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I have no known conflict of interest to disclose.

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Abstract

A major responsibility for nurses is caring for patients during the end-of-life process, as well as helping families and patients cope with the death and dying process. It is well known that death and dying greatly impacts families, but little holistic research has been done on how death and dying impacts nurses' mental and emotional wellbeing. Using databases Google Scholar, Web of Science, and EBSCO, 14 articles were analyzed regarding the impact of death on nurses' mental health. Results show that the age of a patient plays a bigger role on death impact than nursing specialty does, as younger patients' deaths cause greater emotional turmoil than older patients. Cultural values around death also affected the emotional impact a patient's death had on nurses. Nurses from cultures with a more negative attitude towards death experienced greater emotional turmoil when patients died. Religious values were shown to help nurses cope with the dying process. Across studies and specialties, nurses complained of being underprepared to deal with the death and dying process. These common complaints indicate gaps in nursing education that need to be addressed and rectified to preserve the health and mental wellbeing of caregivers.

Keywords: death and dying, nursing, nurse experience, palliative care, hospice care, pediatric care, perinatal care, oncology, nurse education, religious and cultural impact of death

The Caregiver's Conflict: The Toll of Death and Dying on Nurses' Mental Health and

Wellbeing

Nursing is a career that involves a wide variety of responsibilities. In the healthcare setting, nurses are the bridge between doctors, patients, and families. As nurses work with patients, they are responsible for a variety of tasks, ranging from clinical care to a supervisory role (Escrig-Pinol, 2019). These tasks differ slightly among nursing specialties, which are the areas of expertise nurses choose to focus their career in, such as pediatric care nurses or labor and delivery nurses. Regardless of nursing specialty, many tasks remain the same. Nurses across specialties are consistently communicating care plans, changes in patient condition, and potential new medications for multiple patients at a time to multiple departments in the healthcare setting (Escrig-Pinol, 2019). While all these tasks are incredibly important to maintaining an efficient healthcare facility, patient care takes priority over all else (Hagerty & Patusky, 2003).

When nurses are assigned to a patient, they are responsible for more than just that patient's care. Nurses are responsible to care for and know a patient's family, background, illness, lifestyle choices, and any risk factors they may have (Warelow et al., 2008). To obtain this knowledge and provide high quality care, nurses experience a degree of patient contact greater than some other notable healthcare professions. Physicians typically spend 25.5% of their work hours in direct contact with patients (Weigl, 2009), while nurses comparatively spend anywhere from 35.7% to 37% of their work hours in direct contact with patients (Westbrook, 2011). Combining this direct care with medication tasks, communication among the healthcare team, and indirect care, nurses spend 76.4% to 81% of their time providing care for patients (Westbrook, 2011). This high degree of patient contact contributes to the formation of what is

known as the nurse-patient relationship (NPR) (Hagerty & Patusky, 2003). The NPR tends to become a strong source of emotional support for both patients and a patient's family.

The NPR between a nurse and their patients is possibly the most important aspect of providing high quality healthcare. It is considered one of the foundations of nursing care. A patient tends to be more satisfied with their care if there is a stronger NPR (Hagerty & Patusky, 2003). A positive NPR can also influence health care outcomes (Hagerty & Patusky, 2003). The development of this relationship can be conceptualized in a linear pattern. The nurse and patient meet at the beginning of care, trust is established, and the relationship ends once the patient leaves the nurses care (Hagerty & Patusky, 2003). The theoretical applications of the NPR result in the ideal healthcare outcome. Patients receive better care when there is a stronger, more positive NPR, and the nurse moves on to new patients as soon as one's care plan has ended (Hagerty & Patusky, 2003). The practical applications of a positive NPR can be far more nuanced. Duration and intensity of care can cause nurses to become very close with a patient and that patient's family (Warelow et al., 2008). As such, it may be difficult for nurses to be completely unaffected when a patient's care ends, especially if or when that care ends with death.

Death and dying are an unfortunate part of the caregiving process, regardless of what specialty nurses choose to focus their careers in. Mortality rates vary depending on the healthcare setting and specialty. Intensive care units (ICU) can have mortality rates from 7.0%-11.3% (Ensminger et al., 2004), while hospice and palliative care units can have mortality rates ranging from 81%-96% (Harrold et al., 2005). While the impact of death on family has been extensively studied, holistic research on the mental toll death takes on nurses is limited. This paper will review the literature that examines the mental toll death has on nurses, specifically examining the

impact of nursing specialty, cultural and religious impacts, and nursing education on coping with the death and dying process.

