Health Scope. 2023 August; 12(3):e136839. https://doi.org/10.5812/jhealthscope-136839.
Published online 2023 July 22. **Research Article**

Positive Implications of Experiencing Grief for Health Professionals in Iran: A Qualitative Study

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Received 2023 April 15; **Revised** 2023 June 11; **Accepted** 2023 June 17.

Abstract

Background: As an unavoidable experience in oncology departments, grief following a patient's death, coupled with work difficulties, can affect health professionals' individual and work performance.
Objectives: The present research was conducted to explain the positive consequences following the experience of grief for oncology nurses.
Methods: In 2021, the present qualitative study utilized content analysis and interviewed 20 nurses working in the oncology wards of hospitals affiliated with universities of medical sciences in Iran. Purposive sampling was performed, and data were collected through unstructured interviews until reaching data saturation. The data collected were analyzed in MAXQDA10 based on conventional content analysis.
Results: The main concepts were categorized into three themes and seven subthemes. The themes included "promoting and practicing religious beliefs," "feeling rewarded after experiencing grief," and "promoting ethical virtues."
Conclusions: According to the present findings, the nurses identified having profound religious and spiritual beliefs, promoting ethical virtues, and using positive experiences associated with grief over patient deaths as the positive implications of experiencing grief. These results can be employed to design interventions for preventing burnout in nurses and assisting them in providing high-quality care. Strengthening the positive implications of experiencing grief is one way to prevent the negative effects of grief on health professionals. Recommendations include implementing educational programs to improve these outcomes.

Keywords: Content Analysis, Grief, Nurses, Death, Oncology, Religious Beliefs

1. Background

As a stressful occupation, nursing involves extreme psychological pressure in the face of patients with incurable diseases (1), and they are more susceptible to mental illness and suicide risk than the general population (2). Compared to other healthcare specialties, nursing naturally requires facing frequent deaths and closer and more prolonged contact with patients and their families (3-5). Research suggests that the challenge of patient deaths can significantly affect nurses' mental status, interpersonal relationships, and private and professional life (6-8).

In intensive care units, nurses are exposed to the risk of psychophysical and emotional distress (9, 10) in the face of numerous hardships, including patient death and its consequences. Research suggests that caring for terminally-ill patients is associated with death anxiety in nurses (11-13). Dadgari et al. reported moderate death anxiety in 36% and severe death anxiety in 39% of ICU nurses (14). Frequently facing patient deaths can significantly affect nurses' personalities, and its stressful consequences can influence the nursing profession, reduce the quality of teamwork, patient care, and nursing performance, and increase medical errors and tension at the workplace (15, 16). Nurses' failure to effectively cope with their occupational demands can increase their emotional and psychological distance from patients and decrease their interactions with patients and the quality of their care (2). Azmoon et al. showed a significant positive relationship between emotional exhaustion and nurse fatigue dimensions (17).

As a challenge facing oncology nurses, burnout can

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be developed by failing to cope with patient deaths (18, 19). Burnout adversely affects various aspects of nurses' jobs and complicates their working conditions (17). The tensions caused by patient cancer turn oncology wards into a highly-challenging, stressful, and emotionally-exhausting environment for nurses (1, 20). In oncology wards, providing prolonged special care for patients with cancer, especially at their terminal stages, and their cancer-induced psychophysical changes cause psychological distress in the nurses (8, 21). The suffering caused by losing patients also causes stress and grief in oncology nurses (22-24). A cross-sectional study by Boerner et al. on nurses' preparedness for patient deaths showed symptoms of bereavement and grief in over 70% of the nurses facing patient deaths (25).

The strategies adopted by nurses to cope with job difficulties and patient deaths include acceptance of death (3, 18, 26), spiritual exercises (3, 18, 27, 28), asking for the support of experienced colleagues (3, 18), communication and asking for social support (3, 26), and sharing the experience of patient deaths (28). A qualitative study by Khalaf et al. reported spiritual beliefs as a category related to the concept of experiencing grief after patient deaths in nurses (27). Despite the negative experiences, facing patient pain, distress, and death can entail positive implications for nurses. The positive outcomes of experiencing grief include promoting personality traits such as kindness, forgiveness, and hope (26). A review study by Barnes et al. on the experiences of healthcare specialists with patient deaths determined positive outcomes as a category of relieving grief in nurses (29). The positive responses developed by grief in nurses can also cause occupational and personal promotion and increase their awareness of death (30). Understanding grief's positive impact on health professionals helps create learning opportunities and a supportive clinical environment where they can grow and thrive and provides the foundation for a healthy professional life.

