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Original Article

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The Process of Accepting Patient Deaths among Korean Nurses: Grieving over Dying

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Purpose: Nurses' acceptance of patient deaths enables them to practice holistic end-of-life care and pursue positive living. The place where most deaths occur in Korea has changed from home to medical institutions, making it necessary to understand the process through which nurses who practice end-of-life care accept patient deaths. This study aimed to obtain insight into nurses' experiences of accepting patient deaths and to develop a practical theory regarding the context of this process. **Methods:** This qualitative study investigated nurses' process of acceptance of patient deaths based on grounded theory. **Results:** A core category of this process was found to be "grieving over dying", which consisted of the following steps: "being close by", "being attentive", "acknowledging together", and "accompanying." **Conclusion:** This study established that nurses' attentiveness toward dying people is due to their grief over patient deaths, and clarified Korean nurses' process of accepting patient deaths and its related factors.

Key Words: Nurses, Death, Behavior, Grounded theory, Korea

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INTRODUCTION

With advances in medicine and the advent of a more individualized society, the place of death has moved from homes to medical institutions. Deaths at medical institutions accounted for 65.9% of all deaths in Korea in 2009, but this proportion rose to 77.1% in 2019 [1]. As Korean culture moves away from the traditional model of dying in the care of the family and more people spend their last moments at medical institutions, nurses more frequently provide end-of-life care. If nurses do not undergo a proper grieving process as part of end-of-life care, they could become addicted to potentially hazardous substances such as drugs and alcohol, or experience extreme exhaustion that could even lead to suicide attempts [2]. A concept analysis defined nurses' grieving process as "personal feeling for healthy resolution of loss and grief" [3]. Brunelli [3] found that these experiences of loss or sorrow were accepted through denial, anger, disorganization, reorganization, and depression. Kondo [4] defined the mourning process of nurses as experiences of death and caring for the dying, and reported that the core scope of nurses' grieving process should be "handling the pain of participating in death and the dying process." Death acceptance, as the opposite of negative death anxiety, has a neutral or positive connotation [5].

Nurses help dying patients and their families on the frontlines so that they can give positive meaning to death and accept it. Zimmermann [6] argued that health care providers need to accept the death of patients beforehand in order to aid patients and their families to accept the death of the patients. She emphasized that accepting patients' deaths is not the last step for health care professionals, but the first step in providing appropriate palliative care.

The results of a concept analysis of nurses' acceptance of patients' deaths [7] showed that nurses' acceptance could be defined as "the phase which nurses who experienced the death of their patient reach after the grieving process, where they acquire insights about life and death through the reflection of their own lives, and maintain a firm and resolute posture in facing the death of their patients while respecting the dignity of a person in nursing practices." It has also been reported that nurses' acceptance of the death of their patients results in holistic end-of-life care and a pursuit of positive living, and these two phenomena are appropriate outcomes that should be sought in end-of-life nursing practices. Therefore, it needs to be understood which causal, contextual, and intermedial conditions interact for nurses to accept patients' deaths so that they can receive the proper support. We need to identify action and interaction strategies that nurses utilize in accepting patient deaths and reinforce them.

In this study, we aimed to identify the methods that nurses use to face the issues that arise from accepting the death of their patients, and then to develop practical theories to understand and describe the process of acceptance, to ensure healthy acceptance of death and patients' dying process and to provide high-quality end-of-life care. This study is expected to provide basic resources for developing intervention techniques to aid nurses in accepting patient deaths.

METHODS

1. Study design

This qualitative study using the grounded theory approach of Strauss and Corbin [8] was conducted to develop a practical theory that can explain the process of nurses' acceptance of their patients' deaths, through holistic inquiries into nurses' experiences thereof.

