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Original/Research Paper

Psychological effects, coping strategies, and challenges of patient deaths on nurses at Mulago National Referral Hospital, Kampala, Uganda: A qualitative study

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Abstract

Nurses frequently encounter patient deaths, which can lead to psychological stress, yet little is known about these effects in Ugandan healthcare settings. Without institutional support, nurses may experience grief, emotional fatigue, and burnout, affecting their well-being and performance. The current study explored the psychological effects, coping strategies, and challenges of patient deaths on nurses working at Mulago National Referral Hospital, Uganda. This was a qualitative, exploratory study involving six individual interviews and one focus group with eight nurses (14 participants in total). Data were recorded, transcribed, and thematically analyzed to identify emotional effects, coping strategies, and challenges. Nurses reported immediate distress, anger, sadness, feelings of inadequacy, and eventual emotional desensitization. Coping strategies included peer support, prayer, acceptance, and avoidance. Challenges included a lack of psychological support, high workloads, and emotional exhaustion. Patient deaths significantly impact nurses, who rely on informal coping mechanisms. Healthcare facilities should integrate psychological support systems, resilience training, and policies allowing recovery time.

Keywords: Psychological Effects, Coping Strategies, Challenges, Patient Deaths, Nurses, Nursing.

1 | Introduction

According to the World Health Organization (WHO), the psychological effects of patients' deaths on nurses have been a subject of increasing scholarly interest in recent years, reflecting their significant impact on healthcare providers worldwide [1]. Nurses, as frontline caregivers, often develop close relationships with patients, which can lead to profound psychological reactions when a patient dies [2, 3]. For instance, studies have highlighted that nurses in various healthcare settings experience grief, depression, helplessness, fear, hopelessness, burnout, and anxiety following the death of patients, which can affect their mental health and job performance [4]. The emotional toll is exacerbated by the high patient turnover and the nature of critical care, where death is a frequent occurrence [5]. Unfortunately, scholarly work on this subject is limited, and this study aimed to fill the gap. However, close nurse–patient relationships often intensify grief and psychological strain [6-12]. However, some often rely on informal coping strategies like peer support due to a lack of formal services [13-17].

In Uganda, research on this subject is scarce. To address this gap, the current study explored the psychological effects, coping strategies, and challenges among nurses in critical care units at Mulago National Referral Hospital in Kampala, Uganda.

2 | Methods

2.1 | Study design and setting

The study adopted a phenomenological design, as phenomenology seeks to uncover the essence of human experiences by examining how individuals perceive and interpret their realities [18, 19]. The study was conducted at Mulago National Referral Hospital, Uganda's largest and oldest healthcare institution, staffed by over 1,760 professionals. The study population consisted of nurses working in the following wards at Mulago National Referral Hospital: Pediatric Intensive

Care Unit (PICU), main Intensive Care Unit (ICU), and High-Dependence Unit-Acute Care Unit (HDU-ACU).

2.2 | Ethics consideration

Uganda Martyrs University and the Mildmay Uganda Research Ethics Committee granted ethical approval (2023-M282-22866). Written informed consent was obtained from all participants.

2.3 | Sample size

The sample size for this study was 14 participants (6 for in-depth interviews [IDIs] and 8 for the small-group discussion), based on the saturation point [21]. Purposive sampling was used since the study was targeting only nurses who had experienced the death of patients and had been working for at least six months.

2.4 | Data collection

Data was collected through an IDI guide for the IDIs and a focused group discussion (FGD) guide for the FGDs. Data was collected through IDIs and FGDs. Each participant was interviewed independently and at their convenience. The IDIs were audio-recorded, and each lasted for between 20 and 30 minutes. One focus group discussion was conducted, involving nurses from the PICU, the main ICU, and the HDU of the hospital, each comprising 8 participants, and was audio-recorded.

2.5 | Data analysis

The audio recordings were transcribed verbatim, followed by thematic coding for data analysis. Under the thematic coding method, data were organized into codes and categorized into themes to make it easier for research readers to understand participants' experiences and coping strategies [22]. Software NVIVO version 12 and descript were used to aid the data analysis process.

3 | Results

3.1 | Participants

The sample size comprised 14 participants (6 for IDIs and 8 for the small-group discussion). For the interviewees, there was only one male nurse. In terms of age, two nurses were under 30, two were between 30 and 40, and the rest were over 40. They were mostly diploma holders.

