Caring for people who are ill is stressful, even for trained health professionals, particularly when patients die in their care. The NHS is caring for ever-growing numbers of patients, with the added complexities that naturally arise when people live longer with multiple long-term conditions. Clinical intervention usually aims to prevent death, and maintain and prolong life (Cedar, 2017), but we are all mortal; clinical interventions can fail and it may be that there is nothing more that can be done to preserve life. The process of death and dying applies to all living organisms and is classed as an activity of daily living (Cedar, 2012).

In the UK, 80% of people die in hospitals or hospices instead of their own homes (Gomes et al, 2012). Medical advances often prolong and medicalise the dying process, increasing patients’ dependency on palliative and end-of-life care. This means that, on top of other NHS pressures, health professionals – and nurses, in particular – are increasingly charged with managing death and dying for patients in their care.

Many organisations, across healthcare and other sectors, advocate the need for a good death, in which the individual’s wishes around death and dying are respected; one example is Dying Matters (dyingmatters.org). However, far fewer organisations actively acknowledge the emotional toll the death of a patient can have on professional carers, who may have built up a long or deep relationship with that patient (Rodger and Atwal, 2018).

Emotional labour is the process of managing feelings and expressions to fulfil the emotional requirements of a job (Hochschild, 1983). Caring for patients who are dying, and dealing with feelings of bereavement when a patient dies, adds to this emotional labour. Peters et al (2013) showed that the death of a patient can...
bring up many anxieties for staff, and that staff’s own feelings about death can also have an impact on how they deliver care.

All these points raise the question: how do health professionals, who are trained to save and restore lives, cope with the increased emotional labour of caring for patients at the end of their lives and those dying in their care? This article addresses this question, in the context of the wider problem of work-related stress in healthcare. It looks at the need for coping techniques, reviews workplace-based options for managing stress and preventing burnout, and outlines reflections for nurses and other health professionals.

Stress and burnout
The renewed focus on patient-centred care means the role of health professionals has moved from a focus on treatment to one on care (Watson, 2009); compassion and care are listed as being among the six fundamental values of nursing (6Cs) (Department of Health and NHS Commissioning Board, 2012). This can add to the emotional labour of the nursing role.

Bereavement, difficult issues at work and being a carer are all common causes of stress (Bit.ly/MINDStress). Dealing with the death of a patient may also be a cause of increased stress, especially if it is not recognised as such (Rodger and Atwal, 2018). In addition, the ageing of the general population is reflected in the hospital patient population, making it more likely that death will occur in hospital (Wilson and Kirshbaum, 2011).

Freudenberg and Richelson (1980) defined burnout as “a state of emotional, physical and mental exhaustion caused by excessive and prolonged stress” that occurs when people “feel overwhelmed, emotionally drained, and unable to meet constant demands”. They pointed out that burnout caused by a person’s professional life has long been associated with certain work conditions. Maslach et al (2001) identified six main causes of workplace burnout:

- Mismatch in workload – some workers are given more tasks than others who are in the same job;
- Mismatch in control – clarity of the role and responsibility is unclear;
- Lack of appropriate reward;
- Loss of a sense of positive connection with others in the workplace;
- Perceived lack of fairness;
- Conflict between values.

All these can lead to exhaustion, cynicism, inefficiency, absences and attrition. The Health and Safety Executive (2019) demonstrated that stress and burnout is more frequent in staff working in healthcare than in other sectors. Results from further research on the issue of work-related stress for nurses and other healthcare staff is shown in Box 1.

The effect of stress
Increased stress is a major factor in workplace attrition, and can be the result of factors indicated in Box 2. It is perhaps unsurprising that attrition rates among highly trained health professionals are above average and increasing (Office for National Statistics, 2017).

NHS England reported on figures by Public Health England, which showed that staff absence due to poor health cost the NHS in England £2.4bn a year (£1 in every £40 of the total NHS budget), even before the cost of agency staff or medical treatment was taken into account; this led NHS England to announce a major drive to improve the health and wellbeing of health service staff (Bit.ly/NHSWorkplace).

Figures also show that suicide risk is high among nurses: in reporting suicide as the leading cause of death in England in adults aged <50 years, ONS (2017) found that some occupations, including nursing, were particularly high risk. It stated that: “For females, the risk of suicide among health professionals was 24% higher than the female national average; this is largely explained by high suicide risk among female nurses. Male and female carers had a risk of suicide that was almost twice the national average.”

