Passing Away: An Exploratory Study into Physiotherapy Students' Experiences of Patient Death whilst on Clinical Placement

Samantha Powell[1] & Jane Toms[2]

[1]Senior Physiotherapist, University Hospitals Coventry and Warwickshire, Coventry, UK

[2]Senior Lecturer in Physiotherapy, Coventry University, Coventry, UK

Corresponding author:
Samantha Powell, Physiotherapy Department, University Hospitals Coventry and Warwickshire, Clifford Bridge Road, Coventry CV2 2DX, UK
Email: samantha.powell@uhcw.nhs.uk

Abstract

Objectives: Physiotherapy students returning to university following clinical placement commonly reported encountering patient death and often appeared traumatised by the experience. This exploratory study focuses on three main areas: students' experiences of patient death, their feelings and how they coped.

Design: A qualitative research design utilised focus groups to explore students' experiences of patient death. Sessions were audio-taped, transcribed verbatim and underwent independent thematic analysis by the authors. Categories and themes were then agreed.

Participants: Two consecutive final year cohorts were invited to participate in this qualitative study. This resulted in a purposive sample of 15 Physiotherapy students.

Findings: Five overlapping themes emerged: emotional distress, contrasts in reactions, desire to respond professionally, coping strategies and contextual risk factors. Students reported not only descriptions of the patient's death but also the perceived contrast between their reactions and those of experienced staff. The latter were described as 'insensitive' and 'blasé'. This contrast resulted in a breakdown in communication and a suppression of students' reactions as they did not want to appear 'silly' or 'unprofessional'.

There is increasing recognition that effective management of patient death is an important part of health care. This study suggests that if placement is to be an effective learning environment for this aspect of practice then established healthcare professionals and educators need to be positive role models. Without this the values and skills that are necessary for providing quality end-of-life care may struggle to develop, as well as the culture of openness and transparency that is essential so that students no longer feel they have to hide their emotional distress.

Keywords: placements, physiotherapy, death, coping, 'emotional distress'

Introduction

There is extensive research into patient death, the effects on healthcare professionals involved and the coping strategies they employ (Yang & McIlfatrick 2001, Redinbaugh *et al.* 2003, Moores *et al.* 2007, Halpern *et al.* 2009, Shorter & Stayt 2009, Gerow *et al.* 2010, Wilson & Kirshbaum 2011). Much of this research focuses on deaths that occur within palliative care settings despite only 6% of patient deaths taking place in this environment (Office for National Statistics 2012, p11). Whilst the majority (52%) of deaths in England and Wales occur within hospitals (Office for National Statistics 2012, p7), there is little research in this setting.

Investigations into the provision of end-of-life care within the acute hospital show that those providing such treatment are preoccupied with routine practice and curative measures (Costello 2006, Willard & Luker 2006) which may lead to barriers to palliative, comfort or supportive measures (Costello & Trinder-Brook 2000, Willard & Luker 2006). In turn, this may lead to inadequacies in meeting the psychosocial needs of dying patients (Matzo *et al.* 2003, Rich 2005, Willard & Luker 2006). Whilst elements of palliative care are permeating acute hospitals, death remains 'taboo' and is often feared (Rich 2005), consequently the transition from providing life-sustaining treatments to implementing a 'good death' is often poor, which is potentially distressing for patients, relatives and staff (Yang & McIlfatrick 2001, Matzo *et al.* 2003, Willard & Luker 2006, Espinosa *et al.* 2010).

Inadequacies in the provision of end-of -life care have recently received attention as part of the Francis Report (2013), which highlighted a lack of basic patient care and the absence of privacy and dignity during death. Alarmingly, it was also reported that staff were perceived to be 'callous' and 'indifferent' (Francis Report 2013, p13). This was also reflected in the 2012 National Bereavement Survey, which reported that hospitals ranked lowest for "always showing dignity and respect" with figures of 59% of doctors and 52% of nurses appearing to do so, compared with 84% and 82% respectively in hospices. Furthermore, only 44% rated the quality of care across all services in the last three months of life outstanding or excellent (Office for National Statistics, 2012, p3). One of the key recommendations to emerge from the Francis Report (2013) is the initiation of a culture change that promotes openness, transparency and candour and where patient-focused care is not only a priority but delivered by caring, compassionate and committed staff.