2. Selection of study participants

A nurse with extensive experience (spanning 20 years) of end-of-life care in cancer wards and intensive care units was selected as the first participant, who demonstrated "attaining through mouring", "ruminating life and attaining insight of life and death", "dauntless attitude", and "practising dignity of human being", which are the key conceptual characteristics of nurses' acceptance of patients' deaths. Based on an analysis of the data acquired through the first interview session with the first participant, we identified causal, contextual, and intervening conditions during the early stage of the process. Then, in order to confirm the response strategy that occurs in clinical practice, we interviewed another participant who described experiences of accepting patients' deaths while working for 18 years in a psychiatric institution, reflecting a different working environment from that of the first participant. The type analysis showed different results from those obtained by interviewing the first participant; therefore, interviews continued with nursing professionals who practiced in different clinical environments in various regions. Six themes appeared through a meta-synthesis of systematic literature reviews [9] on nurses' experiences of patients' deaths, as follows: "emotional experiences", "facilitating good death", "family support", "inadequacy of end-of-life care issues", and "personal and professional growth." However, these themes did not include characteristics related to a patient's death such as "attaining through mourning" or "ruminating life and attaining insight of life and death" [7]. As such, sampling continued for locations, people, and cases to maximize the density of each category based on the properties and dimensions we identified through analyzing qualitative resources. Nurses with less than 6 months of work experience were not included as participants in the process of determining the timing and direction of theoretical sampling. Concepts were identified through analysis until each category was saturated, meaning that additional observations did not yield new or significant results. We completed our interview sessions after confirming saturation of all categories through interviewing a nurse with more than 40 years of experience at an institution who had observed the deaths of patients and self-evaluated as having accepted patient deaths.

3. Data collection

The data in this study were collected in one-on-one in-depth interview sessions conducted by the researcher during the 6-month period from August 2017 to February 2018. Each interview session was conducted at the time and location of the interviewee's choosing, lasted between 1 and 2 hours, and was digitally recorded. Interview sessions began with an

open question, "Please tell me about your experience of dying patients." The researcher then posed semi-structured questions such as "Were there any changes in your thoughts and behaviors after experiencing the death of a patient?" and elicited perspectives on the process of accepting patient deaths with questions like "How did you personally view your patient's death? Please describe the process." The researcher attentively listened to the stories told by participants during the interview sessions and showed empathy to encourage a more detailed description. The researcher then observed the non-verbal cues of participants, such as complexion, tone, and behaviors, and recorded them during the interview sessions on site. The contents of the interview sessions were transcribed from an electronic recording by the researcher, and then analyzed. Following the one-on-one in-depth interview sessions, two or three additional interviews were conducted through telephone and e-mail. In the process, the researcher verified the contents of the transcription and results of the analysis with the participants and revisited additional inquiries that arose from the analysis process.

4. Data analysis

Qualitative data were analyzed through analytic strategies and coding phases as presented by Strauss and Corbin [8] to explain the process of nurses exploring and fully accepting patients' deaths. An ongoing comparative analysis of the qualitative data was conducted to determine when theoretical saturation had been reached. The qualitative data were analyzed cyclically, through open coding, axial coding, and selective coding. In the in-depth analysis of the collected data, memos, charts, and tables were used to facilitate theoretical conclusions.

In the open coding process, the raw data acquired from the participants were analyzed in varying units, words, lines, sentences, paragraphs, or statements as a whole, and then sub-categories, categories, and specific concepts were created through a theoretical comparative analysis. Based on the questions arising from comparisons between events the next participant was selected and the qualitative analysis continued. Through axial coding, organic connections were identified between structures and processes, in order to understand the essence of fundamental societal processes and to discover the epicenter of the phenomenon and its dynamics. The basis of hypothesis building was established by connecting a category (phenomenon, or basic social process) with conditions, behaviors, interactions, and outcome categories through the axial coding process. The categories were then consolidated at the farthest extent and refined through selective coding, and theoretical saturation was finally achieved when no new characteristics or dimensions emerged. In order to establish core categories, discriminate sampling was used in the selective coding phase to collect additional qualitative data with respect to sites, documents, and people in the past and to saturate the category. Lower-level categories were consolidated into a core category; the fluctuations between categories were then interpreted and the final consolidation scheme was confirmed.