3.2 | Psychological effects

Four themes were identified to represent the psychological effects that nurses experience or the reactions they exhibit when a patient dies:

3.2.1 | Emotional turmoil, anger, and disappointment

Participants shared how the death of the patients triggers all kinds of instant emotional effects, including anger, sadness, and feelings of anxiety or worry. For those with children, the death of a child creates similar visions in their minds regarding their child, which tortures them emotionally. In some cases, it would be challenging to move on to the next patient. Sadly, they are often forced to move on to the next patient before resolving their emotional challenges, since the workforce is limited and nurses are never enough. One disadvantage of this was the increased risk of making mistakes with their next patient. In exact words, one participant put it this way: "…. after a patient dies, especially one you've been attending to, you lose energy and morale. You really need some time to rest and recover. Going straight from handling the body to attending to another patient can lead to mistakes. It's better to have at least one or two hours to process what happened. Only then can you regain focus and continue with your duties effectively…" (IDI Participant 01). Another participant said, "…. "I sometimes fail to sleep after a patient has died. I fail to concentrate at work.… It is disappointing because I am supposed to treat people so that they get healed from their diseases…" (FGD Participant 03).

3.2.2 | Gradual emotional desensitization

Findings showed that some nurses felt nothing and were not emotionally disturbed since death was a common thing that no longer makes news or incites any feelings. One participant put it this way: "…. I don't have any challenges. I'm used to this. When my mother died, I became strong. I've seen many people die—rich people, strong people. So now I don't let grief stay in me for long. I may feel pity for some time, but I move on…" (IDI Participant 02). Another participant said, "…. It becomes normal after watching many people die … you get used to it …I am used to it now…" (FGD Participant 02). Other participants put it this way: "… I'm used to it…" (IDI Participant 06; FGD Participant 01).

3.2.3 | Compassionate relief (Perceiving death as a release from suffering)

Other participants revealed that, in some cases, death looked like a relief to the patient, caretakers, and the nurses themselves, especially for patients with extreme pain and suffering due to chronic diseases like cancer and cardiac malformations, with no recovery in sight. In such cases, nurses always felt some joy, relief, or fulfillment on behalf of their beloved clients. One participant reported it this way: "…sometimes, someone should rest. You look at that patient and say, " Maybe this one is better

off dying because of the way they're suffering. There was a child with cancer who had gone through too much. In such cases, you say, let them go. In the ICU, you prepare your mind. Not everyone will come out…" (IDI Participant 03). Another said, "… despite the pain of losing a patient, you sometimes have joy in the fact that you did your best to save their lives …" (FGD Participant 02).

3.2.4 | Feelings of guilt and professional inadequacy

Some participants reported feeling they were partially responsible for the deaths, which tortured their souls, making them feel guilty, especially where there was a shortage of equipment and resources. As such, following the death of a patient, a nurse might wonder if they did all they could or just messed up and caused the death, as can be observed in one of the quotes below: "…actually, when a patient dies under my care, a lot of thoughts come to my mind. I begin thinking about what the immediate cause of death could have been. Sometimes I question whether my actions or the care I provided may have contributed in any way to the death. And if I start to think that something I did—or didn't do—might have caused it, I feel really bad. I even start to wonder if the patient would still be alive if another nurse had been assigned to them instead of me…" (IDI Participant 04). Another said, "…I sometimes feel guilty … it is like I didn't do enough to save my patient's life…" (FGD Participant 04). Another participant said it this way: "… usually, if somebody has died, it reduces my morale. My morale goes low, even when I know it was not my fault. It could be that the equipment was not there, or the drugs were not there. My morale goes low—very, very low…" (IDI Participant 05).

3.3 | Coping mechanisms that nurses apply to cope with patient deaths

Four themes were identified to represent the coping mechanisms that nurses at Mulago National Referral Hospital use in response to patient deaths.