Caring for the dying patient in hospital can be rewarding (Costello & Trinder-Brook 2000, Matzo *et al.* 2003, Rich 2005) and provide opportunity for personal growth (Yang & McIlfatrick 2001). However, the difficulties in identifying and implementing appropriate care plans to facilitate a *'good death'* can also be traumatic (Costello 2006) and may manifest as either emotional or physical reactions (Rich 2005, Moores *et al.* 2007, Halpern *et al.* 2009). Emotional distress may have long-term detrimental effects both personally and professionally such as post-traumatic stress disorder, burnout, reduced clinical effectiveness (Matzo *et al.* 2003, Clouder 2005, Rich 2005, Halpern *et al.* 2009, Shorter & Stayt 2009) and professional compassion fatigue (Wilson & Kirshbaum 2011, Melvin 2012). Such distress may also limit emotional engagement and thereby contribute to lack of support and compassion for the dying patient and/or their family (Matzo *et al.* 2003, Espinosa *et al.* 2010, Melvin 2012).

There has been growing interest in palliative care related issues in undergraduate medical training programmes which has been reflected in an increase in the number of hours taught (Hillier & Wee 2001, Field & Wee 2002, MacLeod *et al.* 2003, Kelly & Nisker 2010). However, there is little known about the effectiveness of end-of-life care classroom-based teaching and, even when included, Kelly & Nisker (2010) report that the emotional aspect of caring for the dying is often not addressed. Indeed, Clouder (2005) suggests that student health professionals are not exposed to caring discourse, including emotional and affective

aspects of professional learning, at undergraduate level. Some research advocates learning through experience (Hillier & Wee 2001, MacLeod *et al.* 2003), which has been reflected in the types of teaching methods now used in medical schools, that often include meeting a dying patient or hospice placements (Field & Wee 2002). It is also suggested that experiential learning can be enhanced through positive role-modelling (Peterson *et al.* 2010).

Whilst it is recognised in the literature that there is a significant risk to healthcare professionals and students in terms of emotional and physical burnout when exposed to patient death in hospitals, there is little known regarding Physiotherapy students' experiences of patient death whilst on clinical placement in the acute setting. In contrast to the paucity of research elsewhere, Physiotherapy students at Coventry University, during routine post clinical placement debriefing sessions, frequently highlight experiences of patient death. This study therefore sets out to explore third year Physiotherapy students' experiences of patient death within the acute setting whilst on clinical placement. In doing so, it aims to gain a greater understanding of the effects of patient death on Physiotherapy students at both the professional and personal level. Furthermore, this study seeks to identify common coping strategies developed by physiotherapy students who have experienced a patient death whilst on clinical placement.

Methods

This qualitative study used focus groups to explore the potentially rich and complex "ideas, attitudes, understanding and perceptions" (Plummer-D'Amato 2008a, p69) expressed in Physiotherapy students' experiences of patient death whilst on clinical placement. Focus groups have previously been used to explore a wide range of issues relating to end-of-life care from a number of perspectives (Costello & Trinder-Brook 2000, Hudson 2003, Halpern *et al.* 2009, Espinosa *et al.* 2010, Kelly & Nisker 2010) and were therefore considered an appropriate method to employ. Group interviews were selected as peer support was considered important when discussing end-of -life care experiences, and the interaction between members is thought to generate and refine data which individual interviews may not (Kitzinger 2005, Plummer-D'Amato 2008a). Focus group methodology allows investigation of a multitude of perceptions about a defined area (Nyamathi & Shuler 1990).

Ethical approval was granted from Coventry University Research Ethics Committee. Participants were provided with verbal and written details of the project (Hudson 2003) and written consent was gained. Final year Physiotherapy students who had experienced patient death during their training were deliberately sought out, a sampling method typical of focus groups (Hudson 2003, Barbour 2005, Carter & Henderson 2005, Plummer-D'Amato 2008a).

Prior to commencing the focus group demographic details were collected, which included age, sex, clinical placements completed, clinical placements where patient death had occurred, previous experience in health care, religious affiliation and personal experiences of death. There were 15 participants in total with only one male, which is likely to be representative of the physiotherapist population. The age range was 21–31 years. Two thirds of the participants reported personal experiences of death, some within a year. We did not exclude any participants based on this information, but ensured that the risk of emotional distress was managed. Participants were free to withdraw from the study at any time and were advised that they could access formal support following the focus groups should they need it, through the counselling services provided at the university. Participants were made aware of the availability of counselling services in the written information provided and on the consent forms. It was agreed that the researchers would make onward referrals to the service upon request as well as highlighting to participants that the co-author was available for informal support should participants prefer.

