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Bereavement coping strategies among healthcare professionals: A qualitative systematic review and meta-synthesis

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Review Article

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Abstract

Objectives. Coping with a patient's death is one of the most challenging events faced by healthcare professionals in clinical practice. A broad understanding of the coping strategies used by healthcare professionals is fundamental to the development of effective interventions and the provision of good bereavement care. This review aims to systematically synthesize the coping experience of healthcare professionals in the course of their work when they are confronted with patient deaths.

Methods. PubMed, Embase, ScienceDirect, CINAHL, PsycINFO, Web of Science, Cochrane Library, Scopus, and Wiley online library were searched in April 2023 with no restriction on publication date. A 3-stage thematic synthesis method was applied for data integration and analysis.

Results. Thirty studies involving 545 participants met the inclusion criteria and scored a high level on quality assessment ranging from 9.0 to 10.0. Six themes were identified: emotional coping, cognitive coping, behavioral coping, relational coping, spiritual coping, and occupational coping.

Significance of the results. Overall, the coping strategies used by healthcare professionals in response to bereavement were found to be unique and multidimensional. Understanding how healthcare practitioners use emotional, cognitive, behavioral, relational, spiritual, and professional strategies to cope with bereavement will prove extremely beneficial in helping them to manage their grief, and can furthermore promote their professional growth and ensure the provision of excellent bereavement care for patients.

Introduction

Death is an inevitable event, and healthcare institutions, in addition to being crucial sites for treatment and care, are also environments in which loss is encountered (Broad et al. 2013). Bereavement refers to the experience of having lost a loved one (Shear et al. 2013), while professional bereavement is used to describe the grief experienced by professional caregivers following the loss of their patients (Wenzel et al. 2011). To provide quality care, healthcare professionals and patients develop a close relationship, which contributes to the uniqueness of their bereavement experience. The experience of professional bereavement includes a personal dimension of grief, which includes different types of responses, the nature of which may be emotional (continuous grief, loss, helplessness, guilt, anger, powerlessness, emotional exhaustion, depression) (Betriana and Kongsuwan 2020; Groves et al. 2022; Khalaf et al. 2018; Shorter and Stayt 2010; Wenzel et al. 2011; Wolfe et al. 2022; Yu and Chan 2010; Zhang et al. 2022), physical (crying, nightmares, exhaustion) (Betriana and Kongsuwan 2020; Groves et al. 2022; Wolfe et al. 2022; Zhang et al. 2022), cognitive (numbness, self-doubt, self-stigma), and mental (loneliness, loss of life and hope, death anxiety) (Wenzel et al. 2011); however, it also involves a professional dimension, and can result in a sense of loss of professional goals (Barnes et al. 2020), professional exhaustion, and burnout (Granek et al. 2017).

The bereavement experiences of healthcare professionals have gained attention from researchers in recent years. Papadatou (2000) has developed a model of the grieving process as experienced by healthcare professionals. This process which may be understood as a state of continual flux between ruminating on the loss and avoiding grief reactions, and it can be influenced by individual lifestyles and unit work styles. Chen et al. (2018) has proposed an integrated model of the bereavement process by ethnographically integrating the bereavement experiences of professional healthcare workers, which incorporating the perceived nature of patient deaths, bereavement responses, and cumulative personal and professional changes. However, there is no framework that focuses on examining how they cope with bereavement. Crunk et al. (2021) developed the 6-dimensional Coping Assessment for Bereavement and Loss Experiences which categorizes strategies into help-seeking, positive outlook, spiritual support, continuing bonds, compassionate outreach, and social support. Unlike family bereavement, professional

bereavement involves both an individual and professional dimension, whereby each process is accompanied by a profound change in the individual's sense of meaning and identity. As a result, professional coping is unique. By experiencing and overcoming their grief, the participants were able to interpret and make sense of patient deaths, which helped them to achieve professional growth (Conte 2011).

Death is a traumatic and emotional event that is experienced frequently by care providers, and bereavement is a common stressor for healthcare professionals. According to the stress coping model of Lazarus & Folkman (Folkman et al. 1986), coping is defined as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person." Coping with patient deaths is an individual process, and healthcare professionals have their own different subjective perceptions and coping strategies (Zheng et al. 2018). Different coping strategies may have distinct consequences, which can affect the physical and mental health of healthcare professionals, clinical practices, and even the quality of bereavement care provided (Stabnick et al. 2022). Evidence suggests that healthcare professionals are more susceptible to mental illness compared to the general population (Joliat et al. 2019). In addition, it has been reported that 33.5% of doctors and nurses experience negative emotions and cognitive barriers, as well as a total lack of confidence in their ability to provide bereavement care (Lin and Fan 2020). Therefore, it is critical to examine the coping strategies used by healthcare professionals when they experience the loss of a patient, so as to develop effective interventions and enhance bereavement care. The current study aimed to elucidate the following research question: How do healthcare professionals cope with bereavement, and what coping strategies do they use?

Methods

This paper follows the guidelines of the ENTREQ statement (Tong et al. 2012) which was designed to enhance transparency in reporting the synthesis of qualitative research. A systematic review protocol was developed and registered with the International Prospective Register of Systematic Reviews (PROSPERO) (#CRD42023406061).

