World of Health — OFFICIAL JOURNAL OF EUROPEAN SPECIALIST NURSES ORGANISATION

Review

# HEALTHCARE PROFESSIONALS' EXPERIENCES OF COPING WITH PATIENT DEATH AND IMPLICATIONS FOR HEALTHCARE QUALITY: A STRUCTURED NARRATIVE REVIEW

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*DOI: https://doi.org/10.65241/wh.9.1.7*

*For citation: Marinic R, Filipovic B, Ilic B, Joka A, Rotim C, Friganovic A. Healthcare professionals' experiences of coping with patient death and implications for healthcare quality: A structured narrative review. World of Health. 2026:1(9):52-56. https://doi.org/10.65241/wh.9.1.7*

***Received: 20 January 2026** | **Revised: 3 March 2026** | **Accepted: 6 March 2026***

## ABSTRACT:

**Background:** Healthcare professionals working in palliative and end-of-life settings are repeatedly exposed to patient death, which may affect emotional well-being and healthcare quality. Aim: To synthesize literature on healthcare professionals' experiences of coping with patient death and examine implications for professional well-being and healthcare quality.

**Methods:** A structured narrative review was conducted. Databases (PubMed, Scopus, Web of Science, PsycINFO, ProQuest, EBSCOhost, Hrčak, Google Scholar) were searched in March 2025 using predefined Boolean combinations and MeSH terms. Studies published between 2013 and 2025 in English or Croatian were eligible. Findings were synthesized thematically.

**Results:** Twelve studies met inclusion criteria. Emotional burden, coping strategies, educational preparedness, and organizational influences were identified as key domains.

**Conclusions:** Structured education, supervision, and organizational support may mitigate emotional burden and maintain high-quality patient-centred care.

***Keywords:*** *Death, Adaptation, Psychological, Nurses, Palliative Care, Professional Burnout, Quality of Health Care.*

## INTRODUCTION

Palliative care is an essential component of comprehensive healthcare, aimed at improving the quality of life of patients with life-limiting illnesses and their families through the prevention and relief of suffering. According to the World Health Organization, palliative care should be integrated early in the course of illness and provided alongside curative treatment when appropriate (1). Despite this, palliative care is still frequently perceived primarily as end-of-life care, which limits its timely implementation and broader understanding of its scope (2). Previous research has largely focused on the experiences, needs, and outcomes of patients and their families receiving palliative care (3). These studies emphasize symptom control, psychological support, effective communication, and respect for patient dignity as key components of quality care (4). However, an exclusive focus on patients may overlook the experiences of healthcare professionals who deliver this care and who are repeatedly exposed to suffering, dying, and death. Healthcare professionals involved in palliative and end-of-life care face unique emotional and professional challenges. Repeated exposure to patient death may evoke grief, emotional exhaustion, moral distress, and anxiety, and may contribute to burnout and reduced job satisfaction (5,6). Many healthcare professionals report insufficient preparation for managing emotional and communicative demands associated with death and dying, particularly when supporting patients' families (7). Although individual studies have explored aspects of healthcare professionals' experiences of patient death, the available evidence remains fragmented (8-19). There is limited synthesis of how healthcare professionals cope with patient death across different clinical settings and how these experiences influence the quality of healthcare delivery. Furthermore, organisational, and educational factors that may mitigate negative outcomes remain insufficiently addressed. Therefore, a focused review of existing literature is needed to synthesise current knowledge on how healthcare professionals experience and cope with patient death and to examine the implications of these experiences for professional well-being and healthcare quality. The aim of this review was to analyse existing literature on healthcare professionals' experiences of coping with patient death and to examine the implications of these experiences for professional well-being and healthcare quality.

# METHODS

A structured narrative review design was applied to synthesise existing evidence on healthcare professionals' coping experiences related to patient death. Relevant studies published between 2013 and 2025 were identified through a structured search of electronic databases, including Hrčak, PubMed, Scopus, PsycINFO, Web of Science, ProQuest, EBSCOhost/Academic Search Premier, and Google Scholar.