5. Rigor of the study

The quality of the research was ensured by adhering to four standards for rigor in evaluating qualitative research suggested by Sandelowski [10]. First, the participants of this study were selected among nurses who had experienced deaths of patients in different clinical environments to establish the truth value. In the data collection phase, the researcher strived to reach actual truth by conducting theoretical sampling, wherein observations were sampled based on the information obtained from the analysis until the data reached theoretical saturation. While analyzing the recorded transcripts from interview sessions, it was verified whether the concepts, categories, and results aligned with participants' experiences through phone calls and e-mails. When describing the results of the study, expressions were cited from participants describing their experiences to convey the accounts of the nurses vividly to the readers. Secondly, the applicability of the results was ensured by collecting samples through theoretical sampling until the qualitative data achieved theoretical saturation. The results of the study were supported by three non-participating nurses who indicated that they understood the concepts related to acceptance of patient death, that they had accepted the death of their patients, and that the findings of the study aligned with their experiences. Thirdly, the researcher conducted the study on the basis of an understanding of the philosophical background and the proper procedures of the grounded theory approach to ensure consistency in the research. Two qualitative research special-

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ists (professors in the school of nursing) were asked whether the entire process of the study and derivation of the results aligned with the grounded theory method suggested by Strauss and Corbin [8], and they agreed that the study was conducted through appropriate procedures. Fourthly, the researcher acknowledged prior understanding and assumptions on the matters of interest, and recorded them before the beginning of the study to establish neutrality. The researcher strived to achieve a neutral perspective without bias throughout the research process to prevent prior understanding and assumptions from affecting the results of the research, through regular critical reflection on research practices.

6. Ethical considerations

This study began after receiving approval from the Institutional Review Board (HYI-15-126-3). The objectives, processes, and subject of this study were explained to the participants, and they were told that they had the right to refuse to answer any questions that they feel uncomfortable with, and withdraw from participating in the process. Participants were also made aware that reports on the study would be prepared without divulging any personal information, and that all audio recordings and their transcription would be destroyed after reporting the results of the study. Participants were asked to sign a consent form after listening to all explanations, and recording and transcription of interview sessions were done by the researcher. To prevent exposure of recorded data and transcribed data, an identification number was assigned, and the data were stored in a computer locked with a password and a locked drawer. After an in-depth interview session, a gift was offered to each participant in appreciation of their cooperation.

RESULTS

There were 11 participants of this study. Ten were women, one was a man, and they worked in Seoul, Gangwon Province, Gyeonggi Province, and Jeollanam Province in Korea. The participants ranged in age between their 20s and 60s, with an average age of 46 years. Their experience at medical institutions ranged from 4 to 42 years, and was 17 years on average. The participants in this study were selected among those who were in charge of intensive care units, cancer wards, emergency rooms, palliative care wards, geriatric hospitals, or in-home

Table 1. Characteristics of the Participants (N=11).

Participants number	Age (yr)	Clinical career	Clinical career duration (yr)	Marital status	Religion
01	44	Intensive care unit Oncology ward	20	Unmarried	Protestant
02	46	Neuropsychiatric ward	20	Married	Atheist
03	40	Emergency room Palliative care ward	15	Married	Protestant
04	26	Neurology ward Artificial kidney room	4	Unmarried	Protestant
05	34	Emergency room Intensive care unit Artificial kidney room	11	Married	Protestant
06	53	Geriatric hospital	9	Married	Protestant
07	50	General surgery ward Neuropsychiatric ward	23	Married	Protestant
08	54	Home healthcare nurse	25	Married	Protestant
09	49	Intensive care unit Oncology ward	18	Unmarried	Protestant
10	51	Neuropsychiatric ward Geriatric hospital	5	Unmarried	Catholic
11	63	Internal medicine Geriatric hospital	42	Married	Protestant

nursing care, and worked in psychiatry, dialysis rooms, and rehabilitation wards, with the hope that the participants could provide comprehensive accounts of experiences in accepting patients' deaths in various clinical settings. Ten participants were religious. Through open coding, 54 concepts, 22 subcategories, and 9 categories were identified. (Table 1, Figure 1).

1. Causal conditions

1) Facing forgotten death painfully

As expressed through the concept of facing forgotten death painfully, the participants had not previously been aware of death, and then experienced morbid emotions after witnessing the death of a patient that was perceived as a bad death. Participants' initial experience of patients' deaths involved facing death painfully, whereas they had not thought about it before.