The aim of the research, to explore students' experience of patient death on placement, together with existing research was used to develop the interview questions (Carter & Henderson 2005). The interview schedule consisted of five open-ended questions which were piloted in the initial focus group. Probing questions were also used to explore or clarify (Hudson 2003). The questioning route used allows participants to direct discussion and therefore reduces researcher bias. Data from the initial pilot were included in the research since no amendments were made to the original interview schedule, which read as follows:

1. Describe your experience of patient death on clinical placement

2. How did you feel:
    (a) At the time?
    (b) Following the event?

3. How did you cope with the death?

4. Is there anything that hindered your coping?

5. Is there anything you feel could be done to help future Physiotherapy Students cope with the death of a patient?

In total four focus groups comprised of Level 3 students were conducted, each lasting no longer than 90 minutes. They took place over two consecutive years with the first focus group, the pilot, drawing on a different cohort of students from the three that occurred in the following year. Each focus group consisted of between three and five participants with smaller groups deemed more appropriate because of the complexity of the research question (Bowling 2002, Carpenter 2004) and the aim of gaining in-depth views (Plummer-D'Amato 2008a). Group size also took into consideration the sensitive nature of the research focus. The group was considered to be homogeneous in terms of level of education and clinical experience, which is important for obtaining rich, uninhibited data (Barbour 2005, Kitzinger 2005, Plummer-D'Amato 2008a) and reduced the risk of conformity (Plummer-D'Amato 2008b). All interviews were conducted at the university in a private room.

The principal researcher moderated the groups whilst the co-author acted as the assistant moderator and made notes during the discussions. The moderator was at the time of the first focus group a member of the same cohort of Physiotherapy students and at the time of the remaining interviews a junior clinician. The co-author was a senior lecturer with previous research experience, including conducting focus groups. It was acknowledged by the research team that familiarity with the participants might influence discussion within the group; however, insider research can potentially "enhance validity due to the added richness, honesty, fidelity and authenticity of the information acquired" (Rooney 2005, p7). According to Tong *et al.* (2007) and Plummer-D'Amato (2008b), it is difficult to completely eliminate researcher bias within qualitative research due to the researcher's need to engage in the process.

The focus groups were introduced by the moderator, a process that included information regarding the aims and objectives of the study and the roles of the researchers within the context of the interviews, and ground rules were set. Following the interviews participants were informed regarding the motivation for researching the topic. Participants were given a copy of the interview schedule and were given time to make brief notes; with consent these notes were collected to form part of the field data. On completion of each focus group the assistant moderator summarised the main ideas and participants were asked to check if they were in agreement and to add further comments (Hudson 2003, Plummer-D'Amato 2008a).

Data analysis followed a thematic framework (Pope *et al.* 2000, Donavon & Sanders 2005). Firstly the principal researcher transcribed the interviews verbatim; these were read and annotated, enabling the researcher to become familiar with the data. Each transcript was analysed in its own right, following which themes were developed by removing extracts from the annotated scripts and tabulating the data chronologically and later rearranging alphabetically. Relationships between subcategories and then categories were highlighted and themes were developed. To enhance rigour, categorisation and theming were conducted separately by both researchers (Kidd & Parshall 2000). Summaries of the discussions that followed and regular meetings which took place between the researchers added to the process of reflexivity (Hennink *et al.* 2011). Discussion was enhanced by the researchers' variety of experience and perspective. In addition, transparency and honesty during the research process allow readers to draw their own conclusions (Rooney 2005, p7).

