ORIGINAL ARTICLE

The impact of death and dying on nursing students: an explanatory model

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Aims and objectives. To explore nursing students' experiences of death and dying in clinical practice.

Background. The encounter with death constitutes one of the most stressful experiences reported by nursing students during their clinical training. In particular, it can be difficult for student nurses to cope with the patient's suffering, to provide postmortem care and to communicate with the patient and his/her family as death approaches. Although some research has been carried out in relation to this phenomenon, there remains a need to identify and understand the situations and experiences that are of most concern to students, those which may affect their ability to cope and, therefore, interfere with the care they are able to offer to the dying patient and his/her family.

Design. Qualitative descriptive and hermeneutic study.

Methods. Semi-structured interviews ($n = 12$) were conducted with nursing students. Data were collected in 2012–2013. Transcripts were analysed using Colaizzi's seven-step procedure.

Findings. The analysis identified five themes: impact, training in end-of-life care, ethical issues, coping and learning/growth/healing connections. The central theme was the enormous impact the encounter with death had, while the other themes were a response to and/or modulators of this impact. An explanatory model was derived on the basis of the relationship between all these emergent themes.

Conclusions. It is essential to understand nursing students' experience of death so as to minimise its impact. The explanatory model described here could be a useful tool for the design of training programmes on end-of-life care.

Relevance to clinical practice. Adequate training of this kind would help to ensure that future nurses offer high-quality care to patients and their families, minimising the impact of death and preventing emotional fatigue.

Key words: clinical training, coping, impact of death, nursing students, qualitative research

What does this paper contribute to the wider global clinical community?

- Specific training in end-of-life care should be offered at the start of nurse education through a combination of experiential and participatory methods.
- Adequate training of this kind would help to ensure that future nurses offer high-quality care to patients and their families, minimising the impact of death and preventing emotional fatigue.
- Further research is needed to assess the effectiveness of training programmes.

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Introduction

Although death is a natural and inevitable part of the life cycle (Neimeyer *et al.* 2004), people often respond to it with fear and anxiety. Indeed, a fear of death is one of the foundations of all human anxiety (Tomás-Sábado & Gómez-Benito 2003).

Several authors have highlighted how culture and beliefs may shape not only attitudes towards death in general (Neimeyer 1994, Rooda *et al.* 1999, Depaola *et al.* 2003) but also attitudes towards end-of-life (EOL) care, the breaking of bad news, decision-making and advance directives (Kagawa-Singer & Blackhall 2001, Die Trill 2003, Searight & Gafford 2005, Ngo-Metzquer *et al.* 2008). This is clearly relevant to the professional lives of nurses, as they constantly come into contact with death and the suffering of others (Bayés *et al.* 1999, Gray 2009) and this may influence their attitudes. A recent study on obstetric nurses' experience of perinatal death (Puia *et al.* 2013) found that this was an unforgettable event capable of producing anxiety when nurses themselves became pregnant. Research has also shown that nurses' continuous contact with the emotional suffering of others can increase their risk of developing compassion fatigue (Wright 2004, Abendroth & Flannery 2006, Sabo 2006) as a result of the intense emotional effort that is required to provide prolonged care in such cases (McHolm 2006).

Nursing students (NS) will encounter death and suffering during their clinical placements, and the death of a patient, the suffering of others and communicating with a person who is close to death are the main stressors they identify (Thyer & Bazeley 1993, Timmins & Kaliszer 2002, Burnard *et al.* 2008). However, as Ferrell and Coyle (2008) pointed out, being able to cope with the suffering of a dying patient and his/her family is a necessary competence for all nurses to acquire, and it is an aspect that needs to be addressed as part of nurse education programmes (Skilbeck & Payne 2003, De Araújo *et al.* 2004, Aradilla-Herrero *et al.* 2012-2013).

