the study recipients re-sheathed needles and the majority of the recipients reported that they would not wear gloves to handle "bodily fluids". Gruber et al (1989 cited by Huerta & Oddi 1992, 227) states that nurses report their failure to comply with universal precautions stems from insufficient protective equipment, tradition, and lack of specific direction. This emphasises the importance of clear guidelines and motivational education from nurse managers.

Although hospital policy may need further refinement, it would appear that is beneficial in reducing the chances of contracting blood borne pathogens, and hence, will reduce nurses' fears of contagion. Postexposure protocols will support acute care nurses during their period of uncertainty, following possible exposure to HIV/AIDS. Nurse educators and administrators have a duty to ensure that adequate policy and equipment is in place. Nurse educators also have the continuing responsibility and challenge to develop policy that is relevant to nurses' needs (Sullivan & Mills 1990, 13-14). Nurse managers must supply education programs within a "nonthreatening atmosphere", and allow nursing staff to express their concerns and opinions, if they are to motivate nursing staff to follow hospital policy (Flaskerud 1991, 241).

3.1.7 Counselling and the Lived Experience

Counselling for acute care nurses, who may have been exposed to the HIV/AIDS virus, is of paramount importance in relieving the stressors of uncertainty. "Fear of exposure to HIV is a natural response" and therefore it must be "acknowledged as legitimate" (Kazanowski 1992, 43). Reutter & Northcott (1995, 504) state that hospitals should provide peer support and counselling to nurses after any situation that involves possible contamination with blood borne organisms. Counselling should also involve consideration as to how nurses might deal with exposure if it does occur.

Nurses who have been exposed to a patient's blood or body fluids need to inform their employer of all the details surrounding the event, and employers should provide a truthful and professional estimation of the potential risk for contracting HIV/AIDS. If prophylactic treatments are to be employed, the nurse's employer should inform the nurse of any side effects to treatment and the rationale for using the treatment. The nurse should be informed about blood testing and about the times and dates for follow up testing. Emotional support is also vital for the affected nurse (Fahey et al 1993, 408).

Sometimes the fears and anxieties that are associated with HIV/AIDS, and the feelings of uncertainty following possible exposure, may begin to evolve into a phobia. If a nurse experiences a prolonged and acute fear, which is interfering with the nurse's personal and professional life, the nurse may need professional counselling from a psychiatrist or psychologist. A psychiatric nurse or social worker can also be invaluable in this situation (Boland 1990, 43).

Tillett (1989, 48) states that if it becomes known that an employee has an "AIDS-related condition" then counselling should focus on three main areas. Firstly, "confidentiality" should be guaranteed. This is of utmost importance with an issue as sensitive as AIDS. Any nurse who is carrying HIV/AIDS will typically be worried that they may loose their job or become the subject of criticism in the workplace. Secondly, care should be taken regarding the ongoing ability of the employee to continue at his/her job. Nurse managers must treat the effected nurse in the same manner as if the nurse had disclosed some other medical condition, and treat the nurse with trust and honesty. Thirdly, attention should be given to the likely effects on the workplace should the nurse's diagnosis become known by his/her peers. If colleagues learn that a fellow worker has contracted AIDS, the result is usually disruptive. Therefore nurse managers must inform the effected nurse about this circumstance, and offer support should this situation occur (Tillett 1989, 48-49).

Unfortunately however, little literature exists that can isolate whether hospitals are offering counselling to acute care nurses following possible exposure to AIDS, or whether any counselling that is offered is successful. It has however been established that any acute care nurse, who has been potentially exposed to the HIV/AIDS virus in the working environment, will be suffering from many professional and psychological stresses. It remains without question, that if any nurse who has been exposed to a patient's blood, and has had little or no counselling, there lived experience following exposure will be more traumatic.

3.1.8 Information and the Lived Experience

It would appear that acute care nurses have access to ample information regarding the HIV/AIDS virus, its modes of transmission, treatment, and prognosis. In Australia alone, $30 million is spent on AIDS education and prevention each year (Sinclair 1995, 28). Governments are even supporting centers that are dedicated to AIDS research and clinical training (Portillo, Miramontes & Holzemer 1995, 65). Nursing schools are combating the problem by developing and integrating material that addresses the needs of the patient and the needs of the nurse when the issue of HIV/AIDS is concerned (Kazanowski 1992, 42). Hospitals and other health care institutions are implementing educational programs and developing policy that combats the HIV/AIDS issue (Sullivan & Mills 1990, 13).

