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The Modifiability of Grounded Theory

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Abstract

Grounded theories are powerful tools that fit empirical situations and provide "relevant predictions, explanations, interpretations, and applications" (Glaser & Strauss, 1967, p.1). Because of their real-world orientation, grounded theories are particularly appropriate for health care research. They can help professionals understand that certain patterns always seem to emerge, that particular people respond in predictable ways, and that actions produce predictable results (Nathaniel & Andrews, 2007). When physicians and nurses better understand patterns that affect patients, they can work towards altering harmful patterns to improve the quality of patient care. As time passes, one may ask, when do grounded theories become obsolete? When are they no longer useful? The purpose of this paper is to revisit the seminal grounded theory, *Awareness of Dying,* and compare it to contemporary conceptual and descriptive research on end-of-life care, asking the question, is the theory in need of modification?

Introduction

Modifiability is basic to grounded theory. Because they are generated through inductive logic, grounded theories are naturally modifiable. With induction, the analyst generalizes from a number of cases in which something is true and infers that the same thing is true of a whole class. In grounded theory, these inferences take the form of tentative hypotheses (Glaser, 1978). Hypotheses and the theories that they comprise demonstrate predictable patterns that can be observed. Glaser writes, "In GT, a concept is the naming of an emergent social pattern grounded in research data. For GT, a concept (category) denotes a pattern that is carefully discovered by constantly comparing theoretically sampled data until conceptual saturation of interchangeable indices. It is discovered by comparing many incidents, and incidents to generated concepts, which shows the pattern …." (Glaser, 2002, p.4). The grounded theory method corrects for error or bias through constant comparison and abstraction, which further clarifies the underlying latent patterns (Glaser, 2002, rev.

2007). After a theory is developed and published, time passes and new evidence becomes available. A basic strategy to ensure rigor, modifiability allows openness to correction and change as new evidence emerges, ensuring against "pet" hypotheses (Glaser, 1978). With that in mind, this paper revisits the original grounded theory, *Awareness of Dying* (Glaser & Strauss, 1965), compares it to contemporary research findings, and finds it to be in no need of modification.

Awareness of Dying Revisited

Awareness of Dying is a historical grounded theory—the first ever published. Today, a great deal of research focuses on death and dying, but in 1965, *Awareness of Dying* presented eye-opening revelations about how an awareness of the time and mode of death affects patient attitudes and the care delivered by nurses and physicians. The theory was developed by Barney Glaser and Anselm Strauss and was funded by a Public Health Service Research Grant from the Division of Nursing (Glaser & Strauss, 1965a). Glaser and Strauss spearheaded a six-year research program entitled *Hospital Personnel, Nursing Care and Dying Patients.* This research culminated in a number of publications including A*wareness of Dying* (Glaser & Strauss, 1965a*)*, *The Social Loss of Dying Patients* (Glaser & Strauss, 1964*)*, *Time for Dying* (Glaser & Strauss, 1968), *Temporal Aspects of Dying as a Non-scheduled Status Passage* (Glaser & Strauss, 1965b), and *The Nurse and the Dying Patient* (Quint, 1967*)*. *Awareness of Dying* is the most well-known theory that emerged from the study.

Glaser and Strauss, sociologists, and Jeanne Quint, a nurse, conducted intensive field work at a number of hospitals for six years (Glaser & Strauss, 1967). Using a combination of observations and interviews, they aimed to produce research that would contribute toward creating a more rational and compassionate dying process. The investigators had maximum exposure to different aspects of dying within six hospitals—locations where death was "sometimes speedy, sometimes slow; sometimes expected, sometimes unexpected; sometimes anticipated by the patients, sometimes unanticipated…" (Glaser & Strauss, 1968, p. xi). They followed nurses and physicians, watching them work and asking questions. They sat at the nurses' stations, attended staff meetings, and talked with patients. What emerged from this lengthy study was a

groundbreaking theory about patients', families' nurses', and physicians' levels of awareness of the impending imminence of death in particular cases. Glaser and Strauss discovered four distinctly different awareness contexts: *closed awareness*, *suspected awareness*, *mutual pretense awareness*, and *open awareness*. They found that each of these contexts had implications for the quality of the experience for patients, families, nurses, physicians, and other hospital staff.

Much like today, in the 1960s many people chose to die in institutions, leaving intimate care during the last days and hours of life in the hands of strangers. Glaser and Strauss found that Americans, in general, tended to avoid talking openly about dying and health care professionals were no different. Through much of the 20th century, nursing and medical education tended to emphasize the technical aspects of dealing with patients, with little thought about the psychological aspects of care. Therefore, physicians in U.S. hospitals were reluctant to disclose impending death to their patients and nurses were expected to talk with patients about death only with the express consent of physicians (Glaser & Strauss, 1965a). Glaser and Strauss found that this atmosphere of organized secrecy led to a *closed awareness* of the dying process.

