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Chapter 1

Introduction
This chapter begins with an outline of my ontological position and an outline of the concepts of both grief and palliative care. It concludes with an overview of the dissertation chapters. Due to the phenomenological nature of my methodology, I will be writing in the first person as opposed to the third. Consideration of my ontological position is fundamental to Heideggerian phenomenology as the researcher seeks to interpret the world through existence within it (see chapter 3). It was therefore essential that my beliefs, experiences and preconceptions were acknowledged prior to and throughout the research process.

One of the placements during my second year of nursing education was on an oncology ward. On my second day of placement one of my patients sadly passed away. This was my first experience of death and I found it very upsetting. I had developed a strong relationship with this patient throughout the day and although he did have cancer, his death was very sudden and unexpected. As the patient was dying my mentor pulled the curtains around us and told me to sit and hold his hand. She then left me and I remember feeling scared as I did not know what to do. The patient then died and I began to cry as I was upset, scared and angry that I had been left in such a situation. My mentor never discussed the death with me or why she had left me in that position. I remember going home and crying. I didn’t feel that I could talk to anyone about it and I felt very alone. It is still a bad memory for me and an experience that I hope other student nurses do not have to go through. Whilst on the placement I did have other experiences of patients dying, but this experience will always stand out the most in my memory. I felt that my nursing education did not sufficiently prepare me for these
experiences. I also felt that I was not adequately supported through these experiences of grief by my mentor or by my educational programme. Having completed my oncology ward placement I reflected on my experiences and only then did it become apparent to me that I did experience the phenomenon of grief whilst caring for these dying patients.

I wondered how other student nurses felt when caring for dying patients, whether they also had strong feelings of grief and how they coped with these feelings. I also wanted to know if other students felt supported and prepared for these experiences. Feelings of grief effect people in very different ways and I wanted to know if I was reacting appropriately.

Within the nursing literature I found only a small amount of research into the grief experiences of staff nurses, however I found even less research into grief experiences of student nurses. Manson (2008), states that encountering the death of a patient is one of the most anxiety provoking events to face a student nurse, and I would agree with this statement. Throughout the literature, it was constantly highlighted that palliative care is a topic that is very poorly taught across nursing schools (Paice et al, 2006). The combination of my personal experiences and the fact that there has been little research into the topic prompted me to further explore the phenomenon of the student nurses’ experience of grief.

Palliative care is a specific approach to the nursing of a patient who is dying, it aims to improve the quality of the lives of patients and their families through the prevention and relief of suffering (World Health Organisation, 2010). In today’s society palliative care is an essential component of health
care. Healthcare professionals’ knowledge of palliative care ranges from simple awareness to those who are highly specialised within the area (Cairns and Yates, 2003).

I chose to focus my study around the phenomenon of grief. Grief is a term used to encompass a wide range of feelings and emotions. Most people would associate grief or grieving with a person who has lost a close friend, relation or partner. It is rare for such a strong word to be used when describing what a nurse may experience when a patient dies. It is, however, crucial to recognise that nurses do experience grief when caring for dying patients and it is equally important to recognise that it is acceptable for a nurse to suffer from grief. The phenomenon of grief will be discussed in more detail in chapter 2.

The aim of my study was to explore the phenomenon of grief as experienced by student nurses when caring for dying patients whilst on clinical placement. Phenomenology is the research methodology used throughout this study. By exploring, describing and interpreting the experiences that make up the phenomenon, I hope to better understand the grief as experienced by student nurses whilst caring for dying patients on clinical placement.

This dissertation is presented in six chapters. Chapter 2 explores the background and reviews the literature. This chapter clarifies the purpose of my study by considering the wider literature around the phenomenon of grief, nursing education and palliative care. Chapter 3 details the methodology and methods, explaining why hermeneutic phenomenology
was chosen as the research methodology and how the study was conducted. Chapter 4 reports the findings of the study using extracts from the participants’ interviews. Three key themes were identified from the data: grief processes, nursing and nurse education and future possibilities. Chapter 5 discusses the findings in relation to the literature reviewed in chapter 2. Chapter 6 concludes the dissertation and consists of a summary of what the research has achieved, reflection upon the research process and recommendations for future research.
Chapter 2

Background and Review of the Literature
Introduction

This chapter adds context to the dissertation and provides justification for carrying out the research. The phenomenon of grief within the nursing literature will first be examined followed by the education of nurses with respect to palliative care being considered. Finally, I explore the literature on the relationships between student nurses, grief and palliative care education.

Roberts and Priest (2010) state that a literature review should be conducted to demonstrate that the research is important, it is based upon a clear rationale and that it has not been previously undertaken. They highlight that a literature review will provide new information and have a practical application. There is debate among academics as to whether a literature review is relevant when conducting qualitative research. In the past, qualitative researchers did not conduct a literature review at the start of their research as it was believed that a detailed literature review would invalidate the findings of the qualitative research study (Holloway and Wheeler, 2002). Glaser (1978) agrees that the researcher should not consult the literature before conducting their research. He believes the literature may distract the researcher causing them to lead participants in the direction of what has already been discovered. In contrast, Morse and Field (1996) recommend examining previous work critically and using work selectively. They suggest obtaining relevant literature and conducting an extensive content analysis as well as examining implicit and explicit assumptions. It was with this in mind that this chapter was written.
I carried out my literature review using CINAHL and OVID search engines. I searched the terms ‘grief,’ ‘student nurses,’ ‘palliative care’ and ‘nursing education’. I explored a variety of combinations of these terms in order to conduct a more comprehensive search. Whilst reviewing the literature I found that the majority of relevant research was rather dated and was also conducted abroad. Even after carrying out numerous searches, I was unable to locate contemporary research conducted within the UK. It is within these constraints that I present my review of the literature.
The Phenomenon of Grief

Within the literature it was apparent that grief can be defined in a number of different ways. Weinstein (2008) defines grief as the psychological expression of bereavement. Bowlby (1980) sees grief as an adaptive response. Lindemann (1944) defines grief as an acute crisis or series of crises. Cowles and Rodgers (1991) believe that the concept of grief is surrounded by vagueness and ambiguity with a variety of definitions being provided by a variety of researchers. This vagueness and ambiguity surrounding the definition may lead to the recognition of the presence of grief being hindered.

The phenomenon of grief can manifest itself in a number of different ways within an individual. Worden (2002) states that people experiencing grief may undergo feelings such as sadness, anger, guilt and anxiety. He believes that one may also experience behaviours such as sleep disturbances, appetite loss, social withdrawal and absent minded behaviour. Lindemann (1994) describes grief as a syndrome with a predictable course and distinctive symptoms such as somatic disturbances, feelings of guilt, hostility and anger. Perhaps the most famous models of grief was developed by Kubler-Ross (1969) who identified five stages of grief: denial, anger, bargaining, depression and acceptance.

Almost everyone will experience the phenomenon grief, however it is defined or theorised, to varying degrees once or more during the course of a lifetime (Cowles, 1996). Within the context of the nursing profession, the nurse may experience elements of grief after the death of a patient. Buglass
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(2010) acknowledges that death is a situation that is frequently encountered by nurses and as such it is vital that nurses understand the ways in which grief manifests itself. This is not only so that they can help support the patient and their family members, but so that they are also able to cope with their own feelings of grief whilst caring for dying patients. Ginette and Leveillee, (2006) state that the grieving person whether it be friend, family or healthcare professional may develop signs and symptoms of depression whilst grieving. It could be argued that if nurses are experiencing grief on a regular basis it may lead to prolonged feelings of depression. This is likely to have negative implications for the quality of nursing care and the amount of time nurses need to take off work.

Feldstein and Gemma (1995) state that there is little written within nursing literature describing the grief experiences of nurses caring for dying patients. They recognise that nurses’ intense involvement with patients who are seriously ill can create great emotional stress. Despite this, nurses receive little in the way of practical preparation to help them to cope with the stress of working with dying patients. Brunelli (2005) found that the cumulative loss of patients puts a physical, mental and spiritual burden on nurses, not only as nurses, but also as human beings. Stowers (1983), believes that nurses are rarely able to share the grief they experience when their patients die. Instead, they have to face these feelings of grief in their own limited way without support or comfort. He states that nurses may try to deny the presence of grief which could result in the grief reappearing at a later date. This is supported by Lenart et al (1998) who found that nurses repress their feelings of grief. I found this to be true from my own experiences as I did
not recognise the presence of my own grief until long after I had experienced it.

The phenomenon of grief is clearly one that can have a profound impact on an individual’s life. This is why I decided to conduct my study into the grief experiences of student nurses. A key element of my own experience of grief was the lack of nursing education I received around the topic of palliative care.
Palliative Care within Nursing Education

Nurses at all levels of their career play a vitally important role in the delivery of palliative care (Irvine, 1993) and patients requiring palliative care occupy a large percentage of hospital beds (Greer et al, 1983). However, during the 60’s, 70’s, 80’s and 90’s, the literature suggests that the subject of palliative care is one that is poorly taught within nursing education (Wilkinson, 1995, Longman et al, 1988, Quint, 1967, Weber, 1989). Although these studies are now dated, there is little contemporary research with which to provide a comparison.

Robinson et al (1999) state that healthcare in the UK is continually influenced by goals and policies driven from the government and other organisations, for example, the Nursing and Midwifery Council (NMC). An evaluation of the cancer content of pre-registration nursing programmes reported inadequacy and a lack of teaching about cancer and palliative care (Longman et al, 1988). Wilkinson, (1995) agrees stating that previous studies have highlighted that registered nurses are inadequately prepared to undertake palliative care and that they experience considerable stress whilst doing so. I found no recent literature to suggest that there has been any change in the palliative care content of nursing programmes.

