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Portfolio for Professional Doctorate in Counselling Psychology (DPsych)

Interpretative Phenomenological Analysis (IPA): Exploring Palliative Care Physicians' Grief Experiences in the Hospice Context

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This Portfolio has been submitted in partial fulfilment of the requirements for
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Declaration

I hereby declare that the work presented in this portfolio is entirely my own completed under the supervision of Dr Aylish O’Driscoll and Dr Julianna Challenor.

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Preface

The understanding of people as ‘relational beings’ is a core philosophical, academic, ethical, and therapeutic stance in Counselling Psychology (Milton, 2010). This relational understanding extends also to the relationship that individuals may have with themselves, for example, how they relate to their identity and to their social and cultural contexts (Milton, 2010). I hope that these types of relational perspectives, considerations and values will come through in this portfolio. Overall, this doctoral portfolio aims to reflect some of the competencies and skills, and professional and personal growth, that I have developed and gained during the training process. The doctoral portfolio comprises of three parts: 1) a research study; 2) a combined case study and process report, and 3) a publishable journal article.

The integrative and holistic view of what it is to be human is another perspective influencing Counselling Psychology. This can mean, for example, that human distress is aimed to be understood within people’s entire lives and their relationships (Manafi, 2010). We all have experienced distress at some point in our lives and may have some experiences of losing a loved one, but what is it like to experience grief and be grieving as a palliative care physician when death and dying of patients can be an everyday reality? The phenomenological research study in Section A explores a professional grief phenomenon that is situated in a hospice palliative care context.

My training would not be completed without all the clients with whom I have had the privilege to work with and learn from in diverse psychological service settings as part of the clinical skills training in various placements. Demonstrating professional competence in different models of psychological therapies when working with clients is part of Counselling Psychology training. I present a learning experience of using Narrative Therapy in a combined client case study and process report in the Section B.

Although the three sections in this portfolio are distinct pieces of work, a connecting theme of stigma emerges from the present-day-contexts of my research participants and my client’s experiences. Hence, this portfolio sheds light on how people navigate experiences in different contexts and relational circumstances that can be challenging to their psychological wellbeing. Stigmas are suggested to lock people into stereotyped boxes, potentially inhibiting their right to be their authentic and whole selves (Seele, 2017). Although advancements in treating HIV (human immunodeficiency virus) have transformed HIV being a treatable chronic illness, instead of terminal illness, the enduring prevalence of gendered

HIV-related stigma is suggested to still prevail (Herron et al., 2022). Furthermore, palliative care too appears to have a stigma that is thought to be driven by palliative care's negative association with death and dying (Smith et al. 2012). In addition, the professional culture of medicine may also perpetuate the stigma associated with psychological distress and being emotional, and the not coping may be viewed as some kind of weakness, leading to internalised stigma about vulnerability and emotions (Brower, 2021). These ideas and themes of being able to be a whole self, accepting one's human emotions, reconstructing one's identity, developing resilience, navigating human vulnerability, illness, and mortality, have been present both in the client case study and process report as well as in the research study.

The themes of learning and openness to experience and developing a professional identity have been very much present also in my training journey, echoing the themes in this portfolio. The overall training process of becoming a counselling psychologist has required an open and curious mind, and just frankly taking the leap to grow into the profession. It has been a process where personal and professional growth has been expediential, inestimable and unavoidable, when experiencing both challenges and fulfilment, and navigating also with the not knowing and uncertainty. My own lived experiences relating to the sense of shared humanness and experiencing vulnerability have connected me with the people that I have worked with, both with colleagues and clients.

This training and learning process has been also an opportunity to connect with my values and to gain clarity about what is important for me. The opportunities of being able to craft my learning experiences during the training were sometimes overwhelming but at the same time provided a sense of autonomy and empowerment to learn in how many different ways it is possible to be a counselling psychologist. It feels important to me that my work could extend beyond the clinical sector. It feels also very timely and needed in the current societal context that humanistic values are being promoted and lived across disciplines.

Section A: Doctoral Research Study: "Interpretative Phenomenological Analysis (IPA): exploring palliative care physicians grief experiences in the hospice context".

The research study presented in this portfolio shares an exploration of Palliative Care Physicians' (PCPs) experiences of grief in the hospice context. The healthcare professionals' grief as a topic has been often overlooked or minimised. Facing patient death can be a daily reality for PCPs. However, PCPs grief and grief experiences have not received enough attention in the research field. This Interpretative Phenomenological

Analysis (IPA) research study is one of the few qualitative studies investigating PCPs grief experiences in the hospice context. IPA is a method designed to understand people's lived experiences and how they make sense of these experiences in their contexts (Smith et al., 2022). The findings resulted in five Group Experiential Themes (GETs): 1) The Relational Tension; 2) Making Sense of the complex emotional layers related to grief; 3) Managing grief tied to professionalism; 4) A Process of learning to relate to grief; 5) From disconnection from others to connection with self. The GETs and subthemes encapsulated the nuanced experiences, illuminating ambiguity and tensions in participants' experiences. The findings highlighted, that grief is an elemental part of humanity also in the palliative care context. Grief experienced in the hospice context may require learning to relate to vulnerability, managing the cumulative effects of professional grief, and better preparation in emotional involvement with patients. The hidden professional grief may get unrecognised and calls for better validation.

Section B: A Combined Case Study and Process Report: "Working with an individual living with HIV in the context of unexpected life transitions".

This report presented in the portfolio shares a case study and a process report working with an individual living with HIV+ who is going through a divorce, an unexpected life transition. I used Narrative Therapy (White, 2000) approach to provide psychological support for my client at a Clinical Health Psychology Service. Narrative Therapy is a strength-based therapy that encourages clients to illustrate how their dominant stories may often be influenced by wider societal and cultural contexts (White, 2000). As I am stating in the introduction of the case study and process report, working with this client, and supporting her in the unexpected life transition, offered an opportunity to explore how socially constructed messages of stigma can impact the psychological wellbeing of individuals. Working with this client was also an opportunity for me to immerse myself in learning about Narrative Therapy approach when dealing with physical health problems and how having narrative conversations can facilitate a preferred change in the client's life -- it is an approach that can expand possibilities (Simmons & Mozo-Dutton, 2018). This non-pathologising and a hopeful therapeutic approach, and the respectful way of how narrative conversations are conducted, resonated with my values and appealed to me as a practitioner.

Section C: A Publishable Journal Article: "My grief is tied up with the feeling that as a healthcare professional we should be able to cope with anything": IPA study exploring Palliative Care Physicians' Grief Experiences in the Hospice Context.

The final part of this portfolio consists of a publishable journal article that presents the research study. The OMEGA – Journal of Death and Dying was chosen as a suitable publication due to its international and broad spectrum of scholarly and professional readership. Contributions to the journal come from the fields of psychology, medicine, sociology, anthropology, law, education, history and literature.

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Section A:

Doctoral Research

Interpretative Phenomenological Analysis: Exploring Palliative Care Physicians' Grief Experiences

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Abstract

For palliative care physicians death and dying and facing patient loss can be a daily reality. The patient-physician relationship in palliative care can involve high emotional engagement and predispose both parties to vulnerability. Literature indicates that there is a dearth of research examining the grief that palliative care physicians' may experience in their professional roles over patient deaths. It is the author's understanding that studies that explicitly explore the phenomena of palliative care physicians' grief experiences in the hospice context in the UK have not been conducted. This qualitative study aimed to enrich the understanding of the nuanced experiences of Palliative Care Physicians' (PCP) grief in the hospice context. Semi-structured interviews were carried out and the transcribed interviews were analysed by employing an Interpretative Phenomenological Analysis (IPA) method. The six participants of the research study were palliative care physicians working in hospices in the UK. The analytic findings resulted in five Group Experiential Themes: 1) The relational tension; 2) Making sense of the complex emotional layers related to grief; 3) Managing grief tied to professionalism; 4) A process of learning to relate to grief; and 5) From disconnection from others to connection with self. The key findings were discussed and contextualized by linking them to the wider literature. Grief seems to be an elemental part of humanity for physicians in the hospice context but some of the findings suggested that PCPs may need to be better prepared for emotional involvement with patients. Clinical implications for the field and practice of Counselling Psychology, palliative care and other relevant contexts were discussed. The quality and validity, the strengths and limitations of the research study were also discussed, in addition to opportunities for future research.

1. LITERATURE REVIEW

1.1 Overview

This chapter will outline the rationale for this research study to investigate Palliative Care Physicians' (PCPs) grief experiences in the hospice context. The literature review aims to illustrate and survey what knowledge, ideas, and phenomena exist specifically about and related to professional grief and professional grief experiences, and how professional grief experiences have been studied, with the main aim to understand the current state of research on Palliative Care Physicians' (PCP) grief experiences. The organisational pattern for the review is the following. After the introduction to the topic, I will briefly introduce Palliative Care (PC) and Counselling Psychology (CP). Next, key features of grief and professional grief, and related theories, will be introduced with a focus on postmodern grief theories, followed by a brief discussion of PCPs' position in the physician-patient relationship. Then I will explain the literature search strategy, after which a literature review introducing existing research on physicians' grief studies and some emotional reactions studies in the professional context will be examined and critically appraised. Thereafter, grief and professional grief interventions will be addressed. Lastly, I will highlight the gap in PCPs grief research studies in the PC field. The chapter will conclude by outlining the aims and research question for this research study.

1.2 Introduction

Acknowledging the reality that physicians are subject to the same human limitations and vulnerabilities as all human beings has been increasingly recognised in the field of physicians' wellbeing research (Shanafelt, 2021). It could be even claimed that the wellbeing of physicians has become a primary concern internationally due to high prevalence of burnout rates among physicians (Granek & Buchman, 2019; Shanafelt, 2021; West et al., 2018). Some evidence of recent developments in addressing physician wellbeing indicates that physicians' mental health is more and more addressed with the aim of reducing the stigma in the medical field (Brower, 2021; Coverdale et al., 2021). These themes have been also recognised and illuminated in the popular literature in the recent years (e.g., Elton, 2018; Kadota, 2021; Ofri, 2014). But it seems that little value or validation has been placed on the emotional needs and conflicts of healthcare professionals (HCP) and their impact on relationships with patients and families (Knowlton & Katz, 2006). On surveying the literature, it emerges that studying, for example, compassion fatigue (Breen et al., 2014; Dasan et al., 2015; Figley, 1995; Laor-Maayany et al., 2020), burnout of oncologists (Leung et al., 2015; Lyckholm, 2001; Shanafelt & Dyrbye, 2012; Shanafelt et al., 2014), or emotional responses and/or reactions to patient death (Gray et al., 2018; Redinbaugh et al., 2003; Sanchez-Reilly et al., 2013) have received more research interest than physicians' grief experiences (Gilewski, 2012; Sansone & Sansone, 2012). Researchers have recognised that grief arising from patient death and loss can be considered a common experience for physicians (Davies, 2016; Gilewski, 2012; Sansone & Sansone, 2012; Shayne & Quil, 2012). Nevertheless, medical doctors experiencing grief has been a phenomenon that has suffered from the lack of attention in the wider medical culture, and limited coverage in the academic literature and research (Granek et al., 2016; Moores et al., 2007). Little research has been also undertaken in the UK to investigate how physicians are affected by the death of a patient (Gray et al., 2018; Moores et al., 2007).

Although emotions are increasingly recognised as playing a central role in the professional role and development of physicians and other HCPs (Cherry et al., 2014; Helmich et al., 2012; LeBlanc et al., 2015; McNaughton & LeBlanc, 2012), it is argued that emotions have still not received enough explicit attention in medical curricula (Satterfield, 2007; Shapiro, 2011). It is suggested that disenfranchised grief experiences may start during the physician's training years and may be integrated into beliefs and behaviours of what it is to be a medical professional, for example, conveying that displaying emotions is undesirable (Bolier et al., 2018; Doka, 2022; Zambrano & Barton, 2011). This does not come without challenges. For example, Meier et al. (2001), Romesberg (2004), Shayne & Quil (2012) suggest that the negative consequences of unaddressed and/or disenfranchised grief, and grief-related job stress may contribute to developing burnout and compassion fatigue experiences. Reynolds (2002) explains that death may be perceived and experienced as a professional failure and perhaps even as a source of shame for some physicians. This may then also contribute to a perception by physicians that grieving over patients is experienced as unprofessional (Meier et al., 2001). Hence, the unexamined physician's emotions due to professional taboo over emotional experiences can have negative consequences not only for the doctors themselves but may also negatively impact the quality of care they can provide for the patients (Meier et al., 2001; West et al., 2018). Strikingly, literature reveals many first-person narratives and reflections from physicians themselves (Athanasios, 2020; Bereiter, 2008; Chen, 2007; Davenport, 2023; Fatima, 2022; Fournier & Pribaz, 2020; Frank, 2022; Giddings, 2010; Goulding et al., 2014; Mulder, 2000; Shanafelt et al., 2003) communicating the need to have their experiences recognised and validated, and appearing to want to break the taboo of professional grief and a grieving physician.

For PCPs death and dying and facing patient loss can be a daily reality. The patient-physician relationship in palliative care may involve high emotional engagement and predispose both parties to vulnerability (Yedidia, 2007). The literature indicates that the impact of dealing with death and dying on palliative care professionals has been investigated, for example, with multidisciplinary teams (e.g., Chan et al., 2014; Sinclair, 2011; Slocum-Gori et al., 2011), with PC nurses (Funk et al., 2017; Reid, 2013; Robalo Nunes et al., 2018; Shimoinaba et al., 2009; Shimoinaba et al., 2014); and some studies with PCPs (Dunwoodie & Auret, 2007; Swetz et al., 2009). However, as will become evident in this review, PCPs' lived experiences of professional grief in the hospice context have been overlooked or included only as part of studies of emotional reactions. Grief and grief experiences of PC patients (Davis & Deane, 2017), spousal bereavement (Egerod et al., 2019; Sze Ki Cheung et al., 2018), informal caregivers (family/friends) (Skantharajah et al., 2022) and family/caregivers' grief (Tantrarungroj et al., 2022) have been investigated, however, there is a dearth of research examining PCPs' grief experiences. It is the author's understanding that studies that explicitly explore the phenomena of PCPs' grief experiences in the hospice context in the UK have not been conducted.

1.3 Palliative Care and Counselling Psychology

The terms 'end-of-life care' and 'palliative care' are often used somewhat interchangeably in the professional field (Seymour, 2013). Palliative care (PC) is described by World Health Organisation (WHO) as an approach to care that aims to improve the quality of life of patients and their families who are facing problems associated with life-threatening illness (WHO, 2023). Although PC care needs often tend to increase towards the end of life, PC can be provided throughout the course of the individual's illness (WHO, 2023). However, PC is not only a specialist healthcare intervention, but it is also considered as 'a philosophy of care' that prioritises quality of life by aiming to reduce the patient's pain and suffering (Payne et al., 2009). This is attempted by providing support in medical, psychological, psychosocial, and spiritual aspects as part of PC expert care (Dempsey, 2022).

Globally PC services are organised differently and the structure of the services varies (Arias-Casais et al., 2019; Seymour & Cassel, 2017). For example, in the US PC is commonly provided in people's homes and the term 'hospice care' refers to a home-based care for terminally ill patients (Payne et al., 2009). In the UK the National Council for Palliative Care (NCPC, 2023) describes and recognises two types of PC: 1) general palliative care that is provided by the day-to-day professional carers of the patients; 2) specialist palliative care services that are provided for patients and their families by specialist multidisciplinary PC teams. PC can be delivered in different care contexts, including hospitals, inpatient hospices and care homes, as well as in patients' homes (Payne et al., 2009).

The modern hospice and PC movement was originally conseptualised by the late Cicely Saunders in the 1960's (Clark, 1999; Metzger, 2023). Metzger (2023) describes that Saunders' vision of hospice care offered a new approach how the experiences of death and dying could be managed and terminal care honoured by utilising modern medical knowledge and by providing space for existential experiences of death and dying. Saunders (1987) viewed hospice as a place of 'self-transcendence' and 'self-discovery' where patients may process their existential experiences of dying: ”the modern hospice is a resting place for travellers but above all it is concerned with journey of discovery” (p 61). The phenomenon of 'total pain', i.e., a holistic understanding of patient's pain that includes not only physical suffering but also emotional and mental suffering, was recognised by Saunders as a fundamental aspect of hospice care (Clark, 1999; Metzger, 2023). Since the 1960's specialised palliative care has then evolved in the UK from an inpatient hospice model that was established outside of the National Health Service (NHS) (Seymour et al., 2005). In the UK, specialists in PC work across acute hospital, community and inpatient hospice settings, providing direct care to patients and indirect care through education and training of non-specialists (Sleeman et al., 2021). Hospice care context in this research study refers to this type of a specialised and holistic palliative care context that provides inpatient and outpatient, interprofessional and multidimensional hospice care services in the UK.

The nature of the work in PC is often considered emotional and psychological (McWilliams, 2004). Counselling Psychologists (CoPs) are well positioned to understand such demands, as well as the rewards, in patient care within PC, and to provide psychological support to patients, carers and PC professionals (Dempsey, 2022). CoPs working in PC and end-of-life contribute to PC services in various ways (Dempsey, 2022; Payne & Haines, 2002). CoPs provide bereavement support for individuals and groups, and are involved in, for example, dealing with and preventing occupational stress and burnout, providing psychoeducation about bereavement and loss, and offering supervision to PC staff (Dempsey, 2022; Payne & Haines, 2002). Overall, CoPs across all therapeutic contexts operate from evidence-based practice through individual assessment – formulation – intervention – evaluation of intervention with clients (BPS, 2017). Still, PC often does not include CoPs in multidisciplinary teams due to several barriers, such as gaps in PC training and lack of research in the field (Testoni et al., 2022).

As an emerging psychology speciality, Palliative Psychology is receiving increasing attention and advocacy due to the great benefits it can bring to the PC context (Strada, 2018; Testoni et al., 2022). According to Strada (2018) providing specialist-level and evidence-based psychological assessment and interventions is recognised as critical in often complex clinical, psychosocial, psychological, and existential circumstances in PC. Therefore, the establishment of an integrated role with defined competencies is being proposed and called for (Strada, 2018). Currently, there is no accredited curriculum for training as an applied specialist in PC in the UK (Dempsey, 2022; Jünger et al., 2010).

1.4 Grief

The term grief refers to an affective state stemming from loss that may encompass many emotions, often being characterised as sadness, restlessness and despair (Weiss, 2008), or to the affective process of or response to the death of a loved one (Stroebe et al., 2008). Van Wielink et al. (2020) broaden the term: “Grief is about dealing with a sum of total feelings, thoughts, physical sensations and behavior that can be experienced when one separates from something or someone they had a meaningful relationship with, whether voluntarily or forced” (p. 14). Within the field of psychology, grief is sometimes described as “the anguish experienced after significant loss, usually the death of a beloved person that can include physiological distress, separation anxiety, confusion, yearning, obsessive dwelling on the past, and apprehension about the future” (American Psychological Association [APA] Dictionary of Psychology). Loss can be defined as permanently missing something or someone, saying goodbye, breaking the connection and the bond with someone or something with which a meaningful relationship had been maintained (Van Wielink et al., 2020, p. 14). Breen and O’Connor (2007) state that “while bereavement is considered as a universal phenomenon, the experience of grief is not” (p. 209). They conceptualise grief as a unique experience taking place within a broader historical, social, cultural, and political context (Breen & O’Connor, 2007).

Emotion research has provided evidence for culturally universal bodily sensations of emotional states, such as sadness, anger, love, fear, being associated with topographically distinct sensations across West European and East Asian samples (Nummenmaa et al., 2013). It is still recognised that expressions of grief and grief reactions vary according to culture, i.e., in some societies overt expression of grief is encouraged, while in others it is discouraged (Klass et al., 1996). According to Doka (1989, 2002) not all bereavements result in a strong grief response or reactions, and not all grief is publicly expressed. Klass et al. (1996) point that although grief and bereavement are often used interchangeably in the literature, there does not seem to be consistency between the distinctions. Gross (2018) unpacks the terms and suggests that bereavement refers to the loss through death of someone to whom one was emotionally attached, and grief refers to the way the individual responds to the bereavement (pp. 2–3).

This study acknowledges its bias with a Euro-American cultural lens and context but attempts to hold a pluralistic perspective, recognising also that multi-cultural grief is a topic of debate in terms of whether a universal entity of grief can be defined or proved to exist (Klass, 1999).

1.4.1 Grief Theories

Grief research has emerged from many different frames of reference. Despite different orientations in theories, the common core of grief is considered as being rooted to attachments with people or objects (Parkes, 2009). Since a complete account of theories of grief would provide many varied theoretical explanations of the processes and behaviours of grief and mourning (Noppe, 2000), a brief overview of grief theories to showcase the diversity of theoretical lenses is provided next, with the focus on postmodern grief frameworks.

Theoretical ideas about grief might start with Freud's (1917/1953) writings of 'Mourning and Melancholia'. Freud coined the term 'grief work', suggesting that grief is psychological work that involves achieving detachment from the lost person or object (Gross, 2018). Bowlby's (1961, 1969, 1973, 1980) several publications are the roots for the development of 'Attachment Theory' that has been influential in our understanding of attachments, with a contribution from Ainsworth (1978, 1989) who identified individual variations in attachment patterns for children and adults. Although Bowlby's (1969) attachment theory is not a grief theory, it has attempted to answer the question, "…what is no longer accessible when a closest one(s) to us dies" (Gross, 2018, p. 28). Gross (2018) describes that adult grief can be regarded as a form of "…separation anxiety, where feelings derive from the absence of the attachment figure, in response to the disruption of an attachment bond" (Gross, 2018, p. 14). Furthermore, Klass (2000) argues that due to the advanced understanding of systemic influences in grieving, there is actually a need to broaden the ideas of attachments as individuals often participate in multiple levels of cultural systems and are attached to multiple social roles. Additionally, there are further limitations in attachment theory as it can clarify relationships in Western culture but may lack ability to explain relational patterns in all cultures (Klass, 2000).

In contrast to the 'grief work' hypothesis and later phase and stage-based theories that have implied that there is a certain way to work on one's grief, nowadays it is understood and acknowledged that there is no "correct way to grieve" (van Wielink et al., 2020). Hence, stage and phase accounts of grief have been viewed as problematic, and as potentially implying that individuals should pass through some fixed stages (Gross, 2018). For example, Kübler-Ross' (1969) 'Five Stages of Grief' theory was based on Kübler-Ross' (1969) work observing how terminally ill patients prepared for dying (anticipatory grief), describing how people may cope with the process of dying. Longitudinal studies have, however, failed to provide support for stage-based models of emotional responses to grief (Maciejewski, 2007). Another key understanding in contemporary grief phenomena has been the acknowledgement of 'continuing bonds' with the deceased person or people as being necessary and 'healthy' for some grievers instead of letting go (Klass et al., 1996).

Postmodernists, and the more contemporary grief and bereavement approaches, hold that there are many truths and they critique approaches that seem to focus only on the psychological aspects of grief, and instead emphasise the role of individual and personal variations or styles of grieving (Doka & Martin, 2010; Machin, 2008; McCoyd & Walter, 2016), consider cognitive stress (Lazarus & Folkman, 1984), and reflective meaning making (Neimeyer, 2005; Neimeyer et al., 2009), and how people may continue bonds with the deceased person (Klass et al., 1996), highlighting the social and interdependent nature of human relationships as opposed to an individualistic psychological model (Neimeyer, 2005; Klass et al., 1996). Pearce & Komaromy (2022) point that focusing only on the psychological aspects of grief may neglect the bodily experiences of grief and mourning. They also argue that the complex issue of the embodiment of grief has been, like they state, "under-theorised" (Pearce & Komaromy, 2022, p. 393). Thus, postmodernism implies that no individual's grief must follow a certain path and accepts that desired outcomes can be different for all grievers (Klass et al., 1996; McCoyd et al., 2016).

The Dual Process Model (Stroebe & Schut, 1999, 2010), meaning making (Neimeyer, 2000; Neimeyer et al., 2000), and resilience (Bonanno, 2004, 2009; Bonanno et al., 2005) theories are introduced next as samples of postmodern theoretical lenses on grief and bereavement. Although further research is needed, these theories may have applicability to grief and bereavement in different contexts as they are suggested to be able to consider a diversity of grief responses arising from cultural and individual differences, different coping strategies, different relationships, multiplicity of losses, and the need for interpersonal interaction. Professional grief characteristics and existing healthcare professional (HCP) grief models will be introduced in the next section.

Stroebe and Schut's (1999, 2010) 'Dual Process Model' (DPM) of grief formulates grievers' coping as wavering or oscillating between confronting the loss (loss orientation) and compartmentalising it so that the mourner can attend to the life changes (restoration orientations). This model can be considered part of postmodern grief theories because it is not descriptive and can be tailored to individual grievers, acknowledging the complexity of grieving (McCoyd et al., 2016). The DPM differs from the traditional models by describing mourning as cyclical instead of a linear and stage-like process (Neimeyer, 2014). Hence, there will be times when the individual is not grieving, and is perhaps avoiding it, and other times they may be then confronted with the loss. Stroebe and Schut (2016) also later discovered a major shortcoming in their DPM theory in how the concept of grief overload was neglected – not only in their own theory but also largely in the field of bereavement in general. Grief overload, that is, when the grief burdens are somehow experienced as too overwhelming, was incorporated into their model of coping (Stroebe & Schut, 2016). Hence, the possibility that stressors may accumulate was included and recognised (Stroebe & Schut, 2016).

The meaning making model or meaning reconstruction approach after the loss and integrating the loss into a personal narrative of one's life has been developed by Neimeyer (2000) and Neimeyer et al. (2000). It is considered that meaning making process in response to loss can be particularly useful in, for example, circumstances of trauma or a sudden loss (Neimeyer, 2000). The ideas of sense-making or creating a sense of understanding regarding a loss, benefit finding, potential identity change, i.e., the positive or negative reconstruction of self, are essential aspects of this dynamic process (Neimeyer, 2000). It is thought that the stories of grieving people may take multiple forms and new understandings of narratives can enable people to integrate new meanings to their stories (Neimeyer, 2000). Furthermore, Neimeyer (2014) reflects on the development of grief and bereavement theories in the last decades, and it appears that in addition to the intrapsychic components of grieving, more focus has been placed on interpersonal aspects of and relational and societal responses to loss, shaping also our understanding of different responses and reactions to losses.

Lastly, empirical research has highlighted the role of resilience and adaptive suppression of emotions in the grieving process (Strada, 2018). Historically the absence of overt grieving has been considered being indicative of psychopathology (e.g., Bowlby, 1980; Lindemann, 1944; Rando, 1993). This assumption has been challenged, for example, by Bonanno (2004) and Bonanno et al., (2005) who argue that some people do not show overt signs of distress because of an adaptive capacity following a loss. Thus, traditional models have seemingly underestimated people's resilience in the face of loss (Neimeyer, 2014).

1.5 Professional Grief

For the purposes of this study, the term 'professional grief' is used to refer to the grief that physicians may experience when dealing with patient loss, death and dying in the work context. Various other terms, such as ‘staff grief’, also appears in some literature (Shimoinaba et al., 2009), ‘carer grief’ (Doka, 2014), ‘grief in surrogate caregivers’ (Doka, 2002), ‘provider grief’ (Yazdan et al., 2023), and sometimes it is referred to as experiencing grief on ‘a personal level’ in response to caring for a patient as a HCP (Gilewski, 2012).

Professional grief is described as being experienced in certain occupations where death is dealt with on a regular or continuous basis (Chen et al., 2018). Characterisations of professional grief as distinct from familial grief have been attempted. Papadatou (2000) describes such characterisations in five domains: 1) the nature of the pre-existing relationship between the grieving individual and the deceased, accounting also for the nature of multiple losses one is grieving; 2) the duration of grief reactions; 3) the intensity and persistence of grief reactions; 4) the extent and nature of adjustments required in daily living as a result of the loss; and 5) the meaning that is attributed to the death and the process by which it is integrated into one’s life. Further characterisations have revolved around HCPs encountering multiple losses over an extended period – a dimension of professional grief that is not properly understood (Doka, 2002). Furthermore, professional caregivers may grieve for different types of losses after patients’ deaths (Chen et al., 2018). Papadatou (2000) has suggested that the losses that HCPs may be experiencing can be the death of a patient, but also that losses of different categories and meanings may appear. These can be, for example, perceived loss of a close relationship with a patient, perceived loss due to professional’s identification with the family members’ suffering, perceived loss of one’s unmet professional goals and expectations, perceived losses related to one’s personal belief system and assumptions about life, past unresolved losses or anticipated future losses, and facing one’s own mortality (Papadatou, 2000).

Physician grief responses may be modified by a number of personal, environmental and contextual factors (Sansone & Sansone, 2012). Physician grief is sometimes described as ‘intangible’, often remaining hidden and unrecognised (Granek, 2012c), and sometimes even disregarded by professionals themselves (Papadatou, 2000). A wide variation of manifestations of HCPs’ grief may range from no apparent reaction to unanticipated and strong identification with patients and their families (Doka, 1989, 2002). Doka (1989, 2002) has developed the term ‘disenfranchised grief’ to describe and conceptualise grief that is experienced in non-traditional relationships. According to Doka (2002) disenfranchised grief means, for example, that although the person experiences grief, that grief may not be openly acknowledged, socially validated, and those experiences may be neglected and unexpressed. The concept of disenfranchised grief, that integrates psychological, biological and sociological perspectives on grief and loss has, therefore, contributed to the understanding of the complexities of grief in professional contexts (Doka, 2002).

Professional grief may be disguised as part of other phenomena, for example, ‘professional burnout’ (Freudenberger, 1974), ‘occupational stress’ (Vachon, 1987), ‘secondary traumatic stress disorder’ and ‘compassion fatigue’ (Figley, 1995; Stamm, 2010). Rando (1993) has noted that, for example, the experience of anticipatory mourning can manifest clinical characteristics similar to traumatic stress. The concepts may be often blurred. In addition, a further concept, emotional labour coined by Hochschild (1983, 2003), attempts to encapsulate the emotional and affective aspects of work and the emotional regulation when HCPs need to balance between the needs of self, others and the demands of healthcare organisation (Funk et al., 2017).

1.5.1 Professional Grief Theories

Research for this literature review has revealed that empirical research focused on the grief models of HCPs and physicians is scarce (Nathoo & Ellis, 2019; Papadatou, 2000). As Papadatou (2000) states, the understanding of HCPs’ grief experiences is and will be limited by the frameworks of existing traditional theories that refer to the grief occurring when a loved one or close kin dies. Traditional models are not applicable for frequent experiences of death and dying, and multiple losses. A clear understanding of professional grief bereavement and processes is also hampered by the lack of psychometrically sound instruments available to study professional grief. Some descriptive models have emerged.

Nurses’ professional grief seems to have received more attention than physicians’ professional grief experiences (e.g., Gerow, 2010; Madsen et al., 2023; Papadatou et al., 2001; Rashotte et al., 1997). Nursing staff’s grief experience models (e.g., Kaplan, 2000; Khalaf et al., 2018; Papadatou, 2000; Saunders & Valente, 1994) have received some attention and only a small amount of theoretical studies have been conducted into physicians’ grief experiences (Chen et al., 2018; Redinbaugh et al., 2003). For example, ‘A Bereavement Task model’ directed towards nurses (Saunders & Valente, 1994) has attempted to explain the processes involved in overcoming grief. This model includes the tasks of finding meaning, restoring and maintaining integrity, managing affect, and realigning relationships. Managing grief would require successfully accomplishing these tasks (Saunders & Valente, 1994). However, considering the very specialised roles of physicians and nurses, it is reasonable to expect that grief experiences may differ due to differences in professional socialisation and different focus of care care for physicians and nurses (Holman, 1990; Papadatou et al., 2002; Rohan & Bausch, 2009).

Papadatou (2000) proposed a model for HCPs' grieving based on working and researching mainly oncology nurses' experiences and HCPs' reactions to multiple deaths of patients. This model suggests that the grieving process is both an individual and a social-interactive process: "…an ongoing fluctuation between experiencing grief reactions by focusing on the loss experience and avoiding or repressing grief reactions by moving away from the loss experience" (Papadatou, 2000, p. 64). According to Papadatou (2000) this type of oscillation is considered adaptive and necessary for coping with grief experiences, allowing professionals, for example, to attribute meaning to the death of individual patients (Papadatou, 2000). The ongoing fluctuation mirrors Stroebe and Schut's (1999) DPM model. More research could help to explore the varied forms of fluctuation between experiencing and avoiding grief, and the complex interaction between individual and social factors (Papadatou, 2000). This Papadatou's (2000) model is considered to give an opportunity for HCPs to become aware of the nature of different losses, and may also offer multiple choices of how to interpret and experience, and/or when to express or suppress grief at different points. The model may perhaps lack generalisability due to it being derived partly from observations and partly from Papadatou et al.'s (2001) study with Greek and Chinese nurses.

Another hypothetical HCPs' grief model based on occupational style and coping was presented by Redinbaugh et el. (2001). The model attempts to draw upon empirically supported psychological theories which include personality, occupational preferences, stress, burnout and coping (Redinbaugh et al., 2001). It attempts to explain a) why burnout occurs; 2) why different HCPs are likely to respond differently to the grief of their patient deaths; and 3) common coping strategies that promote the resolution of grief. Redinbaugh et al. (2001) suggested that purposeful examination and application of a physician's occupational style to coping preferences can potentially minimise the degree of burnout and job dissatisfaction experienced by physicians and other HCPs.

