Nursing Student Experiences Facing Death for The First Time

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Abstract

The purpose of this review of literature using Cinahl-ultimate, Pubmed and was to explore nursing students' initial experiences of facing dying patient, with an emphasis on contrasts between prepared and unprepared students. The study contrasted various educational approaches, including simulation training, mentorship programs, and emotional support models. Prepared students were more confident, competent, had positive emotional outcomes, and effective coping mechanisms. In contrast, the unprepared students experienced heightened anxiety, emotional distress, and helplessness, testifying to significant educational deficits. The findings point to the urgent need for expanded educational support within nursing education, specifically for enhanced use of simulation-based education, formal mentorship, emotional resilience training, and reflective practice. Addressing these educational needs can significantly improve students' preparedness for end-of-life care, ultimately translating into better quality patient care and the nurturing of students' professional and emotional development. Recommendations for future education approaches are presented, with the importance of integrating comprehensive, systematic support mechanisms into nursing education programs highlighted.

Keywords/tags (subjects)

Nursing students, first experience of death, end-of-life care, clinical education, emotional preparedness, death and dying, simulation training, reflective practice, grief and coping, nursing education.

1 Introduction

In the last moments of life, when all the functions of the body move to an end, death is an inevitable fact that nobody can escape (Yılmaz et al,2015). People who have interacted with the dying person may develop their mindset by factoring in their religious, philosophical, and ethical knowledge and cultures (Jafari et al.,2015).

During their practical experiences, nursing students will come into contact with death and suffering; the main types of stress they discover are the death of a patient, the suffering of others, and interacting with someone near death; therefore there is evidence that undergraduate nursing programs need to enhance their teaching on palliative and end-of-life care in order to give nursing students the clinical skills and knowledge they need theoretically and emotionally (Ferrell et al, 2016; Zolot, 2016). In the prosses of taking care of the dying patient, nurses have to act positively in their communication with the patient and their families to increase the quality of life and be able to give psychological and social support to both the patient and their families. (Browall et al,2010)

By the nature health care professionals are more likely to come contact with death and/or care of the dying, thus its utmost importance that the nursing graduates and those involved in the prosses have the needed skills to handle taking care of the patient and their own mental structure (Anderson & Malone, 2015). Many studies have showed that when the nursing students don’t receive the needed amount of education about the end-of-life, they may experience feeling like death anxiety, thus may affect the quality of the care given to the patient (Wang Y., 2019). In case of the student who have received support by more experienced nurses and were able to apply their way of thinking and behaviors, showed more positive attitudes toward the matter (Henoch et al., 2017). The aim of this study is to gather information of nursing student feelings and experiences towards death and taking care of a dying patient for the first time.

2 Background

2.1 What Is Nursing?

Nursing is the total care of individuals, families, and groups through all states of health—from wellness to illness. The International Council of Nurses (ICN) defines nursing as encompassing disease prevention, health promotion, and care of the sick, disabled, and dying. It also involves active engagement in health policy, education, research, advocacy, and creating safe care environments. This broad scope highlights the profession's commitment to meeting social, psychological, and physical needs alongside clinical care (International Council of Nurses, n.d.). The Royal College of Nursing (RCN) further characterizes nursing as an evidence-led profession in which clinical judgment and scientific evidence combine to deliver patient-centred care. The RCN's definition underscores four core pillars of nursing practice—clinical practice, education, research, and leadership—emphasizing that nurses' responsibilities are diverse. In addition to bedside care, nurses contribute to policy development, health promotion, and continual professional development, all of which are pivotal to improving patient outcomes and advancing healthcare (Royal College of Nursing, 2023).

The practice of nursing has evolved over time with changes in healthcare systems and technology. To improve patient safety and quality of care, nurses today play vital roles in interprofessional teams by adopting the latest technologies and evidence-based practices. Beyond being direct caregivers, modern nurses are also researchers, educators, and policy advocates. This evolution reflects continuous learning and adaptation within the profession (American Nurses Association, 2021). Nursing will continue to expand in scope as it addresses emerging global health challenges and innovations. For example, telehealth, electronic health records, and other digital tools are changing nursing practice, while diversification of the workforce and advanced practice roles are reshaping leadership in healthcare delivery. The Institute of Medicine's landmark report *The Future of Nursing: Leading Change, Advancing Health* calls for nurses to be fully engaged in policy and leadership to meet contemporary healthcare demands (Institute of Medicine, 2011). Similarly, the World Health Organization (2020) emphasizes strategic planning and investment in nursing education and leadership worldwide to strengthen health systems. In summary, nursing is a dynamic, multifaceted profession that continuously adapts to meet the needs of society and the healthcare system.

2.2 Physical Effects of Nursing

Nursing work is physically demanding, often involving heavy tasks such as prolonged standing, frequent patient transfers, and maintaining uncomfortable postures. These activities are primary risk factors for work-related musculoskeletal disorders (WRMSDs) among nurses (National Institute for Occupational Safety and Health, 2023; Demir & Yilmaz, 2024). Repeated lifting of patients and equipment can lead to acute injuries and chronic pain, especially in the lower back, neck, and shoulders. Over time, cumulative biomechanical stress may result in degenerative musculoskeletal changes and persistent discomfort. Continuous exposure to such physical strain without adequate rest contributes to fatigue and can diminish a nurse's physical capabilities. Long working hours and excessive workloads often force nurses to assume static or awkward postures for extended periods, worsening muscle fatigue and allowing insufficient recovery between shifts (Jang et al., 2021). These factors increase the likelihood of WRMSDs and, consequently, may lead to absenteeism or even nurses leaving the profession.

The impact of these physical stressors extends beyond the nurses themselves, as physical strain and injury can compromise the quality of patient care. Higher rates of nurse fatigue, pain, or absenteeism are associated with lower work performance and higher staff turnover, which can negatively affect patient outcomes. Thus, healthcare organizations have recognized the importance of implementing ergonomic interventions to protect nurses' physical health. Measures such as proper lifting equipment and techniques, redesigned workflows to minimize repetitive strain, and adequate staffing to allow to rest have been shown to reduce injury rates and improve nurses' long-term occupational wellness. (National Institute for Occupational Safety and Health, 2023; Demir & Yilmaz, 2024)

In addition to musculoskeletal strain, nurses face other physical health hazards, including exposure to infectious pathogens and toxic substances. Frontline nurses regularly risk contact with infectious diseases through needle sticks or bodily fluids, which can result in illness. Furthermore, chronic stress and the emotional demands of caring work can have physiological effects: prolonged stress has been linked to weakened immune responses, headaches, gastrointestinal disturbances, and even cardiovascular issues. These findings underscore that physical and mental health are closely interconnected. It also points to the value of holistic workplace health programs

that address both the physical ergonomics and the emotional well-being of nursing staff. (Schwartz & Silverstein, 2016)

2.3 Mental Health of Nurses

Nurses play a central role in promoting mental health outcomes for patients through early intervention and integrated care. Those with specialized mental health training can employ comprehensive models—such as the bio-psycho-pharmaco-social (BPPS) model—which integrate biological, psychological, and social factors into patient care (Clark & Clarke, 2014). For example, community health nurses often develop ongoing relationships with clients and are well positioned to detect early signs of depression or anxiety, enabling timely referrals and preventive interventions. Studies show that effective nurse-led interventions, such as health promotion activities and trauma-informed care, are associated with improved patient well-being and reduced hospital admissions (Lake et al., 2021). However, when nurses (especially those not specifically trained in mental health) lack standardized training in recognizing and managing psychological issues, their ability to provide comprehensive care is limited. Gaps in education about mental health comorbidities can lead to fragmented care for vulnerable patients and missed opportunities to address underlying psychosocial problems.

Nurses themselves often experience significant psychological stress due to systemic issues like understaffing, high patient acuity, and the emotional labour inherent in caring professions. During the COVID-19 pandemic, for instance, approximately 30% of nurses worldwide reported symptoms of depression and 25% reported anxiety, largely due to prolonged trauma exposure and moral dilemmas in care (Marvaldi et al., 2021). Even outside of pandemic conditions, nurses in high-pressure environments face rising caseloads and sometimes must enforce restrictive or difficult care decisions, contributing to moral distress and burnout (Foster et al., 2021). Chronic underfunding and resource shortages in healthcare systems exacerbate these pressures, putting nurses at risk for compassion fatigue and prompting some to leave the field. Thus, the mental health of nurses is a critical concern, both for the individuals and for the stability of the healthcare workforce.

