A sudden death on clinical placement: a student's perspective of nurse grief

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Abstract

This paper explores the reflections of a student nurse upon hearing of the sudden death of a patient she had cared for the previous night on clinical placement. Her journey, and those of colleagues she has observed, prompted this paper's discussion of nurse grief, the support mechanisms available and those preferred by nurses, and the potential outcomes if grief is not acknowledged, supported, and managed. Disenfranchised grief is a major factor in the development of prolonged and cumulative grief responses and negative outcomes for nurses, patients, and the collective nursing profession, however the establishment and utilisation of informal support networks has been found to encourage a discussion of feelings and lead to a healthy resolution of nurse grief.

Keywords: nursing, clinical placement, patient death, sudden death, nurse grief, grief responses, disenfranchised grief, nurse support, formal debriefing, informal debriefing, reflective practice.

Case study

During an afternoon shift on her first clinical placement as an undergraduate nurse, a student was responsible for 6 patients under the supervision of her preceptor for that day – Nurse A. It was a quiet shift and this student spent some time sitting on the end of each patient's bed to have a chat. After completing her final observation round and welfare checks on each patient at around 2030, she headed home, ready to return the next day for a morning shift. Upon returning to the ward in the morning, she was ushered into a meeting room along with all nurses on that shift and the nurses from the afternoon shift the previous night. All the nurses present were told a patient had been found deceased at 2230 that last night under suspicious circumstances and the Police were now involved. After speaking with

the Police, the Unit Manager and Nurse A, it was declared that this student had in fact been the last person to see this patient before they completed suicide in their bedspace. As the focus shifted to completing and gathering paperwork and providing statements, the nurses involved were left to deal with their emotions alone. The student's clinical educator was made aware of the situation and despite initially attempting to ignore her feelings and assure her educator that she was not affected, the student finally broke down emotionally from feelings of guilt, sadness, anger, professional incompetence, and grief.

Introduction

Grief in nursing has been a long-neglected and unacknowledged issue in nursing education, research and practice, only gaining recognition after the publication of Kenneth Doka's concept of unacknowledged, or disenfranchised, grief in non-traditional intimate relationships over twenty years ago (Doka, 1987). From Doka's theory came the notion that healthcare providers, nurses in particular, could also suffer from disenfranchised grief due to their non-traditional emotional relationships with patients who have died (Wilson & Kirshbaum, 2011). It is imperative that nurse grief is not only recognised, acknowledged, and accepted within the profession and by employers, but also that appropriate support mechanisms are established and nursing education improved to ensure nurses do not suffer the serious adverse effects of compounded and unaddressed grief. Using the above situation experienced during this student's clinical placement, this paper will explore the concept of nurse grief, the types of support available and the potential outcomes for nurses and the nursing profession if nurse grief is not adequately addressed.

This paper will examine the case study using the reflective model of John's (1995), who used Carper's fundamental ways of knowing in nursing that included the elements of aesthetics, personal, ethics, and empirics but added the concept of reflexivity (Carper, 1978). This additional component encourages personal and professional development through the

reflective process (John, 1995). At each step of John's reflective model, links are made to the concept of nurse grief and the importance of acknowledgment and support.

Personal and empirical reflections – The concept of nurse grief

Personal reflections

This incident occurred during this student's first clinical placement as a nurse, and was her first experience with the death of a patient who had been under her care. As a result, there was a feeling of unpreparedness, particularly for the emotional and professional consequences of this patient's death. There were a number of considerations that compounded the student's grief response. Initially there was a sense of shock that a sudden death could occur in this manner within the ward environment. The student also experienced a feeling of guilt that she had been the last person to see the patient, and may have missed a signal or could have done something to prevent the patient ultimately taking their own life. This then led to a level of anxiety about the situation. In the first few days following this event, quiet reflection led to an acknowledgment of her grief, and the seeking of support from her peers and educators.