2. Objectives

Several factors may affect the emotional, physical, behavioral, cognitive, social, and spiritual consequences of bereavement. Therefore, considering the challenging conditions in the oncology department and the influence of society, culture, and norms on people's understanding of stress and grief, this research was conducted to explore the positive outcomes that oncology nurses experience after going through grief.

3. Methods

The present qualitative study utilized conventional content analysis to explain the positive implications of experiencing grief for oncology nurses. The study population comprised all nurses in the oncology wards of the selected hospitals in Tehran, Mashhad, and Kashan, Iran. Purposive sampling was performed based on maximum variation in contextual factors, including age, work experience, gender, and organizational level. The interviews with 20 nurses continued until reaching data saturation. The eligible participants included those willing to participate in the study, with at least one year of experience in the oncology ward and the ability to understand and convey the concepts to the researcher. The participants were assured of their right to withdraw from the study at their own discretion.

The data were collected through individual in-depth unstructured interviews. The researcher was present in the oncology department and invited the nurses to participate in the study. Before officially beginning the interviews, an orientation meeting was held to orally introduce the researcher and explain the study objectives. The interviews began by asking the participants to introduce themselves and continued with an open question, i.e., "Please tell us about the effects of taking care of patients with cancer in the oncology ward." Depending on the topics raised, the probing questions included "could you give us examples of how your experience of grief caused by patient death has affected your personal and professional life." The interviews' time, location, and duration were adjusted according to the participant's preference. All the participants selected the staff room of their workplace for the interview, which lasted 25 - 60 minutes. The data saturation was reached during the final three interviews, during which no further information was collected. Data saturation was reached during the 20th interview when no new concepts emerged.

Immediately after the end of each interview, the researchers listened 2 - 3 times to the data voice-recorded with the participants' permission and transcribed them verbatim. The data were analyzed using the qualitative content analysis proposed by Graneheim and Lundman (31). The text of the interviews was therefore reviewed several times to acquire a thorough understanding of the content. Similar codes extracted based on the meaning units derived from the descriptions of the participants were then placed in the same category, and themes were specified. The data were analyzed in MAXQDA 10.

The methods used to ensure the data trustworthiness based on the criteria proposed by Guba and Lincoln (32) included maximum variation in the participants,

prolonged contact with the participants and the research setting, providing information on the study objectives, continuous data evaluation, audio recording, data transcription, and analysis immediately after the interviews, and providing feedback for the next interview. The data were reviewed, modified, and confirmed by some participants in the study and outside observers.

4. Results

The present findings were obtained from analyzing the data extracted from interviews with 20 nurses aged 24 - 56 years working in the oncology wards of hospitals affiliated with universities of medical sciences in Iran. The mean work experience of the participants was about 14 years, and the majority were female (Table 1).

Table 1. Demographic Characteristics of the Participants (N = 20) [a]

Demographic Characteristics	Values
Education level	
Bachelor's degree	17 (85)
Master's degree	2 (10)
PhD	1 (5)
Gender	
Female	13 (65)
Male	7 (35)
Age	40.55 ± 9.21
Work experience	13.95 ± 8.79

[a] Values are expressed as Mean ± SD or No. (%).

In the first stage, 203 primary codes were extracted after interviewing the participants. After data analysis and comparison, categorizing codes, and removing similar ones, 20 codes were placed in 7 categories and 3 themes (Table 2).

4.1. Theme 1: Promoting and Practicing Religious Beliefs

"Promoting and practicing religious beliefs" extracted as one of the main themes comprised two subthemes, "promoting religious beliefs" and "believing in prayers and miracles."

4.1.1. Promoting Religious Beliefs

The present research found that religion helps nurses accept patient deaths and reduce their associated anxiety. Observing patient deaths caused most participants to feel closer to God and strengthen their spiritual beliefs.

"We who work here and see people die become very spiritual. Perhaps, that's because other people are deprived of seeing what we witness; for instance, we see how powerless humans are when dying, and everything is in God's hands" (M5).

The participants identified spiritual coping strategies and being connected to the power of God as effective strategies in coping with patient deaths.

