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Research Article

Lived experiences of grief of Muslim nurses caring for patients who died in an intensive care unit: A phenomenological study

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ABSTRACT

Objective: To describe the meaning of the lived experiences of grief of Muslim nurses caring for patients who died in an intensive care unit.
Methodology: Gadamerian philosophy was used to underpin the hermeneutic phenomenological approach followed to analyse and interpret the lived experiences of nurses who cared for patients who died in intensive care units. Fourteen nurses met the inclusion criteria. They were asked to illustrate their experiences of grief using graphic representation. This was followed by face-to-face interviews during which they were asked to narrate and reflect on their experience. The graphic representation and interview transcripts were analysed using Van Manen's approach. Lincoln and Guba's criteria were followed to establish trustworthiness.
Setting: An intensive care unit at a tertiary public hospital in West Sumatra Province, Indonesia.
Findings: Five major thematic categories reflecting the five life-worlds were identified: '*empathetic understanding*', '*balancing self*', '*avoidance*', '*anticipating the future of own death*', and '*relating technologies in bargaining*'.
Conclusion: This study provides further understanding of the meanings of the lived experience of grief among Muslim nurses in intensive care units. Nurses' grief arising from the loss of patients can affect their emotional, cognitive, spiritual, relational and professional well-being. The findings add further knowledge about the end of life in intensive care units.

Implications for clinical practice

- More informed understanding of the meaning of the grief experiences of Muslim nurses in the intensive care unit in relation to intensive care nursing practice.
- This study supports the need for further educational, psychological and institutional support in managing nurses' grief.
- Future research should focus on professional grief management.

Introduction

Grief is a response to a loss (Chan et al., 2013; Conte, 2014). Grief is not only experienced by families when the patient dies, but also by nurses who take care of the patients (Shimoinaba et al., 2014). An Intensive Care Unit (ICU) is a setting that provides intensive and specialised nursing care to maintain life (Marshall et al., 2017). Nevertheless, many patients die in ICUs, causing nurses to witness many deaths. Dealing with the deaths of patients is a challenging experience for nurses as it can often lead to grief (Wisekal, 2014). The factors influencing nurses' grief are their relationship with the patients, nurses' beliefs and culture, their experience of personal loss, a lack of time and space to grieve and the availability of support from supervisors and co-workers (Boerner et al., 2015; Conte, 2014; Shimoinaba et al., 2014; Wenzel et al., 2011).

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Nurses are expected not to express their grief due to possible professional stigma (Wisekal, 2014). Professional stigma occurs when nurses accept the grief of patients and their families, but do not accept their own grief or and that of their colleagues' grief (Doka, 1987). Nurses might not express their grief and therefore keep it inside them or simply neglect or ignore their feelings (Gerow et al., 2010). However, if the grief of nurses is neglected or not expressed, this may result in burnout, cumulative stress and ineffective coping (Gerow et al., 2010). Studies have been conducted across different religions and nations to investigate nurses' experience in caring for patients who died in ICU's (Adwan, 2014; Conte, 2014; de Swardt and Fouché, 2017; Shimoinaba et al., 2014; Wilson, 2014). Many of these studies were undertaken in the context of end-of-life care and did not focus on grief. However, the experience of grief becomes part of all nurses' experience in caring for patients who die. A study by de Swardt and Fouché (2017) concerning the experience of ICU nurses performing post mortem care in South Africa identified three main themes: the care of the dead body, detachment and thanatophobia, that is the fear of death or dying. In this study, the participants found it difficult to distant themselves professionally and emotionally from the dead patient; they emphasised that they were confronted by the reality of their future deaths.

In Islam, it is believed that death should be accepted. Muslims understand that everyone belongs to God and will return to God. Therefore, when a Muslim dies, exaggerated expression of loss and grief are unacceptable. Wailing and other emotionally-charged expressions are not approved (Suhail et al., 2011). These conventions may influence the way Muslim nurses grieve in response to the death of patients. Muslims are taught that death is a reality that cannot be denied, therefore death should be accepted as it is written in the Quran, "*Indeed, the death from which you flee, then surely it will meet you. Then, you will be sent back to the All-Knower of the unseen and the witnessed* (God)" (Quran, 62:8). Muslims are taught to be patient dealing with the death. In the Quran, it is stated that:

> "*And We surely test you with something of fear and hunger and a loss of wealth and lives and fruits, but give good tidings to the patients, who when misfortune strikes them, say, "Indeed we belong to Allah and indeed to Him we will return*" (Quran, 2: 155–156).