Findings and Discussion

Figure 1 illustrates the five themes that were identified and the overlapping nature of those themes. The themes were all closely linked which is demonstrated by the connecting lines around the peripheries. The tram lines connecting the themes to the patient death might be viewed as a Likert scale, which is dependent on its perceived magnitude. This can be illustrated with the theme contrast in reactions; hence participants are placed furthest away from the centre whilst experienced healthcare workers are near to the centre. The themes are presented separately and illustrated throughout by the use of participant quotes. Each theme is considered in the context of the existing literature.
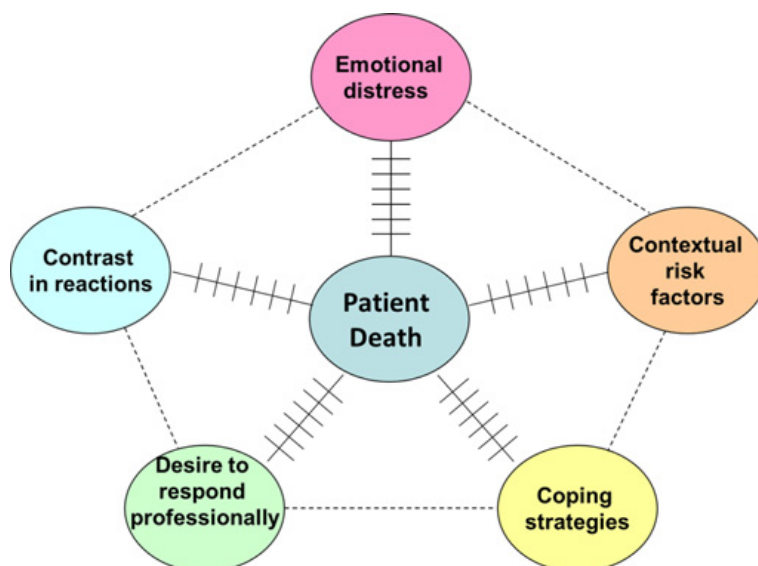

Figure 1 Results diagram.

Emotional Distress: "I burst into tears; I just had to leave the ward"

Students described the "profound effect" of some patient deaths and how they were "overwhelmed" and "traumatised" by their experiences, which was reflected during the discussions when some participants became tearful. The emotions described by participants ranged from shock and distress to feelings of anger and frustration. These responses are

consistent with grief reactions and are reflected in the literature (Shanfield 1981, Stedeford 1994, Costello & Trinder-Brook 2000, Yang & McIlfatrick 2001, MacLeod *et al.* 2003, Matzo *et al.* 2003, Redinbaugh *et al.* 2003, Williams *et al.* 2005, Moores *et al.* 2007, Halpern *et al.* 2009, Kelly & Nisker 2010).

The following remarks illustrate the extent to which participants were upset by patient death:

> "I just went and sat in the staff room just shaking and then I started crying."

> "I still feel quite upset about it really… it was six months ago now."

Most participants did feel that being upset was a normal response to patient death:

> "I think you have to really have a good think about it and get upset about it, it's completely normal."

Feeling upset or saddened by patient death is consistently reported amongst a range of healthcare workers, including ambulance workers (Halpern *et al.* 2009), doctors (Redinbaugh *et al.* 2003, Rhodes-Kropf *et al.* 2005, Moores *et al.* 2007, Kelly & Nisker 2010) and nurses (Yang & McIlfatrick 2001). Over a quarter of emergency workers reported intense discomfort lasting several weeks to several years after attending critical incidents (Halpern *et al.* 2009), which has significant implications in respect of the long-term, cumulative effects of caring for the dying patient. Some nurses reported that they preferred to cry in private (Yang & McIlfatrick 2001), which was reflected in the behaviour described by some of the participants.

One aspect of this emotional distress was the feelings of guilt many participants conveyed:

> "I felt quite guilty that this patient was being treated by a student that probably if he'd been treated by this highly specialised physio then maybe his chance of survival would have been greater."

Feelings of guilt and self-doubt have previously been reported by healthcare professionals (Shanfield 1981, Costello & Trinder-Brook 2000, Yang & McIlfatrick 2001, Clouder 2005, Rhodes-Kropf *et al.* 2005, Rich 2005, Williams *et al.* 2005, Moores *et al.* 2007, Halpern *et al.* 2009, Gerow *et al.* 2010). A study exploring preclinical medical students' feelings towards a potential patient death reported fears of not knowing enough or not doing enough (Williams *et al.* 2005). This fear is thought to be heightened in the novice practitioner (Yang & McIlfatrick 2001).

Contrasts in reaction: "No-one else seems to be upset"

There was an apparent gulf between the responses of participants and those of experienced staff. Experienced professionals were often perceived by participants to view death as 'routine', moving quickly from one patient to another with little emotion, whilst by contrast participants were clearly distressed. Many participants perceived this lack of emotion as 'insensitive':

> "Everybody else was like, was acting as though it wasn't anything."