They have lived their lives without giving much thought to death, and were not aware of how they would face the deaths of patients while working. Participants started their jobs in environments where they were supposed to cure diseases and improve health. Instead, they had to care for dying patients in such an environment and also experienced patient death. Those experiences brought darker emotions and left a scar.

I had lived without thinking much about death. While working, I had not thought about how I was going to face the death of a patient. I didn't know death that well. We had many emergencies and a lot was going on around me, so I rarely talked to patients, so I almost didn't know about death. (Participant 4)

ICUs are like a noisy market. It's too loud and everyone is yelling, machines are beeping. Patients die in such an environment without much respect. It hurts me when I see patients who pass away while receiving treatment for something at their dying breath. (Participant 1)

2) Dying that became difficult

Dying that became difficult means that nurses were exhausted while handling the increased workload due to the death of patients on their own. Participants who faced dying painfully found themselves dealing with confusing emotions, but they did not have even a moment to be mindful of those emotions. Repeated deaths became a lot of work; it was difficult, but no one understood. They could not share their feelings, and sometimes they had to take blame and were reprimanded. They became frustrated, and then exhausted, as they cared for patient after patient.

I had no feelings then. I think I worked like a machine. There were so many things to do, so I couldn't accommodate everything. I couldn't empathize with dying patients. (Participant 3)

Death is just another job I had to take care of. Because I had so much to do, sometimes I thought that it would be better if no one passed away during my shift. I didn't have time to think like 'I feel bad for the patients' or something like that. (Participant 5)

3) Enduring from a step away

Enduring from a step away means that, as experiencing bad deaths of patients became scars, they coped with unresolved and difficult deaths by maintaining distance. By caring on their own for dying patients, who experienced what they perceived as bad deaths, nurses accumulated bruises, but continued to cope nonetheless. However, they needed to be a step away to keep themselves going.

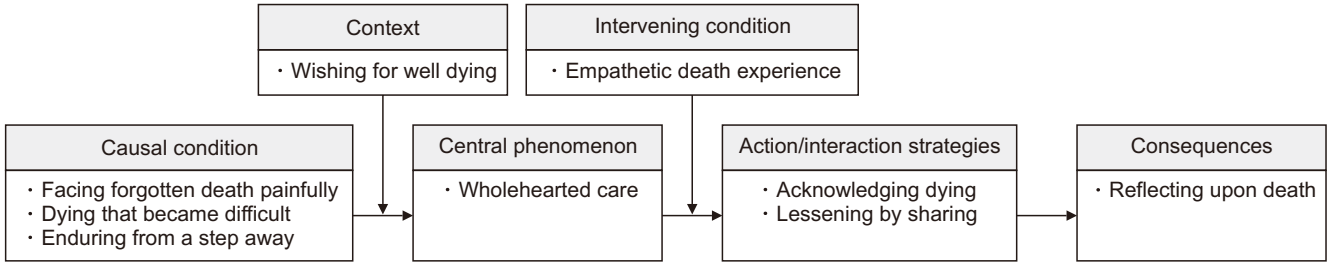

Figure 1. Paradigm model of the process of acceptin patient deaths among Korean nurses.

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It was a psychological challenge to witness death, so all I wanted was to avoid it. I wanted to avoid death. Then, at some point I felt numbness. It might have been a defense mechanism. (Participant 1)

Upon looking at any death, I turn my gaze away; I say to myself that I have nothing to do with this death. After that, however, I feel like I haven't been able to heal the pain at that time. It hasn't healed. I just covered it up. I think I just tried to get by. Just put up with it. (Participant 10).

2. Contextual conditions

1) Wishing for well-dying

Wishing for well-dying refers to nurses' feelings of hope that patients would die well, which they become aware of after experiencing many deaths. Nurses tend to stay with dying patients rather than leaving them, wishing that they would find a good death. Participants saw well-dying as accepting death, dying without loneliness and in comfort, and they came to recognize that they needed a space to send away dying patients better (i.e., acknowledging death in an appropriate place).