Recently, Chen et al. (2018) conducted a meta-ethnographic synthesis of qualitative studies proposing an integrated model of professional caregivers' bereavement processes, based on professional caregivers' own descriptions in the existing literature. Their model integrated findings from 23 qualitative studies, covering different countries, and depicting professional caregivers' bereavement experiences *after* patients' deaths in a process manner. Only one of the studies included PCPs as participants among nurses and social workers in PC units in a hospital in Hong Kong (Chan et al., 2014). This study focused on impact of death work on the 'self' and how palliative care professionals cope with emotional challenges and existential challenges (Chan et al., 2014). Chen et al.'s (2018) findings challenge, for example, Kaplan (2000) and Brosche (2003) ideas of professional bereavement considered as “scaled-down version of familial bereavement” (p. 111). Chen et al. (2018) derived themes consisting of three core concepts: perceived nature of patients’ death, bereavement reactions, and accumulated changes. Patient death is suggested to hold multiple meanings: it can be perceived as a personal loss (loss of a friend), professional loss (sign of failure at work) or trauma (a shocking event) (Chen et al., 2018). Their model attempts to conceptualise how HCPs gradually re-construct their ways of understanding and getting along with their personal and professional selves, personal world and professional world after former assumptions are challenged by patients’ deaths (Chen et al., 2018). These modifications in the meaning structures and accumulated changes may alter how future patients’ deaths are experienced by HCPs (Chen et al., 2018). Limitations included underrepresentation of non-Western studies and heterogeneous sampling in the reviewed studies.

1.5.2 Professional Grief-Related Stress Phenomena

Dealing with ‘emotional labour’ when caring for those who are suffering physically and existentially, and constantly confronting one’s own mortality and vulnerability in a hospice environment is also identified as one of the sources of stress in hospice services (Funk et al., 2017; Goodrich et al., 2015), and may lead to reduced wellbeing (Barnett et al., 2019; Brotheridge & Lee, 2003; Diefendorff, Richard & Croyle, 2006). The daily exposure to seeing patients suffering and the daily emotional work can contribute to compassion fatigue (Mason et al., 2014; Sinclair et al., 2017; Stamm, 2010). Compassion fatigue is conceptualised consisting of two parts: 1) Burnout, experienced as work-related exhaustion, anger, frustration and/or low mood; and 2) Secondary Trauma or Secondary Traumatic Stress (or vicarious traumatisation) that is a negative feeling driven by fear or work-related trauma (Stamm, 2010, p. 8).

Professional grief is considered as forming an ongoing and profound stressor impacting HCPs, as they are required to maintain their sense of wellbeing, avoid feeling overwhelmed, and sustain good quality patient care (Yazdan et al., 2023). While some research reports high burnout symptoms (62%) for PCPs (Kamal et al., 2016), some literature indicates that PCPs describe the lowest levels of burnout and stress together with high levels of satisfaction from work-related sources when compared with other specialities (Dréano-Hartz at al., 2016; Martins Pereira et al., 2016; Ramirez et al., 1995). Literature recognises that unaddressed grief over time and grief-related job stress may contribute to burnout (Lathrop, 2017; Laor-Maayany et al., 2020; Redinbaugh et al., 2001; Shayne & Quil, 2012). There is an increasing interest in recent literature to improve the wellbeing and prevent burnout of PCPs (Fisher et al., 2022; Hill et al., 2016).

1.6 The Palliative Care Physician in the Physician-Patient Relationship

The personal qualities and abilities of the doctor and the dimension of ‘doctor-as-a-person’ are inherent in patient-centred medicine and require consideration (Balint et al., 1993; Mead and Bower, 2000). PCPs can be emotionally impacted in PC work (Granek and Buchman, 2019) and can’t be totally ‘objective’ (Katz, 2006). As Charon (2001) describes the physician’s most potent therapeutic instrument is the self, that involves engagement, compassion and reflection in the physician-patient relationship. Literature recognises that the self-awareness and ability of HCPs and helping professionals to understand the impact of their unconscious reactions in patient care, and of patient care not being compromised by behaviour that originates from unexamined personal issues or losses, are important aspects in the patient care relationship (Longhurst, 1988: Wallin, 2014; Worden, 2009). Objective countertransference (Winnicott, 1949) refers to the normative reactions that the physician may have to the patient’s representation, personality or behaviour (Katz, 2006). The physician’s subjective countertransference (Gorkin, 1987) refers to countertransference that may be evoked because of the clinician’s personal issues, conflicts, history and experiences (Katz, 2006). Shalev et al., (2022) suggest that these key transference concepts from psychotherapy can be used to improve palliative care interventions. Yedidia (2007) states that this can be beneficial in the care relationship, as patients benefit from an authentic engagement of the physician who has the capacity for introspection. By contrast, a physician’s lack of self-awareness can contribute to disconnection from the patient and patient’s family and even from the physician’s self (Knowlton and Katz, 2006).

Moreover, psychological concepts and frameworks such as ‘Attachment Theory’ (Bowlby, 1969) and ‘Attachment Styles’ (Ainsworth, 1978), developmental theoretical paradigms that are increasingly applied and investigated in workplace and healthcare contexts (Adshead, 2010; Cassedy et al., 2015; Harms, 2011; Kafetsios et al., 2016; Zaporowska-Stachowiak et al., 2017), and used in counselling and psychotherapy, may aid in understanding a physician’s predispositions to emotional regulation, relational patterns and vulnerabilities for psychological distress (Adshead, 2010; Shalev et al., 2022). These frameworks can consider how the early developmental experiences of attachments with caregivers may have long-term effects on stress regulation and social relationships in adulthood, especially in care-giving relationships (Adshead, 2010). In the PC context, vulnerabilities in emotional and stress regulation may get activated and may influence how the PCP is able to be present for the dying patients (Shalev et al., 2021; Tan et al., 2005). Patients’ attachment styles can affect their relationship with HCPs adversely as well (Maunder et al., 2006; Shalev et al., 2021; Zaporowska et al., 2017). There is an established body of research in psychotherapy on relationships and attachments, but relatively little attention has been given to understanding individual differences in physicians' attachment behaviour and emotional regulation in caregiving relationships (Kafetsios et al., 2016; Tan et al., 2005). This is a potential area for future research.

1.7 Literature Search

In carrying out the literature review, CityLibrary (the online library resource of City, University of London) was used, and research papers were identified by conducting searches on the following databases: PubMed, APA PscyhINFO, Google Scholar, Sage Journals, Science Direct. In addition, all top nine 'Grief Journals' (Li et al., 2023): *Death Studies*, *OMEGA-Journal of Death and Dying*, *Palliative Medicine*, Journal of Palliative Medicine, *Journal of Pain and Symptom Management*, *Journal of Loss and Trauma*, *American Journal of Hospice and Palliative Medicine*, *BMC Palliative Care*, *Palliative and Supportive Care*, as well as *Qualitative Research Journal* were searched. The search strategy (Appendix A) included the following terms: 'Physician' or 'medical doctor' and 'grief' or 'loss' or 'bereavement' and 'patient death' or 'dying', 'palliative care' or 'end-of-life care'. Further searches were also done with 'emotional reactions'. Full-text published articles, papers and peer reviews with no date restrictions were identified on the topic. Reference lists of papers identified were also examined for any related research and literature. Studies that were not published in English were excluded. The database searches yielded over 5640 articles. Articles were systematically reviewed. Those articles relevant to the topic were included, and articles not relevant, for example, articles concerning death anxiety, attitudes, perspectives, or nurses' experiences, were excluded for the purposes of this literature review.

1.7.1 Professional Grief and Emotional Reactions in Different Medical Contexts

Since physicians' grief takes place within the medical and organisational culture, contextual and environmental factors may influence this phenomenon. For example, the medical culture and the perceptions of the culture may prohibit the expression of grief (Doka,1989). Patient deaths and grief experiences may also vary across different medical settings (Zambrano & Barton, 2011). Emotional reactions – and grief experiences as part of these reactions – to patient deaths of emergency doctors, hospital doctors and medical students appear in the literature and will be briefly covered. Following this, some quantitative studies on HCP grief will be reviewed to illustrate the current limitations of quantitative research with regard to professional grief. Studies in oncology settings will be reviewed, as research specifically into professional grief has been conducted in this area. Thereafter, some studies that contribute to knowledge in the field about professional grief in non-Western contexts will be shared, followed by first-person reflections from physicians themselves. Lastly, PCP grief studies are reviewed.

1.7.1.1 Emergency medicine contexts

The emergency medicine environment's unique aspects may make patient death even more emotionally challenging than in other clinical settings (Strote et al., 2011). Strote et al. (2011) describe that emergency physicians work in contexts where they deal with sudden and unexpected deaths frequently. For example, 95 (66%) out of 145 surveyed academic emergency physicians witnessed a death at least every month (Strote et al., 2011). Strote et al.'s (2011) findings indicate that physicians may be expected to be immune to significant emotional reactions as they are expected to focus on aspects of care that prevent death. Also, it appears that dealing with grief emotions towards patient loss seems to be only rarely mentioned in the emergency medicine literature (Strote et al., 2011). Different emotional responses were reported in emergency department and inpatient settings in Batley et al.'s (2017) study. The former conveyed reactions to the suddenness of the death, i.e., shock, confusion, surprise; and the latter, reactions to the loss of interpersonal connections, i.e., grief, sadness, feeling heartbroken (Batley et al., 2017).

1.7.1.2 Emotional reactions in hospital contexts

Some research has been conducted to explore hospital physicians' emotional reactions to memorable patient deaths in the US (Jackson et al., 2005; Redinbaugh et al., 2003; Rhodes-Kropf et al., 2005). Doctors' emotional reactions to the recent death of 'an average' patient were explored and the effects of level of training on doctors' reactions investigated by Redinbaugh et al. (2003). Their study's 188 participants were attending physicians, residents and interns in general medicine, intensive care and primary care doctors, who cared for 68 patients that died in hospitals. Semi-structured interviews to gather qualitative data and self-administered questionnaires were conducted. Physicians reported moderate levels of emotional impact from the death and most doctors (74%) reported satisfying experiences in caring for a dying patient (Redinbaugh et al., 2003). Their findings also indicated that doctors were moved by the deaths of the strangers for whom they cared, but also that they were often powerfully affected by the deaths of patients with whom they had bonded (Redinbaugh et al., 2003). Their findings indicated that the interns reported needing significantly more emotional support than attending physicians. Further conclusions were that 'the conspiracy of silence' could be more harmful than the experienced emotional reactions (Redinbaugh et al., 2003). Senior doctors appeared to be in an important role in initiating discussions of these issues. Although the Redinbaugh et al. (2003) study investigated 'emotional reactions' it used the Grief Measurement Scale (Jacobs et al., 1986) originally developed for bereaved widows and widowers. This raises questions about the appropriateness and validity of the measure, and the sensitivity around measuring emotional experiences in response to patient death in a professional context. It is questionable whether assessing ‘separation anxiety’, conceptualised by attachment theory, has relevance in a professional context.

Although some research claims to have extended the knowledge that doctors may cope well with a patient death (Moores et al., 2007), the results need to be viewed critically. Moores et al. (2007) in the UK conducted a descriptive survey building on the previously mentioned studies in the US by Redinbaugh et al. (2003); Jackson et al. (2005); Rhodes-Kropf et al. (2005) by surveying 188 hospital doctors with self-administered questionnaires adapted also from Jacobs et al.’s (1986) bereavement and depression scale, combined with elements from Redinbaugh et al.’s (2003) study. They noted also that validity and reliability of self-report measuring had not been established. But some valuable insights were derived such as putting in place different support strategies for doctors of all grades and levels to help doctors cope with and respond to patient deaths (Moores et al., 2007). The researchers also concluded that the ability to experience intense emotions following patient death could be a useful learning opportunity for physicians (Moores et al., 2007).

Kasket’s (2006) phenomenological investigation informed by Colaizzi (1978) on physicians’ experiences and their emotional and behavioural responses to patient death explored how physicians react, change and adapt to death over the course of their professional development. The sample appeared to be a heterogeneous sample of different physicians, e.g., some were surgeons. Some findings conveyed ‘feeling rules’ of the profession such as anti-emotion expectations about ‘not feeling’ or ‘not expressing personal emotions’ being internalised, and that one should not require emotional support. Avoiding/distancing/ hardening and intellectualisation/rationalisation strategies to manage emotional responses emerged according to Kasket (2006). Increasing amounts of discomfort over time appeared to imply decreased resilience, conveying increased mortality awareness and death anxiety potentially playing a role due to greater exposure to the reality of patients dying (Kasket, 2006). Kasket (2006) interpreted that the physicians related to these ideas with denial. While it appears that emotional reactions and experiences can be approached with a learning mindset (Moores et al., 2007), the role of medical culture and the influence of internalised rules on physicians’ emotional reactions and professional behaviour may be strong and pervasive, as was conveyed in Kasket’s (2006) study, for example, with the ‘pulling oneself together’ message being dominant.

1.7.1.3 Medical students' emotional reactions

There is also a considerable body of research that has focused on emotional reactions of medical students to their first experiences of patient deaths (Kelly & Nisker, 2010; Pessagno et al., 2014; Ratanawongsa et al., 2005; Rhodes-Kropf et al., 2005; Smith-Han et al., 2016; Wear, 2002; Wilson et al., 2019). The emotionally powerful experiences reported in these studies included grief reactions when experiencing patient death for the first time. Wilson and Gilbert-Obrart (2021) state that learning how to be in the room with a dying person is reported by students as something that happens by observing more experienced doctors. Early career experiences also imply that initially medical students may identify more with patients than with doctors, thus they get to know their patients, leading to a shock when they die (Wilson et al., 2019). Further, lack of support seems to be a reoccurring theme in early experiences (Meier et al., 2001; Rhodes-Kropf et al., 2005). Overall, as Clandinin & Cave (2008) reflect it seems that the medical training largely focuses on helping students to develop their professional identities as 'technically skillful' and 'medically knowledgeable' practitioners and seems to be lacking in supporting students to become 'caring and compassionate' (p. 765).

Although studies seem to provide valuable insights into early career experiences, it would be useful to do follow-up studies or longitudinal studies to increase the understanding of how emotional experiences and grief responses are navigated as physicians' careers progress and they gain more experience coping with emotional burdens. These may be better elucidated through qualitative methods. Ginsburg et el. (2005) explains that professional behaviour, such as the emotional reactions, in medicine may result from a series of personal negotiations between competing aspects of professionalism specific to the context of each situation. It seems necessary to understand more about the individual and personal negotiations, as physicians or medical students accommodate to the contextual assumptions about emotional rules that may remain invisible. It seems also important to understand further how on an individual level, emotional reactions, and particularly grief reactions and experiences, are navigated when professionalism may expect certain behaviours (Cruess et al., 2014).

1.7.1.4 Quantitative studies

Professional grief is considered a widespread professional phenomenon, but prevalence and intensity of grief reactions among physicians in response to patient death is considered as unknown (Gilewski, 2012; Sansone & Sansone, 2012). According to Genevro & Miller (2010) large, representative, and therefore generalizable studies have not been conducted on grief and bereavement of HCPs. It appears that research to date on grief and bereavement in

HCPs has focused on experiences from the perspective of the individual, even though the emotional costs of bereavement in the healthcare setting are also healthcare system issues (Genevro & Miller, 2010).

A recent scoping review by Chen et al. (2019) provides valuable insights in terms of some of the challenges in quantitative grief and bereavement research. These are, for example, ambiguous definitions of key variables, use of different measurement tools not designed for HCPs' grief and bereavement experiences, and samples of heterogeneous participants (Chen et al., 2019). Chen et al.'s (2019) scoping review of 12 quantitative studies on professional caregivers' bereavement after patients' deaths involved 1317 professional caregivers. They looked at bereavement reactions of professional caregivers who were working in nursing homes, patients' homes and long-term day care centres, and reported covering different contexts with a variety of work tasks, with varying quality/length of patient-professional relationships (Chen et al., 2019). One of the studies (Lobb et al., 2010) included community palliative care nurses, but PCPs' experiences were not covered in any of the 12 studies. All studies occurred in Western countries and mainly in the US (9 studies). The scoping review revealed that none of the 12 studies clearly defined professional caregivers' bereavement after patient deaths but instead the studies seemed to equate professional bereavement with familial bereavement, i.e., close family member dying (Chen et al., 2019). Additionally, the used grief instruments were originally developed for bereaved families. Some studies focused on one memorable patient death, some on grief reactions within a certain period (a whole career, last month), some on typical bereavement reactions to an average patient death. Moreover, researchers reported that quantitative studies and grief instruments may fail to capture the full phenomenon, for example, positive effects, of professional bereavement (Chen et al., 2019). Hence, quantitative studies may underestimate the prevalence and the impact when not using valid measures. Chen et al. (2019) state that this may hinder the understanding of the grief phenomenon, amplifying the ignorance of professional caregivers' suffering. Therefore, to advance the study of HCP grief, a valid and reliable tool is needed that specifically measures professional grief. A clear conceptualisation of professional grief/bereavement is also required (Chen et al., 2019). Such developments may allow for more definitive conclusions to be drawn from studies. Controlled experimental studies are also needed to determine the efficacy of existing interventions. In the meantime, qualitative studies, such as the current study, can contribute to the understanding of what is at the heart of the phenomenon of physicians' professional grief in different contexts.

1.7.1.5 Professional grief experiences in oncology context

The emotionally demanding work of oncologists has been recognised in the literature (e.g., Lyckholm, 2001; Quinal et al., 2009; Shanafelt et al., 2003; Stearns, 2001; Whippen & Canellos, 1991). Qualitative and mixed methods studies have been used to understand oncologists' grief experiences in Israel and Canada (Granek et al., 2012a; 2012b; 2012c; 2013; 2015; 2016; 2017a; 2017b). In one of the most recent studies, Granek et al. (2017b) studied grief symptoms and emotional reactions of 22 Israeli oncologists in different stages of their careers in response to a difficult patient loss by using a Grounded Theory method. Their findings reported both anticipatory grief and grief after patient death, manifested as behavioural, cognitive and emotional symptoms of grief (Granek et al., 2017b). Symptoms intensified particularly in family related factors (Granek et al., 2017b). In a previous study with Canadian oncologists, Granek et al. (2012b) found symptoms of grief similar to those of the Israeli oncologists, implying some generalizable emotional reactions across cultures or medical cultures. Nevertheless, a differentiating finding was that Canadian oncologists did not report close relationships with patients and families (Granek et al., 2012b). Thus, the findings suggest that due to Israeli culture being very family oriented, oncologists in Israel are likely to spend more time with patients and their families, having a closer relationship with them and as a result making patient loss harder for physicians (Granek et al., 2017b). Some findings conveyed that grief over patient death affected not only oncologists' professional lives, experienced as exhaustion and burnout, but also their personal lives, with findings indicating changes to the oncologist's personality, gaining of perspective on life, and a strain on social relationships (Granek et al., 2017b). Physicians may also feel shame about experiencing difficult emotions and/or speaking openly about patient loss to colleagues (e.g., Granek et al., 2012a; Granek et al., 2012b; Granek et al., 2016; Granek et al., 2017a; Granek et al., 2017b). Further, physicians reported wanting their feelings of grief to be acknowledged in the workplace, implying that grief may get unrecognised (Granek et al., 2012d). It should be noted that the findings in these studies may be specific to the medical centres in question or the specific cultures. Additionally, institutional structures and practice models may impact the oncologists' experiences.

1.7.1.6 Emotional reactions in non-Western contexts

Professional grief and grief issues may present differently in non-Western PC contexts (Shimoinaba et al., 2009). Some indication of this emerges in the following examples of studies in non-Western contexts. An interdependent self-concept may place higher value on relationships and emotional connections and feelings of others in non-Western contexts (Markus et al., 1991). For example, due to appreciating collectivism, Chinese family of the deceased patient can have significant influence on physicians' and nurses' professional bereavement experiences (Du et al., 2022). Chinese professional caregivers' (24 physicians and nurses) bereavement experiences after patient deaths were investigated in mainland China (Du et al., 2022). Four themes emerged from their analysis: 1) Dying and death conditions; 2) Professional caregiver characteristics; 3) Professional caregivers' involvement; and 4) the bereaved family. Additionally, the researchers acknowledged the impact of culture and context on professional bereavement experiences and suggested that the healthcare systems and cultural backgrounds should be listed and recognised as influencing factors for professional bereavement experiences (Du et al., 2022).

In another study, findings about faith and spirituality emerged both in Ibrahim and Harhara's (2022) focus group study in the UAE, and Masia et al.'s (2010) phenomenological study about medical doctors' and students' emotional reactions to patient death in South Africa's emergency hospital unit. After losing a patient, the attending doctor may rely on religion for strength, and some doctors may start questioning their religion after losing patients (Masia et al., 2010). The researchers reported that religious or spiritual beliefs may facilitate the process of meaning making but may not put an end to the process of grieving (Ibrahim and Harhara, 2022). To increase the recognition of professional grief experiences and cultural influences in non-Western contexts, further studies are needed to appreciate the phenomenon more fully (Rosenblatt, 2008).

1.7.2 Palliative Care Physicians' Emotional Reactions and Grief Studies

When reviewing literature, it became apparent that research on PC physicians' grief experiences are lacking. Overall, research on physicians' emotional responses and experiences when working in contexts with dying patients is covered by other medical contexts (Aase et al., 2008; Granek et al., 2013; Jackson et al., 2005; Schulman-Green, 2003). There seems to be a limited amount of research on how PCPs experience grief over dying patients compared to nurses' experiences (Funk et al., 2017). Compared to other medical specialities, for example, oncologists, PCPs are suggested to have a different perspective on death and dying (Granek & Buchman, 2019). Granek & Buchman (2019) explain the differences and suggest that instead of viewing patient death as a personal and professional failure, PCPs may perceive the dying phase as a meaningful stage of life where they can support patients and families. To date, the limited research seems to have focused on overall emotional experiences of physicians working in specialist palliative care, and specifically studying their grief experiences has been neglected. Three qualitative research studies involving PCPs (or PCPs as part of a sample) and addressing their emotional experiences to patient deaths will be covered next. As mentioned in previous sections, PCPs have also been part of samples in some previously discussed research studies.

Hubik et al. (2021) recently sought to understand what strong emotional reactions are experienced by doctors working in specialist palliative care. Their qualitative descriptive design included grounded theory techniques and used semi-structured individual interviews to explore PCPs' memories of strong emotional reactions and challenging aspects of PC work, and how emotions were managed and affected in 20 participants' lives in a study in Australia (Hubik et al., 2021). In this study, a multitude of emotional reactions, and a range of emotions, such as sadness, frustration, anger, distress and hopelessness were described by the participants (Hubik et al., 2021). In addition to shock, embarrassment, guilt, anxiety, resentment and fear, some positive emotions, satisfaction, joy and happiness, were reported as well (Hubik et al., 2021). The study explored the emotional reactions related to the overall circumstances of the PC context, and not just the strong emotional reactions related to patient death. Examples of the different circumstances were patient, family and staff distress, as well as system issues eliciting strong emotional reactions (Hubik et al., 2021). Various strategies emerged for managing participants' reactions that included developing self-awareness, debriefs and reflective practices, outside work and external supervision, personal psychotherapy and support of friends and family (Hubik et al., 2021). The researchers concluded that being unaware of one's emotional state may have the potential to negatively impact on decision making, adversely affect patient care and affect personal wellbeing (Hubik et al., 2021). Not only formal support and debriefing practices were important but also the development of informal support networks (Hubik et al., 2021). They concluded that more vulnerable physicians, particularly junior doctors, who may manage their emotions through denial and/or avoidance, could be supported with in-the-moment experiences, which might support them to develop more sustainable coping strategies for their emotional experiences (Hubik et al., 2021). In this study the participants were told that strong emotional reactions were whatever they perceived them to be, and therefore, a variety of subjective experiences may not have been included. Emotional experiences of physicians who are more vulnerable and who may experience emotions more covertly may thus be left unrecognised.

Physicians' emotional experiences, specific to the PC context, have also been explored by Zambrano et al. (2014). A thematic analytic approach was used as a methodology to analyse the experiences of seven PCPs working in a PC specialist context in Australia. Zambrano et al.'s (2014) study about PCPs' experiences, coping mechanisms and the impact of death and dying on PCPs identified overarching themes of: 1) Being with the dying; 2) Being affected by death and dying; 3) Adjusting to the impact of death and dying. Some of the findings revealed that PCPs showing and sharing their emotions with patients and families was experienced as beneficial for the physician-patient encounter and that crying was not perceived with negative connotation. In contrast to, for example, Kasket's (2006) study, these findings may illustrate more diverse beliefs about emotional reactions than in the wider medical culture, perhaps indicating more flexible and tolerant beliefs shaped by the contextual aspects and by PCPs accommodating to the PC philosophy of care. Furthermore, in the findings specifically about grief experiences, the participants reported experiencing grief on 'a professional level' and differentiated this from personal loss experiences (Zambrano et al., 2014), suggesting that professional grief experiences differ from personal life grief. The study also reported participants having expressed that the accumulating effect of experiencing grief was particularly difficult for them (Zambrano et al., 2014). These findings could be expanded by further investigating lived experiences of PCPs, particularly to deepen the understanding of PCPs' grief experiences.

Whitehead's (2012) qualitative study using phenomenological methods explored physicians' experiences of dealing with patient death and how these experiences impacted communication with patients and patient care. This study grew from Kuhl's (2002, 2011) research and was an attempt to explore the 'other side' of iatrogenic suffering, i.e., the experience of physicians dealing with patient death and how their suffering contributed to patients' suffering. Only three of the ten physicians were PCPs, two came from emergency, two from hospital transplant teams, two from family practice and one from intensive care. The heterogenous nature of this sample, from widely different practice areas, was unsurprisingly reflected in the findings. For example, many non-palliative physicians reported that at critical moments surrounding a patient's death they entered a 'mode' or state of mind in which their awareness was intensely focused on the 'actions they needed to perform' (Whitehead, 2012). The three PCPs, by contrast, reported a very different 'mode': being *present with* the patient in a way that provided calm reassurance and support. The findings provide insight into some differences of medical specialities that may influence the emotional experiences of physicians when patients die. Research could consider deepening the understanding of PCPs' emotional experiences, particularly grief experiences.

1.8 Grief and Professional Grief Interventions

Grief counselling has been a long-standing feature of counselling practice (Bowlby, 1961; Freud, 1917/1953). In general, grief is considered a natural and individualised response to different losses, that normally does not need clinical intervention (Shear et al., 2005, 2011). However, some people may have a severe and prolonged course of grief and professional interventions may be required (Killikelly & Maercker, 2017; Nakajima, 2018). Unusual or 'pathological' grief, conceptualised as complicated grief (Nakajima, 2018; Prigerson et al., 1996; Shear et al., 2011), traumatic grief (Jacobs et al., 2000), and later described by the term ‘prolonged grief disorder’ (Prigerson et al., 2008), has been incorporated into the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition ([DSM-5], American Psychiatric Association [APA], 2013) and the International Classification of Diseases 11th Edition ([ICD-11], World Health Organisation, 2022) (Li et al., 2023). Some individuals may be potentially at risk of long-term mental and physical health challenges and/or suicidal behaviours, requiring clinical intervention and treatment. Only a small proportion of the bereaved population, around 10% (Lundorff et al., 2017), is estimated to develop severe symptoms of psychological distress and impairment in functioning (Nakajima, 2018). Grief interventions are designed to alleviate symptoms of grief by providing targeted support and guidance and are tailored to meet the unique needs and circumstances of each individual (Li et al., 2023). Some common types of grief intervention include grief counselling (Boelen et al., 2021; Eklund et al., 2021; Smith & Delgado, 2020; Worden, 2018), cognitive-behavioural therapy (Kavanagh, 1990), family therapy (Kissane et al., 2006) and psychotherapy (Johannsen et al., 2019).

Complications of professional grief and grief-related job stress reactions are not yet fully understood in the field of professional grief of HCPs, although they have been suggested to contribute to burnout and development of compassion fatigue (Laor-Maayany et al., 2020; Romesberg, 2004; Shayne & Quil, 2012). A recent bibliographic analysis by Li et al. (2023) on HCPs’ grief interventions suggests that there is a significant ongoing trend for increasing scientific endeavours to address professionals’ grief and improve their overall wellbeing, accelerated by the COVID-19 outbreak (Albuquerque et al., 2021). Some strategies for coping with professional grief have been investigated, for example by Vachon (1987, 2011), Papadatou (2000) and Granek et al. (2013). Coping strategies in three domains were reported by Granek et al. (2013) consisting of social support and colleague support, and activity-oriented coping including hobbies, taking vacations, spending time outdoors, physical activity, as well as turning to faith, compartmentalisation, denial, or withdrawing from patients.

A narrative review of professional grief interventions in hospital settings by Yazdan et al. (2023) concluded that HCPs largely reported benefits from grief-focused interventions, yet, according to the authors, research was sparse and evaluation methodologies were heterogenous, making it difficult to generalise findings. Notably PC was not represented in this review, although as a hospital speciality it is found to be especially vulnerable to professional grief (Yazdan et al., 2023). Only five of the total 29 articles reviewed used models centred on grief to guide intervention selection or design: Papadatou’s (2000) model of Health Professionals Grieving Process, Saunders and Valente’s Bereavement Task

Model (1994), and the Kübler-Ross Five Stages of Grief model (1969), all of which have limitations (Yazdan et al., 2023). HCPs' grief interventions need a more solid theoretical base.

Furthermore, a systematic review by Carton and Hupcey (2014) explored the research literature on the services available to address healthcare provider grief (HCP). Carton and Hupcey (2014) identified some challenges and limitations in these HCP grief intervention studies. According to Carton and Hupcey (2014) no controlled experimental studies have been conducted to evaluate interventions targeting HCP grief. The studies in the review had not built upon the evidence from the previous studies, thus failing to produce a coherent and progressive body of knowledge on methods of addressing HCP grief (Carton & Hupcey, 2014). Carton & Hupcey (2014) stated that the optimal length of time for grief interventions and the most effective means of addressing grief in HCP also remain unknown. Furthermore, referring to the issue already illuminated in this literature review, many research studies did not clearly delineate grief from compassion fatigue or burnout. Several studies used psychometric grief measures designed to investigate grief over losing loved ones (Hogan et al., 2001; Lev et al., 1983). Echoing previous critique in this review, the study methodology seems to be a major limitation of the existing body of literature on HCP grief (Carton & Hupcey, 2014). Given the potential negative implications professional grief can have on the individual, and also at organisational levels, it is important to advance the evidence-based research in this field (Yazdan et al., 2023).

1.9 Rationale for the Doctoral Research Study

This review surveys the current landscape of how physicians' professional grief experiences, and their related phenomena, have been studied**.** It is not a question anymore of whether the phenomen of physicians' grief exists, but rather that it has often been an unrecognised or unvalidated phenomenon. In the light of the reviewed literature, it can be concluded that the PCPs' professional grief experiences have been understudied. The studies discussed reveal that the context may have an impact on how physicians' grief is experienced. Hence, it would be important to explore PCPs' grief experiences in the hospice context to understand this phenomenon more deeply. The studies seem to lack a more nuanced understanding that an idiographic approach, for example, can offer.

By adopting a qualitative research method and a phenomenological perspective, this study aims to capture more nuanced experiences and address the gap in the literature on palliative care physicians' grief experiences, so giving voice to their lived experiences. This review has stimulated the following questions: 1) What is it like for PCPs to experience grief in the hospice context; and 2) How do PCPs make meaning of their grief experiences of patient deaths in the hospice context?

By attempting to answer these questions, this study aims to develop a rich and nuanced understanding of the PCPs' experiences and contribute to the empirical literature and the wider Thanatological field of physicians' grief experiences. It is also hoped that CoPs will use these understandings and findings in their psychological work and support for PCPs.

2. METHODOLOGY

2.1 Overview

In this chapter the foundational philosophy, the theoretical framework and the rationale for using Interpretative Phenomenological Analysis (IPA) for this research study will be presented. The procedural aspects of the research study, the analytic strategy, ethical considerations, and reflexivity will be outlined.

2.2 Research Aims and Questions

This research study aims to gain better insight into palliative care physicians' grief experiences in the hospice context. The research questions are:

- 'What is it like for Palliative Care Physicians (PCPs) to experience grief in the hospice context?', and
- 'How do PCPs make meaning of their grief experiences of patient deaths in the hospice context?'

2.3 Rationale for Qualitative Research

As stated in the research questions, this study aims to explore and understand the lived experiences of PCPs' grief in the hospice context. How people make sense of their world and how they experience events, i.e., how people make meaning, is investigated by using qualitative methods (Willig, 2021). Eatough and Tomkins (2022) state that particularly when investigating emotional life and related phenomenon, qualitative methods can enable a deeper understanding of how they are *lived*. Scientific research on grief and loss offers various instruments for quantitative assessment of grief responses (Neimeyer & Hogan, 2001). However, as was discussed in the previous chapter, the professional grief phenomenon investigated here may not be captured with these traditional scales. Also, this research study would require a different goal and different research questions. This research study is interested in exploring the quality and the texture of the experiences, rather than cause-effect relationships (Willig, 2021), and therefore, qualitative methods were deemed suitable to meet the aims of this research study. The research paradigm and my epistemological position will be discussed next.

2.4 Research Paradigm and Epistemological Position

The ethos and philosophy of humanistic psychology embedded in counselling psychology (Woolfe, 2016) has guided me in this research project. The Philosophy of Science, a branch of philosophy that refers to the foundations and conceptual roots of science, incorporates beliefs or assumptions of the researcher (Ponterotto, 2005), guiding the practice of research (Lincoln & Guba, 2013). Based on my assumptions about the social world, and the phenomenological and idiographic focus of this research, my research situates itself in the constructivist research paradigm which has laid the framework for this study (Ponterotto, 2005). A postmodern constructivist research paradigm is considered as a philosophical stance of searching for meanings (van der Walt, 2020). According to the constructivist philosophical paradigm, constructing is like learning (Dickson et al., 2016). Honebein (1996) describes that individuals construct their own understanding and knowledge of the world through experiencing things and reflecting on their experiences.