"Constantly witnessing patient deaths as our routine experience, the best thing to do is stay strong and continue working by resorting to spirituality" (M16).

"Ever since I began working in this ward, I try to trust in God in most things. I think one can get good positive energy by trusting in God, which calms them down" (M18).

4.1.2. Believing in Prayers and Miracles

Witnessing patient recovery and survival promoted the cultural and religious background of the participants, who already believed in the healing effects of prayers.

"I wasn't like this before, but I personally witnessed the healing effects of prayers here" (M7).

"Seeing these things here strengthens your beliefs in prayers and the power of God. A patient no one thought would recover is now living in good conditions" (M3).

Some nurses identified miracles as the only reason and interpretation for the recovery of terminally-ill patients.

"We had a male patient with gastric cancer and severe metastasis involving organs such as the liver and kidneys. He was in such terrible conditions that nobody expected him to recover. It was like a miracle. The patient's general condition kept improving steadily, a way that he was ultimately discharged. You couldn't think of anything else but a miracle" (M14).

4.2. Theme 2: Feeling Rewarded After Experiencing Grief

As a positive implication of experiencing grief in the nurses, "feeling rewarded after experiencing grief" comprised two main categories, i.e., "changing attitudes to death" and "rewards of patient care."

4.2.1. Changing Attitudes to Death

Increasing clinical experiences with patient deaths reduced sensitivity to death in the nurses and developed their coping strategies. The nurses reported changes in their attitudes to death. The longer the work experience, the easier the acceptance of patient deaths by the nurses.

"One learns to accept death more easily here. I tell myself we were born one day and will die someday" (M17).

This attitude gradually diminished their fear of death and helped them accept the death of loved ones.

"I'm no longer afraid of even my own death; for instance, knowing I'm going to die soon doesn't scare me at all because death is a right" (M9).

Table 2. The Main Themes of the Concept of Positive Experiences Associated with Grief in Oncology Nurses

Main Theme	Category	Code
Promoting and practicing religious beliefs	Promoting religious beliefs	Observing patient deaths as a factor of closeness to God
		Trust in God
		Becoming more spiritual
	Believing in prayers and miracles	Belief in prayer
		Belief in miracles
Feeling rewarded after experiencing grief	Changing attitudes to death	Acceptance of death
		Death as a life event
	Rewards of patient care	The positive impact of patient care on life
		Taking care of the sick as part of religious duties
		The effect of the patient's prayer on the nurse's life
		God's pleasure
Promoting ethical virtues	Promoting positive behaviors	Improving human qualities
		Trying to understand others
		Gratitude to God
		Patience
	Decreasing attachment to the mundane world	Change in life priorities
		Considering worldly life as worthless
		Fading of worldly possessions
	Taking advantage of life opportunities	The value of life opportunity
		Trying to achieve dreams

"When my father-in-law died, the others cried a lot, but I didn't feel so impatient because I had accepted death and told myself that we all have to die sooner or later" (M11).

The nurses gradually came to terms with death as part of life.

"As part of life, death occurs to everybody due to diseases or any other reasons" (M14).

"I believe death is a transition from one life to another. I feel death is really close to us and that it's something quite ordinary that must happen" (M17).

Without emotional entanglements, they learned to accept the death of patients as their destiny.

"Failing to come to terms with death prevents you from working and providing services in this ward. Moping around in the face of patients turning critically ill also prevents you from doing your job properly" (M9).

4.2.2. Rewards of Patient Care

According to some participants, the reward of patient care is not solely otherworldly. Not only did they describe the patient care experience as gratifying, but they also felt satisfied with its positive effects on their lives.

"Let's assume you help them even momentarily smile and avoid feeling dejected or disappointed. This is really valuable and makes you feel good" (M13).

"Thank God. Working in this ward helps me feel like approaching prosperity every day. It's as if taking care of these patients causes God to help you overcome daily challenges" (M8).

Some nurses identified patient care as a way of practicing religious duties.

"I consider patient care more acceptable than Hajj to God. It will be rewarded. Not that, God forbid, I intend to blaspheme; rather, I think God accepts this too" (M5).

The blessings of taking care of terminally-ill patients emerged in two ways in the life of the nurses, i.e., either directly as a result of God's pleasure or through patient prayers for the nurses.

"I feel even the money I'm paid in this ward is a blessing compared to payments in other wards. I feel as if God sees you differently and rewards you" (M12).

