The impact of patient deaths on acute care clinicians: A scoping review to inform support

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End-of-Life Essentials (EOLE) is a National Palliative Care Project funded by the Australian Government Department of Health, Disability and Ageing, and delivered by Flinders University.

Study background

- End-of-Life Essentials
  - A national education program for acute care clinicians

- Starting assumptions:
  - Clinicians in acute care need preparation for end-of-life care
  - Making the case for education requires a clear evidence base.

Why this matters

- Around 50% of all Australian deaths occur in hospitals
  - ~ 71% of those ≥ 65 living in the community (ABS 2021)
- Only 38% of predictable deaths receive specialist palliative care (AIHW 2024)

Looking ahead: Palliative care need projected to rise 37-65% by 2042 (Luc 2026)

Exposure to patient death is a routine, and increasing, part of acute clinical work.

The problem gap

What we know

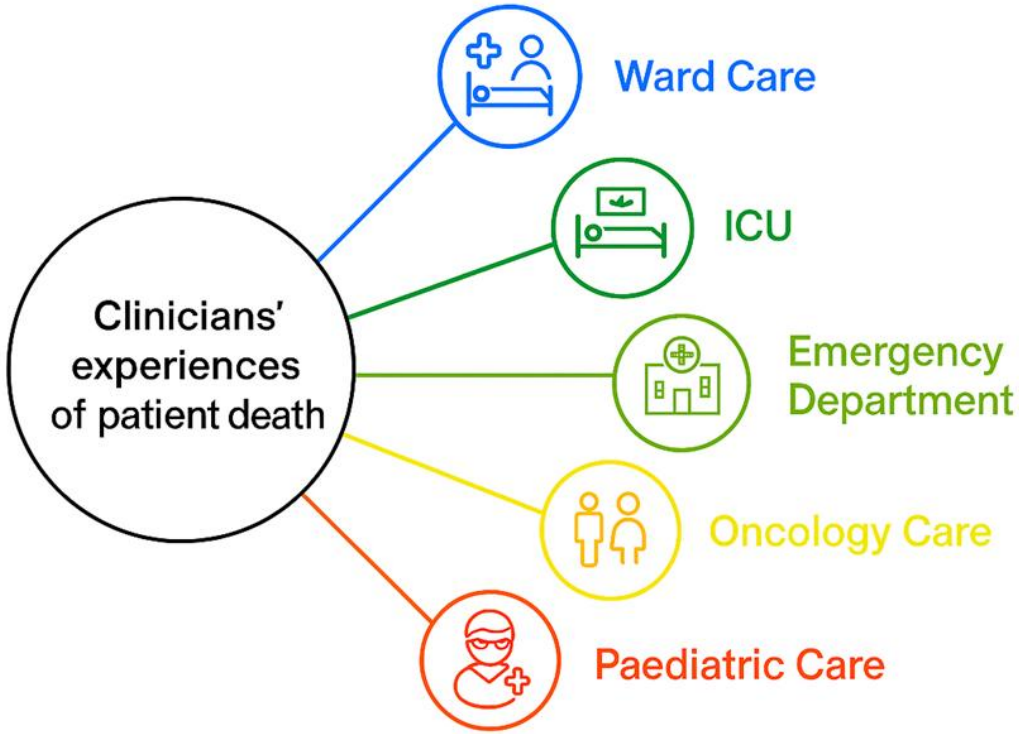
- Cumulative exposure in specialist palliative care associated with:
  - distress, compassion fatigue, burnout
  - meaning, accomplishment, sense of privilege.

What remains unclear

- Evidence outside specialist palliative care is fragmented across settings
- Specific impact of cumulative exposure to patient death
- Role of education in shaping or mitigating these impacts.

Aims of this review

- To map the impact of patient death on acute care clinician
- To explore how education and training are positioned within this literature



How we approached this review

- Scoping review (JBI methodology; PRISMA-ScR)