Methods

Electronic searches utilized Google Scholar, EBSCO, and Web of Science as major databases. Searches on Google Scholar were found by a combination of searching "impacts of death on nurses" and "suicidal ideation among nurses". On EBSCO, three phrases were used to locate articles: "nurses experience" AND "death and dying" AND "mental health or mental illness or mental disorders". The phrase "death anxiety" was used in place of "mental health or mental illness or mental disorders" for several searches. When using Web of Science, the phrases "nurse experience" AND "death and dying" AND "mental health of caregivers" were used to generate results.

A total of 48 articles were found using the searches. 20 articles were eliminated due to an emphasis on the impact of death and dying on family and patients' well-being and mental health rather than the nurses. 8 articles were eliminated due to emphasis on other stressors in nurses' environment rather than the direct impact of death and dying. 6 articles were eliminated due to being dissertations or theses that were not applicable to the subject at hand. This left 14 articles that met inclusion requirements and pertained to the impact death and dying has on nurses' mental health and wellbeing.

Results

Literature on the impact of death and dying on nurses covers a wide spectrum of factors. Some literature focused on specialty impact, while others placed more emphasis on cultural and personal attitudes towards death and dying and the role these conditions play in coping with the death and dying process. Three major categories were noted as the literature was reviewed: nursing

specialty influence on death impact, cultural and religious impact on coping with death, and the role of education and support for nurses in the death and dying process.

Specialty Influence on Death Impact

Palliative Care and Hospice

Palliative care and hospice care are often used interchangeably, and while the specialties are similar and overlap in many areas, there are a few key differences (Hui et al., 2012). Hospice care specifically involves bereavement in end-of-life care and prioritizes making a patient as comfortable as possible instead of attempting to bring them back to full health (Hui et al., 2012). In contrast, palliative care involves care during advanced stages of a disease to bereavement and eventual death (Hui et al., 2012). Hospice care is considered a branch of palliative care in which treatments are ended and pain management becomes priority (Hui et al., 2012). For the purposes of this paper, both palliative and hospice care involve treating patients during the end-of-life process. As such, nurses in these specialties experience high levels of exposure to death and dying, so articles pertaining to these specialties will be reviewed together.

When compared to staff in primary healthcare, palliative nurses experienced lower levels of burnout and secondary traumatic stress (Samson & Shvartzman, 2017). This study was conducted in Israel via surveys distributed to nursing staff. Due to the nature of Israel's national healthcare system, researchers were provided with an easy way to locate the largest healthcare provider and survey the nurses there. It was shown that while palliative nurses did have greater exposure to death, the deaths they witnessed and worked with did not impact them as much as their primary care counterparts (Samson & Shvartzman, 2017). Rather than level of exposure to death being a good indicator for declining mental health, levels of work engagement were a better indicator of burnout and secondary traumatic stress. Greater work engagement indicated

higher levels of burnout and secondary traumatic stress. However, only 250 questionnaires were returned, a sharp contrast from the 850 questionnaires provided to healthcare staff (Samson & Shvartzman, 2017). There was no clarification by researchers as to which surveys were returned by palliative staff compared to primary care staff. This limitation inhibits our ability to know the proportion of palliative care responses to primary care responses; without this knowledge, we do not know how much results may have been skewed by under-coverage in one, or both, response pools.

Findings from a similar study based in Sweden provided insight into why palliative workers may experience less mental turmoil despite high levels of death exposure (Johansson & Lindahl, 2011). Qualitative interviews were conducted with eight registered nurses based in Sweden. These nurses were spread across two different hospitals and had experience in both palliative care and curative care. Interviews revealed several "themes" that highlight the unique relationship with death palliative nurses may have. Many nurses interviewed stated they felt a deep sense of gratitude to be able to help their patients through the dying process, as well as a sense of peace in palliative units due to the more comfortable rooms and overall atmosphere (Johansson & Lindahl, 2011). Palliative nurses also said that while caring for terminally ill patients was an energy draining activity, the task is very emotionally rewarding. This was especially apparent to nurses who would be providing curative care to other patients who, though unwell, are not terminally ill. Curative care was shown to be a respite for these nurses and a positive experience that allowed them to continue with more draining palliative care for other patients (Johansson & Lindahl, 2011).

This study also highlighted a kind of intuitive knowledge that experienced palliative nurses possessed without realizing it (Johansson & Lindahl, 2011). This knowledge allowed

nurses to change themselves to fit specific needs of dying patients prior to each encounter. They altered their demeanor, attitude, and the way they interacted with patients and families based on each patient's unique circumstances (Johansson & Lindahl, 2011). While adapting to your patient is often considered imperative to a nurse's caring capabilities, it appears that palliative nurses have an intuitive ability to adapt to an extent other nurses may not be familiar with. This intuitive knowledge could play a part in why palliative and hospice nurses seem to experience less negative side effects because of exposure to death and dying when compared to their primary care counterparts (Johansson & Lindahl, 2011). The small sample size of this study (n=8) is a limitation, as not enough nurses were interviewed for results to be considered widely applicable. However, these nurses' unique expertise in both palliative and curative care provides unique insight as to why palliative workers may be less impacted by high levels of exposure to death (Johansson & Lindahl, 2011). The extent of how, or why, this unique skillset of palliative nurses helps them better cope with the death and dying process is not well studied and could be expanded upon with further research.