> "She was just really blasé about it." (Comment made regarding a clinical educator.)

Research suggests that through prolonged exposure, healthcare workers become *'desensitised'* to the effects of patient death and therefore require less emotional support

(Redinbaugh *et al.* 2003, Stedeford 1994, p202). Being able to 'turn-off' or establish professional distance is considered a coping strategy (Hopkinson *et al.* 2005, Shorter & Stayt 2009, Espinosa *et al.* 2010, Kelly & Nisker 2010, Peterson *et al.* 2010, Melvin 2012, Williams 2013). However, whilst these coping strategies may protect the healthcare professional from the cumulative effects of providing care for the dying, they do not promote quality, patient-centred compassionate care and may be deemed 'callous' and 'indifferent', as reported in the Francis Report (2013, p13).

One participant described how they were mocked by senior staff after a patient had died during treatment:

> "The next day…they had it as a joke and they went 'hope you're not going to kill any more patients today.'"

The use of black humour by experienced staff was discussed in many of the focus groups and can be used as a way of coping (Hopkinson *et al.* 2005, Halpern *et al.* 2009, Espinosa *et al.* 2010, Williams 2013). One participant found the use of black humour helpful as it allowed staff to discuss the death on some level whilst reducing the seriousness of the event. However, many participants felt the use of black humour was insensitive and the literature suggests that its use may lead to isolation of non-peers (Halpern *et al.* 2009).

Due to the stark contrast in reactions, participants felt that experienced staff were unable to understand or empathise with the emotional reactions of students:

> "My educator, she almost got a bit annoyed that I was getting so upset because I should be treating the patients."

> "I thought 'Are you not recognising what's happened or how I'm feeling about this?'"

This often presented as a barrier to discussion of the emotional reactions to patient death and may prohibit coping. One student said:

> "I was not sure what to do with the emotion . . . you feel that you can't express it to them [qualified staff] and I think that just makes it worse."

Desire to respond 'professionally': "How am I supposed to react?"

A belief developed that there was a 'right', 'professional' way to respond, which led to students either suppressing their emotions or feeling embarrassed if they had demonstrated that they had been affected by the death:

> "I felt really unprofessional; there's all this thing about being professional especially on placement and I just felt really silly."

> "I did feel very embarrassed about getting so upset at the time."

The confusion around sharing emotions and appearing professional has been reported previously (Costello & Trinder-Brook 2000, Williams *et al.* 2005, Gerow *et al.* 2010). It might be argued that if we are to achieve objectives as outlined in the Francis Report (2013), including creating an environment that promotes openness and transparency, then healthcare professionals should be able to openly express any adverse reactions to significant events.

Many participants felt that they simply had to continue with their workload, which mirrored the behaviour of those around them. However, this led to feelings of isolation:

> "I just had to carry on with my day…I was then just kinda left to get on with it."

Grief reactions are often shaped by cultural norms (Matzo *et al.* 2003), with the cultural norm regarding death in acute hospitals manifesting itself in silence (Redinbaugh *et al.* 2003) and secrecy (Costello 2006). The literature suggests it is important that clinical educators recognise a student's response to patient death and that an environment is created that legitimises emotional reactions and enables discussion (Shanfield 1981, Redinbaugh *et al.* 2003, Williams *et al.* 2005, Gerow *et al.* 2010, Kelly & Nisker 2010, Williams 2013), thereby facilitating an ability to cope.

The desire to respond professionally left students confused about their emotional reactions and unsure what to do. Similar findings are reported by emergency workers, who felt fearful of the long-term consequences and stigmatisation of allowing themselves to respond emotionally (Halpern *et al.* 2009). Studies have also reported that other healthcare professionals felt they had to cope with patient loss in a 'professional' manner by putting up boundaries and not over-investing in patient–carer relationships (Rhodes-Kropf *et al.* 2005, Shorter & Stayt 2009, Gerow *et al.* 2010, Peterson *et al.* 2010, Melvin 2012, Williams 2013). Redinbaugh *et al.* (2003, p327) reported that senior doctors who are reluctant to discuss their emotional responses to significant deaths "convey a message about how death is to be handled and potentially isolate learners".