My assumptions and views as a researcher, about what exists (ontology), and how I can acquire knowledge about it and how knowledge can be produced (epistemology) (Willig, 2016), are considered next. Guba & Lincoln (1994) describe that epistemology is concerned with the nature of knowledge, what can be known, what knowledge can be created, and how knowledge can be acquired, whereas ontology is considered with a study of being (what is) and existence (Crotty, 1989). According to Crotty (1989) the ontological stance can describe the researcher's beliefs about what may comprise and constitute as reality. For this research study, I am positioning myself and adopting a philosophical stance of a critical realist. Moreover, my research is informed by a realist ontological perspective that I am combining with a relativist epistemological philosophical stance (Willig, 2016). Critical realism, a philosophical approach to understand science, that originates from Bhaskar (1975, 2008), acknowledges that there is an objective reality beyond human experiences, and also, since people have a subjective understanding of their reality, there are multiple levels of reality. Hence, it could be said that critical realism views that there is 'a domain of real', i.e., there can be stable features of reality that can exist independently of human perspective and observation, for example, emotions can be part of reality having a realist ontological status (Sayer, 1992). Willig (2016) describes further that a realist ontology philosophical perspective views that "…material and social structures or processes can exist and have existence independently of what we might know about them" (p. 2). Therefore, this stance acknowledges, that it may be impossible to produce an objective account of 'reality' (Guba & Lincoln, 1994), and that multiple perspectives on people's realities are possible (Willig, 2021). These perspectives can be contrasted to the positivist ontology which assumes that external world determines one's perception about it (Willig, 2021). That said, as a researcher, I can try to gain knowledge from my scientific and philosophical perspective how the research participants experience their world, but I can never fully know how it feels to be in their position (Smith et al., 2009), as my perspective will always be limited.

2.5 IPA Theoretical Framework and Method

According to Darlaston-Jones (2007) the epistemological position, aligned with my research questions and the purpose of the research study, influence the choice of the research method. The research method chosen for this study, Interpretative Phenomenological

Analysis (IPA), is an approach to qualitative inquiry committed to the examination of how people make sense of their lived experiences (Smith, 1996; Smith et al., 2022). IPA is interested in the individual's subjective experience of the world rather than the objective understanding of it (Willig, 2021). IPA researchers aim to engage with participants' attempts at making sense of their experiences of what is happening to them and their reflections of the significance of the experiences to them (Smith et al., 2022). However, access to these experiences is dependent on what participants tell the researcher about their experiences (Smith et al., 2022).

Larkin et al. (2006) explain that in an IPA approach to data analysis, firstly, the researcher tries to understand the participant's world and attempts to describe what it is like for the participant, and secondly, the researcher tries to develop a more interpretative analytic positioning with the description in relation to a wider context by focusing on the participant's sense-making activities. Smith et al. (2022) further describe that the following three basic principles of IPA need to be aligned for the researcher to be in a position to make connections with theories and interpretations: 1) IPA study needs to be concerned with the participant's relationship to something important for them; 2) there must be thorough interpretative engagement with the participant data; 3) detailed examination of each case and its' context (p. 133).

IPA was operationalised originally by Smith (1996) in Health Psychology and has gained popularity in the field of psychology research (Eatough & Smith, 2017; Finlay, 2009). It is influenced by theoretical ideas and phenomenological philosophies but is not the only phenomenological method to study human experiences (Finlay, 2009; Willig, 2021). For example, 'descriptive phenomenology' (Giorgi, 1985, 2009) and 'hermeneutic phenomenology' (van Manen, 1990) are some of the other phenomenological approaches that share an interest in enquiring what human experiences are *like* (Smith et al., 2022), and, how the person's world is *lived* and experienced (Finlay, 2011). The shared principle of phenomenological inquiry is that experiences are examined in the way in which they occur on their own terms (Smith et al., 2022). IPA integrates philosophical underpinnings from the phenomenological philosophies of Husserl (1971/1927), and the phenomenological and hermeneutic philosophies of Heidegger (1962/1927), Merleau-Ponty (1945/2002) and Sartre (1956/1943) but also draws from a range of ideas in philosophy (Smith et al., 2009, 2022). IPA draws mainly on three philosophies of knowledge: phenomenology, hermeneutics and idiography (Smith et al., 2022; Smith & Nizza, 2022). These will be explored next.

2.5.1 Phenomenology

Phenomenology is considered as an umbrella term under which various philosophical traditions and approaches to the study of human experiences have emerged (Dibley et al., 2020). Finlay (2011) states that widely credited as the founder of modern phenomenology, Husserl's ideas form the base for descriptive, empirical phenomenological research. Husserl's work focused centrally on the process of reflection and finding the essence, the essential qualities, of the experience (Smith et al, 2022). More precisely, as Dibley et al. (2020, p. 6) explain, understanding "the things themselves" meant getting to the essence of the experience itself, and this would be done by unpacking the initial meaning to uncover what was hidden. To approach the lived experience with this perspective or attitude, a special framework would be used consisting of phenomenological reduction or epoché, and bracketing, to avoid the interference of the researcher's preconceptions or experiences of the phenomenon (Dibley et al., 2020). This type of extensive examination and description of things leading to 'the essence' would also require treating all details of perception equally (Langdridge, 2007). The more dwelling in the data and focusing on the 'eidetic reduction', i.e., using the techniques required to get to the essence, the more trustworthy description of the phenomenon as it is experienced is assumed to result as an outcome (Finlay, 2011). According to Smith et al. (2022) Husserl's work has helped IPA researchers to focus centrally on the process of reflection, attentive and systematic examination of the content of consciousness. Furthermore, Husserl's ideas of the *Lebenswelt* (lifeworld), a taken-for-granted world as experienced, is a meaningful structural whole that is shared and experienced by individuals from their unique perspective (Finlay, 2011, p. 45). All phenomenologists are considered to agree that 'lifeworld' is universally present and "….an inevitable structure of being" (Finlay, 2011, p. 125). This 'lifeworld' is described consisting of 'body-subjects' (sense of embodiment); 'sociality' (relating to others in the world, using language and sharing culture and ethnic history); 'spatiality' (being inserted to the world surrounding us); and 'temporality' (living in an unfolding present, determining past, and yet to be determined future) (Finlay, 2011, p. 45).

A Heideggerian framework has allowed the acknowledgement of the researcher's lived experience of the world and of participants, which Husserl did not provide (Dibley et al., 2020). Heidegger, who was also Husserl's student, moved away from Husserl's preference of a transcendental and descriptive approach to phenomenological inquiry (Finlay, 2011). Heidegger developed interpretive phenomenology by extending hermeneutics, the philosophy of interpretation (Reiners, 2012). Although both Husserl and Heidegger claimed to use the phenomenological method, different views and priorities were given. For example, Heidegger resisted reductionism, giving priority to interpretation, in comparison to Husserl, who was interested in grounding knowledge (Giorgi, 2009). The human, *Dasein,* involvement with others, 'person-in-context' and 'relatedness-to-the world' became the focus of Heidegger's work (Smith et al., 2022, p. 13). According to Heideggerian framework, researchers can't exist outside the social world (Smith et al., 2022). Furthermore, it is also considered that researcher's expectations or meanings can't be bracketed from the interpretations (Smith et al., 2022). Hence, in Heidegger's work the phenomenological concept of intersubjectivity (*Miteinandersein*), the overlapping and relational nature of one's engagement in the world is central (Smith et al., 2022, p. 13). In Heidegger's 'Being and Time' (1962/1927) his conception of *Dasein* is best understood as *how* we are instead of *what* we are. Thus, *Dasein* is always 'being-in' and 'being-with' others (*Mitsein*), meaning that the self is never isolated but is always embedded in the world (Brencio, 2022). Smith et al. (2022) explain that the ideas that IPA took on from Heidegger were the ideas of human beings being 'thrown into' a world of objects, relationships and language, as well as the idea that 'being-in-the-world' is always perspectival, temporal and in relation to something, in addition to meaning-making activities being central to phenomenological inquiry (p. 13). Moreover, a central emphasis is on phenomenology, and lived experiences are viewed through the hermeneutic, interpretative lens (Smith et al., 2022).

Other philosophers, for example, Merleau-Ponty (1945/1962) and Sartre (1956/1943), have contributed to outlining the key structures of 'lifeworld', the human existence, and the more interpretative understanding of the lived experience, influencing hermeneutic phenomenology (Smith et al., 2022). For example, Merleau-Ponty (1945/1962) developed further the ideas of the embodied nature of our relationship to the world and lived experience of the body. Merleau-Ponty's views that the body shapes our knowing about the world, and the understanding of embodiment as being closely aligned with the importance of emotional experiences, continue to be core perspectives for IPA researchers (Smith et al., 2022). For example, a contemporary phenomenological philosopher and grief researcher, Ratcliffe (2022), talks about people experiencing things emotionally "… through our feeling bodies" (p. 44). That said, understanding the embodied lived experiences is considered an essential part of understanding an individual's lived experience in phenomenological and IPA research (Smith et al., 2022). Furthermore, when it comes to Sartre (1956/1943), his contribution to phenomenology has been about existential nature. Smith et al. (2022) describe that for Sartre human nature is about the process of 'becoming' instead of 'being', and that individuals have freedom to choose and responsibility for their actions (p. 16).

2.5.2 Hermeneutics

The second key theoretical underpinning of IPA is hermeneutics, which is the theory of interpretation (Smith et al., 2022). Larkin et al., (2006) state that to properly understand and communicate the experiences of participants requires not only describing and representing the participants' stories, but also interpreting these experiences. In IPA the assumption is that the researcher "tries to step into the participants' shoes as far as possible" to understand the experiences from their perspective (Pietkiewicz & Smith, 2012, p. 366). Hence, IPA researchers engage and are involved in a 'double hermeneutic', i.e., "the researcher is trying to make sense of the participant trying to make sense what is happening to them" (Smith et al., 2022 p. 3). Ponterotto (2005) suggests that through this type of active interaction, and as Schmidt (2006) describes it as circular meaning making process, deeper insights into the participant's lived experiences can be reached both by the researcher and the participant. Willig (2021) states that these insights generated from the research will be then a product of the relationship between the researcher and the data, but also, according to Finlay and Gough (2003), of the relationship between the researcher and participant.

Furthermore, due to the dynamic research process in IPA, access to the participant's experience depends on the researcher's own conceptions that require consideration to advance the understanding of the phenomenon (Smith & Eatough, 2021). Hence, in IPA the focus is on the process of engaging with the participant's words and their account, but the cyclical process of attempting to bracket prior concerns is involved in the reflective practice of the researcher, and that way the reflections and prior concerns become part of the research process (Smith et al., 2022). Thus, as Finlay & Gough (2003) emphasise, the reflexivity of the researcher's presence in qualitative research is a defining feature of qualitative studies.

IPA often contains two types of hermeneutic tasks, originating from Ricoeur (1970), that move beyond a traditional phenomenological hermeneutics of empathy and meaning recollection (bringing out the meaning of an experience) towards also embracing a hermeneutics of suspicion (where meaning is hidden and/or latent) (Finlay, 2011, p. 63). Thus, different ways of interpreting data are used in the analytic process, from rich, experiential descriptions that are grounded in the participant's words to approaching the data with more interrogative interpretations (Smith & Eatough, 2021).

2.5.3 Idiography

The third primary theoretical perspective of IPA is idiography. Opposite to the nomothetic approach that is concerned with populations and group-level claims, idiography refers to an in-depth analysis of single cases and examining individual perspectives of study participants, in their unique contexts (Pietkiewicz & Smith, 2012). Rather than focusing on the general, IPA focuses on 'the particular', connecting with hermeneutic phenomenology (Larkin & Thompson, 2012). Smith et al. (2002) explain that IPA's commitment to the detailed examination of the particular case means that it wants to understand in detail what the experience is like for this person, and also, what sense this person is making of what is happening to them. Therefore, according to Larkin et al. (2006), IPA commits to like 'giving voice' to the concerns of the participants, and to contextualising the sense-making from a psychological perspective (p. 102). Due to the idiographic approach, small sample sizes are favoured as IPA studies aim to represent 'a perspective' of a particular phenomenon in a particular context, instead of a population (Smith et al., 2022).

2.5.4 Methodological Issues of IPA

Like any qualitative methodology, IPA also has its limitations. Since phenomenology is concerned with the texture of experience, IPA requires data that is rich and detailed, and first-person accounts of participants' experiences (Smith et al., 2022). Highly structured interviews can limit the opportunity for the participant to speak freely and be heard. In-depth, personal discussion is preferred. Hence, IPA is dependent on skilled interviewing as participants should be able to the tell their story, be able to reflect, and to make sense of their subjective experiences (Smith et al., 2022). Language may also prescribe what participants *can* think and feel due to socially constructed ideas or ways of talking, which therefore may shape the experience (Willig, 2021). Equally, as a non-native English-speaking researcher I am aware that not only the participants' ability to capture nuances and subtleties of language may influence the expression of the experience, but also that the researcher's skills and abilities may impact the quality of IPA. Since IPA is co-created, phenomenological analysis is always *an interpretation* of the participant's experience that also involves the researcher's view of the world (Willig, 2021). The epistemological and methodological limitations mean that it is impossible to reveal the 'pure' experience of the participant (Larkin et al., 2006, p. 108). Furthermore, Larkin et al. (2006) state also that revealing the participant's experience depends on the researcher's sensitive and responsive work.

2.5.5 Consideration of Other Methods

Multiple methodologies and methods are available for the qualitative researcher (Finlay, 2015). Methodology refers to the overarching approach and includes both philosophy and methods, while method refers to procedures of gathering and analysing data (Finlay, 2015, p. 165). Having also considered other approaches to this study, the chosen IPA methodology was preferred as being consistent with my adopted epistemological position and the purpose of the study. The prime reason for choosing IPA over other qualitative approaches was that it is a method that allows for a deeper understanding of PCPs' grief experiences, focusing on idiography and meaning making of PCPs' grief experiences in a context where a normative understanding of grief experiences may not apply. Other qualitative methodologies were considered in the early stages of the research study. For example, Grounded Theory (GT) methodology, developed by sociologists Glaser and Strauss (1967), was designed to generate new, contextualised theories (Willig, 2021). GT is viewed as being more preoccupied with uncovering social processes than as being suitable for exploring the nature of an experience in psychological research (Willig, 2021). That said, the purpose of this research study was not to generate an explanatory theoretical model about how and why something occurs, which would call for a GT approach (Starks & Brown Trinidad, 2007). Willig (2021) explains that in the GT method it is assumed that the data speaks for itself and there is no role for researcher's reflexivity (Willig, 2021). GT is also heavily influenced by positivist epistemology and is therefore not compatible with my epistemological position (Willig, 2021). However, Charmaz's (2014, 2015) contemporary approach and revision of GT adopts GT theory strategies, but differs, for example, by adopting a reflexive stance, and by adopting a relativist epistemology. Moreover, as the GT method did not align with my aims to explore the internal world of the participants and their meaning making, it deemed not suitable as a method for this study.

Other methodologies such as Thematic Analysis (TA), developed by Braun and Clarke (2006), which underpins both GT and phenomenological analysis, and a descriptive phenomenological approach, were considered but rejected for various reasons. Compared to IPA, TA is a philosophically neutral method and focuses on producing descriptive accounts of patterns and themes that may apply to larger groups and populations, and which does not share IPA's commitment to idiography (Finlay, 2015; Willig, 2021). In terms of using a descriptive phenomenological approach, my critical realist epistemological position did not align with descriptive phenomenological approach's focus on attempting to reveal 'pure' descriptions and attempting 'direct seeing' of people's experiences (Matua & van der Wal, 2015). Since my aim was to study PCPs in a particular context, I concluded that IPA was a more suitable approach as it could consider contextual features of the experiences in relation to other influences of, for example, medical culture and/or hospice culture. In addition, it appears that grief research has been criticised for not considering the influence of the context in which it takes place (Breen & O'Connor, 2007). Therefore, having considered my research question and the theoretical underpinnings of other qualitative methods, IPA was chosen as a suitable approach to study the PCPs' lived experiences. As an interpretative and hermeneutic philosophy and a method, employing IPA could allow me to gain a deeper understanding of the participants' experiences in their context.

2.6 Procedural Aspects

2.6.1 Sampling

Sampling of this research study was theoretically consistent with the IPA framework (Smith et al., 2009). In IPA studies, samples are selected purposively to offer insights into a particular experience and/or particular perspective on the phenomena of the study (Smith et al., 2022). A general recommendation is to recruit a small homogeneous sample, enabling a detailed case-by-case analysis with the aim of producing an in-depth examination of the phenomena (Smith et al., 2009). The recommended sample size for IPA at Doctoral level in the UK is six to eight participants (Turpin et al., 1997), which was the sample size that I aimed for. Sampling was a convenience sample and participation was self-selected.

2.6.2 Participant Criteria

Doctors in palliative medicine can work in hospitals, hospices and in the community with home visits (National Health Service [NHS], Palliative Medicine). Since the research question was designed to particularly understand specialist Palliative Care Physicians' (PCP) grief experiences in the hospice context, it meant that inclusion criterion was a PCP working in the hospice context during the interview period, and not for example, in the hospital. The PCP inclusion criteria also meant that the participant needed to be a palliative care speciality doctor or a doctor/physician in palliative care speciality training. The PC speciality training usually takes minimum of six years in the UK (NHS, Palliative Medicine). It was also reasonable to assume that a minimum of one year of experience would be an appropriate estimate to have gained experience in a palliative care work and to have experienced patients dying and having grief-related experiences. Since the study was conducted in English and took place in the UK, the language criterion was defined as English.

Table 1
Participant Inclusion and Exclusion Criteria

Inclusion Criteria
• Adults (18+ years) • A Speciality Palliative Care Physician/Doctor or a Physician/Doctor in Specialist Palliative Care training in the UK. • Be currently working in a hospice. • Have work experience in a hospice setting, minimum 1 year. • Have experienced patients dying in a hospice. • Be able to speak and communicate in English.
Exclusion Criteria
• Other palliative care professional. • Non-English speaker. • Palliative care work experience less than 1 year. • Palliative care Physician/Doctor working/residing outside the UK. • No experience of patient death in the hospice setting.

2.6.3 Recruitment

The recruitment of the participants was done by contacting two hospices via email in the Greater London area in the UK. Both hospices showed interest. After the hospices' Ethics Committees approved the study, the recruitment officially started. The two hospices' Medical Directors approached their PCPs and informed them of the voluntary opportunity to participate in this study. Those PCPs interested in the study contacted me directly via email to plan and agree the interview once their eligibility was confirmed. Hence, the participants for this research study were recruited by self-selection and those who fulfilled the inclusion criteria (Table 1) were included in the study. Another recruitment strategy was to post information and a recruitment flyer advertising the study on Twitter (Appendix B). This did not result in any direct contacts. One participant offered to forward information to PCP registrar colleagues via an email distribution list. This snowball strategy resulted in three contacts.

The participants received the Participant Information sheet (Appendix C) by email. The participant information sheet explained the participant criteria, the purpose of the study, confidentiality, anonymity, the voluntary nature of participation, and the opportunity to withdraw even after consent and up to the analysis write-up stage. It also outlined potential benefits and risks of participating in this research. Participants could take their time to make an informed decision. All in all, nine potential research participants contacted me, of which one did not meet the criteria (worked in a hospital), two did not proceed to interview (followed up with email), leaving six research participants who met the inclusion criteria. At a later stage, a third hospice was contacted to try to recruit perhaps two more participants, but no response resulted from this contact. As this time coincided with the early stage of the COVID-19 pandemic, it was agreed with my research supervisor that six participants, who were at that stage already interviewed, was a sufficient number of participants, meeting the IPA criteria of sufficiently rich data, and the suitability of the accounts was confirmed (Willig, 2021). In addition, I reflected with my supervisor that the pandemic context and the pandemic crisis experiences might influence the phenomenon studied, as the six participants were recruited and interviewed in the pre-pandemic era.

2.6.4 Participants

Table 2 presents the participants' pseudonyms, their clinical roles, and the years of experience in palliative care. The participants consisted of five females and one male. Their case descriptions (Appendix D) capture and introduce the participants' personal journeys and work experience in the PC field, and the information they wanted to share about themselves at the start of the interviews allowing rapport to be established. All participants were given a pseudonym. Any possible identifying information has been anonymised throughout the study.

Table 2

Characteristics of Participants and Pseudonyms

Pseudonym	Sex	Clinical Role	Experience in PC (years)
Aanya	Female	Speciality PC Doctor/Registrar	3–4
Harry	Male	Speciality PC Doctor/Registrar	6
Helen	Female	Speciality PC Doctor/Registrar	3
Jeanne	Female	Medical Director/ Consultant Speciality PC Doctor	11
Mary	Female	Consultant Speciality PC Doctor	9
Rachel	Female	Speciality PC Doctor/Registrar	5

2.6.5 Data Collection

2.6.5.1 The interview schedule

The interview schedule (Appendix E) was designed to facilitate a discussion around relevant topics, with possible prompts, and provided a loose agenda for the one-on-one interview, progressing from generic to more specific level, with open-ended questions (Smith et al., 2009). The interview schedule was discussed with the research supervisor for overall suitability, for example, having open and expansive questions, not making assumptions (Smith et al., 2022). The schedule had many questions but these were listed more as options and possibilities for what could be asked around the phenomenon. Hence, the interview schedule provided a guide instead of a script, allowing me to follow participants' priorities and concerns in the participant-led interview (Smith et al., 2022). Smith et al. (2022) mention that sometimes an interview guide is not even necessary, however, as a novice researcher it was helpful to have 'a map' to orient to the topic and hold the space for the participant. In one interview a participant in a senior role had to take/make a couple of calls, and the interview guide helped to keep the frame for the conversation with these interruptions. Recording was paused during the calls.

2.6.5.2 Semi-structured interviews

Semi-structured interviews were conducted to collect data. Data collection methods in IPA can also be focus groups and single case studies (Smith et al., 2022). Collecting data with focus groups might shift the focus more to a group dynamics level (Tomkins & Eatough, 2010). However, my intention was to approach this topic from an idiographic standpoint. One-to-one interviews were also deemed more practical from an organisational perspective, as well as being flexible, so allowing participants to accommodate the interview to their schedule. The interviews took place in participants' preferred locations and time slots: five interviews were conducted in hospices and one in a research institute affiliated with the participant. An informed consent (Appendix F) was obtained from the participants at the start of the interview. I took the time to explain their rights, confidentiality and anonymity, and checked whether they had any questions or concerns before we started. I also explained that the interview could be paused at any time if there was a need for a pause or a wellbeing concern. The interviews lasted approximately 60–90 minutes and were audio-recorded.

Since the aim in IPA is to enter the participant's 'lifeworld' (Smith et al., 2009), it was important to build rapport and to gain the trust of the participant. The data collection event should elicit detailed stories, thoughts and feelings from the participant (Smith et al., 2022, p. 54). Hence, I approached the interview with the aim of engaging in a dialogue with the participant and "…having 'a conversation with a purpose'" (Smith et al., 2022, p. 54). The interview schedule was also devised so that participants could start by sharing their experience to date in PC, proceeding then to broader questions relating to PC context, and continuing with experiences of patients dying, allowing the participant to take the lead in the direction they wanted to go. As I was familiar with the interview schedule content, it allowed me to use the questions flexibly with each participant. There were individual differences between participants, some being more talkative and open, some more reserved, and less expressive. Prompts were used more with some participants than others. The beginning and concluding questions were roughly the same for each person. For example, one of the last questions was: "*Are there any other experiences or thoughts or memories or influences related to what you have shared and what we have discussed that come to your mind that I have not asked you and you would like to share*?". This assisted in covering what felt important but was not touched upon.

After the interviews the participants received a Debrief Letter (Appendix G) that included contacts for support organisations, in addition to the consent form, of which they could keep a copy. The participants had an opportunity to ask questions.

2.6.5.3 Data storage and protection

All necessary steps were taken to protect and store the research data. I used a password-protected audio-recorder and stored the recordings and transcripts during the data analysis in an encrypted folder in a password-protected computer on a fully encrypted hard drive. By removing all identifying details from the interview scripts, and by treating the material sensitively and soundly, and storing the audio-recordings and transcripts safely and responsibly, confidentiality was ensured. After completion of the analysis, the recordings and transcripts will usually be kept for 10 years as per City, University of London's institutional guidelines. The recordings will be deleted, and the transcripts destroyed according to the guidelines.

2.7 Ethical Considerations

Ethical approval (Appendix H) was obtained from City, University of London's Research Ethics Committee (ETH1819-0100) for this research study. Ethical approvals were also granted from the two hospices. The research study project adhered to the guidelines of the British Psychological Society's (BPS) Code of Human Research Ethics (BPS, 2014). All measures were taken to handle the data in accordance with the Code of Ethics and Conduct (BPS, 2021) as well as the GDPR regulations (HRA, 2018).

Ethical considerations have been implemented in various areas and stages of this research study project (BPS, 2014). To protect the participants' anonymity, they were informed and assured that all personal information would remain strictly confidential and anonymous. All steps have been taken to protect participants from being identified or associated with their organisations. Additionally, since participants were reflecting and making sense of their subjective experiences that were often related to their patients, I felt an added responsibility to manage the data related to the deceased patients with respect and integrity. Respect for the dignity of persons and people provides a philosophical foundation for many ethical principles in CP but also across other professional disciplines (BPS, 2021). Participants themselves adhered to their professional code of conduct to protect the patients' privacy, anonymity and confidentiality in the interview situation. My role as a researcher was to make sense of the participants' sense-making about their lived experiences and to be concerned about the meanings rather than the facts or factual information about any person.

Furthermore, having an awareness of power-relation imbalances between the researcher and the participant is an important ethical consideration (Brinkmann & Kvale, 2005). Factors that contribute to the power imbalance can be, for example, that the researcher may have certain competencies that the participant doesn't have, the interviewer initiates the interview and terminates it, and the interviewer asks the questions and the participant's role is to answer (Brinkmann & Kvale, 2005). According to Haverkamp (2005), the goal is to establish trustworthy research relationships. By communicating all the participants' rights in the research study, and the information needed to give informed consent, as well as attempting to conduct the interview in a conversational manner, I aimed to reduce these power dynamic imbalances and to contribute to a trustworthy relationship. Although IPA requires in-depth interviews, it is necessary to consider how much the participant wants to share about their experiences and respect what they want to disclose. I acknowledged that participants' professional roles might inhibit sharing their experiences, feelings and thoughts freely. Additionally, it is important to mention that I entered this research as an outsider to the context. I was no longer in a placement in one of the hospice's bereavement services during the research project.

It was also my responsibility as a researcher to monitor how the interview was affecting the participant. Good research conduct requires also to consider participants' wellbeing (BPS, 2014). As this study investigated mortality-related grief experiences, I was aware and prepared that the participants might experience emotional reactions and potentially distress related to their experiences. I communicated to all the participants that stopping the interview was allowed at any time. There were moments that were moving or emotionally touching for the participant but none of the participants needed a break or additional support during the interview. I checked whether the participants needed a break or had any other wishes so that they could communicate their needs. I respected the boundaries that my role in the interview was being there as a researcher and not as a CoPT. However, I used my presence, body language, active listening skills and verbal communication skills in the interview situation to build trust and rapport, which are skills that I have acquired as a CoPT and which might have benefitted the interview situations.

Options for further support after the interview were discussed with each participant. None of them expressed a need for such support. Instead, the conversations indicated that all participants left the interview perhaps having gained something from the opportunity to reflect and talk about their experiences. Thus, as well as assessing the risk, it is valuable to consider that engaging in an in-depth interview process can be affirming and even transformational (Finlay, 2015, p. 172).

The ethical responsibility to take care of myself was also a consideration. I was aware that my research supervisor was available and responsive if I had any concerns, as well as that the opportunity to use personal therapy existed.

2.8 Dissemination

Upon the completion of the thesis, research participants are given access to a summary of the study. In addition, they will have access to the full doctoral thesis via City, University of London's website. The two hospice organisations will receive a report of the findings. The findings can be also presented in another form if preferred. Furthermore, since the broad professional audience for this study can include counselling psychologists, palliative care professionals and medical doctors, the findings from the research study can be disseminated in various publications that may include academic journals in the field of Counselling Psychology, Palliative Care, Death Studies/Thanatology, and Medical Education.

As part of my professional identity development and growth I have come to realise and appreciate that sharing knowledge and contributing to societal discussions is not only of personal value, but also an ethical consideration for CoPs to promote the profession and benefit society (Hanley, 2016). Thus, there are numerous opportunities and avenues for CoPs to disseminate their work (Hanley, 2016). Presenting in conferences can also be an outlet to share findings and to contribute to the general discussion about grief and loss, death and dying, and emotional wellbeing of physicians/medical doctors both at a national and at an international level.

2.9 Reflexivity

Qualitative methodologies emphasise reflexivity and all qualitative methodologies recognise that the researcher is involved in the research process (Finlay & Gough, 2003). Finlay & Gough (2003) state that in order to contribute to the integrity and trustworthiness of the research study, researchers need to be able to identify and reflect upon their own experiences and assumptions when they are engaging with research participants' experiences (Larkin & Thompson, 2012). Being reflexive when conducting qualitative research means that the researcher applies self-awareness and acknowledges the impact of the researcher in the research throughout the process (Finlay & Gough, 2003; Willig 2021). Epistemological and personal reflexivity are central elements of IPA research (Willig, 2021). I have attempted to discuss and reflect on the methodological reflexivity throughout the thesis. Empirical reflexivity, which mainly concerns the interpretations in data analysis, is discussed in Section 2.11. My personal reflexivity, discussed in Section 2.9.2 below, reflects my values, motivations and reactions needed to consider the impact of my perspectives in this research (Finlay, 2015).

2.9.2 Personal Reflexivity

My personal interest in this topic has evolved through various experiences. Although the rationale to conduct this research is embedded in the literature, the interest in understanding more of this grief phenomenon grew alongside personal experiences. Understanding a variety of human experiences across the lifespan has been a core value for me in becoming a Counselling Psychologist.

As a first year CoPT I gained experience in offering psychological therapy and bereavement counselling in a hospice bereavement service supporting bereaved family members of deceased patients. I was not working with dying patients in the hospice. Thus, there were things that I didn't know, see, or experience, but I kept thinking, what is it like to work as a doctor in this hospice context? Do they grieve? What are their grief experiences like? What is it like to deal with death and dying, and loss and grief every day? As Kasket (2011) states, "…professional doctorate aims to address real-world challenges and issues encountered in the field" (p. 4). The need for greater knowledge of this area became apparent as I then later also worked in a hospital staff counselling service supporting healthcare professionals with their psychological wellbeing. Later, I also gained experience in supporting clients and patients with long-term physical health conditions in a specialist secondary care service, witnessing the experiences of patients. Hence, the importance of holding the complexities of coping with grief, loss, distress, but also connecting with hope, resiliency, purpose and strength became evident, whether it was the patients or healthcare professionals as my clients.

I am aware that I have some foreknowledge of the phenomenon, both practical but also theoretical, and I recognise that my conceptualisation of the phenomena will be also influenced by my personal experiences of loss and grief, in addition to general knowledge of the field and public discourses (Haverkamp & Young, 2007). Using self-reflection throughout the research process has helped to understand how my personal experiences, beliefs and values may impact the research, and how the research equally may impact me as an individual and professional. It is recognised that attempting to minimise the impact of researcher biases by being open about them is an ongoing process throughout the study (Larkin & Thompson, 2012). For example, this was particularly relevant during the COVID-19 pandemic and working with my analysis. As a researcher of grief experiences, I experienced being part of a collective sorrow and the variety of losses many experienced, for example, loss of employment, loss of sense of safety, free movement and loss of loved ones. I noticed myself being in a parallel process with some of the research participants, needing to separate feelings and sensations: "this is her grief, not mine", when engaging with deep and heavy analytic work on the transcripts. Research journal and research supervision have been key in this learning process for me as a novice researcher to deal with my assumptions and observations, highlighting the impossibility of holding a neutral stance.

Therefore, not what I know, but rather how I use the knowledge will matter in this research study, since it is acknowledged that it is impossible to approach a research topic without existing beliefs and assumptions (Haverkamp & Young, 2007). I am also 'a person-in-context', and it is recognised that I can never fully escape 'the preconceptions' (Larkin et al., 2006). In addition, during the research project, I unexpectedly had my subjective experience of becoming a patient myself, adding another lens to how I may reflect and interpret the world around me. As a middle-aged parent, I am also aware of the limitations of a human lifespan.

Lastly, I recognise that there is a desire in me as a CoPT to contribute to wider society in normalising human experiences, often complex and multifaceted, and which are mostly normal responses to sometimes abnormal circumstances.

2.10 Analytic Strategy and Processes

2.10.1 Analytic Strategy

The interview transcripts were analysed using an IPA approach. IPA itself can be understood as a stance or a perspective rather than as a distinct method (Larkin et al., 2006). The analytic focus in IPA is directed towards understanding how participants make sense of their experiences and the meanings related to these experiences (Smith et al., 2009). Although there is no single method and IPA allows flexibility and innovation in the analytic strategy, for practical reasons I adopted Smith et al.'s (2009, 2022) guidelines for 'doing' analysis. Their general principles and steps in the analytic process provided a sense of manageability in a process that is inevitably demanding, non-linear and complex.

The first step of the analysis was transcription of the interviews. The process of transcribing involved paying attention not only to words but also, for example, to pauses and chuckles, etc. These I have indicated as three dots for pauses… and used parentheses indicating, for example, laughter [chuckle]. The process of analytic coding of the transcripts started with reading and re-reading the first case as a first step (Smith et al., 2022). Listening to the audio-recordings provided a first opportunity to note down and bracket some reflections and observations. For example, I was surprised by the sense of some participants not knowing how to grieve and noticing having assumptions that participants 'should' know how to do this. Immersing oneself in the data required both listening to the interview to notice different nuances as well as engaging with a detailed reading of the data. The initial, line-by-line noting was the most detailed and time-consuming phase. There are multiple ways of engaging with this, but I adopted Smith et al.'s (2009) process of noting a) descriptive comments, i.e., description of the content; b) linguistic comments, i.e., specific language and/or metaphors used; and c) conceptual comments, i.e., engaging at a more interrogative and conceptual level. These ways of coding and engaging with the data helped to attend at a very detailed level to the participant data. It also helped to shift between different analytic perspectives on the data. I documented this process by creating different columns next to the transcription for the notation in a Word document (Appendix I).