Strobl et al (2014) found that doctors under investigation for medical negligence had higher rates of suicide and feelings of post-traumatic stress than nurses in the same situation. Now that nurses have more responsibility in clinical decision making than nurses in the same situation, they may also be subject to closer scrutiny and experience the stress associated with that.

Issues around death and dying
Whitehead (2014) looked at the experiences of doctors dealing with patient death and
found that “physicians can experience very strong and lasting emotional reactions to some patients deaths, and also that patient death can elicit intense experiences related to professional responsibility and competence”. He identified five main points associated with “memorable patient deaths”:

- Although physicians saw death as a “normal” part of medical care, there were “memories beneath the surface” that haunted them;
- They experienced intense feelings of responsibility over life and death decisions, and an awareness of expectations from families;
- The death of a patient often caused them to question their own competence;
- Unexpected details connected them to the “meaning or emotion” of the event and these “breakthrough experiences” were often accompanied by a sense of identification with the patient;
- At critical moments surrounding a patient’s death, non-palliative physicians were more likely to focus intensely on the actions of care, while palliative physicians focused on the importance of “simply being present” with dying patients when nothing else could be done.

Wilson and Kirshbaum (2011) identified the following themes from the literature on how nurses coped with the death of a patient:

- Theoretical context around loss and grieving – for example, disenfranchised grief or grief not openly acknowledged, such as that found in professional carers;
- Emotional impact and compassion fatigue – for example, nurses experienced greater emotion when nursing younger patients who were dying but more compassion fatigue when caring for patients dying from long-term conditions;
- Work culture – for example, while nurses are expected to be empathetic, they may not be permitted to grieve;
- Personal situations and life experience – although staff are expected to take a professional approach, they may have more care and empathy with patients if they have had similar personal life experiences; this creates a “personal–professional interface” between their own life events and their professional interactions.

Other studies observed that nurses found the deaths of children and young people most stressful, while that of older patients was easier to cope with; death was seen as part of the natural ageing process and caring could sometimes be rewarding (Ingebretsen and Sagbakken, 2016; Bloomer et al, 2015). Exposure to a range of patients and increased numbers of deaths increased the use of coping mechanisms (Andersson et al, 2016). Boerner et al (2015) found the grief experienced by staff could be similar to that of the family.

Coping strategies

Use of coping strategies has been shown to alleviate stress and enable staff to work more effectively (Lee et al, 2016). Merluzzi et al (2011) suggested a number of self-care practices for increasing wellbeing and reducing stress, such as:

- Meditation;
- Exercise;
- Hobbies;
- Mindfulness training.

These might benefit healthcare staff.

Resilience training

Resilience is the ability to recover and recuperate quickly from a challenging or devastating situation (Hunter and Warren, 2014). Bouncing back with resilience can equate to better patient care and outcomes as nurses will be more alert, positive and able to communicate clearly and concisely. Resilience training and understanding how to use coping mechanisms are crucial for accomplishing a more positive work–life balance (Health Insights, 2017). Practising resilience can help nurses rise through the ranks in their career,
while increasing work enjoyment and the ability to exercise good judgement (Sieg, 2019). The American Psychological Association suggests nurses can increase their resilience by:

- Maintaining good, positive relationships;
- Accepting that there are circumstances that are out of their control;
- Sustaining optimism and a hopeful outlook for the future (Bitt.ly/APSResilience).

Engaging in health-promoting behaviours – for example, eating a well-balanced diet, engaging in regular exercise such as running or swimming, and getting enough sleep – are also ways to increase personal resilience. However, organisations should not put the onus on workers, as often there are organisational stressors that can be reduced – for example, problems that contribute to a blame culture.

### Self-care and mindfulness

It is hard for us to care about others unless we care about ourselves. As well as the basics of diet, sleep, exercise and such like, there are other ways to increase self-care (Sanso et al, 2015). Being aware of our own needs and taking time out for ourselves are important elements of self-care that link with our feelings of self-worth. The problems we may find we have, however, are finding time to care about ourselves and feeling that we are worth caring about.