3.3.1 | Acceptance of death as an inevitable part of life

Many participants described developing a mental and emotional posture of acceptance towards death. This coping mechanism appeared to be shaped by repeated exposure to patient deaths and personal experiences with bereavement. Nurses expressed the view that death is a natural and expected part of the healthcare environment. This form of acceptance helped the nurses to detach from the trauma of loss emotionally and enabled them to continue their duties. It involved both conscious reasoning ("death is natural") and involuntary emotional dulling. One participant reflected on how the loss of their own mother helped build this emotional toughness and made them more able to cope professionally: "…when my mother died, I became strong. So these days, I don't even feel so much. I've seen very many die—rich people, strong people—they have all died, so now I move on…" (IDI Participant 01). Another participant put it: "… you know death is always there. One day, someone must die..." (IDI Participant 03). Another participant put it: "… After that patient dies, you remain strong for the other patients… You accept that it has happened, and decide to keep strong for the sake of other patients..." (FGD Participant 06). Such reflections demonstrate how the normalization of death becomes a psychological shield for these professionals.

3.3.2 | Social and peer support systems

Another powerful coping strategy expressed by participants was the reliance on peer support. Nurses described how speaking with colleagues and engaging in shared emotional expression helped to process grief and maintain morale. This kind of support often came informally, in the form of conversations, shared silence, or encouraging words after a difficult shift, as one participant explained: "…we comfort each other. We talk with others and encourage one another..." (IDI Participant 03). Another described how group resilience made coping easier: "…. all of us see these things, so we talk, and we move on together…" (IDI Participant 05). This informal group support filled the gap left by a lack of formal counseling or psychological services.

3.3.3 | Institutional and educational support mechanisms (limited or informal)

While some participants reported deriving benefit from institutional activities such as family conferences, this support was not structured or intentionally designed for grief counseling. Rather, it was incidental learning that nurses picked up during case discussions and interactions with doctors. These conferences, though not directed at staff emotions, helped nurses mentally prepare for difficult cases by deepening their understanding of patient prognoses. A participant shared this benefit: "… it is during family conferences that I learn a thing or two… they prepare you for anything…" (IDI Participant 05). However, there was a persistent concern about the lack of formal training or guidance on handling grief. Participants made it clear that coping was largely left to personal strength or informal peer support. One nurse stated: "… I have not gone for any training on grief—not here..." (IDI Participant 01). Another added: "... there's no support from the hospital for grief or loss..." (IDI Participant 03). Another participant reported, "... for the years I

have been at this hospital, I have never witnessed any support from the hospital regarding how to go through the trauma that comes with losing patients..." (FGD Participant 04). The ICU environment, where deaths were more frequent, also conditioned some nurses to become emotionally prepared. In that context, psychological readiness was part of the unit's operational culture. As one nurse noted: "… here in ICU, anything can come out. You must be ready…" (IDI Participant 06). Another participant said, "… this environment has taught us to be resilient and withstand the psychological trauma that can come with patient deaths …" (FGD Participant 03).

3.3.4 | Personal coping techniques and self-care

A final theme involved internal, personal efforts to manage the emotional impact of death. Participants described strategies such as "letting go", "not keeping it in", and mentally focusing on other patients as means to avoid emotional collapse. These coping approaches seemed to involve deliberate emotional distancing and redirection of energy toward ongoing responsibilities. For instance, one nurse shared: "… I don't keep it in me for long… I move on…" (IDI Participant 06). Another added: "…. after that patient dies, you remain strong for the other patients…" (IDI Participant 02). Another participant added: "…. It has become normal … we lose patients all the time, and we have learnt to be strong…" (IDI Participant 02). This shift in attention was seen as necessary due to staffing shortages and the need to care for multiple patients, even as they internally grappled with the emotional burden of loss.

3.4 | Challenges nurses face when trying to cope with patient deaths

Five major themes were identified to represent the core challenges that nurses encounter while coping with the psychological burden of patient deaths:

3.4.1 | Inadequate institutional support

Participants highlighted the absence of structured institutional mechanisms to help them process grief and emotional trauma associated with patient death. Several participants reported that they had never received any formal training or counseling on grief management. They described how there were no emotional debriefing sessions or forums where nurses could share their feelings and experiences after losing a patient. The lack of emotional support from management left nurses to deal with grief on their own, leading to internalized stress and unresolved psychological burdens. One participant expressed this lack of institutional effort by saying: "… I have not gone for any training on grief—not here…" (IDI Participant 04). "… trainings are rare… I haven't heard of any training for staff on how to handle grief or losing patients …" (FGD Participant 04). Another one added: "… we've never had any meeting about how we feel after death…" (IDI Participant 03). This situation leaves nurses vulnerable, as they are expected to function professionally without mechanisms in place to address their psychological well-being following emotionally charged events like patient deaths.