Inadequate mental health content in nursing curricula and inconsistent continuing education opportunities undermine nurses' preparedness to handle psychological aspects of care. While psychiatric nursing specialists receive focused training, general nursing students often graduate with minimal instruction on managing conditions like dementia, delirium, or trauma in their patients (While et al., 2007). This educational gap can contribute to "diagnostic overshadowing," where nurses attribute a patient's symptoms solely to physical illness and overlook underlying mental health issues, delaying appropriate interventions. Strengthening mandatory mental health education in undergraduate programs and adopting clear competency frameworks for mental health (such as those used in community crisis teams) could help bridge this divide (Lake et al., 2021). Better preparation would empower all nurses—not just mental health specialists—to provide more effective, holistic care that addresses both body and mind.

Certain patient populations, such as older adults with chronic illness or dementia, are particularly at risk when nurses are not equipped with mental health skills. These patients often experience loneliness, cognitive impairment, and complex medication regimens, yet nurses may lack training in geriatric mental health to fully support them (While et al., 2007). The BPPS model advocates for integrated care plans, but without established protocols and training, it can be challenging for nurses to coordinate physical and psychological care. The COVID-19 pandemic further highlighted disparities: social isolation measures and reduced healthcare access hit elderly and mentally ill populations especially hard. This underlines the imperative for trauma-aware and culturally sensitive responses in nursing care (Marvaldi et al., 2021).

Tackling these mental health challenges for nurses requires systemic reforms. Investments in the nursing workforce—through regulated staffing ratios, structured training programs, and supportive work environments—can alleviate stress on nurses. Research indicates that implementing peer support groups, ensuring safe nurse-to-patient ratios, and providing education on trauma-informed care can reduce burnout and improve job satisfaction (Foster et al., 2021). Policy measures such as requiring ongoing professional development and enforcing competency standards can maintain care quality while easing the burden on overextended nurses (Lake et al., 2021). By prioritizing both nurse well-being and patient-centered models, healthcare systems can build resilience and sustain a nursing workforce capable of coping with modern complexities. Interprofessional collaboration is also key: effective mental health care relies on teamwork among nurses, physicians, social workers, and others. Communication and coordination across disciplines, as

emphasized by the BPPS approach, ensure that patients receive integrated care (Clark & Clarke, 2014). For example, community mental health teams often include nurses working alongside psychiatrists to provide home-based treatment and prevent unnecessary hospitalizations (While et al., 2007). Standardized competencies for such teamwork can improve consistency of care and help vulnerable populations receive comprehensive support (Lake et al., 2021).

The lingering effects of crises like the COVID-19 pandemic illustrate the importance of resilience in nursing. Nurses endured increased patient mortality, resource shortages, and constantly changing protocols, all of which heightened anxiety and burnout (Marvaldi et al., 2021). Those without access to peer support or training in coping strategies were especially vulnerable to stress-related exhaustion (Foster et al., 2021). On the other hand, the pandemic accelerated some beneficial changes, such as wider adoption of telehealth, which improved access to mental health services for patients but also introduced new workflow challenges for nurses (Lake et al., 2021). Moving forward, sustained policy attention to nurse mental health and retention is needed to rebuild a strong post-pandemic nursing workforce that can handle increased complexity in healthcare.

2.4 Death

Death is a complex phenomenon with multiple dimensions; it cannot be understood merely as the cessation of biological processes. In a biomedical context, death is defined as the irreversible cessation of vital functions. However, the meaning of death extends far beyond this clinical definition, shaped by religious, spiritual, cultural, and individual interpretations. Because of these layers of meaning, death is not simply a medical event but an experience that carries profound personal and collective significance. (World Health Organization, 2019)

Attitudes toward death vary widely across cultures. Many cultures view death not as an absolute end, but as a transition or transformation marked by rituals and customs. For instance, some Eastern traditions regard death as part of a cycle (e.g., the soul’s journey through reincarnation), whereas most Western societies tend to view death as a final endpoint to life. These differing cultural perspectives influence how societies mourn, remember the deceased, and ascribe meaning to loss (Walter, 1994). Religious beliefs also heavily inform conceptions of death. Major world religions offer varied explanations for what death signifies and what may follow. For example, Christianity and Islam promise resurrection or an afterlife, providing hope of continued existence beyond

death. Hinduism and Buddhism emphasize the cyclical nature of life and death through reincarnation. Judaism often focuses on living a meaningful life in the present while acknowledging death as a transition to closeness with the divine. Such beliefs not only console the bereaved but also establish moral frameworks and communal rituals for dealing with death (Koenig, 2012).

Spirituality, which can be distinct from organized religion, involves individuals' personal quest for meaning and transcendence. Many people develop their own spiritual understanding of death, drawing on a blend of traditions or personal experiences. Spiritual perspectives can help individuals find peace with mortality, fostering acceptance and emotional coping at the end of life. For example, existential philosophies suggest that confronting the reality of death can deepen one's appreciation for life and encourage more authentic living (Yalom, 2008). In healthcare, understanding the diverse ways that death is viewed and experienced enables professionals to respond more compassionately to patients and families. Nurses who recognize the biological facts of death while also appreciating its cultural, religious, and spiritual dimensions are better equipped to provide sensitive end-of-life care and bereavement support. An integrated awareness of mortality allows healthcare providers to support dying patients and their loved ones in a manner that respects their values and beliefs, ultimately contributing to more person-cantered and holistic care at life's end.

2.5 Professional Development of Student Nurses

Ongoing professional development in nursing is a continuous, dynamic, and lifelong process that includes formal learning, skill acquisition, and personal growth. Nurses must remain clinically competent, stay abreast of new developments in healthcare, and deliver safe, effective patient care. Continuous professional development gives nurses the updated knowledge and abilities needed to meet rapidly changing patient demographics, emerging diseases, and advances in medical technology (Institute of Medicine, 2011). Key components of career development include continuing education through additional degrees, specialty certifications, and training courses. Engaging in lifelong learning not only sharpens clinical skills but also facilitates the integration of the latest research evidence into practice – a critical factor in improving patient outcomes and ensuring high-quality, up-to-date care (World Health Organization, 2020).

Mentorship and leadership opportunities are also crucial for professional growth. Effective mentorship pairs novice nurses (or students) with experienced professionals to guide skill development, critical thinking, and professional socialization. Having a mentor can help a nursing student or new graduate build confidence and learn best practices by example. Leadership training prepares nurses to take on roles in decision-making, quality improvement, and healthcare management. Strong leadership skills among nurses have been linked to better job satisfaction, lower turnover, and more efficient healthcare teams (Benner, 1984). Ultimately, professional development is both an individual responsibility of the nurse and an organizational priority. Healthcare institutions that invest in robust professional development programs create a culture of continuous learning. Such environments help nurses manage stress and prevent burnout by fostering personal resilience and growth. In the fast-paced healthcare environment of today, a sustained commitment to professional development is essential for maximizing nursing practice and supporting long-term success in patient care (American Nurses Association, 2015).

Reflective practice is another core element of nursing professional development, especially when combined with mentorship and formal education. Reflective practice involves nurses (and students) critically examining their own experiences, decisions, and reactions in order to learn and improve. By regularly reflecting, nurses can identify areas for improvement, acknowledge successes, and apply lessons learned to future patient care. This process deepens their self-awareness and aids in developing communication skills, emotional intelligence, and stress management techniques – all central to effective and empathetic care (Schön, 1983; Green, 2019). For nursing students and new nurses, engaging in reflective journaling or debriefing sessions after challenging clinical experiences (such as a patient's death) can facilitate coping and learning. Over time, reflection contributes to continuous improvement in clinical decision-making and patient outcomes. When nursing programs integrate reflective exercises, along with ongoing education and mentorship, they create a comprehensive professional development approach. This helps prepare nurses not only in technical competencies but also in the emotional and ethical aspects of care, which is particularly important in situations like end-of-life care that challenge a nurse's personal and professional capacities (Green, 2019).

