

SOUTH AFRICAN PROFESSIONAL NURSES' EXPERIENCES OF CARING FOR HIV/AIDS PATIENTS

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ABSTRACT

Qualitative research was conducted in a particular hospital in the Limpopo Province of South Africa. The researchers explored the emotions which professional nurses experience while caring for HIV/AIDS patients, the factors that give rise to these emotional experiences and how the therapeutic relationship was affected thereby.

The intention was to explicate the participating nurses' personal experiences and the nature of the therapeutic relationship, considering their perceived risk of contracting HIV infection whilst caring for HIV/AIDS patients.

A generic qualitative research design was applied. Professional nurses who rendered care to HIV/AIDS patients on a daily basis were approached for participation. Focus group interviews involving a sample of purposively selected professional nurses were conducted. During data analysis a process of qualitative analysis, induction and synthesis was followed. Frankl's philosophy of meaning in life served as a conceptual framework for interpreting the research findings.

The research results reveal that the participants experienced negative emotions due to the perceived risk of contracting HIV infection as a result of accidental or intentional exposure to blood or body fluids of infected patients. This negatively impacted upon the participants' ability to engage in ethical practice and maintain a therapeutic relationship with these patients. However, there was evidence that some of the participants experienced a sense of fulfilment and were able to discover meaning in their lives in the workplace.

Keywords: Acquired Immune Deficiency Syndrome (AIDS); High-risk working environment; Human Immune Deficiency Virus (HIV); Nursing care; Qualitative research; Therapeutic relationship.

THE RESEARCH PROBLEM

Southern Africa is the epicentre of the global Acquired Immune Deficiency Syndrome (AIDS) epidemic. Globally, the number of persons living with AIDS in 2007 was 32 million and the number of newly infected persons was 2.5 million. Southern Africa

accounts for 35% of all people living with AIDS and 32% of all new Human Immune Deficiency Virus (HIV) infections in 2007 (UNAIDS 2007:1 & 8).

An estimated 5.41 million South Africans were living with HIV infection in 2005 and the estimated HIV prevalence among the adult population (15-49 years) was reported as 18.8% (UNAIDS 2007:11; UNAIDS 2006:15-17). South Africa's Department of Health (2004:11) proactively anticipated that the spread of the disease will gradually erode the ability of health care workers to cope with the health care needs and demands of those suffering from HIV/AIDS.

South Africans are not legally compelled to disclose their HIV status and patients may keep their status confidential. Research by Pretorius, Goldstein and Stuart (2005:47), as well as by Sethosa and Peltzer (2005:38) reveal that HIV positive persons tend not to disclose their status because of feelings of embarrassment, shame and fear of stigmatisation, prejudice, discrimination and breach of confidentiality. In South Africa, professional nurses are ethically bound to keep their patients' HIV status confidential. The HIV status of patients therefore remains unknown to nurses unless specific patients choose to disclose their status. As a result nurses are at risk of contracting HIV infection in the workplace (Ehlers 2006:657,659; Van der Wal 2005:209).

The ethical and professional codes of practice guide professional nurses towards maintaining a trusting relationship and providing care that promotes the wellbeing of their patients. This includes the obligation to meet the health care needs of persons with HIV/AIDS, and apply ethical principles while caring for them. However, the South African public remain reluctant to reveal their HIV status. Nurses are perceived to stigmatise and ostracise HIV/AIDS patients. The nursing profession is faced by a major challenge, namely to regain the respect and trust of their patients and the public alike with regard to their ethical integrity (Maelane 2001/2002:26; Oosthuizen 2005:72-74; Van Dyk & Van Dyk 2003:8-9).