"I personally believe lots of good things in my life are associated with the services I provide for these patients and their prayers for me" (M18).

"The patients' prayers really work. I believe in them

and witness their effects on my life" (M13).

4.3. Theme 3: Promoting Ethical Virtues

As a positive implication of experiencing grief in the nurses, promoting ethical virtues comprised three categories, i.e., promoting positive behaviors," "decreasing attachment to the mundane world," and "taking advantage of life opportunities."

4.3.1. Promoting Positive Behaviors

Most participants found their work in the oncology ward to have promoted their ethical virtues and positive behaviors. They tried to promote their humanity through forgiveness, compassion, and empathy.

"Witnessing numerous deaths here and thus being ready to die sooner or later causes you to be kind-hearted and avoid aggression, declining the requests of patients and their accompaniments and breaking hearts" (M11).

"My behavioral changes since I began working here include my efforts to put myself in others' shoes, being more empathetic, and having more positive attitudes" (M8).

Witnessing terminally-ill patients close to death, most nurses reported their improved gratitude for their divine blessings.

"Seeing these patients, who used to be in their own right with hopes for the future and never imagined this situation, I try to count my blessings" (M18).

Some participants found difficulties in and energy intensiveness of caring for terminally-ill patients to promote their spirit of patience and tolerance.

"Becoming heavily involved in patients' problems here appears to strengthen my spirits and patience" (M12).

"The difficulties of working in this ward have promoted my tolerance of hardship. I can well endure seemingly unbearable difficulties for others" (M10).

4.3.2. Decreasing Attachment to the Mundane World

Witnessing patient deaths as part of life improved their understanding of life in the participants, changed their priorities, and caused them to describe the mundane world as worthless.

"Compared to other wards, working here seems to soften your spirits, change your perspective of life, and cause you to find the world totally worthless" (M12).

"You know, my perspective of life has dramatically changed, as I no longer pay attention to trivial matters such as fashion, rumors, and gossip" (M16).

The new spiritual and material understanding developed in the participants devalued materialism in their life.

"Everything can be compensated, e.g., financial problems; health is the most important thing. You shouldn't take material issues seriously because they are really not worth it" (M12).

"For me, material issues no longer feature prominently in my life. I see life differently. Working in these wards makes you understand more and not think about material things" (M5).

4.3.3. Taking Advantage of Life Opportunities

After facing and accepting patient deaths, the participants gradually began making efforts to make the most of their opportunities and value life.

"My views on life have changed. I value my time more and try to have a plan for every moment" (M5).

"When I go home, I feel like God has given me a new lease on life. I think I have so many opportunities that other people don't, and I must make the most of them. I try to use every moment of my life in a better way" (M18).

Feeling close to death and valuing life caused the nurses to understand that they should seize the day to realize their ambitions.

"I tell myself that I must make efforts to achieve my wishes in such a short life before it's too late" (M10).

5. Discussion

Patient deaths constitute one of the numerous stressful situations facing nurses. They may differently experience the grief associated with patients' death, pain, or suffering. The results of this comprehensive qualitative study showed that "promoting and exercising religious beliefs," "promoting ethical virtues," and "feeling rewarded after experiencing grief" constitute the three main themes of the concept of the positive experiences of grief in oncology nurses.

All nurses who are emotionally, physically, and occupationally involved with patients are affected by their death. Although patient deaths can be differently perceived from the perspective of nurses, the present findings suggest this process develops similar beliefs in most nurses. Given Iran's cultural and religious background, this attitude emerged in two main forms, i.e., "promoting religious beliefs" and "believing in miracles." The participants identified connecting to spirituality and their religious background, such as praying, as valuable experiences. A qualitative study by Sato also found resorting to spirituality, prayers, and the holy book to help nurses face the grief of patient deaths (9). Moreover, a review of 16 qualitative articles by Zheng et al. reported spiritual practices, including prayers and other religious

activities, as the nurses' essential coping mechanisms for patient deaths (3). In addition, a qualitative study by Khalaf et al. reported faith and religious beliefs as a category of the concept of experiencing grief by nurses following patient deaths, which approached them to God and promoted their spiritual beliefs (27). In line with the present findings, these results suggest that the implications of grief in nurses include promoting their spirituality.