The analytic focus is on attempting to enter the participant's world, and beginning to understand in what ways the participant talks about and understands the phenomenon, identifying similarities, differences, echoes and contradictions within the account (Smith et al., 2009). Close reading and exploratory noting focused on what is it *like* for the participant. Alongside this, more interpretative noting started to develop, engaging me with more hermeneutic and reflective work (Smith et al., 2022). Moving between the part and the whole, as part of the hermeneutic cycle, meant that the interpretations could move away from the original text, but they needed to always arise from the participant's words. This exploratory noting for the first case was reviewed with my supervisor to ensure sufficient details were included.

The next step was the consolidation of the first participant's data set consisting of the transcript and the layers of notes. By constructing Experiential Statements, that related directly to participant's experiences of the data set, the analytic shift moved to primarily working with the most important features of the exploratory notes (Smith et al., 2022). These Experiential Statement summaries are expressed in phrases that speak to the experiential core, reflecting the participant's words, thoughts, and also the researcher's interpretation (Smith et al., 2022). Next, I printed and cut the Experiential Statements, and spread them on the floor to form and cluster Personal Experiential Themes (PETs) (Smith & Nizza, 2022; Smith et al., 2022). The bird's-eye view helped to get a sense of the whole data set when shifting the pieces of paper around on the floor. I looked for patterns, similarities and connections between the Experiential Statements, and seeing which statements were "…acting as a magnet pulling other statements toward" each other to form clusters (Smith & Nizza, 2022, p. 49). Each of the clusters, PETs, was given a title to reflect its characteristics (Smith et al., 2022), for example, "Aanya's grief tied to a professional boundary holding her back", and so creating a table of PETs for the participant (Appendix J). These described steps: initial reading, writing exploratory notes, constructing Experiential Statements, clustering the statements, and developing PETs were then repeated for each transcript and each participant's case, and hence, each participant's data was thought about in its own terms (Appendix K) (Smith et al., 2022).

The next step in the analysis was then to work with all participants' PETs to develop Group Experiential Themes (GETs). Developing the GETs, the higher-order group themes, meant that these themes needed to demonstrate a shared quality that also included the unique individual experiences. Since using the bird's-eye view strategy was so helpful, I applied it to developing GETs as well. The purpose was to look for "…convergences and divergences at the highest level of organisation from the previous analytic stages" (Smith et al., 2022, p. 100). This dynamic process of comparing different PETs across the participants to look for commonalities, tensions and divergences resulted in a first draft of higher order clusters. Then I moved to working digitally with clustering the PETs to GETs. Case-level notes and Experiential Statements, in addition to PETs, were also involved to ground the GETs to participants' experiences. Eventually a whole table of GETs formed with subthemes (Appendix L). The GETs were named to reflect the shared quality of the participants' experiences. This 'gestalt' of themes also illustrated the relationships between the themes and how some themes, for example, 'GET4: A Process of learning to relate to grief' overlapped with other GETs. Some participants had experienced their first patient deaths early in their careers, and these PETs were not included since the experiences took place in contexts other than hospice ones. The draft of the diagrammatical representation of Group Experiential Themes (GETs) and subthemes representing the interrelationship of the GETs was discussed with my research supervisor before the write-up stage of the analysis began.

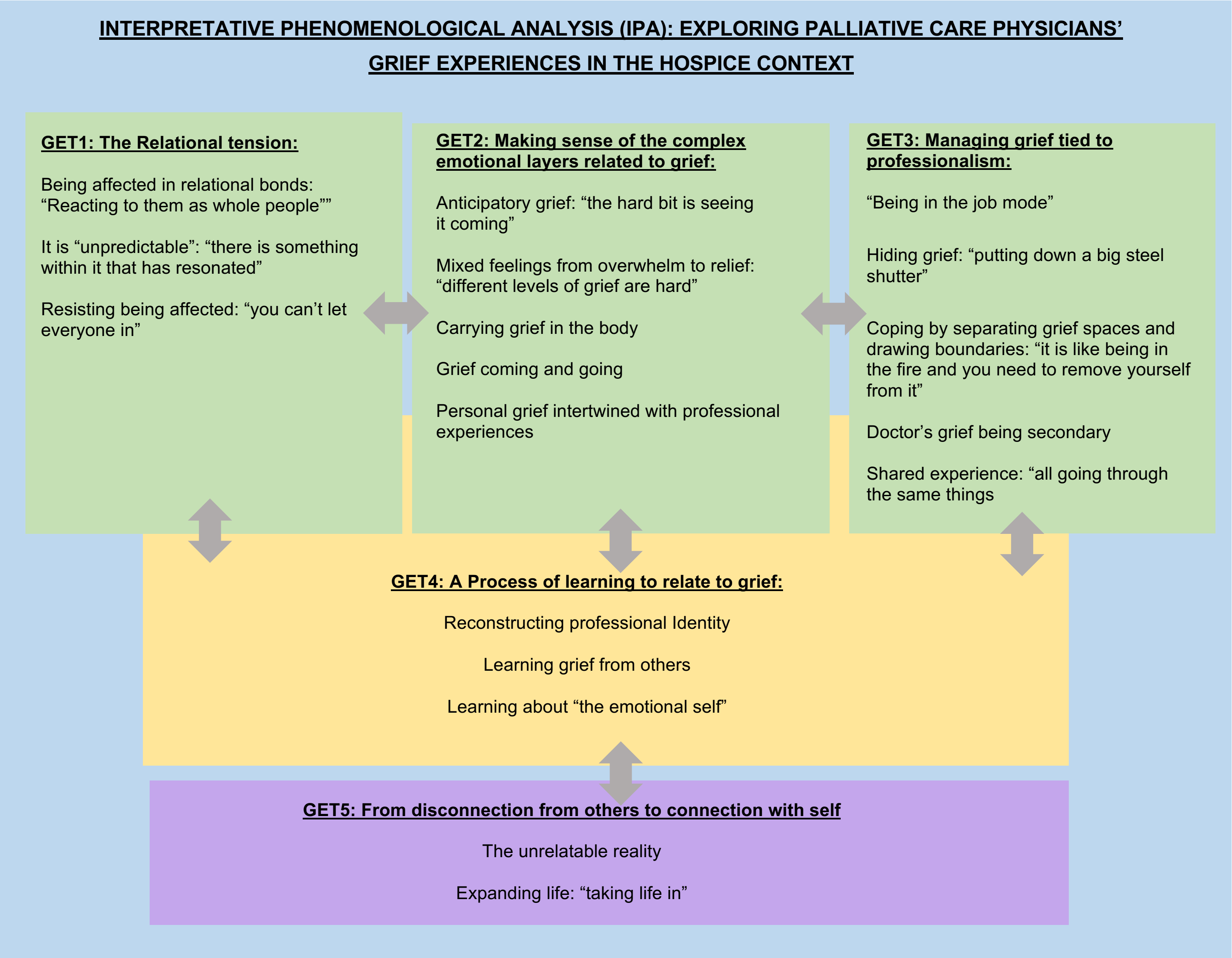
2.11 Empirical Reflexivity

In this section I mainly reflect on the interpretative aspect of IPA and the epistemological implications for the research. The richness of qualitative data offers various possibilities for an entry into the hermeneutic circle, as was the case with this data set (Larkin et al., 2006). It was a challenging task to have the responsibility as a researcher of constructing interpretations that are grounded in the participants' accounts when at the same time the interpretative layers offer multiple options of what kind of knowledge and understanding can be produced. The aim is to develop meaningful and diverse insights (Willig, 2021). I used different levels of interpretation by applying a 'hermeneutics of suspicion' and a 'hermeneutics of empathy' – terms originally coined by Ricoeur (1970). Larkin and Thompson (2011) talks about balancing these two standpoints as a *both/and* approach, assuming both an empathic stance and *what is it like* to be the participant, and attempting to be critical of *what appears to be* the case. Hence, the analytic phase was at times overwhelming but adopting these different lenses also helped to turn away from facts (what) towards meanings (how) (Eatough & Shaw, 2019). As part of the hermeneutic cycle, my position shifted from descriptive to interpretative, trying to stay close to participants' voices, and from feeling as if everything is important to leaning more towards meaning making and interpretative position. Applying multiple perspectives of interpretation eventually supported in illuminating the phenomena. The suspicious lens offered perspective too, for example, in interpreting the meaning of systemic and wider societal influences on the participants' experiences. Similarly, utilising the experiential features of the life-world lens for interpretation that include embodiment, temporality, relationality and spatiality (van Manen, 1990) also enabled me to move to more layered interpretations (Eatough & Tomkins, 2022). To conclude, this analytic process brought to live the importance of CoPs needing to develop the professional skill to tolerate uncertainty, ambiguity and to remain open and receptive to the phenomena, applicable both in clinical work and research endeavours (Kasket, 2011).

3. ANALYSIS

3.1 Overview

This analysis chapter presents five Group Experiential Themes (GETS) and 18 subthemes developed from six semi-structured interviews to explore and make sense of the palliative care physician's lived experiences of grief in the hospice context.



INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS (IPA): EXPLORING PALLIATIVE CARE PHYSICIANS' GRIEF EXPERIENCES IN THE HOSPICE CONTEXT

GET1: The Relational tension:

Being affected in relational bonds: "Reacting to them as whole people""

It is "unpredictable": "there is something within it that has resonated"

Resisting being affected: "you can't let everyone in"

GET2: Making sense of the complex emotional layers related to grief:

Anticipatory grief: "the hard bit is seeing it coming"

Mixed feelings from overwhelm to relief: "different levels of grief are hard"

Carrying grief in the body

Grief coming and going

Personal grief intertwined with professional experiences

GET3: Managing grief tied to professionalism:

"Being in the job mode"

Hiding grief: "putting down a big steel shutter"

Coping by separating grief spaces and drawing boundaries: "it is like being in the fire and you need to remove yourself from it"

Doctor's grief being secondary

Shared experience: "all going through the same things

GET4: A Process of learning to relate to grief:

Reconstructing professional Identity

Learning grief from others

Learning about "the emotional self"

GET5: From disconnection from others to connection with self

The unrelatable reality

Expanding life: "taking life in"

Figure 1: Diagrammatical representation of Group Experiential Themes (GETs) and Subthemes representing the interrelationship of the GETs.

Following the IPA analytic process, the GETs were developed to illustrate and present the instances from the individual participants, and to tell their story about the understanding of their experiences at the group level (Smith et al., 2022). According to Smith et al., (2022) the main organising principle in the table of GETs is to show convergence and high-level connectivity between the participants' experiences and within them, to demonstrate unique and individual ways in which participants are reflecting that shared quality.

It is important to point out that these GET themes are not entirely discrete and may often overlap and intertwine. For example, the GET4 theme: 'The process of learning to relate to grief' comes through and is intertwined with other GETs. I have attempted to derive the theme labels from participants' actual words, corresponding to their lived experiences and meaning making, which is consistent with the ethos of IPA. When composing the themes, I have attempted to show the interconnections and tensions within the themes and between them. These higher order GETs comprise subthemes that are not all applicable to all participants (Appendix L) but provide breadth and depth of participants' worlds and their experiences related to grief in the hospice context.

Each theme aims to move between general thematic description, participant quotes, and interpretation so as to present the IPA analytical results and to tell the participants' stories (Smith et al., 2022).

The Discussion chapter will examine the relationship between the analytical material and existing research literature and the theoretical understandings introduced in the Introduction.

3.2 The Relational Tension

The first Group Experiential Theme (GET) covers how across all the interviews there appears to be a sense of relational tension between being emotionally affected due to knowing the patients more deeply in a caring context that supports relating to the patients more than as objects of care, and at the same time, when establishing attachments, holding the distancing reality that the patient will die. All participants make sense of dealing with the reality that it is unpredictable in terms of which patient, attachment or relational circumstance will elicit grief. Analysis also reveals the participants' awareness of needing to resist or regulate their attachments with the patients to not get emotionally invested with everyone.

3.2.1 Being Affected in Relational Bonds: *"Reacting to them as whole people"*

This subtheme encapsulates what comes across in all the interviews: that the patients are related to as individuals, instead of as objects of care, which seems to make it then harder for the doctor when the patients die.

The participants' meaning making reveals that the context of the hospice as a professional setting seems to have family-like qualities that support connecting with patients more deeply. For example, in the excerpt below Helen uses the image of "family atmosphere", suggesting that the relationships and the relational dynamics in the hospice context are experienced within a unique culture that feels like "a family":

> *"I think hospice as a whole has a much more kind of homely feel about it […] 'try not to look medical at all'." Helen, p. 5–6, l. 107–116*
>
> *"So, much more kind of family atmosphere." Helen, p. 6, l. 118–119*

As a comparison, Helen shares below her experience in a larger hospice setting that was not conducive for grief. It seems that due to it being a larger organisation, with attendant institutional factors, she was not able to develop emotional bonds with patients. This suggests that grief could be escapable and even avoided in some hospice settings. Helen's lack of 'transference', such as movement of feelings or connection, also implies emotional detachment and disconnection from grief experiences. Helen's sense-making below suggests that the experienced attachment proximity in a professional care relationship is meaningful for her, and even desired, as she seems to be longing for these experiences:

> *"But when I think about kind of patients and grief that have really got to me, it's – there isn't really anyone in this last year… that I've felt, er, as sort of a transference as it were with, whereas I can, you know, remember vividly patients from… my first hospice role because… they stayed with us for so much longer. It was a very small hospice." Helen, p. 7, l. 132–153*

Experiences of holistic and family-like involvement in the patient's care seem to shift the assumptions of professional distance and the barriers of emotional involvement of doctors. Helen's and Harry's experiences imply that the family-like events, e.g., a wedding, the birth of a baby, are intrinsic in hospice care, strengthening attachment rather than detachment. For example, in Helen's wedding ceremony memory, the possible imbalance of power between doctor and patient seems diluted:

> *"but we had a huge ceremony that all the staff attended […] And it was an amazing experience to watch her walk down the aisle. It's probably one of the last times she walked." Helen, p. 9, l. 201–209*

Harry's reflections resonate with Helen's experiences that looking after patients becomes more meaningful when professional distance is weakened, and the patients are humanised:

> *"And in the end, they, um. I think the wife had a C-section early … so that at least he could hold the baby. And then he died. And then. Yeah. That really gets you." Harry, p. 15, l. 271–282*

The broader analysis indicates that participants are grieving the loss of patients and loss of relationships with them, having connected with the patients' humanness. Rachel's and Helen's excerpts below illustrate that patients gain access to their internal world causing an affect, despite the metaphoric boundary of skin as a protective membrane, when feeling the relational connection and being connected to the permeable shared humanness:

> *"I think because of …The time that we spent with them and it being a very small unit, we formed… attachments… a lot quicker, a lot deeper than I ever have since. Not that I haven't been with patients that I have been very involved with but just the ones that 'get under your skin'." Helen, p.14, l. 306–314*
>
> *"But then I think it's when you feel a piece of their humanity and that kind of gets in." Rachel, p. 16, l. 304–308*

The theme of having the time and space to get to know the patients more deeply and on a personal level seems to appear in the analysis in various accounts. For example, Helen and Jeanne grieve patients that they connected with over time as they share being affected by the patient deaths:

> *"And she must have stayed with us about three, three months […] So, I saw her every day, saw her family every day […] And we had a sort of a connection." Helen, p. 8, l. 182–191*
>
> *"I knew her for quite a long time. I saw her as an outpatient for probably 18 or 19 months and then she deteriorated, and she came into the inpatient unit and she died here. Erm, and again her, her death affected me." Jeanne p. 11, l. 192–200*

Rachel's excerpt below echoes with the above experiences and resonates with the idea of family-like relationships with patients because doctors have the opportunity, space and time, to develop deeper attachments with patients:

> *"maybe because we know our patients so much more deeply than I would have done in orthopaedics. Erm. So yeah. We are reacting to them as whole people." Rachel, p. 89, l. 1783–1787*

Her statement of "reacting to them as whole people" seems to capture some kind of essence of this theme. It could be suggested that Rachel's sense-making encapsulates two interpretations. The participants are grieved as "whole people", not only as patients, and it can be implied from the overall analysis that doctors themselves are also reacting to the losses as "whole people", i.e., grieving patients both as professionals and as human beings due to developing attachments with patients and then losing them. For example, in Jeanne's case the connection is experienced as so real that there appears to be a fantasy of a potential friendship:

> *"What was difficult was that if I had met her in a different setting not in sort of professional situation, I think I would have really liked her, there would have been potential for us to be friends and so…I think that made it very difficult situation." Jeanne, p. 9, l. 156–163*

The absence of the patient is tangible, and Jeanne seems to be grieving the loss of the patient's embodied presence and their relationship:

> *"it was just sadness that she had been there and then she wasn't there anymore." Jeanne, p. 13, l. 244*

To conclude, as can be implied from the participants' accounts, and from Jeanne's sense-making below, the emotional impact of developing and losing relational attachments seems to then be experienced as "harder" and grief-inducing:

> "*And so, when they die, that is hard, that it is harder." Jeanne, p. 15, l. 273–276*

3.2.2 It is ***"Unpredictable"*****:** ***"there is something within it that has resonated"***

The theme of the 'unpredictability' of experiencing grief, in relation to which patients, attachments or circumstances elicit grief responses, emerges from the accounts of all participants.

Aanya's sense-making suggests that an attitude of tolerating the inevitable uncertainty of being emotionally affected is needed. It seems that she is looking for some logic, "you can't predict it", as if to prepare, but the lack of it, instead, seems to be an integral aspect of her experience of grief in the hospice context. Aanya's deep *[sigh]* implies that not knowing what emotional states the trigger releases can feel hard and heavy, even a disturbance.

> *"I realise that [sigh] you can't predict the patient that would trigger something for you. And everyone has their own personal triggers. And what will affect one person… won't affect me and vice versa." Aanya, p. 105, l. 1761–1766*
>
> *"So, I think I've realised there isn't necessarily a pattern." Aanya, p. 107, l. 1800–1801*

There is a sense of unpreparedness within this theme that comes across, as participants need to deal with the losses and the sadness. Rachel and Helen seem surprised that patients who affected them profoundly were very different from them:

> *“But in some ways she was very different to me. She lived a different life. She was, erm, she was gay. I'm not. She was an author. She lived a very creative life, just completely different life to me.” Rachel, p. 10, l. 171–180*
>
> *“a young girl that was my age. Erm, very kind of different background. She came from ‘a travelling family’. She'd spent some time in prison […].” Helen, p. 7, l. 159–163*

Mary’s excerpts imply her learning to relate to her grief as “a surprise” (*p. 61, l. 1259–1261*) and as “it's just unexpected” (*p. 59, l. 1211–1222*), but also as an enigma “it's not always what you think it's going to make, elicit that response from me” (*p. 21, l. 430–434*). As for Mary, sadness seems to be experienced without there necessarily being any underlying triggers:

> *"for whatever reason. That person made you sad.” Mary, p. 61, l. 1239–1257*

Additionally, her account conveys that the experience seems puzzling and not easily articulated as to who or what type of patient can elicit grief responses in her. However, her statement: “there is something within it that has resonated” seems to refer to something existing that has personal meaning, and which can’t be clearly defined:

> *“The people who stick with you are... the people who you either become more emotionally attached to or… it is…traumatic…there is something within it that has resonated…or been particularly difficult.” Mary, p. 6, l. 101–109*

Contrary to others, Jeanne carefully expresses ‘surprise’ in her active sense-making from a divergent view. Her ‘surprise’ is rooted in ‘the fact’ that she is not affected by patient deaths more often. Her careful commentary could imply that there is a worry of judgement if she doesn’t experience grief so often, as she chooses to explain and make sense of differences in the emotional impact according to the seniority of roles.

> *“Sometimes I am surprised about…more deaths don’t affect me [saying this very carefully]. […] I don’t know…the more senior you get the less you have very close links with the patient.” Jeanne, p. 70, l. 1012–1013*

Harry’s experience with regard to the theme ‘unpredictable’ resonates with Jeanne’s. The unpredictability of seeing the actual physical dying event, the event that on the one hand is ‘predictable’ in this lifeworld and on the other seems still like an unusual occasion. He reveals that doctors don’t see it that often and shares in two parts of the interview that one of the few occasions that elicit grief responses for him – “make[s] him cry at work” – is “when you see actually someone die” (*p. 26, l. 482–490)*.

> *“physically dying in front of you and you are there when they take their final breath. And that moment is so… it’s sort of the most important moment, you know? […] And … that’s very emotional.” Harry, p. 27, l. p. 494–502*

Like other participants in the analysis, he attempts to make sense of the reasons for strong emotional resonance and being affected by the death of a patient. Harry appears to conclude that “maybe it’s not a logical thing. It’s just the emotional thing, actually” (*p. 28, 511–516)*.

3.2.3 Resisting Being Affected: *“you can’t let everyone in”*

Across all interviews, a thematic pattern arises from the analysis of participants needing to resist or regulate their attachments and relational involvement with patients.

Previously we saw Helen finding developing closer attachments with patients meaningful and desired. However, Helen is experiencing some level of resistance or questioning by her social realm as “some people” find this experience unrelatable and unimaginable. Equally, it seems that this is something she has tried to make sense of herself too:

> *“Well, I mean, I think… all the patients that ‘get under your skin’ are the ones that really made me know… that this is the right thing. And I, know some people say, well, how can you deal with that pain that you feel each time you get close to someone and, and then, then they die? And it is painful at the time. But I think that’s also part of the reason… Why I like it, because it’s… that’s human.” Helen, p. 18, l. 373–383*

Her question seems to encapsulate some of the essences of this analysis about grief experiences. There seems to be tension in holding the duality of 1) “getting close” to patients as a professional and being likelier to experience grief; and 2) a conscious resistance or regulation happening in not getting close to everyone:

> *“You know, you can't let everyone in. And, and, I realise you'd, you'd be in tears all the time [laughing/chuckle] if that were the case. But I mean, I am… in day-to-day life there are people that you like and people you don't like, but you have to treat them all… er, equally.” Helen, p. 19, l. 402–410*

The emotional consequence of “letting everyone in”, which perhaps means integrating and letting all patients matter to her, suggests that Helen’s grieving could potentially not be manageable. Her chuckle after she describes the possibly uncontrollable scenario indicates that this is an image of a doctor who almost feels more ‘unrealistic’ than ‘funny’. It seems as if there is a professional imperative to be composed and in control of her emotions. Equally, as can be implied from her sense of responsibility to provide equal care, a doctor “being in tears all the time” could not look after the patients and would be disruptive.

Both Mary and Helen emphasise “needing to be aware” of their own emotional responses to patients due to a sense of responsibility to treat everyone equally, implying the need to be equally attached or detached to patients. Their excerpts seem to convey that “showing emotions” and grieving more deeply for some patients and not so much for others could imply inequal treatment, which could be considered unprofessional.

> *“You have to be…aware of what you're feeling in a re-, response to human being so it's easy to spend hours with the nice little old lady who makes you laugh and is terribly grateful for everything you do. But you might want to spend five seconds with this nasty, smelly, grumpy old man. Erm. Well, actually, they both, those people are just as part of your care.” Mary, p. 48, l. 973–991*

The resistance to being affected by and to grieving for patients also implies having a protective, self-preserving function. Rachel’s image below, “you’d end up just in a cooler…rocking in a corner [a nervous chuckle]”, illustrates a potential scenario that conveys fear of not being able to cope, and suggests that the potential consequences of *not* resisting or regulating how the patients affect her could be very disruptive, even dangerous to her wellbeing.

> *“Whereas a lot of the time, I suppose, under skimming the surface of all these things, because you couldn’t do this for every single patient, you’d end up just in a cooler … rocking in a corner [a nervous chuckle], so yeah.” Rachel, p. 23–24, l. 424–436*

Jeanne’s account conveys her becoming more conscious: “I have to be more aware of this” (*p. 18, l. 330–339)*. This illustrates the need to regulate or resist developing emotions towards patients after being massively impacted by a death of a patient that mattered to her. Jeanne’s reference to ‘subconscious learning’ seems to indicate that some part of her is now ‘holding back’ so as not to get too close to patients. Jeanne also recognises that there is an aspect of self-protection going on: “I can’t stop having it again” (*p. 18, l. 330–339*):

> *“whether I almost subconsciously I’d learn from (patient A) that there was a part of me that I couldn’t let her affect, because, because, (patient A) definitely affected me so much.” Jeanne, p. 20, l. 353–357*

Mary brings into this theme a ‘rationalist’ approach conveying that she aims to approach patient relationships “logically” and “practically” (*Mary, p. 15–16, l. 304–320)*. This illustrates an attempt to hold both a self-preserving strategy and being equally attached and/or detached to patients. By applying a rational approach Mary seems to have more of a sense of control in regulating her emotional attachments:

> *"My job…demands that, erm, I am… that you have to balance your personal relationship with each human being with the need to think about that situation logically… and practically." Mary, p. 15, l. 299–304*

3.3 Making Sense of the Complex Emotional Layers Related to Grief

This Group Experiential Theme illustrates the complexity of feelings related to grief experiences that are evoked from looking after the patients as well as dealing with the relatives and families. The analysis of participants' experiences reveals that grief in the hospice context seems to contain many types of responses that are woven into the many layers of the participant's lifeworld.

3.3.1 Anticipatory Grief: *"The hard bit is seeing it coming"*

As can be implied from the accounts of Harry, Jeanne, Rachel and Aanya, the doctors seem to be holding an anticipatory tension: a process like a journey that can't be stopped but needs to be travelled with the patient. The expression of "you sort of see it coming and the hard bit is seeing it coming" (*Harry*, *p. 6, l. 99–109*) encapsulates the anticipatory grieving being like a temporally extended process, rather than an emotion, where the grief seems omnipresent.

The theme of anticipatory grief is described as 'being on a journey' by Aanya. Her account suggests that she is accompanying the patients in their grief and grieving with them "with the patients, on their journey" *(p. 32, l. 444–448)* and the anticipatory grief ends with the death*:*

> *"So, yes, it's, I feel like I grieve with them on their journey and not…Not so much after [big sigh/sigh of relief], although I do remember them." Aanya, p. 37, l. 520–524*

'Hard conversations' arise as part of this grieving phase. Aanya and Rachel express the difficulty and sadness of needing to communicate to the patients and to face the reality that "this is the start of you dying", implying that this is some kind of start of their grieving as well:

> *"I think I recognise, I do recognise [chuckle] that a lot of the time it is really sad what we're doing and having to have that conversation with someone about 'Yes, you are dying. This is the start of you dying'. And it's really, really sad, at times, to say that." Rachel, p. 60, l. 1169–1193*

Rachel's account further conveys that the sadness seems unavoidable: "there is no two ways of that really" *(p. 61, l. 1195–1211)*, but also that having the difficult conversations feels uncomfortable and even unreal: “it is funny, I have never … thought in my previous life that anyone needed it, that I will be talking to patients about how they’re going to die” (*p. 61, l. 1195–1211).* Despite these challenging tasks, the personal meaning of these discussions seems to include personal satisfaction at being able to accompany this grief phase: “in a funny way enjoy doing them. And I’m trying to do well. […] So, I do feel quite satisfied… doing that.” *(p. 65–66, l. 1278–1290).*

Harry and Jeanne express a sense of frustration when the patient “is not accepting” their dying. Their experiences of the anticipatory tension are expressed as feeling “torn” (*Jeanne, p. 12, l. 227–232)* and “being pulled at the heartstrings” (*Harry, p. 4, l. 64–84)*, implying very visceral and embodied experiences:

> *“And there’s lots of tension between him, erm…wanting to seek treatment, but also recognising that he’s approaching the end. And it kind of really pulls at the heartstrings when you see somebody wasting really their last time…last weeks.” Harry, p. 4., l. 64–84*

Harry expresses on three occasions the anticipatory grief being the most difficult part, “the hard bit” *(p. 6, l. 99–109)* for him as a palliative care physician and experiencing grief at work. It seems that holding “the tension of knowing” that the patient will die and balancing the sometimes one-sided acknowledgement of the reality of “how things are gonna go” feels heavy and powerless – “you’re are still worried” – and helpless – “the hard bit is seeing it coming” *(Harry, p. 6, l. 99–109).* The excerpt below illustrates this tension being experienced as harder than the grieving afterwards:

> *“But the, the hard bit is knowing what’s gonna happen. And I think the tension between… what I know and what they know. Especially when somebody…is… perhaps… denying… that their time or knows that they’re dying but is doing things that one should not be doing when one’s dying [chuckling/laughing] […] But equally, it … erm, that tension is quite hard. And just knowing how things are gonna go…rather than the… the actual grieving afterwards.” Harry, p. 8, l. 141–153*

The anticipatory tension and grieving is ‘expected’ to end when the patient dies. Jeanne expects relief, echoing Harry’s experiences, but realises that sometimes there isn’t relief because, truthfully speaking, she is not accepting the dying:

> *“there wasn’t that sense of relief and, also so I think they are the patients that I actually didn’t want them to die.” Jeanne, p. 7, l. 126–131*
>
> *“So, which is quite hard because all of our patients are dying.” Jeanne, p. 8, l. 132–133*

3.3.2 Mixed Feelings from Overwhelm to Relief: *"Different levels of grief hard"*

This subtheme captures the mixed emotions that most of the participants experienced in response to patient deaths, conveying that different dimensions of grief exist in their stories.

A general sadness seems to be present overall in participants' experiences. As one of the senior doctors, Mary's grief responses seem to be more restrained and expressed in a controlled way, to the extent that "traditional grief reactions", implying generally accepted reactions, seem to occur less often *(p. 22, l. 447–449):*

> *"I don't think I that I, other than tears or teary and feeling sad. I don't, I am not of those people that runs outside and throws up or erm does, er, anything more extreme than that so." Mary, p. 59, l. 1224–1229*

Helen's excerpts illustrate the theme of mixed emotional reactions and internal experiences. She reflects that "even an expected death" can be upsetting and evoke feelings of "shock":

> *"and a big red box comes up that says 'patient RIP'. And I guess, so there will be at that moment kind of a… a little bit of…shock, even if it is expected. Erm." Helen, p. 42, l. 791–803*

Helen's many questions seem to refer to an internal questioning that is occurring, suggesting also that she is dealing with feelings of doubt and guilt when reading final entries of "patient RIP", in addition to experiencing a deep sense of responsibility about the patient's wellbeing when they die:

> *"Was anyone there? Was it peaceful? Were they alone?" Helen, p. 43, l. 805–819*
>
> *"Did I miss something? Was it something I did… or didn't do? […] But … there's always that doubt, I think that there is something that a mixed… feeling of responsibility. I guess." Helen, p. 41, l .842–861*

Helen's self-doubt, questioning, and her upset state of mind seem to be short-lived, restrained and suppressed due to the constraints of work duties, and her need to orient to the professional formalities of paperwork and responsibilities:

> *"And, I don't think I feel very much anymore when I'm, I'm doing that. That's, you know, a formality." Helen, p. 41, l. 821–829*

As the previous subtheme suggests, themes relating to experiences of relief are present in the analysis. For example, Harry describes sometimes feeling an aspect of relief in relation to patients dying. However, the relief seems to be mixed with suffering and pain, leaving a lingering feeling of unfairness:

> *"So, I think an aspect of it is relief. But there's also sometimes, you know, there is that why did this happen to that person?" Harry, p. 15, l. 268–271*

Ambivalence is present in Harry's and Rachel's reflections, conveying a sense of "feeling that feeling of oddness" (*Harry*, *p. 13, l. 238–244)* and confusion about an appropriate response to patient death:

> *"I think I just couldn't shake him off. That sounds really strange. So, it wasn't a grief process. I don't know what it was. I guess it was just getting him out from my system. And I wasn't happy that had died. But I was relieved, in a way, that I didn't have to be involved in with him anymore. And I think I felt really guilty for feeling like that. Erm. That was really strange." Rachel, p. 86, l. 1713–1717*

Rachel's sense of guilt at being alive and the sense of unfairness also indicate experiences of moral distress and frustration, mixed with Helen's feelings of "peacefulness" related to "the best death she could have gotten" (*p. 13, l. 257–267*). These are also part of the layered and multifaceted grief responses when participants speak about grieving for younger female patients who die:

> *"It sounds really silly, we had another young lady who had the same pyjama trousers that I had at home [laughing] and after she died, I couldn't wear her pyjama trousers, my pyjama trousers, that were the same as hers, because I just felt guilty that I was still, I was actually older than her, I was still alive. Erm." Rachel, p. 29, l. 551–561*
>
> *"I guess the overwhelming sense was that it just wasn't, it's not fair. This woman was 33, to be dying. Erm. But also, it was also very peaceful and very beautiful." Helen, p. 11, l. 245–249.*

Experiencing grief "on different levels" becomes evident in Rachel's sense-making which conveys an overwhelming sense of existential grief. The deeper, hidden layer, embedded in the everyday events and in the continuous, accumulative, and emotional strain, seems to force Rachel to face not only her own but also the mortality of all human beings:

> *"And so, it's obviously something upsetting me on different levels. So, erm it might not even be grief for one particular person, but it might just be that kind of general … aspects, existential grief. You're all going to die. Erm. It's the mortality. We're all being, you know, exposed to mortality every day." Rachel, p. 75, l. 1469–1476*

However, on the surface, Rachel's sadness about the patients seems "not long lasting" and "not really deep", grief being "like dust", as if a thin layer of emotion is coating everything temporally *(p. 29, l. 551–563*):

> *"But then it doesn't last long. Like dust. I think the longest is probably a month, maybe […]" Rachel, p. 29, l. 561–566*

> *"I suppose with the maturity in the job, I've just come to realise that although I feel sad for these people, I didn't really know them on a really deep level." Rachel, p. 30, l. 577–581*

3.3.3 Carrying Grief in the Body

Most participants share the bodily impact of grief that is experienced as emotional tiredness and heaviness in the body. Some of these experiences are illustrated in this subtheme. The emotional load that they seem to be 'carrying' suggests grief being an embodied experience that orients participants to withdraw and disengage from others. The participants' interpersonal engagement with the social world seems to be ruptured as the emotions require processing.