Eligibility criteria for selecting studies

Inclusion criteria

Studies were included if they met the inclusion criteria: (1) Participants: Included studies with healthcare professionals as participants, defined as a population who study, advise on or provide preventive, curative, rehabilitative, and promotional health services based on an extensive body of theoretical and factual knowledge in the diagnosis and treatment of disease and other health problems according to the World Health Organization (WHO 2019); (2) Interest of phenomena: Coping strategies or coping experiences of healthcare professionals in response to bereavement; (3) Context: The context included any settings in which professional bereavement was experienced; (4) Study design: Qualitative research methods included but were not limited to phenomenological research, grounded theory, ethnography, or qualitative data from mixed research studies.

Exclusion criteria

(1) Non-English literature, (2) protocols, (3) conference abstracts, (4) duplicate publications, and (5) full text not available.

Search strategies

A combination of subject terms and free words were used for literature searching. The search was conducted in PubMed, Embase, ScienceDirect, CINAHL, PsycINFO, Web of Science, Cochrane Library, Scopus, and Wiley online library in April 2023. Search keywords included "nurs*," "docto*," "physician*," "surgeon*," "medical personne*," "health personnel," "medical staff*," "health care personne*," "healthcare professional," "healthcare provider," "bereavement," "grief," "mourning," "patient death," "death of patient," "patient loss," "loss of patient," "experience," "feelings," "perception," "perspective," "attitude," "need," "expectation," "qualitative research," "qualitative study," "phenomenology," "grounded theory," "ethnography," "focus group," and "case stud*." The Boolean operator "AND" and "OR" were also used to connect the related concept, and there were no search date limits in this study.

Quality assessment

Two researchers independently assessed the quality of the literature using the Critical Appraisal Skills Programme (2018). A total of 10 items were evaluated, and the suggested answer categories for each evaluation item were: Yes, No, Unclear, and Not Applicable (NA). The Critical Appraisal Skills Programme (CASP) Checklist was used for critical appraisal, and it has been widely applied in qualitative studies. However, it does not provide a scoring system; we therefore used the Reviewer Guidelines for Using the CASP Checklist developed by Butler, which is divided into 3 categories: high, medium, and low. Items with scores less than 6 were eliminated.

Information extraction

Two researchers independently screened the literature by reading the title, abstract, and full text according to the inclusion and exclusion criteria of the literature. A standardized data extraction form was used for data extraction, which contained authors, year of publication, country/region, methodology, data collection method, participants, settings, sample size, data analysis method, and major findings. Group discussions or consultation with third partners were conducted in the event of disagreement during the screening and extraction of the literature.

Data synthesis

The included studies were imported into NVIVO 11 software for inductive coding in thematic narrative synthesis. The 3 stages proposed by Thomas and Harden were followed to guide this synthesis: the coding of text line-by-line, the development of descriptive themes, and the generation of analytical themes. The synthesis was primarily conducted by one researcher, and the findings were discussed and verified by the other researchers.

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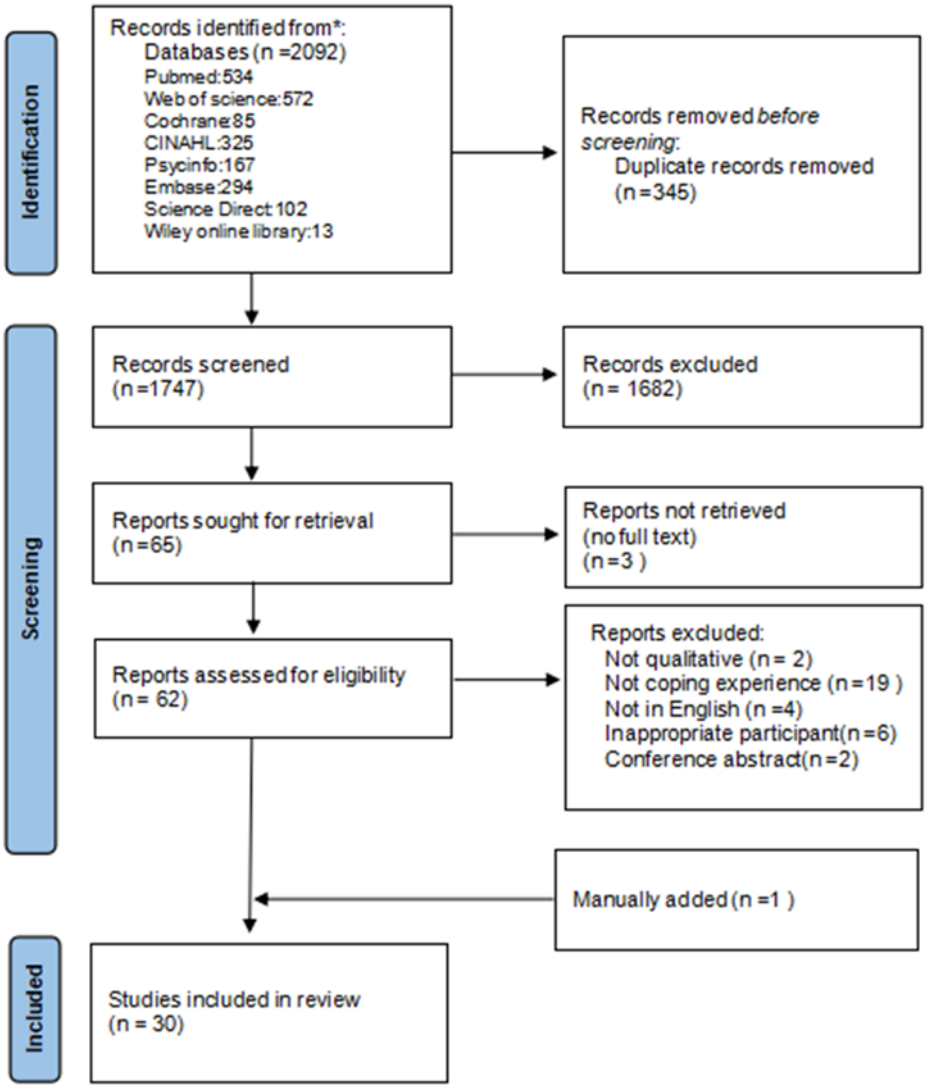

Figure 1. PRISMA flowchart of study selection and exclusion.