Empirical Reflections

Nursing students are introduced to death and dying as part of their university studies, however the emphasis in the early stages of nursing training usually focuses on the acquisition of new clinical knowledge, skills, and values. The situation outlined in this case study created a different set of challenges than the new student nurse was prepared for at this early stage of her nurse training. The most significant challenge for this student nurse was not the actual experience of death but the lack of support available to deal with the resulting grief. The student nurse had previously encountered death in her personal life, and the subsequent grief process was well supported by family and friends. This was in stark

contrast to the clinical experience of a sudden death, where nursing staff and management ignored or trivialised the student's grief response. She was offered no support, formal or otherwise, in the wake of this tragic occurrence.

Nurse Grief

Nursing is a profession which most individuals enter due to a desire to care for others. Indeed, nurses develop much more personal relationships with their patients than any other healthcare professional due to the intimate nature of the frequent, ongoing care they provide to patients (Peterson, et al., 2010). Nurses place a high value on this relationship with their patients, often regarding it as an essential component of the care provided, especially when their patient is dying (Stayt, 2010). However when these patients die, nurses experience grief responses that can be manifested in a wide range of cognitive, physical, emotional, or behavioural symptoms (Caine & Ter-Bagdasarian, 2003). Symptoms of grief relating to a patient death reported by nurses include overwhelming sadness, tearfulness, decreased self esteem, anxiety, anger, aggression, fatigue, sleep disturbances, difficulty concentrating, guilt, fear, uncertainty, nightmares, chest pain, decreased appetite, gastrointestinal problems, social withdrawal, and feelings of decreased professional competency (Anderson, Ewen, & Miles, 2010; Caine & Ter-Bagdasarian, 2003; Dietz, 2009; Peterson, et al., 2010; Shorter & Stayt, 2009).

While it is primarily the nature of the nurse's caring relationship with the patient and their family that causes a grief response upon the patient's death, certain personal, educational, and cultural factors have also been found to impact upon the manner in which an individual nurse approaches and deals with death (Lobb, et al., 2010; Wilson & Kirshbaum, 2011). Personal experiences of death outside of work can have a positive effect on a nurse's attitude towards death and dying if the death has been well-addressed and integrated into their lives (Wilson & Kirshbaum, 2011). However, if the nurse's experience of death in their personal life is unresolved or unaccepted, this can result in increased

vulnerability when encountering the dying patient, and a greater potential for unresolved grief (Wilson & Kirshbaum, 2011). A lack of undergraduate education on nurse grief and healthy coping strategies, coupled with hospital cultures that regard death as the ultimate failure of medical intervention also contribute to the unpreparedness of nurses to confront death and the mental and emotional distress experienced once the patient dies (Lobb, et al., 2010).

It is crucial to both nurses' emotional and professional wellbeing and the ongoing provision of quality, emotionally-connected care to patients that nurses experiencing grief are well-supported to deal with their emotions in a positive manner (Peterson, et al., 2010).

Ethical Reflections – What support is available to nurses?

Ethical Reflections

The complexities of this case became clearer to the student the day after the patient's sudden death, however it was not until there was time for reflection and clarification from peers and the literature that it became apparent just how ethically challenging this experience was. It was evident that support was required on both a personal and professional level; however, the culture of self-restraint and denial in the face of death that was presented by the other clinical nurses as the appropriate behaviour initially made the student feel that she was not entitled to feel grief and certainly not entitled to request any support.

Available support

Undoubtedly, a major obstacle in nurses receiving adequate support when processing their grief are in fact the nurses themselves – not recognising or acknowledging the impact a patient's death has had emotionally and mentally often results in a nurse sweeping his or her feelings under the proverbial rug in order to 'get on with things' and remain strong for the family and other patients (Gerow, et al., 2010; Wilson & Kirshbaum,

2011). In addition, time constraints, scheduling requirements, and overt and covert nursing culture can discourage nurses who do recognise their need to grieve from taking the time and accessing the supports necessary to process his or her loss and work through all emotions in a healthy, well-supported manner (Conte, 2011; O'Conner & Jeavons, 2003; Wilson & Kirshbaum, 2011). As a result, nurses are left to deal with their grief at home, alone and unsupported. The following sections outline the types of support available to help nurses address their emotional reactions to a patient's death, adopt healthy coping mechanisms, and avoid cumulative grief or stress disorders.