3 Aim and Purpose

The aim of this study is to describe and explore the nursing student feelings and experiences towards death and taking care of a dying patient for the first time. The purpose of the study is to provide information of the student's experiences about caring for dying patients for the first time to support practice mentors and teachers in education institutions to make this encounter easier to handle and cope with. So, the research question is:
What are the factors affecting the nursing student's experience when facing death for the first time?

4 Method

4.1 Literature review

This thesis employed a literature review methodology. A literature review is a systematic approach for identifying, evaluating, and interpreting existing research on a given topic. It provides context and background for a research question and helps avoid duplication by building on prior findings. According to Marshall (2010), a literature review is "a systematic method for identifying, evaluating and interpreting work produced by researchers, scholars and practitioners." Conducting a thorough review ensures the study is grounded in relevant knowledge and highlights gaps or issues in the existing research. Literature reviews are fundamental to high-quality research in medical and nursing education, as they maximize the relevance and impact of scholarly work (Maggio et al., 2016). In undertaking a literature review, researchers are expected to leverage multiple sources – academic databases, journals, and even consultation with experts or librarians – to gather as much pertinent information as possible (Maggio et al., 2016). It is important for the reviewer to remain organized and focused on synthesizing findings, rather than simply summarizing each source separately (Knopf, 2006).

There are several advantages to conducting a literature review. First, it offers a broad overview of research in an area, which is especially useful if the researcher is unfamiliar with the field. Second, it helps identify inconsistencies, gaps, or controversies in the literature, pointing to areas where further investigation may be needed. Third, a review can reveal successful research methods or theoretical frameworks used by other studies, which can inform the current study's design (Knopf, 2006). In summary, a literature review allows researchers to place their work in the context of the

larger body of evidence, discover new insights, and ensure that their approach meets professional and scientific standards.

For this thesis, a comprehensive search strategy was employed to collect relevant literature on nursing students' first experiences with patient death. The information was gathered from databases such as Cinahl and PubMed searching for articles circling around nursing student facing death/caring for a dying person experiences or perspective, using inclusion criteria (Table 1). Several studies were chosen to undergo further examining, based on the relativity of the title several articles were removed and the proceeding to be examined based on abstract, after this stage remaining articles were gone to a full review of the article and in order to be chosen undergone the clinical appraisal based on Hawker et al. (2002).

Table 1. Inclusion/Exclusion criteria

Inclusion	Exclusion
peer-reviewed	Full text not available
between 2010 and 2023	articles that were not in English language

Inclusion criteria included peer-reviewed studies published in English between 2010 and 2023, focusing on nursing students' or nurses' experiences with death and dying in clinical practice. Studies that did not directly address these themes, were not available in full text (free or with Jamk license), or were not written in English were excluded.

Inclusion criteria were defined using the PICOS framework (Population, Phenomenon of Interest, Context, and Study Type) (Table 2). The population of interest was *nursing students* (undergraduate student nurses). The phenomenon of interest was their *experiences or perspectives* related to the care of dying patients. The context focused on *death, dying, or end-of-life care* scenarios encountered during clinical training. To ensure the review was up-to-date and evidence-based, only studies published in English from 2013 to 2025 (inclusive) were considered, and all had to be peer-reviewed publications. Both qualitative and quantitative studies were included, as well as review articles that synthesized student nurse experiences in end-of-life care. Studies were identified through systematic searches of academic databases such as CINAHL and PubMed using these

keywords “Nursing students or student nurses or undergraduate student nurses,” “death OR dying OR end-of-life care,” and “student Experiences or perspective” in both databases. Reference lists of relevant articles were also screened to capture any additional studies not found in the database search.

Table 2. Pico’s table, inclusion criteria

Inclusion criteria (PICOs)	
Population (participants)	Nursing students or student nurses or undergraduate student nurses
Phenomena of Interest	Experiences or perspective
Contexts	Death or dying or end of life
Types of studies	In English, peer reviewed, published from 2013 to date

4.2 Data Selection

The data selection process followed a structured and systematic screening approach, aiming to ensure the inclusion of relevant, high-quality peer-reviewed research aligned with the research purpose. The CINAHL Ultimate and Pub Med database was utilized due to its strong coverage of nursing and allied health literature. The references for the relevant articles were screened and an initial search yielded a total of 295 articles.

The screening process was conducted in three phases. First, the titles of all 295 articles were reviewed. Based on relevance to the research topic regarding to the title of the article in the search, 63 articles were selected for further evaluation. In the second phase, the abstracts of these 63 articles were assessed based on the relevance to our research question, and 15 were retained for full-text review. Finally, a comprehensive reading of the full texts resulted in 9 articles meeting the predefined inclusion criteria and quality standards based on quality appraisal (appendix 1) using Hawker et al (2002) with the desired score to be between (32-40). These articles were ultimately used for data analysis.

The selection process is illustrated in the table below:

Table 3. screening phase

Screening Phase	Number of Articles from both databases
Initial search results after removing duplicates	295
After title screening	63
After abstract screening	15
Final articles selected	9

This selection process ensured that the final dataset was both thematically relevant and methodologically robust for qualitative content analysis.

4.3 Data Analysis

After gathering the data were analysed using a qualitative content analysis was done based on Critical Appraisal of Selected Studies (Hawker et al., 2002). This study employed qualitative content analysis to examine nursing students' experiences with death and dying, as reported in nine peer-reviewed research articles. The method enabled systematic identification, coding, and categorization of patterns within the textual data. According to Elo and Kyngäs (2008), content analysis is particularly suitable when the aim is to obtain condensed and comprehensive descriptions of a phenomenon, with the end goal of generating categories or themes directly from the data.

The content analysis followed the conventional content analysis framework described by Hsieh and Shannon (2005), wherein categories are derived inductively from raw data without preconceived coding schemes. The nine selected studies were read multiple times to ensure immersion and familiarity. During the open coding phase, significant statements and expressions that reflected the students' emotional, cognitive, and experiential responses to death were highlighted using color-coded labels. This visual method of coding supported the identification of recurring units of meaning across studies (Graneheim & Lundman, 2004).

After coding, similar codes were grouped into subcategories and subsequently merged into higher-order categories or themes. The process was iterative, with ongoing comparisons across data sources to refine categories and validate thematic saturation. This method enabled the formulation of key themes that reflect the core experiences of nursing students during end-of-life care.

Identified Themes and Categories

Through this process, three main themes emerged, each encompassing multiple subcategories:

1. Emotional and Psychological Impact

    Initial shock and fear of death
    Emotional distress and helplessness
    Growth, meaning making, and transformation

2. Learning and Educational Readiness

    Theoretical vs. practical knowledge gaps
    Value of simulation and mentorship
    Desire for more structured end-of-life training

3. Professional Development and Coping Strategies

    Importance of reflection and peer support
    Use of defense mechanisms and distancing
    Emergence of professional identity

Each theme was supported by quotes or findings from multiple articles. For example, Parry (2011) described students feeling "emotionally overwhelmed and underprepared," while Henoch et al. (2017) emphasized the value of preparatory education and guided clinical exposure. These cross-study validations enhanced the credibility of the themes.

Trustworthiness of Analysis

To ensure trustworthiness, the four criteria proposed by Lincoln and Guba (1985)—credibility, dependability, confirmability, and transferability—were applied. Credibility was maintained through prolonged engagement with the literature and repeated coding validation. Dependability was enhanced by keeping a clear audit trail of decisions throughout the analysis. Confirmability was supported by triangulating findings across multiple independent studies. Finally, transferability was ensured by providing thick descriptions and context-rich excerpts that can guide future curricular and pedagogical applications in nursing education.