Borhani et al. (2014) used qualitative methods to explore ICU nurses' perspectives about end-of-life care in an Islamic context in Iran. In their study, interviews with 12 Muslim ICU nurses revealed four major themes. These were: commitment to care; awareness of the patients dying; caring relationship; and dealing with barriers and ethical issues. The commitment to promoting end-of-life care was associated with a spiritual environment in the Islamic context. Some participants stated that they cried on the death of the patients because they thought of the patients as their family members and felt that they did not like the patients to die on their shift. However, a small number of participants revealed that they preferred not to work with dying patients, but offered no further explanation regarding this issue. Another study by O'Neill et al., 2017, which was conducted in Bahrain, involved interviewing Muslim nurses about the end-of-life care in an ICU. It was found that talk about death was avoided. Nurse participants tend to carry out order-oriented care. In this they waited for an order from the physicians and did not play an active role in the decision-making process. They reported that they were not willing to be involved in end-of-life decision making because they believed that making judgment should only be undertaken by a higher power (God). Suhail et al. (2011) stated that Wahabi Muslims in Pakistan claimed that ritualised mourning and the extensive showing of grief in public are discouraged in Islam because it shows lack of acceptance of God's will about death. In their study the majority of the participants reported firm beliefs about God's will stopping them complaining and mourning. In contrast to those studies, Shanmugasundaran et al. (2010) investigated culturally competent care at the end of life based on a Hindu perspective which found that grief should be expressed openly. In the period of impurity, the mourners were required to forego pleasures in order to exhibit grief and sorrow.

A range of studies have investigated nurses' experiences of grief in dealing with patients' deaths (Conte, 2014; Gerow et al., 2010; Shimoinaba et al., 2014; Wilson, 2014). Related studies consist of the consequences of nurses' grief, including burnout and job dissatisfaction (Adwan, 2014), professional compassion fatigue (Melvin, 2012), and coping managements used in dealing with patients' deaths (Cook et al., 2012; Rice et al., 2014). The majority of previous studies have been conducted in the context of children's disease (Adwan, 2014; Conte, 2014; Cook et al., 2012) and oncology (Conte, 2014; Wenzel et al., 2011). Most of these studies were conducted in Western countries. A limited number of studies were conducted concerning end-of-life care in an Islamic context, but did not focus particularly on grief (Borhani et al., 2014; O'Neill et al., 2017). This study aims to describe the meaning of the lived experiences of grief among Muslim nurses who cared for patients who died in an ICU.

Methods

Gadamerian philosophy underpinning hermeneutic phenomenology was used to guide the methods followed in this study to collection, analyse, and interpret data. Since some meanings of the lived experience are difficult to verbalize and describe in words, aesthetic expression through graphic representation was used to facilitate the communication of the grief experience as lived by nurses who have experienced the death of patients in the ICU.

Research question

"*What are the meanings of the lived experiences of grief among Muslim nurses who cared for patients who died in the intensive care unit?*"

Design

Hermeneutic phenomenology is a way of reflecting the fundamental structure of human lived experiences (Van Manen, 2014). One of the strands and traditions of hermeneutic phenomenology is Gadamerian philosophy (Van Manen, 2014). The Gadamerian perspective proposes that when the experience is shaped into an object, the meaning of the human lived experiences will become deeper (Gadamer, 1975). In this study, the participants were asked to illustrate their experiences of grief through graphic representation followed by narration during a face to face interview.

Setting

This study took place in an ICU at a tertiary public hospital in West Sumatra Province, Indonesia. This ICU provides invasive monitoring and basic life support with supported technologies and has eight beds and total of 16 nurses. The records of patients' deaths are around two to three per month. Other healthcare providers included physicians, nutritionist, pharmacists, and physiotherapists. In addition, nursing and midwifery students undertake clinical practice over some periods in this unit. The use of a mechanical ventilator is routine. The nurses are required to take ICU training alternately, starting from the most senior nurses to the junior nurses. Up to the date of data collection, a small number of participants had still not received ICU training.

However, all the nurses had been trained in basic trauma and cardiac life support (BTCLS). Direct current (DC) shock could be delivered by trained nurses in the team with the physician.

Ethical approval

Ethical approval for the study was obtained from The Social and Behavioural Science, Institutional Review Board, Prince of Songkla University, Thailand (number 2017Nst-Qn 039). Approval to access the setting was obtained from the head of the human resources department of the hospital (permit number 099/250/RSAM-SDM/X/2017). The head nurse was fully informed regarding the study before the participants were approached. The participants were told the details of the study and invited to sign informed consent before the data were collected. The information about the participants was kept confidential and their names were substituted by code numbers in reporting the data. The participants could stop the interview anytime when they felt uncomfortable. They were advised that if they needed psychological assistance they would be referred to a psychologist free of charge.