Not only do successful palliative care nurses seem to possess intuitive knowledge on how to guide a patient and their family through the death and dying process, but they also display a level of comfortability with death not found in many other specialties (Johansson & Lindahl, 2011; Seno, 2010). A study interviewing six hospice nurses known for their skill in navigating the death and dying process found that the most successful palliative or hospice nurses are very comfortable with death (Seno, 2010). This study suffers from a small sample size (n=6), a limitation not noted by the researchers. However, the mean duration of nursing experience was 22 years, and all six nurses had a variety of healthcare experience in hospice, acute care, critical care, or intensive care (Seno, 2010). While it is important to note the study's limitations, the in-

depth interviews with these six nurses provided interesting insight as to why hospice and palliative nurses do not experience as many negative consequences from a patient's death as their primary care counterparts. These nurses cited experience as the primary component to their comfortability with death (Seno, 2010). This appears to be unique to the palliative care specialty, as literature regarding other fields of nursing did not note a correlation in death impact or attitude with experience in the field (Rivera-Romero et al., 2019; Seno, 2010).

These findings were not consistent among all palliative care workers (Croxon et al., 2017). In qualitative, semi-structured interviews conducted in rural Australia, newly graduated nurses who entered the palliative care specialty cited greater emotional damage, especially when it came to dealing with their first patient death (Croxon et al., 2017). These new grad nurses also stated they felt underprepared and overwhelmed as they entered the palliative care field (Croxon et al., 2017). The lack of preparation and education for new nurses when coping with death and dying will be addressed in greater detail in a later section.

The emotional impact of new nurses varied between the participants (Croxon et al., 2017). Some new graduates found the dying process easier to cope with, especially if they had a strong nurse-patient relationship in place. Others found death incredibly draining to deal with and were still learning how to cope with the death of their patients and move on (Croxon et al., 2017). While this study provides valuable, personal insights into palliative care for newly graduated nurses, researchers acknowledge the small sample size (n=7), female only response group, and the common university all obtained their degree from (Croxon et al., 2017). These new grad nurses also specifically worked in rural settings, forcing them to bear most of the burden of patient death and dying process (Croxon et al., 2017). While these limitations call the

findings into question, responses from the nurses interviewed show a clear correlation between death and the emotional wellbeing of newly graduated nurses (Croxon et al., 2017).

Many studies hypothesized that greater exposure to death and dying would have a negative impact on nurses' mental health and wellbeing (Croxon et al., 2017; Johansson & Lindahl, 2011; Samson & Shvartzman, 2017). Due to the nature of these specialties, hospice and palliative care often have some of the highest mortality rates by specialty, regardless of healthcare setting. According to the common hypothesis, nurses in these specialties should experience some of the greatest impact from death based on the high death rates in their units. However, the findings are much more nuanced than this hypothesis (Samson & Shvartzman, 2017; Croxon et al., 2017). Rather than specifically relying on exposure to death in palliative care, impact of death appears to stem more from time spent in the palliative unit, where that unit is located, and duration of palliative care experience (Croxon et al., 2017; Johansson & Lindahl, 2011; Samson & Shvartzman, 2017).

Intensive Care Units

Intensive care units (ICU) were designed to provide a space for patients in hospitals to remain under continuous mechanical ventilation. Over time, ICUs have adapted to allow hospitals to have a place that offers uninterrupted care to critically ill patients. The ICU is segregated to multiple units, the most notable being surgical intensive care unit (SICU), medical intensive care unit (MICU), pediatric intensive care unit (PICU), and neonatal intensive care unit (NICU) (Wenham & Pittard, 2009). For the purposes of this review, the literature regarding ICUs will be reviewed together.

Death rates in hospitals are often the highest in ICUs, with mortality rates ranging anywhere from 6% to 36% depending on location (Rivera-Romero et al., 2019). To understand

how these nurses responded to death and dying in ICUs, one study conducted a semi-structured interview with eighteen ICU nurses who had at least one year of experience working in the ICU (Rivera-Romero et al., 2019). Responses revealed two major categories: the emotional response of nurses and the care those nurses provided during the end-of-life process. Findings indicated that the closer a nurse was to the patient and their family, the greater their feelings of uselessness, sadness, and grief. The age of the patient also affected the emotional impact of death, as a younger patient dying generated stronger feelings of grief than an older patient. To cope with death and dying in healthcare, some nurses generated distant attitudes towards their patients to avoid becoming attached, while other nurses felt inadequate and untrained to perform end of life care.