Quint’s (1967) seminal research highlighted inadequacies in the educational preparation of palliative care nurses. Quint argued there was a need for a more systematic approach to nursing education on death and dying and that this would be maximised in a supportive clinical environment. Quint’s study profoundly influenced the way in which death education was incorporated
and taught within nursing schools (Copp, 1994). Since this time, there have been additional attempts to improve pre-registration nursing preparation for practice such as the Department of Health (DoH, 1999) ‘Making a Difference to Nursing and Pre-registration Education’ and the Royal Collage of Nursing ‘A Framework for Adult Cancer Nursing’ (RCN, 2003). Despite these attempts, a recent review conducted by the NMC raised concern as great variation was found in the competence of students in areas such as communication, medicine administration and decision making (NMC, 2005). Each of these areas is vital to the delivery of effective palliative care.

The National Institute for Clinical Excellence (NICE, 2004) has recently recommended a set of national guidelines to prepare a ‘suitably trained workforce’ capable of providing supportive and palliative care services for people with cancer, as well as their families and carers. These are significant developments as the need to prepare an effective and informed workforce at all nursing levels is recognised. Rather than just focusing on post-registration nurses, pre-registration nurses are also taken into consideration. However, despite these guidelines focusing on all levels of nursing, Cunningham et al (2006), argue that the majority of studies into palliative care are only concerned with post-registration nurses. Evidence of this is The NHS Cancer Plan, developed by the Department of Health (2000) which aimed to increase the number of nurses involved in the delivery palliative care. The plan recommended further training of nurses who were already qualified but did not suggest improving the palliative care training provided to undergraduate nurses.
The majority of research into palliative care education is very dated and I did not find any contemporary research on the topic. This suggests that there is a need for more contemporary research into pre-registration nursing students and palliative care education. My research does provide an insight into palliative care education for pre-registration nurses as it is a topic that most of my participants commented on in relation to their grief experiences.

From the background research I conducted, it was clear that there was insufficient teaching around the subject of palliative care. It was also clear that the phenomenon of grief is one that needs further focus and acceptance within nursing and nursing research. Experiencing grief on a regular basis can lead to depression within nurses (Ginette and Leveillee, 2006). Many nurses repress or deny their feelings of grief (Stowers, 1983, Lenart et al, 1998). I believe that further research into the phenomenon of grief will raise awareness of its potential manifestations among nurses, leading to grief being more readily recognised and accepted within the profession.
Cooper and Barnett, (2005) interviewed 38 first year student nurses with the aim of examining aspects of caring for dying patients that caused anxiety for students during their first year of training. Data were collected via students’ reflective diaries and two focus group meetings. The authors revealed eight different themes relating to students’ anxiety about caring for dying patients: coping with the physical suffering of the patient; what to do and say; the type of death; last offices; the severing of the relationship with the patient; cardiopulmonary resuscitation; coping mechanisms and interventions that would improve the student nurse experience. The study concluded that as opposed to a personal fear of death, it is pressures from aspects of the caring role that was the main source of anxiety amongst student nurses. Whilst in certain ways my research will be similar, this study focuses on anxiety in relation to caring for dying patients. My research focuses on the phenomenon of grief as experienced by student nurses, and therefore, is different in its scope.

Beck, (1997) conducted a phenomenological study exploring nursing students experiences of caring for dying patients. He found that student nurses experienced a range of emotions including sadness, fear, anxiety and frustration when caring for patients at the end of life. Students also felt an integral aspect of the care involved was providing support for the patients’ families. An overwhelming feeling of helplessness was reported by participants with regard to their role as the patient’s advocate. Whilst this study also uses phenomenological methodology, there are three key differences between this research and my own. Firstly, the focus of my study
was different, as I wanted to specifically know about student nurses experiences of grief when caring for dying patients. Secondly, Beck’s study was carried out in America whilst my research focused on nursing students from two nursing institutions within the UK. Finally, this study was carried out 14 years ago whereas my study provides a more contemporary view on the topic.

Hurtig and Stewin, (1990) investigated the effect of death education programmes and personal experience on the attitudes of student nurses towards death. It was found that attitudes towards death among inexperienced students who took part in an experiential teaching programme were more positive than those of similar students who received a didactic or placebo teaching programme. These findings suggest that death education in the early stages of a nurse’s education can have a beneficial effect on attitudes and experiences towards death. Despite this suggestion, research conducted years later concludes that end-of-life care education needs further improvement. White, Coyne and Patel (2001) used a survey to determine the end-of-life care educational needs and competencies of oncology nurses in various states across the USA. Most participants indicated that palliative care education was of high importance, but a third of respondents to the survey had received less than two hours of palliative care education in two years. It was concluded that the educational curricula for end of life care needed vast improvement. This study was conducted using a sample of only 56 nurses who all worked in the same medical centre in America. Due to this small sample and the fact that this research was undertaken in a different country, it is difficult to generalise these findings to nursing schools within
the UK. This American study used a survey approach, but I feel that due to the sensitive nature of the phenomenon of grief, interviewing participants would be the best way to provide the most meaningful data for my study.

Cairns and Yates (2003) believe there are improvements to be made in Australia regarding palliative care education. They state that the growing demand for palliative care means that health care professionals are expected to deliver palliative care as a core element of practice. They highlight that training in palliative care is a recent addition to the undergraduate healthcare curricula in Australia. They also suggest strategies for improving palliative care education including a national undergraduate curriculum for palliative care, an expansion of training opportunities for registered practitioners and further recognition of specialist palliative care practitioners. However, these recommendations are based purely on the authors’ opinion and are not substantiated with empirical research.

Paice et al (2006), highlight that there is little attention devoted to palliative care in most undergraduate nursing curricula. They believe that this results in nurses being poorly prepared to meet the needs patients approaching the end of their lives. Consequently, Paice et al (2006) carried out a study in which they recruited 60 graduate nurses to attend an end-of-life Nursing Education Consortium Graduate training course. Before attending the course, the participants were asked to complete a survey about the adequacy of the end-of-life content within their curriculum as well as their perceptions of overall end-of-life care education at their university. The participants were asked to complete a survey immediately after the course and then given the same survey to complete again 12 months after the Nursing Education
Consortium Graduate training course completion date. Paice et al (2006) found that the participants reported significant improvements in the adequacy of end-of-life content within their universities having completed the Nursing Education Consortium Graduate training course. They concluded that the end-of-life Nursing Education Consortium Graduate programme effectively improves faculty and university expertise in end-of-life care and expands the palliative care content within graduate nursing curricula. This programme is now used across America in various nursing schools (Malloy et al, 2008). Whilst this programme has been found to be very useful in America, there is no such programme being run in the UK suggesting cultural differences in end-of-life care education. I hoped that my research would touch on the topic of end-of-life care education, providing insight into UK student nurses’ opinions.

Cunningham et al (2006), state that there is little evidence relating to student nurses’ perceptions of their experience with cancer or palliative care patients in the UK. This is the case even though, student nurses are likely to be the ones caring for these types of patients in a variety of clinical settings during their student nursing programme. Cunningham et al (2006) believe that information gathered would provide an insight into students’ perceptions of their experiences. Particularly interesting would be the educational and clinical support available to prepare them to care effectively for palliative care patients at an early stage in their clinical practice. This recommendation suggests there is a necessity for my research and highlights the gap in the nursing literature around the student nurses experiences of caring for dying patients, particularly in the UK.
Lloyd-Williams and Field (2002) found there had been many studies undertaken evaluating palliative care training in the undergraduate medical curriculum, but little attention is paid to undergraduate nurse education in palliative care. As a result, they developed a questionnaire about palliative care provision within the curriculum and sent it to all senior tutors in the UK. The majority of respondents (82% of the 44 respondents’) stated that they felt education about palliative care should be a core component of entry level diploma and degree education. Sixty seven percent of respondents indicated that they had difficulty in finding appropriately qualified staff to teach the subject. The authors concluded that current undergraduate nursing curricula are unlikely to equip nurses with sufficient skills to offer adequate palliative care. As awareness of the large number of patients who should be receiving palliative care becomes increasingly well recognised, it is essential that student nurses receive adequate basic training in this area. If this is to be achieved, there needs to be an increase in the provision of palliative care clinical placements and skilled teaching personnel. I anticipated that education would be a factor that affected my participants experiences of grief, as it was a factor that affected my own experiences of grief. I hoped that participants would provide information on their experiences of palliative care education.

Summary

From my review of the literature, it is clear that there is little research into student nurses experience of grief whilst caring for dying patients on clinical placements. Whilst I found this alarming, I was heartened in knowing that my research was both justified and long overdue. From the relevant literature
I did examine, it was clear that a quantitative methodology was commonly adopted. Due to the personal and sensitive issues relating to grief and palliative care, a qualitative approach is much more appropriate (this is discussed further in chapter 3). The majority of the literature examined was conducted a considerable number of years ago and very little of this literature is focused within the UK. My proposed research is both timely and appropriate providing a contemporary view of the phenomenon from a British nursing student’s perspective.