During the second author's personal encounters with nurse practitioners prior to the current study, nurses verbalised their fears of being infected with HIV and indicated that this impacted negatively on their morale and efficiency. This is in accordance with the study by Ncama and Uys (2003:16), which revealed that nurses are afraid of contracting HIV infection despite available precautionary measures. While conceptualising this study, the researcher argued that the nurses' fears might negatively impact on their abilities to render high quality and compassionate nursing care to HIV/AIDS patients. The need to explore the worlds of those nurses who render nursing care to HIV/AIDS patients was thus identified. Generic qualitative research was conducted to answer the following over all question: What is the experience of professional nurses while caring for HIV/AIDS patients?

The empirical phase of this research was guided by the following specific research questions:

- What emotions do professional nurses experience while caring for HIV/AIDS patients?
- What factors are perceived to give rise to the nurses' emotional experiences?
- How do professional nurses view their therapeutic relationship with HIV/AIDS patients?

The purpose of the research was to explicate the participants' personal experiences and the nature of the therapeutic relationship, considering the nurses' perceived risk of contracting HIV whilst caring for HIV/AIDS patients.

UNDERLYING ASSUMPTIONS

This study was based on various assumptions, namely basic principles assumed to be true without proof or verification (Polit & Beck 2008:14). The underlying assumptions were:

- Human beings live in a world of experience that abounds with both cultural and social influences.
- Human beings constantly assign meanings to their experiences.
- Personal experiences and constructed meanings are communicated through language and motion.
- Qualitative research supports narrative data collection, in order to capture the lifeworlds of people and the meanings that they assign to their experiences.

PHILOSOPHICAL GROUNDING

Viktor Frankl developed a paradigm in psychology that focuses on the importance of meaning in life. Frankl was inspired by the existentialism of the twentieth-century German and Swiss philosophers Martin Heidegger, Karl Jaspers, and Ludwig Binswanger. According to Frankl (1969:22, 41, 52, 54) being human means living a meaningful life. Life gives each individual an assignment and one has to learn what that assignment is. Meaning is something to discover rather than to invent. It is there to be seen, not something created by human imagination. This means that humans should discover the specific meanings of the moment rather than to talk about meaning of life in general (Frankl 1975: 113 & 115).

Meaning is found through creating a work or doing a deed, encountering someone, and experiencing goodness, truth or beauty. According to Frankl each event or task in life can become meaningful. Frankl offers the thought that all of life has meaning that can never be taken away from the individual. Meaning can be found – even in hopeless situations – by the attitude humans choose. Humans can choose to suffer with dignity

and to turn unavoidable suffering into human achievement. Hence a meaningful attitude towards pain, guilt and death supports a meaningful life (Frankl 1969:69-75).

Existential frustration occurs when humans fail to find meaning in life and to live a meaningful existence. Existential frustration is a part of everyone's experience, in one way or another, so it isn't pathological in itself (Frankl 1969:31 & 64). Existential frustration is characterised by experiences of apathy, aimlessness and emptiness. Humans seem to be responding to these experiences with unusual behaviours that hurt themselves, others, society, or all three (Frankl 1969:83). An enduring, pervasive pattern of existential frustration, where one experiences one's life as being mostly empty and meaningless can lead to an existential vacuum; of which the most important symptom is boredom.

The essence of being is self-transcendence, namely the ability to rise above one's instincts and drives, and grow beyond oneself (Frankl 1969:18, 50, 52). It denotes the ability to rise above adverse conditions and circumstances, and do something about it (Frankl 1969:16, 74, 75). Self-transcendence also means to be able to reach out beyond oneself to encounter a higher being or other human beings and to fulfil meaning (Frankl 1969:18, 19, 31). Love and conscience are manifestations of self-transcendence. Love is an intentional act. Conscience is the intuitive and creative capacity to find meaning in hidden situations, and to distinguish between right and wrong. Through conscience one is able to judge one's deeds in moral and ethical terms (Frankl 1969:18 & 63; Havenga-Coetzer 2003:24).

Applied to this study, nurses have the ability of self-transcendence while faced with challenging working conditions. Meaning in life in the workplace can be achieved by rendering high quality care (work), being caring practitioners (love) and experiencing the art of nursing (aesthetic experience). Failure to do so may manifest in existential frustration which could negatively impact on a nurse's ability to maintain a therapeutic relationship with the patients and to render high quality care.