Results

Study selection

A total of 2092 studies were initially identified, and 1747 studies were retained after removing duplicate records. A total of 1682 studies were excluded after screening the titles and abstracts, and 29 studies were finally included after a thorough review of the full text of the selected 62 articles. One additional study was included by tracking the references of the included literature, and a total of 30 studies were finally included and analyzed. Figure 1 shows the PRISMA flowchart of the whole selection process.

Study characteristics

All 30 included studies were published between 1997 and 2022. Twenty-nine were qualitative studies and 1 was an online survey with open-ended questions. Three were doctoral dissertations and 27 were journal publications. Of the 30 studies, 9 were from the United States, 4 from Canada, 3 from Australia, 3 from China, 2 from the United Kingdom, and the remaining 9 were from Canada, Jordan, Thailand, Philippines, Israel, Indonesia, Singapore, Ireland, and South Africa, respectively. The included healthcare professionals included physicians, oncologists, palliative care occupational therapists, speech–language therapists and audiologists, and nurses. The basic characteristics of the included literature are shown in Table 1. The quality scores of included articles ranged from 9 to 10, and the quality of all included studies was high, indicating the reliability of their findings. Table 2 shows the CASP Checklist and scores for the selected papers.

Meta-synthesis of qualitative data

A total of 14 descriptive themes were obtained and analyzed to create 6 analytical categories: emotional coping, cognitive coping, behavioral coping, relational coping, spiritual coping, and occupational coping. Table 3 shows the process of theme development.

Emotional coping

Two categories of emotional coping were identified: emotional catharsis and emotional detachment. The main method of emotional catharsis was crying (Conte 2011; Khalaf et al. 2018;

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Table 1. Characteristics of included studies in the review

Author	Year	Country	Phenomena of interest	Methodology	Data collection method	Participants	Data analysis method	Setting	Results
Rashotte	1997	Ottawa	The grief experience of pediatric intensive care nurses when patients die.	Heideggerian phenomenological approach	A flexible, guided interview with open-ended questions	6 registered nurses	Colaizzi procedure	Hospital	Self-expression; Self-nurturance; Termination of relationship activities; Engaging in control-taking activities; Self-reflection.
Yang	2001	UK	The experiences of intensive care nurses caring for patients who are dying.	Phenomenological descriptive approach	Semi-structured interviews	10 nurses	Colaizzi procedural steps	Hospital	Considering nurses' attitudes to caring for the dying; Stressors associated with this care; Coping strategies that intensive care nurses adopt.
Gerow	2010	USA	The lived experience of nurses surrounding the death of patients.	Heideggerian phenomenological approach	Semistructured interviews	11 registered nurses	Heideggerian hermeneutical methods and van Manen's progression	Selected by participants	Reciprocal relationship transcends professional relationship; Initial patient death events are formative; Nurses' coping responses incorporate spiritual worldviews and caring rituals; Remaining "professional" requires compartmentalizing of experience.
Shorter	2010	UK	Critical care nurses' experiences of grief and their coping mechanisms when a patient dies.	Heideggerian phenomenological approach	Semistructured interviews	8 critical care nurses	Colaizzi's 7-step framework	No mention	The death experience; The death thereafter.
Yu	2010	China	ICU nurses' response to the death of patients.	Qualitative method of interviews	Interviews	12 nurses	Content analysis	No mention	Emotional reactions; Coping with dying; Facilitators of care; Barriers to care.
Thompson	2010	Canada	The experiences of novice nurses with their first patient death in critical care.	Interpretive description	Unstructured interviews	5 nurses	Analytic framework of interpretive description	No mention	Anticipating death, Transition from life to death; The moment of death; Being with the family; Carrying on.
Conte	2011	USA	The lived experiences of loss and grief in pediatric oncology nurses.	Qualitative descriptive research	Unstructured interviews	11 pediatric oncology nurses	Colaizzi's method	Internet	Connectedness; Doing All One Can; Healing.
Wenzel	2011	USA	Oncology nurses' perspectives on professional bereavement.	Descriptive qualitative study	Focus groups	34 oncology nurses	Content analysis	Hospital	Dimensions of work-related loss; Working through bereavement.

(*Continued*)

Table 1. (*Continued.*)