The experience of bodies being like vehicles for carrying emotional experiences are shared in participants' narratives. Aanya shares that there seems to be a releasing aspect of not needing to "carry" the weight of grief anymore when the patient dies:

> *"because actually… in a way, you don't have to carry that emotion so much anymore." Aanya, p. 31–32, l. 432–442*

Rachel echoes this idea of releasing the pressure and the heaviness from the body by crying:

> *"Oh, it was just like a pressure that I had to get out. [chuckle/laughter]. Yeah. I couldn't have not cried at that point. Erm." Rachel, p. 43, l. 844–846*

The accumulation of grief load leading to somatic symptoms and feeling drained in the body due to the emotional tiredness is conveyed in Rachel's account: "there will be times where you, get you think, 'oh, I can't, can't go into work today or… anymore'" (*p. 74, l. 1452–1454*). The grief overload seems to be difficult to "disentangle it from feeling burnt out […]" (*Rachel, p. 73, l. 1445–1450*). It seems also possible that the grief emotions are absorbed from others and the environment, as her sense-making below suggests:

> *"it can just feel like everyone's dying. It's just so depressing. And I think that's when I realised actually, that actually something's getting to me. Erm. Because the work is not particularly hard and heavy in terms of. So, it wouldn't be burn-out because I'm exhausted physically, not like in a hospital way or just rushing around. Erm." Rachel, p. 74, l. 1456–1467.*

The theme of carrying the weight of grief in the body, until she actually can't any longer, is shared in Jeanne's excerpt below. The sense of "being knocked sideways" due to a grief reaction to a patient's death also illustrates a paralysing experience of a grief response preventing her from interacting with the outside environment:

> *"And I was completely and overwhelmingly exhausted. I don't think I had ever experienced exhaustion like it. Even at a time that I had small children. I was totally knocked sideways by it, erm, and I can remember going home feeling completely… and for my children because I could not, I couldn't think of doing anything else. I couldn't really engage with anything else." Jeanne, p. 9–10, l. 180–190*

The thematic pattern of withdrawing from interpersonal engagement due to grief experiences is also reflected in both Harry's and Rachel's experiences.

> *"I think I find it very tiring […] I think all of those thoughts and emotions … sort of pull you down a bit. Erm. I think. I guess that I am sad and, I tend to get quieter [thinking] I'm sort of quiet, quiet inside and at work, I have a bit of a loud, chatty persona." Harry, p. 54–55, l. 995–1016*

For Rachel, the physical exhaustion stemming from "emotional tiredness" seems to also contribute to her withdrawing from the social world. She recognises the demanding quality of emotional labour feeling "draining":

> *"I think sometimes I can feel really tired at the end of the day. It is not a particularly physically hard job, but maybe walk up and down the ward a little bit. So, it's not like a physical tired, I suppose it's more an emotional tiredness. And on the tube all the way home, I just feel absolutely drained. Erm. On a difficult day." Rachel, p. 59, l. 1153–1161*

3.3.4 Grief Coming and Going

This subtheme attempts to illustrate the temporal experiences of grief and the non-linear nature of grief experienced as "coming and going". The phenomenology of grief in this context appears to consist of short-lived episodes but is also unconsciously experienced and temporally extended. The analysis suggests that the passage of time does not seem to move the participants' grief away nor seal it off from appearing again.

The wave-like force of grief "coming and going" in Jeanne's excerpt implies grief emotions varying in intensity, being changeable and fluid, and "not fixed" within boundaries of time. There seems to be an aspect of learning over time "as I have gotten older" to accept that grief has its own schedule:

> *"I think [sigh] erm, [silence] but I think, what I sort of think what I have learned as I have gotten older is that it comes and goes. It is not like a sort fixed of you grieve for six weeks or you grieve two days or It sometimes comes and goes." Jeanne, p. 31, l. 483–488*

As for Helen, she makes sense of grief's appearance being experienced as short-lived episodes on a conscious level and "then kind of moving on", indicating that the context needs her to orient to work tasks. The comparison to her personal life experiences of grieving is used to make sense of the temporal quality of grief experienced in a professional context:

> *"I think it's a lot shorter. Yeah. I think in my experience […] that's, that's It's been kind of a momentary maybe an hour or so of, of feeling sad, but then kind of moving on. Whereas, personally… personal grief, I think can last for days, weeks, even, well you know, with my granddad years. So, you know, so I think it's something about time." Helen, p. 35, l. 664–676*

Patient deaths that have happened years ago are sometimes felt acutely and easily accessed in the present time, suggesting that "moving on" (*Helen, p. 35, l. 664–676*) or "putting it aside" (*Jeanne, p. 55, l. 788–809*), do not necessarily seal off grief from appearing again. Jeanne's excerpt below reveals a more conscious presence of grief being experienced and extended in time:

> *"I remember those feelings. I think sometimes the acuity of the feeling lessens but you I still, you can still feel it. I can still feel although it is less intense the feeling that I had when I walked past and I knew she died, I can still feel that feeling." Jeanne, p. 32, l. 490–497*

The unconscious dynamics of grief experiences seem displaced when the feelings are suppressed or controlled, "you put it to the side", due to contextual constraints. It seems that the displaced grief appears again in situations that are not connected to deaths and losses:

> *"I think sometimes you put it to the side or make it kind of aside, either you know, something totally different like you know, if there is a difficult management meeting, something weird happens, and actually you suddenly think that, this is, this is too much, this is, this is too much emotion now. And, I think, sometimes, you know, I will just cry at something and thinking 'Why am I crying about this?'." Jeanne, p. 55, l. 788–809*

The thematic pattern of grief having its own powerful temporal dynamics also comes across in Helen's account. Helen is sharing a disorienting spatial experience of strong emotions being encountered in a Schwartz Rounds meeting *(p. 52, l. 990–1005).* It feels incomprehensible and unimaginable for Helen to still be reacting so strongly: "I was blubbing so hard" about a patient's death that took place some years ago. Helen experiences being moved back in time: "I was transported, as it were, back into that place [...]" (*p. 52, l. 990–1005*). Not only the temporal experience seems powerful: "feeling it all over again", but also in her mind she is "right back in that room" *(p. 46–47, l. 880–908)*, implying that grief emotions are also perceived as sensorimotor and spatial experiences.

The uncontrollable dynamics of grief "coming and going", without cohesion or order, come through below in Mary's sense-making echoing grief's non-linear dynamics: "just like the weather and everything else". There is a sense of Mary learning to accept the disturbance of emotions and leaving them as mysterious, allowing unconscious feelings to come and go:

> *"And human beings can be irrational, chaotic, crazy things… as just like the weather and everything else. And, erm, you can acknowledge something is interesting, but you can't always explain it […] And sometimes my subconscious will go, like 'Oh', two days later, something might occur to me." Mary, p. 64–65, l. 1330–1357*

3.3.5 Personal Grief Intertwined with Professional Experiences

The participants' reflections illuminate the hidden layers of everyone's life-worlds and individual loss-histories being present in everyday work life. The theme of participants' personal grief experiences blending into their subjective emotional reactions at work conveys multifaceted features of experiencing grief as a professional.

Rachel recognises that grieving for her father seems to be intertwined with her sadness when impacted by the grief reactions of a patient's relative, who "was sort of sobbing hysterically and that *really* got to me" (*p. 19, l. 356–357*). This implies that the professional role does not seem to be a barrier to emotional experiences from one's personal life that surface in work interactions.

> *"Well, I think, I hadn't thought about it, I think it really was, my dad died just before starting here, probably about six months before starting here. And I wasn't with him. So, [teary/moved]. Sorry … [voice breaks]. So, I would have been her. So, yeah. It was very, very hurtful. Yeah. [nervous laugh/recollecting herself]. So that's why [a teary chuckle]." Rachel, p. 21–22, l. 377–390*

As for Mary, she shares having lost both of her parents and acknowledges grieving her mother since a young age. Mary seems to be wondering about the possibility of these personal layers of grieving "getting transmitted to other loss reactions", conveying personal and professional experiences fusing into a certain way of behaving, perceiving, feeling and thinking when she reflects about "being slightly that way":

> *"I think I have always been slightly that way. Even before I started doing palliative care and became a doctor… but… erm, and I do sometimes ponder whether or not it gets transmitted into other loss reactions. My father died, erm, [number] years ago. My mom died when I was [age] child. Erm. So, a long time ago." Mary, p. 24, l. 476–489*

The personal loss-history seems to provide a lens and a perspective through which Mary interprets all her loss experiences, with grieving being an everyday experience for her in some form:

> *“But I still…grieve for… in… erm, pretty much every day as part of that process, but. Erm. So, I, I can't say what I don't think. I was… having seen a few other colleagues lose their parents in the last few years.” Mary, p. 25–26, l. 506–514*

Both Helen and Aanya share how they have developed an increased awareness of how their own pain and suffering from personal circumstances impact them as doctors:

> *“It doesn’t cross my mind that it's an issue until they say that. And then even then I say, yep, that's. It is someone else. That’s not. It is not my mom […] And I got, I was given a vignette. It's like, this is Mrs. Jones. She's got [type of] cancer. And I just ran out of the room [chuckle].” Helen, p. 69–70, l. 1321–1343*
>
> *“So, erm for example, I lost my dad nearly 10 years ago… erm, to, to cancer. He was a 50- year old man when he died. So, actually that’s probably part of the reason why I find that age patient quite difficult.” Aanya, p. 40, l. 571–581*

Jeanne describes the impact of a unique personal experience of herself almost dying due to a sudden emergency health situation. Jeanne’s experience reveals how a personal experience of facing one’s own death is intertwined into her work experiences and potentially “bringing out” emotional consequences that can leave her feeling vulnerable and identifying with grieving families:

> *“If I had died, which had been a complete possibility, then you know, people around me would have like, you know, would have been like how I would have felt for all these other people, a hugely difficult thing to think about.” Jeanne, p. 57, l. 840–851*

3.4 Managing Grief Tied to Professionalism

This Group Experiential Theme encapsulates the unique strategies and struggles of managing grief as a professional in the hospice context. Five subthemes that emerge under this overarching theme give insights into how participants manage their grief emotions in this emotionally demanding context and illustrate how they as doctors and human beings find ways to cope and relate to the grief phenomenon that seems tied to being a professional.

3.4.1 “Being in the job mode”

Participants talked about “being in the job mode” as a way of managing and suppressing grief. This action “mode” suggests an intentional choice to not experience grieving or express grief. The analysis also suggests that this mode seems to be a socially shared script or an implicit rule of professionalism of how to behave and manage grief emotions.

This arises in Jeanne’s account on several occasions. The “mode” seems to encapsulate an overall personal and protective strategy for Jeanne to manage the accumulative load of dying patients and to suppress her emotional responses when she is working.

> *“It, with a patient, I think, it is appropriate sometimes to cry. But then actually you have to move on, because it is, this is a job, and you have to be around other people that need you.” Jeanne, p. 31, l. 479–482*

> *“But even in palliative care there is an element of that, element of ‘I am in job mode’, ‘I’ve got stuff to do’. It’s just that sometimes you do think about it, either, you know, you go home and sitting or having a lunch or something and you just think, actually, this is really difficult.” Jeanne, p. 47, l. 681–68*

The excerpt below suggests that “I am in job mode” seems to be an internalised, almost a rigid, rule for her. “Being in job mode” could also be a socially shared schema where the “getting on with” seems to mean suppressing the grief and emotions and focusing on the practical tasks. Being in action seems to be valued:

> *“But I think, for example, if you were to. If your grief was to show, sort of er, some profound sadness. After more than a day or so, there would be a sense of ‘this is your job, you need to get on with it because there is a lot of practicalities’ […].”Jeanne, p. 106, l. 1538–1550*

The theme of socialising Junior Doctors to this cultural script on how to behave and feel emerges as well:

> *‘Oh, this is, can to be really hard, actually […] That actually, this is what you do. And it is ok to be affected by somebody, that’s ok. But you then need to pick yourself up and move on and get on with it.” Jeanne, p. 107–108, l. 1548–1574*

For Aanya, “being there to do a job” seems to also suggest her having picked up what is culturally expected on managing emotions and not allowing herself to connect with patients on a deeper level.

> *“Erm, so you don’t build up that connection or that a lot of the time you are as a problem solver to try and help fix whatever their sufferings are or their problems and symptoms are. So, you are there to do a job.” Aanya, p. 42, l. 604–616*

The challenges of this “mode” and difficulties of not staying present with the losses and grief emotions are conveyed in Helen’s and Harry’s accounts. Below, Harry indicates feeling powerless as the job demands him being in action rather than being with the grief emotions:

> *“Here we have as long as it takes to grieve, because you've got to get onto the next one.” Harry, p. 19, l. 337–353*

Helen’s “And then we just had to carry on” conveys her not having options other than suppressing grief, due to professional responsibilities, and indicates powerlessness, echoing Harry’s experiences:

> *"And then we just had to carry on… and there are other patients in the hospice one time. Someone else came into her bed probably the following day. And it's just that. So, I call in, turn over." Helen, p. 10, l. 235–239*

The socially shared experience of "being in the job mode" seems to function positively in the short term as it helps to manage the emotional burdens, however, it seems to be accompanied by recognised risks and potential long-term negative consequences, as Harry expresses:

> *"But if you do that too much, you don't allow space to re-, relieve yourself of your emotional burdens, then, it's, you know, that's… the way to burn out." Harry, p. 21, l. 390–399*

Further, Harry's account implies that there is a palpable sense of frustration towards the current social script that does not seem to allow time and space to express feelings. His use of the words "it is dangerous to underestimate" conveys fear and distress at needing to adapt to professional norms that do not seem to allow time and space to mark the feelings of loss:

> *"So, I think one of the things that, you know, time… time is needed…and, and I think you can't, it's dangerous to underestimate… the importance of being able to process the emotion." Harry, p. 21, l. 403–405*

Contrary to other participant experiences, Mary's account suggests that she is *taking the time* to check in with her emotions, despite echoing other participants' sense of pressure to "move on" and to be in action. It could be interpreted that there may be some learning involved in recognising the importance of acknowledging her feelings, as she refers to her seniority, implying that she has gained experience:

> *"I try my best to acknowledge… that feeling, as someone who is one of the more senior doctors here. I need to move on, a lot of time quite quickly to them, making sure that the people, as long as I have checked that I am ok." Mary, p. 48, l. 973–991*

3.4.2 Hiding Grief: "putting down a big steel shutter"

Construction-like language and images seem to be used in many of the participants' descriptions to illustrate their intrapsychic attempts to disconnect from grief emotions or to keep them invisible from others. This subtheme captures the thematic pattern of what seems to be participants 'hiding grief'.

Rachel describes "shutting doors" and recognises part of her "being closed off", conveying her attempts to suppress feelings. It seems that "closing off" emotions is protecting Rachel from emotional pain and feeling vulnerable:

> *"I don't know why she got these 'doors shut down'. I mean, I can react to them as humans, but there's a part of me that's just really 'closed off', I think." Rachel, p, 10., l. 182–193*

Rachel's sense-making conveys that she is struggling with not only feeling but also showing vulnerability: "I think I just don't want to start crying [chuckle], erm" (*p. 50, l. 971–972*). She is using construction-like language to make sense of how grief emotions and experiences are kept hidden. The mental physical barriers, such as "the door", and below, "putting down a big steel shutter", seem to be Rachel's coping strategies to hide her deeper feelings from colleagues and to keep the grief suppressed in order to be able to function: "normally I can keep it [grief] suppressed in different situations" *(p. 51, l. 989–990).*

However, it seems that her protective and figurative mental "armour" is sometimes vulnerable and not able to keep her "closed off" and protected from feeling the grief emotions:

> *"But I think from time to time there will be 'a chink in my armour' [laughing]." Rachel, p. 15, l. 285–287*

Aanya talks about "putting on a professional stance" as a coping strategy to hide her feelings. Her excerpt implies that there seem to be value-related assumptions that are specific to the profession and to which others are also aligning. It could be interpreted that putting on this stance seems to reflect implicit professional rules of grief needing to be hidden and not to be seen:

> *"I think doctors are very good at putting on a professional stance and hiding often how they feel. And I think you tend to see it more behind closed doors, erm. Yeah, I think [sighing] yeah, you don't see it. Erm. Because they're there to do their job and they don't have time." Aanya, p. 54, l. 1454–1465*

In addition, Aanya's strategy of intentionally "not wearing emotions visibly" *(p. 89, l. 1489–1500)* resonates with the thematic pattern of hiding emotions from others to appear professional. However, it seems that hiding inner emotional experiences is challenging: "it's hard to hide these things from how you feel like on your face" *(Aanya, p. 16, l. 252–257).* The hiding seems to consist of conflicting feelings, on the one hand, "wanting to have a good cry", and on the other hand, wanting to hide emotions both from colleagues and from patients:

> *"I'm actually… still trying to remain professional. It's quite hard sometimes when you work because the hospice is quite a close-knit community as, as a team. And yes, it's completely fine to express how you're feeling, but sometimes you don't want to in front of everyone else. Sometimes you just want to go and have a good cry." Aanya, p. 58, l. 894–893*

Paradoxically, the hospice seems to have a non-judgmental culture about expressing feelings, but Aanya herself may be having conflicting beliefs about showing emotions. She shares that doctors' grief is hidden: "a grieving doctor looks like any doctor. I don't think you would see it, erm, on the surface anyway" (*p. 87, l. 1447–1452),* implying that doctors might be conforming to a cultural script of keeping internal emotional struggles hidden and not showing emotions publicly, even if expressing them is ‘allowed’ in the hospice context. Aanya reveals that the hiding also seems to include “pretending that you are matter of fact”, leading to dealing perhaps with a sense of inauthenticity (*p. 16, l. 257–262*).

Jeanne shares how she uses compartmentalising to manage her grief feelings but also feelings of fear of not knowing how to manage grief, which she mentions on three occasions in her account:

> *“it is the sort of I think I do keep a lot of things in a box because I am frightened about what is gonna happen if I unlock the box.” Jeanne, p. 59, l. 883–887*
>
> *“And I think it is a fear of what do I do, if I go there, because what is that going to lead to. I don’t know. That makes me, that makes me, sort of anxious, and I don’t know [laughing], I don’t know if I want to go there [nervous laugh].” Jeanne, p. 61, l. 904–906*

The above excerpts suggest that Jeanne seems to be hiding grief emotions from herself due to a fear of experiencing some sort of discomfort. The unattended, compartmentalised grief emotions seem to have become something to be feared, leaving her feeling helpless. This experiential avoidance could be maintaining a belief of not being able to cope with integrating these difficult emotions into her experiences.

A theme of hiding professional grief due to public expectations is shared by Helen. She reflects that “the public”, the outside social world, expects “us”, referring to herself and all doctors, to have the appearance of a stoical professional, whose emotions are invisible:

> *“an image that comes to me, it is kind of a, almost kind of ‘a stiff upper lip, kind of very stoical, get-on-with-the-day-job, put-it-to-the-back-of your-mind’, and I don’t know why… that’s what I kind of, I feel like we…perhaps…should… or what the… Public…expects us to be.” Helen, p. 40–41, l. 758–767*

This suggests needing to conform to a mentality that expects one to hide and suppress the emotions from one’s present experiences. For Helen, however, this seems to mean there is an internal conflict around needing to do so, resonating with Aanya’s experiences of needing to “pretend”. Helen’s excerpt below reveals the hidden, but more authentic, experience underneath the professional appearance:

> *“Whereas, as I’ve said in my experience, that’s not necessarily the… the case. We have been just as emotional as family members.” Helen, p. 41, l. 769–774*

However, Helen too, like Aanya, expresses that the hospice context does allow and accept an open reflection of grief, perhaps in a cognitive form, even though the appearance of emotional expressions is “hidden”:

> *“But it's all…quite hidden and. But. Yeah. I think. But, but reflected upon openly and honestly. So, it's not something that's never spoken about.” Helen, p. 39–40, l. 741–750*

3.4.3 Coping by **Separating Grief Spaces:** ***“it is like being in the fire and you need to remove yourself from it”***

Participants’ sense-making suggests that the grief experiences are intertwined with embodied and spatial experiences. Participants talk about physically needing to separate grief spaces by removing themselves to a different space. This seems to function as a coping mechanism to allow participants to get back into their working mindset, and to create time and space away to regulate their emotions. Hence, the need for oscillation between ‘loss-oriented spaces’ and ‘restoration-oriented spaces’ is evident in many participants’ accounts, suggesting it being necessary for wellbeing and healthy functioning.

Aanya’s images of “it’s like being in the fire constantly” and “it can get a bit hot”, illustrate the hospice wards experienced as emotional zones that do not allow enough containment and safe space for reflection when being “bombarded by grief” (*Aanya, p. 90, l. 1505–1509*):

> *“I think you need to sometimes… it can get ‘hot’, a bit… It's like being in the fire constantly, sometimes you need to remove yourself from the… from it. And it helps to get some perspective.” Aanya, p. 59–60, l. 918–923*

Participants’ reflections suggest that the grieving body, when it can’t seem to hide the emotions anymore, needs to be physically moved to a different grieving space. Helen and Rachel both share that they “had” to leave the ward to cry in a different room, as they speak about wanting to avoid personal embarrassment about expressing their emotions or appearing unprofessional:

> *“And I had to run out of the room.” Helen p. 10, l. 218–226*
>
> *“But I was just like, I am not going to be in here anymore [chuckle] and I had to leave the room, leave the ward… Erm, just to recollect myself [chuckle].” Rachel, p. 18–19, l. 332–372*

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Being “away from the workspace” seems to mean for Helen an opportunity to “get into my mindset again”, allowing time and space for emotional regulation and relieving the emotional burdens. Both Helen and Rachel speak below about regulating their emotions outside the ward by having “a cup of tea” (*Helen*) and “cup of coffee” (*Rachel*), like symbolically soothing the body: “it’s like medicine for everything” (*Helen, p. 60, l. 1150–1163*) when sitting in a separate space:

> *“a bit of kind of silent reflection away from the workspace. So, I might come off the ward and come down here and have a cup of tea or […] just to get into my mindset again… before I go back to the ward.” Helen, p. 62, l. 1171–1188*

> *“Off you go” and “have a cup of coffee.” Rachel, p. 43, l. 848–864*
> *“When I came back, I was still really upset [laughing nervously] and someone said to have another coffee, and I ended up having four coffees [chuckle].” Rachel, p. 7, l. 122–130*

Themes of separating and setting boundaries between work and home were also shared by at least half of the participants. Grief experiences seem intertwined with the participants’ personal lives, requiring intentional boundary setting. Rachel and Aanya use expressions that describe grief emotions being like embodied constitutes parts rather than describe emotions using feeling words:

> *“Some patients that just… kind of hit you in the heart, it’s really hard to, to not carry that home.” Aanya, p. 27, l. 351–3540*

> *“I feel it has woven itself into all of my life.” Rachel, p. 70, l. 1377–1378*
> *“I do bring it home…”. Rachel, p. 69, l. 1360*

Separating oneself from the embodied emotional burdens seems easier when externalising the emotions and treating emotional burdens as physical entities:

> *“So, certainly, I pretend that I throw them out of the [car] window on the way home to kind of [laughing]. To kind of… Erm. So I don't take that the day home with me.” Aanya, p. 26, l. 344–349*

3.4.4 Doctor’s Grief Being Secondary

Managing other people’s grief is described by all participants as being a big part of the work. The sense of ultimate responsibility to support others, as when Harry expressed “holding all up” (*Harry, p. 36, l. 664–669*), seems to be shared by participants of all tenures. Aanya, Harry and Helen shared that the responsibility of “managing everybody else’s grief” sometimes felt like a challenge:

> *“The first thing [in terms of challenges] that comes to mind is managing everybody else’s grief.” Aanya, p. 52, l. 785–787*

> *“I suppose the difficulty with… grieving as a palliative care professional is that it's not just your grief, it's managing the grief of others. So… it can be really difficult and… sometimes it's… a lot.” Harry, p. 38, l. 693–697*

The participants' accounts convey how everybody else's grief seems to have a primary role, suggesting that the grief of doctors, as surrogate caregivers, becomes secondary, and perhaps they are not recognised as being as important as families and relatives, or the patient, in the grief hierarchy. As a medical leader of her team, Jeanne talks about "putting herself aside" (*p. 52–53, l. 769–779*), indicating putting her emotional experiences and needs aside, which seems to be part of having "the ultimate responsibility of supporting others" (*p. 122, l. 1837–1840*). Jeanne talks about her whole focus being on other people, staff members and the bereaved family members, indicating that their experiences are validated while hers are left unacknowledged:

> *"Erm, whether that be family, friends, or whether that would be your own team. You need to, you feel like you need, you need to make sure everybody is ok. Sometimes you think, sometimes you don't acknowledge how it has made you feel." Jeanne, p. 50, l. 744–749*

Aanya's experience almost indicates negligence and lack of care towards her own emotional needs: "the challenge is in trying to support everyone around you that you forget sometimes to look after yourself" (*Aanya, p. 58, l. 832–848*), conveying how her grief experiences also come second to a colleague's grief:

> *"But I didn't have chance to even process how it made me feel because I felt so bad for her [a nurse colleague] [nervous chuckle] and I wanted to comfort her and allow her space." Aanya, p. 58, l. 832–848*

As one of the senior doctors, Mary, too, spoke about her sense of responsibility and the duty of care to support others: "I have my responsibilities and duty of care to… the team involved" (*p. 49, l. 993–1001*), resonating with other participants' experiences that seem to position emotional needs in second place. There is a sense that senior doctors' grief responses and emotional needs may remain unacknowledged by the system too: "I have clinical supervision, but that's not necessary a great [inaudible] it's, that's more around decision making." (*Mary, p. 49, l. 1010–1016*)

There is an overall sense that the grief experiences of a doctor can't be equated with a patient's grief, resonating with the theme of grief hierarchies. As Aanya's excerpt suggests, the healthcare professional's grief, although an integral and unavoidable part of caring for dying patients, can't be shown outwardly due to the unequal position in relation to patient's grief:

> *"Actually, if your doctor looks, is looking sad and, I'm not sure they would actually equate it to what they're going through." Aanya, p. 18, l. 284–287*

Aanya's excerpt implies that displaying feelings might disenfranchise the families' grieving. Displaying her grief is experienced as being a burden to others, suggesting that Aanya's grief is disenfranchised by herself too:

> *"because erm, I think we carry a responsibility… to… listen to how they're feeling and how their families are coping and not wanting to burden them with our pain." Aanya, p. 14, l. 226–230*

A contrasting experience was shared by Helen, whose excerpt suggests an experience of validation when sitting and sharing a cup of tea, and grieving a patient with the bereaved sister of the patient, implying that both their grief experiences are enfranchised and have equal quality:

> *"And, you know, I even saw her a kind of a year afterwards. […] So that was… really nice. And I think that helped sort of… both of our… grief over him, if you like, as well." Helen, p. 16–18, l. 353–362*

3.4.5 Shared Experience: "All Going Through the Same Things"

Even though the previous themes seem to suggest that grief in the hospice context appears individually suppressed, hidden, or experienced as a secondary phenomenon in the grief hierarchy, a divergent pattern also emerges from the data. The theme of grief recognised as a shared experience recurs in most participants' sense-making. Participants often refer to a shared sense of "everyone is feeling the same", allowing emotional expression to appear more visible in their narratives.

In Helen's sense-making below, grief seems to concern everybody, "the whole ward", and is not dependent on a participant's professional role or the attachment relationship with the patient. It appears as inescapable, affecting "even down to the ward clerk":

> *"So, I don't think anyone that's worked here has never been kind of affected by grief within their role. […] And, and when she [patient] died, the whole ward, again was kind of upset, even down to the ward clerk who barely had any kind of contact with her, but just knew so much about her from everyone talking about her." Helen, p. 29, l. 593–595*

Helen's illustrative language below implies the shared grief reactions being powerful experiences, breaking down the individual emotional regulation barriers: "all of us just broke down in tears". One patient's death impacting everyone and crying together seems like a striking experience for Helen:

> *"Well, myself and a consultant and another doctor were in the room…and all of us just broke down in tears. […] everyone was in floods of tears. And I just remember*

> *we were kind of all inconsolable. And that just really stuck with me that just how, how one person can really get to so many people." Helen, p. 10, l. 218–235*

The unhidden and visible expression at all levels of seniority, and everyone being "in floods of tears", conveys the sense of "all feeling the same", which may not be so obvious in general, considering the previous themes of grief actively being hidden or moved to a different space.

Aanya too speaks about the collective sense of "everybody struggling" due to the accumulation of deaths, describing the cumulative effect as: "Whoa, it is too much" *(p. 61, l. 935–945)*. The death does not seem to leave anyone untouched. The distress of the cumulative grief seems to be taking forms of staff "feeling angry" and "snapping with each other" as the magnitude and too-rapid succession of losses seem hard to manage and integrate:

> *"So, people start getting snapping with each other and angry and cross words… But it's because everybody is just struggling with the enormity of death." Aanya, p. 61, l. 947–954*

Many participants also speak about "Schwartz Rounds" being a structured forum for all staff to come together to discuss emotional aspects of work and share vulnerabilities. Helen seems to find that these sessions have "a special atmosphere" and are "an arena for being emotional" (*p. 48, l. 913–923).* As for Aanya, the sessions seem like a "very good space for people…to share about personal and professional grief" *(Aanya, p. 93–94, l. 1564–1576),* conveying how the shared emotional expression benefits from safe and contained space. The sense of "all going through the same things" conveys the validation of shared emotional experiences:

> *"But I think… we're very unique in this setting in that we're all going through the same things and understand… everyone's sort of experiencing and that we… are all human." Helen, p. 27–28, l. 565–574*

Themes of recognising different preferences and feelings about group experiencing occur in participants accounts. For example, Rachel expresses nervousness and even fear about sharing her emotions in the Schwarz Round: "not feeling brave enough" to speak but recognising that she benefits from the shared understanding of "we're all feeling normal" (*Rachel, p. 47, l. 907–922*). Harry shares Rachel's reservations with regard to group experiencing, expressing his preference for not sharing his grief emotions with other doctors. "it has its ups and downs. I think for me, it's difficult to really get into things in a group." (*Harry, p. 23, l. 429–436*).

Lastly, it appears that the sense of shared understanding can be experienced even many years later. Jeanne expresses a shared sense of experience with a nurse. Her statement "so you can talk and share that, the feelings that you have about her even a decade on and she understands and…" *(p. 29, l. 464–466)* conveying the importance of her feelings being validated and enfranchised, when due to her professional role her feelings may often be positioned as secondary.

3.5 A Process of Learning to Relate to Grief

Learning to relate to grief in the job emerges as a Group Experiential Theme in participants' experiences. The accounts reveal that medical training does not prepare doctors to deal with grief.

3.5.1 Reconstructing Professional Identity

When reflecting on their grief experiences, many participants speak about needing to learn to be a doctor in a different way. Helen states: "in this area, erm, you kind of can't do what you have been trained for" *(p. 68–69, l. 1298–1307)*, which seems to suggest that doctors are required to reconstruct their professional identity to a more relevant identity in the hospice context.

The analysis reveals that an adaptation from a stereotypical doctor's identity as a "hero" who sees "death as an enemy" (*Mary, p. 30, l. 606–612*) to belonging to "a subgroup" that accepts death as an entity, seems fundamental and unavoidable. The below sense-making by Mary implies that this process of needing to adopt an identity of a minority group that is different from "the main field" *(p. 29, l. 591–599)* seems to also require acceptance and learning to relate to dying as part of life, to be able to meet the needs of palliative care work where patients are provided with emotional and psychological support.