RESEARCH DESIGN

According to Avis (2005:4-5) and De Villiers and Van der Wal (2004:243; 238-239), qualitative research is a systematic approach which enables researchers to capture peoples' subjective accounts of social life through flexible and unstructured methods of inquiry. Through qualitative research, researchers are able to obtain in-depth understanding of human beings, their relationships and their experiences. The research participants were given the opportunity to verbalise their signification of part of their professional lives as accommodated by the generic qualitative research design applied during this study.

RESEARCH METHODS

The accessible population for the current study comprised professional nurses working in clinical units in a particular hospital in the Limpopo Province of South Africa. The term 'professional nurse' refers to a person who is registered as a nurse in terms of Section 31 of the Nursing Act no 33 of 2005 (South Africa 2005:6). Professional nurses who have had at least two years of working experience, and who rendered care to HIV/AIDS patients on a daily basis, were considered for participation in the study. Purposive sampling was employed to ascertain a sample of information-rich participants. According to Henning (2004:71) purposive sampling enables researchers to select the people most suitable to "wander with" on the research journey.

Fifteen professional nurses (three males and 12 females) participated in the study. The sample size was not predetermined. According to Bowling and Ebrahim (2005:525), and De Villiers and Van der Wal (2004: 238), qualitative research involves collecting data from small samples to obtain in-depth, contextualised understanding of human phenomena. Henning (2004:71) explains that sampling, in qualitative research, is about selecting spokespersons on the topic of interest rather than obtaining a recurrentative sample. Completeness of description therefore overrules recurrentativeness.

Approval to conduct the current research was obtained from institutional authorities, and voluntary informed consent from participants was secured prior to data collection. The participants' narratives revealed how their fears resulted in unethical practice – these revelations were potentially damaging to their professional reputations. Participation involved some risk, hence the need for anonymity and confidentiality. A code was therefore assigned to each participant and these codes were used throughout the data analysis. This ensured that participants' identities were protected. In addition, participants were also requested to keep the proceedings of the focus group interviews and the identities of their peers confidential. Data were stored in a secure place and the researcher refrained from discussing what the participants said with other persons. The identity of the hospital where the research was conducted was also kept secure.

The semi-structured focus group interview was adopted to generate data. It was anticipated that the participants would be willing to talk openly about their experiences once they realised that others shared their views and experiences. According to Kitzinger (2005:56 & 58), focus group interviewing is a collective activity allowing participants to reflect on common experiences. It allows a researcher to prompt and focus discussions around a particular issue. Eight interview sessions, each involving three to four participants, were conducted. Each participant attended two sessions. Ninety minutes were allocated for each interview session. The interviews were captured on audio-tape. Sampling and data collection were continued until data saturation was achieved. According to Streubert Speziale and Carpenter (2003:68) data saturation has occurred when no new themes or essences have emerged from the participants and the data are repeating.

The interview guide comprised two open-ended questions which were supplemented by probing questions, namely:

- How do you experience caring for HIV/AIDS patients at your workplace?
- How do your personal experiences influence the therapeutic relationship with HIV/AIDS patients?

Examples of the probing questions used, included:

- Tell me more about the risks that you are exposed to.
- Tell me more about the feelings which you mentioned.
- Tell me why you ran away instead of attending to the patient.

Due to the emotionally disturbing nature of the research topic, a secure environment was chosen, and privacy was maintained. Questions posed to the participants were carefully phrased, and the participants were treated and approached in an empathic manner.

According to Bowling and Ebrahim (2005:523), listening to recordings of interviews and reading the transcriptions of interviews are part of the analysis process. The audio-taped interviews were listened to and transcribed. The transcriptions were read and reread prior to the coding process. Text units were specified and then the transcriptions were imported into QSR NUD*IST 4.0.