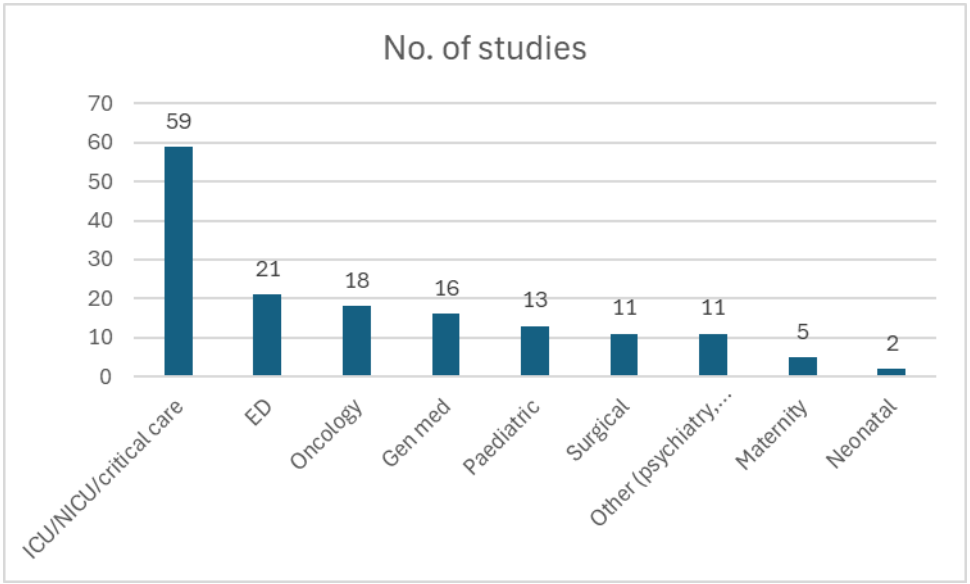
- Inclusion criteria:
  - Acute care clinicians and members of the care team
  - Outcomes or described experiences clearly linked to patient death
  - High-income countries (World Bank, FY2026)
  - All primary, peer-reviewed literature
  - English language, 2010-2025.

- Databases: Medline, Embase, CINAHL, PsycINFO

Findings: General characteristics

N = 94 included studies

- 60% quantitative (mostly cross-sectional) vs 32% qualitative
- Nurses dominant (68%)
- ICU/critical care = majority setting (63%)



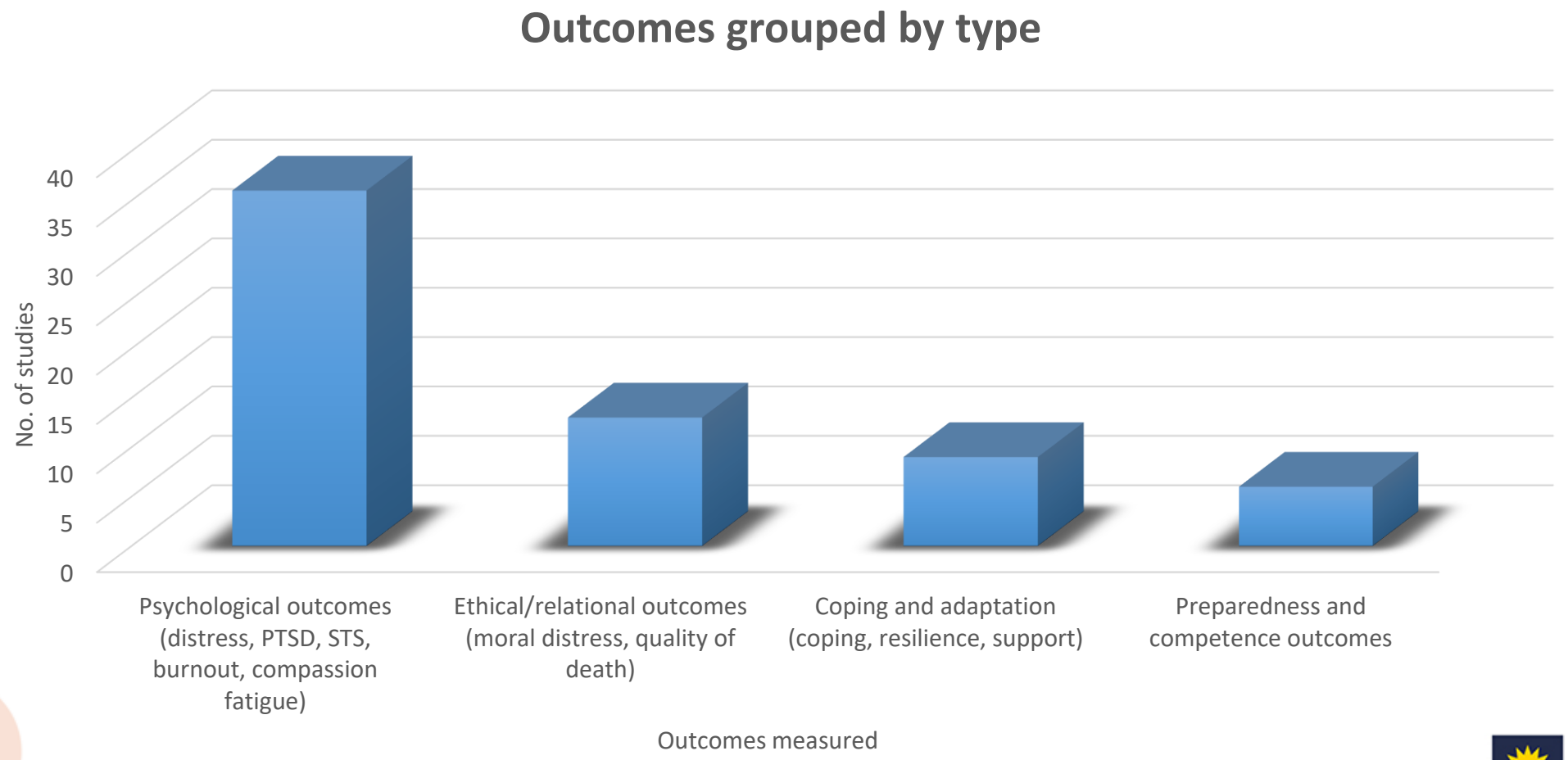
Only 13 intervention studies.