Formal debriefing methods

Critical incident stress (CIS) debriefing is a component of CIS management that provides a safe, non-threatening environment where nurses can share information, process the incident, and express emotions with other nurses under the facilitation of an individual with professional training in debriefing, counselling, or death and dying (Caine & Ter-Bagdasarian, 2003; Hanna & Romana, 2007). While a study of Western Australian Emergency Department nurses found that 41% of nurses sought debriefing after a critical incident and debriefing was offered to 80% of nurses questioned, 59% of nurses stated that routine debriefing for cumulative stress and grief was not offered and only one respondent stated that formal group debriefing suited their needs (Ross-Adjie, Leslie, & Gillman, 2007). Many participants blamed a lack of qualified debriefers, a lack of follow-up or ongoing support, feeling inhibited in a group environment, and the inability of staff to attend available debriefing due to shift and workload constraints (Ross-Adjie, et al., 2007; Shorter & Stayt, 2009). Those who have attended formal debriefing sessions report benefit gained from sharing their feelings and emotions with peers who had experienced similar incidents: realising they were not alone in their response and hearing of how others were handling their stress (O'Conner & Jeavons, 2003; Theophilos, Magyar, & Babl, 2009; Tuckey, 2007).

These debriefing sessions were designed to be offered following a critical incident - defined in the literature as “any sudden, unexpected event that has an emotional impact sufficient to overwhelm the usual coping skills of an individual or group, and that causes significant psychological distress in usually healthy persons” (Caine & Ter-Bagdasarian, 2003, p. 59). Formal debriefing in hospitals, however, is generally only offered after a particularly traumatic or stressful incident that involves a group of staff members, such as following a resuscitation effort; and as such, individual nurses confronted with a patient’s death in the course of their shift are often neglected. In addition to this phenomenon observed throughout my undergraduate clinical placements, surveyed nurses have indicated an unwillingness to access formal support as their participation could be construed by colleagues and management as an inability to cope with the emotional demands of nursing, potentially losing respect or promotion opportunities (Shorter & Stayt, 2009; Wilson & Kirshbaum, 2011). As a result of the logistical and cultural problems discussed above, alternative supports must also be available to ensure nurses are appropriately protected and supported to minimise the development of abnormal stress and prolonged grief responses.

Informal debriefing methods

Many studies have found that the prevailing nurse culture, specifically in high-acuity areas of nursing such as the Intensive Care Unit (ICU) or Emergency Department (ED), demands that nurses are tough and able to handle any situation that arises (Griffin, 2008; Wilson & Kirshbaum, 2011). As a result, nurses increasingly turn to their peers for support and advice on how to cope effectively with the demands of their work, especially following a critical incident that exceeds the limits of their normal, internal support mechanisms (Espinosa, Young, Symes, Haile, & Walsh, 2010; Peterson, et al., 2010). The results of many studies have uncovered a strong preference for relying on informal networks of support following the death of a patient, with nurses talking to colleagues and friends both within and outside the work environment, and seeking advice, comfort, and support from peers who have previously experienced nurse grief (Peterson, et al., 2010; Shorter & Stayt, 2009;

Wilson & Kirshbaum, 2011). In some instances, it was enough to be assured from senior nurses that it was ok to cry (Peterson, et al., 2010).

In a paper written by an Intensive Care nurse outlining her emotional experiences dealing with patient death throughout her career, the author advocates the importance of speaking openly with other nurses about her deepest inner experiences in safeguarding against burnout (Couden, 2002). Her willingness to discuss her feelings with her colleagues encouraged other nurses to share their feelings – creating an informal in-hospital support network (Couden, 2002). The opportunity to debrief after a patient's death and openly express emotions around death have also been reported to create a much less stressful caring environment for dying patients and reduced rates of prolonged grief-related symptoms for the nurses involved (Lobb, et al., 2010; Wilson & Kirshbaum, 2011). Brosche's (2003) grief care plan was developed specifically to describe the nurse's grief response using the seven overlapping and intertwining stages of shock and denial, disorganisation, volatile reactions, guilt, loss and loneliness, relief, and reestablishment. This plan relies heavily on the use of a consistent support network, permissive listening in a non-judgmental atmosphere, and the expression of deep inner feelings in order to avoid the internal conflict, adverse physical and behavioural manifestations, and prolonged grief responses that occur when feelings of grief are ignored (Brosche, 2003).