Mindfulness and self-compassion help with self-care, and have been shown to enhance patient care (Barratt, 2017). Mindfulness helps us focus on the here and now, letting past worries dissipate and allowing us to observe our feelings in a detached manner. However, mindfulness is a skill that often requires attending a course or reading a book, which can be off-putting for busy professionals.

### Reflexive practice/Schwartz Rounds

In reflexive practice, health professionals recount and reflect on a scenario they found, or are finding, problematic to deal with. This can be done as a team, or across teams as in a Schwartz Round. Staff discuss their feelings about what has happened and reflect on them with each other, and with others, who can add similar reflections of their own. The point is to be open and vulnerable with each other, professional and without recrimination.

The Point of Care Foundation promotes Schwartz Rounds and reflexive practice to help boost staff wellbeing and improve patient care; Box 3 lists strategies the foundation recommends staff adopt that may help to protect their wellbeing.

### Organisational culture

We are told to look to ourselves first before blaming others and to take responsibility for our actions – but sometimes it is the culture of the organisation that may be at fault. The Point of Care Foundation makes recommendations for leaders of NHS organisations, national agencies and regulators on how to create supportive workplace cultures. Some studies into Schwartz Rounds have identified positive results for the workplace culture (Maben et al, 2018; Goodrich, 2012).

Some organisations employ supervisors with mentorship roles, while there are supervisory models that have also been shown to increase staff care (Wallbank and Hatton, 2011).

### Chaplaincy services

Coping strategies such as mindfulness and reflexive practice often require staff training or investment in formal, organised practice. In addition, when engaging in group models of reflexive practice, staff can sometimes feel there is a conflict of interest; they may also feel unsure or vulnerable about sharing with colleagues or line managers issues or worries that relate to competence and professionalism.

Other potential sources of support, which do not involve any of the above, are chaplaincy services. Healthcare chaplains are trained in offering multifacit and multicultural spiritual and pastoral care for people – no matter whether they are religious or secular – and are well placed to deliver services to staff as well as patients (Rusted, 2017). They understand and follow NHS guidelines for clinical governance, competencies and confidentiality (NHS England, 2015).

Healthcare chaplains offer:

- Independence from nursing professional bodies but maintain the same standards of professional practice;
- Confidentiality;
- Experience of death, dying and bereavement in families, and a shared understanding of the emotional labour for nurses;
- Pastoral or spiritual care, as required by the individual;
- One-to-one listening;
- A safe space and their own training and expertise in providing compassionate care;
- A freely available service that can be accessed once or several times to suit the needs of the nurse;
- A source of support that does not necessitate the nurse learning new skills.

### Conclusion

Medical advances and an ageing population contribute to more people dying in hospital and mean that health professionals are managing patients who have multiple health needs and are sicker and frailer than would have been the case even a decade ago. Caring for people is stressful, even for professionals trained to care, and caring for people who are dying adds to this emotional labour.

Workplace environments that do not support staff wellbeing can reduce staff morale and efficiency. It should also be noted that the cost to the NHS of staff stress, burnout and attrition is not only...
Box 4. Reflection exercises

Reflection 1
Pause to remember a patient who made an impact on you, especially if that patient died in your care. How did you feel when your care for them ended? Did you seek any support for your feelings and who do you feel helped you most?

Reflection 2
Think of a time when you felt very stressed. What feelings – physical, mental, emotional, spiritual – did you have? Did these feelings lessen your ability to perform your work? Did you speak to anybody about them? Write down how you really felt and how you think it affected how you behaved and worked.

Reflection 3
Does your organisation provide a safe space for you to talk about work worries? Do you have people you can talk to? What would you like to help you cope? Write a list of your coping mechanisms.

Reflection 4
Mindfulness uses meditation techniques to focus on the now. The meditation can be short and can, therefore, be useful at any time. Have you ever tried any mindful practice? Try taking a deep breath when you are between patients; counting to 10, focusing on your breath going in and out, and letting go of any other thoughts and feelings. Does that help?

Reflection 5
Healthy organisations offer help to employees, sometimes through occupational health initiatives. Have you thought of using these services? Find out what is on offer at your organisation to help you.

Reflection 6
Are you aware of the chaplaincy/spiritual care departments in your healthcare organisation? Did you know they are there for non-religious people too? Have you ever thought of using their services to help you? What would (if anything) prevent you from using them?

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