Background

Qualitative research conducted in the UK and USA has found that nurses experience shock and distress when faced with the inevitability of death and also that their first encounter with a dead body has a major impact (Kiger 1994, Parry 2011). Kent *et al.* (2012) noted that among NS this experience could produce ruminative thoughts and vivid memories for a long time afterwards. Another reported cause of anxiety among NS is having to provide postmortem care, especially as regards seeing and handling the body (Cooper & Barnett 2005, Parry 2011), tasks for which they lack preparation

(Terry & Carroll 2008). Lillyman *et al.* (2011) found that breaking bad news, interacting with the dying patient and his/her family and the impact of seeing the patient deteriorate rapidly were all examples of emerging themes linked to negative experiences among NS. Another factor to consider is that the impact of death on NS may be heightened by the fact that many of them are in the final stages of adolescence, with its associated emotional burden (Jenkinson 1997).

Studies carried out with Latin American samples have found that NS report feelings of loss, fear and defeat when faced with death, but also that they regard listening, truth-telling and supporting the dying patient as important aspects (Vargas 2010). Research in this cultural context has also highlighted how NS may feel sadness, impotence and guilt, as well as a fear of doing harm when informing relatives of the patient's death (Da Silva Brêtas *et al.* 2006, De Oliveira *et al.* 2007). In a study of Argentinian NS, Mutto *et al.* (2010) found that they preferred to minimise their contact with dying patients so as to protect themselves from the emotional impact.

In the Asian context, Huang *et al.* (2010) found that the death of a patient had a considerable impact on NS, who reported feeling guilty, incompetent and trapped emotionally. However, the nurses sampled in this study also experienced self-affirmation, and despite the difficulties encountered in managing these situations, they felt their skills had increased as a result. In line with this, other studies (Shih *et al.* 2006, Liu *et al.* 2011) have found that while NS may experience surprise and a reluctance to let go in the face of death, this can be accompanied by a commitment to their profession and to caring for the dying patient.

This brief review of the literature highlights the importance of studying nursing students' encounters with death and dying in relation to their own social and cultural context, as only then will it be possible to identify and understand the situations and experiences that are of most concern to them and which may affect their ability to cope.

Methods

Aim

The aim of this study was to explore nursing students' experience of death and dying during their clinical training.

Design

An interpretative phenomenological approach was used to explore nursing students' experiences regarding the death of a patient. Based on their accounts of their experience, a

reflexive hermeneutic process was followed to arrive at an understanding and interpretation of the phenomenon.

Sample

Participants were recruited through convenience sampling (Table 1) by three university lecturers who were not part of the research team. The main researcher then contacted the proposed students to arrange an interview. The inclusion criteria were that they had already experienced the death of a patient during their clinical placements but had not yet received any academic training on palliative care or similar topics and also that they were capable of speaking about their experience without this proving overly distressing (Hewitt 2007). The final sample comprised 12 students (mean age 23·5 years, ±5·2). Nine interviews were conducted and analysed during the first half of 2012 until data saturation was reached. A further three interviews were carried out during the first quarter of 2013 to corroborate the data.

Data collection

Interviews were carried out by the main researcher (ME), who was trained in data collection. Audio recordings were made of the semi-structured interviews, each of which was conducted in a normal university classroom. Steps were taken to ensure a quiet setting without interruptions, and each interview lasted between 60–90 minutes. The interviews were conversational, with the interviewer maintaining an attitude of openness and attentive listening so as to encourage spontaneity on the part of the interviewee (Hermanowicz 2002). A field diary was also used. At the end of the interview, the meaning of the data was clarified with the interviewee. The interview guide was drawn up on the basis of a prior literature review, but any additional themes that emerged during the interviews were also incorporated (Table 2). Data collection ceased when the saturation point was reached.

Data analysis

Data were analysed according to Colaizzi's seven-step procedure (Colaizzi 1978; Table 3). The entire process of obtaining results was based on hermeneutic circles, interpreting the whole in relation to its parts and the parts in relation to the whole, incorporating the contributions of deconstruction and reconstruction so as to arrive at an understanding of the narrative (McConnell-Henry *et al.* 2009). Data analysis was performed with the help of ATLAS.TI, version 7.