To extract common themes regarding nursing students' first experiences with death. Initially, titles and abstracts were screened to ensure each study met the inclusion criteria. Full texts of eligible studies were then read carefully, and key information was charted, including the study context, methods, and main findings related to student experiences of patient death. During analysis, particular attention was paid to nursing students' emotional reactions, perceived competence or inadequacy, coping strategies, and recommendations given by the authors for education or support. The analysis process was iterative and thematic. Recurring concepts or patterns across the studies were coded and grouped into broader thematic categories. Through comparing and contrasting findings from multiple sources, two overarching categories emerged: experiences of students who felt *prepared* for patient death versus those who felt *unprepared*. Within these categories, several subthemes were identified that appeared consistently in the literature. For example, studies repeatedly described confidence and competence in end-of-life care among well-prepared students, and conversely anxiety and fear of making mistakes among unprepared students. The coding and theme development were conducted independently by the authors and then discussed jointly to ensure consistency and reliability in interpretation (appendix 1).

In total, the literature review synthesized findings from a diverse set of studies, including qualitative interviews of nursing students, quantitative surveys on attitudes toward death, and integrative reviews of educational interventions. The included studies spanned several countries and cultural contexts ranging from south American, African and middle eastern countries, which provided a rich perspective on the phenomenon, studies in question were qualitative research. Despite differences in context, the thematic analysis revealed strikingly similar emotional and educational challenges faced by student nurses when encountering death for the first time.

Below is an example of the data analysis used:

Familiarization & Initial Reading

Each of the nine Original Articles was read multiple times. Key statements, quotes, and findings relevant to nursing students' emotional reactions, perceived preparedness, coping strategies, and educational experiences with death were **highlighted**.

Color-Coding of Concepts

Selected meaningful phrases were color-coded according to emerging concepts. Here's an example using a few actual excerpts:

Excerpts from Articles	Color Code / Concept Label
"I didn't know what to do when the patient passed, I just froze." (Parry, 2011)	*Fear and Uncertainty - Red*
"The simulation helped me feel less scared and more ready when I met a dying patient in real life." (Gillan et al., 2016)	*Simulation as Preparation - Green*
"After reflecting with my supervisor, I understood I had done my best, and that helped me cope." (Cerit, 2019)	*Reflective Support - Blue*

Theme Development

Final themes were shaped by clustering similar subcategories. For example:

Main Theme: "Student Nurses Experiencing Death Feeling Prepared"

Subtheme 1: *Confidence and Competence*

Subtheme 2: *Positive Emotional Experience*

Subtheme 3: *Effective Coping and Resilience*

Main Theme: "Student Nurses Confronted with Death and Inadequacy"

Subtheme 1: *Fear and Anxiety of Making Mistakes*

Subtheme 2: *Emotional Distress and Feelings of Helplessness*

Subtheme 3: *Need for Enhanced Educational Support*

Each theme was supported by at least 3–5 coded statements from multiple articles, increasing trustworthiness through data triangulation.

Clustering into Subcategories and Themes

These codes were then grouped into broader subcategories. For example:

- Fear and Uncertainty + "felt helpless" + "anxious" → **Emotional Distress**

- Simulation as Preparation + "mentorship helped me" → **Preparedness through Education**

- Reflective Support + "peer debriefing" → **Healthy Coping Strategies**

Example quote used:

“It was a deeply emotional experience, but I felt ready and calm because I had already done this in simulation” (Gillan et al., 2016).
→ This quote was used in the subtheme *Confidence and Competence* under the prepared student group.

5 Result:

The outcomes based on this literature review showed that there existed two dominant themes regarding nursing students' first experiences of patient death: preparedness and unpreparedness. Those students who showed a high level of preparedness—developed through strategies like simulation learning, clinical experience, mentorship, and systematic reflection—achieved positive outcomes. They showed emotional resilience, developed a professional identity, and showed greater confidence in the provision of end-of-life care (Mutto et al. 2010). Those individuals also showed a greater tendency to utilize effective coping strategies, like support from colleagues and taking part in formally structured debriefing, to regulate the emotional aftereffects related to death. This outcome posits that systematic and early experience dealing with death within nursing practice can encourage resilience and act as effective preparation for actual clinical situations (Edo-Gual et al. 2014).

In sharp contrast, nursing students described themselves as poorly prepared reported circumstances typified by intense emotional distress, increased anxiety about making mistakes, and feelings of powerlessness when first interacting with terminally ill patients (Parry, 2011). These participants often perceived a lack of adequate preparation instruction during nursing school and often had to rely on themselves to work through difficult emotional situations (Gillan et al, 2016).

Overriding themes included anxiety, coping, and ongoing uncertainty about their novice practitioner competencies. Nursing education interventions most frequently included increased utilization of simulation training, increased focus on palliative care, and the provision of mentorship in addition to debriefing support. This situational disparity highlights the necessity of implementing a death education course in nursing school curricula to enable the integration of death content, and to prepare nursing students for clinical-level practice, as well as personal and professional expectations. (Mutto et al. 2010, Edo-Gual et al. 2014)

5.1 Student Nurses Experiencing Death Feeling Prepared

Prepared students /feeling prepared	Competence Positive Emotional Experiences Resilience
Feeling unprepared	Fear and Anxiety of Making Mistakes/causing the patient's death Feelings of Helplessness

Table 4. Result themes

Competence

The nursing students became more confident and competent after undergoing formal education interventions, such as simulation sessions and clinical practical education (Gillan et al, 2016). The simulation sessions exposed the students to real and practical information that had a positive impact on their comfort and performance in providing end-of-life care (Edo-Gual et al. 2014). The students confirmed that repeated practice minimized stress, enhanced decision-making when at clinicals, and allowed them to put theoretical principles into practice in the correct manner (Fluharty et al., 2012). Moreover, practice within clinical environments reinforced classroom learning, which focused the students adequately when they were faced with real patient care scenarios, thereby facilitating the transition from theory to practice easily (Cerit, 2019).

Particularly, the simulations removed the students' anxiety by exposing them to simulated but realistic end-of-life environments, role-plays and high-fidelity manikins allowed the students to hone complex clinical abilities without risking real patients (Ek et al., 2014). Feedback and repeated practice provided throughout the simulation immensely increased their preparedness and clinic performance (Gillan et al, 2016). The students appreciated how the simulations facilitated their capacity for dealing with challenging emotional situations, gaining effective communication skills, and practicing compassionate care effectively (Huang et al. 2010).

Clinical mentorship and experienced nurses were also instrumental in instilling confidence among the students. Effective mentorship provided reassurance, constructive feedback, and positive guidance that were significant in feeling competent. Students always described how watching experienced nurses perform best practice was significant to them, providing role models around which to build their professional identity and clinical confidence in handling end-of-life care situations. (Cerit, 2019)

Positive Emotional Experiences

Dying patient care was predominantly portrayed by the students as a privilege and noble experience. The majority of the respondents experienced high personal satisfaction in providing empathetic care, feeling privileged to be with the patients during the special moments of life (Gillan et al, 2016; Ranse et al, 2018). These were not only clinical interventions but intense human interactions, hence rendering them emotionally mature, empathetic, and compassionate towards the end-of-life patients and families (Hall-Lord et al. 2018). Students perceived their affective end-of-life care experiences favorably and reported that meaningful patient and family relationships had been established. The relationships were professionally and effectively rewarding and allowed students to appreciate the humanistic aspects of nursing care substantially (Edo-Gual et al. 2014). Students appreciated being able to comfort and dignify patients and families in their time of need, and this contributed to their overall nursing identity and professional satisfaction (Ek et al., 2014).

Second, legitimation of emotional experience in end-of-life care was reinforced by students' reports to support their professional decision to pursue nursing as a caring practice. Peaceful and dignified dying, made possible by their caring presence, reaffirmed their career commitment and acted as an internal source of motivation towards ongoing professional education. Students were

most likely to describe these experiences as turning points, shifting how they saw nursing care from technical competence to wholistic, person-in-practice practice. (Ranse et al., 2018)

Resilience

Healthy coping skills were considered to be ultimate achievements of focused training in palliative care. Resilience was cultivated via facilitated reflection, formal debriefing, and constant guidance by clinical mentors that allowed the students to cope with emotional reactions in an adaptive manner (Cerit, 2019). These formal interventions provided students with the ultimate skills of successful coping with emotional distress, reducing burnout rates, and promoting long-term emotional well-being in practice (Mutto et al, 2010).