The sample size of this study (n=18) is too small for results to be statistically significant, as is the trend with many studies assessing the impact of death and dying on nurses. Researchers attempted to mitigate this by assessing interviewers' communication and interaction capabilities prior to interviewing participants, and the questions were carefully analyzed to allow participants to give accurate answers that would enrich analysis. Volunteers' years of experience and ages varied from one to fifteen years in the ICU and 28 to 50 years of age. This wide range of ages and experience, along with careful researcher analysis, provides unique insight onto the impact of death. Age and experience in the ICU did not appear to influence the impact of death on nurses' emotional and mental wellbeing. Rather, the impact of death was correlated with the strength of nurse-patient relationship and the age of the patient (Rivera-Romero et al., 2019).

The impacts of an emotionally distant nurse are difficult to ignore. Families and patients often do not receive high quality end of life care, as the concept of death tends to be uncomfortable for nurses, especially in primary care settings like ICUs (Rivera-Romero et al.,

2019; Seno, 2010). Nurses who are comfortable with death are found to provide the best end-of-

life care (Seno, 2010). An interesting comparison is found between palliative and ICU nurses.

Both specialties experience high mortality rates, yet palliative care nurses are shown to be more

comfortable with death and have a less negative impact from high levels of death exposure

(Rivera-Romero et al., 2019; Samson & Shvartzman, 2017). This may stem from the intuitive

knowledge palliative nurses appear to possess, as discussed in a previous section (Johansson &

Lindahl, 2011). This knowledge may allow palliative nurses to be more comfortable with death

than their ICU counterparts (Johansson & Lindahl, 2011; Rivera-Romero et al., 2019; Samson &

Shvartzman, 2017; Seno, 2010).

Another impact on the death and dying process is cultural disparities between ICU nurses

and families of patients. A study utilizing focus group interviews in Australia found that quality

of end-of-life care in the PICU setting differed from Anglo-Australian nurses and families of

patients from a variety of linguistic and cultural backgrounds (McKinley & Blackford, 2001).

Interviews were qualitative and allowed nurses to freely respond without coercion or influence

from the interviewer. These interviews revealed that understanding of death differed between

nurses and these families. This created a disparity between the two parties, as hospital policies

reflected nursing understanding of death, and the culturally diverse families suffered because of

it. These cultural disparities added greater stress to PICU nurses at this hospital, and along with

the already high emotional stress of working in an ICU setting specifically with children, the

emotional impact was heightened (McKinley & Blackford, 2001; Rivera-Romero et al., 2019).

This study from Australia has a small sample size (n=6), which is a limitation noted by

the researchers (McKinley & Blackford, 2001). The cause of this small sample size was the

specific requirements these PICU nurses had to meet to be included in the study. The selected

nurses had direct experience with communicating with culturally diverse families whose child

eventually died while in the PICU. However, the hospital these nurses worked at experienced

high levels of cultural disparity, as around 30% of children admitted to the PICU were from

culturally diverse families (McKinley & Blackford, 2001). Elevated levels of stress were noted

in PICU nurses dealing with culturally diverse families, on top of the fact that they were dealing

with children in an intensive care setting (McKinley & Blackford, 2001; Rivera-Romero et al.,

2019).

Pediatric, Perinatal, and Obstetrics Units

Pediatric and perinatal units specialize in care regarding children and newborns (Woods,

2005). Obstetric units are another term for labor and delivery units, which specialize in maternal

care throughout a pregnancy, delivery of a newborn, and care for a newborn immediately after

delivery (Ben-Ezra et al., 2014; Woods, 2005). As these specialties all deal with young patients,

the literature regarding these units will be reviewed together.

Data from Woods' dissertation regarding death impact on labor and delivery nurses was

compiled from a large variety of studies spanning multiple disciplines, and interviewing as many

as 194 nurses for some studies (Woods, 2005). Findings indicate that nurses feel greater distress

following the death of a young patient when compared to the death of an older patient. The wide

span of data and large sample sizes adds to the validity of the findings and collaborates earlier

research regarding levels of death exposure and nurses' mental health and wellbeing (Samson &

Shvartzman, 2017; Woods, 2005). However, given this is a dissertation, a severe limitation is

that the paper is not peer reviewed.