> *"There is a subgroup of us who, are within us, who are actually able to accept it actually possibly better than with lot of our colleagues. That is, actually part of living is dying, although the culture has changed hugely over the last five, 10 years" Mary, p. 30–31, l. 614–625*

Helen also echoes Mary's sense-making of the professional identity reconstruction which in this medical specialty field requires skills in addressing and being with the emotional suffering of patients:

> *"not saving someone's life, but it's it is making them better in, kind of, more. It can be in a physical sense, but more kind of in an emotional and psychological sense. So that's the… key." Helen, p. 72, l. 1371–1377*

Rachel speaks about the process of shifting from 'an active doer:' "we were trained to do things [*chuckle*]", to a 'being identity', like a palliating identity, someone who is attending to the patient's emotional and psychological needs, and "just talking to them" (*Rachel, p. 71, l. 1508–1512*). This reconstruction seems to include needing to cope with a sense of loss of 'the old', not so relevant, medical identity:

> *"So, yeah, it was quite a big thing to let go off…It took me about a year or two to let go off that need to do things. Sometimes the best thing to do is nothing, but it can be really hard and I think when you are used to that, that can manifest itself, it's feeling a bit down as well." Rachel, p. 77, l. 1514–1527*

This process that seems to require "letting go" of the doer identity seems challenging, involving feelings of helplessness and frustration, including needing to come to terms with a sense of guilt "of not doing a proper job" (*Rachel, p. 71, l. 1508–1512*), of not doing and being "busy in action" (*Rachel, p. 78, l. 1534–1539*). Rachel also speaks about recognising that she has become better at listening and sitting with patients' distress (*p. 84, l. 1664–1671*) and has become more empathetic (*p. 84, l. 1661–1662).*

In Harry's account below we can sense frustration towards the wider medical culture's lack of recognition that the emotional labour of grief emotions is not recognised or valued as "work", implying his experience being reduced. His expression of the medical culture's implicit message of "work is doing, not work is feeling" coins his disappointment towards the "patriarchal" system's narrow lens of what behaviours seem to be valued and recognised:

> *"And even in a speciality like palliative medicine, which is, you know, doesn't have the same gender imbalance but has the opposite gender imbalance to the rest of the medical profession. Still quite kind of, you know, almost a patriarchal 'work is doing, not work is feeling', which is… a shame." Harry, p. 24, l. 456–464*

3.5.2 Learning Grief from Others

The importance of learning "how to be in response to grief" from senior colleagues is expressed by Aanya. Learning from seniors and how they model grief responses, their coping, and engagement with feelings, is considered important as this seems to give "an unsaid permission" to do the same (*Aanya, p. 126–127, l. 2116–2131*). It seems that this modelling provides "space and permission" (*Aanya*, *p. 126–127, l. 2116–2131)* and provides examples of what is socially acceptable behaviour to express grieving:

> *"Learning how to do this job from seniors is really important. And seeing how they are.. in response to grief, It helps you to realise what the boundaries are." Aanya, p. 122, l. 2067–2072*

As more senior herself, Jeanne acknowledges that she is still learning about grieving and conveys being influenced by other people, such as nurses and patients' relatives. It seems that she is attempting to understand herself better and to develop herself as an emotionally intelligent doctor:

> *"You see so much of, you see so many relatives, but also staff, you know who have bereavement and things, and how they deal with that. And you, some things you can identify with and some things you don't, you know, identify with, and some things you can really, you know, sort of really, I think learn from [says 'learn from' very carefully], actually." Jeanne p. 118, l. 1750–1759*

Participants' reflections conveyed a sense of not being prepared to deal with grief in their training years. Harry's account reveals some underlying assumptions and expectations that doctors have about dealing with grief: "You should be able to deal with that because you are a doctor" (*p. 746–774*). He speaks about being taught to be "a professional" (*Harry, p. 40, l. 723–725*), implying that being taught to be a professional excludes dealing with emotions or vulnerability:

> *"I mean, certainly… we don't, you know, we don't get taught how to grieve, we don't get taught how to deal with death. We get taught how to certify a body and… to verify death. But we don't get… we don't think about how to react to it." Harry, p. 43–44, l. 796–80*

Aanya's excerpt echoes other participants' experiences that 'learning on the job' is required:

> *"No, I don't think it does… at all. I don't think any of my medical training prepared me." Aanya, p. 82–83, l. 1313–1316*
>
> *"I think that's something that's learnt on the job. And I think you can't teach it. I think you have to learn it… through experience. I think they could teach you coping mechanisms and how to process things." Aanya, p. 82, l. 1329–1339.*

Paradoxically, despite recognising the lack of preparedness, many of the participants share still being perplexed that junior colleagues find it emotionally hard to face death or deal with grief emotions, indicating how deeply held are the assumptions around being able to cope. Hence, it seems that teaching new generations to be healthier with emotional responses is recognised as important by both Mary and Harry who work also as medical educators. Mary talks about grief being a taboo in the medical field, that is: "quite not spoken and not visible. Hidden." (*p. 41, l. 846–849*), suggesting that she seems to be on a mission to teach doctors to be emotionally "healthier":

> *"My generation of doctors, we. It [grief] was not encouraged or underserved or talked about. Generally, we would work very hard and then drink very hard and then come back to work the next morning and do the same again. Erm. That's obviously no longer acceptable. And we try and encourage a new generation of doctors to be much more expressive and talk and try… I make a conscious effort." Mary, p. 38, l. 769–792*

Harry too seems to want to shape doctors' ability to deal with human emotions at the training stage: "medicine is about relationships. Erm. It's not about, you know, it's not about you being a faceless scientist." *(Harry, p. 40, l. 733–737)*. This implies that Harry has learnt these aspects potentially from his own experiences as part of the identity reconstruction.

3.5.3 Learning about "The Emotional Self"

Another thread that emerges within the theme of reconstructing one's professional identity is that of learning about one's "emotional self", which is an expression that Mary uses in her account.

Vulnerability is expressed as being difficult for many of the participants. Jeanne shares her leaning:

> *"Acknowledging… that, ack-., acknowledging that as a person and as a professional that you are vulnerable." Jeanne, p. 36, l. 532–537*

For her, there seems to be a fear of "mishmashing" the personal and professional identities and confusion: *"should I be putting on my job head?" (Jeanne, p. 67, l. 964–969).* She seems to experience inflexibility in integrating how to feel as a professional and as a person, when also facing bereavement in her personal life.

Jeanne expresses below that her grief: "is tied up at my perspective", highlighting that the professional expectations of doctors needing to cope with everything seem to be deeply engrained in her professional identity. The internal expectations and beliefs around controlling grief and vulnerability seem rigid:

> *"I think it is one these really difficult things, because I think, I think a lot of it that my grief is tied up at my perspective, tied up with the feeling that as a healthcare professional we should be able to cope with anything." Jeanne, p. 28, l. 447–451*

The work context heavily requires engaging with grief and loss but many of the participants struggle with integrating vulnerability into their professional identity. The analysis also reveals other participants having internal beliefs and norms about how their emotional experiences are "tied up" with their professional identity, implying limited flexibility for emotional expression. Rachel's sense-making indicates holding "ideas" of a professional identity of someone who “fixes” everything for others, and therefore, it seems there is an expectation that she can’t be the one showing vulnerability, i.e., “crying”.

> *“I don’t know… Erm. But I suppose I’ve still… got these ideas, cause often… being a doctor. Everyone looks for you to kind of fix everything. Err well, that’s how I feel.” Rachel, p. 51, l. 1005–1013*

Jeanne and Mary share these beliefs about vulnerability, conveying inflexibility and a fixed mindset about their emotional self:

> *“part of me thinks it is not a weakness [laughing]. Part of me it’s sort of engraved in me that it is a weakness. And that is really difficult. It is really difficult.” Jeanne, p. 65, l. 944–955*

Mary expresses her nervousness on the spot: “I was a bit nervous about having this conversation. And I had anxiety that I might get upset, erm, anything else like that […]”, referring to her “fears and anxieties about expressing emotional, showing vulnerability” *(p. 71–72, l. 1493–1504).*

Most of the participants talk about continuing to learn more about their emotional selves, like Mary who connects this to some core beliefs potentially stemming from early experiences:

> “*Erm. I think. I am … still trying to learn … to be more aware of my emotional self.” Mary, p. 46, l. 933–935*
>
> *“Erm. I'm a person… having been brought up in a way that, erm,… er, you only let certain emotions visible… to other people and things like grief… was something that you… should keep to yourself and to be embarrassed by.” Mary, p. 46, l. 937–945*

For Mary and Jeanne, both senior doctors, learning about their emotional selves seems to mean needing to overcome their fears of feeling vulnerable, with the overall goal of becoming better doctors:

> *“But I also recognise part of this is that actually… having this conversation is learning more about ourselves so that we can do better and be better at the things. So intellectually as if counteracting my own innate instinct” Mary, p. 73–74, l. 1530–1540*

Jeanne’s reflections suggest her developing more awareness that grieving and being vulnerable seems to involve a process of learning about her emotional self: “I think I am still learning, learning about myself and learning, yeah.” *(p. 94, l. 1317–1330)*. Her sense-making conveys developing psychological flexibility:

> *“made me I suppose more…I suppose more aware of myself. And more [chuckling/laughing], that is really funny [laughing], more aware of myself as a human,*

> *as opposed to [chuckling/laughing] a functioning machine [laughing like she made a joke]". Jeanne, p. 97, l. 1385–1381*

3.6 From Disconnection from Others to Connection with Self

The final Group Experiential Theme encapsulates experiences relating to how participants speak about their reality and normality as not being understood by the outside social world. The analysis reveals that the participants perceive their reality to be something that has become their normality, where death and dying are part of life, and grief accompanies it. The first subtheme captures the sense of *disconnection* between the hospice reality and the outside social world. The second subtheme captures how being faced with mortality and grieving can be inspiring, and salutogenic, instead of undermining. Participants seem to be expanding their lives in different ways and becoming more *connected* to their personal values and individual needs.

3.6.1 The Unrelatable Reality

Themes of navigating in between two social realities that appear to be disconnected from each other appear in the analysis. All participants talk about experiencing that their reality and normality are not understood by others. Participants' reflections convey a disconnection between the hospice and the outside social world realities, with others not being able to relate to their experiences.

There is a sense that the unrelatable reality and the disconnection seem to be maintained possibly due to doctors' grief not being a socially acknowledged phenomenon and the PCPs losses not being recognised. Rachel's sense-making below conveys not being able to explain her reality to people outside palliative medicine due to her trying to be conventional and socially correct: "no-one really wants to talk about it anyway…outside of medicine" (*p. 63, l. 1241–1249*). It seems that Rachel is polishing the reality by appearing "fine" on the surface:

> *"And, I think… that's not the truth, actually. Cause I think on a very superficial level, of course, we are ok. Erm. But actually, when you dig down a little bit. Of course, it is really hard and sad. But I'm trying to say to people outside of medicine 'No, it's fine'". Rachel, p. 63, l. 1227–1239*

Rachel's "fine" might also function as a safety blanket to shield herself from other people's unhelpful reactions: "You know, it's just… polite… conversation, they don't actually want to hear how 'unfine' it is." *(p. 63, l. 1241–1249).* It seems that there is a perception that Rachel's emotions need to be masked to protect the outside social world since society does not want to see or hear about the reality, as Aanya states:

> *“it's still ‘a taboo’. We don't like to talk about death. They don't imagine that one day they or their loved ones will die”. Aanya, p. 67, l. 1045–1059*

> *“Whereas I see it daily and I know that [laughing voice] they will die at some point. So, I face that reality.” Aanya, p. 68, l. 1061–1063*

At least half of the participants also seemed to be attempting to protect people outside the hospice context because their reality may be perceived as unrelatable and causing distress. For example, Rachel and Aanya share the following:

> *“also, because I don’t want to them or scare them about how death could be. Erm. And no-one really wants to talk about it anyway… outside of medicine, like at, you know, at a dinner party [chuckle] Erm.” Rachel, p. 63, l. 1241–1249*

> *“But…I guess in a way you have to be quite guarded when you talk about it […] Bringing that stuff up can be distressing for some people to hear. And I don't want to pass distress …people around me.” Aanya, p. 6, l. 1065–1075*

Jeanne reflects on her experiences of speaking at fundraising events and finding herself being in an unrelatable space: “sort of funny place to be in…” to describe the unrelatable reality of hers: “this is what I do” *(p. 108, l. 1574–1587)*. Mary, too, echoes navigating in between these experiences of different realities where, on one side death and dying are normality and everyday reality, and on the other side, the reality is perceived as “sanitised”, society “pretending” that the reality of death and dying does not exist. This seems to create a sense of palliative care doctors’ grief experiences being disenfranchised, echoing other participants’ experiences:

> *“We sanitise the world so much that most people don't see death and dying.” Mary, p. 32, l. 650–665*

> *“And so…Then we just try to pretend it doesn't happen and the nasty thing will go away.” Mary, p. 33, l. 667–669*

Although most of the participants share that their family members are supportive, they all reflect feeling that people don’t seem to be able to relate to their emotional landscape due to not being ‘medical’, even when a partner is in another medical speciality. For example, Harry and Aanya share that:

> *“She [wife] will often…She sees more…horror is probably not the right word, but she sees more in these experiences than I do. And, I think that’s just because I’m used to… what happens.” Harry, p. 46, l. 834–848*

> *“Because I don’t think anyone else really understands. I think other colleagues, medical colleagues, nursing colleagues, etc. understand to an extent. But I don’t think*

> *people really fully…can immerse themselves in that unless they've either experienced grief at work." Aanya, p. 69, l. 1080–1094*

To conclude, there is a sense in participants' narratives that the grief experiences seem to be only understood if one belongs to the professional context in which death and dying is normality and professional grief the companion of that, potentially adding complexity to the interactions between the individual and society, and how they feel supported by others.

3.6.2 Expanding Life: "Taking Life In"

This subtheme captures the thematic pattern of expanding life, illustrating participants connecting with their desires and their personal values as a consequence of grieving their patients and witnessing loss. The analysis suggests that facing the grief and loss experiences from patient deaths seems to have potential for developing salutogenic outcomes of existential and personal growth, and positive change. Jeanne's expression of "taking life in" is used in the title, because it captures the participants' awakened desires to live life with intention, with a heightened awareness of the temporality of life.

Most participants talk about gaining new perspectives of valuing everyday life and connecting with their personal values more as a result of grieving their patients. For example, Rachel speaks about how experiencing and witnessing grief has "changed her viewpoint", implying that this has made her grasp the importance of everyday joys. There seems to be an active effort to intentionally "appreciate the small things" (*Rachel, p. 70, l. 1388–1394)*, which she expresses as "hanging onto it", suggesting an increased awareness that her agency and independence are not to be taken for granted.

> *"Erm. It just makes me really realise to hang onto to it and enjoy it." Rachel, p. 71, l. 1396–1397*

Aanya too expresses a changed perspective: "Over time, I have realised that there is more to life than my job" *(p. 115, l. 1944–195)*. Her reflections below imply reassessing her approach to life and not wanting to live "with regrets" (*Aanya, p. 118, l. 1993–2001*). It seems that she is learning from her hospice experiences of witnessing patients' "life creeping up and ending", and using the awareness of the temporality of life as a motivation to connect with her personal values:

> *"And you see so much in the hospice… that… people are so busy doing life that… life crept up on them and ended. And I don't, I don't want to live that way with regrets." Aanya, p. 118, l. 1993–2001*

The theme of ‘expanding life’ emerges from the accounts of Jeanne, Mary and Aanya who speak about their desires to travel and expand their life contexts. Learning new skills and spending time with people that are important to them seems to imply intentionally creating space for life and joy outside work, as Aanya recognises: “I guess I see more opportunities. I'm more spontaneous than I used to be” *(p. 115, l. 1958–19662).* Jeanne’s sense-making also implies that her grief functions as an emotionally uplifting energy: “So, I do try to turn it into … sort of positive, life, li-, life affirming and recognising the fact that you are still alive” *(Jeanne, p. 104, l. 1477–1499).*

In the excerpts below there is a palpable awareness of participants’ own mortality. “Taking it in” is an expression from Jeanne that seems to represent the approach to live life fully and with intention, also echoed by Aanya who is “embracing the life”:

> *“I have been desperate to travel more. Because I suppose part of me is thinking life can be short. And you have to take it in as much as you can, yeah.” Jeanne, p. 116–117, l. 1711–1736*
>
> *“life is short and. You know, eh, it's important to, to, to do things that are important to you. And, you know, having children and not firstly everything about career and having time for family, and embracing the life that you have because it can just change.” Aanya, p. 116–118, l. 1967–1991*

Lastly, some participants also convey empowerment and a process of individuation, which could be interpreted as stemming from the awareness of one’s own mortality and closer connectedness with one’s personal values, and perhaps also resulting from the change in their reconstructed identity:

> “Erm. *It's made me more clear about sometimes the things I don't want to. And it's my turn. And some of the things I do want.” Mary, p. 44, l. 890–898*
>
> *“I think, I think it's, it's positive. I, you know, definitely…have more of a direction and I know what I want and what I would settle for, what I would compromise on.” Helen, p. 58–59, l. 114–118*

4. DISCUSSION

4.1 Overview

The discussion chapter will present the key findings and contextualise the analytic data, by linking them to the wider literature. The rich and multifaceted analysis offers opportunities for some of the findings to be discussed in more detail in later publications and disseminated in other contexts. This chapter also considers clinical implications for the field and practice of Counselling Psychology (CP), palliative care (PC) and other relevant contexts. The quality and validity of the research and the strengths and limitations will be discussed. Lastly, opportunities for future research will be considered, in addition to final reflections about the research project.

4.2 Key Findings

The key findings, which are considered illuminating the useful characteristics of this phenomenon and having significance for improving interventions, are presented in this section, with a discussion of how they may relate to the existing literature. This research study builds on the scarce literature on palliative care physicians' (PCP) lived experiences of grief, offering useful insights into what is it like to experience grief in the hospice context. It has attempted to answer the following questions and to explore the nature of lived experiences of PCPs: 1) What is it like for PCPs to experience grief in the hospice context; and 2) How do PCPs make meaning of their grief experiences of patient deaths in the hospice context? The analytic findings resulted in five Group Experiential Themes: 1) The relational tension; 2) Making sense of the complex emotional layers related to grief; 3) Managing grief tied to professionalism; 4) A process of leaning to relate to grief; 5) From disconnection from others to connection with self.

4.2.1 Relational, Professional Grief

This study contributes to the understanding of grief in the hospice context, where grief may appear as a natural consequence of forming emotional bonds with patients (Hall, 2014). The findings suggest that participants developed emotional bonds and connected with patients more deeply due to the holistic PC culture. Most of the participants' reflections on their grief experiences conveyed a family-like atmosphere contributing to closer relational dynamics and strengthening the attachment proximity in the professional care relationship, leading to grieving some patients' deaths, even years later. Such characteristics are recognised in the literature as being conducive to grief, as the professional boundary becomes more permeable

(Moss et al., 2003). It is suggested that the construct of professional distance as a medical cultural ‘rule’ may act as a barrier to grief; however, in this context the family-like atmosphere seemed to dissolve the stance of detachment (Moss et al., 2003). Divergent experiences also emerged, which conveyed the impact of contextual and institutional factors to professional grief experiences. For example, a participant did not develop close attachments or grieve anyone when working in a bigger hospice.

The findings of this study question the rigidness of the general suppositions regarding rules of detachment in the hospice context. Yedidia (2007) describes that the prohibitions against emotional involvement with patients may often begin already in medical training due to the beliefs that expression of emotion needs to be censored to protect the wellbeing of patients and to minimise exposing physicians to vulnerability. This study illustrates and contributes further to the understanding that emotional involvement in the patient-doctor relationship can be experienced as meaningful and even desired for the PCP. Many participants described it as meaningful when professional distance was weakened and the patients were humanised, despite the inevitability that grief will be experienced “harder” when bonding with patients is consequently grief-inducing. The findings resonate with Stamm’s (2010) concept of compassion satisfaction*,* described as the positive aspect of working in the helping professions. Physicians working in end-of-life care seem to find satisfaction in connections with dying patients as enriching and mutually healing, counteracting the stressors (Chochinov et al., 2015; Kearney et al., 2009). Zambrano et al. (2014) similarly report that PCPs’ ‘intense connections’ with patients were a recurring theme. A high level of involvement with patients was accepted and preferred as a more valuable doctor-patient encounter (Zambrano et al., 2014). Similar findings have been reported in the oncology context (Granek et al., 2017). High involvement with families and bonding with patients is meaningful but as a consequence this contributes to intensifying physicians’ grief experiences (Granek et al., 2017).

A noteworthy finding was that doctors seemed to be grieving patients as ‘whole’ persons, implying meaning both as human beings and as professionals. This indicated that patients were seen and known more than as patients, as individuals, and relationships were also built with family members. Barnard et al. (2000) echoes these experiences of PC as ‘whole-person care’, not only in the sense that the whole person of the patient (body, mind, and spirit) is the object of the care, but also in that the whole person of the caregiver, the PCP, is involved. Hence, these findings shed light to an under-recognised area in research, about ‘doctor as a person’ in the care relationship and of understanding doctors’ emotions in the care relationship, something which has not received much attention in the literature (Balint et al., 1993; Mead & Bower, 2000; Winefield et al., 1996).

This relational field appeared as fundamental to participants' experience of the meaning of grief, though not without its tensions and challenges. Hence, the Group Experiential Theme of 'Relational Tension' exemplified grief as a relational theme that involves negotiating relational distance and proximity (Stroebe et al., 2008). The findings reflect that the relational environment of the hospice can work for the benefit of the PCP but also to the detriment of the PCP griever. Navigating and holding this tension of the attachment vs. detachment negotiation was challenging for participants. The existence of tensions between an empathetic caring connection and emotional distance is recognised in the consulted literature (Candrian, 2014; Kessler et al., 2012; Sorensen and Iedema, 2009; Stayt, 2009). The navigation of attachments may feel emotionally satisfying but at the same time cause emotional suffering due to the pain and loss that accompanies the joy of connecting with patients (Choo Wee et al., 2020; Fatima, 2022). These tensions are suggested to stem from the prohibitions against emotional involvement with patients that are conveyed in general medical training (Fatima, 2022; Halpern, 2001).

Although meaningful bonds with patients were desired, the findings suggested also that integrating all emotional responses and allowing themselves to grieve everyone seemed unrealistic and impossible for participants. Fears of allowing themselves to be affected by all patients were conveyed as being detrimental to participants' psychological wellbeing, potentially disrupting their capacity to work and function. A senior PCP reflected aiming for "a rationalist" approach, implying an attempt to balance the personal relationship with a human being with logic and rationality, offering a different approach, potentially because of learning and gaining experience. Participants' sense-making also suggested that senior doctors may be less affected by patient deaths and experience grief less due to spending less time with patients. Researchers have identified that junior-level doctors may be more vulnerable and affected than senior level doctors since they spend more time and develop bonds with patients (Choo-Wee et al., 2020; Redinbaugh et al. 2003). Hence, developing self-awareness and being more conscious of how patients are impacting PCPs is required and needs to be employed.

Furthermore, participants sense-making implied that they needed to develop a capacity to tolerate being in uncertainties and maintain openness to the complexities of human experiences. This resonates with Keats' (1817) philosophical concept of 'negative capability' (Rejack, 2019). The 'It is unpredictable' subtheme conveyed that all participants attempted to make sense of the logic of what patient, attachment or circumstance would elicit grief and grief responses. An integral dimension of experiencing grief in this context, that was expressed in divergent ways, was the need to surrender to the lack of logic, pattern or triggers. Experiencing grief was described as being unpredictable and surprising, for example, sometimes participants were surprised that not more deaths affected them. The findings, hence, conveyed PCPs requiring accepting the ‘unpredictable’ nature of what elicits grief, but also, the challenge of needing to deal with the sense of ‘unpreparedness’.

To conclude, it could be considered that rigid assumptions of professional distance and the barriers to emotional involvement could be challenged, echoing Yedidia (2007), that they are potentially illusory. Instead, better preparation of how to be in patient-physician relationships may be called for. The findings relate to PCPs potentially benefitting from improving their capacity to understand their own and other people’s emotions and behaviour, which then enables them to regulate affect and distress. Improving mentalising or reflective functioning (Fonagy et al., 2017) capacities of HCPs can help to build effective therapeutic relationships benefitting both the patient and the HCP (Free et al., 2023).

4.2.2 Disenfranchised and Deferred Grief

The findings in the ‘Being in the job mode’ subtheme suggest that, in the hospice environment, PCPs’ grief may be often deferred, put aside, or postponed due to contextual demands and job constraints, such as looking after patients’ needs as well as colleagues’ and team members’ wellbeing. These experiences seem to relate to the concept of disenfranchised grief (Doka, 1999). HCPs grief must be blocked out due to workplace demands and immediate workplace responsibilities, potentially causing suppression of medical professionals’ feelings (Doka, 1999; Faulkner, 1995). Some participants conveyed powerlessness and frustration, even fear, in the face of such professional expectations. The findings illuminate how internalised and implicit rules may be limiting and problematic, considering that the nature of PC work is highly emotional (Funk et al., 2017). Medical culture’s implicit ‘rules’, expressed by one participant as “*work is doing, not work is feeling”*, might add to a sense of PC work being devalued. Moreover, many participants talked about this ‘mode’ being like a way of managing and suppressing the grief. Importance and value were being placed on “getting on” to the next patient, not only because of contextual demands but potentially also as a protective strategy to manage emotions. A similar mode has appeared in Kasket’s (2006) study, presented as “There’s Always the Next Patient” – an emotion management rule implying that emotions need to be suppressed or otherwise emotions may lead to a process that could prevent the physician from doing the work. That said, divergent experiences emerged within this theme, for example, a senior PCP was intentionally taking the time to acknowledge feelings even amid the pressure to ‘move on’. These findings reflect individual differences in how participants face loss(es), with some of them also conveying resilient capacity and positive adjustment to adversity (Mancini &

Bonanno, 2009).

Moreover, the findings in this research study indicated that doctors may be feeling that they are ‘lesser mourners’ whose grief seems secondary in the hierarchy, providing further understanding of the PCPs’ grief experiences. As was conveyed in the ‘Doctor’s grief being secondary’ subtheme, participants were ‘deferring’ their own grieving and emotions due to the deep sense of professional responsibility to support everyone else – patients, relatives and colleagues. Own emotions were either put aside or left unacknowledged. Participants’ grief was not equated to patients’ or family members’ grief, conveying that participants may feel unentitled to their grief feelings or responses due to their professional status (Brooks, 2016; Doka, 2002). The relational lens of grief suggests that grief and grieving is influenced by others’ witness, acknowledgment and validation (Peskin, 2019). Deferring grief may reflect the existence of ‘grief rankings’ in a relational system, i.e., who has the priority in grieving, and who has to ‘defer’ grief in accordance with the implicit rules (Peskin, 2019). It could be argued that these grief hierarchies may be operating within this grief system (Stroebe et al., 2008). Hence, the findings echo Robson & Walter’s (2013) ideas that disenfranchised grief is not binary, i.e., either disenfranchised or enfranchised, but rather more complex, hierarchical and socially regulated in this context.

4.2.3 Anticipatory Grief

Anticipatory grief is a type of grief that is described as being an emotional response that occurs before true loss and is generally recognised in hospice and palliative care as a grief phenomenon (Moon, 2016). It is suggested as not only being experienced by the terminally ill person or the person with an advanced disease but also by family, friends and caregivers (Shore et al., 2016). The research findings importantly indicated that the participants, as professional caregivers, experienced grief also before the death of the patient. Interestingly, physicians’ anticipatory grief has not received much attention in the literature (Kumar & Nyatsuro, 2020).

Anticipatory grief is conceptualised as being an active psychological process of thoughts and emotions that connotes a range of intensified emotional responses towards an impending loss (Fan, 2020; Rando, 1986). It is noteworthy that some conceptualisations about anticipatory grief seem to be not only about ‘emotions’ but about various ‘processes’ (Rando, 1986). Participants described their anticipatory experiences being like accompanying patients in grieving, for example, grieving the loss of their abilities or grieving their lives ending. PCPs recognised being grievers, for example, grieving the loss of the future that the patient will never have. The anticipatory grief process was described by one participant as “grieving with them on their journey". Strikingly, the findings revealed that most of the participants expressed the anticipatory grief phase as being often harder than the grief post-death, and that they grieved less afterwards. Moreover, 'being' with suffering patients rather than 'doing' something for or to them can be challenging not only for more junior doctors but also for a seasoned PCP (Arbore et al., 2006). The anticipatory grief phase may be better tolerated by understanding one's countertransference responses to suffering as a tool, instead of emotional experiences viewed as obstacles for care, that may support more compassionate and authentic caregiving (Arbore et al., 2006).

The diversity of experiences reflected that there was no single way of capturing the emotions and experiences of anticipatory grief. For some, the anticipatory grief actually included a dimension of relief of the suffering being over when the patient died, and the anticipation could then end. Another participant used terminology around "everything being resolved" to characterise his experience of being affected, and of anticipatory grief leading to a resolution. This anticipatory phase also included tensions stemming from, for example, having hard conversations about the start of the dying and feeling torn if the patient was not accepting their dying, conveying a sense of frustration and feelings of helplessness. Positive experiences were also conveyed as coexisting with anticipatory grief, such as feeling satisfaction when 'the death talk' with the patient was experienced as being helpful for the patient. However, sometimes there was no relief in the anticipatory phase. One participant's sense-making revealed that she did not want the patient to die, and her feeling of being torn emerged.

4.2.4 Multilayered Grief

The mixed emotions, and sometimes conflicting internal experiences, in response to patients' deaths in this study resonate with the current understanding of the possibility of experiencing a wide range of grief responses (Bui, 2018; Redinbauch et al, 2003; Zambrano et al., 2014). Arbore et al. (2006) describes and recognises that professionals who work with the dying may experience countertransference feelings such as aversion, shame, anger, and sorrow. In addition, relief, guilt and many other kinds of emotions that may not seem to be linked to loss can be experienced (Van Wielink et al., 2020). Although the ubiquitous nature of grief was present in all accounts, different emotional experiences and layers of grief emerged in the findings. Some participants conveyed grief reactions being controlled and restrained. A senior PCP described traditional grief reactions being rare for her. Other reactions that were reported were a sense of relief mixed with guilt, self-doubt, in addition to a sense of ambivalence. Even the sense of 'oddness' or 'feeling strange' implied participants questioning whether it was grief at all that they were experiencing.

Thus, this study expands the body of knowledge by illuminating the nuanced and layered phenomenon of grief, which may go unrecognised if ‘traditional’ or ‘strong emotional reactions’ are the sole focus (Hubik et al., 2021). The paradox seems to be that invisibility and keeping emotions hidden would often be identified as a “tacit and uncodified skill” for HCPs (Gray & Smith, 2009), and professionals seem to aim to pursue what is professionally valued. However, a less visible grieving style or the relative absence of grief symptoms and the ability to function appear not to reflect denial or blocking out pain but can indicate an inherent and adaptive resilience in the face of loss (Bonanno et al., 2005). This will be discussed in a later section.

Furthermore, the findings illuminated the existence of a grief layer that was not displayed or did not have ‘a traditional reaction’ but was perhaps more of a mood, reflecting Heidegger’s (1962) contention that our human awareness of ‘being-towards-death’ produces anxiety. Although being faced with one’s own mortality was present in most of the accounts, one participant’s sense-making related to the concept of ‘existential grief’ or ‘existential suffering’, a constant sense of mortality of all human beings, conveying sadness, anxiety, but also acceptance. In the literature, existential grief is referred to as the sadness experienced over the inability to find meaning in loss (Stephenson & Murphy, 1986). This overwhelming sense of accumulated grief and emotional strain was not related to a particular patient but to the overall meaning making of grief experiences. Differing from reactive grief related to a particular loss, existential grief can arise from a realisation that death is a part of life (Stephenson & Murphy, 1986). Heidegger’s (1962) existential notion of being ‘thrown’ into the world and into human existence resonates with this participant’s realisations of ‘thrownness’, a concept of Heidegger’s (1962) that includes being mortal and the realisation that life is inevitably moving from birth towards death (Cohn, 1997, p. 70). PCPs are faced with human efforts to try to understand suffering and make meaning in grief.

Lastly, although the interview schedule did not cover experiences of personal grief, most participants reflected in their sense-making about their personal life loss-histories conveying importance for them. The findings revealed that personal life grief experiences seemed intertwined with work experiences, giving shape and texture to grief experienced in the professional context. Some personal grief experiences seemed to fuse into a certain way of behaving, perceiving, feeling and thinking when participants reflected about the hidden layers of their loss-histories. Participants’ own pain and suffering from personal losses seemed to have left them feeling vulnerable and triggered as doctors. These findings indicated that their professional role or identity did not function as ‘a barrier’ or as a protection against emotional experiences from their personal life surfacing in work interactions but rather revealed participants' vulnerability as humans. Early life experiences with death and loss are suggested to impact how HCPs interpret and cope with death at work, highlighting the importance of subjective ways of interpreting and understanding these experiences (Papadatou, 2000; Worden, 2009). Attachment theory and research on physicians' attachment styles could provide useful insights into the influence of one's unique emotions and history (subjective countertransference) to emotional responses and reactions in professional care work. This is an unexplored area in PC (Altilio & Sumser, 2016).

4.2.5 Cumulative Grief

Somatic experiences, such as feeling drained and physically exhausted from emotional tiredness, conveyed the accumulation of grief load in the 'Carrying grief in the body' subtheme. Hence, the findings indicate that the patient losses as disruptions seem to be experienced more perhaps as accumulations than as absences. Emotional tiredness was felt by the participants as physically draining even though the work itself was not experienced as physically demanding. It seemed that not only the weight of their own grief feelings was experienced as heavy but also possibly the feelings of others were absorbed from the environment. This resonates with Ratcliffe's (2022) phenomenological work about grief which suggests that through our feelings we experience our surroundings, echoing the important aspects of grief as an embodied emotional experience. The findings also suggest that the participants' interpersonal engagement with the social world was ruptured due to the somatic impact, and their reflections implied that participants were withdrawing from others. Bodily experiences, and the relationships between grief and the body, have often been ignored by both researchers and practitioners in the field of bereavement (Brinkmann, 2017; Pearce & Komaromy, 2022). The findings of this study highlight the importance for CoPs to understand and not to ignore the impact of grief in the body, and the bodily grief experiences, and to work with the whole person (Pearce & Komaromy, 2022; Wahl, 2003).

Too much emotion of loss without respite or, the opposite, avoiding confronting emotions of loss, can be harmful according to a Dual Process Model (DPM) (Stroebe & Schut 1999, 2010). Oscillating between 'loss orientation', when attempting to modulate grief-related feelings, and 'restoration orientation', i.e., getting on and continuing with life, gaining temporary relief from emotional draining, are described as providing a sense of balance (Stroebe & Schut, 2010). The findings from this study suggest that creating this sense of balance and oscillation is challenged when participants' grief is tied to a professional context and participants are dealing with multiple losses. A consequence of 'cumulative load of grief', when there is no time to integrate the impact of what has been witnessed or experienced, and to learn from it, is recognised both in physician (Dane, 1995) and in nursing literature, and it is noted that there are possibilities for burnout (Marino, 1998; Shorter & Stayt, 2010), and for developing an emotional state of chronic mourning (Dane, 1995). Papadatou's (2000) HCPs' grief processing model integrates the exposure to multiple deaths of patients and may have applicability in this context. In addition, Stroebe and Schut's (2016) updated theory, with the concept of 'grief overload', offers descriptions of how bereaved people may deal with overload, and the attendant mental and physical exhaustion (Schaufeli et al., 2009). Hence, these descriptions may be appropriately applied to HCPs' processing of grief, as they consider social setting, and recognise cultural and individual variations in coping (Papadatou, 2000; Stroebe & Schut, 2016).