According to Bowling and Ebrahim (2005:524) data reduction is achieved by means of coding. In this study open coding was applied. Open coding entails ascribing the codes from the content of the transcripts (Bowling & Ebrahim 2005:525). Nodes, namely category units, were created in QSR NUD*IST 4.0 and a definition was assigned to each node. The researcher considered the node definitions to determine how each text unit should be coded. The coded data were subsequently categorised and the node reports printed. The printed node reports were read, and the meanings that emerged from the data in the new format were identified. The coding system was subsequently refined.

TRUSTWORTHINESS

Trustworthiness refers to the degree of confidence qualitative researchers have in their data (Polit & Beck 2008:768). Strategies proposed by Lincoln and Guba (1985:80-82) were applied to enhance the trustworthiness of this research. Information-rich participants were selected who provided in-depth accounts of the phenomenon under study. Dense descriptions of the research data in the full research report (dissertation) were also provided. Repeated focus group interviews were conducted until data saturation occurred.

The second author, as interviewer, explicated her views and beliefs on the research topic. Her professional training and experience could have influenced her stance towards the

study. She therefore refrained from voicing any opinions, criticisms or judgements during data collection. She conducted a literature review after data collection was completed and selected a theoretical framework to guide the interpretation of the data. The participants were given an opportunity to validate the research findings. These measures were aimed at limiting the introduction of pre-conceived ideas on the study and to enhance neutrality. An audit trail was established to enable others to judge this study for its dependability. The research methods were documented and the interviews were recorded on audio-tape to capture the original responses.

RESULTS

The data revealed that the participants experienced negative emotions because of a perceived risk for contracting HIV infection and that this resulted in unethical behaviour on their part. Conversely, some of the participants were able to maintain a positive attitude towards rendering nursing care to HIV/AIDS patients. These persons verbalised their inner satisfaction for being able to make a difference in the affected persons' lives.

THE WORKING CONTEXT OF THE RESEARCH PARTICIPANTS

The participants explained that they were at risk to contract HIV infection. They indicated that being infected means suffering from a debilitating disease and dying from AIDS. They were exposed to accidental contact with HIV positive patients' blood, secretions and excretions. They were also exposed to contracting tuberculosis through droplet transmission. The participants said:

"I remember one day when I was suctioning the patient, the secretions splashed into my eyes as they were not protected."

"One day after delivering a baby, I wanted to administer Konakion to the baby. When I opened the vial, it cut my finger. There was blood on my finger although I wore gloves. I was traumatised by that experience. I was afraid to go for a HIV test."

According to Ehlers (2006:660) nurses are easy targets for people who intend to spread HIV infection on purpose. This study confirmed that HIV positive patients often tried to expose the nurses and their relatives to their faeces, blood or secretions. The participants explained:

"They have told themselves that they cannot die alone; other will die with them."

"There was a guy who did not accept his HIV positive status. He tried to infect many people. When I inserted an intravenous infusion, he removed it so that his blood would splash on me. If you have a cut and you wear one pair of gloves that is torn, you may contract HIV."

“Most of the patients who do not accept that they are HIV positive, do not cooperate. When you change their soiled linen they may wipe their faeces all over you in order to infect you. Sometimes the faeces contains blood.”

Surprisingly, the participants mentioned that the ethical requirement of keeping the HIV status of patients confidential increases their risk of contracting HIV infection. This is because nurses who are unaware of the status of their patients may fail to apply the necessary precautionary measures. Similarly Young, Forti and Preston 1996 (cited by Chan, Ho & Day 2008: 1059) found that a sample of rural nurses in the USA was not in total compliance with universal precautionary measures especially if they thought that patients were HIV negative or they were unaware of their HIV status. During the latter study 63.5% of the respondents (n=555) indicated that nurses should know the HIV status of their patients.