The following chapter will provide the rationale for the methodology I selected to explore the phenomenon of grief as experienced by student nurses on clinical placements, this is followed by a detailed description of the methods used.
Chapter 3

Methodology and Methods
Introduction

This chapter will focus on the methodology underpinning my research. Theoretical and philosophical principals will also be considered. Holloway and Wheeler (2002) state that the methodology is the underlying rationale and framework of ideas and theories determining the approaches, strategies and methods adopted. The term methods refers to the way in which the data is collected (Parahoo, 2006).

Webb (2002) believes that one particular research methodology is no stronger or more impressive than another. Methodologies are not true or false, only more or less useful depending on how appropriate they are to the research being conducted (Silverman, 1993). Therefore, this chapter will explore the different methodologies available in order to select the most appropriate for the research. There are two main approaches within nursing research: quantitative and qualitative. Both of these approaches have a different underlying philosophy. This chapter will look into these different research approaches and highlight why a qualitative approach is more appropriate for this study.
Methodology

Quantitative approaches to research are underpinned by the philosophies of a positivist approach; they tend to be viewed as the more traditional approach based on scientific method. A positivist approach refers to a general set of orderly disciplined procedures used to acquire information (Polit and Beck, 2004). Quantitative research design usually has a hypothesis to be tested and results are considered to be objective (Gerrish and Lacey, 2006). A quantitative approach would be inappropriate for this research study as I do not have a hypothesis to be tested. The research aims to uncover information about a person’s lived experience and therefore what the findings will show is unknown. I aim to better understand the phenomenon of grief as experienced by student nurses whilst caring for dying patients on clinical placement. I do not intend to measure, develop theory or identify cause as would be intended in a quantitative study.

Qualitative research is underpinned by the philosophy of naturalism. Naturalistic methods of inquiry attempt to deal with issues of human complexity, exploring them directly (Polit and Beck, 2004). Qualitative research does not focus on statistical association or ‘cause and effect’ relationships. Qualitative research focuses subjectively on the dynamic and holistic aspects of human interaction (Polit and Beck, 2004). The emphasis in qualitative research is on illustrating social phenomena and human experience. Qualitative research explores behaviours, perspectives, feelings and experiences of people (Holloway and Wheeler, 2002). Webb (2002) states that qualitative methodologies are more appropriate when the focus of the enquiry is one of exploration. Qualitative methodology is the most
appropriate for my research as results from my study will not be easily measured or quantifiable as required in a quantitative research approach. Quantitative research would not provide the same depth of insight into the participant’s feelings and experiences about the chosen phenomena.

Within a qualitative approach to research there are a variety of methodologies that can be used. The main qualitative methodologies are ethnography, grounded theory and phenomenology (Pharoo, 2006). Each of these approaches was considered for its possible advantages and disadvantages before a decision was made as to which would be the most appropriate approach to the study.
Ethnography

Ethnography is described as the direct description of a group, culture or community (Holloway and Wheeler, 2002). Polit and Beck (2004) define ethnography as a qualitative enquiry into the description and interpretation of cultural behaviour through field work and a written text. The approach is based on the assumption that culture is learned and shared between members of a group and can therefore be described and understood (Morse and Field, 1996). Ethnography as an approach requires the researcher to go to the culture of interest and immerse themselves within it, hoping to create intimacy with the participants involved in the culture (Streubert and Carpenter, 1999). As Ethnography is concerned with cultural behaviour, it is not relevant to my research, as my research question focuses on individual experience.
Grounded Theory

Grounded theory uses observations of people in their own environments along with data gathered from interviews to develop hypotheses and theories (Pharoo, 2006). Grounded theory uses interviews to develop theoretical propositions which are then developed through a process of comparison (Roberts, 2008). The researcher aims to discover theoretically complete explanations about specific phenomena (Streubert and Carpenter, 1999). As grounded theory attempts to observe people to generate theories, it is not appropriate or relevant to my study. The aim of my research is to understand the student nurses experience of grief, not to generate theory, therefore this methodology was not selected.
Phenomenology

Phenomenology is a methodology which focuses on discovering the meanings of individual’s lived experiences (Polit and Beck, 2004).

Phenomenology is seen as a rigorous, critical, systematic investigation of phenomena, that is, what people experience (Greatrex-White 2007).

Phenomenology is the study of phenomena in relation to a phenomenon. The term phenomenon refers to the ‘thing’ that people experience whilst the term phenomena refers to the ‘what’ of that experience (Greatrex-White, 2008).

For example, I wanted to better understand the phenomenon of grief as experienced by student nurses caring for dying patients on clinical placement. What I have collected as data is phenomena, that is, what the nursing students experienced in relation to the phenomenon grief (Greatrex-White, 2008).

Phenomenological enquiry aims to uncover the structure of the lived experience of a phenomenon. It searches for the meaning people give to a phenomenon and its accurate description through the everyday lived experience (Rose, Beeby et al, 1995). Morse and Field (1996) believe that phenomenology is not just a research methodology, but also a philosophy. Phenomenology is becoming a more popular research methodology amongst nurses because it considers the whole person, valuing their experiences (Ball, 2009). Phenomenologists believe that only those who have experienced a phenomenon can effectively communicate it to the rest of the world. Thus, phenomenology provides an understanding of an experience from those who have lived the experience (Mapp, 2008). There are two main
approaches within phenomenology, descriptive phenomenology developed by Husserl and hermeneutic phenomenology developed by Heidegger.

Phenomenology as a research approach has an interpretive tradition rooted in philosophy and was conceived by the German philosopher Husserl (Parahoo, 2006). Husserlian phenomenology looks to discover and describe phenomena exactly as they are presented to our consciousness (Maggs-Rapport, 2001). The major aim of a descriptive phenomenological approach is to generate a description of a phenomenon of everyday experience to achieve an understanding of its essential structure (Giorgi, 2003). Husserl’s approach to phenomenology involves bracketing, intuiting, analysing and describing data gathered. Bracketing is used in order to set aside the preconceived knowledge and beliefs of the researcher (Hamill and Sinclair, 2010). Husserl believed that in order to view phenomena in its primordial state, all beliefs and preconceptions of the outer world must be suspended, this process is known as bracketing (Corben, 1999). Part of the bracketing process involves unknowing our own interpretations of similar experiences. As I have previously experienced the phenomenon of grief whilst caring for dying patients on clinical placement, it would not be possible to create true bracketing for my study. Therefore descriptive phenomenology is not an appropriate approach.

By contrast, Heidegger, a student of Husserl, believed that describing the individuals experience was not enough. Heidegger (1962), states that the term ‘being’ is always the being of an eternity, which refers to anything at all that has existence of some sort (Plot, 2003). Heidegger (1962) offers an interpretation of being-in-the-world, which refers fundamentally to how we
make sense of the world, our place in it, and how we become aware of this place. Heidegger does not focus on human being and its everydayness for its own sake, but as a way of finding out the meaning of ‘being’ in general (Horrocks, 2000). He placed great importance on knowing the way in which participants came to experience phenomena (Parahoo, 2006). Hermeneutic inquiry emphasises understanding more than description and relies on interpretation (Greatrex-White, 2007). Hermeneutic phenomenology seeks to describe and interpret people’s personal experiences from their own perspective (Van Manen, 1990). An important difference between Heideggerian and Hessurlian phenomenology is that Heidegger does not use the notion of bracketing (Parahoo, 2006). Koch (1995), states that one cannot separate description from one’s own interpretation. Heidegger believed that it was not possible to bracket and instead aimed to understand and interpret phenomena, trying to make sense of the world through existence within it (Maggs-Rapport, 2001).

The methodology used within this study was hermeneutic phenomenology informed by the works of Heidegger, Van manen and Greatrex-White. This was because the findings of the study were interpreted as opposed to only described. This resulted in a greater understanding of the phenomenon of grief as experienced by student nurses, rather than merely the description of grief. I aimed to describe and interpret student nurses’ experiences of grief. A hermeneutic phenomenological approach allows my participants to talk about the experiences they have encountered in a way in which only they can. Participants will be able to talk about what they perceive to be important within the topic, as opposed to answering a structured set of
interview questions which may lead the participant to answer in the way the interviewer wants, rather than in a way that is more appropriate to their personal experience (Greatrex-White, 2007). It can be concluded that this type of research will necessitate the use of different methods which I will now explain.
Participants in hermeneutic phenomenology are selected to take part in the study because they have experienced the phenomenon. The participants are therefore selected specifically to match the requirements of the study (Robson, 1993). Key individuals are identified in order to provide more meaningful data (Parahoo, 2006).

The study was conducted in the University of Nottingham, Faculty of Medicine and Health Sciences, Division of Nursing. Potential participants consisted of student nurses from the Masters of Nursing Science, Degree and Diploma courses at the University of Nottingham who had experienced grief when caring for dying patients whilst on clinical placements.

I recruited the participants by asking course secretaries to send an email to all student nurses from the masters, degree and diploma courses at the University of Nottingham. These emails provided detail of my research and requested students who had experienced grief on placement to participate in the research. This is accepted as sound ethical practice and reduces the criticism of cohesion. From all of the participants who replied to my initial request, I chose the first 8 students from a range of years and courses. The main rule when selecting a sample for phenomenological investigation is that all participants must have experienced the specific phenomenon and all must be able to put their lived experience of the phenomenon into words (Polit and Beck, 2004, Greatrex-White, 2008).
### Participant Demographic

<table>
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<tr>
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<th>Course</th>
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Data Collection Process

Data were collected via phenomenological interviews. Hermeneutic phenomenological interviews were deemed the best way in which to gain data as they were able to provide rich, deep and meaningful data about the phenomenon. Unstructured interviews are deemed to be the main method of data collection in phenomenological research. However, there are other potential methods such as focus groups, written narratives and participant observation (Parahoo, 2006). I will discuss why unstructured interviews were chosen for my research.