## SEARCH STRATEGY

The search strategy combined free-text keywords and controlled vocabulary.

The following keyword combinations were used:
(death OR dying) AND (coping OR coping strategies) AND (healthcare professionals OR nurses) AND (palliative care OR end-of-life care). Where applicable, Medical Subject Headings (MeSH) terms were used, including "Death," "Palliative Care," "Health Personnel," and "Adaptation, Psychological." Database-specific adaptations were applied.

## INCLUSION AND EXCLUSION CRITERIA

Studies were included if they:

- addressed healthcare professionals' experiences of coping with patient death;
- involved professionals working in palliative, end-of-life, intensive, emergency, or related care settings;
- were published between 2013 and 2025; and were available in English or Croatian.

Exclusion criteria included editorials, letters, and articles not addressing coping with patient death among healthcare professionals.

The eligibility criteria were predefined to ensure transparency and consistency in the study selection process. Inclusion and exclusion criteria were developed based on the research aim and focused on empirical studies examining healthcare professionals' experiences of coping with patient death. Studies were required to involve healthcare professionals working in palliative, oncology, intensive care, emergency, or related clinical settings and to be published between 2013 and 2025 in English or Croatian. Non-empirical publications, studies not addressing coping with patient death among healthcare professionals, and articles published before 2013 were excluded. The detailed inclusion and exclusion criteria are presented in Table 1.

Table 1. Inclusion and exclusion criteria.

| Category | Inclusion criteria | Exclusion criteria |
|---|---|---|
| Study focus | Studies addressing healthcare professionals' experiences of coping with patient death | Articles not addressing coping with patient death among healthcare professionals |
| Population | Nurses and other healthcare professionals working in palliative, oncology, ICU, emergency, or related settings | Studies focused exclusively on patients or families |
| Study design | Qualitative, quantitative, cohort, integrative, or scoping reviews with empirical data | Editorials, letters, conference abstracts, opinion pieces |
| Publication period | 2013–2025 | Published before 2013 |
| Language | English or Croatian | All other languages |

## STUDY SELECTION AND QUALITY ASSESSMENT

The study selection process was conducted in a structured, stepwise manner. After removal of duplicate records, titles and abstracts were screened according to predefined inclusion and exclusion criteria (20). Potentially eligible articles were retrieved in full text and assessed for final eligibility. Reasons for exclusion at the full-text stage were documented. A total of twelve studies met the eligibility criteria and were included in the final synthesis. The selection process is presented in Figure 1.

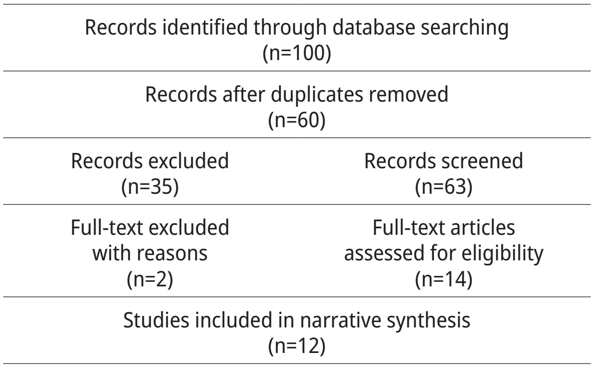

Figure 1. PRISMA 2009 flow diagram of study selection process.

## LANGUAGE LIMITATIONS

Only studies published in English and Croatian were included, which may have resulted in the exclusion of relevant studies published in other languages. Due to the narrative design of the review, no validated critical appraisal tool (e.g., JBI or CASP) was applied. Methodological quality was assessed descriptively based on study relevance, clarity of objectives, and methodological transparency. This approach may introduce subjective bias and is acknowledged as a limitation. Findings were synthesised thematically due to heterogeneity in study design, populations, and clinical settings.