Coping strategies: "Don't just dismiss it"

One of the main coping strategies used by participants was discussion. Participants predominately spoke with peers and recognised that it was more useful to discuss events with others who had clinical knowledge, and were reassured if they had similar experiences:

> "It's quite nice knowing that other people are going through the same thing; that helps."

These findings are supported by similar studies (Hopkinson *et al.* 2005, Rhodes-Kropf *et al.* 2005, Rich 2005, Halpern *et al.* 2009, Espinosa *et al.* 2010, Peterson *et al.* 2010, Williams 2013). Shorter & Stayt (2009) report that nurses working in adult ICU preferred to discuss patient death informally with colleagues, despite having more formal support available, as they felt that discussing death in this manner was less inhibiting. Other means of discussing critical incidents with peers were the use of online interprofessional forums. Clouder (2005) suggests that such forums are an invaluable resource for students, who are potentially isolated and more vulnerable.

Lacking confidence and seeking reassurance regarding competence following patient death have previously been reported amongst nurses (Espinosa *et al.* 2010) and emergency workers (Halpern *et al.* 2009, Williams 2013). It is particularly important that students gain reassurance as many participants reported feelings of guilt linked to the level of care they were able to provide. Some participants described finding reassurance from discussing the death with senior staff, particularly if they shared similar experiences. However, some participants reported that they felt uncomfortable discussing their emotions with seniors as they might appear unprofessional or feared they would not receive the same understanding:

> "I don't think I'd feel comfortable talking to any educator about it…particularly if you're trying to put on a professional face."

These findings are reflected in a study by Redinbaugh *et al.* (2003), who reported that the majority of junior doctors did not discuss significant deaths with seniors and those who did found seniors to be unhelpful. Other studies report that formal debriefing was either

absent, did not address the psychosocial aspects of dying or did not offer emotional support to the care givers (Rhodes-Kropf *et al.* 2005).

Some participants found using written reflection helpful:

> "I think writing your feelings down makes you think logically about what's happened and why, and why you are feeling the way you are…it makes things a bit easier."

One participant described how they had previously developed coping strategies through formal counselling which they were able to utilise following experiences of patient death. Others agreed that formal counselling and debriefing might be helpful, which is a strategy that has also been advocated in the literature (Costello & Trinder-Brook 2000, Redinbaugh *et al.* 2003, Moores *et al.* 2007, Kelly & Nisker 2010).

Participants recognised that patient deaths were difficult to prepare for and believed they could only learn to cope effectively through experience, again a finding reflected in previous literature (Hopkinson *et al.* 2005, Williams *et al.* 2005). One participant, whilst recognising that patient death had been emotionally distressing, felt that it was also a positive experience as it allowed them to start to develop coping strategies:

> "You've got to deal with it… it's probably better to have the experience early on while you have that sort of support around you from educators, counselling services at the university and your peers."

It is important to note that if development of those coping strategies is as a result of less positive role modelling, then the resultant learning could promote the continuation of the negative behaviours the Francis Report (2013) seeks to eradicate. However, it is important to remember that this study explored the experiences of patient death within a specific student population.

Contextual risk factors: "For me that's what really stuck out"

Some of the deaths discussed might be considered 'routine'; however, others were clearly traumatic. For example, one participant described finding a patient whom they had been treating collapsed:

> "He was about to go home and…this guy…just fell flat on his face and I just didn't think this way was a very nice way…to go."

Another participant described the death during treatment in the gym of a patient who was expected to go home shortly:

> "He just collapsed…then the crash team came and they started CPR on him…they couldn't do anything for him and he just died."

There appeared to be a number of factors that made the deaths discussed more significant and ultimately increased the risk of emotional distress experienced by participants. These were termed 'risk factors' by the researchers and included: unexpected deaths, first patient deaths and the situation in which the death occurred or was managed:

> "For her to die when she only came in for something quite minor…that was quite shocking."

> "I think it was the first time really…that I found the hardest."

> "They just opened her curtain and basically sorted the body out there and then."

Forming an attachment to the patients and their families was a commonly reported 'risk factor':

> "I didn't think how I would get attached to the patient, attached to their family and how I'd feel."

Participants described building a good rapport with certain patients who "hit a nerve" or "struck that cord", which was dependent on the patient's personality and participants' ability to relate to them or identify with the death:

> "He was so much like my Granddad, who had died just before I came to uni, I think that is why I got so close to him."