Focus groups is a method of enquiry involving a group of people who have had similar experiences being interviewed in a group in order to obtain thoughts and feelings on a particular topic (Holloway and Wheeler, 2002). Although focus groups do provide rich data (Streubert and Carpenter, 1999), the method does have some criticisms. Focus groups can lead to participants being influenced by expectations and ideas of others, this may lead to participants feeling reluctant to express their own views (Holloway and Wheeler, 2002). Morse and Field (1996), also highlight that one member of the group will often dominate and coerce other members into adopting their view point. As I am asking participants in my study to talk about experiences which are very personal and delicate, it would be inappropriate to expect them to do so in front of a group of strangers. A focus group would not provide the depth and richness of data that I hoped to receive from individual interviews.
Written narratives are a method of enquiry which can provide large amounts of rich data when exploring a specific phenomenon (Greatrex-White, 2007). However, due to time constraints, this method of enquiry was deemed to be inappropriate for my study. Written narrative is a method that has proved very successful in certain research areas, such as nursing study abroad (Greatrex-White, 2007). However, due to the sensitive nature of my research topic it seems more appropriate to have the researcher present as if the participant became distressed, there would be an opportunity to offer counselling if required.

Although participant observation offers valuable data to provide a deeper understanding of human behaviour (Holloway and Wheeler, 2002), it was deemed an unrealistic method for my study. The method would require large amounts of time to be spent observing student nurses on placement. It would also be impossible to select in advance the appropriate time and situation which would be vital to observe. The main focus of the research was the participant’s thoughts and feelings, these would not be clearly expressed through the observation of the participant.

The data collection method I chose for my research was recorded one-to-one un-structured interviews, as using unstructured interviews allows the participants to tell their own stories and draws a vivid picture of their experience. Analysis of such data leads to a greater understanding of the phenomenon (Sorrell and Redmond, 1995). Holloway and Wheeler (2002), state that unstructured interviewing allows flexibility with the researcher following the interests and thoughts of the participants. The interviewee is able to take control of the interview and the interviewer has the opportunity
to ask to hear more about what they have heard (Rubin and Rubin, 1995). There are however some disadvantages to the unstructured interview method, Holloway and Wheeler (2002), state that unstructured interviews can create the highest amount of ‘doss rate’. This is the amount of interview material that is of no particular use to the researcher’s study.

Sorrell and Redmond (1995) state that the more comfortable the participant, the more likely it is that they will reveal rich information. As I was a student nurse interviewing other student nurses, this hopefully made the participants feel more comfortable and more willing to reveal desired information. It has also been highlighted that unstructured interviews require great skill on behalf of the researcher (Sorrell and Redmond, 1995). In an attempt to address this issue, my dissertation tutor provided me with a training session in the art of conducting an unstructured interview, which aimed to provide me with an opportunity to rehearse the procedures and highlight any potential pitfalls and limitations. This training session also highlighted potential problems with; the wording of the questions, following the research procedure and protocols, and proposed methods or instruments to be used within the study (Van Teijlingen and Hundley, 2001).

Interviews consisted of one main question with some prompts being used and took place in the seminar rooms in the Division of Nursing within the University of Nottingham. The interview question asked was “Tell me about your experiences of grief when caring for dying patients whilst on clinical placements?”. Following this question the interview was unstructured in order to allow participants to express their experiences in as much detail as they felt necessary, with the interviewer providing prompts in order to
further explore certain issues (Thornburg, 2002). Interviews lasted between 30 and 90 minutes, depending on what each participant had to say (Berg and Dahlberg, 1998). The interviews were electronically recorded in order to provide a rich source of data for analysis after the interview had taken place. I recorded the interview rather than made notes in order to avoid losing the detail of participants' description of the experience (Mapp, 2008). Recording allowed the participants' words to be used as accurately as possible (Holloway and Wheeler, 2002). Interviews were then transcribed by hand.
Data Analysis

Data analysis within phenomenology consists of a variety of analysis methods. All of these methods transcribe data which is then coded into themes. Themes are identified by key words in the transcript (Robinson, 2006). The data analysis was been guided by the work of Heidegger (1962), Van Manen (1990) and Greatrex-White (2007). All interviews were transcribed by myself by hand. Although this was a time consuming process, it was beneficial as intensive and repeated listening to recordings allowed me to remain close to the data and increased my understanding of the phenomena (Greatrex-White, 2007). The analysis process involved reading and re-reading each interview transcript repeatedly, I then began to identify meaningful units by coding the transcriptions (Van Manen, 1990). Throughout the reading I constantly looked for ways in which the phenomenon of grief manifested itself in the experience of each student. This process helped me to identify how the meaningful units related to each other. I was then able to group these meaningful units into themes (Greatrex-White, 2007).

My own biases, along with my own ontological position, guided the ways in which I grouped the meaningful units into themes. This resulted in the data analysis being based on my own interpretation. The interview transcripts were analysed without the use of computers, I felt that it was important to work with the raw data rather than a neater version of the transcripts which using a computer programme would involve (Greatrex-White, 2007).
Ethical Implications

Ethical implications were taken into consideration throughout the course of the research. Qualitative research is a dynamic unpredictable process that may result in ethical concerns arising (Healy and Fallon, 2010). Ethical approval was granted by the University of Nottingham Medical School Research Ethics Committee (see appendix). Ethical issues may have arisen from the fact that during the investigation, participants were asked to re-tell experiences they may have found upsetting, this may have cause participants some degree of distress. The supervisor of my, Dr Sheila Greatrex-White, had agreed to provide counselling for participants who may have become distressed during the interview. Also, if the participant remained distressed after the interview, referrals could be made to the university counselling service. Potential ethical implications that may have arisen throughout the research process are discussed below.

All interviews were completely confidential and participant anonymity was maintained throughout the process. Data which had been recorded and transcribed was kept securely on a pass worded programme which only relevant people had access to. Interviews took place in complete privacy and female pseudonyms were used for both male and female participants in order to protect identity and ensure confidentiality.

Participants of the study were fully informed about the nature of the research as well as the potential risks and benefits allowing them to make a rational decision about whether to take part (Polit and Beck, 2004). Participants were each provided with a participant information sheet detailing all relevant
information about the study and providing relevant contact details should they need to seek further information. Before signing the consent form, the participants were reminded that they were able to withdraw their consent at any stage during or after the interview process and were asked if they have any further questions about the study.

Participants had the choice of whether to take part in the study. Emails were sent to all nursing students at the University of Nottingham (see appendix 5), it was the individual’s choice to respond to this email and volunteer to take part in the study. Throughout the research process, participants came to no harm. Involvement in the research study did not place participants at a disadvantage or expose them to situations for which they had not been prepared (Polit and Beck, 2004). Extra care was taken throughout the research process to ensure that participants were fully prepared for the interviews with the relevant information being provided beforehand.
Study Limitations

I conducted the interviews myself and therefore was known to some of the students. This may have caused participants to give biased answers as they may have not wanted to divulge particular information to a peer. Also due to the nature and time restraints of the study, the participants consisted of only 8 students from only two different nursing establishments. As a result, the findings cannot be generalised to all nursing students’ experiences of the phenomenon. However, I believe that the richness of detail provided by the study will help illuminate the under researched area of student nurses experiences of grief.
Summary

This chapter has discussed why hermeneutic phenomenology is the most appropriate methodology to use for my research. The chapter has also established the most suitable method to use for the collection of data. Details of how I conducted the study were also presented and processes critically examined. Ethical issues and Potential limitations to my study have been highlighted with potential solutions to these issues being provided. The following chapter presents the study findings.
Chapter 4

Findings
Introduction

This Chapter presents the identified themes of relating to participants’ experiences of grief whilst on clinical placement. As the study is hermeneutic phenomenological research, my own biases, along with my own ontological position, guided the ways in which the data was grouped into meaningful units and themes. This resulted in the findings being based on my own interpretation (Greatrex-White, 2008) (see chapter 3). Heidegger (1962) argues that all understanding is interpretive and arises from our being in the world. It is recognised that each phenomenological researcher may produce different findings and interpretations based on their own background and interests. It is possible that a different researcher may choose to interpret and present that data in a different way. Therefore the findings of this study form ‘a truth’ rather than ‘the truth’ about student nurses’ experiences of grief. The interviews provided a vast quantity of data, each interview producing between 8 and 21 pages of transcript (see appendix 1). The examples used in this chapter are small portions of the transcriptions.

Following the analysis process, three main themes were identified:

- Grief Processes
- Nursing and Nurse Education
- Future Possibilities

The themes have been presented separately, however in reality, they are not entirely independent from each other. In many cases, transcript held multiple meanings which overlapped themes. For example, when participants talked about facing the unknown, this affected their grief process, as it made them
feel tense and scared, however, facing the unknown also relates to nursing education as participants felt that a lack of educational preparation that led to them feeling this way. Nevertheless, data has to be organised for presentation and I have therefore chosen to represent the data in this way (Greatrex-White, 2008). The themes identified are fundamental to my understanding of the phenomenon.