Author	Year	Country	Phenomena of interest	Methodology	Data collection method	Participants	Data analysis method	Setting	Results
Hinderer	2012	USA	How nurses dealt with patient deaths and how they internalized the experience.	Phenomenological descriptive design	Semi-structured interviews	6 critical care nurses	Colaizzi's method	Selected by participants	Coping; Personal distress; Emotional disconnect; Inevitable death.
Granek	2013	Canada	What protocol and coping strategies oncologists turn to cope with patient loss.	Grounded theory	Semi-structured interviews	20 oncologists	Line-by-line coding	Oncologist's office	Protocol on dealing with patient loss; Coping with patient loss.
Shimoinaba	2014	Australia	Japanese palliative care nurses' experience of loss and grief.	Grounded theory	Face-to-face in-depth interviews	13 Japanese nurses working in palliative care units	Coding and categorizing	Selected by participants	Anticipating loss of patients; Loss of relationship with patients' deaths; Nurses' personal and cumulative prior losses; Loss of their professional goals as a palliative care nurse.
Anyadike	2014	USA	Understand how the oncology nurse individually manages their grief experiences.	Grounded theory	Semi-structured interviews	8 oncology nurses	Data coding	Selected by participants	Magnitude of loss; Practicality and Practice of Understanding Emotionality; Personal Walk with the Spirit; Expression and Essence of Love.
Granek	2016	Canada	Pediatric oncologists coping strategies when their patients died.	Grounded theory	Semi-structured interviews	21 pediatric oncologists	Line-by-line coding	Hospital	Engagement coping; Disengagement coping.
Hogan	2016	Canada	The experiences of emergency nurses who care for patients who die in the emergency.	Interpretive descriptive approach	Semi-structured interviews	11 ED nurses	Thematic analysis	No mention	It's not a nice place to die; I see the grief; Needing to know you've done your best.
Bacon	2017	USA	Nurses' experiences with FTR deaths.	Phenomenological approach	Semi-structured 1:1 interviews	14 nurses	Colaizzi's 7-step method	Private setting selected by participants	Coping mechanisms are important; Immediate peer and supervisor feedback and support are needed for successful coping; Subsequent supervisor support is crucial to moving on; Nurses desire both immediate support and subsequent follow-up from their nurse leaders after every FTR death.
Khalaf	2018	Jordan	The lived experiences of nurses' coping mechanisms following patients' death.	Phenomenological approach	Focus groups	21 Jordanian nurses	Colaizzi's 9-step framework	Hospital	Working through the grief experience; Seeking control over grief; Diversity of actions around patients' death; Nurses facing challenges.

(*Continued*)

Table 1. (*Continued.*)

Author	Year	Country	Phenomena of interest	Methodology	Data collection method	Participants	Data analysis method	Setting	Results
Treggalles	2018	Australia	The lived experience of professional grief among occupational therapists.	Interpretive phenomenological approach	Semi-structured interviews	6Australian palliative care occupational therapists	Approach outlined by Creswel	No mention	Knowledge of self; Giving permission for connections and feelings; Filtering experience; Being present at work and at home.
Mirwald	Mirwald 2019	USA	The experiences of nurses with patient death.	Qualitative case study	In-person and telephone interviews	8 nurses	Inductive thematic analysis	Hospital	Conversation; Family; Type of death; Disenfranchisement.
Betriana	2019	Thailand	The meaning of the lived experiences of grief of Muslim nurses caring for patients who died.	Hermeneutic phenomenological approach	Interviews	14 nurses	Van Manen's hermeneutic approach	Tertiary public hospital	Empathetic understanding; Balancing self'; Avoidance; Anticipating the future of own death; Relating technologies in bargaining.
Mateo	Mateo et al. 2020	Philippines	Nurses' experience in dealing with a dying patient.	Phenomenological study	Semi-structured interviews	6 nurses	The cool and warm analysis	No mention	Acceptance; Borderline; Competency; Diverting; Equal care.
Granek	2019	Israel	How personnel cope with these types of events.	Grounded theory	Semi-structured interviews	61 healthcare professionals	Line-by-line coding	Private setting selected by participants	Colleague support; Seeking professional help; Setting boundaries between their work and home life.
Betriana	2020	Indonesia	The grief reactions and coping strategies of Muslim nurses in dealing with the death of patients.	Phenomenological qualitative study	Semi-structured interviews	14 nurses	Thematic analysis	Tertiary public hospital	Four reactions of grief; Four factors influencing reactions of grief; Three coping strategies used in dealing with death.
Chen	2021	China	Professional caregivers' experiences of bereavement after patient deaths.	Qualitative description	Face-to-face semi-structured interviews	24 physicians and nurses	Thematic analysis	Private setting selected by participants	The nature of professional bereavement experiences; The meaning of patient deaths; Immediate bereavement reactions; Long-term changes; Coping strategies.
Chew	2021	Singapore	Experiences, challenges and coping strategies of new nurses dealing with pediatric death	Descriptive qualitative study	Semi-structured interviews	12 new paediatric nurses	Thematic analysis	Tertiary public hospital	A spectrum of emotions; The "blame" game; Getting through the grief; New nurses' wish list.
Shimoinab	2021	Australia	ED nurses' experiences with children's death, coping strategies and support needs.	Descriptive qualitative study	Semi-structured interviews	24 registered nurses	Thematic analysis	Selected by participants	Nature of emergency department work; Working with families; Coping and support.

(*Continued*)

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Table 1. (*Continued.*)

Author	Year	Country	Phenomena of interest	Methodology	Data collection method	Participants	Data analysis method	Setting	Results
Morrissey	2021	Ireland	The impact and responses of MHNs to a client suicide.	Descriptive qualitative study	In-depth interviews	10 nurses	Six-phase thematic analysis framework	Selected by participants	Hearing the news; Experiencing the impact of grief; Grieving privately; Searching for meaning; Questioning practice.
Wolfe	2022	USA	Physicians' grief and coping responses.	Prospective qualitative study	Focus groups	11 physicians	Thematic content analysis	No mention	Characteristics of an impactful pediatric patient death; Physician grief and coping responses; Novice physician training that impacted physician stress; Coping response after patient death.
Zhang	2022	China	Nurses' experiences coping with patient death in China.	Qualitative research	Semi-structured, in-depth, face-to-face interviews	15 clinical nurses	Thematic analysis method	Tertiary public hospitals	Negative emotions from contextual challenges; Awareness of mortality on its own; Coping style.
Groves	2022	USA	Nurses experience symptoms of grief or distress following the suffering and death of a patient in the PICU.	Electronic survey	Qualitative question	104 nurses	Thematic content analysis	Online	Continuum of emotional responses; Emotional prompts; Coping; Resilience.
Nagde	2022	South Africa	The moral injury experienced by South African SLT&As in patient death and dying, and how they overcame the injury.	Qualitative narrative research design	In-depth interviews	25 SLT&As	Thematic analysis	Skype	Moral injury experienced by the SLT&As due to patient death and dying; Coping mechanisms employed or suggested by SLT&As to overcome their moral injury due to patient death and dying.