Ethical considerations

The study was approved by a university research ethics committee. All participants were informed that their responses were anonymous and that participation was voluntary. They all signed informed consent.

Rigour

The principal investigator took into account her own experience as a nurse educator, and during the study, she kept a diary record of the emotions and personal opinions that studying the phenomenon aroused in her (Malterud 2001). The relationship between the investigator and the students was considered to be exclusively research based, rather than a student–teacher type relationship.

Reflexivity was maintained throughout the process of analysis, returning time and again to the data. To verify

Table 1 Sample data

Code	No. of interview	Age	Year	Gender	University	Date of interview
P1	1	20	1	Female	1	1st half of 2012
P2	2	37	2	Female	2	1st half of 2012
P3	3	28	2	Female	2	1st half of 2012
P4	4	28	2	Female	2	1st half of 2012
P5	5	20	2	Female	1	1st half of 2012
P6	6	21	2	Female	1	1st half of 2012
P7	7	23	2	Female	1	1st half of 2012
P8	8	25	2	Male	2	1st half of 2012
P9	9	22	2	Female	3	1st half of 2012
P10	10	20	3	Female	1	1st quarter of 2013
P11	11	19	2	Female	1	1st quarter of 2013
P12	12	20	2	Female	1	1st quarter of 2013

Table 2 Interview guide, showing the questions put to participants

Do you remember what and how you felt when you first
  experienced the death of a patient? What do you think it was
  about the experience that made you feel that way?
What do you remember about the first time you had to provide
  postmortem care?
What do you think would have helped you during those first few
  moments after the patient died? And a few hours later?
Was there anything, or did anything happen, that you think made
  it more difficult for you to cope with the situation?
When people talk about 'a good death', does this make sense to
  you? How would you describe it? What is good about it?
When people talk about 'a bad death', does this make sense to
  you? How would you describe it? What is bad about it?
What do you think it would be useful for you to learn so as to be
  able to support and care for a dying patient and his or her family?

Table 3 Analysis: application of Colaizzi's seven-step procedure

1. Listen to the interview recordings several times, transcribe them,
   and then read and re-read the transcriptions, taking into account
   the information regarding non-verbal communication that
   accompanies the discourse.
2. Extract from each transcript significant statements related to the
   experience of death and dying.
3. Formulate meanings from these significant statements and apply
   a code to them (units of meaning). These codes should be verified
   by another researcher.
4. Sort the formulated meanings into categories or clusters.
5. Compare the different transcriptions and categories several times
   in order to identify any discrepancies and validate the results.
6. Identify and describe the fundamental structure of the
   phenomenon, its essence, the themes.
7. Present the transcripts and the results to the participants so that
   they can validate the findings.

that the data were accurate, the interview transcripts were
sent to participants, all of whom expressed their agreement
with the content.

The data were triangulated through various procedures.
During the initial coding stage of the content analysis, the
data were independently confirmed by a second researcher.
The final results containing the themes and subthemes
were summarised and given to participants for validation
purposes. This was done by means of nine interviews, in
which all the participants corroborated the results. Com-
plementarily, these results were also assessed by another
researcher who was not part of the study team. Finally, a
further three interviews were conducted with NS who
were recruited through the same inclusion criteria used for
the original sample. These students also confirmed the
results, and no new themes emerged from these inter-
views.

Findings

The data were first condensed into 31 categories that corre-
sponded to statements of content in the transcripts.
Through a process of abstraction and interpretation, these
categories yielded 20 subthemes and, finally, five themes
(Table 4).

Impact

The main theme that emerged in all the interviews con-
cerned the enormous *impact* that the first experience of a
patient's death had on the NS. This was described as an
experience that *you never forget, it really sticks in your
mind (P2) (00:04)*. This theme includes three subthemes
(see Table 4).