Participants

A purposive sampling method was used to select the participants. Fourteen participants participated in the study. The inclusion criteria were: (1) being a Muslim nurse; (2) having experienced the deaths of patients in an ICU and (3) working for at least one year in an ICU.

Of the fourteen participants, eleven participants were women and three were men with ages ranging from 25 years to 40 years (mean 32, SD 4.4). Four participants were single and ten participants were married. One participant had experience of being trained in end-of-life care; thirteen participants did not have training experience in palliative care or end-of-life care. The length of experience in nursing was from 3 to 20 years (mean 9, SD 4.9) and length of experience in the ICU was 1–11 years (mean 3.3, SD 2.7).

Data collection

After obtaining ethical approval, the researcher submitted a letter for permission to carry out the study to the hospital. The researcher contacted the head nurse of the ICU and explained the procedure of the study. The head nurse contacted eligible participants. Of the 16 nurses in the ICU, 14 participants agreed to participate in this study. The participants were told that their participation was voluntary, and they were assured that they could stop their participation any time without penalty. After the participants expressed their agreement to the head nurse, the researcher contacted the participants and explained the details of the study. After they were fully informed the participants were invited to sign their informed consent. After giving their written consent, participants were asked to illustrate their experience of grief after patients' death through graphic representation on a blank piece of paper and were allowed to use colours. They were given as long as they wished to complete the task. After they had drawn, the participants were asked to reflect on the meanings of what they had drawn. Reflecting on these in interviews took about 45 to 60 minutes. Each interview was recorded and notes were taken. The data were collected from October 2017 to December 2017.

The open ended questions given to participants were as follows:

- *Can you tell me about the drawing you have just done?*
- *How did you feel when you experienced the death of your patients?*
- *What are your reactions in response to the deaths of the patients?*
- *What did you do to make yourself feel better about the deaths of the patients?*

Data analysis

The graphic representation and interview transcriptions were analysed using Van Manen's hermeneutic approach (2014). Audiotaped data was transcribed verbatim by the researcher. Both the researchers undertook and formed the categories manually. The interview transcriptions, together with the graphic representations, were read carefully several times so that the researchers could immerse themselves in the data. Significant words, phrases, and statements in the transcriptions were highlighted. The same meanings/themes were grouped and categorized into thematic categories. These categories were set out within the five lived worlds used in Van Manen's approach (2014). No software program was used in the process of analysis.

The five lived worlds included: lived other; lived body; lived space; lived time and lived things. According to van Manen (2014), lived other is how self and others experienced a phenomenon, which refers to grief experience in this study. Lived body explains how the body is experienced in respect to phenomenon either as a subject or an object (van Manen, 2014). Lived space explains how space is felt in respect to the phenomenon (van Manen, 2014). Lived time guides the notion as to how time is experienced in respect to the phenomenon. Lived things provide guidance about how things or technologies are experienced in respect to the phenomenon (van Manen, 2014).

Trustworthiness

Trustworthiness was established following four criteria by Lincoln and Guba (1985). These were credibility, transferability, dependability, and confirmability. Credibility was obtained by triangulation and members checking. The triangulation methods used in this study involved the use of two data sources, including graphic representations and interview transcriptions. After each interview, the researcher restated the answer for the participants in order to clarify whether the information gained matched each participants meaning. These data were clarified in the daily journal written up by the researcher during data collection. The daily journal was used to achieve confirmability by recording the time and date of data collection, features of the context, the physical setting where the data collection took place, the researcher's own reflections and questions and interpretations that came up during interviews. Transferability was established by providing 'thick' or detailed descriptions of the phenomenon. Dependability was established by external audit with expert review.

Findings

Five thematic categories were identified and reflected within the five existential worlds. The identified themes were: '*lived other: empathetic understanding*'; '*lived body: balancing self*'; '*lived space: avoidance*'; '*lived time: anticipating the future of own death*' and '*lived things: relating technologies in bargaining*' (Fig. 1).

Lived other: empathetic understanding

Participants felt grief through experiencing patients' death because they understood the patients' death as their own loss. They reflected on the patients' condition, such as age, gender, and other personal condition and related it to their personal life. This created grief and empathy.