Other types of support available

While formal debriefing and informal support are the most common support mechanisms available for nurses experiencing grief responses, a nurse's grief can also be allayed by the perception that the patient had a 'good death', which involves having the chance to complete important life and relationship tasks and say goodbye to loved ones, while receiving the best possible care and being comfortable to the very end (Lobb, et al., 2010). However, when a patient suddenly or unexpectedly dies, the nurse cannot take comfort in this particular outlook, potentially exacerbating his or her grief response.

Research has found that education and training surrounding death, dying, and nurse grief, such as that provided routinely for Oncology and Palliative Care nurses, results in nurses being more prepared and comfortable dealing with patient death (Brosche, 2003; Lobb, et al., 2010). These articles strongly advocate the inclusion of education on grief responses and effective coping strategies during initial nurse orientation (Brosche, 2003; Lobb, et al., 2010).

Studies have also identified a multitude of other support mechanisms that can be instituted by employers depending upon the needs of the nurses within their unit. These interventions range from staff retreats, specialised grief teams, individual counselling, and ongoing grief support groups, to quick defusing sessions at the end of a shift, narrative journal writing, and granting nurses leave to attend the funeral service of their patient (Brosche, 2003; O'Conner & Jeavons, 2003; Wallace, 2009; Wilson & Kirshbaum, 2011).

Aesthetic Reflections – Risks of unacknowledged grief

Aesthetic Reflections

In seeking and accepting the type of support that the student nurse felt she required following this unexpected patient death, she was able to successfully avoid compounding her grief with maladaptive coping strategies. This empowered her to feel confident in her ability to manage future patients' deaths in a healthy manner and thus allowed her to develop positively as a nurse. In speaking with other graduate nurses about their experiences surrounding patient death, it became apparent that nurse grief is not only rife – it is completely ignored and unsupported by the prevailing nurse culture. As a result new nurses are at risk of accepting the status quo and feeling that grief is not valid and thereby does not require attention and support, while adopting negative coping strategies and fostering negative attitudes towards patient death.

Disenfranchised grief and maladaptive coping mechanisms

The support a nurse receives in his or her early encounters with patients' deaths is seen as formative and impacts strongly upon the nurse's future management of grief responses and the amount and type of support sought or utilised (Gerow, et al., 2010). Nurses who were allowed to grieve and process their loss in a supported environment developed healthy coping mechanisms with which to handle future death experiences and experienced positive personal growth (Conte, 2011; Gerow, et al., 2010). However, without acknowledgement and support, nurses are forced to rely solely on their own internal methods of coping, which are commonly insufficient to deal with the intense emotions felt after a patient's death (Anderson, et al., 2010; Gerow, et al., 2010). This phenomenon is referred to in the literature as disenfranchised grief, a result of grief being unacknowledged and therefore unexpressed and unsupported, and forces nurses to adopt ineffective and negative coping strategies such as normalisation, compartmentalisation, and/or emotional dissociation, all of which lead to increased role stress and eventual burnout (Anderson, et al., 2010; Gerow, et al., 2010; Peterson, et al., 2010). Normalisation involves putting the patient's death into perspective by viewing it as a natural, inevitable process, while compartmentalisation is an unconscious psychological defence mechanism employed to avoid the mental anxiety caused by conflicting emotions – one simply denies the problem exists and is indifferent to the suffering both around and within themselves (Gerow, et al., 2010). Studies have found that nurses who are unable to cope effectively are likely to increase the emotional and psychological distance between themselves and future patients, limiting their emotional involvement as a protective barrier against experiencing further grief (Espinosa, et al., 2010; Gerow, et al., 2010; Peterson, et al., 2010; Shorter & Stayt, 2009). This emotional dissociation or professional distance is not only maladaptive for the nurse, but discourages other nurses from dealing with the realities of death and provides sub-standard care to the dying patient and their loved ones (Brosche, 2003; Couden, 2002; Espinosa, et al., 2010).