## RESULTS

A total of twelve studies met the predefined inclusion criteria and were included in the final narrative synthesis. The included studies were conducted across diverse geographical contexts, including Australia, Croatia, Iran, Indonesia, Japan, Spain, Denmark, the Netherlands, and the United States. Methodological approaches varied and included qualitative studies, cohort studies, integrative reviews, scoping reviews, and systematic reviews. Most studies focused primarily on nurses, although several involved broader healthcare professional groups. Zheng et al. (2018) reported that nurses experienced emotional distress and relied heavily on peer support following patient death (8). Similarly, Rabbetts et al. (2019) described emotional strain and limited professional support among home-based palliative nurses (9). Bloomer et al. (2023) highlighted grief and emotional exhaustion among ICU nurses (10). Novak (2014) found that approximately 25% of nurses reported symptoms consistent with burnout (11). Rahnama et al. (2023) identified emotional and ethical conflicts in end-of-life care (12). Mu et al. (2019) reported communication challenges and emotional strain in paediatric ICU settings (13). Betriana and Kongsuwan (2020) emphasised the importance of religious coping and social support (14). Hirata and Kobayashi (2023) discussed hope and uncertainty in paediatric end-of-life decision-making (15). Puente-Fernández et al. (2020) reported significant emotional impact and avoidance coping (16). Madsen et al. (2023) identified variability in nursing interventions for grief support (17). Collet et al. (2022) emphasised person-centred communication (18). Geller and Evans (2020) reported limited preparedness among emergency staff (19). The main characteristics and key findings of the included studies are summarised in Table 2.

Table 2. Summary of included studies.

| Author, Year | Country | Design | Sample | Key findings |
|---|---|---|---|---|
| Zheng et al., 2018 | Australia | Qualitative | N=16 | Nurses reported emotional distress and reliance on peer support following patient death. |
| Rabbetts et al., 2019 | Australia | Qualitative | N=12 | Home-based palliative nurses described emotional strain and limited professional support. |
| Bloomer et al., 2023 | Australia | Integrative review | — | Nurses experienced grief and emotional exhaustion after patient death in ICU settings. |
| Novak, 2014 | Croatia | Cohort | N=102 | Approximately 25% of nurses reported symptoms consistent with burnout. |
| Rahnama et al., 2023 | Iran | Qualitative | N=8 | Nurses experienced emotional and ethical conflicts in end-of-life care. |
| Mu et al., 2019 | USA | Qualitative review | — | Nurses reported communication challenges and emotional strain in paediatric ICU settings. |
| Betriana & Kongsuwan, 2020 | Indonesia | Qualitative | N=14 | Religious coping and social support were central coping mechanisms. |
| Hirata & Kobayashi, 2023 | Japan | Systematic review | — | Hope and uncertainty were key elements in paediatric end-of-life decision-making. |
| Puente-Fernández et al., 2020 | Spain | Systematic review | N=17 | Death had significant emotional impact; avoidance coping was reported. |
| Madsen et al., 2023 | Denmark | Scoping review | N=22 | Variability in nursing interventions for grief and bereavement support. |
| Collet et al., 2022 | Netherlands | Qualitative review | N=50 | Person-centred communication improved patient experiences. |
| Geller & Evans, 2020 | USA | Integrative review | N=16 | Emergency staff reported limited preparedness for end-of-life situations. |

Twelve studies were included in the final synthesis. Most studies employed qualitative methodologies and predominantly involved nurses, although some included multidisciplinary healthcare teams. Across studies, healthcare professionals reported grief, sadness, emotional exhaustion, helplessness, and moral distress following patient death. Emotional burden was particularly pronounced in intensive care units and paediatric settings. In some studies, approximately one-quarter of nurses reported symptoms consistent with burnout. Frequently reported coping mechanisms included peer support, informal debriefing, emotional distancing, reflective practice, meaning-making, and religious or spiritual coping. While many professionals relied on personal resilience and collegial support, structured psychological support was inconsistently available. Several studies highlighted insufficient formal education in end-of-life communication and coping strategies. Professionals reported feeling inadequately prepared to manage conversations with families and to process their own emotional reactions. Training programmes and supervision were associated with improved perceived preparedness and confidence. Organisational conditions significantly influenced coping capacity. Staffing shortages, workload pressures, limited supervision, and inadequate institutional support increased emotional strain. In contrast, interdisciplinary collaboration and supportive leadership were associated with improved resilience and quality of care.