Impact of what death implies. This impact was associ-
ated with feelings of impotence, frustration and anger,
related to the irreversibility, universality, uncertainty and
fear of the unknown that is produced by death:

…But what I find really hard is the sense of impotence, that after
death… and now what? The body is here, but it's not breathing, not
speaking… what should I do? Is the person gone? We don't know
why… that's it, it's all over, we've done everything we could… and
that's how it ends? I don't know, it's… phew! (P4) (0:27)

Impact of seeing the dead body. Seeing the dead body
and the associated physical changes is a reminder of human
vulnerability and was described as making an enormous
impact. Indeed, most of the students said that they still
remembered the first time they saw the face of a dead body:

It made a real impact on me when they put the body in a special
bag… they closed it up and… phew, treating it as if it were just a
body… but closing that bag, good grief, I think that's what really
affected me, apart from seeing the person dead. (P1) (00:08)

Fear of emotional contagion. With respect to the patient's
family, all the students said that the impact of the experience
was even greater when witnessing the suffering of relatives,
and they expressed a fear of emotional contagion:

I felt really bad… the patient's daughters were more or less my age
and… I don't know, you empathize, you put yourself in their shoes
and then the experience becomes even more intense…. (P3) (00:14)

The students also said that the impact of death was mod-
ulated by the patient's age, it being greater the younger the
person was. Similarly, a sudden death had a bigger impact

Table 4 Categories, subthemes and themes of qualitative content analysis

Categories	Freq.	%	Subthemes	Themes
Feeling uncertain	6	50·0	Impact of seeing the dead body	Impact
Feeling impotent	8	66·6	Impact of what death implies: fragility,	
Feeling frustrated	7	58·3	irreversibility, finitude, certainty, etc.	
Being affected	12	100·0	Impact of not being able to talk about	
Feeling sad	7	58·3	death	
Silence	3	25·0	Fear of emotional contagion	
Awareness of mortality	7	58·3		
Fear of suffering	9	75·0		
Not knowing what to say	12	100·0	Training in how to break bad news	Training in end-of-life
Not knowing what to do	11	91·6	Training in managing your emotions	care
Fear of doing harm	8	66·6	Training in postmortem care	
Confusion regarding knowledge about end-of-life treatments	5	41·6	Training in relation to palliative sedation and the concepts of euthanasia and withholding/withdrawal of life support	
Lack of awareness about physical changes to the dead body	8	66·6		
Attitudes of health professionals toward death	5	41·6	Ethical care Ethical dilemmas	Ethical issues
Unfinished business	11	91·6	Beliefs	
Emotional suffering	7	58·3	'Good' and 'bad' death: Being allowed	
Spiritual suffering	6	50·0	to die	
Pain	11	91·6		
Being alone	6	50·0		
Doubts about what is needed	4	33·3		
Talking	12	100·0	Accepting death as part of life	Coping
Crying	4	33·3	Talking about death	
Sharing	9	75·0	Support from qualified staff	
Doing things for the patient and family	8	66·6	Being involved in patient care Beliefs	
Spirituality	6	50·0		
Enriching experience	10	41·6	Professional learning	Learning, growth and
Special experience	9	91·6	Personal learning: growth	healing connections
Privilege	6	58·3	Healing connections	
Acquiring knowledge	10	50·0		
Gaining experience	11	41·6		

than did a death resulting from a progressive illness. The impact was also greater when the relationship with the deceased had been more well established.

Training in EOL Care
This theme consists of four subthemes (see Table 4).

Training in managing your emotions. All the students said that they often did not know how to deal with the emotional reactions that emerged when providing care and support to the patient and his/her family, and they expressed a need to acquire competences that would facilitate the expression of emotion:

What do you say to this person? How should I start the conversation so that they cry, shout... so that they get it all off their chest?