> "*If the dead patients were elderly, I reflected on them as my parents. I imagined if that situation happened to my parents. Oh God, suppose the patient was my mother. I thought about my family, my parents*". (Participant 9)

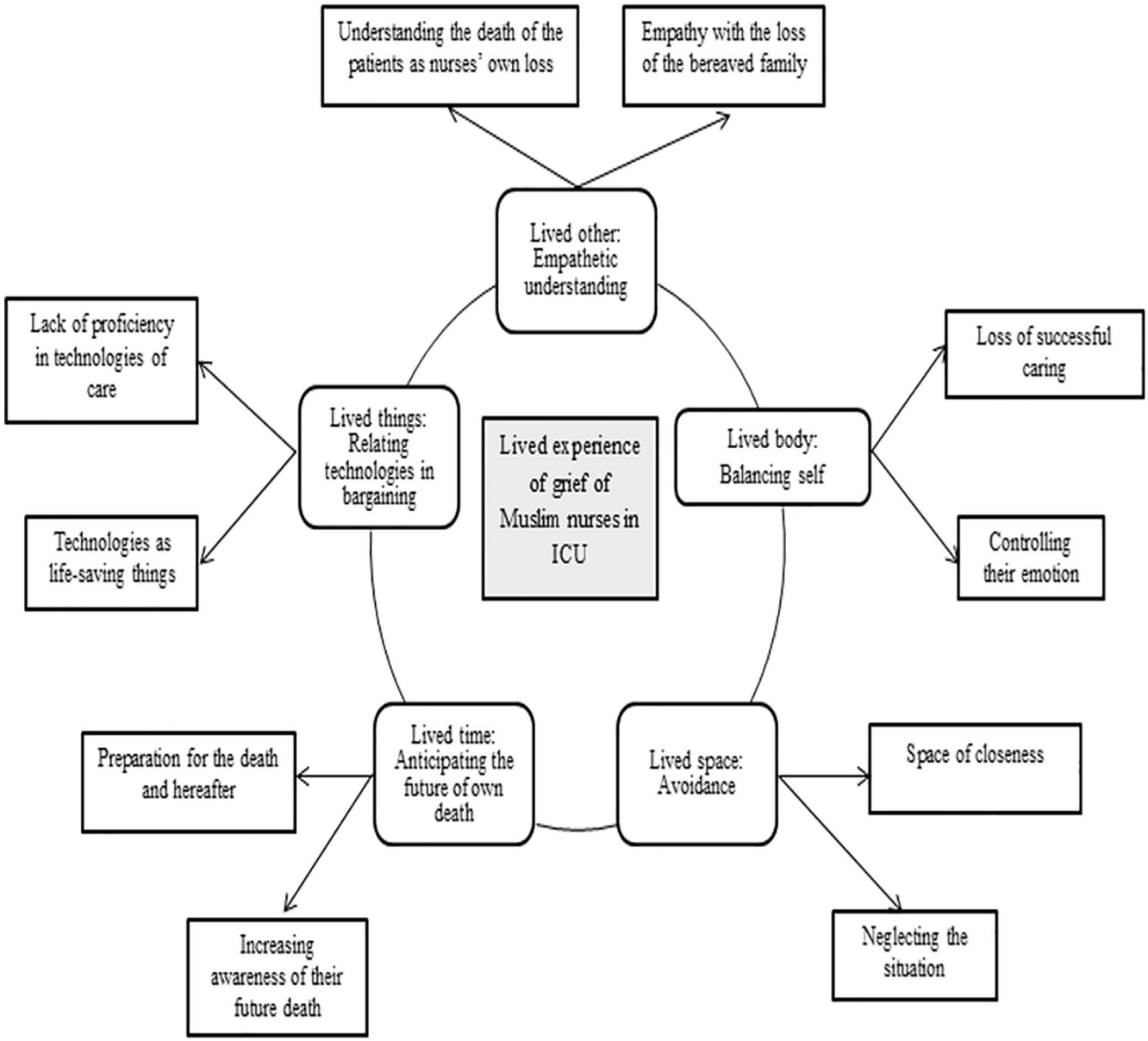

Fig. 1. Thematic categories and themes in the life-worlds of the grief experience of Muslim nurses who cared for patients who died in an intensive care unit.

The illustration of this grief experience is depicted by fallen leaves from a big tree (Fig. 2). The big tree represents a nurse with the strong heart, but when he was faced with the death of the patients who shared similar characteristics as his family members, he felt sadness and empathy in his heart like the leaves that fell from a big tree.

Participants' grief is connected with the patient's family bereavement. Nurses understood the feeling of loss felt by the family and they appreciated it as they felt the same.