Overall, a noteworthy understanding emerges from this study that 'pure grief' may be difficult to distinguish from other emotions and bodily experiences (Brinkmann, 2017). The grief overload may lead to experiences of burnout but this has been neglected in grief models of coping, and most grief theories may fail to recognise and understand embodied experiences of grief (Stroebe & Schut, 2016). This was evident in the research study. For example, one participant's experience indicated that the grief overload might sometimes be hard to disentangle from feeling burned out. States of exhaustion and biological, psychological and social dysfunction may be also linked to other conceptualisations of secondary traumatic stress disorder, or compassion fatigue (Papadatou, 2000; Stamm, 2010). Since physicians' physical and emotional exhaustion can also lead to a loss of empathy and affect the physician-patient relationship (Hulail, 2018), it may be necessary to expand the theoretical understandings. For example, integrating the contextual understandings from Stamm's (2010) framework of compassion fatigue may be necessary, as well as drawing from theories such as attachment theory and attachment styles in order to help make sense of the professional caregiver's capacity to tolerate and manage emotional stress in an emotionally demanding context (Adshead, 2010; Cassedy et al., 2015; Shalev et al., 2022).

As is evident from the findings, constraints from strained workloads can hinder taking the time to process emotions and can promote suppression of grief in the PC context (Funk et al., 2017). Offering and creating 'a safe space' for reflection and an environment in which all feel safe to acknowledge their emotions emerged in the analysis as being important. The findings in the subtheme 'Coping by separating grief spaces and drawing boundaries: "it is like being in the fire and you need to remove yourself from it"' illustrate how PCPs need to separate themselves from the cumulative load of grief and need 'time and space' to relieve emotional burdens. Similarly, the sense-making in the subtheme 'Being in the job mode' sheds light on some of the challenges of taking 'time and space' to attend to emotions, revealing the challenge of individual adjustment and coping in this context. Funk et al. (2017) echo that the lack of ‘time and space’ can prevent HCPs from integrating the affective grief experiences arising from patient deaths into their overall experiences.

Furthermore, a sense of powerlessness emerged in the analysis as participants attempted to create separation but felt that the grief load would inevitably get intertwined with their personal life. The participants’ sense-making suggested that oscillation, and particularly, intentional spatial and even geographical oscillation (Walter, 2007) between ‘grief spaces’, not only within the hospice but also between hospice and home, was necessary for healthy coping. Intentional boundary setting between work and home appeared to also be applied so as to not ‘carry’ the grief home and to take blocks of ‘time-off’ from work.

Lastly, the temporal experiences of grief dynamics shed light on the non-linear and dynamic experiences of grief. It seems that the suppressed or displaced emotions were not sealed off from appearing again, as described in the ‘Grief coming and going’ subtheme. The findings offered a further understanding that instead of grief being like a series of “minigrief” reactions (Holland, 2002), or as some participants’ experiences implied, being sometimes “momentary sadness”, divergent experiences also appeared. As shared by some participants, grief feelings arose even years later, unwilled, and in unexpected situations. According to Stroebe and Schut (2010), this is natural. This oscillation, sometimes described as wave-like movement, can occur within one day or months later (Stroebe & Schut, 2010). Modern bereavement science recognises that grief is not linear and orderly, and perhaps requires flexibility (Holland & Neimeyer, 2010). The oft-used term, ‘processing grief’, can also add to the illusion that on a given day, a person is done, ‘getting over it’ with feeling their grief (Van Wielink et al., 2020). Thus, the findings of this study can be useful in normalising PCPs’ individual experiences and creating more understanding work contexts, as oscillation between grief and getting on with life may not occur without challenges (Walter, 2009).

4.2.6 Transformative Grief

In contrast to traditional assumptions about grief being exclusively a negative state, positive appraisals and/or beliefs in self-growth from difficult events have been found to be as common as negative appraisals (Bonanno, 2004; Stein et al., 1997). Transformation and growth linked to the concept of post-traumatic growth may be considered the highest form of change associated with grief (Tedeschi & Calhoun; 1996). According to this framework, positive changes can occur, especially with those who respond to the loss in adaptive ways (Tedeschi & Calhoun, 1996, 2004, 2008). By adopting a stance that does not limit or reduce grief to ‘an emotion’, the research findings have conveyed that grief can also be a transformative experience (Markovic, 2023). According to Paul (2014, 2015) a transformative experience can: 1) teach the individual something that they could not have known without having the experience; and 2) change the individual's point of view, core desires and preferences. This research study's findings resonate with these perspectives that grief and bereavement can produce 'multidimensional changes', growth and transformation, as many participants conveyed growth experiences. These types of changes such as constructive identity change and developing greater awareness of life's fragility, ideas that are also talked about by Gillies & Neimeyer (2006), are also overlapping themes within the analysis and reflect the findings about reconstructing professional identity. In addition, the findings further contribute to an understanding that grief can hold multidimensional responses, and that negative states and positive feelings in grief can coexist (Bonanno, 2009; Seligman & Csikszentmihalyi, 2000).

The kinds of growth experiences described by people who have faced the struggle with bereavement tend to fall into five general categories: the experience of the emergence of new possibilities, changes in relationships with others, an increased sense of personal strength, a greater appreciation for life, and changes in existential and spiritual orientations (Tedeschi & Calhoun, 2004). It should be noted that the literature around positive changes from grief and loss is mainly developed from research on significant interpersonal losses. People who experience grief have reported enduring positive outcomes in interpersonal relationships, personal strengths, and life perspectives (Capps & Bonanno, 2000; Schoulte et al., 2012 Stein et al., 1997). The findings in the "Expanding life: 'taking life in'" subtheme echoed these dimensions. Many PCPs implied having gained clarity about their personal values. Most participants reflected gaining a new appreciation of and perspectives on valuing everyday life. Some of the participants had desires to expand their life contexts in different ways, for example travelling more and/or taking up new interests. The findings suggested that participants connected with life-affirming energy, perhaps due to an increased awareness of mortality conveyed in the analysis. Similar professional rewards in palliative care work are supported in the literature as well (Kearney et al., 2009; Slocum-Gori et al., 2011; Yedidia, 2007). Within the context of grief research there appears to still be, however, a gap between the theoretical construct of grief and strength-based psychology (Schoulte et al., 2012).

4.2.7 Grief Requiring Vulnerability

Delgado (2021) critiques that the mainstream literature about vulnerability in the healthcare field seems to have failed to attend to vulnerability from the perspective of healthcare professionals, who are confronted with emotional and physical suffering. The heightened sense of vulnerability and fear that may accompany grief seem to be less commonly discussed (Sim et al., 2014), or recognised as an aspect of grief (Rando, 1993). One of the striking features within the analysis was the apprehension to experience and/or show vulnerability that grief requires. The ‘Hiding grief: “putting down a big steel shutter”’ subtheme emerged from participants applying different adaptive strategies. Participants used language and like ‘embodied metaphors’ as concrete extensions as they shared their attempts to manage an internal conflict of authentic experiencing of emotions vs. wanting to ‘hide grief’. Their sense-making indicated adopting intrapsychic strategies to avoid communicating vulnerability to the outside world, and implied a fear of feeling vulnerable. A sense of complying with public expectations about doctors needing to be stoic was present as well in the analysis. Some experiences suggested experiential avoidance stemming from the lack of skills to feel and integrate difficult emotions, conveying helplessness and fear. To support psychological flexibility, individual coping and navigating with vulnerability, PCPs may benefit from developing skills and learning to accept unpleasant thoughts, feelings and sensations. There is a growing interest in investigating Acceptance and Commitment Theory (ACT) (Ruiz et al., 2008) and Mindfulness-based interventions (Gerhart et al., 2016) tailored to the experiences of PCPs, which can promote psychological flexibility.

Paradoxically, it emerged in the findings that vulnerability was difficult to manage on an individual level, due to limiting beliefs about one’s own vulnerability as ‘a weakness’, but on an organisational level, it emerged that vulnerability was recognised openly in the hospice culture. The subtheme of ‘Shared experience: “all going through the same things”’ implied that grief was a collective experience. Feeling vulnerable was collectively accepted and supported in the hospice contexts. Different support systems were in place, such as debriefings and clinical supervision, Schwartz Rounds, in addition to spontaneous collegial coffee/tea meetings where PCPs could offload emotional burdens. It is recognised that opportunities for PCPs to share the emotional impact of their job with colleagues and members of multidisciplinary teams are beneficial in the PC context (Zambrano et al., 2014). Supportive work environments may counteract the stressors at work (Vachon, 1995). Sharing vulnerability in some other medical specialities may sometimes be considered risky, for example due to fear of appearing unprofessional, or even a potential liability (Granek et al., 2013). Findings illuminated divergent experiences and individual differences in how comfortable participants were in showing their vulnerability. Moreover, individual needs were often overridden by the professional duty to support others.

In contrast to the collective sense of understanding and supporting each other within the hospice, many of the participants’ accounts illuminated a sense of disconnection to the outside world. Hospice experiences and the emotional landscape appeared as being unrelatable to ‘outsiders’. ‘The unrelatable reality’ subtheme emerged from all participants’ shared experiences, implying that their work reality and ‘normality’ were not understood by others. Participants preferred sharing about their work and stresses with medical colleagues, but even with them, the hospice reality and emotional landscape seemed unrelatable if the medical colleague did not/had not worked with death and dying. Swetz et al. (2009) echo these experiences, stating that PCPs preferred using professional relationships over family and friends to relieve emotional burdens. It is possible that participants’ personal meanings and lived experiences around grief may go unrecognised, as the ‘outside world’ may not be able to create space and time for PCPs’ grieving, potentially due to the social stigma around death and dying.

4.2.8 Reconstructing Professional Identity

Compelling findings emerged within the analysis indicating that participants seem to be engaging in an identity development process that acknowledges their vulnerability. Grief experiences seem to act as a catalyst to professional identity transformation. Relevant to the understanding of how PCPs relate to grief is that physicians are suggested to develop collective defences, which can include depersonalisation, sublimation, and denial of vulnerability as part of becoming a professional (Gerada, 2019). According to Gerada (2019), medical doctors’ deep-rooted ‘medical self’ identity, that may merge *both* professional and personal identity, is developed to protect the doctors from emotional burdens of work (Gerada, 2019). In this research study, participants seemed to be going through a process of moving away from ‘a hero that saves lives’ identity to a more authentic identity position, as a human being and as a professional, to be better able to cope with grief and human mortality. This resonates with Erikson’s (1982) ideas that it becomes like necessity to repress some existing identity parts. Participants in this study, and like other medical doctors, needed to internalise a more relevant identity for their medical context (Cruess et al., 2014). Some PCPs’ sense-making conveyed that, in this context, they recognised the need to learn to sit with and support patients’ grief but also, as part of the process, to identify themselves as grievers. This process emerging from a generic physician identity to a more discipline- and/or role-specific identity (Cruess et al., 2014; Jarvis-Selinger et al., 2019) sometimes can result in ‘identity dissonance’ due to elements of the pre-existing identity conflicting with those required by the profession (Monrouxe, 2010) – a theme that was present in the findings.

The findings could also relate to the conceptual framework of ‘meaning reconstruction in bereavement’ by Gillies and Neimeyer (2006) which suggests that in grief, meaning making is an active process and an adaptation to a loss or losses, frequently involving constructing a new reality, and involving identity change. Identity change is suggested as being an adaptive process of the reconstruction of self where individuals may become more resilient (Gillies & Neimeyer, 2006). PCPs identity change seemed necessary as a response to the reality that they are required to be alongside and in response to the emotional demands of patients, families and colleagues, more so than in any other area of medicine (Bharmal et al., 2019; Bury, 2006). Some participants identified belonging to 'a subgroup' of medical professionals who are better able to cope with the emotional realities of dealing with grief and human mortality than colleagues in other medical specialties. Instead of 'doing something for the patient', 'being with the patient' is needed when dealing with grief (Van Wielink et al., 2020).

Furthermore, literature offers some research about medical doctors' socialisation to emotions and about their professional identity development (Bolier et al., 2018; Cruess et al., 2014; Hafferty et al., 2009; Jarvis-Selinger et al., 2019). An adaptive developmental medical identity formation process is conceptualised as happening simultaneously at two levels: 1) at the collective level, which involves the socialisation of the person into appropriate roles and forms of participation in the community's work; and (2) at the level of the individual, which involves the psychological development of the person (Jarvis-Selinger et al., 2019). The findings in the 'Learning about "the emotional self"' subtheme implied that at the individual level, many participants needed to learn, and recognised that they were still learning, about their "emotional self", as expressed by one participant, and how to relate to their grief and grieving. This implicit learning process seemed to include acknowledging and learning that as a professional and as a person, one is vulnerable.

Learning to relate to grief seemed to happen through socialisation and learning by experience, where senior doctors played a central role. Many participants expressed that their medical training did not prepare or 'teach' them how to respond or relate to grief, but instead, it seemed to be "learned on the job". The literature echoes that physicians may be lacking training on how to deal with grief and emotional burdens of their work (Bharmal et al., 2019; Genevro & Millet, 2010; Moores et al., 2007; Rabow et al., 2000). Socialisation, which is different from training (Hafferty, 2009), is suggested to consist of a complex network of personal experiences, reflection on these experiences, and social interactions that take place in a learning environment (Bolier et al., 2018). Observing how senior colleagues respond and behave was described as given "a permission to grieve" by one participant. Mentors and peers can enable professionals to learn these skills (Bury, 2006). However, Hafferty (2009) believes that some learning may be implicit or unconscious. Overall, a concern arises around how senior physicians' learning can be supported. Interestingly, one senior PCPs' sense-making implied her learning how to grieve from nurses, patients' relatives and even from patients themselves. Reflective practice is increasingly used and considered to be a core element of professionalism (General Medicine Council, 2000; Mann et al., 2009). Self-reflection can be done in many forms. Reflective writing can provide a valuable opportunity to reflect and learn from professional and personal issues encountered in PC work (Borgstrom et al., 2016). Furthermore, tailored supervision in learning how to experience, express and respond to emotions can address individual differences and needs (Bolier et al., 2018). The findings may help to make the PCP identity formation and learning processes an explicit phenomenon and to encourage PCPs to actively reflect on their progress (Cruess et al., 2014).

4.2.9 Resilience as a Grief Trajectory

This last section looks at the opposite perspective or grief phenomenon – dismissed in mainstream psychology and literature – whereby the most common trajectory in grief seems to be one of resilience, i.e., most people coping well with grief (Bonanno, 2004, 2009; Bonnano et al., 2002). The modern science of bereavement seems to encounter a narrow perspective of traditional bereavement, and suggests that for most people, grief may not be overwhelming (Bonanno, 2009). There is a growing recognition of the concept of resilient capacity in grief. This does not imply that people experience no upset related to the loss or aversive event, but rather that their overall functioning is preserved and they adjust well with minimal disruptions (Bonanno et al., 2002; Bonanno, 2004: Mancini & Bonanno, 2009). Despite the emotionally demanding work context and coping with multiple losses, many PCPs seemed to accommodate to losses relatively quickly and be able to attend to their work and patients. Hence, taking a meta-perspective of the overall findings it seems important to highlight how these themes also illuminate the resilience of participants in the face of loss and death. Instead of participants being debilitated, many expressed feeling privileged and honoured to do the work, their purpose being providing ‘good deaths’ to patients, indicating their resilience and functioning. It is however noteworthy that coping with multiple losses has not been well established in bereavement theories. Some studies in other contexts talk about adaptive habituation as a further perspective on coping with multiple losses and grief (Cherney & Verhey, 1996). More research is needed about adaptability, resilience and ‘positive’ experiences of coping with grief in a work context where individuals deal with multiple losses. Furthermore, consistent with modern scientific perspectives of bereavement, it is important for CoPs and researchers to attempt to hold a range of possible outcomes or ideas, instead of rigid ones, of what is ‘proper’ grief behaviour, and to be aware of biases in judgement.

4.3 Applications and Implications for Counselling Psychology and Other Contexts

The research findings from the current study, and their position within the existing literature, offer various insights and understandings with practical implications and opportunities.

Whereas perhaps before the COVID-19 pandemic grief was often overlooked and minimised, understanding the phenomenon of PCPs' grief is now more topical than ever (Kates et al., 2021: Rabow et al., 2021; Wallace et al., 2020). The pandemic and its effects revealed how healthcare systems need to take greater responsibility both to prepare HCPs and to support them in their professional and personal grief by validating their experiences and offering adequate support systems (Rabow et al., 2021).

CoPs can provide a range of psychological and emotional support for PCPs, as they work in staff wellbeing and occupational health services and contribute to the development of supportive working environments (Orlans, 2003). However, by formally integrating CoPs' and psychologists' roles into PC teams, and developing formalised training, defining roles and competencies for psychologists (Jünger et al., 2010), evidenced-based and specialist-level interventions could be offered. In all medical specialisms, the stigma of talking about experiences of patient deaths needs to be reduced and psychologists need to be made more available to physicians (Kasket, 2006). Good psychological support in PC is everybody's right and support should be available (Payne & Haines, 2002).

The findings highlighted the importance of being able to take time and space to attend to one's emotional experiences. Both individual and system interventions are essential and needed. The findings indicated that some participants preferred one-to-one psychological support over group settings, although at the same time they appreciated a shared sense of collective support. Hence, individual psychological support and counselling can act as a secure and holding base for the physician to be seen and have their experiences validated and this should be available for PCPs. As also illustrated in the findings, personal life loss-histories, that may get intertwined with work situations, may be also better explored and made sense of in an individual support setting.

The idiographic approach highlighted that each griever's experiences are different. The lack of emotional ventilation does not mean that grief and grieving is not happening, and many will heal without professional help (McCoyd & Walter, 2016). However, it is suggested that precisely in cases of disenfranchised grief the therapeutic support can play an important role in witnessing the story that has had to remain hidden but needs to be heard, and the meaning of loss explored (Van Wielink et al., 2020). In the light of the findings, hospices may consider offering individualised support to PCPs, as they may be already grieving when the patients are still living. Further, the contextual understanding that arises from this study indicates that suppressing grief and deferring emotional experiences in this context may be needed as a coping strategy, and therefore this should not be pathologised. Instead, it is important for PCPs to know that they will have an opportunity to be heard and their feelings recognised later in a safe space, either with peers, colleagues, supervision or psychological support. PCPs can learn to suppress the grief until they find a suitable moment to grieve (Bury, 2006). Pragmatic arrangements such as a dedicated room to take time and space to attend to one's emotional needs were reflected as being important for PCPs wellbeing.

Staff support services could offer integrative therapies drawing from pluralistic approaches, giving attention not only to cognitive and emotional processes but also to the body's internal experience of grief and loss. Recognising the impact of grief in the body, the exhaustion and emotional burden, sometimes felt as physical tiredness, that may be mixed with symptoms of burnout, is a noteworthy finding for CoPs. CoPs have a special understanding of using the body as a therapeutic tool (Finlay, 2011), and can draw from body-oriented therapeutic interventions and body-awareness techniques to support addressing grief (Wahl, 2003).

As the research study valuably highlights, junior- and senior-level doctors may have different 'emotional realities' and they may be impacted by grief to different extents, due to varying levels of patient contact and different stages of experience and on-the-job learning. It seems important that support systems directly explore what the individual needs are for emotional support. Senior PCPs who feel/are responsible for others need to also have emotional support and space to explore their experiences. Their role in offering 'emotional leadership', i.e., modelling to other PCPs how to navigate, express and manage emotions, appears crucial in how doctors learn to deal with and relate to grief.

The reported process of ongoing learning about 'the emotional self' indicated that PCPs may benefit from learning skills such as developing psychological flexibility, and new, more flexible ways of thinking and feeling in emotion-eliciting situations. For example, ACT (Acceptance and Commitment Therapy) interventions can support PCPs in relating to unhelpful interpretations of emotions, thoughts and situations in more useful ways, and to facilitate acceptance and self-compassion (Hayes et al., 2004).

Furthermore, PCPs may be at different stages in reconstructing identities, which can be assisted by supporting meaning reconstruction and how the grief experiences have changed them as people. CoPs recognise that people can evolve as a result of adverse experiences and they can support PCPs in their existential growth and post-traumatic growth processes, and trajectories of resilience.

In professional caregiving it is possible to allow oneself to retain sensitivity to patients whilst retaining integrity, and being congruently present, but not enmeshed (Bury, 2006). In the light of the findings, it seems necessary to better prepare PCPs for emotional involvement in the physician-patient relationship in PC (Yedidia, 2007). Patients benefit from the emotional involvement of the PCP (Yedidia, 2007). Clinical supervision by CoPs can provide a venue and a container to learn from and reflect on the relational, patient-doctor relationships, experiences and attachment-detachment tensions. It is also recommended that the use of reflective practice be implemented as a standard practice within PC settings (Moon, 2011). Counselling psychology’s conviction for a relational framework is something that honours reflexive practice (Manafi, 2010, p. 32). Becoming knowledgeable about and understanding one’s own personal framework or beliefs regarding grief through engaging in development of self-awareness is necessary (Moon, 2011). Considering also the PCPs’ pivotal role in educating and training PC and medical professionals (Selman et al., 2017), PCPs’ skills and capacity to manage and cope with their own professional grief is vital.

This research study supports the need for the provision of grief training and practice *before* specialist PC training in order to provide curriculum content, experiential learning opportunities, and supportive and reflective practice to deal with emotionally demanding aspects in medical care (Bharmal et al., 2019; Sikström et al., 2019). Hulail (2018) suggests that medical organisations could employ experts with strong humanistic knowledge and skills, and experience in interpersonal skills, to support the evolution of professionalism and humanism among medical students. CoPs are well positioned for this.

A useful consideration for CoPs is that grief theories' major limitation is that they tend to involve generalisations (Gross, 2018). CoPs are, therefore, recommended to reflect on their views on ‘grief theories’ as they may have fallen into conventional or generalised ways of thinking that theories are meant to be applied to everyone equally. Postmodern, conceptual approaches to ‘grief work’ allow grievers and supporters to tailor their interventions and avoid thrusting uniform models on grievers (McCoyd & Walter, 2016). In addition, CoPs should retain a critical perspective regarding the tendency to medicalise normal events such as bereavement and grief. Lastly, sensitive use of terminology by professionals that protects neutrality and avoids assumptions that would pathologise individuals will allow for the representation of a much broader domain of the human experience following losses (Tedeschi & Calhoun, 2007).

4.4 Evaluation of Research

4.4.1 Research Validity and Quality

According to Smith et al., (2022) research validity assesses the extent to which the design and methodological approach used in a study are fit for purpose and the study is a meaningful piece of qualitative research (p. 147). There are diverse ways of thinking about validity for qualitative research, however, Yardley's (2000, 2008, 2017) criteria for good-quality research have guided me throughout the research project. I have attempted to demonstrate throughout the chapters how the criteria are adopted in this research study. Some examples of the criteria (Yardley, 2000, 2008, 2017) are outlined here:

1) **Sensitivity to context**: To demonstrate sensitivity to context, I conducted a literature review that covers extensively the theoretical and relevant psychological literature on grief, professional grief, palliative care physicians' and physicians' emotional experiences, extending beyond psychological literature. Throughout the research project I have engaged broadly with relevant literature. Participants' perspectives and wellbeing have been considered throughout the project, from interview stage to post-interview stage. For example, interviews were arranged in locations that were suitable for participants/their schedules. Attentiveness to the wellbeing of participants was applied. I have considered research participants as experiential experts in this topic that I am investigating (Nizza & Smith, 2022). This positioning has helped me to be sensitive to participant-researcher power differentials. Ideas around how the participants will benefit from the research findings in their context have been developed throughout the project.
2) **Commitment and rigour:** My commitment to conducting high-quality research covered various aspects. Recent changes in IPA terminology were applied and accommodated in the data analysis (Nizza & Smith, 2022). Methodological competence was developed in research methods courses during the doctoral training and I immersed myself in IPA literature. Participating in IPA research groups helped me gain an appropriate level of proficiency, get feedback on the interview schedule, discuss procedural aspects and practise analytic coding. Seeking feedback from my research supervisor to drafts ensured sufficient proficiency and quality in analysis. Further, presenting a research poster at the Counselling Psychology Division Annual Conference in York, UK, in 2023 and attending the first European Grief Conference

2022 in Copenhagen demonstrated my commitment to develop as a researcher and contribute to the development of the grief and bereavement field.

3) **Transparency and coherence:** A coherent, transparent and detailed account of the data collection and analysis, supported by quotations verbatim from the transcripts to ground the interpretations, is presented in the Methodology chapter. Various relevant materials can be found in the Appendix section.
4) **Generating useful knowledge** and 5) **Impact and importance:** Knowledge Contribution and Impact and Importance are considered in the Section 4.3 above.

In addition to these more generic quality markers in qualitative research, I have also drawn from Nizza et al. (2021) four quality indicators specifically developed for IPA to help researchers produce good IPA when writing the analysis: 1) attempting to construct a compelling unfolding narrative; 2) developing a vigorous experiential and/or existential account; 3) engaging in a close analytic reading of participants' words; and 4) attending to convergence and divergence (Nizza et al., 2021). The analysis attempts to demonstrate several of these simultaneously.

4.4.2 Research Strengths and Limitations

It is the author's understanding that the PCPs' grief experiences in the hospice context in the UK have not been directly investigated using phenomenological and qualitative methods. Rafalin (2010) points that the strengths of interpretative qualitative research studies are that they have the benefit of making a unique contribution to the CP field and also interdisciplinary fields, as is the case of this study, as they often can illuminate diverse experiences of unique populations in particular contexts. This study has aimed to show both breadth and depth, nuance and variation to offer a rich illustration of an overlooked phenomenon. Moreover, the idiographic work has allowed the author to enter and capture some of the intangible dimensions of the experiences. It is the author's understanding, that the areas identified through IPA have received less recognition in PCP grief phenomenon studies, and therefore, the research will expand the current literature base with these compelling findings, hopefully in a way that increases recognition, validation and support for PCPs' grief experiences. Since the IPA analysis is a joint product between participant and analyst, due to the hermeneutic stance, it can be claimed that all findings are to some extent unique, as they are co-created in a dialogue with the researcher. Different findings and narratives would be likely to emerge with another researcher.

In addition to its strengths, this study comes with limitations. Firstly, the concept of grief can be understood in multiple ways. To allow the phenomenon to appear as it unfolds for each person, grief or professional grief were not defined to participants in the interview. Postmodern understandings of grief hold that there can be many truths. Hence, the different societal, cultural and personal understandings of grief may have varied. Then again, this may have also contributed to a multifaceted illustration of the grief phenomenon that is relevant to this context. In addition, many of the lived experiences were retrospectively recollected, which may have impacted the ‘in the moment’ experiencing and affected the accuracy of memories.

The sample of participants was homogenous in the sense that they were all PCPs working in hospice contexts in the Greater London area. Heterogeneity of the participants within the sample was represented as one male and five females, two consultant-level PCPs and four registrars. Five participants were ethnically white and one non-white. Increased diversity in cultural backgrounds, race and ethnicity could offer a fuller understanding of the phenomenon under study. Participants were all from a self-selecting group, motivated to share their experiences, indicating a certain willingness and/or capacity to expose themselves to feeling vulnerable. Self-excluding individuals might have contributed different experiences.

The IPA findings are not expected to be duplicated in other samples; however, they may provide value in similar contexts (Yardley, 2008), for example, in end-of-life care settings in hospitals. Hence, this study recognises that idiographic study with unique specific findings does not offer value in generalisability, but it can offer a significant contribution through connecting the findings to the existing psychological literature (Smith et al., 2022).

Since the results were co-constructed through researcher-participant interaction, they reflect the situational and contextual characteristics as well. The interviews took place in participants’ work contexts, and perhaps their ‘professional stance’ might have prevented the sharing of some experiences so as to maintain their professional role. Then again, this might have been beneficial, as the phenomenon under investigation was about grief being explored in a professional context. Participants also knew that I was a Trainee Counselling Psychologist and might have had their own biases about sharing their vulnerabilities with a mental health professional. My training and skills, on the other hand, may have helped to hold the space for conversation, one that may be different to their everyday life conversations.

4.5 Recommendations for Future Research

In addition to those research recommendations highlighted in the Section 4.3, there are further recommendations for future research. Firstly, methodological pluralism combining both qualitative and quantitative studies could be used by researchers if/when discussions concern provision of psychological support for PCPs in order to level up development of support service systems. Institutions and organisations can play a significant role in preventing or intervening in cases of burnout or other negative outcomes (Keidel, 2002), and they need to understand the importance of staff support. For example, the anticipatory grief phase may get unrecognised. Psychometric anticipatory grief evaluation measures (Holm et al., 2019) and psychometric instruments should be developed for HCPs and professional caregivers.

Secondly, psychological distress among the palliative and hospice workforce has been evident in the post-pandemic studies (Kates et al., 2021). Medical personnel experienced death at unprecedented rates during COVID-19 pandemic, amplifying some crisis and coping behaviours and feelings (Wallace et al., 2020). Further investigation into how PCPs cope with multiple losses and grief could be valuable in order to build on Bonanno et al.'s (2002) and Morin et al.'s (2017) work on resilience to loss and chronic grief in the face of traumatic events, in a professional context.

Lastly, different demands around how people wish to die in the future may impact PCPs' emotional burdens and emotional labour; how they grieve and can experience grieve should not be overlooked. Assisted dying, a polarised topic in the UK (Sleeman & Owen, 2021), was mentioned in the research interview by one participant who raised concerns of: "Who knows how we are going to grieve?". It could be expected that psychological distress about ethical and moral injury issues, as well as emotional burden and physician identity dilemmas, will increase. Further understanding of how PCPs can be supported is needed (Evenblij et al., 2019).

4.6 Overall Reflections

Conducting this IPA research project has changed me in aspiring me to put into practice a phenomenological attitude in my psychological counselling work and in research. I believe that this philosophically informed approach will support me in attending to lived experiences with novelty and in appreciating the diversity of human beingness, avoiding the temptation to fall into universal predictions and hopefully making me a better CoP when working with different individuals and social contexts.

I recognise that this research project may have been influenced by the particular context in which it was written. The research project was started pre-COVID 19 and is finishing post-pandemic. The collective grief not only from the pandemic but also the collective grief that lingers from the conflicts in and in crossroads of Europe have been part of the context of the research project write-up stage. The research project was also situated in a personally challenging health context, time, and healing journey, leading me to face my own mortality. Hence, what it means to enter “the other side” of grief (Bonanno, 2009), and to embody human resilience and adaptability when faced with impinging challenges resonates with me.

Lastly, it was a privilege to meet the research participants where they were in their grief learning journeys and career trajectories. I hope this study has succeeded in giving voice to them. This study also wants to recognise and honour those patients who have died. Their presence and personalities still live in the stories of the participants. As a researcher, I learned something from the life-worlds of each participant -- it has been a privilege to be trusted with these accounts.

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Appendix A: Literature Search Strategy

Search words / Poolean phrase:

Palliative care or end-of-life care AND physician or medical doctor AND grief or bereavement or loss and dying or patient death

(palliative care or end of life care) AND (grief or loss and bereavement) AND (medical doctors and physicians) AND (patient death or dying)

No date restrictions

1. Death Studies	US
2. Omega-Journal of Death and Dying	US
3. Palliative Medicine / Sage Journals	UK
4. Journal of PalliativeMedicine	US
5. Journal of Pain and Symptom Management	US
6. Journal of Loss and Trauma	US
7. American Journal of Hospice and Palliative Medicine	US
8. BMC Palliative Care	UK
9. Palliative and Supportive Care	UK

- APA PsycINFO 289 -> no PCP grief studies
- PubMed 350 -> no PCP grief studies
- Science Direct 320 -> no grief studies
- Google Scholar 22 700 -> not PCP grief studies
- Death Studies 308 -> no PCP grief studies
- BMC Palliative Care -> 416 -> no PCP grief studies
- Palliative Medicine (Sage Journals) 416 -> no PCP grief studies
- Palliative and Supportive Care 1498 -> no PCP grief studies
- Journal of Palliative Care (Sage Journals) 560 -> no PCP grief studies
- Qualitative Research Journal (by Association for Qualitative Research) -> no PCP grief studies
- SAGE Journals 1804 -> no PCP grief studies
  - Journal of Palliative Care
  - Palliative Medicine
  - Palliative Care and Social Practice
  - OMEGA Journal of Death and Dying
  - American Journal of Hospice and Palliative Medicine
  - Nursing Ethics
  - Illness, Crisis & Loss
  - Journal of Holistic Nursing
  - Journal of Pediatric Oncology Nursing
  - InnovAiT
  - Journal of Child Neurology
  - Etc.

Appendix B: Recruitment Flyer

INVITATION TO PARTICIPATE

We are looking for **Medical Doctors** to contribute to a Doctoral research of

Palliative care physicians' GRIEF EXPERIENCES in the hospice context.

Taking part in this study involves participating in one session of 60-90 min. conducted as one-on-one interview.
To contribute to this study and for more information please contact:

DPsych Student Researcher | Ms Jonna Kayatz | jonna.kayatz.1@city.ac.uk
Research Supervisor | Dr Aylish O'Driscoll | aylish.ODriscoll.2@city.ac.uk

City, University of London | DPsych Counselling Psychology Programme

Sincere thank you for your interest.