Although it would appear that nurses have access to a large amount of information, nurses consistently feel ill informed regarding the issue of HIV/AIDS. In their study of nurses knowledge and attitudes in three nursing settings, Steele & Melby (1995, 884) concluded that only 21% of nurses testified that they had enough information about HIV/AIDS, and 35% believed they were adequately trained to care for AIDS patients. Akinsanya & Rouse (1992, 401) also concluded that out of the 717 hospitals that they surveyed, nurses displayed a lack of sufficient knowledge regarding HIV/AIDS. This fact is particularly disturbing when it is considered that judgemental attitudes and fears are significantly related to a lack of knowledge. Stanford (1988, 47) states that nurses knowledge levels are generally unsatisfactory and attendance at HIV/AIDS educational programs is also a matter of concern.

As mentioned earlier, there is a clear need for quality information that meets the needs of acute care nurses, and also deals with their fears, attitudes and prejudices (Kemppainen et al 1996, 297). Nurses are 'front line' staff who require the knowledge and skills to be able to care for patients with confidence. The best way to ensure that nurses are equipped to care for patients with AIDS and are able to cope if they accidentally become exposed to the patients blood or body fluids, is for nurse managers to examine their staff's needs and implement educational interventions accordingly (Demirbag & Ridenour 1995, 129-130).

Nurse educators can supply additional information about particular cultural, religious or personal values, that may be inappropriate, in order to overcome these perceptions and fears. One such example would be to invite a homosexual person, a person with AIDS or a substance user to give a lecture in the educational program. The involvement of such lecturers may reduce the nurses' preconceptions or hang-ups regarding these people. This approach would allow the nurses to confront their fears and learn more about themselves and others (Flaskerud 1991, 242).

Nurse education programs must include information about HIV/AIDS, it's modes of transmission, preventative methods and treatment (Laschinger & Goldenberg 1993, 449). Nurses must be clearly informed that the risks of contracting HIV/AIDS from any source are very small. Nurses must also be involved in planning the educational experience in order to feel empowered (Demirbag & Ridenour 1995, 132).

Although there seems to be a large amount of information available to acute care nurses regarding HIV/AIDS, the information has to be accessible and relevant if it is to

assist the acute care nurse through his/her lived experience, following possible exposure to the virus. Educators must tailor their teaching programs to meet the psychological needs of the nurses as well as their professional needs. This process calls for some innovative approaches on behalf of the educator, as well as the involvement of the nurses themselves.

3.1.9 Summary of the Literature Review

It can be seen from the literature review that potential exposure to the AIDS virus can be a frightening experience for acute care nurses, and indeed nurses in general. Nurses who have been potentially exposed to the AIDS virus through contamination from patient's blood or body fluid, typically report feelings of fear anxiety, loss of control and also report that denial and avoidance are frequently used as coping mechanisms.

Nurses' fears and anxieties stem from their knowledge of HIV/AIDS and their social and cultural background. Nurses' fears range from fears of the unknown to fears of death. Prejudices and phobias are also woven into the nurses' psyche. Nurse educators must understand the psychology behind such fears, and be aware that nurses' attitudes will not change unless the individual is empowered to do so.

Relevant information regarding the transmission and management of AIDS must be accessible to all nurses. Protocols and standards are in place to assist nurses to reduce the risks of exposure to blood borne contaminants, and to guide the nurse should contamination take place. It is up to the health-care institutions to refine such policies and it is up to the individual nurse to utilise them. Counselling is crucial to assist nurses to cope following potential exposure, however it is unclear as to how much counselling is actually given, or how effective it is.

Finally, little information is available as to the lived experience of acute care nurses following possible exposure to the AIDS virus, and available studies do not involve a phenomenological perspective. Without such information it is difficult to properly understand what acute care nurses are experiencing during their period of uncertainty,

following possible exposure to HIV/AIDS in the nursing environment, and even harder to assist them through this period. This fact would further support the need for the proposed study in this area.