Because I'm sure they feel angry... what do I do? What do I say to them? (P2) (2:1/1:86)

Training in how to break bad news. The students commented that intense emotions of this kind are particularly present when having to break bad news:

When you have to break bad news ... How to you go about it? Where do you find the words? ... Seeing somebody breakdown in front of you and knowing that you have to cope with it ... I think training is very important... (P2) (2:1/2:74)

Training in relation to palliative sedation and the concepts of euthanasia and withholding/withdrawal of life support. It also emerged that students did not really

understand what was meant by palliative sedation, or the difference between euthanasia and the withholding or withdrawal of life support:

There's a lot of confusion about these topics... I think more training is needed as that would also help with the dying process. (P4) (10:3)

Training in postmortem care. Most of the students commented that seeing how the dead body changed physically both surprised and affected them, and they highlighted the need for specific training that would enable them to talk more about death and to develop the skills required by EOL care:

I didn't know that a dead person turns yellow so quickly, and that the body temperature ... it drops really quickly... and of course, touching it... you realize that the body is heavy, that it's yellow and cold, but in fact very little time has gone by... (P9) (9:9 7 9:13)

The theoretical training in this area didn't help me... what I found most helpful was a talk we had from a woman with cancer, how she feels about it all... (P9/2) (47′)

Ethical issues
This theme has four subthemes (see Table 4).

Ethical care. The students highlighted the importance of providing humane care and of treating the patient with respect and dignity, even after he or she has died:

I tried to say my goodbyes to the patient... when he died, I tried to be there for the family... to be respectful, to say goodbye in my own way... removing the line, closing his mouth, and making him as presentable as possible for the relatives to see. (P5) (5:5/5:58)

Ethical dilemmas. In terms of ethical dilemmas, doubts emerged in relation to the practice of palliative sedation:

Patients and relatives aren't given all the information they need... I think that if the family had had more knowledge they wouldn't have administered the sedation, and I also think it's important to listen to the patient, because maybe he wanted to be 'with it' right to the very end, rather than being so drugged up... (P11) (47′)

Beliefs. Beliefs and values was another subtheme that emerged. The students felt it was important to respond to spiritual needs and to respect the beliefs of the patient and family.

'Good' and 'bad' death: being allowed to die. A good death was characterised by the absence of pain, not feeling alone, being at peace, having dealt with any unfinished business and having said one's goodbyes:

Leave the slate clean... if you have to ask somebody to forgive you, then do so, if you have to say something, then say it...sort out your differences, don't leave unfinished business... I think it's really important to bring things to a proper close, as it will help you to die in peace, it's like saying to yourself: 'now I've done all there was to do' ... (P1) (1:58)

The students also said that 'being allowed' to die contributed to a good death, by which they meant that if both the patient and the family accept the process of dying, such that the patient is 'allowed to let go', then the passage is somewhat easier:

Up to a point the person chooses who will be there when he dies... when he's allowed to die and to let himself do so, when both he and his relatives accept death ... (P10) (45:5)

I've seen patients who died once the relatives had left... they didn't want the family to see them suffer and die, and to a certain point they chose to die alone... and the family allowed that and took it well. (P9/2) (53′)

As regards a bad death, the students associated this with pain, distress, being alone and leaving unfinished business, not being able to 'close the book'.

Coping
This theme includes five subthemes (see Table 4).

Accepting death as part of life. One of the thoughts that students described as being most helpful concerned accepting death as part of the life cycle and keeping this in mind, as by doing so, it was possible to live a fuller life with greater awareness:

Being at peace, content... satisfied with what you've done... this helps, and we all need to remember that just as we were born into this world, one day we will die... (P5) (01:02:12-8)

Support from qualified staff. They also said that the support of qualified staff was helpful, especially when this involved advice about what to do or reassurance:

Being with a qualified member of staff... that they explain it to you with an air of calm.... that they help you and say to you, 'don't worry, it's not your fault, nor anybody's'... (P4) (00:14:17-1)