One participant drew a picture of a patient's husband holding the baby left by the dead patient as representative of her concern for the patient's family (Fig. 3). She stated:

> "*If the patient died, I thought about how the baby's life would be and how the husband would take care of the baby*". (Supplementary Fig. 7)

In addition, the way the family reacted to patients' deaths influenced nurses' grief.

> "*Yes, it was sad. When I saw the patient died, the family cried, I cried too*". (Participant 1)

Lived body: balancing self

When the participants experience grief, they perceive the death as the loss of their successful caring. Nevertheless, at the same time that the participants felt grief, they were supposed to continue their professional duty. This situation puts them in a middle position between balancing their reaction of grief due to the failure of their caring and continuing their professional duty by controlling their emotion.

> "*Those patients whom we thought would get better. With appropriate care, the patient should get better. But sometimes, when we thought like that, the patient died. I felt upset, because I felt when I took care of them, the patient would be better*". (Participant 4)

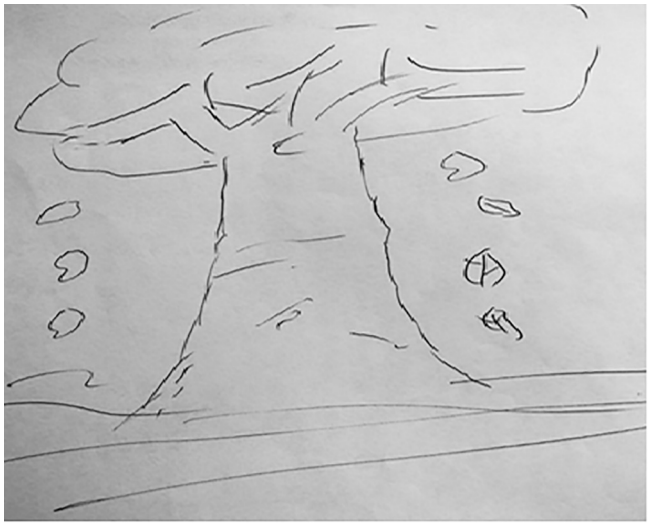

Fig. 2. The fallen leaves.

Fig. 3. Empathy with the loss of the bereaved family.

The illustration of this grief experience was depicted by a picture of a smiling woman on the left as the nurses' goal of caring and the patient in the bed and nurse at the bedside to show the reality (Fig. 4). The participant stated:

"*Maybe I feel disappointed. Because when I take care of the patients and the patients show improvement, I feel happy, the caring is successful. But if the patient dies, I feel disappointed and sad*". (Participant 1)

At the same time that nurses experience grief, they feel that they have to continue and maintain their work professionally. Therefore, they tried to control their emotion.

"*Kept it inside so my tears were not shed. I thought it did not seem good if my tears were shed. So, I hold them back inside*". (Participant 1)

The participants employed spirituality and relied on faith to help them control their emotions.

"*For me personally, I prayed. "Oh Allah, please strengthen me not to shed my tears*". *Sometimes I recite prayer*". (Participant 11)
"*Since there is a statement in our religion that the death is already decided, so I feel it affects my psychology to deal with patients' death*". (Participant 10)

The illustration is depicted by a picture of a nurse standing near the patient's bed and family members (Fig. 5). The participant stated:

"*When we just explain to the family the condition of the patients, we are not supposed to get carried away*". (Participant 4)

Lived space: avoidance

The environment of the ICU supported the nurses' role to create close connections with the patients. The ICU was described as

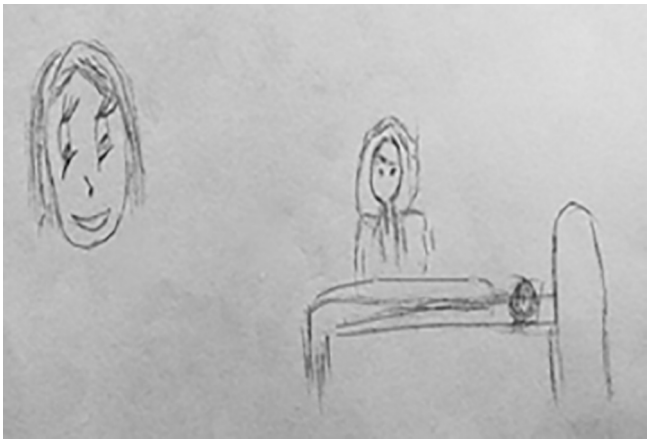

Fig. 4. Loss of successful caring.