According to Glaser and Strauss, *closed awareness* occurs when patients are unaware of their own impending death (Glaser & Strauss, 1965a). Physicians, nurses, and other staff members purposely maintain the fiction that the dying patient might recover. They are careful not to arouse the patient's suspicions by their words or actions. Physicians and nurses use certain tactics to maintain closed awareness. These tactics include giving patients an incorrect or partial diagnosis, manipulating the conversation so that patients will make inaccurately optimistic interpretations of their situation, and avoiding spending time with patients to minimise the possibility of revealing clues. During periods of closed awareness, nothing is done to arouse patients' suspicion. Thus, patients are allowed to act on the false supposition that they will recover. This context does not allow patients to close their lives with proper rituals. Because of the organized deception, relatives' grief cannot be expressed openly.

In some cases, patients begin to suspect, with varying degrees of certainty, that hospital staff believe them to be dying. Glaser and Strauss labelled this context *suspicion awareness*

(Glaser & Strauss, 1965a). Glaser and Strauss found that patients who were suspicious engaged in several strategies to attempt confirmation of their suspicions. Strategies included announcing their own impending death to check the reaction of staff members, talking about their symptoms while listening intensely for clues, and attaching significance to every word and gesture of staff members. However, although they search for clues, patients are unlikely to have sufficient medical knowledge to interpret them. If staff members believe that a patient suspects terminal illness, they attempt to counter those suspicions with strategies similar to ones used to maintain closed awareness. For example, nurses may act as if a patient is merely ill, rather than dying, by being impatient with the patient's suspicions and acting in a distracted, cheerful, or brisk manner. Nurses may send a clear message that they are too busy to talk or instruct the patient to ask the physician. Essentially, they discourage the patient from talking about suspicions by refusing invitations to talk. Glaser and Strauss found that this type of deception places patients, relatives, and staff under considerable strain and creates an atmosphere of tension. Suspicion awareness tends to be converted into other types.

Another context, *mutual pretence,* occurs when staff members and the patient know that the patient is dying, but everyone pretends otherwise (Glaser & Strauss, 1965a). All parties are careful to maintain this fragile illusion, utilizing strategies such as focusing on safe topics and purposely avoiding dangerous topics. If an inadvertent word or action threatens the fiction, patients and staff pretend that it did not happen. As time passes, pretence is piled upon pretence. Mutual pretence has positive effects. It can serve to ensure privacy and dignity for patients and minimize family members' discomfort. Generally, mutual pretence can create an atmosphere of serenity. Although staff members might feel relief, mutual pretence may eventually lead to considerable stress. Pretence is challenged by pronounced physical deterioration or when patients feel they cannot face death alone. When this occurs, patients are likely to make the transition to open awareness.

In the context of *open awareness,* both staff and patients know and acknowledge that the patient's condition is terminal (Glaser & Strauss, 1965a). Open awareness is often a stable context. Paradoxically, patients may experience open awareness about the terminal nature of their condition, but remain in closed

awareness about particular aspects of death such as mode and time. These facets of the patient's impending death are only revealed if family and staff judge them not to be upsetting or unpleasant for patients. Glaser and Strauss found that selective mutual pretence in the presence of open awareness is a common strategy to deal with upsetting topics. Pressure is placed on patients to behave correctly. As they become more aware, patients are expected to behave with dignity, avoid displays of emotions, and maintain the fight to stay alive, except if death is certain or suffering is intense. Generally, patients are expected to conform to staff members' conception of propriety. Glaser and Strauss observed that staff members appreciate patients who die with dignity and grace. When nurses perceive that patients are not dying properly, they admonish, coax, and appeal to higher authority, such as a physician or priest, to help control patients. During open awareness, patients and staff members may negotiate for the relaxation of the usual hospital routine. Negotiations are more likely to be successful if patients are considered to be dying in an "acceptable" way.

Glaser and Strauss (1968) found that many staff members, especially nurses, prefer open awareness since they get satisfaction from being able to comfort patients. Open awareness is also good for patients in that it allows them the opportunity to "get their affairs in order" and close their lives according to their ideas about proper dying. It allows them to talk openly with relatives. However, open awareness has some disadvantages for patients. They may not be successful in bringing closure to their lives and may die with more anguish and less dignity than those who die in closed awareness.