Debriefed workshops following simulated and real-life clinical interactions were optimal in promoting resilience (Huang et al. 2010). Students enjoyed deconstructing their clinical decisions and emotional reactions with students and tutors alike so that they could reverse and decipher them on an emotional level. Organized reflection of this kind served to put things into perspective, kept emotive distress at a minimum, and enhanced subsequent coping with these kinds of problems (Gillan et al., 2014).

Furthermore, resilience was reinforced by the presence of constant emotional and psychological support from clinical mentors and faculty. Having listening mentors who recognized the students' emotional reactions and provided practical wisdom enhanced their emotional resilience considerably. Students became empowered, better positioned to deal with the emotional intricacies of end-of-life care, and more assured in their ability to provide high-quality, compassionate patient care on a day-to-day basis. (Gillan et al 2016)

5.2 Student Nurses Confronted with Death and Inadequacy

Fear and Anxiety of Making Mistakes

Inadequate student nurses were more fearful and anxious of making mistakes, particularly in the aspect of communicating with end-of-life care patient and family (Ranse et al., 2018).

They were largely fearing because they lacked knowledge, particularly a lack of experiential, practical training and limited simulation practice. This fear of getting it wrong also had a strong impact on their confidence, promoting avoidance behavior and reduced engagement in end-of-life care activities (Gillan et al 2016). Other students also had some hesitation regarding the technicalities of end-of-life care, such as medication management, symptom management, and proper recognition of the process of dying. Students were not afraid to admit fear of upsetting patients or creating discomfort inadvertently or through a lack of sufficient practical experience. Students' self-doubt and uncertainty were also evoked through a lack of exposure to planned clinical placements and a lack of mentoring support (Cerit, 2019). Moreover, students also expressed significant concern regarding emotional expectations of end-of-life care because they were afraid that their emotional reaction would undermine their professionalism and clinical decision-making (Hall-Lord et al. 2018).

Students were afraid that their emotional reaction would overwhelm their performance and make them withdraw or back off from engagement in meaningful end-of-life cases overall. This was followed by lack of time for affective preparation and lack of formalized emotional support in their study calendar. (Gillan et al., 2014)

Feelings of Helplessness

Students commonly reported feeling overwhelmed by distress, helpless and overwhelmed by their initial death experiences (Parry, 2011; Gillan et al., 2016). Emotional unreadiness to deal with the overwhelming emotions of patient death were among the primary reasons for such negative outcomes. Students felt unsupported and isolated with minimal emotional or psychological resources, often, to deal with distress (Edo-Gual et al. 2014).

They were adverse experiences tainted with inadequacy, guilt, and sorrow. Students mainly reported situations under which they were conflicted to balance their professional mandate and emotional reaction and hence resulting in internal conflict and emotional suffering. Internal conflict employed in an attempt to address students' uncertainty about their suitability in nursing practice and hence their emotional suffering and powerlessness. (Öz, et al, 2012)

Insufficient systematic emotional support and learning of coping skills in their course made their distress worse. Poor coping skills and reflective practice were cited by students to facilitate long-term emotional distress and susceptibility to burnout. Students thus pointed to the necessity for pedagogical interventions in emotion management and resilience building in an effort to prepare future nurses to manage the emotional aspect of end-of-life care. (Cerit, 2019)

Need for Enhanced Educational Support

The request for increased education support within nursing courses, particularly in end-of-life care, has been repeatedly made by students in multiple studies. Most students indicated educational preparation deficits, highlighting the lack of practice experience and experiences and exposure to more realistic, better-organized simulations of end-of-life scenarios (Gillan et al, 2016). This lack of preparedness always equated to more anxiety and reduced confidence when students faced actual clinical experiences of dying patients, showing that theory class was not enough for overall preparation (Cerit, 2019).

Students highly advocated for additional simulation-based training and extended clinical placements with a specific emphasis on end-of-life care. They noted that, if properly incorporated, simulations allow them to practice essential skills in a controlled and secure setting, reducing significantly their stress and increasing practical proficiency (Gillan et al., 2014). Students also highlighted the importance of reflective debriefing sessions following such simulations, highlighting their role in emotional processing, critical thinking, and enhanced clinical judgment, which ultimately translate into greater professional development and preparedness (Ranse et al, 2018).

Moreover, the availability of mentorship and ongoing psychological support from teachers and clinical supervisors was emphasized as important aspects of quality educational support. Students clearly stated that they required ongoing mentorship to reassure and motivate them in clinical placements, especially in emotionally challenging experiences related to death and dying (Gillan et al, 2016). This mentorship not only enhanced their clinical skills but also contributed immensely to their emotional resilience, so the students became more competent and emotionally well-prepared to provide empathetic and effective end-of-life care (Cerit, 2019).

6 Discussion

The findings of the literature review substantiate the general principle that systematic education interventions, such as simulation training, mentorship, and reflective support, have a transformative impact on nursing students' preparedness to meet death for the first time. This confirms the background theory of the multidimensionality of death—where clinical, emotional, and spiritual dimensions intersect—and hence requires integrated educational preparation (Yalom, 2008; Ek et al., 2014). Specifically, studies show that simulation learning creates a psychologically safe environment where students can bridge the theory-practice gap (Gillan et al., 2016; Fluharty et al., 2012). This supports the explanation given in the background that nursing students often enter clinical practice with limited opportunity to transfer knowledge into practice, especially in emotionally charged scenarios such as end-of-life care.

Simulation was not only associated with the learning of technical skills, but also with enhanced emotional and communicative competence, which are equally important in palliative care (Cerit, 2019). These outcomes are consistent with Ferrell et al.'s (2016) teaching recommendations, who support experiential and scenario-learning as part of modern nursing curricula. Furthermore, the contribution of simulation to the mitigation of death anxiety, as noted by Wang (2019), is evidenced here in this thesis's findings: students who went through simulation felt less anxious and more confident when they actually encountered patient deaths.

Most importantly, positive affective experiences were strongly associated with learning readiness. Prepared students described their first death experience to be emotionally fulfilling, leading to increased compassion, emotional maturity, and a stronger professional identity (Ranse et al., 2018; Ek et al., 2014). These themes reflect Benner's (1984) theory of professional growth that emphasizes development through learning experiences. In this respect, encountering death—when properly facilitated through education—occurs as a turning point of professional growth. This also highlights the point raised in the background that death, when deciphered as a significant experience, can facilitate the development of deeply humanistic values in care (Koenig, 2012; Yalom, 2008).

In contrast, inexperienced students experienced high levels of anxiety, emotional distress, and fear of failure, a finding that is consistent with the work of Öz et al. (2012) and Parry (2011). Their

inadequate coping was not only a result of a lack of technical proficiency but also a lack of emotional preparation, and this suggests a clear shortfall in nursing education. As highlighted in the background earlier, nursing students are often exposed to death without adequate exposure to its psychosocial dimensions. This misalignment between the curriculum and the reality of expectations generates emotional immobility and can even discourage students from pursuing high-stress fields like oncology or critical care (Jafari et al., 2015). In addition, student avoidance behaviors—avoiding conversation with dying patients or emotionally distancing—coincide with the findings of Henoch et al. (2017) and further support the need for education reform.

Students also understandably advocated for greater simulation and clinical experience, together with mentored guidance and reflection time to allow their development (Gillan et al., 2014; Cerit, 2019). Findings are echoed in curriculum models such as the CARES competencies (Ferrell et al., 2016), which propose the addition of emotional resilience and death education as core nursing competencies. The student responses provided in these studies point towards the urgent need to adapt existing pedagogical practices to harmonize with the realities of nursing practice, especially in multicultural environments where beliefs and rituals related to death are extremely divergent (Walter, 1994).

The worth of mentorship was another theme that was repeated. The students identified mentorship not just as a source of clinical guidance but also as a critical source of emotional support in their first encounters with death (Gillan et al., 2016; Parry, 2011). This is consistent with the professional socialization model, where senior nurses shape the values and behaviors of students (Benner, 1984). Mentorship created a secure space for reflection, emotional expression, and role modeling of empathetic care. As seen from the background, mentorship relations are significant in learning technical and empathic skills required in palliative care.