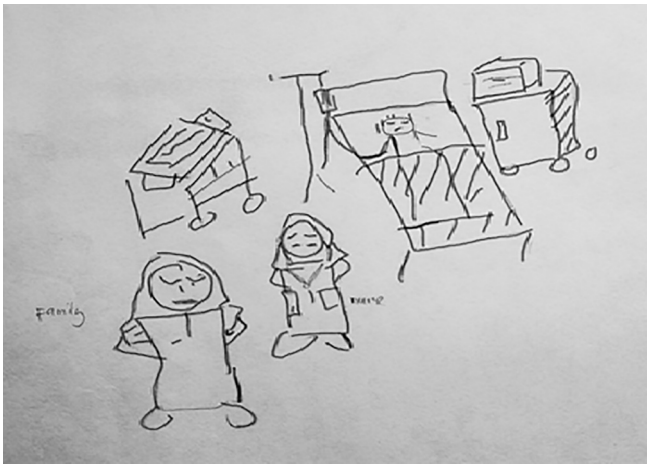

Fig. 5. Controlling their emotion.

having a small number of patients, beds arranged in front of the nurse station, and total care of patients. In these conditions, the space of the ICU was experienced as a closed space which created a deeper connection with the patients leading to greater grief when patients died. The closeness between nurses and patients was shown by the picture of a crying nurse near the dead patient (Fig. 6).

> "*Here in the ICU, because we help to fulfil every patient's need, so there will be feeling like... how to say? The relationship is closer. In the morning, we helped patients for bed bath, we feed them so that we feel closer to them, and the grief because of their deaths is deeper too*". (Participant 3)

The grief experienced by the participants is a hurtful experience that some nurses choose to neglect.

> "*Sometimes I ran away, hiding. Sometimes my colleagues would call me. But, I felt pity easily. Sometimes I could not face that (patients' death)*". (Participant 2)
> *It's better to avoid (when the patient died), otherwise I would get carried away.* (Participant 1)

Lived time: anticipating the future of own death

Anticipating the future of one's death indicates hope and expectation of a future death. When the participants grieve, the time is experienced as a moment when their awareness of death increases, leading them to prepare for their own death and hereafter. Seeing many deaths makes them think about their future death and how they want to die.

> "*I think death is a must and will come. But we don't know the time. There are different responses of patients at the dying time. Some are calm, some others are lamented. There, I got lesson, which way I will be later*". (Participant 5)

This grief experience is depicted by the picture of the blossoming flower and withered flower as the illustration of life and death (Fig. 7). Life is illustrated as the blossoming flower and death as the withered flower.

As the participants' awareness of their own death increases, they think about their preparation to face death and hereafter.

> "*Have to prepare myself and my faith. So, when death comes, I'm prepared to face the days after life*". (Participant 10)

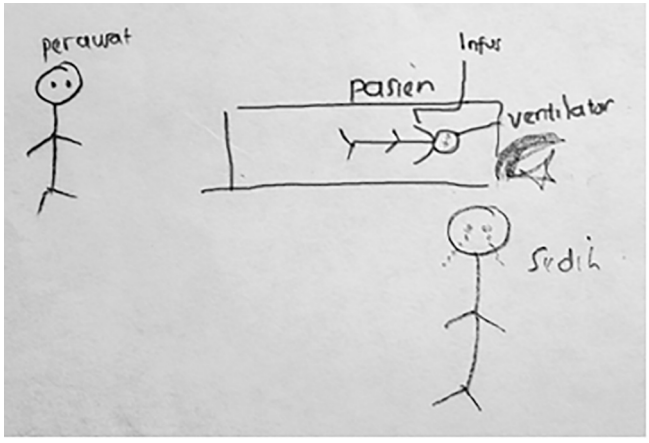

Fig. 6. Space of closeness.

This grief experience is depicted by a picture of a stair and cloud at the end of the stair (Fig. 8). The stair is the representation of her experience of grief when going towards the cloud which is the hereafter.

Lived things: relating technologies in bargaining

The ICU is surrounded by assorted technology described by participants as equipment such as direct current (DC) shock, mechanical ventilators, and endotracheal tubes (ETT). When their patients died, the participants 'bargained' by stating that if they could deliver or had sufficient knowledge and skill about these technologies, their patients would be saved.