Interview extracts have been quoted verbatim, allowing participants experiences to be authentic. To maintain anonymity pseudonyms are used for individual examples, this is sound ethical practice. In order to not disclose any identity, female pseudonyms have been used for both male and female participants.
Grief Processes

In chapter 2, grief was described as a phenomenon that manifests itself in a number of ways and encompasses a wide variety feelings and emotions. Worden (2002) states that grief refers to a broad range of feelings and behaviours that are common after loss. Feelings such as sadness, anger, guilt and anxiety, and behaviours such as sleep disturbances, appetite loss, social withdrawal and absentminded behaviour. All of the participants described the feelings they experienced in their interviews. The emotions that were apparent from the data were very strong, negative feelings. Powerful words were used by the participants in order to relay their emotions:

“I felt really shaken, cause it was my first death, I’ve always been scared as to how I would react...” (Katie).

“I still feel very sad about it...” (Katie).

Crying is a response to emotions often experienced in grief. One of the participants explains how she reacted after a patient died:

“...One of the Auxiliaries said ‘are you ok?’ and as soon as he asked me I just lost it and burst into tears...” (Megan).

Due to the nature of the British culture that we live in, people often believe that it is not socially acceptable to express their emotions in public. A number of participants talked about how they waited until they got home before they felt comfortable in expressing these emotions.
“… emotions work in different ways, cause it was only when I got off the ward that I started to think about it, it upsets you. So it made me feel confused as to how I should be feeling.” (Louise).

“…when I got home, you sort of think about what went on that day, I remember sort of sitting and having a bit of a cry to myself, so just sitting and thinking things over…” (Louise).

“I was quite surprised at how sad I felt, it took me by surprise and I was a bit cross with myself, but it’s just how I was.” (Natalie).

Guilt is an emotion that is very closely linked with grief (Worden 2002, Lindemann 1994, Bowlby 1973). All of the participants interviewed talked about feelings of guilt that they experienced.

“For us, if someone dies, you almost feel that you’ve failed in what you’re doing, so someone who’s killed themselves, it’s your job is to stop them from doing that so if you haven’t, you do feel like you’ve kind of gone wrong somewhere.” (Sophie).

“I think guilt is just a natural emotion, you’ll always think there is something more you could have done.” (Louise).

“Cause it’s not common to have people die in mental health, it’s a lot harder. And you feel kind of guilty as well… so it’s kind of guilt and then kind of the sadness that a friend passed away.” (Sophie).

“… guilt isn’t the right emotion to feel. It’s all very psychological, the feelings afterwards and you’ve got to learn to realise that this is an actual progression that was going to happen.” (Louise).
“I think I found it very distressing because everyone questions, what more could I have done?” (Louise).

One participant got very upset during the interview. This really made me aware of how seriously these experiences can affect an individual. As a novice researcher I felt quite tense not knowing how to react. I let the participant carry on talking letting her know that if she wanted to stop the interview then we could. However, she chose to carry on saying:

“Sorry, you don’t realise how much it upsets you, and it’s nice to have the opportunity to talk about it. To talk about it without somebody saying you’re being too morbid...” (Elizabeth).

On reflection, I was happy that I could provide this participant with the opportunity to talk about these experiences. I believe that taking part in the research gave her some comfort, as she was able to recognise that her feelings and experiences related to the topic were respected.

Sleep disturbances and appetite loss are well documented as ways in which grief manifests itself (Worden, 2002). One participant talked about the particularly violent death that they experienced. This participant was on placement at a residential home for people suffering with mental disorder. This participant was looking after one patient when they committed suicide by burning themselves to death. This was a particularly violent and traumatic death to experience and in that sense was very different to deaths experienced by other participants. The participant stated how these manifestations of grief affected them:
“I’d had a few dreams about it, because it was such a violent way of doing it.” (Sophie).

“I felt Shell Shocked, like when ever I’d eat something I’d feel like, almost like an out of body experience… it felt like you were, almost like watching yourself doing it, and just eating, you just didn’t want to eat, and I felt shit really.” (Sophie).

“… still getting the odd dream, and they wouldn’t necessarily be a dream about the event, they’d be, like I used to take her to the shops quite a lot, and I’d be dreaming of that and stuff, it’d be really weird. She was in a few dreams quite a lot, which normally doesn’t happen.” (Sophie).

This experience suggests that the more traumatic the death experience, the more profound the grief. On hearing of this experience it made me as the researcher realise how important the job we do as a student nurse is. This participant, by the age of 21, had experienced through their nursing training, things that other people could not even imagine. I recognised that we, as student nurses can experience situations that can spill over affecting the rest of our lives.

When grief feelings became overwhelming, participants developed their own strategies to deal with their feelings. Over a third of participants talked about coping mechanisms and how they dealt with their feelings:

“I think reflection definitely helps make sense of what is going in my head, and whether its making me feel anxious… and I think walking, I walk a lot, it just gives you that space.” (Natalie).
“I’ve got my own strategies of reading, listening to music, going out running...and I think they really help get me out of the little bubble of nursing and let me express my own life and own hobbies and interests...break away, have my own life...its quite hard to escape...” (Emily).

“Peer support is a good way of going through it so, I would have maybe found some way of finding where you could talk to other students who have experienced the same as you, even if they had a forum where students could just talk about things like that, I think it always helps when other people have had the same things...” (Sophie).

All of the participants talk about their experiences from a student nurse perspective. They talked about how being a student nurse affected their experience of the phenomenon of grief. Being a student nurse is difficult as you are only on the ward for a number of weeks trying to be part of a team of people who have worked with each other for years. So when experiencing a phenomenon such as grief, it can be hard to get the acceptance and support you need from others on the ward. The majority of participants spoke of the ward team and ‘fitting in’, how they were perceived and how it made them feel. Being an outsider was an important aspect in the student nurses experiences of grief.

“You know what they’re like sometimes, you know, look you up and down and cause you’re in light blue they think you’re incompetent.” (Megan).

“I didn’t want them to think I was sort of a ‘loser’ student that just couldn’t cope, and so it was hard.” (Katie).
“Everyone’s really really upset, and you think well they’re all going to support each other and I’m not going to get any of that because I’ve only been here for 3 weeks and I’m not part of the team.” (Megan).

This made me think about my own personal experiences. I found it hard, being an outsider and not a real part of the ward team. I felt uncomfortable and very vulnerable expressing my emotions around a ward team who were essentially strangers to me.

One participant seemed to contradict them self. They began by saying they felt they should hide their emotions, however they then went on to say that they did cry, and they found it very therapeutic to recognise their grief.

“But then you’ve got the whole thing of the British stiff upper lip, kind of don’t dwell on it, and I recognise the grief is there, and I think it’s important to acknowledge those feelings, but not to make a big drama out of it.” (Natalie).

“Once I’d had a cry I found it quite cathartic. I think more than anything it made me take stock actually... it gave me perspective I think is what I’m trying to say.” (Natalie).

One of the main aspects participants commented on was confusion of where their professional boundaries lay. Participants recognised their grief feelings, but didn’t know the appropriate way in which to express them.

“Why am I feeling like this? I wasn’t related to them, I didn’t know them.” (Louise).
“I didn’t know where my professional boundaries were, I was like should I hug him?...I wish my mentor had been there, cause I didn’t know how to react.” (Katie).

“I’m not meant to have those close links to a patient, but you’ve got to realise that it doesn’t mean that you have formed an unreasonably close link, it’s just a natural human emotion that if you see something distressing, to be upset.” (Louise).

Given the caring and holistic nature of nursing, I found it quite concerning that participants seemed scared to express their caring nature, as they did not want to be deemed unprofessional. Hugging a person who is upset and has suffered a great loss seems a very natural thing to do, it seems strange that someone may feel uneasy about doing so, due to professionalism. We are educated about the holistic approach to nursing, however it is clear that there seems to be some issues relating this theoretical concept to a practice setting.

The majority of participants also spoke about the unknown, not knowing how they should feel or act. This again may be due to British society and cultural views. Society and culture provides a structure, governing what we say and do, however we are also individuals with a brain, a voice and a spirit, able to make our own decisions (Greatrex-White, 2008). Grief is not a topic that is openly talked about. Due to this, participants did not feel prepared for what happens when someone dies.

“...it’s the unknown isn’t it, not knowing what happens next, not knowing what to expect... it’s just sort of continuously walking round in the darkness, not knowing what happens next.” (Katie).
“I just felt quite tense about it, and I think I hadn’t realised but the reason I was feeling so tense was because I’d been concerned about displaying emotion on the ward in the first place, and because it was the first time, I don’t think you know how you’re going to react but, I didn’t have any idea, I was worried about getting the balance right. Because it would be inappropriate to be bawling your eyes out for hours. But at the same time I didn’t want to just deny that I felt bad, cause that wouldn’t be particularly helpful.” (Natalie).
Nursing and Nurse Education

Robinson et al (1999) state that healthcare in the UK is continually influenced by goals and policies driven from the government and organisations, such as the Nursing and Midwifery Council (NMC). Nursing education takes place both within lectures and within clinical practice, both theory and practice are important factors within nursing education. All participants commented on the education and support they received from both their nursing programme and their clinical placement areas.

Whilst participants did find it difficult fitting in with the ward team, some reported receiving quality support from clinical placement.

“...I do personally think that oncology, they work together really well. So when the doctor found out that he’d died, she took us all into the clean utility and was like ‘I’m really sorry guys, but he’s died.’ And just took time out to reflect, and she was actually really good... she just went round one by one and said what had happened, what we could have potentially done wrong and how we could work on the experience, which was really good.” (Katie)

“...my placement area was good. We had a debrief on the unit and that helped, they had a team psychologist in who did a session with everyone and people were offered private counselling if they wanted it.” (Sophie).