Within that situation, we experience a lot of things, and between those a lot of things, they are paved with (experiences) so we say, help the patients based on that and have good remaining moments. (Participant 9)

The places where one faces death (someplace one acknowledges mortality), they have teamwork involving several people and (patients) are accepting that they are facing death, so the subject of death could bring a certain mindfulness regarding people's lives. (Participant 9)

3. Phenomenon

1) Wholehearted care

Wholehearted care means working towards well-dying, focusing on dying patients who acknowledge their mortality. Participants worked to the utmost of their abilities with passion amidst the heavy burden of handling patients' deaths. As time passed, they gathered experience and knowledge. They could sense patients' mortality, and cared for patients whose fate was determined. When predicting the death of a patient, they could assess what they had left in their lives. The participants knew that improving the quality of life remaining for dying patients leads to well-dying. They helped patients and guardians accept the death of patients, so they could face the moment peacefully.

I feel more comfortable when I am able to say goodbye to patients in person and be with them when they pass away. It's hard, but it's good that I can greet them at their last moment like their family. I didn't feel scared. I close their eyes, and say 'I love you' and 'you've done a good job', caress their faces, and tell the family to have a moment with them. (Participant 6)

When I open my heart and stay faithful, I feel more comfortable when patients pass away. That is how I think the nurses should mourn. Knowing they are dying, we open our hearts, share things, lock eyes together, be kind, listen to each other's stories, and share the same feelings. That's how to spend quality time with a patient. (Participant 8)

4. Intervening conditions

1) Empathetic death experience

Empathetic death experiences refer to death experiences where nurses could feel empathy for dying patients as family members or acquaintances, after getting to know patients who initially felt there to be a distance by conversing with them. Nurses talk to patients and spend a considerable amount of time together with them, so patients become friends rather than clients. The participants felt compassion and empathy towards dying patients, and they could understand the feelings of caregivers who were facing the imminent loss of a family member. At some moments, the dying moments of a friend touched their heart. The participants also took part in the process of dying, and death became meaningful for them.

We keep seeing patients while providing in-home nursing care, so we spend time like a family. It feels different, and I get emotionally attached. We get to know the guardians and become friendly. Because we know everyone, we go to their funerals, we go to their morgue, it's a very close relationship. (Participant 8)

Death without building rapport felt distant from me, but in cancer wards, I felt like these deaths were—how should I say?—shared with me. It was a death process that we were all in together, I was in it together with them. It felt comforting. I told them this to ease their minds. When I send away people that are close to me well, it feels like my emotions are also being sorted out. (Participant 1)

5. Action/interaction strategies

1) Acknowledging dying

Nurses acknowledge mortality by accepting the fact of patients dying as "meaningful" and "something that happens." While experiencing many deaths of patients, they found the unresolved meaning of death and they could accept patients' passing as part of the law of nature. After they acknowledged their mortality, they could work towards providing care to facilitate an accepted death, a non-lonely death, and a comfortable death.

The process of (patients dying) is always different, and it is important to accept that. That (look of the dying patient) is just one step of the way, I could just accept that. I realized. Everybody gets sick, and death is fate. Death is inevitable and everyone must go through that. I accept that as it is. (Participant 5)

You have to go away when the time comes, you cannot avoid dying. When facing death, you rely on some higher power. I entrust it. It's not my will, so I accept death as it is naturally. (Participant 11)

2) Lessening by sharing

Lessening by sharing means being having the capacity to care for dying patients, being understood relying on faith, and helping colleagues. When death was accepted, participants were able to obtain the composure they needed to provide care to dying patients. They could share and alleviate their tremendous workload with their colleagues. Participants who cared for dying patients were encouraged and supported. They were not alone.