CHAPTER FOUR: PROPOSED FINDINGS

4.1 Proposed Findings

As mentioned earlier, the literature review in phenomenological research must be carried out after the research has been completed, in order to prevent the researcher becoming biased by the literature. However, based on the preliminary literature review in this research proposal, it is expected that acute care nurses would describe their lived experience in terms of their fears and anxieties. Nurses may state that potential exposure to the HIV/AIDS virus caused them to be terrified as to the situation's outcome, resulting in intellectual, physical and social trauma and disruption. Nurses may report a profound loss of control or an inability to think rationally about the situation. Themes may emerge which express how nurses' personal and family lives have suffered as a result of their possible exposure to HIV/AIDS. Conversely, nurses may indicate that their professional lives are most greatly influenced by their feelings of concern and apprehension.

Nurses may identify gaps in their knowledge levels or inadequate direction and policy as being major life difficulties following the possible exposure. Emerging themes in this area may centre on inadequacies in inservice information or a lack of understanding toward the steps to be taken following possible exposure to blood borne pathogens. Nurses may consistently identify the need for comprehensive education to be carried out, on a regular basis, in order to reduce their negative feelings following possible exposure.

Nurses may report heavy reliance on such coping mechanisms as denial or diversion in order to protect their mental integrity. The proposed study may reveal some

commonly used coping mechanisms, such as physical exercise or debriefing to others, which may be beneficial to all nurses who have been potentially exposed to the blood or body fluids of a patient in their care.

Themes may emerge which isolate common misconceptions, or cultural and societal norms that may need to be focussed upon by nurse managers and educators. Homophobia and fear of the unknown may be the most significant fears, that nurse managers may need to concentrate on, in order to reduce the stresses associated with the lived experience. Nurses may even question the expectations placed upon them to 'deal with' the situation or to change their attitudes.

The general essences of being unprepared, uninformed and unable to cope with the situation of possible exposure to HIV/AIDS, are expected to be most evident from the proposed phenomenological study.

As nurses explain their individual lived experience it is hoped that common points of concern would be expounded, which in turn, would allow fellow nurses to better meet the needs these nurses.

CHAPTER FIVE: REFERENCES

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Appendix 1

RESEARCH CONSENT FORM

The lived experience of the acute care nurse, following possible exposure to the Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) in the working environment.

I, _____, having been invited to participate in a study of 'The lived experience of the acute care nurse, following possible exposure to the Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) in the working environment', do voluntarily give my consent to participate. I acknowledge that I have been given opportunity to ask questions regarding the study and such questions have been answered to my satisfaction.

I am aware that my identity will not be revealed during the study and I reserve the right to withdraw from the study at any time, if I so desire, and will not suffer any retribution.

I formally give my consent to be interviewed in order to fulfil the study's requirements and I understand that the interview will be tape-recorded. I also give my permission for the findings of the research study to be published.

I understand that that I have the option to contact Avondale college's Human Research Ethics Committee at, Avondale College, PO Box 19, Cooranbong, NSW, 2265, or telephone (02) 4980 2222, or fax (02) 49802118, should I have any complaints concerning the manner in which this research is being carried out.

Signature of Participant:_____

Signature of Witness:_____

Date:_____

Appendix 2

INVITATION TO TAKE PART IN A STUDY

Dear fellow colleague, I invite you to take part in a Phenomenological research study that will look at 'The lived experience of the acute care nurse, following possible exposure to the Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) in the working environment'.

Unfortunately, acute care nurses have a possibility of being exposed to HIV/AIDS through exposure to a patient's blood or body fluids. Although the risk of contracting HIV/AIDS in this manner is known to be very small, nurses who have found themselves in a situation of potential exposure report feelings of fear and anxiety. The lived experience of the acute care nurse, during the window period of testing, can be traumatic and frightful for nurses and their families.

There is a real shortage of published material that explains what this lived experience is like for acute care nurses. Nurses needs and concerns during this period of uncertainty and stresses have not been identified in any great detail.

Without such relevant information nurse managers, and also staff colleagues, may not know how to best offer support and assistance to such nurses. An understanding of this lived experience will also help with the development of policy and education programs that will better meet the needs of acute care nurses in this situation.

The proposed study in this area will be carried out using the Phenomenological Research Design of Helen Streubert. Participants will be interviewed and the sessions will be tape-recorded to assist analysis. During the course of Streubert's research method, significant themes will be isolated and an exhaustive description of the phenomenon will be developed. The results of the study will be available at the library of Avondale College, at the Wahroonga Campus, on the grounds of The Sydney Adventist Hospital.

Should you desire to assist in this study, please contact Andrew Brownlow at telephone number ********.

Looking forward to your assistance,

Andrew Brownlow.

SYDNEY ADVENTIST HOSPITAL
LIBRARY