According to Mahatelo (2003:7) nurses often have to contend with shortages of medical supplies and equipment, including the most basic necessities for protecting them against hospital-acquired infection. The current study revealed ineffective precautionary measures in the research setting. Although the participants had access to protecting aprons, masks and gloves, the masks and gloves were often torn. One participant explained:

“I may contract HIV infection by using gloves or masks that are torn. Sometimes when I open a new box of gloves I discover that only two or three gloves are in tact. In that case I am forced to put on two to three pairs of gloves at a time.”

In a previous study, Ncama and Uys (2003:17) found that trauma nurses are dissatisfied with employer and managerial support. Similarly this current study revealed a perceived lack of institutional support for nurses. This inadequate institutional support was evident in the restrictions placed on the use of multiple pairs of the available low quality gloves. The infection control department discouraged the use of more than one pair of gloves at a time due to economic considerations. The participants explained that this lack of support meant that those in managerial positions did not care about the caregivers of HIV/AIDS patients, namely the nurses. According to one participant:

“The infection control people do not allow nurses to put on more than one pair (*of gloves*). They always tell us about the economy of the hospital.”

Those in management positions often failed to ensure that an adequate number of nurses were employed at the health care organisation. The number of AIDS patients admitted to the health care setting increased daily. One participant indicated that about 75% of those admitted to a specific clinical unit suffered from AIDS. Caring for these patients could be physically and psychologically exhausting. Nurses who worked under pressure were careless and neglected applying the relevant precautionary measures. This increased their risk of contracting HIV.

Their high work load impeded upon the participants' ability to ensure optimal patient safety. The hospital management consequently blamed the nurses if something happened to the patients. A participant explained:

“Sometimes patients are confused. These patients may leave the ward and go to the bush to hang themselves. They may even jump through the window. The management often holds the nurses responsible when patients are missing.”

THE EMOTIONAL EXPERIENCES OF THE PARTICIPANTS

The term ‘experience’ denotes to undergo an emotional sensation (WordReference.com English Dictionary 2006). The research results revealed negative emotions, which apparently lead to unethical behaviour on the part of participants and an inability to establish a therapeutic relationship with the patients.

The participants explained that was is difficult for them to care for HIV/AIDS patients knowing that they were at risk of contracting HIV. Contracting HIV would mean stigmatisation because people would suspect that they had engaged in irresponsible sexual practices. The participants consequently revealed the negative emotions that they experienced as a result of fear of stigmatization.

A previous study by Ncama and Uys (2003:17) revealed that knowledge about AIDS and AIDS counseling courses contributes towards a reduction of fear among nurses. This current study contradicted this finding, because two participants were trained AIDS counselors and seven had attended AIDS counseling short courses. Their training apparently did not prevent them from being fearful about contracting HIV from their patients. The participants were frightened to care for HIV/AIDS patients. Their fears for and prejudice towards their patients resulted in diminished job satisfaction and motivation levels. They specifically feared physical contact with these patients. The participants indicated that their fears could be counteracted by establishing reliable precautionary measures. The participants' fears also impacted on their private lives as they became fearful of sexual contact with their intimate partners, as indicated by one participant:

“They (*professional nurses*) lose interest in sexual intimacy with their husbands because they always think of those men lying in beds critically ill suffering from AIDS.”

The participants verbalised that they often experienced uncertainty because they were uninformed about their patients' HIV status. Periods of uncertainty also occurred while they awaited their post-exposure test results. Furthermore, the participants mentioned that they often experienced depression, which was particularly acute after their exposure to blood, excretions or secretions of HIV positive patients. One participant referred to an instance during which the secretions of a critically ill AIDS patient accidentally splashed into her eyes. She explained:

“I felt depressed for the whole day and I prayed to God that I must not contract HIV as I was trying to help the patient. I asked God to protect me. After two to three days the depression was gone.”