What we can do is to recognize nurses who are in pain. Telling them 'Was that hard? I thought it would be", and letting them know I understand them. I tell my colleagues that we are together with patients during their most important time, so don't take their death too hard. I'd say they will see a lot of people dying, and I hope that this one will be resolved, and I add, once it does, nursing will seem different. (Participant 1)

I was told that there was nothing anyone could do, and I was the one who worked hardest. Patients' caregivers also thanked me, saying that they should have listened to me sooner. Fortunately, I didn't have to say anything, everyone was so accommodating by just looking at me, someone talks to me, someone encourages me, someone let me take some time off, it was very helpful. (Participant 2)

6. Consequences

1) Reflecting upon death

"Reflecting upon death" includes "embracing in life", "wounds healed", "thankfulness", and "living together." By experiencing the death of a patient, the participants had the opportunity to contemplate life and death, and they could reflect on their life. They could think about what kind of death they should face. Life and death are not separate concepts, but they were thought of as an interconnected process.

I thought about myself watching a patient pass away. It made me reflect on myself and pictured how would I be like, just before I die. Upon watching the death of patients, I thought a lot about "How I should live? And how I should die?" I would like to lead a good life and I'd like someone to be there at my deathbed. (Participant 5)

When I see a lot of deaths, sometimes I ask myself, why I am doing all this with my life when it will eventually fade away. The feeling that I am taking weights off of my shoulder, it feels like I am healing myself. (Participant 3)

7. Core category

1) Grieving over dying

Based on this study, we derived the core category of nurses' practices in accepting patients' deaths as "grieving over dying." Although grieving is a largely personal response to death, nurses' grief for the deaths of patients was presented in the

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form of wholehearted care in the dying process so that the patients could go through well-dying. Nurses who have acknowledged and accepted the deaths of their patients strived to care for dying patients with compassion to improve the quality of life in their remaining time. In this study, care for a patient's well-dying, or grieving for the mortality of the patient, which was a grieving response of the nurses, was only possible when nurses acknowledged and accepted the process of dying. Through grieving for the dying, the nurses who had been exhausted through end-of-life nursing care tended to heal and grow (Figure 2).

DISCUSSION

Patient death is often seen as a limitation of medicine in medical institutions, as maintaining life is the main priority. However, death is also a routine phenomenon in medical institutions [11]. Nurses often experience negative emotions including hypersensitivity, powerlessness, guilt, insecurity, despair, resistance, and anger [9] when they provide care for dying patients. These negative emotions usually stem from the fact that most nurses did not give much consideration to death when starting their jobs, and when they face death, they perceive it as a dreaded event that should have been avoided [12]. The participants in this study learned to recognize that a patient is dying through multiple experiences of caring for dying patients as well as their knowledge base in medicine, as medical professionals. As a natural process towards anticipated loss with a predicted passing, nurses experience anticipatory grief before the departure [13]. The participants of this study hoped that patients would experience well-dying, and showed a grief response of wholehearted care towards patients. Grief is a cultural expression of thoughts and emotions after going through bereavement, and it occurs on a personal level [14]. Previously, it was understood that grief was a response towards the dead. In a professional context where no space, time, or emotion is allowed to grieve about death, which can be construed as the end of medical treatment [15], the participants of this study expressed grief through the practice of wholehearted care.

Among 11 themes about well-dying (a successful dying process) that were identified through a systematic literature review, the most prevalent themes in research on health care professionals, in decreasing order, "preference on the dying process", "state of painlessness", "emotional well-being", and "dignity." The sub-themes of "preference on the dying process" include location, method, and time of death. Some people prefer to die in their sleep, while some people want to prepare for their departure. Themes regarding the family's acceptance of the treating environment and impending death were also identified [16]. Previous research on defining well-dying included all the subcategories of "knowing well-dying" that were derived from this study. The recognition of the concept of well-dying, obtained through repeated experiences of staying at the deathbed of patients and caring for them during their dying process, has become a resource that can allow nurses to help dying patients to achieve well-dying. Therefore, it needs to be verified whether including content about well-dying in the training curriculum for nursing students and new nurses would be effective to help them accept the death of patients.