Death is not as common in pediatric or perinatal units, but the emotional response to pediatric or perinatal death is much stronger (Woods, 2005). As indicated in earlier studies, the younger a patient is the higher the impact of death on nurses tends to be (Rivera-Romero et al., 2019; Woods, 2005). Findings regarding this are consistent with the literature regarding pediatric and perinatal death (Woods, 2005). These results are similar with findings from articles analyzed in previous sections, indicating that higher levels of death exposure are shown to increase levels of stress or burnout for nurses, with the exception of palliative care nurses (Samson & Shvartzman, 2017; Woods, 2005). When analyzing fetal demise experiences for labor and delivery nurses, distress scores were highest for nurses who cared for bereaved mothers and deceased fetuses extremely often, while they were lowest for nurses who performed these cares infrequently (Woods, 2005). Levels of preparedness also played a role in distress as a response to fetal demise. Nurses who felt more prepared to deal with fetal demise experienced greater levels of distress, while nurses who felt less prepared to handle fetal demise reported lower levels of distress (Woods, 2005).

The correlation between levels of preparedness and distress levels runs contrary to findings in other studies, as nurses across the literature consistently cited lack of preparedness as a major stressor when facing end-of-life care (Croxon et al., 2017; McKinley & Blackford, 2001; Rivera-Romero et al., 2019; Seno, 2010; Woods, 2005). Whether the levels of preparedness cited by labor and delivery nurses reflects overconfidence rather than superior education and training is unknown (Woods, 2005).

A longitudinal and cross-sectional study was conducted with nurses who worked in a medical center in Israel known for its high volume of patients (Ben-Ezra et al., 2014). Results from this study show an increase in post-traumatic stress disorder (PTSD) symptoms, depressive

symptoms, and psychosomatic symptoms after nurses were exposed to perinatal death. When compared to nurses who had not been exposed to perinatal death, there was a significant discrepancy between exposed nurses versus unexposed nurses. While the initial sample size was 70, only 27 nurses gave consent for the study. This 39% response rate is similar to past studies regarding hospital personnel working in extreme conditions. However, the sample size is less than 30, making it smaller than necessary to be considered statistically significant. Researchers attempted to mitigate this by ensuring sample size (n=27) were consistent across the longitudinal study conducted and the cross-sectional study (Ben-Ezra et al., 2014).

Nurses in pediatric, perinatal, and labor and delivery units are shown to be at greater risk for harmful impacts from patient death due to traits many of these nurses appear to possess (Ben-Ezra et al., 2014; Woods, 2005). Obstetric nurses tend to be extremely empathetic and show a tendency to blame themselves for infant or fetus death (Ben-Ezra et al., 2014). This may be due to their proximity to fetuses in the delivery room, as obstetric nurses are often the closest to infants as they are delivered (Ben-Ezra et al., 2014). These studies all indicate that level of exposure to death plays a role in nurses mental health, and that the young age of these patients worsens the symptoms (Ben-Ezra et al., 2014; Rivera-Romero et al., 2019; Samson & Shvartzman, 2017; Woods, 2005).

Oncology Units

Oncology units specialize in treating cancer patients, from the time they are admitted until they are either in remission or dead. Research indicates that even as cancer treatments are improving, the levels of oncology nurse emotional exhaustion and burnout is rising (Philips & Volker, 2019).

One of the biggest contributors to oncology nurses' emotional fatigue is inadequate time or space to grieve patient losses. One study interviewed seven oncology nurses who were members of the Central Texas Oncology Nursing Society to gather data on the impact of death on oncology nurses (Philips & Volker, 2019). These nurses had an average of 10.6 years of oncology experience were interviewed. The interview was semi-structured and allowed participants' freedom of responses, and from the responses themes among oncology nurses were established. These oncology nurses described an initial "all in and then" where they were completely emotionally invested in their patients, followed quickly by an intense emotional low after their first significant patient loss. This was often followed by complete emotional withdrawal to cope with patient death. This coping mechanism is reflected by other studies focusing on nurses in the ICU (Philips & Volker, 2019; Seno, 2010). Several of the nurses in this study had to leave oncology for a time to recover from the emotional turmoil they experienced (Philips & Volker, 2019). Participants cited they received no formal education for dealing with their own or other emotions. Due to the small sample size (n=7), results from this study cannot be widely applied to all oncology nurses (Philips & Volker, 2019). However, the length of these nurses' experience in oncology and the cumulative number of patient losses provides unique insight on the emotional toll of oncology.

A study in China found that for many Chinese oncology nurses, their age played a role in how much the death and dying process added to their emotional distress (Zheng et al., 2015). This study was conducted with semi-structured interviews and a sample of 28 nurses who had all cared for terminally ill patients in mainland China. Chinese oncology nurses stated that emotional distress was suffered due to the stigma around death in Chinese culture. The impact of these cultural attitudes will be analyzed in greater detail in the following section. Findings from

this study indicated that a nurse's age played a part in how much death impacted nurses' mental health. Younger nurses were incredibly affected by what they described as "moral distress" due to the conflict of providing quality care and the expectations of their culture. In contrast, older nurses did not experience the same levels of emotional or moral distress and were shown to have an easier time coping with the death and dying process. This contrasts with studies conducted on ICU nurses, where a nurse's age did not appear to influence the impact of deaths in their units (Rivera-Romero et al., 2019) Despite emotional distress caused by the death and dying process, many of the nurses cited personal and professional growth due to providing end of life care, even if their culture does not allow them to call it that (Zheng et al., 2015).