Some participants' narratives revealed their concerns for the wellbeing of others although they experienced negative emotions themselves. These participants worried about the devastating implications of HIV infection for the patients' significant others. They were concerned about the health of the intimate partners of HIV infected patients and the wellbeing of the dependants of breadwinners who died of AIDS. They also worried about HIV positive babies being born. One participant captured this by stating:

“The husband died without disclosing his HIV status. When I met the deceased person's wife I became worried, hoping that she might have done something to improve her health status. I could not inform her about her husband's HIV positive status. I felt depressed particularly considering that, according to my culture, the woman should marry the deceased husband's brother.”

ETHICAL CONSEQUENCES OF THE PARTICIPANT'S EXPERIENCES IN THE WORKPLACE

‘Ethics’ is a generic term for various ways of examining and understanding the moral life (Pera 2005:4). Although professional ethical codes are designed to protect the rights of nurses and their patients, the secrecy surrounding the HIV status of patients appeared to be detrimental to the emotional wellbeing of the participants. Being uninformed about their patients' HIV status caused inner feelings of hopelessness because they were unable to make informed decisions about self-protection. They argued that, if nobody protected them, then they had to protect themselves. Consequently the participants breached the principle of confidentiality. Although confidentiality is officially maintained in the health care settings, they used non-verbal gestures to secretly communicate their patients' HIV status among themselves, to other colleagues and to other patients. A participant explained:

“Once we encounter a positive patient, we would check whether she has all the signs we read about in the book. If we suspect that the patient is HIV positive we secretly inform others about this, using nonverbal cues. The HIV positive patient will eventually realise that she is treated differently than other patients.”

The ethical principle of informed consent was often violated, as the participants secretly drew blood for HIV testing, particularly involving patients who refused to be tested or those who did not respond to treatment. If the results were positive the participants retrospectively persuaded the patients to give their consent to be tested. A participant offered the following explanation:

“When a critically ill patient does not respond to treatment we draw blood for HIV testing without the patient’s consent. If the results are positive we quickly ask the patient to give consent to be tested. We cannot counsel a HIV-positive patient or tell the doctor about his/her HIV-status if consent has not been obtained.”

The occurrence of discrimination against HIV/AIDS patients emerged from the data. The participants indicated that they would prefer not to care for these patients if given a choice, especially since some patients deliberately tried to infect nurses. This supported the findings by Tyler-Viola (2007:403) which indicated that nurses have higher prejudice scores and are less willing to care for women with HIV than women who are HIV negative. The latter study also revealed that nurses have stronger intentions to care for women without HIV than women infected with HIV. This current study further revealed that the participants rewarded the patients who behaved well with good nursing care, indicating that nursing care was rendered conditionally, as explained by a participant:

“If the patients behave well the relationship between the patient and the nurse is good. The nurses will not go near a patient who tries to infect them. You cannot go near somebody who wants to hurt you.”

The narratives revealed the occurrence of patient neglect and abandonment. The participants were sometimes faced with the ethical dilemma of whether to expose themselves to the risk of HIV infection or to withhold nursing care from the patient. The narratives revealed that having to resolve this type of dilemma was a painful experience because this meant that the participants had to confront their own consciences. The participants explained:

“I sometimes neglect HIV/AIDS patients because of being uncertain of my safety.”

“I sometimes face an ethical dilemma. Sometimes midwives are unaware that the second stage of labour is approaching. In the olden days we used to deliver babies with our bare hands. Nowadays you may consider not delivering the baby bare handed if the baby is delivered unexpectedly. What should I do under these circumstances? Should I deliver the baby or should I leave the mother to deliver on her own? I really do not know how to handle such a situation but it pains me.”

“It also reminds me of a certain case. A HIV positive woman was in labour. When she entered second stage, every nurse ran away and she delivered the baby alone, as they refused to help her.”