Finally, the results confirm the significance of reflective practice and continuous professional development, as pointed out in this thesis's theoretical background. The concept of the "reflective practitioner" by Schön (1983) is widely supported in the results, where students who were subjected to debriefings or reflective journaling scored higher in resilience and insight. Educational programs that promote reflection cause nurses to have a greater understanding of themselves, to better regulate their emotions, and ultimately to prepare them to provide holistic, person-

centered end-of-life care. Incorporating these practices into the undergraduate curriculum can bridge the emotional divide so many students encounter upon encountering death.

Lastly, the outcomes not only validate existing literature but also expand upon it by specifying twin importance of emotional and clinical readiness to end-of-life care. The results strongly suggest that intentional improvement of simulation training, reflective practice experience, and mentorship programs has the potential to produce a generation of nurses who are clinically competent as well as emotionally robust and ethically sensitive when faced with death in practice.

7 Conclusion

In summary, nursing students' experiences with death for the first time vary significantly based on their educational preparation. Structured educational interventions—specifically simulation training and mentorship—have been shown to positively impact students' confidence, competence, emotional experience, and resilience (Cerit, 2019; Fluharty et al., 2012; Gillan et al., 2016). In this regard, integrating these elements more strongly into nursing curricula is imperative (Ferrell et al., 2016).

Students repeatedly express the necessity for more simulation exposure in order to effectively bridge the theory–practice divide. Simulation in the practice environment offers students a secure, realistic setting in which to build essential competencies and reduce their anxiety, clearly demonstrating the value of experiential learning (Gillan et al., 2014; Fluharty et al., 2012).

Emotional preparation was also incorporated as a significant component of nursing education. Emotionally prepared students, through structured support and intentional guidance, reported significantly better experiences and coping strategies during clinical practice, demonstrating the importance of integrating emotional training alongside technical skills (Cerit, 2019; Ranse et al., 2018).

Conversely, poorly prepared students experienced negative feelings including anxiety, fear, and emotional trauma (Parry, 2011; Öz et al., 2012). Such experiences underscore the urgent need to enhance nursing curricula by incorporating systematic emotional and psychological preparation (Wang, 2019).

Mentorship emerged as a predominant influence on student preparedness. Students consistently emphasized the importance of having emotionally supportive mentors to provide clinical guidance and emotional reassurance, validating the value of formal mentorship programs in nursing education (Gillan et al., 2016; Ranse et al., 2018).

Reflective practice was also identified as vital for continuous professional development. Regular opportunities for reflection enabled students to process their emotions, enhance self-awareness, and critically evaluate their clinical performance—reinforcing the need for structured reflection in nursing education (Schön, 1983; Cerit, 2019).

Addressing the current knowledge deficit through curricular change and targeted interventions can significantly improve students' preparedness for end-of-life care. Increased educational support, including simulation training, mentorship, emotional education, and reflective practice can better equip nursing students to face the emotional and technical demands of clinical practice (Ferrell et al., 2016; Murnane et al., 2023).

Finally, intensive and integrated educational interventions that combine practical training, emotional support, mentorship, and reflective learning are essential. These strategies empower nursing students to become resilient, empathetic professionals capable of delivering compassionate, competent care during one of the most vulnerable moments in a patient's life: the end of life (Ek et al., 2014; Gillan et al., 2016).

7.1 Ethical Consideration

Although this thesis is a review of literature and does not involve primary data collection or direct contact with human participants, it is still necessary to reflect on the ethical principles informing both this review and the research studies upon which it is based. Awareness and critical consideration of such reflections maintain scholarly rigor and demonstrates ethical awareness in dealing with sensitive topics such as death, dying, and student nurses' emotional responses.

One of the most fundamental ethical concerns in primary research on nursing students' experience of death is the rule of informed consent. In primary research, participants must be clearly informed of the research purpose, procedures, potential risks, and their right to withdraw at any

time without threat of penalty (American Psychological Association [APA], 2020). This is particularly necessary when the participants happen to be students, who may feel pressured to respond positively due to hierarchical authority with instructors or clinical preceptors. Voluntariness of participation and freedom to refuse or withdraw need to be explicitly stated (Orb, Eisenhauer, & Wynaden, 2001). The literature that was discussed in this thesis, including qualitative interviewing and survey research, generally demonstrated observance of these practices of consent to ensure autonomy and ethical integrity.

A second prominent ethical issue is protection of data and confidentiality. Since the subject—students' emotional reactions to death and dying—is highly sensitive, researchers will have to provide anonymity through coding practices or pseudonyms and data storage procedures that safeguard information (Beauchamp & Childress, 2019). The reviewed studies, such as Parry (2011) and Ranse et al. (2018), display great concern with participant anonymity, with ethical clearances obtained and attempts to de-identify the answers. This comes in handy not just in the protection of participants' privacy but also in the establishment of an atmosphere where students feel they can give highly personal reflections, thus boosting the quality and genuineness of data (Polit & Beck, 2017).

Also, the psychological impact of research involvement must be adequately managed, particularly where experiences involve death, fear, and distress. Nursing students looking back at their first encounters with death may reopen and relive grief, anxiety, or trauma. It is therefore ethically imperative that research provision ensures availability of psychological help centers, e.g., counseling or debriefing, as necessary (Gelling, 2016). Even though this thesis does not generate new emotional load during data collection, it critically reviews research with vulnerable student populations and points out a requirement of emotional safeguarding protocols in research with these populations.

In terms of this literature review, ethical research conduct also includes faithful representation and sourcing, avoidance of plagiarism, and honesty of synthesis. This thesis has adhered stringently to these standards by incorporating only peer-reviewed, ethically conducted studies and by properly citing all sources that have been used. Adherence to the ethical principles of integrity and responsibility in secondary research protects the original authors' rights and ensures the resulting knowledge to be valid as well as ethically sound (Resnik, 2015).

To put it briefly, although this paper was not on primary research, it has seriously engaged with ethical issues in literature it synthesizes. Ethical research soundness in the case of nursing students' experiences with death largely hinges on informed consent, emotional protection, and secrecy of information. This thesis complies with these concerns and practices scholarly and professional integrity by being a responsible and ethically responsive synthesis of literature.

7.2 Validity and Reliability

Validity and reliability are ensured in a literature review to make the conclusions valid, reliable, and depict the state of knowledge about the topic appropriately. In this thesis, which was conducted on the first-time experience of nursing students on patient death, these guidelines were adhered to strictly while conducting the research.

Validity in this case is the extent to which included studies represent phenomena in question—nursing students' preparedness for and reaction to patient death—and to what degree they representatively answer the guiding question of this research. For more content validity, this thesis employed an in-depth documented and systematic process of searching through three major scholarly databases: CINAHL and PubMed. The use of PICOS-defined inclusion criteria (Population, Phenomenon of Interest, Context, and Study Design) guaranteed inclusion of peer-reviewed, relevant studies of undergraduate nursing students and their experiences with end-of-life care only.

All nine articles utilized in the analysis—referred to as The Original Articles—met strict inclusion criteria for date (2013–2025), language (English), study population (nursing students), and topic (death, dying, end-of-life care). These articles were accessed from a broad range of countries and cultures (e.g., Australia, Ireland, Turkey, Sweden, Norway, Brazil, and China) and provided a cross-cultural topping to enhance the external validity of the review. Interwoven among these geographically disparate settings were commonalities, including simulation preparedness, mentorship, coping, and emotional distress among the unprepared. This provided a measure of universality and robustness to the findings.

Reliability was maintained strictly through the use of clear and reproducible procedures throughout the review process. Search terms, databases, and inclusion/exclusion steps were all recorded in an audit trail. The rationale to include or exclude particular articles was determined by clearly

stated relevance to the research query and was checked and agreed on by both thesis authors. In addition, qualitative content analysis—manual color-coding of similar themes and experiences across the studies—gave systematic and routine data management. Themes such as "Confidence and Competence," "Emotional Distress," and "Need for Educational Support" did not emerge randomly but inductively from multiple happenings within the dataset. Such thematic saturations increase the reliability of the findings as concurrent themes still emerged across diverse articles and cultures.