Previous studies have reported similarities between the emotional responses to patient deaths and the attachments that had formed with patients and relatives (Payne *et al.* 1998, Costello & Trinder-Brook 2000, Yang & McIlfatrick 2001, Redinbaugh *et al.* 2003, Halpern *et al.* 2009, Gerow *et al.* 2010, Melvin 2012). This also corresponded to the amount of time participants spent with patients (Shanfield 1981, Payne *et al.* 1998, Costello & Trinder-Brook 2000, Redinbaugh *et al.* 2003, Shorter & Stayt 2009, Melvin 2012) and the care givers' ability to identify with the death (Payne *et al.* 1998, Yang & McIlfatrick 2001, Rhodes-Kropf *et al.* 2005, Rich 2005, Halpern *et al.* 2009, Shorter & Stayt 2009, Kelly & Nisker 2010, Williams 2013).

Implications

Each theme has provided valuable insight into students' experiences of patient death on placement. One of the most significant themes was the perceived contrast in reactions such that many qualified staff were perceived as being 'insensitive' and the student's own emotional response as being 'unprofessional'. The coping mechanisms of qualified physiotherapists are an area that should perhaps be explored since what students perceive as 'insensitive' may reflect adaptive or maladaptive coping behaviours. The contrast in reactions results in a breakdown in communication such that students attempted to conceal their reactions rather than reveal them and learn how to cope with them. Preliminary sharing of this research with local clinical educators revealed an uncomfortable acknowledgement of the validity of these findings. A follow-up study of clinicians' perceptions would be valuable.

Clinical placements provide a powerful learning experience in which students may experience patient death. As the previous literature suggests, preparing for experiences of patient death and learning how to cope with such experiences cannot simply be taught via classroom-based teaching. If experiential learning with positive role-modelling is agreed to be essential, then a major concern is the lack of positive role-modelling described by students in this study. Indeed, their descriptions corroborate the findings of both the Francis Report (2013) and the 2012 National Bereavement Survey (Office of National Statistics).

The findings have also highlighted common contextual 'risk factors' that made certain deaths more emotionally demanding for Physiotherapy students than others. This information can be used as a potential means of preparing Physiotherapy students for clinical placements and to highlight to clinical educators and visiting tutors circumstances in which students are more likely to require support, enabling a more proactive approach.

Limitations

The study explored the experiences of patient death within a specific student population and therefore the findings are not considered to be representative of experiences at a larger scale (Carpenter 2004). Its aim was to explore Physiotherapy students' experiences of

patient death, both negative and positive, and although no one came forward to share a neutral or positive experience, that does not necessarily mean they did not occur.

The focus group moderator had no previous experience of conducting a focus group, which might result in the interview schedule having been applied more rigidly leading to less spontaneous discussion (Kidd & Parshall 2000). However, Carter & Henderson (2005, p215) maintain that a qualitative researcher simply requires the same skills that are needed in "everyday social life", something that was reflected in the free-flowing conversation and the rich descriptive findings that were elicited.

Conclusions

This study has illustrated that there are considerable barriers to overcome if student placements are to be effective learning environments for this aspect of practice. There is increasing recognition that managing patient death effectively is an important part of health care in the acute hospital setting and there are initiatives to promote clinical competency in the physical and practical aspects of management. What is less apparent is consideration of initiatives and training to support health professionals when it comes to managing their own, or others', emotional distress. The literature and this study suggest that if this facet of management is not considered there is potential for the emotional distress experienced to interfere with optimal care of the dying person and their relatives, as well as to have long-term implications for the health professional concerned.

In order to develop Physiotherapy students' ability to provide end-of-life care and to cope with the emotional distress that can be part of it, much greater understanding of this complex role is required. Central to students learning to provide quality end-of-life care is the importance of established healthcare professionals and educators in practice being able to manage their own reactions and coping ability in order to become positive role models. Clouder (2005) describes a transition that student health professionals undergo when learning to care, which requires a balance of selflessness and responsibility enabling them to meet their own and their patients' emotional and physical needs. Without this the values and skills that are necessary for providing quality end-of-life care, highlighted in the Francis Report (2013), may struggle to develop. This includes a culture change towards openness and transparency where students no longer feel they have to hide their reactions.

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