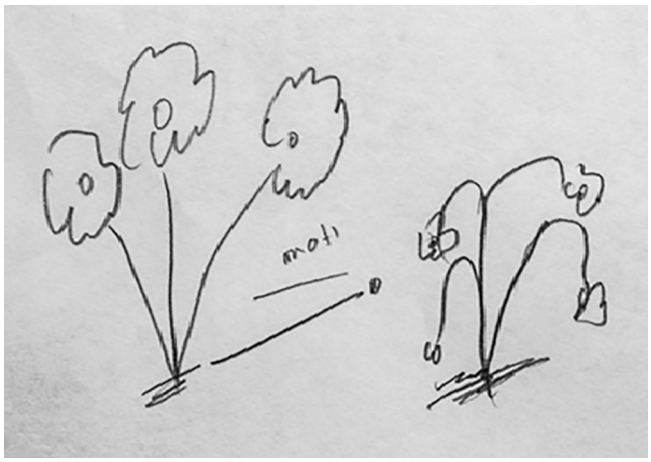

Fig. 7. Present life and future death.

Fig. 8. Preparing for the death and hereafter.

"For example the patient got VT (Ventricular tachycardia), and I had no chance to use DC shock at that time, then the patient died. Then, I keep remembering it. Oh, why didn't I use DC shock at that time? Suppose that I used DC shock, the patient might still be alive". (Participant 2)

The illustration of this experience is depicted by a picture of patients in their beds with the monitors (Fig. 9). This shows the environment of the ICU, that is one surrounded by technologies that she wished she could use in advance to save the patients.

In addition, they realize that knowledge and skill about technologies are valuable in the ICU. Lack of proficiency in the technologies of care made them feel powerless and guilty when their patients died.

"*For example, here we use ventilators. We have to know how to control them. If they beep, sometimes their volume decreases, or something is wrong, and we need to know what we should do…… So, we need to have basic knowledge about that, like from training, we can update our knowledge*". (Participant 9)

This experience of grief is depicted by a picture of a book as a representative of valuable knowledge and watering a flower as a representative of nursing care (Fig. 10). Like the flower, if the patient is not cared for carefully without adequate knowledge and skill, the patient may die.

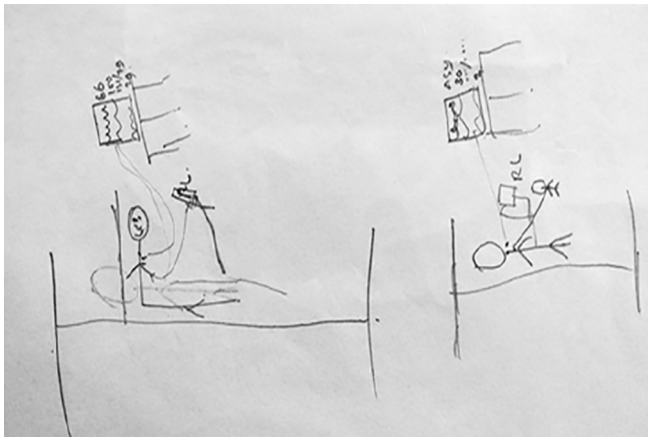

Fig. 9. Technologies as life-saving things.

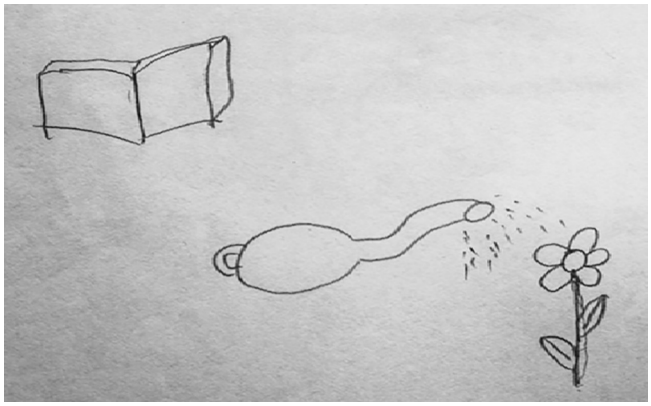

Fig. 10. Realising not being proficient in technologies of care.

Discussion

The meanings of the lived experiences of grief among Muslim ICU nurses were: empathetic understanding; balancing self; avoidance; anticipating the future of one's own death; and relating technologies in bargaining. The most prominent finding is 'empathetic understanding'. This showed the nurses' ability to empathize with others as they understood the feelings and situation of the patients and their families. In this study, nurses' empathetic understanding is also connected as nurses met patients with the same characteristics as their family members who had already passed away. The death of those patients recalled their memories about their own loss. This finding accords with a study by de Swardt and Fouché (2017) which explored the ICU nurses' experiences of the post-mortem care of patients who died in an ICU in South Africa. Their findings revealed that ICU nurses referred to patients as their family members resulting in personalizing the deaths of the patients. Similarly, a study by Shimoinaba et al. (2014) explored the loses experienced by Japanese nurses. It was found that seeing patients' deaths resulted in nurses remembering their personal loss, particularly when the patients were similar to their loved ones. However, both these previous studies were conducted in the context of non-Muslim nurses, but they had the same feeling of empathy which is significant for professional nurses. Carper (1978) explained empathy as an essential part of the aesthetic way of knowing in nursing where nurses have the capability to understand others' feeling.