Talking about death. One of the things that most helped modulate the impact of death was being able to talk about

it, as this facilitated the expression of feelings. Some of the students talked about it with a relative, while others shared their experiences with a placement tutor or with friends:

... I'd already spoken to my Mum on the phone, and by the time I got home I needed to explain everything, I needed to get it off my chest with somebody who would understand me. (P10) (37:00)

Being involved in patient care. The students also said that being able to provide care to the patient and family and/or being present at the time of death helped them to cope, as they then felt they had been useful:

Spending longer with death, having been able to care for the patient, bathing him, being at his side... going through that experience helps, you can understand it more ... (P9/2) (45′)

Learning, growth and healing connections
This theme has three subthemes (see Table 4).

Personal learning: growth. All the students agreed that the encounter with death had been a learning experience that had made them more aware of their own vulnerability and of the importance of living life to the full:

Having seen that it's such a thin line between life and death... I want to live my life more intensely... seek out what I like...fight for it... enjoy my friends, my family, my quality time... get the most out of the days and years, live intensely and enjoy life... because little separates life and death. (P1) (1:55-1:6)

Healing connections. Most of the students described their experience of the dying process as something that led to personal growth, as an enriching experience that brought them feelings of peace and/or well-being:

Even though it's hard, I'm helping... and that comforts me... I think that I'm helping someone to have 'a lovely death'... whenever I think about the first time a patient died, I smile... it's not just a feeling of pity, there's also a smile, which seems like a contradiction, but that's how it is... I was moved, it was hard but at the same time it brought me peace... yes, it brought me peace. (P3) (00:55:22-7)

Professional learning. The students also said that they had learnt things from a professional point of view, in that they had acquired greater knowledge about the process of dying and the needs of patients and families. This kind of learning was highly valued by the students, as they recognised that the experience had not only increased their

competences in this area, but had also helped them to modulate their own response to death.

Explanatory model

Having gathered these findings, the initial interviews were then analysed again so as to compare the results as a whole. This enabled us to identify relationships between the different themes and to derive an explanatory model (Fig. 1). The model is built around a central theme, namely the enormous *impact* that the first experience of patient death has, while the remaining themes appear as a response to, as needs of or as modulators of the impact. One of the outcomes of this series of events is learning and personal growth on the part of NS, and this can also modulate the impact that the death of a patient has.

Discussion

The results of this study show that the first experience of the death of a patient has a considerable impact on NS. Indeed, this is an event of enormous emotional significance that is never forgotten and which may have lasting effects, both personally and professionally (Rhodes-Kropf *et al.* 2005, Chen *et al.* 2006, Kent *et al.* 2012). The strength of the impact is likely related to the fact that the death of another person confronts us with our own fragility and mortality, as well as that of our loved ones, and it also serves as a reminder of the certainty and universality of death (Costello 2006, Lehto & Stein 2009, Peters *et al.* 2013). These results are important, because the way in which NS experience this first encounter with death will determine the kind of protective mechanisms they adopt, which in turn may influence their subsequent responses to grief (Gerow *et al.* 2010). It is also worth noting that our findings are consistent with those of studies conducted in non-Western cultures (Huang *et al.* 2005, Shih *et al.* 2006, Liu *et al.* 2011), suggesting that the death of a patient has a universal impact that bridges different cultural contexts and belief systems. Our results are also in line with previous research as regards the impact of seeing the dead body and helping with postmortem care (Johnson 1994, Cooper & Barnett 2005, Rhodes-Kropf *et al.* 2005, Parry 2011).