Awareness of Dying was published by Glaser and Strauss in 1965, before the authors published their groundbreaking book describing the new research method. The method changed many people's opinions about how to do research (Glaser & Tarozzi, 2007). One of the unique tenets of the grounded theory method as described by Glaser and Strauss provides that grounded theories can be modified as new facts and understandings emerge (Glaser & Strauss, 1967). Because they are modifiable, grounded theories remain vivid and relevant as time passes. Thus, subsequent research enriches and elaborates grounded theories.

Current Research

The purpose of reviewing contemporary literature is to

compare the current conceptual and descriptive research on death and dying to Glaser and Strauss's theory and to determine if recent findings warrant modification of the original theory. Compared to 1965 when *Awareness of Dying* was first published, recent trends show a slight decline in the percent of people who die in institutional settings. Even so, more than 40% of people in the U.S. die in hospitals surrounded by nurses and other hospital staff (Flory et al., 2004). There has been a flurry of health care research focusing on end-of-life issues in recent years. Yet, 45 years after the publication of *Awareness of Dying*, nurses and doctors continue to control information and influence the awareness context. They either delay, modify, or temper full disclosure, despite public and professional appeals for open awareness (Field & Copp, 1999). Even in the face of increasing knowledge and improved care of the dying, some patients continue to be denied the opportunity to prepare for death, (Quinlan & O'Neill, 2009).

Contemporary research shows that open awareness of dying remains desirable since it enables life planning to proceed and offers some control over the manner and timing of death (Seale, Addington-Hall, & McCarthy, 1997). Open awareness enables patients to exercise some control over their last months and days of life (Field & Copp, 1999). Recent research demonstrates that there is still much room for improvement, particularly in relation to people dying with a diagnosis other than cancer. In recent years, an increased percent of patients with cancer experience open awareness (83.9%), yet despite the influence of Glaser and Strauss's theory, this increase has not been reflected with other life-limiting conditions such as end-stage cardiovascular disease (51.6%), respiratory disease (71.4%) and other conditions (42%) (Seale, et al., 1997). Seale, et al. concluded that while open awareness is the most prevalent context, medico-biological factors, such as cause of death, and socio-cultural factors, such as social class, contribute to variation in awareness contexts. Patients dying of cancer are more likely to receive a terminal prognosis in an explicit way compared to those with end-stage cardiorespiratory disease. This leaves patients to surmise that they are dying (closed awareness) on the basis of their own knowledge (Exley, Field, Jones, & Stokes, 2005). Nonetheless, for a variety of reasons some patients do not want to discuss their impending death or have it openly acknowledged, which for them is a matter of privacy (Quinlan & O'Neill, 2009). They exercise a

right to engage in mutual pretence, a major concept acknowledged by Glaser and Strauss (1995a) that is consistent with current thinking on patient autonomy.

Even today, health care professionals remain in control of the type and amount of information patients receive. This leads Field and Copp (1999) to conclude that disclosure is conditional rather than open, implying that there is a certain inconsistency between this stance and the idea of open awareness. But this conclusion is not new. Glaser and Strauss (1995a) acknowledged that open awareness is complex and not an absolute state in which everything is known. Even in open awareness, staff may choose not to discuss some aspects of death, such as time and mode, with patients. Although open awareness is thought to be the preferred context, it can be quite stressful for staff when, for example, patients wish to talk about their imminent death. With a working knowledge of the theory, patients, relatives, and health care staff can anticipate consequences of the current awareness context.

Patients and physicians still engage in "pretence awareness" in which both know the prognosis, but tell each other "recovery stories" (The, Hak, Koeter, & van Der Wal, 2000). Corresponding with Glaser and Strauss's concept of mutual pretence, contemporary researchers find that pretence awareness leads to false optimism and does not allow patients to make informed end-of-life choices and say their goodbyes (Francke & Willems, 2005). Research suggests that this can only be achieved in the context of openness. Consistent with *Awareness of Dying* (Glaser & Strauss, 1965a), poor communication among the terminally ill, their families, and hospital staff continues (Yabroff, Mandelblatt, & Ingham, 2004), resulting in patients not being involved in decisions about the type of treatment or support they want while dying (Quinlan & O'Neill, 2009).

After decades of research, there are still gaps in end-of-life health care training of health professionals (Rabow, Hardie, Fair, & McPhee, 2000). Many physicians begin practice unprepared to talk openly with patients about poor prognosis (Lamont & Christakis, 2001), using deliberately oblique language and euphemisms (Quinlan & O'Neill, 2009). Glaser and Strauss (1965a) refer to this as *silent disclosure,* a state that eventually initiates the mutual pretence awareness context. Yet open, timely and skilled communication is highly valued by patients and their

relatives in end-of-life care (Carline et al., 2003). Consistent with Glaser and Strauss's theory (1995a), nurses continue to shape expectations of patients and distract attention away from upsetting thoughts (Hopkinson, Hallett, & Luker, 2005). *Awareness of dying* theory suggests that unless careful, nurses who utilize such strategies consistently, may serve to maintain closed awareness or mutual pretence.