Table 2. CASP Checklist and scores for selected papers

No.	Author	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Total score	Quality rating
1	Chen	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10.0	High
2	Wenzel	Y	Y	Y	Y	Y	U	Y	Y	Y	U	9.0	High
3	Wolfe	Y	Y	Y	Y	Y	U	Y	Y	Y	U	9.0	High
4	Betriana	Y	Y	Y	Y	Y	U	Y	Y	Y	U	9.0	High
5	Zhang	Y	Y	Y	Y	Y	U	Y	Y	Y	Y	9.5	High
6	Betriana	Y	Y	Y	Y	Y	U	Y	Y	Y	Y	9.5	High
7	Gerow	Y	Y	Y	Y	Y	U	Y	Y	Y	Y	9.5	High
8	Shorter	Y	Y	Y	Y	Y	U	Y	Y	Y	Y	9.0	High
9	Rashotte	Y	Y	Y	Y	Y	U	Y	Y	Y	Y	9.5	High
10	Yu	Y	Y	Y	Y	Y	U	Y	Y	Y	U	9.0	High
11	Groves	Y	Y	Y	Y	Y	U	Y	Y	Y	U	9.0	High
12	Khalaf	Y	Y	Y	Y	Y	U	Y	Y	Y	Y	9.5	High
13	Chew	Y	Y	Y	Y	Y	U	Y	Y	Y	Y	9.5	High
14	Shimoinab	Y	Y	Y	Y	Y	U	Y	Y	Y	U	9.0	High
15	Bacon	Y	Y	Y	Y	Y	U	Y	Y	Y	U	9.0	High
16	Granek	Y	Y	Y	Y	Y	U	Y	Y	Y	Y	9.5	High
17	Granek	Y	Y	Y	Y	Y	U	Y	Y	Y	Y	9.5	High
18	Hogan	Y	Y	Y	Y	U	U	Y	Y	Y	Y	9.0	High
19	Nagdee	Y	Y	Y	Y	Y	U	Y	Y	Y	Y	9.5	High
20	Morrissey	Y	Y	Y	Y	Y	U	Y	Y	Y	Y	9.5	High
21	Hinderer	Y	Y	Y	Y	Y	U	Y	Y	Y	Y	9.5	High
22	Mateo	Y	Y	Y	Y	Y	U	Y	Y	Y	Y	9.5	High
23	Shimoinaba	Y	Y	Y	Y	Y	U	Y	Y	Y	Y	9.5	High
24	Treggalles	Y	Y	Y	Y	Y	U	Y	Y	Y	Y	9.5	High
25	Yang	Y	Y	Y	Y	Y	U	Y	Y	Y	U	9.0	High
26	Mirwald	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10.0	High
27	Thompson	Y	Y	Y	Y	U	U	Y	Y	Y	Y	9.0	High
28	Anyadike	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10.0	High
29	Conte	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10.0	High
30	Granek	Y	Y	Y	Y	Y	U	Y	Y	Y	Y	9.5	High

Q1 Was there a clear statement of the aims of the research?
Q2 Is a qualitative methodology appropriate?
Q3 Was the research design appropriate to address the aims of the research?
Q4 Was the recruitment strategy appropriate to the aims of the research?
Q5 Was the data collected in a way that addressed the research issue?
Q6 Has the relationship between researcher and participants been adequately considered?
Q7 Have ethical issues been taken into consideration?
Q8 Was the data analysis sufficiently rigorous?
Q9 Is there a clear statement of findings?
Q10 How valuable is the research?

Shimoinaba et al. 2021, 2014; Thompson et al. 2010). As mentioned by the interviewer, "For me, crying is a necessary process, and I have to get it out." The participants reported that it was important that they expressed discomfort when they experienced traumatic events, and they could only accept their grief by acknowledging their loss and emotions. Therefore, they chose a form of direct emotional release.

Emotional detachment was identified as another emotional coping strategy used by the participants. This refers to their ability to separate their emotions, which is achieved by maintaining a psychological distance from the patient and their grief (Bacon 2017; Betriana and Kongsuwan 2019; Chen et al. 2023; Chew et al. 2021; Conte 2011; Gerow et al. 2010; Granek et al. 2016; Groves et al. 2022; Hinderer 2012; Mateo et al. 2020; Mirwald 2019; Shimoinaba et al. 2021, 2014; Shorter and Stayt 2010; Thompson et al. 2010; Treggalles and Lowrie 2018; Wolfe et al. 2022; Yu and Chan 2010). Psychological distancing and low engagement were protective mechanisms that helped medical professionals to protect

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Table 3. CASP Checklist and scores for selected papers