The Hawker critical appraisal tool was applied to critically appraise the methodological quality and soundness of all studies included during the assessment of the articles. Studies with weak study design, uncertain methods, or poorly documented articles were removed to further ensure only credible sources were selected for the findings. Critical appraisal also helped minimize bias by ensuring conclusions were drawn based on high-quality studies.

Triangulation—use of multiple sources, modes of data, and perspectives—was a second major way of enhancing both validity and reliability (Morse et al., 2002). Combining findings from qualitative interviews, mixed-method studies, and questionnaires, the thesis benefited from multiple lines of evidence, reducing reliance on one specific methodology or perspective. That in other research (e.g., Cerit, 2019; Ranse et al., 2018; Gillan et al., 2016) similar conclusions were being reached makes synthesized themes more credible.

For ensuring confirmability and credibility, the reflexive approach was used in this thesis: coders coded, read data in isolation, worked out and compared differences. This kind of inter-rater reliability avoids the bias of one individual in the identification of themes and improves dependability of the review process (Noble & Smith, 2015).

In addition, peer-reviewed systematic analyses and meta-syntheses (e.g., Wang, 2019) were also cited in an attempt to cross-verify salient themes in this review with salient themes in more broad analyses of the same or similar topics. Cross-verification thus guaranteed that primary findings—i.e., on nursing students' emotional and educational preparedness—coincided with existing scholarship and therefore provided validational support to findings.

Conclusion and Suggestions for Further Study

Lastly, validity and reliability in the present review of literature were achieved by systematic searching of the literature, clear inclusion criteria, source triangulation on data sources, and evident thematic analysis. Care was exercised to maintain replicable and rigorous methodology; results offer a solid synthesis as to what nursing students are able to do when they are first exposed to mortality among patients and what informs that interaction.

Gaps remain to be filled. For example, while simulation and mentorship were identified to be beneficial interventions in a wide variety of settings, more studies are needed to determine the long-term effects of such interventions on nurses' professional identity formation as well as their resiliency. More research may also consider looking at investigating the influence of cultural and spiritual factors on students' responses to death, especially among non-Western cultures. Second, qualitative studies that observe the growth of nursing students through cumulative exposure to death, and development in teaching support as a result, need to be conducted.

Third, an extension of the volume and range of research here will better inform teaching approaches and prepare nurses-to-be better for one of the most emotionally challenging but most vital aspects of their work: the care of the dying.

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appendix 1. Critical Appraisal of Selected Studies (Hawker et al., 2002)

Article (Author, Year)	Aim/Purpose	Study Design	Population/Sample	Strengths	Limitations	Relevance to Thesis	Hawker Score	Quality Rating
Huang et al. (2010)	Explore nursing students' first encounter with patient death during clinical practice (Taiwan).	Descriptive qualitative (phenomenology); one-on-one in-depth interviews with Colaizzi analysis.	*N=*12 nursing students (~20 years old) in an acute care ward experiencing a first patient death.	– Rigorously analysed narratives (data saturation reached at 12 interviews) yielding rich thematic insights (e.g., *dread/terror*, feeling "trapped," post-death adjustment). – Clear focus on pre-, during, and post-death experiences provides a	– Single-site and cultural context (Taiwan) may limit generalizability beyond similar settings. – Small sample (although saturation achieved) and possible recall or social desirability bias when recounting emotionally charged events.	Directly illuminates the emotional and practical challenges of a **first death experience**, showing initial shock, fear, and eventual coping strategies. Findings underscore the need for better preparation and support – core to the thesis on	34/40	High

				holistic view of student coping.		student nurses' first death encounters.		
Mutto et al. (2010)	Assess the state of end-of-life (EOL) education for nursing students and its impact on their attitudes/experiences with dying patients (Argentina).	Cross-sectional **survey** (multicentre, descriptive).	*N=*680 undergraduate nursing students (years 1–5) across 8 nursing schools in Buenos Aires.	– Very large, multicentre sample improves representativeness and statistical power. – Quantified key outcomes: most students had direct contact with dying patients and held positive caring attitudes; 98% **desired more training in EOL care**, highlighting a clear educational gap.	– Self-reported attitudes and experiences (no objective or qualitative measures) and no control group or intervention. – Context-specific: Argentinian curricula at the time lacked formal palliative training, which may differ from other countries (limits transferability of	Demonstrates that **unprepared** students commonly feel anxious and insufficiently trained for patient death. Fifth-year students showed more emotional distancing than first years, indicating coping by detachment. Strongly supports the thesis argument that current education often leaves	36/40	high

					specific numeric results).	students underprepared, and students themselves call for better EOL training.		
Parry (2011)	Investigate student nurses' experiences of their **first death** in clinical practice (UK).	Qualitative (exploratory descriptive; presumably phenomenological interviews).	*N*=?? (Small sample of student nurses – exact number not stated in excerpt, likely ~5–10 – who had their first patient death during training).	– Pioneering focus on the *very first* death experience, addressing a critical formative moment for nurses. – Thematic analysis yielded four clear themes (e.g., the **emotional impact** of the death, **skills required** to cope, the **role of support/mentors**, and personal coping	– Very limited sample from a single institution, which may not capture diverse experiences (limits generalizability).– Retrospective recall of first death experiences could be influenced by time lapse or subsequent experiences, potentially	As one of the earliest studies directly examining this issue, it vividly confirms that a first patient death is **emotionally distressing and challenging** for students (e.g., feelings of inadequacy and anxiety). It emphasizes gaps in skills and support, directly	35/40	high

				mechanisms), providing actionable insights for education and support.	introducing recall bias.	underpinning the thesis rationale that first death encounters require better preparation and guidance.		
Ek et al. (2014)	Describe first-year nursing students' experiences of witnessing death and providing end-of-life care (Sweden).	Qualitative (interviews; phenomenological **thematic analysis** as part of a longitudinal study).	*N=*17 nursing students at end of their 1st year of training (from multiple universities) who encountered patient death.	– Robust sample size for a qualitative study (*n=17*) and use of a well-defined analytic framework (van Manen's hermeneutic approach) ensure credibility and depth.– Identified four nuanced themes: (1) **Anticipation vs. reality of death** ("the thought	– Conducted in a specific cultural context (Swedish nursing education), where attitudes towards death may be influenced by secular norms, possibly affecting applicability elsewhere.– Participants were from the end of first year only; findings might	Offers direct evidence of **novice students' emotional turmoil and growth** when first facing death. Students initially feared death greatly, but actual exposure, while still triggering anxiety and feelings of helplessness, also taught them the	36/40	High

				of death is more frightening than the actual experience”), (2) **Daring to engage** with dying patients, (3) **Feeling insufficient** in the face of death, and (4) **Confronting one’s own emotions**. These themes poignantly highlight common student struggles and learning moments.	differ for students at other stages or those with repeat exposures (though study is part of a longitudinal project, only first-year data are reported here).	value of engaging with dying patients. This aligns closely with the thesis, underscoring the transformative learning that occurs and the need for reflection/support after first death experiences.		
Edo-Gual et al. (2014)	Examine the impact of death and dying on nursing students and develop an	Qualitative (grounded theory approach to build a	*N=*34 nursing students (approx.; not explicitly given here, but likely a	– Provides a **theoretical framework** for understanding nursing students’ reactions to death,	– Specific sample and cultural context (Catalonia/Spain) may shape the model	Highly pertinent: it consolidates how **encountering death affects students’ personal**	34/40	High