## DISCUSSION

This structured narrative review synthesised findings from twelve studies examining healthcare professionals' experiences of coping with patient death across diverse clinical contexts. The identified thematic domains—emotional impact, coping strategies, education and supervision, and organisational factors—demonstrate that coping with patient death is not solely an individual psychological process, but a phenomenon with broader implications for healthcare systems and quality of care. The emotional burden consistently described across studies aligns with established models of occupational stress and burnout. Emotional exhaustion and moral distress may influence professionals' cognitive functioning, communication patterns, and interpersonal engagement. In end-of-life care contexts, where communication sensitivity and relational continuity are central to quality care, unaddressed emotional strain may compromise empathic engagement and shared decision-making processes. From a healthcare quality perspective, coping capacity can be conceptualised as an underlying structural determinant of care quality. Healthcare professionals experiencing cumulative emotional strain may demonstrate reduced tolerance for complex interactions, increased avoidance behaviours, or diminished reflective capacity. Although the included studies did not directly quantify patient-level outcomes, the association between burnout and reduced professional performance has been widely documented in broader healthcare literature. Therefore, insufficient support for coping with patient death may indirectly affect patient satisfaction, continuity of care, and team functioning. Education and structured supervision appear particularly relevant in this context. Training in end-of-life communication and grief processing enhances perceived competence, which may translate into improved patient and family interactions. Competence and confidence in managing emotionally demanding situations are essential components of patient-centred care. In this sense, educational preparedness can be viewed as a modifiable factor contributing to quality improvement initiatives. Organisational factors further mediate the relationship between coping and care quality. Supportive leadership, formal debriefing opportunities, and adequate staffing levels were associated with greater professional resilience. Organisational environments that acknowledge emotional burden may foster psychological safety, which is increasingly recognised as fundamental to high-quality team performance. Conversely, environments characterised by high workload and limited institutional recognition of emotional strain may amplify burnout risk and negatively affect collaborative practice. Importantly, the findings suggest that coping with patient death should not be framed solely as an individual competency deficit. Instead, it should be addressed as part of broader healthcare quality strategies that integrate workforce well-being into system-level planning. Quality of care is inseparable from the well-being of the professionals who deliver it. Policies aimed at strengthening emotional support structures, supervision models, and communication training may therefore contribute simultaneously to workforce sustainability and patient-centred care standards. Future research should explicitly investigate the relationship between coping mechanisms, burnout indicators, and measurable quality outcomes, such as patient satisfaction, communication effectiveness, and interdisciplinary coordination. Integrating workforce well-being metrics into quality assessment frameworks may provide a more comprehensive understanding of healthcare performance.

## LIMITATIONS

This structured narrative review did not include formal methodological quality appraisal using validated tools, which may limit reproducibility. The restriction to studies published in English and Croatian may have excluded relevant research. Furthermore, the predominance of qualitative studies and focus primarily on nurses may limit generalisability to other healthcare professions.