AN IMPAIRED THERAPEUTIC RELATIONSHIP RESULTING FROM THE PARTICIPANTS’ EXPERIENCES IN THE WORKPLACE

The term ‘therapeutic relationship’ refers to the nurse-patient interactions that are characterised by caring, mutual respect and trust, which serves to protect the legal and ethical rights of HIV/AIDS patients (Oosthuizen 2005:70-71). The participants’

ability to establish a therapeutic environment appeared to be compromised by ethical constraints, the emotions that they experienced and their reactions to their emotions. A participant captured this inability to establish a therapeutic relationship as follows:

“I feel uncomfortable to build a relationship with a patient who wants to infect me.”

The participants explained that they often distanced themselves from their patients. Because of their fears of infection, the participants frequently refrained from touching their patients. Even if physical touch occurred, the presence of gloves contributed towards a perceived distance between the participants and the patients. The participants explained:

“I do not want to touch or massage HIV/AIDS patients because of my fear of contracting the virus. When I know that my patients are not HIV positive I often massage them in order to build a good relationship with them.”

“The therapeutic relationship between the nurse and the patient is negatively affected. We put on gloves whilst feeding AIDS patients because the patients may vomit unexpectedly. We therefore do not actually touch them.”

The participants' narratives revealed their negative attitudes towards HIV positive patients who insisted on keeping their HIV status confidential. To them, this insistence meant that the patients were self-centred and unconcerned about the wellbeing of others. The participants explained that they tended to label these patients as uncaring and unfeeling, and therefore unworthy of care. As a result of this, the participants themselves became uncaring caregivers to those patients. They explained that it was acceptable to neglect these patients and stated:

“There was a HIV positive patient who refused to divulge her positive status to the husband and she continued having a sexual relationship with the husband without using a condom. It was obvious because she was pregnant. These HIV patients do not have feelings for their partners. They prefer to spread the virus. I think you may as well neglect them because they don't care for others.”

The perceived secrecy surrounding the patients' HIV status hampered open communication between the participants and their patients. For example, the participants explained that they could render appropriate health education to patients if they were unaware of their HIV status. A participant said:

“The fact that the diagnosis of the AIDS patients is confidential makes it difficult for the registered nurses to communicate with them about the disease.”

THE DISCOVERY OF THE MEANING IN LIFE WHILE CARING FOR HIV/AIDS PATIENTS

Despite the struggle to come to grips with the difficult working context, some of the participants were apparently able to transcend these circumstances by adopting a positive attitude and maintaining a caring approach towards patient care.

A participant expressed her ability to reach out to a higher being, namely God, as a means of self-transcendence while others indicated that they often reached out to their peers. Evidence of especially strong peer support emerged from the data. The participants explained:

“I pray every morning that God should give me strength to nurse HIV/AIDS patients.”

“The nurse to nurse relationship is very good. We cling to and support one another. Strong group cohesion usually exists.”

An ability to discover meaning in life through love (being a caring practitioner) and doing a deed (rendering care) emerged from the data. One participant demonstrated a non-judgmental attitude and expressed her commitment to care for HIV/AIDS patients despite her fears. This individual explained that she experienced a sense of fulfilment for being needed and being able to meet the needs of HIV/AIDS patients. She said:

“I also experience good feelings because AIDS patients come to the hospital when they are really in need of care. I enjoy helping these patients because they need us.”

Furthermore, the concern which some of the participants expressed for the patients and their significant others, and their peers' unethical behaviours indicated their conscience at work, which was a manifestation of self-transcendence. Some participants indicated that they supported the patients in different ways despite their own fears. They explained that the patients had access to health education, counselling and referral to the appropriate services. They often referred the patients to appropriate professionals such as social workers who provided them with food parcels. Psychologists (available to those patients who could pay for the services), pastors, and nurses rendered counselling services. The participants gave assistance to those patients who wished to disclose their HIV-positive status to their families, friends, partners and relatives. They supported those who struggled to accept their HIV positive status. The participants also provided the relevant health education about diet, safe sexual practices and the consequences of exposing others to the risk of HIV infection. A participant said:

“I counsel them (*the patients*) even if they deny their HIV positive status. I give them health education on a healthy diet and how to practice safe sex. I advise them to be retested if they are unconvinced about the previous test results.”