In confirming the results of the present study on the acceptance of death by nurses, a review study by Zheng et al. recruiting nurses facing patient deaths reported the formation of belief in death as the inescapable and uncontrollable destiny (3). A qualitative study by Peterson et al. also found accepting patient deaths as an inevitable part of life to constitute a concept associated with the experience of patient deaths (18). The present nurses were found to have thought about death. Similarly, Betriana and Kongsuwan found the themes of experiencing the grief of patient deaths in nurses to include predicting their own death. Witnessing patient deaths raised awareness of death in nurses and helped them accept and prepare for their own death (33).

The longer the time spent with terminally-ill patients, the more positive the perception of taking care of these patients (34). The grief of experiencing patient deaths in nurses can lead to positive responses, including occupational promotion and increased awareness (30). As in the present study, one of the extracted categories was the "reward of patient care," the participants in a qualitative study by Kent et al. found themselves privileged after experiencing patient deaths, and over half of them attributed their positive, satisfactory, and rewarding feelings to taking care of terminally-ill patients and their deaths (35). According to a review of 12 qualitative studies by Barnes et al., the categories of the experience of patient deaths among healthcare specialists include positive implications of patient deaths for nurses (29). Focusing on positive outcomes and experiencing adaptation were also found to alleviate the grief. All the above findings indicate that taking care of terminally-ill patients can yield positive feelings such as satisfaction in nurses despite all its challenges and stresses.

Experiencing grief can positively affect individual personality (26). The present results showed that promoting ethical virtues in the face of patient deaths can serve as a dimension of flourishing humanity in nurses through developing behaviors such as forgiveness, patience, and thankfulness. Decreasing attachment to the mundane world and taking advantage of life opportunities also developed their profound comprehension of life. A review of qualitative studies by Zheng et al. showed that patient deaths and their associated emotional entanglements promote personality in nurses and affect different dimensions, such as their perception of the value of life (3). Likewise, research has shown that when caregivers experience grief, they develop healthy coping strategies, experience positive personal development and promote professional growth (30, 36). As a result, oncology nurses may find that their work positively impacts them. In contrast to these studies, a review article by Zheng et al. found unpleasant memories of patient deaths to decrease resilience in newly-graduated nurses, despite adopting adaptation strategies such as showing feelings and consolation and taking care of other patients (28).

5.1. Conclusions

Occupational difficulties such as stressful events and facing terrible psychophysical conditions of patients and their death can influence nurses' individual and professional performance in oncology wards. In the face of these difficulties, the present study nurses relied on spirituality, changed their view of life and death, and tried to promote their humanity and behaviors. They attributed positive changes in their life to the services they provide to patients, strengthening their religious beliefs. The positive implications of working in oncology wards can help nurses promote their humanity. In addition, due to the impact of these positive experiences on mental health, the adverse consequences of difficult and stressful work conditions are greatly reduced. To prevent burnout in oncology nurses and promote their satisfaction and quality of patient care, they should be learned how to deal with incidents such as patient deaths by participating in routinely-held training programs. Our current findings may be useful for managers wishing to plan intervention programs to prevent the negative effects of grief experience. It is suggested that future studies evaluate the factors affecting the positive implications of experiencing grief. Further study is needed to identify effective ways to reinforce the positive outcomes of the grief experience. Finding ways to strengthen the positive consequences of grief enables health professionals to cope with the negative consequences of grief and leads to job satisfaction and mental health.

Acknowledgments

The authors thank all the participants in this study who shared their valuable experiences. This paper describes the research results performed for a Ph.D. degree in nursing. The authors also appreciate all the authorities who supported this research.

Footnotes

Authors' Contribution: Study concept and design: E.E.; acquisition of data: E.E.; analysis and interpretation of data: E.E. and M.T.; drafting of the manuscript: E.E.; critical revision of the manuscript for important intellectual content: E.E. and M.T.; study supervision: M.T. All authors read and approved the final manuscript.

Conflict of Interests: The Authors declared that they had no conflict of interest.

Data Reproducibility: The dataset presented in the study is not publicly available due to ethical restrictions to maintain the participants' anonymity. The corresponding author can be contacted on reasonable requests regarding the dataset.

Ethical Approval: This study is approved under the ethical approval code of IR.KAUMS.REC.1400.004.

Funding/Support: The Kashan University of Medical Sciences provided the funding under grant number 99259.

Informed Consent: Written and signed informed consent was obtained from all participants before beginning the study.

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