The sample size (n=28) of this study is not large enough for results to be considered widely applicable to all Chinese nurses. However, researchers located participants through a series of requirements to eliminate lurking variables, which is likely the source of the small sample size. All participants had to have experience working with dying oncology patients for at least six months, be eighteen years or older, be a willing participant, and speak Chinese (Zheng et al., 2015). All twenty-eight participants met these requirements and provided answers via a semi-structured interview, which was pretested on two nurses to ensure the questions were valid. Despite the short sample size, the findings provide unique insight onto the impact of a nurse's age in oncology units and the ways it may add further stressors to the work environment (Zheng et al., 2015). Oncology nurses seem to experience greater levels of emotional turmoil beyond the death and dying process of their patients, as additional stressors seem to worsen the impact of a patient's death (Philips & Volker, 2019; Zheng et al., 2015).

Cultural and Religious Impact on Coping with Death

Reviews of the literature surrounding death and dying revealed that culture and religion may play a greater role on the impact of death than nursing specialty. While age of patients and strength of relationships play a major role in death impact on nurses' mental wellbeing, the cultural and religious impacts are important to analyze (McKinley & Blackford, 2001; Mercer & Feeney, 2009; Rivera-Romero et al., 2019; Woods, 2005; Zheng et al., 2015).

Cultural Impact

Chinese oncology nurses experience a unique culture surrounding death and dying (Zheng et al., 2015). Death and dying in Chinese culture are considered extremely taboo, and death is never discussed with cancer patients even when it is a very likely outcome of their treatment. Nurses rarely even used the term "end-of-life care", but the care provided matches the principles utilized in western end-of-life care. This provided an additional stressor to the dying process as oncology nurses tried to navigate the taboo death culture with a dying patient and said patient's families. Younger nurses were particularly affected by this moral dilemma, and many Chinese oncology nurses stated these attitudes made it difficult for them to perform quality end of life care, as they could rarely discuss death in blatant terms due to cultural expectations (Zheng et al., 2015).

Another study was conducted to examine the impact of cultural differences on hospice nurses as they worked with death and dying (Mercer & Feeney, 2009). Interviews with four British hospice nurses were compared with identical interviews from four Filipino nurses (Mercer & Feeney, 2009). Like the Chinese oncology nurses, the culture of the British and Filipino hospice nurses greatly impacted their perception of death (Mercer & Feeney, 2009; Zheng et al., 2015). Findings indicated that Filipino nurses seemed to resist the ideals of hospice philosophy (Mercer & Feeney, 2009). These ideals of hospice revolve around allowing patients

to "letting patients die with dignity". Interviewed Filipino nurses had a difficult time "letting" a

hospice patient die and felt they were not allowed to try to save their life. As with the Chinese

oncology nurses, these added cultural stressors worsened the death impact (Mercer & Feeney,

2009; Zheng et al., 2015). Whether this was due to the taboo around death in their culture, like

with the Chinese oncology nurses, was not addressed in this study. The British focus group was

more inclined to embrace hospice ideals of a good and dignified death and found a sense of

peace from fulfilling their role as a hospice nurse (Mercer & Feeney, 2009). Helping patients

have a good death and helping families understand that their loved one had a good death

provided a sense of purpose for the British nurses. The cultures surrounding these two groups

appeared to influence how well they were able to cope with patient death and how much these

deaths impacted their wellbeing, which resembles findings from the study involving Chinese

oncology nurses (Mercer & Feeney, 2009; Zheng et al., 2015).

The small sample size of this study (n=8) is a limitation of the research (Mercer &

Feeney, 2009). This was mitigated by inclusion criteria implemented by researchers. This

criterion included being employed by the hospice organization of interest for at least two years to

ensure hospice experience and be fluent in English due to the nature of data collection. The

requirement of fluency is another limitation of the study. While necessary due to the data

collection method, this limits the Filipino nurses who could be interviewed, as many Filipino

hospice nurses may not be fluent in English and could therefore not be included in the study. Not

only this, but only one male nurse was included in this study. All the British nurses were female,

and all but one of the Filipino nurses were also female. This illustrates skewed gender

demographic in the sample taken. There was also a difference in range of experience working in

hospice. All participants were required to work a minimum of two years, and the British nurses

had a range of three to 13 years of experience while all four Filipino nurses had only worked

three years. Researchers stated that these discrepancies were reflective of the different

demographic patterns of hospice workers based on culture, and therefore would not interfere

with their findings (Mercer & Feeney, 2009).