Analytical themes	Descriptive themes	Sources
Emotional coping	Emotional catharsis	12,14,23,27,29
	Emotional detachment	1,3,6,7,8,10,11,13,14,15,17,21,22,23,24,26,27,29
Cognitive coping	Death attribution	10,12,20
	Reflection	1,3,5,6,7,8,9,13,14,15,18,19,21,24,27
	Positive reframing	1,2,11,17,18,23,29
Behavioral coping	Escape from death	4,5,6,16
	Social communication	1,2,3,4,5,8,9,11,12,13,14,15,16,17,18,19,20,21,23,26,27,29,30
	Daily routine activities	1,2,3,9,16,17,18,22,24
Relational coping	Boundary-setting	9,16,17,24,28,30
	Relationship termination activities	9,20
Spiritual coping	Beliefs	2,4,6,7,13,14,16,17,19,25,26,28,29
Occupational coping	Providing optimal care	17,22,25,28,29
	Reflection on career roles	3,13,20,26,27,29
	Shift in career goals	1,6,14

themselves, allowing them to proactively manage triggers of emotional vulnerability, avoid trauma for a short period of time, and manage their emotional health and well-being. Moreover, these strategies were regarded as essential for healthcare professionals, given that they had to provide high-quality care to patients, support grieving families, and remain calm and rational so that they could carry out their professional duties.

Cognitive coping

Cognitive change was identified as an important strategy that helped healthcare professionals to cope with bereavement experiences, and it involved death attribution, reflecting on life and death, and positive reframing.

Death attribution was identified as a form of cognitive coping. To cope with the loss of patients and to avoid self-blame, some participants relied on ideas of fatalism, and believed that the loss of their patient was fated and beyond their control (Yu and Chan 2010). Other participants (Khalaf et al. 2018) viewed patient deaths as being unrelated to the care provided, or sought rational explanations for patient deaths by framing the experiences within biomedical and sociocultural perspectives (Morrissey and Higgins 2021).

Reflecting on life and death was another important cognitive coping strategy among the participants, as it helped them to come to terms with death and make sense of it. The experience of death enabled the participants to reconceptualize and accept it (Chen et al. 2023; Gerow et al. 2010; Shorter and Stayt 2010; Zhang et al. 2022). They recognized death as an inevitable part of life, realized the sacredness and fragility of life, and even reflected on their work and life (Chew et al. 2021; Wolfe et al. 2022). In addition, the participants reflected on each death event, the self-coping strategies that they used, and the quality of care provided, while striving to find a sense of meaning and satisfaction in clinical practice (Bacon 2017; Chew et al. 2021; Hinderer 2012; Hogan et al. 2016; Nagdee and Andrade 2022; Rashotte et al. 1997; Shimoinaba et al. 2021; Thompson et al. 2010; Treggalles and Lowrie 2018).

The participants also actively and positively reframed the impact of the bereavement process in order to minimize their experience of loss. For example, they reported the following: "I would think about all of the positive patient miracles I was involved in at work" and "I felt like I was the right person there at the right time and I was doing the best work that I could." The participants tried to focus on the positive aspects of their work, such as all of the care that they provided to patients and their families, the positive impact of their daily interactions with them, and the meaning and value of their work, which helped healthcare providers to nurture their inner strength and resilience (Chen et al. 2023; Conte 2011; Granek et al. 2016; Groves et al. 2022; Hogan et al. 2016; Shimoinaba et al. 2014; Wenzel et al. 2011).

Behavioral coping

Behavioral coping involved escape from death, social communication, and carrying out routine activities. Grief is a painful experience, and healthcare professionals may actively ignore and avoid death (Betriana and Kongsuwan 2019, 2020; Granek et al. 2013; Zhang et al. 2022). Some participants expressed an unwillingness to discuss patient deaths. They reported that they chose not to enter a patient's room and had even hidden themselves in order to avoid situations that required them to provide death care.

Social communication was divided into formal debriefing and informal communication. Formal debriefing refers to debriefing meetings at which the participants had an opportunity to express their experiences and feelings, so that they could communicate and connect more closely with team members (Bacon 2017; Hogan et al. 2016; Rashotte et al. 1997; Shimoinaba et al. 2021, 2014; Shorter and Stayt 2010; Wenzel et al. 2011; Wolfe et al. 2022). Informal communication describes situations in which the participants were able talk with peers (Bacon 2017; Betriana and Kongsuwan 2020; Chen et al. 2023; Chew et al. 2021; Conte 2011; Granek et al. 2016, 2013, 2019; Groves et al. 2022; Hinderer 2012; Hogan et al. 2016; Khalaf et al. 2018; Mirwald 2019; Morrissey and Higgins 2021; Nagdee and Andrade 2022; Rashotte et al. 1997; Shimoinaba et al. 2021; Shorter and Stayt 2010; Thompson et al. 2010; Wolfe et al. 2022; Zhang et al. 2022), leaders (Bacon 2017; Shimoinaba et al. 2021; Zhang et al. 2022), friends (Granek et al. 2016; Khalaf et al. 2018; Morrissey and Higgins 2021;

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Rashotte et al. 1997; Thompson et al. 2010), and family members (Bacon 2017; Chen et al. 2023; Granek et al. 2016, 2013; Khalaf et al. 2018; Morrissey and Higgins 2021; Rashotte et al. 1997; Thompson et al. 2010). Peer communication, in particular, was the most common coping strategy used by participants who shared similar work environments and traumatic experiences, and compassion, listening, and understanding were important social support resources for the healthcare professionals.

Daily routine activities were viewed as opportunities for relaxation and also a positive coping strategy used by the participants. These activities included periods of rest, hobbies, shopping, exercise, vacations, and spending time with family, all of which helped the healthcare professionals to alleviate stress and reduce negative feelings (Chen et al. 2023; Granek et al. 2016, 2013; Hogan et al. 2016; Mateo et al. 2020; Rashotte et al. 1997; Treggalles and Lowrie 2018; Wenzel et al. 2011; Wolfe et al. 2022).