Emotional and professional outcomes for the nurse and the nursing profession

As discussed thus far, nurse grief produces symptoms varying from sadness and crying through to social isolation and depression (Wilson & Kirshbaum, 2011). If grief is continually unmanaged and unsupported, the nurse begins to experience the effects of cumulative grief which impact not only upon the nurse personally and professionally, but upon patient outcomes, employers, and the entire nursing profession (Conte, 2011; Shorter & Stayt, 2009). A nurse's responsibilities and workload is ever-constant, and as the effects of unmanaged grief worsen, productivity and morale is affected by chronic pain, disillusionment, increased absenteeism, decreased job satisfaction, and a reduced ability to respond adaptively to stressors (Caine & Ter-Bagdasarian, 2003; Couden, 2002; Jenko, Seymour, & Stone, 2011). This in turn causes negative patient outcomes, fragmentation of the workgroup, burnout, and exacerbated staff shortages (Caine & Ter-Bagdasarian, 2003; Conte, 2011; Hanna & Romana, 2007).

Reflexivity - Experiences of grief from a nursing students perspective

Reflexivity

As a result of appropriately acknowledging and reflecting upon her experience as outlined above, the student nurse developed important coping skills and felt well-equipped to deal with patient deaths in the future. She acknowledged the importance of utilising available supports and allowing herself the opportunity to grieve. As a result she can now provide the best clinical and emotional care for her patients and their families, while showing other nurses that nurse grief is real and deserves attention. The culture of nursing needs to change in order to adequately support nurses dealing with patient deaths – this will only occur once

supports are widely available and nursing education acknowledges the grief response and teaches positive coping mechanisms.

The literature on both nurses' and nursing students' experiences with grief support the findings of this specific case study, and emphasise the importance of students being taught appropriate coping skills (Mallory 2003). Jones (2010) also identifies the significance of appropriate reflection to assist with coping with the fallout of clinical events. What appears to be lacking in the literature is how a nursing student copes with an unexpected, sudden, or violent death. This may potentially suggest that there is different form of grief experienced by nurses compared to that which they experience after an expected patient death. The sudden death of a patient and their effect on nursing students is not well researched and is an area needing further study.

Conclusion

Sadly this case study highlights the common occurrence of a lack of acknowledgment and support of nurse grief within the clinical environment. However there were some key personal and professional lessons that occurred for the student as a result of her experience with sudden death. The support of the clinical educator and the university lecturer enabled the student to constructively work through this experience. The clinical educator initiated many informal conversations and suggested the student access the institution's staff counselling service. The university lecturer supported the student through the process of reflection that has been reported in this paper. More informally, a close friend was on hand to sort through the student's feelings of guilt and personal responsibility and provide some perspective. In addition, this student completed personal education on the topics of palliative care and nurse grief that enabled her to confront future patient deaths with knowledge, maturity, compassion, and a working knowledge of effective coping mechanisms.

Most nurses will experience the death of a patient at some point during their careers, expected or otherwise. It is vital that nurses and nursing students are educated on the normality of experiencing grief when a patient dies and the various methods they can employ to deal with their grief in a positive manner, enabling them to continue to provide a high level of personalised, empathetic, and connected care to all future patients. This paper addressed the importance of adequate support in managing nurse grief and found that while formal debriefing has its merits in the theoretical literature, its use in nursing is hampered by logistical, practical, and cultural issues; thereby making informal debriefing with peers the far more popular choice amongst nurses dealing with a patient's death. With nurses in multiple specialty areas electing to have an informal chat with a colleague or friend to express their grief and emotions and obtain advice and reassurance, this method of debriefing holds promise in reducing the long-term effects of unaddressed and poorly managed grief, combating disenfranchised grief, and reducing role stress and burnout.

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