A nurse's personal culture is not the only stressor that may be added when performing

end-of-life care (McKinley & Blackford, 2001). Conflicts between a nurse's culture and the

patient's culture can complicate patient care and add increased stress to the dying process. The

most notable of these discrepancies was a language barrier (McKinley & Blackford, 2001). If a

family could not understand the signs posted throughout the hospital or instructions from

healthcare personnel, confusion and misunderstanding between hospital staff and a patient's

families arose frequently. This further complicated the death and dying process, as sensitive

information would often be misunderstood by families or nurses (McKinley & Blackford, 2001).

Nurses faced with these cultural disparities felt an added burden of providing adequate care, as

they were concerned that the culture of the hospital did not allow them to properly help families

through the death and dying process. This added stress worsened the death impact on PICU

nurses' mental health and overall wellbeing (McKinley & Blackford, 2001).

Religious Impact

Nurses across specialties have noted the importance of religion in both their lives and in

the lives of their patients (McKinley & Blackford, 2001; Woods, 2005; Zheng et al., 2015).

Chinese oncology nurses paid special attention to patients' religious background and noted that

despite the taboo around death, spirituality had a positive influence for their patients (Zheng et

al., 2015). None of the nurses interviewed in this study reported utilizing spiritual support of

their own for coping with death and dying in oncology (Zheng et al., 2015).

This contrasts with other studies of nurses in the western hemisphere. Woods'
dissertation cited a qualitative study of interviews with NICU nurses in the United States who
stated that speaking to pastors or chaplains were important aspects of stress management, as well
as praying (Woods, 2005). ICU nurses based in the United States in another semi-structured
interview cited religion as a major coping mechanism when dealing with the death of a patient
(Woods, 2005). Nurses in this study noted that religious beliefs and support decreased their
distress in response to death and dying and helped them accept the death of patients with less
grief (Woods, 2005).

Nurses' Education Impact on the Death and Dying Process

As noted in previous sections, rates of compassion fatigue, burnout, secondary traumatic
stress, and PTSD are increasing in nurses across specialties, except for palliative care nurses
(Ben-Ezra et al., 2014; Samson & Shvartzman, 2018). While much of this decrease in nurses'
mental health can be attributed to high levels of death exposure, a large portion can be attributed
to lack of end-of-life care curriculum in nursing schools (Croxon, 2017; Rivera-Romero et al.,
2019; Seno, 2010; Wallerstedt & Andershed, 2007). Past studies indicated that there were no
major gaps in nursing education in regard to the death and dying process, however, more modern
research shows a need for more formal training for end-of-life care (Thompson, 1986;
Wallerstedt & Andershed, 2007).

When Edward Thompson (1986) conducted his study of palliative and curative care
nurses' attitudes towards death and dying, his findings showed that despite high exposure to
death and dying, nurses tended to have a positive outlook on their careers and life. Thompson
gave fifty-two nurses surveys to be completed on their own time. The nurses all worked full time
day shifts and returned responses under promises of anonymity. Findings showed that nurses'

anxiety surrounding death was associated with the unit they worked in, whether it be pediatric, surgical, or palliative units. Palliative care nurses were shown to have lower levels of death anxiety, while pediatric nurses had some of the highest levels. Findings also showed that nursing education at the time was efficiently preparing nurses for dealing with end of life, and none of the nurses cited being underprepared by their education as a source of stress. The sample size (n=52) was large enough to be considered statistically significant, but the responses only included one male nurse, and all the nurses sampled came from the same hospital (Thompson, 1986). Researchers noted that experience did not play a significant role in death impact, a finding that is noted in more recent research regarding ICU nurses as well (Rivera-Romero et al., 2019; Thompson, 1986). At the time, researchers also did not note any discrepancies in nursing education (Thompson, 1986). However, more recent studies have called some of these findings into question and discrepancies in nursing education have been noted in more recent years. (Ben-Ezra et al., 2014; Samson & Shvartzman, 2018). This emphasizes a need for end-of-life training in modern nursing education that is no longer being filled.

Nurses working with end-of-life care have a great need for support, education, and preparation to provide quality end of life care. A more recent study was conducted to see if death and dying was the greatest contributor to work-related stress (Wallerstedt & Andershed, 2007). Researchers in this study collected information through qualitative interviews with nine nurses. Findings showed that poor management and leadership left nurses feeling unsupported and their needs unmet, adding greatly to work-related stress. In interviews with researchers, nurses stressed how important support, education, and preparation was for dealing with patients and families during the death and dying process. Notable gaps in both workplace support from management and the nurse's education were noted in the qualitative interviews. The small

sample size (n=9) is a limitation acknowledged in the study, as well as clinical knowledge the

interviewers already had that may have influenced follow up questions asked to the nurses during

this interview (Wallerstedt & Andershed, 2007).