	explanatory model of how students experience and cope with patient death (Spain).	conceptual model of students' experiences) – *Journal of Clinical Nursing* paper.	diverse sample of Spanish students across different years – *assuming* from context of an explanatory model study).	integrating multiple factors (emotional, cognitive, educational) into an explanatory model. This offers a higher-level insight beyond individual themes, helping to generalize findings across settings.– Likely rigorous method (grounded theory) with constant comparison, ensuring that the model is well-founded in the data and encompasses common	(e.g., influence of cultural attitudes toward death), so applicability of the model to students in other countries may require adaptation.– The study's breadth (seeking a broad model) might sacrifice some depth of individual experience; also, detailed sample characteristics and potential response biases are not clear from the summary.	**and professional development**. For the thesis, the model from this study can offer a conceptual lens – for instance, illustrating stages or factors (like prior experiences, support systems, personal spirituality, etc.) that determine whether a first death experience is processed in a healthy way or leads to lasting fear. It essentially supports the thesis by highlighting		

				patterns in student experiences.		areas to target in nursing education to improve students' coping with first-time loss.		
Gillan et al. (2016)	Explore Australian nursing students' stories of end-of-life care **simulation** and how this educational experience influences their preparedness for real patient deaths.	Qualitative (narrative inquiry). High-fidelity simulation used as an educational intervention, followed by narrative reflections (with follow-up).	*N=*8 undergraduate nursing students in Australia (self-selected due to interest in palliative care) who participated in a simulated end-of-life scenario; reflections collected immediately and 6–8	– Innovative approach: used **simulation as a proxy for a first death encounter**, allowing students to experience and process death in a controlled environment. This yielded personal narratives showing increased confidence and skill in EOL care without the risk of actual	– Participants were **volunteers with a palliative care interest**, introducing selection bias; these students may be more motivated or less anxious about death than average, potentially skewing results toward positive experiences.– The experience was simulated, which, while	Very relevant: highlights how **proactive educational strategies (simulation)** can better prepare students for real encounters with death. Students in this study reported feeling more competent and less shocked in subsequent real-life deaths because	33/40	high

			months post-simulation.	patient harm.– Longitudinal element: Positive attitudinal changes were **sustained 6–8 months** after the simulation, suggesting lasting educational impact (adds to trustworthiness of outcomes).– Rich qualitative data through narrative methodology, supported by theoretical rigor (use of Clandinin's narrative inquiry framework, as cited), giving voice to	realistic, is not identical to an actual patient death – emotional responses might differ in real clinical settings. Transferability to actual first clinical death encounters is inferred rather than directly observed. – Small sample from one region; findings might not capture the range of student experiences (especially those who avoid such electives).	the simulation served as a formative first encounter. This directly supports the thesis theme that preparation (through training or simulation) can mitigate the negative aspects of a first death experience and improve student outcomes (confidence, emotional coping).		

				students' subjective experiences.				
Cerit (2017)	Determine whether targeted training on death and dying can improve first-year nursing students' attitudes toward death and caring for dying patients (Turkey).	Quantitative **pretest–posttest** intervention (one-group, no control).	*N=*81 first-year nursing students; received a structured educational program on death and end-of-life care. Measured attitudes pre- and 1-month post-training using standardized scales (DAP-R, FATCOD).	– Intervention study providing empirical evidence that education can shift attitudes: students' fear of death decreased and positivity toward caring for dying patients increased significantly after training (e.g., mean Death Attitude Profile scores improved from ~146 to 153, *p*<0.05).– Decent sample size (*n=81*) for a single-cohort	– Lack of a control group makes it difficult to attribute changes solely to the training (no comparison against normal curriculum or external factors).– Short follow-up; we do not know if attitude improvements persisted long-term or translated into improved clinical performance when students eventually faced an actual	Relevant as evidence that **educational preparation can significantly improve students' readiness**. While not directly studying an actual first death encounter, this study shows that students who undergo death education may handle those encounters with less anxiety and better attitudes. It strongly reinforces the	37/40	high

				study and use of validated instruments lends credibility to findings. Clear, measurable outcomes support causal inference that training was effective in fostering more positive attitudes.	death.– Focused on **attitudes** rather than directly observing experiences, so it infers preparedness from attitude change rather than capturing emotional experience of a first death.	thesis advocacy for enhanced death education: training was proven to reduce students' negative perceptions of death and increase their self-assurance in caring for the dying.		
Hall-Lord et al. (2018)	Investigate Norwegian and Swedish nursing students' **concerns about dying** (self and patients) and sense of coherence, comparing	**Mixed methods** (quantitative surveys + qualitative interviews).	*N=*143 nursing students (64 Norway, 79 Sweden) in first and third year who completed the "Concerns About Dying" (CAD) questionnaire and	– Comprehensive approach: combined cross-sectional data (allowing year-level and cross-country comparisons) with qualitative depth. Quant findings revealed	– Although cross-national, both samples are Scandinavian (relatively similar societal attitudes to death and education systems), which may limit extension of	Very high relevance: it directly addresses how **student perspectives on death evolve with education and experience**. Notably, third-year students felt more	35/40	High

	first-year vs. third-year students; additionally, describe students' experiences caring for dying patients during training.		Sense of Coherence scale; plus *n=*11 students interviewed about their experiences with dying patients.	meaningful trends (e.g., by third year, students had **fewer personal death concerns**; first-years without prior healthcare experience had more anxiety about dying patients), while interviews provided context (students described caring for a dying patient as challenging but also as an opportunity for learning and personal growth).– Sample spans two countries, enhancing generalizability	results to very different cultures.– The qualitative sample (11 students) is small relative to the survey sample, and we don't know if they were all third-years or mix; their experiences, while illustrative, might not cover all viewpoints (e.g., those who struggled might not volunteer to be interviewed).– Use of multiple instruments and languages (Norwegian/Swedish)	prepared and less fearful than first years, suggesting that curriculum and clinical exposure over time alleviate some anxieties. However, all students found caring for a dying patient to be *"a challenge to endure, perform and learn"*, reinforcing the thesis point that first (and early) encounters with death are stressful and demand better pedagogical support.		

				within similar cultural contexts and showing consistent patterns across settings (e.g., both Norwegian and Swedish students showed reduced death anxiety by final year).– Clear implication for education: the need for *“teaching methods and individualized support”* to help students cope was explicitly identified.	could introduce measurement variance, though not reported as an issue.	This study supports the thesis by empirically showing that with improved training and support (and passage of time), students can become more comfortable with end-of-life care.		

Ranse et al. (2018)	Explore third-year nursing students' **lived experiences** of caring for a dying patient (in many cases, the students' first direct experience with death in their training).	Qualitative (hermeneutic phenomenology with thematic analysis).	*N=*6 nursing students in their final year (Australia) who had cared for a dying patient; in-depth interviews were conducted and analysed interpretively.	– Deep, reflective insights captured through hermeneutic phenomenology. Despite a small sample, the analysis was rich, yielding three key themes: **"being caring"**, **"unexpectedness in witnessing an expected death,"** and **"experiencing loss."** These themes articulate how students strived to provide compassionate, family-cantered care, yet were taken aback by the physical and	– Very small sample from a single institution – while appropriate for phenomenological depth, it may not capture the full diversity of student experiences (e.g., all participants might have been relatively resilient, or conversely, particularly affected).– Students were in their final year; some might have had prior exposure to patient death (though first significant experience	Offers nuanced evidence aligning with the thesis: even as near-graduates, students found their first experiences of a patient dying to be filled with **surprise, emotional challenge, and introspection**. They encountered unexpected aspects of dying (despite death being anticipated clinically) and felt personal loss, highlighting that no matter the level of training,	32/40	High

				emotional realities of death and subsequently grappled with personal grief and self-reflection. – Strong methodological rigor for qualitative research: clearly defined approach (hermeneutic phenomenology), and findings are grounded in participants' direct narratives (enhancing credibility). The study gives voice to student nurses' internal processing of death – an often-	was the focus). This could mean the "first time" aspect varies per individual, potentially confounding the pure first-encounter perspective slightly (the study doesn't explicitly state all were first-time encounters, just that they *had cared for a dying patient in final year*).– Findings context-specific to Australian clinical training environments (though likely similar in	the first death can deeply affect a student. Importantly, students also identified ways they coped and learned (e.g., valuing relationships, questioning their actions, finding meaning), reinforcing the thesis theme that support and reflection are key to processing first death experiences in a healthy manner.		

				neglected perspec-tive.	other developed countries).			