In dealing with their grief, nurses tried to balance themselves. The death of the patients put them in the position where they perceived it as a loss that reflected on their successful caring because they could not save the patients' lives. Despite the feeling of giving unsuccessful caring, they understood that they need to control their emotions. The participants reacted to the patients' death by controlling their emotions, neglecting the situation, and 'bargaining' with technologies. Controlling their emotions can be related to two points. Firstly, 'professional stigma' in which nurses are supposed to deliver professional care to patients and family concerning grief, but being unable to accept their own and their colleagues grief (Wisekal, 2014). Secondly, 'disenfranchised grief' which was explained as an unacknowledged grief that is not recognized publicly (Doka, 1987). The grief experienced by nurses was not supposed to be acknowledged openly, resulting in their controlling their behaviour and emotions in a way that is socially accepted.

Neglecting the situation is a common way used by humans when they are under stressful conditions. Some participants in this study chose to neglect the death situations of the patients. The participants admitted that their avoidance was a way they coped with the situation. Shimoinaba et al. (2014) revealed that nurses distanced themselves from patients and families to protect themselves from emotional pain because of the loss. In addition, Conte (2014) found that 'alienation' was used by nurses as a coping mechanism in dealing with the deaths of patients. In his study, alienation was explained as a method used when nurses distanced themselves and their loved ones from stories regarding work-related loss to protect themselves from emotional distress caused by experiencing the deaths of patients.

Even though neglecting the situation occurred, the death of the patients is a condition that cannot be totally neglected by nurses in the ICU. Therefore, it was found that nurses used religious teaching to help them to control their emotion. They admitted doing *dhizkr* (prayer) to control themselves and to rely on the Islamic teaching that the death has been decided, and when a Muslim dies, the deceased will go back to God. In the Holy Quran, it is stated that "To God we belong and to Him shall we return" (Quran, 2: 156). Even though the majority of the participants had not experienced

of end-of-life care or palliative care training, after such experiences, they found their own coping strategies to help them cope with this situation. For those who thought their proficiency in technologies was still lacking, they 'bargained' with the technologies when their patients died. This condition occurs because they are surrounded by technologies and they think that these technologies can save life.

As Muslims, they believe in the hereafter. Experiencing the death of patients became a moment when their awareness of their future death and the hereafter increased. With regards to cultural and religious beliefs influencing grieving, this study found that Islamic religious beliefs influenced the way nurses experienced grief due to the death of the patients. The participants anticipated their future death and the hereafter when they faced the death of the patients. This finding links with Islamic teaching: Muslims will encounter the hereafter in which Muslims will face an eternal life and will be rewarded or punished based on how they lived their life. One of the verses in the Holy Quran stated: "Say, 'God causes you to live, then causes you to die, then He will assemble you for the Day of Resurrection, about which there is no doubt', but most of the people do not know" (Quran, 45: 26). The participants understood that they will meet eternal life after death for which they have to prepare from now.

Limitations

This study was conducted in a single unit in a tertiary public hospital in Indonesia. Due to the common culture and the context of the dominant Muslim community, it may not be relevant for a Western audience with few Muslim nurses and patients. Therefore, future studies in different contexts are recommended for useful comparison. Moreover, some participants had experienced a personal loss and related their experience of grief regarding their patients' death with their prior experience of loss. Further study to identify the pre-suppositions that influence the experience of grief is recommended.

Conclusion

This study shows the meaning of the lived experience of grieving of Muslim nurses who cared for patients who died in an ICU. The description of the meanings of the lived experience is: *empathetic understanding and balancing the self with anticipating the future of one's own death while avoiding and relating technologies in 'bargaining'*. This study also highlighted the need for emotional and educational support as well as institutional support for ICU nurses. It is suggested that professional grief management, such as counselling, debriefing and emotional support from supervisors and co-workers after patients' death, is needed to understand and facilitate nurses' feelings after the deaths of patients and to help them cope with their grief. In addition, the findings of this study drew attention to the anticipating of future death. Thus, end-of-life care with a spiritual approach is recommended since the Muslim nurses relied on religion statements to accept the death. Furthermore, training concerning nursing knowledge and skills-related nursing intervention in the ICU is recommended to address the lack of proficiency in dealing with technologies of care.

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Conflict of interest

None to declare.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.iccn.2018.09.003.

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