Findings from this study contrast with research from Thompson (1986), indicating that

nurses may have a greater need for end-of-life education now than they did in the past. This need

is noted across many other articles mentioned earlier. Complaints of lack of education were

echoed in other studies regarding dealing with end of life (Rivera-Romero et al., 2019;

Wallerstedt & Andershed, 2007). ICU nurses complained of lack of confidence and training

regarding end-of-life care (Rivera-Romero et al., 2019).

Newly graduated nurses in particular cited lack of education and preparation when faced

with death and dying as a major stressor (Croxon et al., 2017). These specific newly graduated

nurses worked in palliative care, a specialty that centers on the death and dying process. Despite

this specialty emphasis on death and dying, nurses in palliative and hospice still reported having

to learn on the job and not having much, if any, formal training for helping families and patients

through the death and dying process (Croxon et al., 2017).

Oncology nurses cited lack of education on coping with death and dying as a source of

stress (Philips & Volker, 2019). These nurses specifically cited unpreparedness for dealing with

their own or others' emotions from their formal education. As emotional support tends to be a

major component of effective caregiving from nurses, a lack of emotional regulation education

could be a worrying failure of current nursing education in the training of new nurses (Philips &

Volker, 2019).

As these complaints of lack of education and training are repeated from nurses regardless

of specialty, age, experience, or culture, it is apparent that nurses are no longer adequately

prepared for end-of-life care even if past research may have indicated otherwise (Ben-Ezra et al., 2014; Croxon, 2017; Rivera-Romero et al., 2019; Samson & Shvartzman, 2018; Seno, 2010; Thompson, 1986; Wallerstedt & Andershed, 2007).

Discussion

The research shows that while all death appears to have an impact on nurses' mental health, there are factors and circumstances that worsen death impact. The age of a patient and specialty of nurse appear to play a role in the emotional turmoil a nurse experiences because of patient death. Younger patient death is shown to have a greater impact across studies. Nurses who traditionally deal with young patients, such as pediatrics, perinatal, and oncology, were shown to experience more emotional backlash from deaths than palliative or hospice care counterparts. While the specialty and age of patients played an important role, religion and culture also affected death impact. Nurses whose cultures traditionally had taboo attitudes toward death and dying were shown to experience greater emotional hardship from death. This effect was also noted when there were cultural discrepancies between patients and nurses. While culture and religion could have a negative influence on the impact of death, they could also be help nurses cope with the death and dying process. Religious beliefs from nurses helped to lessen the emotional consequences of a patient's death. Throughout the studies, the biggest stressor nurses across specialties and cultures complained of was lack of education and preparation for dealing with the death and dying process.

Many of these articles had similar limitations regarding their research methods. Most of the research was conducted using qualitative interviews with small sample sizes. Most nurses selected were from the same hospitals, care facilities, or nursing programs. While the in-depth, semi structured interviews allowed nurses to elaborate on their personal experiences with death and dying, the sample sizes were rarely large enough to make findings widely applicable. There

was also a lack of male nurses interviewed; however, this is likely due to nursing being a female dominated career, and it may have been more difficult for researchers to find and locate willing male nurse volunteers. Research across studies attempted to mitigate these limitations with thorough question and response analysis to eliminate confounding variables of research. Most research regarding death impact on nurses is not current, however, more recent studies are focusing on the impact COVID-19 has had on nurses, rather than the impact of death itself.

Future research should incorporate larger sample sizes of nurses from a variety of educational backgrounds to shed further light on the mental and emotional toll death and dying takes on nurses. Nurses from a variety of educational backgrounds should be incorporated into studies, as current research indicates preparedness from nursing education may play a large role in death impact. The impact of nursing education quality and how that relates to death impact is an area that needs to be further studied. Nurses across studies complained of lack of education and preparedness for the death and dying process and end of life care, even in palliative and hospice units that specialize in caring for dying patients. Gaps in nursing education need to be filled regarding this issue to ensure high quality care for patients and prospering emotional health and wellbeing for the nurses that care for them. Without changes to nursing education, nurses will continue to feel overwhelmed and underprepared in the face of death, something that comes so often given the nature of their career. Along with this, the negative impact death has on nurses highlights a need for greater support from healthcare facilities. Death and dying impacts everyone who witnesses the process. Regardless of their training or the expectations of their career, nurses are no exception to this and need greater amounts of education and support in order to provide high quality care to patients and their families while also preserving their own mental health and wellbeing.

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