Against today's background of increased capacity for technological interventions, clear decisions about the right time to die may be more difficult than in the past, making it even more important for patients and their relatives to be involved in decisions about end-of-life care (DelVecchio et al., 2004). *Awareness of dying* has the potential to provide a very effective basis for dealing with these continuing problems since it can be used to guide communication among everyone involved in terminal care. Effective communication is powerful since it confirms humanity, instils a sense of security, and is essential to meaningful care (Ryan, 2005). In that regard, Glaser and Strauss discuss explicitly how to change awareness context and offer guidance on how to deal with potential problems as a consequence of changed awareness.

Awareness context continues to shape discussions in relation to disclosure (Field & Copp, 1999) and has been instrumental in re-focusing care on the individual who is dying, rather than on the protection of others through non-disclosure (Field, 1996). There is still much to be gained by applying Glaser and Strauss's *awareness contexts* to current health care practices, especially since the emotional needs of dying patients continue to be overlooked (Quinlan & O'Neill, 2009). Recent studies have tended to focus on the quantitative measurement of the quality of dying and death (Downey, Curtis, Lafferty, Herting, & Engleberg, 2010; Mularski, Curtis, Osborne, Engelberg, & Ganzini, 2004). These studies generally rely on the perception and recall of relatives, which may alter with time. Some researchers believe that it is far easier to measure objective and observable items rather than subjective and emotional ones (Hinton, 1996). Moreover, there is increasing recognition that many other factors influence the quality of dying (Downey, et al., 2010). Downey et al (2010) note an absence of a theoretical foundation for end-of-life research in the literature. If this surprising assertion is true, a multivariate theory with strong explanatory and powers is needed to serve as a framework for improving end-of-life experiences for all

concerned. Newly examined and found to be pertinent, Glaser and Strauss's seminal theory, *Awareness of Dying,* has the potential to guide research and practice in this substantive area.

One final note, contemporary literature about death and dying cited in this paper consists of descriptive and conceptual products of research focusing in death and dying, an area of intense focus during the last few decades. The body of amassed knowledge in this and other related substantive areas sets the stage for the development of a formal theory. More abstract and generalizable than the present substantive theory, formal theory can be widely used in lectures, readings, and consultations. Formal theory can correct extant theory by modification, giving deeper but transcending understandings, extending the general implications of theory, and the cumulative construction of theory. Formal grounded theory may be used to guide other research since it gives clear theoretical direction to the research by its grounding. And because it is abstract of people, place and time, it is easy to apply to many substantive areas (Glaser, 2007). Awareness context offers a useful conceptual tool for research and practice and is, at the same time, ripe for formal theory development.

Conclusion

Awareness of Dying encourages nurses and physicians to be sensitive to predictable processes and to alter their actions to improve care. The theory sensitizes health care professionals to universal problems that surround end-of-life care and provides them with a means of making things better. By understanding the contexts of awareness and the effects of their words and actions on dying patients, nurses and physicians are better able to honestly deal with patients and families as death approaches. Striving toward evidence-based practice, contemporary nurses and physicians can be assured that *Awareness of Dying* is an enduring and vivid theory that explains how the context of patients,' physicians,' and nurses' awareness can determine the manner in which patients experience their last days and how awareness context can be altered to support patient autonomy and dignity in accordance with their wishes. It reveals the transparency of health care professionals' attitudes and actions towards dying patients, which can leave them confused, misinformed, and anxious and can deny them opportunities to set their affairs in order. It shows that nurses and physicians who

are honest and sensitive to dying patients may be able to better assist them to conclude their lives with proper rituals, encouraging open expressions of grief among patients and their families.

Glaser and Strauss found that compassionate physicians and nurses who confront the dying process honestly, give patients permission to express their thoughts openly and avoid feelings of aloneness at the end of life. Nevertheless, in the face of today's increasing awareness and improved care of the dying, some patients are still denied the opportunity to prepare for death. Thus nearly half a century after it was first published, *Awareness of Dying* is needed to serve as a theoretical foundation for improving the quality of nursing and medical care. Even though there has been a plethora of research surrounding the end of life, recent findings support the original theory and no modifications are warranted. Glaser and Strauss discovered an important theory whose explanatory power remains undiminished with time and therefore continues to provide a conceptual framework for research and practice. The theory is as fresh and useful in guiding practice as it was when it was written and is poised for formal theory development.

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