“It was effective, effective grieving, but that was probably because I was so well supported and a lot of people on the ward were going through the same stuff.” (Megan).
“It was very much a team approach cause I remember at the time, the staff nurse sort of, I remember her going to the treatment room and having a couple of tears, and the staff nurses and the sister just really pulled together and just helped each other get through.” (Louise).

“Well the team were actually really good cause it happened like two days before I finished placement there, and they invited me back for the supervision, otherwise I wouldn’t have had any debriefing, so I had to go back for that and they offered if I wanted any counselling or one to one talk…” (Sophie).

“We had some nurses that were on the ward cause of staff shortages, and they sort of came in at the end of the shift and were like, you know, ‘I’ll drive you home so you don’t have to get the bus.’ And so that was really good, like the teams really good, and that’s important.” (Katie).

“I think I was anticipating my mentor and the ward team to be a bit more short with me, I was expecting them to say ‘oh come on, don’t be silly, pull yourself together,’ and they didn’t, actually that came from me.” (Natalie).

“My mentor said if I needed anytime or anything that I could go and sit out and talk about it...With them being quite used to it they can obviously support each other and work together as a team and I think that that reflected on me and made me feel more confident with the care of the dying.” (Jane).
Two participants spoke about the support that was offered by the hospital Chaplin. This was found to be another source that offered support in the clinical setting:

“When I was there the Chaplin came up and they, you know, spoke to the staff nurses, and said I’m not here from a religious point of view, I’m just here to support you guys cause I know you’ve had a bad run of it.” (Megan).

“They had the Chaplin come to the ward to speak to all of the students, so that if people did want to speak to the Chaplin, you could go to him.” (Louise).

The quality of support provided to participants in clinical practice was a stark contrast to the support provided by their nursing programme. All participants mentioned the involvement of their nursing programme. The overwhelming majority felt let down and unprepared by their nursing programme with respect to their experiences of grief.

“I felt quite let down really. Because they’re always, kind of on paper they’re trying to say we’ll offer you all this support and all this, and they didn’t really...” (Sophie).

“...the school of nursing, I don’t know, I don’t feel massively supported by them...they don’t prepare you a massive deal. I think though the whole of our training they really skirt around death and dying...” (Megan).

“...what we need is more direction on how you might feel...it’s not wrong to feel like these emotions...” (Louise).
“It would have been nice to have a bit more, I mean they know what they’ve been through it when they were working in practice, so you’d expect them to offer you a bit more support, and also for them to prepare you better for it.”

(Sophie).

“I didn’t feel prepared in the first year at all if I’m being honest. I don’t think we were very well prepared for what actually happens in reality...”

(Elizabeth).

The majority of students mentioned lectures they received on the topic of palliative care, however participants highlighted that they did not find these lectures very helpful. Participants also commented that they only received one or two hours of lectures throughout the whole of their course, which they believed was insufficient. The lectures were reported to have been brief and not to have focused at all on how they may feel when a patient died.

“...within lectures you get nothing...we don’t get practical advice from the school of nursing, like to prepare you, and you need that very early on...”

(Megan).

“And our lectures were very much geared to the bereavement process in the families or the patients, but not much as a student, I think they need to realise that the student is bereaved as well as the families, so I think there is something missing there.”  (Louise).

“I think they could do with...earlier lectures directed specifically at how to care for someone who is dying and about the emotions you can expect to experience.” (Louise).
“...I think we had a one hour lecture about death, dying and bereavement...but there was nothing about healthcare professionals and how you can cope and what sort of coping strategies might help in that situation. Which I think is quite poor actually...” (Katie).

“...beforehand I think we had like one session on dealing with grief and it was not really any good.” (Sophie).

“I just should highlight that I don’t think that we get enough education...I felt unprepared.” (Elizabeth).

The majority of participants reported a lack of support from their nursing programme. This lack of support seemed to distress participants and was a factor that they felt very strongly about.

“...the psychological support isn’t there and you’re definitely not prepared for how you’re going to feel...I don’t feel like there’s support from the school of nursing, just because you wouldn’t know who to go to.” (Megan).

“I don’t personally feel that there is a good support network there within the School of Nursing. I don’t think that they make it very openly accessible...” (Louise).

“...there was very little support provided by the school of nursing.” (Katie).

“And they don’t give you support when you’re on placement... it’s very much that you’re left to your own devices when you’re on placement and what happens on placement stays on placement.”(Louise).
The way in which participants expressed these opinions may have been due to the fact that I was interviewing them. As I am also a student nurse, I am a peer to the participants. If the interviews were conducted by a lecturer, participants may not have felt comfortable in expressing such opinions.

Over a third of participants offered ways in which the nursing programme could improve the emotional support they provide students.

“... if they just said you know if you’re struggling, here’s my email address, email me and I’ll meet with you and try to help you through it.” (Megan).

“...they don’t seem to acknowledge that it’s something that happens to students on placement... if we had more sessions on how to deal with it, instead of just what grief is... and some sort of peer group.” (Sophie).

“...they didn’t give any time to discussing like our emotions or how we might feel, I think probably it would have benefited me to think beforehand...” (Natalie).
Future Possibilities

All participants talked about how their experiences of grief will shape their future nursing practice. The majority of participants stated that even though it was an unpleasant experience, it was an experience they are glad they had. This is a notion that Heidegger refers to as the fore-structure of understanding. Heidegger (1962), states that we interpret and understand experiences through our past: our fore-having, our present: our fore-sight, and our future possibilities: our fore conception.

“I think you need to go through experiences of something like that... I think I’ll be alright now that I have gone through that process, you know what to expect and it’ll be easier.” (Louise).

“...I think having had the experience, I’ve developed a bit more of an understanding of what to expect...” (Louise).

“...I’ll now know how I deal with grief. How I deal with the situation and that everyone deals with it very differently.” (Katie).

“So it kind of helped me develop my practice, but it’s not something I want to go through again anytime soon.” (Sophie).

“I was kind of glad that I could have it so early on in my training so that it wasn’t something I kept putting off until later and then it would build up into this huge thing that I would be scared to do, so I’m glad I got it out of the way.” (Jane).
“It doesn’t frighten me, I wouldn’t be afraid to develop the sort of relationship where you are going to...you are grieving at the end of it when someone dies.” (Natalie).

“I feel like my confidence has grown and I feel I can offer that patient the care that they need at that time cause I have more knowledge about the Liverpool care pathway and things that dying patients require.” (Jane).

“In first year it was something I was doing for myself, where as now I feel like I’m doing it for the patients and their relatives.” (Jane).

The majority of participants talked about how these experiences will influence their future after they have qualified, when they themselves are the staff nurse.

“...a lot of paediatric nurses, like people in my cohort, haven’t actually had a death yet, and I don’t think I’d like to do it as a qualified nurse, just cause I think you just need to sort of have that testing period.” (Katie).

“To be honest, I’m glad it happened in a way...glad it happened while I was a student to kind of prepare me for it when I’m working...you need to keep doing your job when something like that happens and if you haven’t ever experienced it before, I think it would be harder...”(Sophie).

“Even though she was being so blasé about it, it just made me think...I hope I’m never like that...” (Megan).

“It just made me think I hope I never turn out like that. I hope I never come across as cold or shallow or I don’t have time for somebody.” (Elizabeth).
“I feel having done it as a student I feel more prepared to do it when I’m not a student. And I think that having support from the mentor helps me for when I have to do it on my own when I’m qualified.” (Jane).
Summary

This chapter has used direct quotes from the participants in order to portray their experiences, thoughts and feelings. These findings reveal the innermost feelings of the participants experienced at difficult and emotional times in their nursing education. These findings have made me consider how we as students are expected to deal with these situations. I have reflected on my own personal feelings from similar experiences. In the next chapter these findings will be discussed in relation to the previous literature surrounding the phenomenon of grief experienced by student nurses whilst caring for dying patients on clinical placement.
Chapter 5

Discussion
Introduction

This chapter discusses the essential components of the phenomenon of grief experienced by student nurses by placing the findings into the wider literature context. On the basis of phenomenological interviews with eight student nurses, three themes were identified: grief processes, nursing education and possibilities for the future. These themes will be used to shape the discussion chapter. Evidence from the review of the literature will be used in order to enhance the understanding of the phenomenon of grief as experienced by student nurses. Consideration is given to the place this research has within the wider field of literature and to the implications of the research findings on the student nurses’ experiences of grief.
Grief Processes

Feelings, Emotions and Guilt

It is clear from the research findings that all participants experienced grief processes whilst caring for dying patients. Reese (1996) defines the grieving process as the way one develops a peace with one's self in relation to a loss and then moves on with their life. From the findings it is clear that this development of a peace has taken place, at least to a certain extent, with the majority of participants. Each participant talked about their reactions at the time. These reactions included crying, feelings of guilt and sadness. Participants then go on to talk about how their grief developed; they were able to see that they should not be feeling guilty and that there was nothing else they could do. Participants then go on to talk about how they feel now. They stated that they are still sad about the death when they think about it, but they do not often think about it and it does not affect their daily life. They have made a peace with the death. Although most of the participants have been able to develop a peace with the loss of their patient, one participant seemed to still be troubled by their experience. This participant talked about a particularly violent death that she experienced and how it affected her. After seeing this death, she experienced sleep disturbances, appetite loss and out of body experiences. She then attended debriefings and counselling provided by the placement in order to come to terms with the death. The grief still affects her now as she states that she still has the occasional dream about the patient. Brunelli (2005) found that the repetitive loss of patients puts not only a physical, but also a mental and spiritual burden on nurses, not only as nurses but also as humans. My research
findings suggest that this may be the case as this participant reports a mental and spiritual burden in the form of dreams and out of body experiences. As the participant was still experiencing these dreams at the time of interview, it is possible that her grieving process is not yet complete as, using Reese’s (1996) definition, she does not seem to have developed a peace with this death experience.