3.4.2 | Staff shortages and workload pressure

The interviews revealed that heavy workloads and limited staffing made it practically impossible for nurses to take time to process the emotional toll of death. Participants frequently mentioned that after a patient dies, they are expected to quickly move on to the next patient without time to grieve or even catch their breath. This constant pressure was noted to contribute to emotional suppression and potential mistakes in patient care. One participant clearly illustrated this by stating: "… you move from handling the body to another patient… it can lead to mistakes…" (IDI Participant 01). Another participant said, "… there is no time to heal from grief or trauma of losing a patient because there are many other patients to attend to…" (FGD Participant 03). Another participant added: "… you're forced to continue even when you're not okay because nurses are few…" (IDI Participant 06). These responses suggest that institutional and systemic constraints not only worsen the emotional experience of death for nurses but also increase the risk of burnout and care-related errors due to insufficient recovery time.

3.4.3 | Moral distress and guilt

Another prominent theme was guilt and moral distress. Some nurses questioned whether their actions (or inactions) contributed to the patient's death. This was especially true in cases where a lack of supplies or limitations in clinical intervention could have influenced the death. Participants reflected on how they often internalize patient deaths, wondering if they could have done more. One participant shared this internal struggle: "…I start to think maybe if I had done something differently, they would still be alive…." (IDI Participant 02). Additionally, the chronic shortage of critical resources, such as equipment and medications, often left nurses feeling helpless, further amplifying their sense of guilt and professional inadequacy. As one participant mentioned: "…It could be that the equipment was not there, or the drugs were not there…" (IDI Participant 04). This emotional toll from moral questioning adds another layer of complexity to the challenges nurses face, particularly in under-resourced settings.

3.4.4 | Emotional exhaustion and burnout

Repeated exposure to death without psychological recovery mechanisms or support structures eventually leads to emotional fatigue. Participants described a slow decline in morale and motivation as they continued to experience multiple patient deaths over time. This cumulative grief, when not addressed, contributes to emotional burnout and even desensitization. One participant reported: "… usually, if somebody has died, it reduces my morale. My morale goes low, very, very low…" (IDI Participant 03). Another nurse added: "… it is heartbreaking to lose a patient… that's when I lose the morale of being a nurse …" (FGD Participant 04). Another said, "… when it's too much, you just feel drained. It becomes hard to stay strong…" (IDI Participant 04). This emotional exhaustion not only affects individual nurses' well-being but also undermines the quality of patient care and staff retention.

3.4.5 | Taking it personally: Emotional bonding with patients

A recurring and deeply emotional challenge reported by participants was the strong personal attachment nurses often develop with patients. This bond goes beyond professional duty, especially in cases where a nurse has cared for a patient over a long period, witnessed their pain, or formed close interactions with the family. The death of such a patient is not experienced merely as a clinical event but as a personal loss, making the grieving process more intense and harder to cope with. Participants admitted that when this kind of emotional connection exists, the death becomes painful and haunts them longer. One nurse reflected: "… there are patients you become close to—when they die, you take a long time to forget. Especially the children…" (IDI Participant 02). Another participant said, "… after attending to your patient for some time, you become friends… losing them is too painful…" (IDI Participant 04). Another participant shared: "… sometimes you get attached. You even know their parents, their favorite things… when that child dies, it hits you hard…" (FGD Participant 06). This emotional personalization makes it more difficult for nurses to remain emotionally neutral or compartmentalize their grief. It also complicates recovery because it is not always recognized or addressed through formal coping mechanisms.

4 | Discussion

The psychological impact of patient deaths on nurses is profound and multifaceted, influencing emotional well-being, professional identity, and quality of care. These findings can be understood through Lazarus and Folkman's Transactional Model of Stress and Coping, which posits that stress arises from an individual's appraisal of a situation and their perceived ability to cope [24]. Nurses' responses to patient deaths reflect both primary appraisals (perceiving death as a threat or loss) and secondary appraisals (evaluating coping resources), shaping emotional outcomes and coping strategies.

Nurses reported intense sadness, grief, and diminished morale after patient deaths, particularly when they had developed close bonds with patients. This aligns with Kostka et al., (2021) [4], who found that recurrent exposure to death leads to emotional exhaustion and mental erosion among nurses. Similarly, Öcalan et al., (2024) [23] observed that novice nurses experience heightened distress, often questioning their competence.