In line with previous research (Burnard *et al.* 2008, Warnock *et al.* 2010), one of the situations that our students reported as being particularly stressful was having to break bad news, an aspect that may be influenced by the difficulties health professionals have in sharing information and the decision-making process with patients. The interviews with students also highlighted a clear need for specific
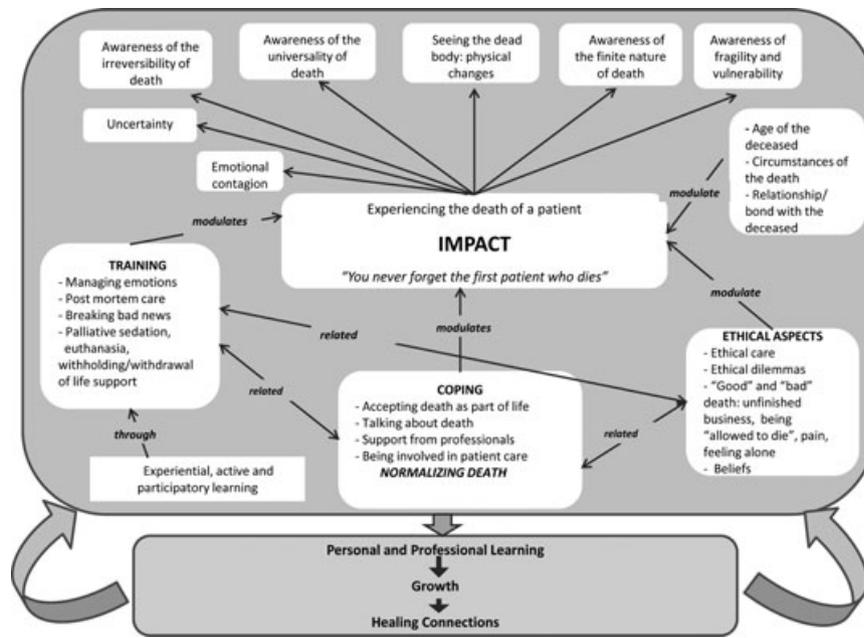
Figure 1 Explanatory model of nursing students' experience of death and dying during their clinical training.

training on communication skills and on managing emotions so as to foster a more therapeutic nurse–patient relationship (Tizón García 2007). Such training would help in terms of enabling more personalised care and avoiding emotional contagion, thereby reducing the likelihood of nurses suffering compassion fatigue (Najjar *et al.* 2009, Sabo 2011). Consequently, training in social and emotional competences could help them to develop the empathy and respect that are required in order to provide compassionate care (Adam & Taylor 2013).

In a recent literature review, Peters *et al.* (2013) highlight the need to establish EOL care programmes so as to reduce levels of death anxiety and compassion fatigue among nurses, and to provide future professionals with the skills they need to reduce the emotional toll of their work. In the present study, being able to talk about and share one's experiences was one of the things that NS felt most helped them to 'normalise' the death of a patient. In this context, Wong and Tomer (2011) refer to the need for a greater acceptance of death, which would include a deeper understanding of the meaning of life. According to these authors, talking about death facilitates learning and favours a more respectful and compassionate treatment of others. Although theories of coping have traditionally focused on the management of distress and negative emotions, Folkman (1997) suggested that it is also important to consider the role played by positive psychological states in coping with highly stressful situations. Example discussed by this author

is the ability to find positive meaning in the stressful event. The results of our study support this idea, as the NS were better able to deal with the dying process when they saw it as a learning opportunity, one in which the care they gave was of help to the patient. They also stated that spiritual beliefs and practices could help both the nurse and the patient in the process of meaning reconstruction when facing the pain of a life that is ending (Depaola *et al.* 2003, Mount *et al.* 2007, Giske 2012). A further point of note is that, in their view, training on all the above issues should be based on experiential and active learning that is integrated around realistic scenarios.