Elements of Kubler-Ross’ (1969) five stages of grief was experienced by participants to various extents. Sometimes, anger was experienced towards other staff members as a number of participants felt that more could have been done for their patients. Aspects of depression were experienced by some participants. For some cases this depression was brief consisting of a few tears, for others, feeling sadness lasted for a longer period of time. The majority of participants did meet the last stage of grief; acceptance. Participants were able to see that there was nothing more that they or anyone else could have done for the patient and they accepted the death.

Beck carried out a similar study to mine in 1997 in the USA. I was interested to compare the findings of this study with my own which provides a more contemporary and culturally relevant view on the topic. Beck (1997) found that student nurses experienced sadness, fear, anxiety and frustration when caring for dying patients. He also reported students felt an integral aspect of care was providing care for the patients’ families and that students experienced overwhelming feelings of helplessness with regard to their roles as the patients’ advocate. Similar emotions were expressed by my participants in relation to their experiences of grief. However, whilst issues such as caring for the patients’ families and roles as the patients’ advocate
were highlighted by my participants, they were not reported as the most important factors affecting their experiences of grief. Due to the fact that my research focused specifically on the participants' grief experiences, topics were discussed that directly affected their experiences, such as their education.
It Is OK to Cry

There are many research articles written in relation to nurses helping a patient or family member through his or her grief, but there is very little contemporary research about the grief experienced by nurses. Lenart et al (1998) found that nurses repress their feelings of grief. This finding is supported by Stowers (1983) who believes that nurses try to deny the presence of grief. My study makes similar suggestions as participants talked about hiding their grief emotions as they did not want to appear weak. One of the participants mentions the ‘British stiff upper lip’; she did not want to appear as if she could not cope and therefore tried to hide her emotions. Another participant felt that she could not appear upset because she was a nurse, and seeing people die is part of the job. Participants were worried that they would appear weak if they were to express their emotion and cry. This may be due to British culture. Death, dying and grief are not topics that are commonly talked about in our society. In order to be a nurse you need to be physically and emotionally tough and nurses tend to know this before they go into the profession. This may be why nurses do not admit to their grief and feel vulnerable in expressing their emotions when a patient dies.

Feldstein and Gemma (1995), state that nurses’ involvement with seriously ill patients can generate emotional stress, but they receive little preparation allowing them to cope with the stress they will experience. This was evident in my research as one participant said she appreciated the opportunity to talk about her grief experiences, she did not feel able to talk about them in day to day life. Cultural boundaries mean that nurses are often left to deal with feelings of grief alone, with no direction or help from others.
A Student Nurse Perspective

Another factor that contributed to the participants’ experiences of grief was experiencing it from a student nurse’s perspective. It is well documented throughout the literature that being a student nurse is exceptionally challenging with constant academic and emotional stress (Hamill, 1995, Evans and Kelly, 2004, Rhead, 1995). The death of a patient is highlighted as one of the main causes of this stress (Timmins and Kaliszer, 2002).

All of the participants talked about their experiences from a student nurse perspective. They talked about how being a student nurse affected their experience of the phenomenon of grief. Student nurses are on the ward for a limited number of weeks and trying to become part of a team with people who have worked together for years is difficult. When experiencing a phenomenon such as grief, participants found it hard to gain the acceptance and support they required from others on the ward. The majority of participants spoke of the ward team and ‘fitting in’, how they were perceived and how it made them feel. Being on placement for such a short period of time can be extremely daunting for students. One participant stated she felt that the staff were really supportive of each other when their patient died, but she was overlooked as she was there for such a short period of time. Participants highlighted that ward teams have a way of helping each other through the grief, but student nurses can often be excluded from this.
Nursing and Nurse Education

Palliative Care and the Nursing Curriculum

Cunningham et al (2006) state that there has been very little research carried out regarding the preparation of nursing students and their experiences, particularly with regards to palliative care. My study has provided an insight into these areas, and will therefore contribute to a topic that has been insufficiently researched within the current nursing literature.

Given the limited amount of literature, it is clear that nurses do not receive adequate education on death, dying and bereavement (Lockard, 1989, Cairns and Yeates, 2003, Paice et al, 2006, Lloyd-Williams and Field, 2002, Quint, 1967 and Arber, 2001). Although much of this research is now dated, my findings suggest that this may still be the case today. The lack of palliative care information within lectures is an issue that all of the participants highlighted. Participants stated that they received one lecture on death, dying and bereavement and that the content of this lecture was not helpful. Paice et al (2006) found there is little attention devoted to palliative care in most undergraduate nursing curricula. The findings of my study support this as participants were surprised at how little palliative care education they received throughout their nursing programme. Participants reported that the lack of lecture time spent on the topic of palliative care left them feeling unprepared.

Lockard (1989) found that the subject of death, dying and bereavement received inconsistent and inadequate attention within the education of student nurses. Similarly Arber (2001) comments that palliative care in the
UK is not as extensive as it should be and needs a greater emphasis within the nursing curriculum. Despite the fact that these studies are now dated, my participants also reported a lack of palliative care education, suggesting that there has been little improvement made since these studies were carried out.

NICE (2004) released a document ‘Improving Supportive and Palliative Care for Adults with Cancer’. The aim of this document is to help patients, families and carers to cope with the cancer and its treatment. Whilst this document is extremely important, there is no consideration given to helping nurses and student nurses to cope. This is an issue that the majority of participants highlighted. Participants reported that lectures focused on the patient and the family’s grief, but nothing was mentioned about their grief as student nurses. They reported that at no time did a lecturer offer places to go for support or what a student should do if they were experiencing feelings of grief.
Support within the Educational Nursing Programme

University nursing courses are extremely challenging for the student; consisting of academic, physical, emotional and psychological challenges. Long placement hours, academic assignments and the fact that the majority of nursing students will be living away from home for the first time, makes it even more emotionally and psychologically challenging for student nurses. This coupled with student nurses experiencing the death of a patient can lead to psychological distress (Gibbons, 2010), low levels of self esteem (Edwards et al., 2009) and depression within student nurses (Rhead, 1995).

Despite these research findings, the main issue that all of the participants commented on was their educational programme and the lack of support it provides for students. The majority of participants stated that they felt let down and unprepared by their nursing programme. The lack of emotional and psychological support is something that participants felt very strongly about. Participants covered all branches of nursing: adult, child and mental health, and were from two different nursing establishments. This suggests that the lack of support is not specific to one branch of nursing as the same conclusions were reached by students from all three branches and two different nursing schools. One participant summed it up by saying ‘what happens on placement stays on placement’. She believed that the nursing programme did not want to know about placement issues as they seem to be very separate. I find this rather concerning as one would assume that emotional and psychological support should be an issue of high importance within nursing programmes.
Ways to Improve Support

Squires (2010) believes that nursing is a particularly challenging subject to study at university requiring academic rigour, professional ethos, emotional maturity as well as mental and physical stamina and resilience. He believes that emotional support, guidance reassurance and advice during difficult times can be of equal importance to academic competence, particularly when learning in clinical practice. A lack of support from the nursing programme is an issue that all participants felt very strongly about. The majority of participants reported that they felt very let down by the nursing programme as they did not receive the amount of psychological support that they needed from educational sources.

A third of participants suggested ways in which nursing programmes might improve the provision of emotional and psychological support. One participant suggested that a group counselling session once a month would be helpful to allow participants to talk about any aspects of the course or their placements. One participant stated that something as simple as having an email address of someone you could talk to about death and dying would be a way in which the nursing programme could improve the emotional and psychological support they provide for students. Peer support was a concept that participants reported would have helped with their grief and made their experiences more manageable. Participants reported that peer support would be valuable as they believe that only other student nurses who have had similar experiences can really understand what a grieving nurse is going through. Squires (2010) reports that the Florence Nightingale School of Nursing and Midwifery at King’s College London host a student run council.
The council aims to provide support for nursing students needing help or advice with any aspects of the academic course or placement, and is a very well used service. Although there are counselling services available to students, my findings suggest that these services are not well used. A peer support group would, perhaps, provide a less formal environment where students would feel more comfortable talking about their experiences.
Mentorship and Clinical Practice

Although participants found it hard experiencing grief from a student nurse perspective, some participants reported good aspects of the support they received on clinical placement. Student nurses’ practical experience is thought to be one of the most important aspects of their educational preparation for entry into the profession (Pellatt, 2006). Whilst the amount of research into mentoring is very limited, Milton (2004) believes that being a mentor to an aspiring nurse is an awe-inspiring responsibility. Participants stated that they received support, not only from their mentors, but from other members of staff on the ward. In two cases, the hospital chaplain visited the ward, speaking to staff and students about the support they could provide. One participant reported how her placement area invited her back to take part in debriefing and counselling sessions after experiencing a particularly violent death. One participant said that the doctor on the ward took everyone aside to talk through the patient’s death with them. She found this very helpful as it made her realise that there was nothing else that could have been done for the patient. Whilst good experiences of the emotional support received on clinical placement were reported, Casdedine (2005) believes that due to staff shortages and high patient workloads, support of students is a matter that the university’s school of nursing should be more involved in. This is interesting as the majority of participants did not report receiving any support from their educational programmes, but did receive support from their placement areas.
Future Possibilities

Personal Achievement

All participants talked about how their experiences of the phenomenon of grief will affect their future nursing careers. Whilst participants commented on how difficult and unpleasant their experiences were, on the whole, participants were glad that they had experienced the phenomenon as a student. Participants believe that they will now be more educated and emotionally prepared for when they experience the phenomenon in the future. This finding is reflected in other research. Deary et al. (2003) found that as student nurses ratings of personal distress within a situation increased, so did their levels of personal achievement. In other words, the more distressing a situation, the more the participant felt they achieved by experiencing the situation. Participants believe that this will impact on their future nursing careers as they will approach similar situations with more confidence, knowing that they have been through it before.