The participants in this study could empathize with the position, situation, and emotions of dying patients and their fami-

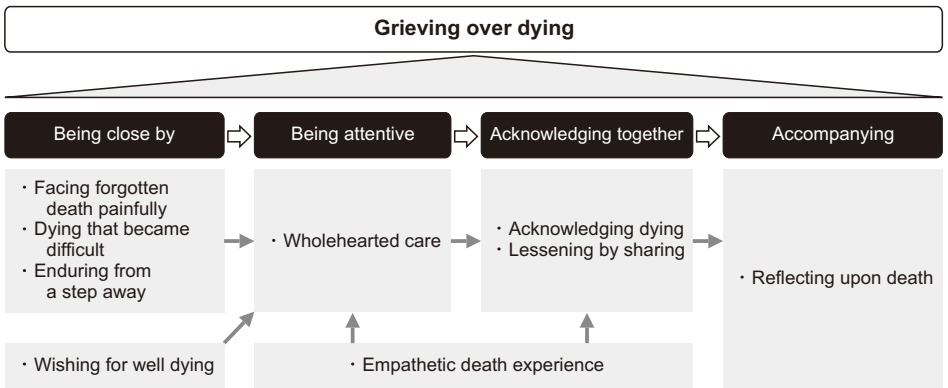

Figure 2. Framework of 'Grieving over Dying'.

lies through experiencing the death of patients with whom the nurses had a chance to form closer relationships. Kondo and Nagata [17] pointed out that the 'empathetic death experience' of an individual nurse could enable them to 'profoundly intervene in the dying process', as a positive aspect of nurse engagement. Normal conversations, even in an intensive care unit environment, were the starting point of relationships that were seen as crucial by both experts and families [18]. Similarly, a previous study argued that the development of closer and more personal relationships among nurses, terminal patients, and their family members through the process of relationship-centered care could impact the overall process [19]. This study also demonstrated that the empathetic dying process through routine conversations positively affected participants' grieving process for dying patients. Therefore, a work environment that allows routine conversations among nurses, patients, and caregivers is integral, as well as appropriate training on the dying process.

Zheng et al. [20] argued in their research on nurses' responses to the death of patients that nurses utilize internal and external resources as response strategies. As internal resources, death beliefs allow nurses to see the death of patients as a part of life that cannot be avoided and accept it as an issue of fate that cannot be controlled, which is similar to the concept of "acknowledging dying" as presented in this study. External resources included the concept of "share and assuage." "acknowledging dying" and "lessening by sharing" were parts of "grieving over dying" and "acknowledging thgether." Medical institutions need to hold discussions on accepting the death of patients, rather than regarding it as a limitation of medicine, so that nurses could provide appropriate care for dying patients and create an environment for a patient to go through well-dying.

In this study, we discovered that nurses tended to experience posttraumatic growth [21] in the process of accepting the death of patients. Posttraumatic growth refers to positive changes through psychological struggles arising from stressful life events [22]. "Growth", the last phase of "grieving over death", refers to the participants' experience of growth through alleviating their pain by accepting the death of patients. The findings of this research match the result that the traumatic experience of nurses not only brings negative effects like "recognizing pain", but also acts as a growth-inducing factor after a traumatic experience with deliberate reflection [23]. According to the results of this study, we believe that training programs to improve the quality of palliative nursing care should be directed towards helping nurses accept the death of patients. Therefore, we expect other research to be conducted in order to educate nurses on the process of accepting their patients' deaths, and to evaluate the effects of those training programs.

In conclusion, we found that nurses did not grieve as a response to the death of patients; instead, they grieved through practices of wholehearted care for patients on their deathbed before they passed away. Nurses who recognized and accepted that patients were dying provided attentive care so that the remaining time of the dying patients would be more comfortable. It was also confirmed that the practice of grief through wholehearted care was an integral factor that allowed nurses exhausted by end-of-life nursing care to heal and grow. Nurses who grieved through the dying process also tended to recuperate and find personal growth. They did not forget that people are bound to die, and then led a healthy life along with mindfulness of death. In order to help patients to go through well-dying, patients, caregivers, organizations, and society also need to acknowledge the process of dying and death and to accept these processes.

CONFLICT OF INTEREST

No potential conflict of interest relevant to this article was reported.

SUPPLEMENTARY MATERIALS

Supplementary materials can be found via https://doi.org/10.14475/jhpc.2021.24.1.56.

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