Relational coping

Boundary-setting and relationship termination activities were common relational coping strategies used by the healthcare professionals. Boundary-setting, which is a defense mechanism, helped them to maintain an appropriate psychological distance from patients and their families, and to resist the onslaught of distressing emotions. This strategy was effective in helping physicians and nurses to carry out their work and to cope with their bereavement experiences (Anyadike 2014; Granek et al. 2016, 2013, 2019; Rashotte et al. 1997; Treggalles and Lowrie 2018). Relationship termination activities included attending funerals, writing letters, and conducting follow-up interviews, which were considered to be effective coping strategies for healthcare professionals to help them to manage feelings of loss (Morrissey and Higgins 2021; Rashotte et al. 1997).

Spiritual coping

Spiritual coping strategies mainly involved the spiritual beliefs of the individual, including their religious and non-religious beliefs. The participants expanded their spiritual strength through use of religious statements and prayers, and religious-based support helped them to cope with patient deaths (Betriana and Kongsuwan 2019; Chew et al. 2021; Conte 2011; Mirwald 2019; Shimoinaba et al. 2021; Wenzel et al. 2011). For example, the healthcare professionals reported the following: "God has helped me through this" (Gerow et al. 2010), "I think that praying and reading the Bible can support and inspire you, to some extent" (Nagdee and Andrade 2022), "Give my nerves to God" (Shimoinaba et al. 2021), and "Religion is very important to me; it helps me to accept the inevitability of death and dying" (Yang and McIlfatrick 2001). Furthermore, some participants, though not religious, had their own belief systems, inner voices, and internal hopes, and their spirituality and faith helped them to cope with patient deaths (Anyadike 2014; Granek et al. 2016, 2013).

Occupational coping

Three occupational coping strategies were identified: providing optimal care, reflection on career roles, and shift in career goals.

Providing optimal care to dying patients was a coping strategy used by nurses after they had experienced the loss of a patient, and it involved comforting and respecting the patient, equal caring, compassionate care, and selfless love (Anyadike 2014; Conte 2011; Granek et al. 2016; Mateo et al. 2020; Yang and McIlfatrick 2001).

Professional bereavement also caused healthcare professionals to reflect on their professional roles. While novice nurses struggled with professional bereavement and even questioned their job role (Morrissey and Higgins 2021), they recognized that dealing with bereavement was part of a nurse's job (Thompson et al. 2010). Some experienced participants believed that they could still provide meaningful care to their patients' families, even when no cure could be found, which helped them to find a sense of meaning in their role as nurses (Conte 2011). In addition, they also felt that it was crucial to learn about the value and complexities of the profession through bereavement (Mirwald 2019; Wolfe et al. 2022).

Shifting to different career goals was also identified as an occupational coping strategy. Some healthcare professionals claimed that if they had sufficient knowledge and skills, their patients could have been saved (Betriana and Kongsuwan 2019; Chen et al. 2023), and they used the following expressions to describe their feelings: "should have done more" and "if we had sufficient knowledge of these technologies, the patients could have been saved." These beliefs made them more motivated to develop their medical knowledge. However, some medical professionals recognized the limitations of medicine and set more realistic goals for their careers (Chen et al. 2023). Other participants noted the necessity of inner strength, which helped them to adopt a gentle and assertive approach to their nursing work, so as to better support their patients' families through the grief process (Shimoinaba et al. 2021).

Discussion

This systematic review examined 30 qualitative studies of the coping strategies used by healthcare professionals who had experienced the loss of their patients, and 6 different coping styles were identified. The findings confirmed the multidimensional and unique coping strategies used by healthcare professionals when they experience bereavement. This manuscript not only contributes to deepening our understanding of this phenomenon, but also provides a framework for designing appropriate interventions to help healthcare workers to respond more effectively. Therefore, this study could be used to provide a basis for evidence-based practice.

Consistent with extant literature describing the field of professional bereavement coping, our findings support the use of a variety of coping styles by healthcare professionals. In contrast to Zheng's study which focused on internal and external resources, we concentrated on the coping strategies themselves and examined multiple dimensions. In addition, distinct from the coping strategies proposed by Crunk, our review also identified the form of occupational coping, which can be understood as a specific coping style used by healthcare workers when they experience professional bereavement.

Emotional coping involves emotional catharsis and emotional detachment. Similar to Zheng's results, healthcare professionals use crying as a mechanism of emotional release. Unlike crying in response to grief, the crying of healthcare professionals during the coping process is a conscious emotional release. In addition, healthcare professionals also use detachment as strategies to manage their emotions. There are 2 main reasons for this. First, healthcare professionals engage in multiple roles when providing bereavement care: they offer patient-centered and family-centered care, and are simultaneously advocates and communication mediators (Raymond et al. 2016). They have to manage their emotions as effectively as possible in order to remain rational, and in a

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position to perform their professional duties. Second, healthcare professionals are obliged to learn how to conceal their emotions because invisible rules about emotional displays control the extent to which care providers can outwardly express their emotions (Brighton et al. 2019). Emotional responses are often regarded as a sign of weakness, and care workers often feel that they have to suppress their emotions until an appropriate moment to grieve presents.