With regard to ethical issues, our findings are in line with the literature suggesting that ethical dilemmas are common in the context of EOL care (Oberle & Hughes 2001, Ferrell 2006). As Oberle and Hughes (2001) pointed out, nurses must live with decisions made by doctors, patients and families, as well as with the uncertainty surrounding what is the best thing to do, and all this can create moral and emotional distress (Rietjens *et al.* 2007, Broeckaert 2011). Two of the issues that raised doubts among our NS concerned how much the patient should be told and the clinical justifications for the use of palliative sedation and how it differs from euthanasia. Also, within the ethical domain, all the students defined a 'good' death in terms that were consistent with the literature on this topic (Saunders *et al.* 2003, Shea *et al.* 2010). However, an aspect that has not previously been reported but which

they felt contributed to a good death was 'being allowed to die', in the sense of both the patient and the family accepting that the former is going to die. In this context, they also mentioned the importance of dealing with any unfinished business, something which they felt was a key aspect of a good death.

Despite the impact that the first experience of death can have, all the students also spoke about a process of learning and growth. Various studies (Byock 2002, Huang *et al.* 2005, Wong *et al.* 2009) have suggested that having to face the reality of death can act as a stimulus to personal growth, as it enables the person to take on board difficult experiences, giving them meaning and incorporating them into a system of values. The learning and personal growth described by our students may be understood in terms of what Mount *et al.* (2007) called 'healing connections', which result from being able to find meaning or significance in suffering. Making healing connections means that the person discovers healthy responses to suffering, for example recognising the importance of the present moment, being able to let go and accepting that some things are beyond our control, such that we may be required to make a leap of faith or trust to fate. Of relevance here is the work of Viktor Frankl (1996), who argued that the fundamental task in human life involves the search for meaning, the ability to make sense of what happens to us. In the context of caring for a patient who has reached the end of life, meaning may lie in the dynamic and healing relationship that can be established between patient and caregiver (Mount *et al.* 2007).

Finally, mention should be made of the explanatory model derived from the results of this study. The model relates the impact of death to an awareness of the universality, irreversibility and uncertain nature of this event. Previous research has noted how the contact with death reminds us of our own mortality and may heighten death anxiety (Byock 2002, Neimeyer *et al.* 2004). The major impact of the first experience of death has also been described by other authors who highlight the need for training on this issue (Huang *et al.* 2010, Kent *et al.* 2012, Whyte *et al.* 2013), especially the need for EOL training to address ethical matters and to teach coping strategies and ways of managing emotions (Ferrell *et al.* 2005, Whittaker *et al.* 2006, Aradilla-Herrero *et al.* 2012-2013). We believe that our explanatory model provides a useful basis for the design of such training programmes, which need to ensure not only that student nurses develop the competences required to provide EOL care to patients and their families, but also that they are equipped to cope with the impact that their clinical responsibilities can have and that they become capable, therefore, of facilitating a patient-centred death (Clark 2003). Indeed, only if professionals are able to manage the impact of these situations will they be able to offer the high-quality care that patients deserve (Aradilla-Herrero *et al.* 2014).

Limitations

This study does have a number of limitations. The first of these relates to the use of a convenience sample, as this meant that all the students came from the same geographical area and also shared the same ethnic background and culture. The sample is also relatively small, although the final number of participants was determined by the data saturation point, which in this case was reached after nine interviews.

Conclusions and relevance to clinical practice

The impact that the first experience of death can have on student nurses justifies continued research in this area. One way of complementing the present results would be to consider other variables such as attitudes towards death and the effects these can have on the care provided by nursing professionals and students. It would also be necessary to evaluate the outcomes of training interventions.

Students require training in how to manage their emotions so as to facilitate their contact with patients and families, and also to prevent emotional fatigue. They would also benefit from the development of coping strategies that enable them to acknowledge death as an inevitable part of life. Specific training on ethical issues and dilemmas arising in the context of EOL care could also help to reduce their emotional distress. All such training should begin before student nurses start their clinical placements, thereby giving them some initial preparation for their first encounter with death.

In conclusion, the fact that the proposed explanatory model is based on the needs expressed by student nurses themselves makes it a useful tool with which to design training programmes on EOL care, and as such, it may help to optimise the care that is offered to both patients and their families.

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