Findings: Quantitative data

A wide range of studied outcomes

- Psychological distress/PTSD/acute stress
- Work-related stress/emotional impact of work
- Burnout
- Moral distress
- Compassion fatigue and compassion satisfaction
- Secondary traumatic stress
- Coping strategies/styles
- End of life preparedness/competence/attitudes
- Quality of death/care evaluation
- Other (e.g., resilience, empowerment)

Findings: Quantitative data



Findings: Qualitative data

Seven clear themes

1. Sustained emotional labour and cumulative distress
2. Oscillation between emotional engagement and protective distancing
3. Moral distress and ethical strain within constrained systems
4. Organisational context shaping distress, care, and support
5. Emotional isolation beyond the workplace
6. Ensuing personal impact and identify transformation
7. Perceived preparedness, skills, and professional competence

Findings: Qualitative data

Sustained emotional labour and cumulative distress

- *Every death takes a little part of me.*

Oscillation: emotional engagement and protective distancing

- *There are days I come to work and am present physically, but I have to check out emotionally.*

Findings: Qualitative data

Moral distress and ethical strain …

- *I felt like I was harming a child… not being able to do what I knew was right.*
- *We all felt horrible keeping this man alive who was just never going to have any quality of life.*

Findings: Qualitative data

Organisational context shaping distress, care, and support

- *There is no time to ask the questions you want to… it becomes a vicious circle with frustration.*
- *The thing that's made the biggest difference… is having a team approach so that you can share the burden.*

Findings: Qualitative data

Emotional isolation beyond the workplace

- *None of the people in my life outside of work have any frame of reference for this.*

Ensuing personal impact and identify transformation

- *I'm sure that it has shaped who I am… and probably not always in such a positive way.*
- *That day … would impact the care that I provide to every other patient.*

Findings: Qualitative data

Perceived preparedness, skills, and professional competence

- *I felt utterly and completely alone… not knowing what to say to a family.*
- *We don’t really get taught exactly… you’re just thrown into that situation.*

Findings: Interventions (n = 13)

Three levels of intervention

1. Organisational and relational
2. Reflective and peer-support approaches
3. Individual (education/training, self care)

Education and training implications

77% of studies made explicit statements on the role of education.

What appears to be assumed about education/training:

- improves knowledge and confidence
- supports communication
- builds coping and resilience.

Education and training implications

The included studies also suggest that education:

- Is not sufficient alone
- Is rarely evaluated directly
- May not translate into practice if misaligned with acute setting realities
- May increase moral distress.

Conclusions

- Exposure to patient death in acute care has cumulative and ongoing impact
- Impact is shaped by context, systems, and support
- Education is necessary but not sufficient
  - Likely to work best when embedded in systems
  - Role remains under-examined.

Education is widely proposed but not yet clearly understood.

References

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Thank you for your interest

End-of-Life Essentials: https://www.endoflifeessentials.com.au/

Research Centre for Palliative Care, Death and Dying (RePaDD): https://www.flinders.edu.au/research-centre-palliative-care-death-dying

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