In terms of behavioral coping, almost all studies have shown that healthcare professionals actively cope by means of self-activities (rest, hobbies, shopping, sports, vacations), social interactions (peer interactions, friend interactions, family interactions), and organizational support (debriefing, leader support), which highlights the importance of behavioral coping strategies. Through these remarkable activities, individuals are able to release stress and reinvest in a meaningful life, which is consistent with Zheng's research (Zheng et al. 2018). In addition, we identified avoidant coping strategies as a response to patient deaths. Although this coping style is uncommon, it reflects how helpless some people can feel when they are confronted with bereavement. Personality has an important influence on bereavement coping, and professionals adopt different coping styles to deal with death at work. This underscores the need to help individuals to cope effectively, while taking into account their unique personalities and experiences.

In clinical practice, death involves the loss of a close relationship with a particular patient with whom one has shared part of a significant journey, and this means that healthcare professionals inevitably come to adopt relational coping strategies. On the one hand, they may isolate themselves from the relationship by setting boundaries; that is, they set boundaries at work and consciously distance themselves from the patient and their family. Therefore, healthcare organizations should pay close attention to any disengagement behaviors exhibited by their healthcare staff, and provide timely support. On the other hand, healthcare professionals may also end the relationship formally, by attending funerals and writing letters. Traditionally, participating in a funeral provides an opportunity to "say goodbye," signaling the end of the relationship (Burrell and Selman 2020). However, the included studies noted that some participants expressed uncertainty about attending funerals and were unsure when or if they should separate from their patients' families (Granek et al. 2013). This highlights a need for future research to examine the attitudes and practices of healthcare professionals toward attendance at their patients' funerals.

While a spiritual reaction may take the form of "question of religion" (Chen and Chow 2021), spiritual coping is an important method for healthcare professionals, as it allows them to utilize their own spiritual resources to cope with bereavement and it is to some extent an effective protective strategy. This review found that most participants utilized religious beliefs and individual philosophical beliefs to transcend themselves, draw strength, and find meaning in their lives. Charzyńska defines spiritual coping as an attempt to overcome stressors based on transcendence, which is categorized into 2 types of coping: positive coping and negative coping (Charzyńska 2015). Positive spiritual coping addresses difficult situations by resorting to meaning-seeking, focusing on moral values and religion. A study (Soola et al. 2022) showed that positive spiritual coping was the main coping method used by medical staff. Given the prevalence of spiritual coping practices in healthcare settings, it is helpful for hospital managers to offer spiritual coping workshops to enhance the spiritual values of their staff members and promote the adoption of positive spiritual coping strategies.

It is noteworthy that we recognized some new codes when examining the coping strategies of healthcare professionals, namely, occupational coping. The experience of bereavement is an opportunity for professional growth and it promotes reflection on the meaning of job roles and goals. As Chen et al. (2023) suggests, the professional bereavement coping process is driven by the meaning that participants attribute to the death of a patient. They can find role meaning, gain inner strength, and achieve fulfillment in the care that they provide to their patients. Furthermore, this coping strategy is a transformative process. Similar to the findings of a recent study (Arantzamendi et al. 2024), coping with bereavement is an iterative and dynamic process that evolves with clinical experience. This also suggests that hospital managers should pay attention to key elements of the coping process to help healthcare professionals find meaning and promote personal growth and intrinsic value.

The synthesized results provide a basis for improving the bereavement coping skills of healthcare professionals. Among the existing studies focusing on the bereavement coping skills of professionals, the Self-Competence in Death Work Scale developed by Chan et al. (2015) focuses on both emotional and existential coping dimensions. Our findings support a multi-faceted perspective of professionals' coping skills to develop targeted intervention programs and help healthcare workers to deal with grief and loss effectively. In addition, medical administrators can determine the coping practices of their medical personnel by evaluating these 6 dimensions, so as to provide multi-faceted coping resources to improve their coping strategies and promote individual and professional growth. Furthermore, although we identified several coping strategies used by healthcare professionals when they experience the loss of a patient, the literature suggests that certain forms of coping are akin to a double-edged sword. For example, setting boundaries is a common coping strategy, and on the one hand, it can help healthcare professionals to maintain an appropriate distance and continue to work effectively. On the other hand, high levels of death anxiety among healthcare professionals may stimulate the use of avoidance as a coping strategy, which can lead to poor job performance and a decline in individual health (Nia et al. 2016). Thus, it is crucial to develop a professional bereavement coping strategy scale in order to assess the coping strategies used by healthcare professionals and examine the relationship between personal coping strategies and outcomes.

Limitations

It is important to acknowledge several limitations of this systematic review. First, the review only included studies published in English. Coping strategies for professional bereavement may differ across cultures, which means that we might have missed some perspectives and evidence from publications in other languages. On the other hand, gray literature was not included in this review, which may have led to bias. Furthermore, like other qualitative reviews, this manuscript might be influenced by the subjective perspectives of the authors.

Conclusion

This review synthesized 30 qualitative studies involving 545 participants during the period from 1997 to 2022, reporting on the coping experiences and strategies of professional bereavement among healthcare practitioners, and 6 coping strategies were identified. It highlights the inevitability of healthcare professionals experiencing

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bereavement and the multidimensional nature of their coping styles. Healthcare professionals can use positive reframing to help them cope with the loss of a patient, give meaning to their job roles, transcend themselves, and gain inner strength. Healthcare administrators can also focus on the bereavement coping process by exploring the 6 strategies, enhancing bereavement coping skills, and improving the quality of bereavement care by providing bereavement education, spiritual coping workshops, and organizational support for medical staff.

Supplementary material. The supplementary material for this article can be found at https://doi.org/10.1017/S1478951524001147.

Competing interests. The authors declare that there is no conflict of interest.

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