Repeated exposure to death often resulted in emotional numbness among nurses in high-mortality units such as ICUs. While some viewed this as an adaptation, others feared it signaled compassion fatigue, a phenomenon described by Khalaf et al., (2018) [25] as emotional depletion due to sustained caregiving. Richardson & Greenle (2020) [26], however, challenge the inevitability of compassion fatigue, noting that resilience and social support can buffer its onset.

Some nurses expressed relief when death ended prolonged suffering, particularly in pediatric cases. This perspective aligns with Lief et al., (2018) [27], who found that the perceived quality of death influences caregiver distress. While Western studies emphasize ethical deliberations in end-of-life care, the Ugandan context reflects a pragmatic acceptance rooted in compassion and survival, consistent with reappraisal processes in the Transactional Model.

The most taxing theme was guilt, with nurses questioning whether they could have done more, especially in resource-limited settings. This mirrors findings by Dall'Ora et al., (2020) [28], who highlight the interplay between personal responsibility and systemic failures in shaping moral distress. Unrealistic expectations from families and chronic shortages amplify this burden, echoing Lief et al., (2018) [27]. By contrast, Zheng et al., (2018) [29] argue that structured debriefing and resilience training can significantly reduce guilt, underscoring the role of institutional support in moderating stress appraisals.

Coping strategies are essential for nurses who frequently encounter patient deaths, as these experiences can evoke profound emotional distress. This study identified four major coping themes among nurses at Mulago National Referral Hospital: acceptance of death, social and peer support, institutional and educational mechanisms (mostly informal), and personal coping/self-care strategies.

A dominant coping mechanism was philosophical and emotional acceptance of death as a natural occurrence. This aligns with Lledó-Morera & Bosch-Alcaraz (2021) [30], who found that rationalization and mental reframing serve as defense mechanisms for nurses facing pediatric deaths. However, while their study cautions that such strategies may inhibit full grief processing, the current findings suggest that acceptance can function as a long-term adaptation strategy, reducing emotional disruption during subsequent patient care. Spiritual framing of death was present but less pronounced than in studies from Nigeria and other African contexts, where Faronbi et al., (2021) [31] reported strong reliance on religious coping.

Peer support emerged as a critical coping resource, with nurses engaging in informal conversations and mutual encouragement to process grief. This finding resonates with Faronbi et al., (2021) [31] and Zhang et al., (2021) [32], who demonstrated that peer debriefing fosters emotional validation and resilience, even in the absence of formal therapy.

The study revealed minimal formal institutional support for grief management. Nurses reported incidental learning during family conferences or patient handovers, but these were not designed to address staff emotional well-being. This gap contrasts sharply with recommendations by Zheng et al., (2018) [29] and Rahnama et al., (2026) [8], who advocate for structured interventions such as simulation training, reflective spaces, and counseling services.

Individual strategies included emotional distancing, compartmentalization, and maintaining professional focus. These approaches reflect emotion-focused coping within Lazarus and Folkman's framework, enabling nurses to regulate emotional responses while fulfilling clinical duties. Similar techniques, such as mindfulness and cognitive reframing, are documented in Zhang et al., (2021) [32] as effective for stress reduction. However, self-care practices such as prayer, meditation, or recreational activities were reported infrequently, in contrast to findings of a study by Peterson et al., (2010) [33], which emphasized their role in sustaining emotional health.

5 │ Conclusions

While nurses at Mulago National Referral Hospital employ various coping mechanisms to deal with the psychological impact of patient deaths, such as teamwork, spiritual acceptance, and self-consolation, their ability to cope effectively is significantly hindered by systemic (or institutional) and emotional (or personal) challenges. These include inadequate institutional support, heavy workloads, moral distress, emotional exhaustion, and deep emotional bonding with patients. Without structured psychological support and workplace interventions, nurses are left to navigate grief alone, which not only affects their mental well-being but also risks the quality of patient care.

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Authors' contributions

Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work: SSB, KP; Drafting the work or revising it critically for important intellectual content: SSB, KP; Final approval of the version to be published: SSB, KP; Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved: SSB, KP.

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Competing interests

We do not have potential conflicts of interest with respect to the research, authorship, and publication of this article.

Availability of data and materials

The datasets used during the current study are available from the corresponding author on request.

Using artificial intelligent chatbots

None.

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