## CONCLUSION

This structured narrative review synthesised current evidence on healthcare professionals' experiences of coping with patient death and underscored the multidimensional nature of this challenge. Across diverse healthcare systems, patient death was consistently associated with emotional burden, including grief reactions, moral distress, and symptoms of burnout. Coping strategies were predominantly informal and individually driven, while structured educational and organisational supports were inconsistently available. Findings indicate that coping with patient death should not be conceptualised solely as an individual psychological task, but rather as a systemic issue embedded within healthcare delivery structures. Educational preparedness, access to supervision, and institutional recognition of emotional strain appear central to strengthening professional resilience. Healthcare organisations that implement structured support mechanisms may not only improve workforce sustainability but also reinforce conditions necessary for high-quality, patient-centred care. From a policy perspective, the results suggest that workforce well-being should be integrated into healthcare quality frameworks and strategic planning. Emotional support structures, communication training in end-of-life care, and formal debriefing protocols may be considered components of quality assurance rather than optional professional development activities. Policymakers and healthcare leaders should recognise that maintaining healthcare quality is closely linked to protecting the emotional and psychological well-being of professionals exposed to repeated patient loss. Although direct patient-level outcomes were not measured in the included studies, the established relationship between burnout, communication quality, and team functioning highlights the potential systemic consequences of unaddressed emotional burden. Integrating professional well-being indicators into healthcare performance evaluation systems may therefore represent a constructive step toward sustainable quality improvement. Future research should prioritise longitudinal and intervention-based designs to examine the effectiveness of structured coping support models and to clarify the relationship between workforce resilience and measurable healthcare quality outcomes. A more explicit alignment between occupational health policies and healthcare quality strategies may contribute to both professional sustainability and improved patient experiences.

## REFERENCES

1. World Health Organization. WHO definition of palliative care. Geneva: World Health Organization; 2020.
2. Radbruch L, De Lima L, Knaul F, et al. Redefining palliative care—A new consensus-based definition. Lancet Oncol. 2020;21(7):e302–e311.
3. Gomes B, Calanzani N, Higginson IJ. Benefits and costs of home palliative care compared with usual care for patients with advanced illness. J Pain Symptom Manage. 2014;47(4):784–793.
4. Singer PA, Martin DK, Kelner M. Quality end-of-life care: patients' perspectives. JAMA. 1999;281(2):163–168.
5. Maslach C, Jackson SE. The measurement of experienced burnout. J Occup Behav. 1981;2(2):99–113.
6. Epstein EG, Hamric AB. Moral distress, moral residue, and the crescendo effect. J Clin Ethics. 2009;20(4):330–342.
7. Clayton JM, Hancock KM, Butow PN, et al. Clinical practice guidelines for communicating prognosis and end-of-life issues. Med J Aust. 2007;186(12):S77–S108.
8. Zheng R, Lee SF, Bloomer MJ. How nurses cope with patient death: a systematic review and qualitative meta-synthesis. J Clin Nurs. 2018;27:e39–e49.
9. Rabbetts L, et al. Experiences of rural palliative care nurses coping with patient death. Collegian. 2019;26(5):567–573.
10. Bloomer MJ, et al. Grief and emotional labour in intensive care nurses: an integrative review. Aust Crit Care. 2023;36(1):45–52.
11. Novak M. Burnout among oncology nurses. Coll Antropol. 2014;38(2):789–795.
12. Rahnama M, et al. Nurses' experiences of ethical conflicts in end-of-life care. Nurs Ethics. 2023;30(2):234–245.
13. Mu PF, et al. Paediatric ICU nurses' experiences of patient death: a qualitative review. J Clin Nurs. 2019;28(15–16):2874–2885.
14. Betriana F, Kongsuwan W. Grief reactions and coping strategies of nurses dealing with patient death. J Clin Nurs. 2020;29(15–16):3059–3070.
15. Hirata H, Kobayashi M. Hope and uncertainty in paediatric end-of-life care: a systematic review. Jpn J Nurs Sci. 2023;20(1):e12456.
16. Puente-Fernández D, et al. Emotional impact of patient death on nurses: systematic review. Int J Environ Res Public Health. 2020;17(3):1234.
17. Madsen B, et al. Bereavement interventions in oncology nursing: a scoping review. Eur J Oncol Nurs. 2023;62:102220.
18. Collet MO, et al. Person-centred communication in end-of-life care: qualitative synthesis. Patient Educ Couns. 2022;105(4):876–884.
19. Geller G, Evans M. Emergency department staff and end-of-life care preparedness: integrative review. J Emerg Nurs. 2020;46(3):321–329.
20. Moher D, Liberati A, Tetzlaff J, Altman DG; PRISMA Group. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. PLoS Med. 2009;6(7):e1000097.