Participants were glad to have this distressing experience as a student nurse rather than experience a patient dying for the first time once fully qualified. Experiencing these distressing situations as a student nurse helped participants in the sense that they felt they had a safety net in the form of their mentors. This was especially the case with the child branch student nurse. She reported that it is very uncommon to experience the death of a child on placements and she is glad that she gained this experience whilst she was a student.
Reflecting on the Past: Improving the Future

Jones (2010) states that when people are faced with distressing situations, they can react in a learned behaviour. Nursing students are often challenged to adopt new behaviour patterns and ways of dealing with situations. This requires student nurses to explore their own feelings and reactions to a situation. Jones (2010) believes that without reflection, nurses can risk burnout, emotional distress or disengagement.

The majority of participants talked about how their experiences will influence their practice after they have qualified. Due to the sensitive nature of these experiences, meaningful lessons were learnt by the participants. Using reflective thinking, students are able to assess the experiences they have encountered and determine if they handled them well. If the participant had a bad experience, they would spend the time reflecting on the situation, thinking of ways similar situations could be improved in the future. One participant sums this up by saying “I hope I never turn out like that”. This exemplar shows that the participant has reflected on her experience and concluded that she did not feel comfortable with the way the nurse acted. This realisation will affect her nursing career as she will strive to never treat a dying patient in the same way that her mentor did. Similarly, when participants experienced good situations, they will take the good things they have learned in order to improve their own practice in the future.
Implications of the Findings

There has been little attention paid to grief experienced whilst caring for dying patients in the past, especially from the student nurse perspective. Though the findings of this study cannot be generalised to all student nurses’ experiences of grief whilst caring for dying patients, this research contributes to the essential knowledge around the subject area and the phenomenon of grief. Grief experiences were found to be very emotionally and psychologically challenging for participants and will stay with them for the rest of their lives. Whilst these experiences were extremely demanding on student nurses, causing high levels of distress, most students were able to take positive aspects of the experience which will help them in their future nursing career.

One aspect of these grief experiences that participants reported was the lack of emotional and psychological support provided by their nursing programme. This finding is essentially the most important as it can be easily improved. If there is one thing taken from this study, I hope it is this realisation that more support should be provided to student nurses especially when it comes to feelings of grief and palliative care. Student nurses are the future of nursing and it is important that they enter their career feeling confident and capable, rather than haunted by bad experiences from their past. The recommendation of starting a peer group counselling session would help to take this step. This is a simple, inexpensive and effective way to improve the support provided for student nurses.
A longer term recommendation my study suggests is a change in the nursing curriculum. It has been made clear that throughout nursing education, palliative care is a subject that is overall, very poorly taught (Lockard, 1989, Kelly et al, 1999, Cairns and Yates, 2003, Paice et al, 2006, Lloyd-Williams and Field, 2002, Quint, 1967 and Arber, 2001). This has been commented upon in the past, yet my study suggests that nothing has been done to reconcile this issue. I hope that my research will help to raise awareness of this issue and help to improve nursing education across the nation.

In addition to these implications that have been taken directly from my study findings, I can also make the same implications based on my own experience. Upon reflection, it is clear to me that this research process was highly influenced by my own personal experiences (see chapter 2). The exposure to experiences of other student nurses has provided me with the opportunity to discuss, compare and interpret the thoughts, feelings and emotions surrounding a topic very close to my heart. This has initiated a much deeper reflection on my own experience of the phenomenon of grief. I believe that this research has lead to a great deal of personal benefit and would recommend that other students be given the opportunity to discuss their thoughts and feelings on the phenomenon of grief. Participants found the experience helpful as it allowed them to talk about thoughts feelings and memories.
Summary

This chapter has discussed the research findings in relation to the wider literature on the phenomenon of grief. Implications of the research have been highlighted in relation to the emotional and psychological support provided for student nurses and the future of nursing education and the nursing curriculum. The final chapter will include reflection on the research process with recommendations made for future research.
Chapter 6

Conclusion
Reflection on the Research Process

As a novice researcher, carrying out an empirical research study employing phenomenological methodology did prove to be challenging. I was learning throughout the research process and although guidance was provided to me by my supervisor, I do admit that my inexperience may have resulted in limitations to my research.

Carrying out phenomenological interviews as a novice researcher did prove to be difficult. Unstructured interviews require high levels of skill on behalf of the interviewer in order to produce rigorous data. The interviewer is required to listen actively, analyse and probe issues that may or may not have been anticipated whilst still allowing participants to recount their own experience (Gerrish and Lacey, 2006). Upon reflection on my own interview technique it is clear that I did feel anxious when carrying out these unstructured interviews. I found that probing and not allowing the participant to come to a standstill was very unnatural to me, especially when considering the sensitive nature of the topic being discussed. I found it difficult to give power to the participant as I felt I wanted to control the situation. It was extremely difficult for me to overcome my instinct to ask leading questions. I did find myself very nervous before the first interview worrying that I would not be able to keep the participant talking for long enough. Fortunately, the first participant provided a very thorough interview lasting over an hour (see appendix 1). This really boosted my confidence for the rest of my interviews. An in depth reflective account of my interview process can be found in appendix 2. My reluctance to interrupt participants may have produced some data that did not aid the understanding of the
phenomenon of grief. However, I do believe that if the participant deemed it important enough to talk about, it must be relevant to their own personal experience of the phenomenon. This is sound phenomenological research practice.

A more experienced interviewer may have been able to extract a larger amount of relevant, in-depth information. However, I do believe that my interviews did generate a vast amount of data proving very useful and able to answer the research question posed. Allowing participants to speak their mind without interruption meant that participants were able to develop a flow really exposing their deepest thoughts and feelings. The fact that I am a peer to all of the participants (I am also a student nurse), perhaps encouraged participants to feel comfortable divulging more meaningful information. Participants may have been more reluctant to divulge such information if they were not able to relate to me and did not feel so comfortable with me. I believe that the confidence given to me in the first interview grew and that I was successful in gaining a large amount of meaningful data.

Hermeneutic phenomenology is based upon the researcher’s interpretation of the data. I recognise that my own biases, experiences and my own ontological position will affect the way in which I interpreted the data. I was concerned that I was misrepresenting participants reading the wrong meaning into what they were saying. However, Van Manen (1990) states that interpreting the data is a more accurate process. He believes that formulating thematic understanding is a free act of seeing and meaning, not a rule-based process. Taking this into account, I recognise that the way the data has been presented is based upon my interpretation and is not one
definite way or seeing the phenomenon of grief as experienced by student nurses when caring for dying patients.

The research generated a large amount of rich data which held more meaning than was possible to represent in my findings. Time constraints posed a great limitation to my research. Had I more time, I would have been able to conduct a more in depth analysis. Following Greatrex-White (2007) I recognise that I have not done the full justice to either the data or the participants.

Generalisations cannot be made from my study as the study is small in both size and context. However, generalisation was not the intention of this study, nor is it of any hermeneutic phenomenological study (Greatrex-White, 2008). The methods are appropriate for achieving the purpose of the study, understanding a phenomenon from the perspective of those who experience it. Great consideration was taken when selecting the most appropriate methodology and methods for this study. I believe that the methodology and methods used have indeed allowed me to successfully better understand the phenomenon of grief as experienced by student nurses on clinical placement.
Recommendations

In spite of the limitations, I do believe that the study is a very valuable piece of research; providing some important insights into student nurses’ experience of grief whilst caring for dying patients on clinical placement. Time constraints have resulted in justice not being done to either the data or participants and I would suggest that more hermeneutic phenomenological research is conducted to allow for further analysis and interpretation of the phenomenon and thus extend my own findings.

To provide a more in depth understanding of the phenomenon it would have been beneficial to interview a greater number of students from a variety of different universities and nursing programmes. This would help to create a broader view of the phenomenon, however, it would be inconsistent with the phenomenological methodology which aims to minimise variability within a sample in order to uncover the true essence of the phenomenon. If, in the future, a larger scale study is conducted allowing effective comparisons to be made, I recommend that different methodology is used.
Summary

My research has successfully explored the phenomenon of grief as experienced by student nurses caring for dying patients on clinical placement. Three themes were identified: grief processes, nursing and nurse education and future possibilities. The research process has proved a considerable learning opportunity, providing great personal benefit. This research contributes to the essential knowledge base of an under researched subject, highlighting areas for improvement in both nursing practice and nursing education. I hope that this research will provoke interest in student nurses’ grief experience inspiring future research.