One of the participants offered suggestions on how to improve patient care, saying:

“I recommend that the ward staff should be increased. AIDS patients should be admitted to specialised wards. Nurses and volunteers who are willing to nurse these patients should be allowed to do so. Some patients are kept in the hospital unnecessarily. Most of them often need basic nursing care and medicines. I recommend that the family members should receive advice on how to care for these AIDS patients. This will ensure that other (*HIV negative*) patients also receive the care that they deserve.”

While institutional support was lacking in some respects, it appeared to be available to the participants in the form of advice and follow-up care after exposure to the HIV infected patients’ blood or body fluids. These available services were, however, reactive while proactive support measures were lacking.

CONCLUSIONS

The participants’ narratives revealed instances of an inability to discover meaning in the patient care setting where HIV/AIDS patients were being cared for. Generally the participants experienced negative emotions and they consequently engaged in unethical behaviours. This was due to their perceived risk for contracting HIV infection and especially their fears of patients who deliberately tried to infect them, combined with the inadequate precautionary measures. The participants’ efforts to reduce the perceived risk, together with their negative emotional experiences, gave rise to an impaired therapeutic relationship with the patients. They needed to be assisted in transcending their circumstances; to enable them to engage in ethical practice and to render care which is characterised by commitment and compassion.

On the other hand, evidence of the ability to self-transcend and to adopt a positive attitude towards their difficult working conditions also emerged. Those participants who were able to self-transcend appeared to focus on the health care needs of their patients and the welfare of the patients’ next of kin, as opposed to their own fears and prejudices.

While post-exposure institutional support and peer support were available to the participants, there was a need to establish effective precautionary measures to prevent HIV infection. There was also a need to establish a counselling service for the participants. The participants who confirmed their commitment and compassion could serve as positive role models for those who opted to engage in unethical practices, on how to rise above their fears to render high quality nursing care.

RECOMMENDATIONS

It is recommended that the intentional and unintentional risk factors should be minimised by reviewing the existing universal precautionary measures and educating patients about the consequences of trying to infect nurses intentionally. In-service education

about HIV and AIDS should be offered to nurses to increase their knowledge and expel myths about HIV transmission.

In order to enhance the nurses' ability to engage in ethical practice the institutional managers ought to hold regular sessions during which ethical issues related to HIV/AIDS are discussed. Those attending should be reminded of the patients' right to receive high quality nursing care. The consequences of stigmatisation of and prejudice towards others should also be addressed. The compassionate and committed participants could be utilised to serve as mentors for those who struggle to come to grips with the risks involved in rendering nursing care to affected patients.

Institutional support, available to the participants, should be extended to include general counselling services to those who render care to HIV/AIDS patients. Pre- and post-testing counselling services ought to be available to participants who have been exposed to HIV.

Follow-up research should be conducted to determine why patients suffering from HIV/AIDS try to expose nurses to HIV infection. Research is also required to investigate the coping mechanisms of those nurses who succeed in rendering compassionate and committed care despite the risk for contracting HIV infection.

CONTRIBUTION AND LIMITATION OF THE STUDY

This study was limited in scope because the data was generated involving a small sample of professional nurses working in one hospital. The findings of the research are therefore not generalisable. However, in a qualitative research generalisability is not intended (De Villiers & Van der Wal 2004: 242). Because this research explicated many hidden issues and practices in the specific research setting, it is now possible for the institutional managers to implement remedial measures aimed at protecting the rights of the nurses and the patients alike.

CONCLUDING REMARKS

This qualitative study revealed that the participants' exposure to accidental and intentional risks for contracting HIV infection leads to generally negative emotional experiences. Their subsequent reactions resulted in unethical practices and an impaired therapeutic relationship with their patients. However, instances of meaningful nurse-patient engagement also emerged. Some participants are able to maintain positive attitudes towards the HIV/AIDS patients and strive to render high quality patient care.

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