This study has been reviewed by and received ethics clearance (ETH 1819-0100) through the School of Arts and Social Sciences, City, University of London. If you would like to complain about any aspect of the study, please contact the Secretary to the Senate Research Ethics Committee on 020 7040 3040 or via email: Anna.Ramberg.1@city.ac.uk

City, University of London is the data controller for the personal data collected for this research project. If you have any data protection concerns about this research project, please contact City's Information Compliance Team at dataprotection@city.ac.uk

Appendix C: Participant Information Sheet

PARTICIPANT INFORMATION SHEET

Title of study: **An Interpretative Phenomenological Analysis (IPA): Exploring Palliative Care Physicians' Grief Experiences in the Hospice Context.**

Name of the principal investigator:
Ms Jonna Kayatz (Student Researcher) and Dr Aylish O'Driscoll (Research Supervisor).

I, Jonna Kayatz, Trainee Counselling Psychologist and a DPsych Student Researcher will be carrying out this research project as part of the requirements for the Doctorate in Counselling Psychology programme, City, University of London. The research is being supervised by Dr Aylish O'Driscoll, a Registered Psychologist, a Senior Research Tutor and a Lecturer at the City, University of London.

We would like to invite you to take part in this research study. Before you decide whether you would like to take part, it is important that you understand why the research is being done and what it would require from you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the purpose of the study?
The purpose of the study is to investigate and explore palliative care physicians' (Medical Doctors') grief experiences in the hospice context. Grief is an integral part of the normal process of caring for dying persons. However, the phenomenon of physicians experiencing grief over patient deaths has remained invisible and hidden in the context of wider medical culture. It will be a valuable opportunity for you to talk about your experiences over patient deaths as a physician working in a palliative care setting, and an opportunity for you to reflect on your emotions, thoughts and behaviour and what is related to your experiences.

Why have you been invited?
Palliate care settings and hospices are being contacted to invite participants to join this research study. You can take part if you consider fulfilling the following inclusion criteria set for the purposes of the study. In total around 8 participants will be included in an in-depth, case-by-case examination of the phenomenon.

This research study welcomes you to take part, if you consider fulfilling the following criteria:

- You are a Specialist Palliative Care Physician/Medical Doctor or Physician/Medical Doctor in Specialist Palliative Care training in the UK.
- You are currently working in a hospice context.
- You have work experience in a hospice setting for minimum 1 year.
- You have experienced patients dying in a hospice.
- You speak and communicate in English.

Do you have to take part?

Participation in this research study is completely voluntary and it is up to you to decide whether or not to take part. It is also important to understand that you do not have to answer any questions about anything you don't want to answer. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason without being disadvantaged or penalized in any way. However, withdrawal is possible up to the point, where the data has been anonymised and the writing up the data analysis has started.

What will happen if you take part?

You will be invited to one session of 60-90 min. conducted as one-on-one interview with the Student Researcher in a location that is convenient for you.

Expenses

Possible travel expenses (within the Greater London area) will be covered by the researcher, if needed.

What do you have to do?

Your participation will involve answering open-ended questions about your grief experiences in the hospice context. You will take part in a face-to-face, one-time, semi-structured interview lasting approximately 60-90 minutes in a location that is convenient for you. The research method used is Qualitative research method called Interpretative Phenomenological Analysis (IPA) that is often used to study individuals' subjective experiences. To protect your confidentiality, no personally identifying information, for example, names, locations, or organisations, will be used in any write-up of this research, nor in any later journal publication. If you would like a copy of the report once it has been completed and appraised, I will be happy to provide you with a copy.

What are the possible disadvantages and risks of taking part?

Taking part in this research project and in the one-time interview shouldn't involve any greater risk of physical or mental harm than you would experience in your everyday lifestyle. Disadvantages and risks may include that when talking about personal experiences, there may be a chance that as a consequence of engaging with these events, experiences and/or emotions, you may feel uneasiness, discomfort or distress. Should this happen we can stop or pause the interview and consider how to provide you the support you think you need in that situation and going forward. Other disadvantages may include taking the time to participate in this interview.

I would like to emphasise that your confidentiality will be protected at all times and no personally identifying information, names, locations, organizations, will be used in any write-up of this research or any possible later journal publications.

You will have an opportunity to ask questions at the end of the interview and share if you have any concerns.

What are the possible benefits of taking part?

Possible benefits may be for you to have an opportunity to reflect on your grief experiences and as a result to improve your self-awareness. Depending on your personal experiences you may also experience, as a result, new insights in your personal wellbeing and wellbeing at work. Engaging with your grief may induce growth, cultivate perspective transformation and improve work satisfaction. Your contribution and your reflections may contribute to the wider understanding of grief experienced in the medical culture, considering that physicians experiencing grief in the medical culture has been quite an invisible phenomenon and something that has not received much attention in the academic research.

What will happen when the research study stops?

After the research analysis is completed, the collected data will be kept usually for 10 years, in accordance with guidelines set out by City, University of London's institutional guidelines. After which the recordings will be deleted and the transcripts destroyed. The recordings will be stored safely and encrypted to protect the confidentiality. The collected participant data will not be used in any other research or purpose, even if the project for some reason had to stop.

Will you taking part in the study be kept confidential?

Research data will be kept and stored securely at all times. Laptop and recorder will be encrypted and password protected. Data generated by the study will be retained in accordance with the University's policy on Academic Integrity. The data generated in the course of the research will be kept securely in paper or electronic form for a period of ten years after the completion of a research project.

- Any information that you provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party.
- No identifiable personal data will be published. The identifiable data will not be shared with any other organization.
- Before anonymization the researcher is the only person to have access to the data. After the anonymization also the research supervisor may have access to the data.
- Interview recordings will be stored safely, password protected and encrypted to protect confidentiality.
- Your personal information will not be used in any other purpose or future use.
- Interview recordings and research documents will be stored safely by the researcher.
- After the research analysis is completed, the collected data will be kept usually for 10 years, in accordance with guidelines set out by City, University of London's institutional guidelines. After which the recordings will be deleted and the transcripts destroyed. The recordings will be stored safely and encrypted to protect the confidentiality. The collected participant data will not be used in any other research or purpose, even if the project for some reason had to stop
- Data transfers to and from the UK are not expected or involved in this study but it is important to know the data is processed to the same standards as within European Economic Area (EEA)
- The information will be held by City as data controller and processed for the following purpose(s): for the purposes of lawful basis for processing under General Data Protection Regulation (GDPR):
    - The legal basis for processing your personal data will be that this research is a task in the public interest, that is City, University of London considers the lawful basis for processing personal data to fall under Article 6(1)(e) of GDPR (public task) as the processing of research participant data is necessary for learning and teaching purposes and all research with human participants by staff and students has to be scrutinised and approved by one of City's Research Ethics Committees.

What should you do if you want to take part?
If you wish to take part, please contact Ms Jonna Kayatz by email jonna.kayatz.1@city.ac.uk

What will happen to the results of the research study?
The doctorate thesis will be made available on the City Research Online. Further possible dissemination options will be counselling psychology, palliative care and/or medical journal publications. In all these cases, your data will be kept anonymous and identifying information with any organizations will be kept anonymous and confidential. If you wish to receive a copy of the thesis once it has been completed and appraised, I will be happy to provide you a copy.

What will happen if you do not want to carry on with the study?
If at any time you do not want to carry on with this study and you wish to withdraw from this study, you may do so without any further explanation and without being disadvantaged or penalized in any way.

Who has reviewed the study?
This study has been approved by City, University of London, School of Art and Social Sciences Research Ethics Committee. Ethics code: ETH 1819-0100.

Further information and contact details
If you have any questions you might want to ask, please contact

DPsych Student Researcher: Ms Jonna Kayatz
Email: jonna.kayatz.1@city.ac.uk |Tel: +44 (0)75 26627812

Research Supervisor: Dr Aylish O'Driscoll, Department of Psychology
Email: Aylish.ODriscoll.2@city.ac.uk | Tel: +44 (0)20 7040 8500

Data Protection Privacy Notice: What are your rights under the data protection legislation?
City, University of London is the data controller for the personal data collected for this research project. Your personal data will be processed for the purposes outlined in this notice. The legal basis for processing your personal data will be that this research is a task in the public interest, that is City, University of London considers the lawful basis for processing personal data to fall under Article 6(1)(e) of GDPR (public task) as the processing of research participant data is necessary for learning and teaching purposes and all research with human participants by staff and students has to be scrutinised and approved by one of City's Research Ethics Committees.

What if I have concerns about how my personal data will be used after I have participated in the research?
In the first instance you should raise any concerns with the research team, but if you are dissatisfied with the response, you may contact the Information Compliance Team at dataprotection@city.ac.uk or phone 0207 040 4000, who will liaise with City's Data Protection Officer Dr William Jordan to answer your query.

If you are dissatisfied with City's response you may also complain to the Information Commissioner's Office at www.ico.org.uk

What if there is a problem?

If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through City's complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is:

An Interpretative Phenomenological Analysis (IPA):
Exploring Palliative Care Physicians' Grief Experiences in the Hospice Context (ETH1819-0100)

You could also write to the Secretary at:
Anna Ramberg
Research Governance & Integrity Manager
Research & Enterprise
City, University of London
Northampton Square
London
EC1V 0HB
Email: Anna.Ramberg.1@city.ac.uk

City holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Thank you for taking the time to read this information sheet.

Appendix D: Participant Case Descriptions

Aanya

Aanya, a non-white female, has been qualified as a doctor for eight years. She did her first ever Junior Doctor job in palliative care as foundation doctor in 2011. According to her "the four month post got her interested in palliative care". Then five years later she got her "first job in a hospice". Aanya worked as a palliative care speciality doctor for three years. She then moved as a palliative care registrar to the current hospice, where she had been working for seven months at the time of the interview. Aanya reports that she has got "nearly four years of hospice experience". She says that it was her first job. Aanya describes that she didn't have much experience at medical school with palliative care. She got really interested in "doing it as a job" and it "just kind of sparked that enthusiasm" and she decided to pursue it later. Aanya says that her first experience was "a hospital job" and describes it as "supernumerary" and was "just there to learn". But then as part of that experience she was sent to a local hospice for two weeks "to just to kind of see how it is run". Aanya states that '"just the environment and the way they did holistic medicine absolutely captivated me", and from there she decided "that was what I wanted to do". Aanya was interviewed in the hospice.

Harry

Harry, a white male, has been a doctor for ten years. He reports being in "a specialist palliative care for six of those years, either in clinical side or academic side". At the time of the interview, he was half-way through his specialty training. He states having worked in four different hospices and one hospital palliative care team. Harry works also as a medical educator and does part-time academic research. Harry was interviewed in a research institute location due to his preference.

Helen

Helen, a white female, shared that whilst at medical school her mother had cancer and that experience made her think of going into oncology. As a Junior Doctor she noticed herself "feeling drawn to end of life care and symptoms control aspects more than treating cancer". Her experience working in a small hospice confirmed that she wanted to pursue Palliative Medicine. At the time of research interviews, she had been training for two years as a Registrar, and one year being in Specialty Care training to become a Consultant in Palliative Medicine. Helen was interviewed at the hospice where she was working. She learned about the study through her Medical Director. She stated that her motivation to join came from her "enjoying the Schwarz Rounds, and that arena of reflecting and re-experiencing things". She considered that "the interview was another opportunity to do that in a more private context". Helen was interviewed in the hospice.

Jeanne

Jeanne, a white female, is a Consultant in Palliative Care and has been a consultant for about 11 years. After qualifying she did General Medicine, always knowing she wanted to do something 'medical', but for a long time she didn't know she wanted to do 'personal care'. Jeanne realised that she wanted to do Palliative Medicine when she was doing acute medicine. She did her registrar training less than full time due to having children that at time. After becoming Consultant, she has predominantly worked in hospices. She reported having done inpatient work, community work and outpatient work, and according to her she has “seen patients in where-ever it is the right place for them”. Jeanne stated that she wanted to take part in the research as she finds research important on ‘a really basic level’ and wanted to help. She was very curious about how the findings will be, as according to her, “it is associated with mental health, emotions and acknowledging people’s human parts”. She said that “grief is important and it is not spoken about”. Jeanne was interviewed in the hospice.

Mary

Mary, a white female, reported that she had no interest in being a Palliative Care doctor at the medical school. She stated that she wanted always to “do something heroic in acute general medicine”. She was intrigued by the “strange group of nurses” who would make her patients feel better “in ways that she really didn’t understand” but had “a tendency to follow them around”. The palliative care consultant spotted her doing this and rang her whilst she was finishing her membership exams. She applied for specialist training in both the General Medicine and Palliative care but stated that “palliative care number came first”. According to her it was a lifestyle choice in the end, and the thinking that “it was more likely to give her long term satisfaction”. After her registrar training in London, she became a Consultant in 2011. She had been working for the hospice for 9 years. Mary was interviewed in the hospice.

Rachel

Rachel, a white female, reported graduating in 1997. She expressed that she wanted to do orthopaedic surgery and since then “set out and followed that pathway”. She reported doing her “house jobs”, basic surgical training posts and higher surgical training as a registrar. She described that then she left in her fourth year as a registrar, because she realised “it wasn’t for her”. At that time, she was pregnant and finished a half a year post in ICU and left medicine completely. Rachel was “out” about six years but then she realised that she ‘missed medicine’ and started thinking coming back. She then “found” palliative care, which she says they “didn’t study at all at college”. Rachel described that “it was completely new” to her but “seemed to be everything I wanted to do in medicine”. After doing “a return to medicine job” she got a job at the hospice, where she had been at the time of the interview for five years. She stated that she is working part time. Rachel was interviewed in the hospice.

Appendix E: The Interview Schedule

Proposed Interview Schedule

Thank you very much for taking part and taking the time for this interview.

1. Firstly, can you tell me a bit about your experience to date in the palliative care field?

2. *(Preample)* Palliative care physicians face death and dying, and mortality in their everyday life at work.

    a. Can you tell me about your experiences of patients dying?
    b. Do any particular cases come to your mind?
    c. What sense did you make of that/them?

3. (Preample) “We have certain concepts of grief in research and the society…”
I am wondering what does grief in work context mean to you as a healthcare professional and as a medical doctor?

    d. How do you experience it?
    e. What are the main issues that you are facing?
    f. How do you see it being different, grief in the work context than grieving or mourning over a loss of a significant attachment?
    g. What image comes to your mind when you imagine/think about a grieving doctor?

2. How did you experience grief in some of the events/situations when a patient died?

    a. Prompt: soon after/much later (time), emotional, physical, behavioural
    - How did it feel? How did it feel in your body?
    - What was going on in your thoughts?
    - How did it impact your behaviour?
    - Was there something that you were surprised about?

3. Have the grief experiences changed anything for you?

    a. What has helped and what has made it difficult?

4. What do these changes mean to you?

5. How do you manage the grief or grief experiences in your work context?

    a. Are there ways that you internally manage the grief?
    b. How is it managed within the team?

6. How do others respond to your grief?

7. What has been the impact of these experiences for you?

8. Are there any other experiences or thoughts or memories or influences related to what you have shared and what we have discussed that come to your mind that I have not asked you and you would like to share?

9. How did you find doing the interview? Was there anything about the discussion that you found helpful/unhelpful for you? Would you like to share more about that?

10. Is there anything else that I have missed? Anything else that you would like to say?

11. What was your motivation to take part in this interview? Was it what you expected it?

Appendix F: The Participant Consent Form

PARTICIPANT CONSENT FORM

Title of the Study:
An Interpretative Phenomenological Analysis (IPA):
Exploring Palliative Care Physicians' Grief Experiences in the Hospice Context. (ETH 1819-0100).

Please initial box

1	I confirm that I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records.	
	I understand this will involve to:	
	• be interviewed by the researcher	
	• allow the interview to be audiotaped	
	• complete questionnaires asking me about my basic background information	
2	This information will be held by City as data controller and processed for the following purpose of lawful basis for processing under General Data Protection Regulation (GDPR): The legal basis for processing your personal data will be that this research is a task in the public interest, that is City, University of London considers the lawful basis for processing personal data to fall under Article 6(1)(e) of GDPR (public task) as the processing of research participant data is necessary for learning and teaching purposes and all research with human participants by staff and students has to be scrutinized and approved by one of City's Research Ethics Committees.	
3	I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organization.	
	AND I understand that, if I so wish, I will be given a transcript of data concerning me for my approval before it is included in the write-up of the research.	
	AND I understand that the completed and appraised thesis will be available on the City Research Online. No identifiable personal information will be published, no information that could lead to the identification of any individual or organisation will be disclosed in any reports on the project.	

4	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalized or disadvantaged in any way.	
5	I agree to City recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on City complying with its duties and obligations under the General Data Protection Regulation (GDPR).	
6.	I agree to the arrangements for data storage, archiving, sharing.	
7	I agree to the use of anonymised quotes in the publication.	
8	I agree to take part in the above study.	

If you need to get in touch over any aspect of this please email:

[redacted] [redacted]
[redacted]

[redacted]
[redacted]

Name of Participant Signature Date

Name of Researcher Signature Date

When completed, 1 copy for participant; 1 copy for researcher file.

Appendix G: The Debrief Letter

An Interpretative Phenomenological Analysis (IPA):
Exploring Palliative Care Physicians' Grief Experiences in the Hospice Context.

DEBRIEF INFORMATION

Thank you for taking part in this interview. I very much appreciate your time and help with this project and having the opportunity of listening to your experiences.

The intention of this interview has been to allow you to discuss your experiences of grief when working as a palliative care physician in a hospice. You were asked questions about your grief experiences when caring and working with dying patients in the hospice. I hope it was an opportunity for you to take a moment to engage with your inner life and perhaps as a result you might have learned something about yourself or about your experiences. Hopefully it was useful for you to spend time talking about them.

The purpose of the research is to gain more understanding of how do palliative care physicians experience grief in the hospice context. Research indicates that engagement with grief dynamics can contribute to personal and professional growth, whereas unexamined emotions may lead to physicians experiencing distress, burnout or disengagement. Your contribution and your reflections have therefore been valuable, especially considering that physicians experiencing grief in the medical culture has been quite invisible phenomenon and something that has not received much attention in the academic research.

At the end of the interview, I asked you, how did you experience the interview, and also if it raised any difficult issues for you. If you are experiencing any feelings of discomfort or emotional distress or something else unusual as a consequence of the interview, please have a look at the list below for further support.

You can contact these organizations for further support or help on a confidential basis. If you have any questions for me or my supervisor you might want to ask, please contact:

[redacted]

[redacted]

Finally, if you wish to receive a copy of the final report once it has been written up and appraised, you can always get in contact with me later. Sincere thank you for your time and help with this project. Ethics approval code: ETH 1819-0100.

<u>List of Support Organizations:</u>

NHS Direct
Tel: 0845 4647
Web: www.nhsdirect.nhs.uk

British Psychological Society
To find a psychologist with experience of particular areas of mental health.
Tel: 0116 254 9568
Web: www.bps.org.uk/psychology-public/find-psychologist/find- psychologist
Email: enquiries@bps.org.uk

Health & Care Professions Council (HCPC)
To check the professional registration of a psychologist and other healthcare professionals.
Web : www.hpc-uk.org

British Association for Counselling and Psychotherapy (BACP)
Potential clients can find a suitable counsellor in their particular area.
Tel: 01455 883316
Web: www.bacp.co.uk

Doctor's Support Network
Peer support for doctors and medical students with mental health concerns.
Tel: 01455 883316
Web: http://www.dsn.org.uk/dsn-activities

The NHS Practitioner Health Programme. Supporting the Health of Health Professionals.
The Practitioner Health Programme (PHP) is a confidential, NHS treatment service for doctors, dentists who are unable to access confidential care through mainstream NHS routes due to the nature of their role and/or health condition.
Web: http://php.nhs.uk/

GP Health Service
A confidential NHS service for GPs and GP Trainees in England, helping with issues relating to mental health concern, including stress or depression, or an addiction problem.
Web: http://gphealth.nhs.uk
Tel: 0300 0303 300
Email: gp.health@nhs.net

Mind Infoline
Mind provides information and advice and can help direct people towards appropriate resources for further help.
Tel: 0300 123 3393
Web: www.mind.org.uk

Samaritans
Support line available 24 hours a day, 365 days a year.
Tel: 116 123

Email: jo@samaritans.org
Web: www.samaritans.org

Appendix H: The Ethical Approval

CITY
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Dear Jonna

Reference: ETH1819-0100

Project title: An Interpretational Phenomenological Analysis (IPA): Understanding palliative care physicians' grief experiences and meaning making over patients' deaths

Start date: 22 Oct 2018

End date: 31 Dec 2020

I am writing to you to confirm that the research proposal detailed above has been granted formal approval from the Psychology low risk review. The Committee's response is based on the protocol described in the application form and supporting documentation. Approval has been given for the submitted application only and the research must be conducted accordingly. You are now free to start recruitment.

The approval was given with the following conditions:

- ...
- ...
- ...

Please ensure that you are familiar with City's Framework for Good Practice in Research and any appropriate Departmental/School guidelines, as well as applicable external relevant policies.

Please note the following:

Project amendments/extension

You will need to submit an amendment or request an extension if you wish to make any of the following changes to your research project:

- Change or add a new category of participants;
- Change or add researchers involved in the project, including PI and supervisor;
- Change to the sponsorship/collaboration;
- Add a new or change a territory for international projects;
- Change the procedures undertaken by participants, including any change relating to the safety or physical or mental integrity of research participants, or to the risk/benefit assessment for the project or collecting additional types of data from research participants;
- Change the design and/or methodology of the study, including changing or adding a new research method and/or research instrument;

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- Change project documentation such as protocol, participant information sheets, consent forms, questionnaires, letters of invitation, information sheets for relatives or carers;
- Change to the insurance or indemnity arrangements for the project;
- Change the end date of the project.

Adverse events or untoward incidents

You will need to submit an Adverse Events or Untoward Incidents report in the event of any of the following:

a) Adverse events

b) Breaches of confidentiality

c) Safeguarding issues relating to children or vulnerable adults

d) Incidents that affect the personal safety of a participant or researcher

Issues a) and b) should be reported as soon as possible and no later than five days after the event. Issues c) and d) should be reported immediately. Where appropriate, the researcher should also report adverse events to other relevant institutions, such as the police or social services.

Should you have any further queries relating to this matter, please do not hesitate to contact me. On behalf of the Psychology low risk review, I do hope that the project meets with success.

Should you have any further queries relating to this matter please do not hesitate to contact me.

Kind regards

[redacted]

Psychology low risk review

City, University of London

Appendix I: A Transcript Extract of Aanya's Coding

Aanya supporting colleagues instead of giving space for her emotions	823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844	P: I can think of *many* examples. I had this patient who was 40 with breast cancer, had small children, and I remember sitting in the office writing my notes about someone else. And I hadn't seen that patient that day. And one of my nurses came in and she was 40 and she had small children. She just came in, close the door. She just broke down in tears. And said, "I can't do this". And she, all she needed was to talk about it, just to process it. But *I didn't have chance to even process how it made me feel because I felt so bad for her [nervous chuckle] and I wanted to comfort her and allow her space.* So I think that can be a challenge is in trying to support everyone around you that you forget sometimes to look after yourself.	Frequent experiences A nurse identified with a terminally ill patient, similar age and having children Sadness and grief expressed in tears, devastated (broke down to tears) Aanya was aware that the nurse needed some space to talk about her emotions (closed the door) Nurse's needs override Aanya's need to take time to reflect how she is feeling. Realised that she didn't have chance to think about her emotions. She was compassionate towards the nurse's feelings, feeling bad for her. Looked after, comforted the nurse. Giving space, grieving space. Challenge to remember to look after herself.		Doctors supporting others with their grief/grief experiences and emotional distress. Realising that her own emotions, grief, were disenfranchised due to her role as physician, and being the one who is there for others. Doctor's grief unacknowledged due to no chance to attend to it	
	845	R: MMh-hmm.				
Aanya's 'sorting time' to process emotions needed	846 847 848	P: Erm. Which is why my commute time is great for processing personally *[subtle laughter].*	Uses commute time for personal processing of emotional load Grief is a process – needing time to process		Creating space for her own emotions, grief as in the hospice she may not have time. Other's needs are attended first, due to her professional role. Grief, emotions disenfranchised due to professional role, expectations. Grief is a process – needing time to process and integrate what she 'keeps' and what can go (car commute and throwing things out of the window) Doctor is there for others, who supports the doctor?	
	849	R: Mmh-hmm.				
	850	P: Erm. I think…				
	851 852	R: So, something about the space and time?				
Helpful to have space away from the hospice – enough distance	853 854 855 856 857	P: Yeah. Having, having space and time. But al-, … I am also quite precious about my personal time. I find that really helpful to have space away from the hospice.	Own time has become important (precious) valuable Space away -> important to have physical separation from work place		Protecting and valuing the separation of work and home contexts -> leaving he grief to work and throwing processed emotions and burden out of the car window…. Boundaries Active separation, taking action to separate to avoid bringing work events to home/personal life	
	858	R: Mmh-hmm.				

Risk of work eating into personal life – Aanya feeling strict about processing work	859 860 861 862	P: And actually, if I find that I don't process what's happening at work… sort of fairly quickly, it *does eat into my personal life…*	Recognising that if she doesn't do the processing of work stuff It erodes to personal life, uses or or takes away a large part of something valuable, such as time => her personal life, space (not work)	'eat into my personal life' => damage something by eroding or corroding it. use up a quantity of profits, resources, or time.	Recognising the emotional needs to process work matters and not to delay or avoid it, as otherwise they intrude her personal life.. As if no control and wanting it to use up personal life/time/resources	
	863	R: Yeah.				
	864 865 866	P:…and it can affect me. So, because I'm quite precious about that,	Events at work can impact her, have influence on someone/something, or to cause a change in someone/something Affecting her => causes strong feelings Trying to protect one's personal life	'precious' => something of great value, not to be wasted or treated carelessly. 'being deeply affected by something' => causes strong feelings		
	867	Mmh-hmm.				
	868 869 870 871 872 873 874 875 876 877 878 879 880 881 882	P: especially the baby on the way *[chuckle] erm,* and I'm quite strict about processing it and making sure that I talk about it with colleagues here. I find it difficult to talk to my husband and family about it because they're not medical, and they don't work in this field. Erm. So, talking to other doctors and nurses, actually I found much more helpful, to be able to process it. Or I talk to doctors who don't work here, but are palliative care doctors and we kind of talk to each other about difficult cases, to help process.	Beign pregnant reminds her to be more boundaried and to process at work her emotional load with her colleagues Difficult to talk to own husband or family about work matters – matters are not familiar Sharing with her doctor colleagues and nurses has helped her Other palliative care doctors working elsewhere have been also good to reach out as per her experience Discussing challenging cases with other PC doctors		Her colleagues are there for her too if she takes responsibility and is active in processing her work matters Work-life boundaries A work context that people outside hospice don't understand le understands it Family members 'protected' by not talking about work, also, indicates being such a context that they may find it difficult to relate Other PC colleagues easier to share, helpful to talk to, mutual understanding	
Making space for everyone who is struggling with 'burden of grief' tricky	883 884 885 886 887 888 889 890	R: Mmh-hmm. P: But erm. So I think, yeah, making space for myself, making… enough space for others, supporting my Juniors can be quite tricky. The more junior doctors, especially the ones who are rotating through and do… really struggle sometimes with	It takes effort to make space for her own grief, for others', and Junior Doctors' grief Particularly difficult for rotating Junior Doctors with the burden of grief	Burden of grief -> heavy, struggling,	Understanding that grief needs space, a challenge to find the time and space to process own grief, and also supporting colleagues, junior doctors.. Is the grief more visible, expressive, public and not hidden, not suppressed or how is it different that it feels hard?	
	891 892	the burden of grief that they're seeing. Erm.		Seeing (verb) indicates grief is visual	Junior Doctors are not used to it – not seeing elsewhere – visible in medical field?	
	893	R: Mmh.				
Aanya trying to remain professional: wanting to go and have a good cry but not in front of everyone else	894 895 896 897 888 889 890 891 892 893	P: I'm actually… still trying to remain professional. It's quite hard sometimes when you work because the hospice is quite a close knit community as, as a team. And yes, it's completely fine to express how you're feeling, but sometimes you don't want to in front of everyone else. Sometimes you just want to go and have a good cry.	Wanting others to perceive her as a professional. Challenge to keep this up as relationships with colleagues 'tight knit community' There is a permission to express feelings in the group Not want others to see her expressing feelings Admits that prefers crying privately, going away	'a tight knit community' => a group of people who care about each other and who are very friendly with each other.	Fear of being considered unprofessional, expectations of her role (control vs, losing control) But expressing feelings would be completely 'fine' (the paradox), she would not be thought less of a colleague for crying at work Wants to hide her crying Not only professional conduct but societal that 'grief' is private phenomenon	

Appendix J: A Sample of clustering Experiential Statements and PETs (Aanya)

Personal Experiential Themes PET	Experiential Statements	Example Transcript extract
PET 1: Aanya's experience of being affected: relating to patients as more than patients	**Aanya being affected by complex patients: sticking with her**	"….. And I think they're the ones that have tended to stick with me."Aanya, p. 3, l. 62-67 "[…]And I found that hard to watch…" Aanya/p. 9/L. 155-159
	Patient reminding of own losses/attachments	"…., people who I can relate to is like my parents' kind of age that I find hard so…. I *remember very vividly* this gentleman…….... He was *only 50*." Aanya/p. 4./L. 69-78 "But I remember that it was, it was the challenge, but also thinking he,…you know, could be my… dad's age" . "Aanya/p. 8/L. 134-137 "…And yeah, you could, it was just, you could kind of see him in… that sense." Aanya/p. 9/L. 139-141
	Relating with a patient as a person – building a rapport	"But I also found… I got along very well with him as a patient, well as a person. ….." Aanya/p. 5./L. 88-93 "…..but we had all built up such a rapport with him, it was hard seeing him suffer." Aanya, p. 11, l. 176-178
PET2: Aanya's grief reactions unpredictable	**Whole world descending to hospice – knowing them as a family**	"But I think I remember him… so much because his, his like his whole world kind of descended on the hospice. So he sort of came to us.-….. We got to know them as a family as well." Aanya/p. 7/L. 111-115
	Unpredictable what patient will trigger	"I realise that *[sigh]* you can't predict the patient that would trigger something for you. And everyone has their own personal triggers. And what will affect one person… won't affect me and vice versa" Aanya, p.105/l.1761-1766
	Can't predict a pattern - unpredictable	"I realise that *[sigh]* you can't predict the patient that would trigger something for you. And everyone has their own personal triggers. And what will affect one person… won't affect me and vice versa" Aanya, p.105/l.1761-1766
	Some patients being vividly remembered	"It's, it's not easy to forget the person because I, the people that I talked about come readily back to mind." Aanya, p. 32, l. 439-442 "I *remember very vividly* this gentleman who had widespread esophageal cancer. He was *only 50"*. (Aanya, p. 5/l. 75-78) "And he knew that, you know, it was a hard conversation. I remember quite vividly *[chuckle]". (Aanya, p. 13/l. 204-206).*
PET3: Difference between professional and the personal grief – grief present in different lives (Aanya)	**Personal losses grieved throughout the life**	"I think… in your personal life. Or in my personal life, the people I've lost, I've felt that absence like through my throughout, the rest of my life. Aanya, p. 40, l. 571-575
	Aanya becoming aware of personal triggers	"So, erm for example, I lost my dad nearly 10 years ago…erm, to, to cancer. He was a 50 year old man when he died. So actually, that's probably part of the reason why I find that age patient quite difficult." (Aanya/p. 40/l. 571-581)"
	Aanya trying to keep 'actual life' and 'profession life' separate – patients not present in 'actual life'	"And. But I grieve his absence…..it's very different because it's, he was so present in my life, whereas our patients aren't present in our lives, in the our actual lives, that they're present in our professional lives. But they're not present in our personal lives. And I think that's… the difference is keeping the professional and the personal separate to an extent as much as one can." Aanya, p. 41, l. 583-598
PET4: Aanya in a job mode - there to do a job	**"There to do a job" – not spending every minute to engage and build up connection**	"But you don't spend every minute with them. You don't. Erm. And you kind of don't engage in that, in that same way. [..] Erm, so you don't build up that connection ……. So, you are there to do a job." (Aanya/p. 42/l.604-616) "And your job is there to give them the best possible. ….."(Aanya/p. 42/l.618-623
	Aanya feeling more emotions when putting herself in the patients shoes	"I don't think you get that when you have patients, then I suppose it depends … how much you put yourself in their shoes. It's hard" (Aanya/43/l.625-638)
PET5: Aanya's grief tied to professional boundary holding her back	**Aanya's sense of always keeping a professional boundary – "holding me back"**	"So, it is different when…but I get when it's your patient and you are the doctor. I think there is always that sense of… keeping a professional…. Boundary. I guess there is always something that kind of does 'hold me back' from fully… kind of allowing myself to connect too much." (Aanya/p. 38/l. 535-550)
	Experiencing the protecting boundary needed to be able to do the job	"I think not… to the point that hinders care……or the way I look after my patients, but I think, if I took on every aspect of their grief, I wouldn't get to do my job. So…" (Aanya/p. 38/l. 552-558).
PET6: Aanya Hiding personal feelings	**Aanya keeping personal feelings to herself – putting on professional stance**	"But it was one of those kind of, I think, his doctors and perhaps less so with the nursing team. But, Doctors, we tended to kind of, we wouldn't share our personal feelings with him, even though we had a good rapport. " Aanya,p. 13, l. 208-214 "doctors are very good at putting on a professional face ….."I know from, from my own personal self, I wouldn't… necessarily wear my emotions visibly. Or at least I hope not, erm, more because when I'm here, I have to do my job and do it well and I don't want..like…" Aanya, p. 89, l. 1489-1500
	Aanya adapting to 'doctors don't much share' the common culture	"I think it's seen, I think it's the common culture where, in the hospices I've worked in a few hospices, and I don't think that, that the doctors so much share with the patients… how they personally feel." Aanya, p. 14, l. 220-225
	Aanya experiencing tension of own inner reality and social expectations – hard to hide and pretend	"I think, I think, it depends on *how it's shown.* I mean, I would always, you know, to any patient, I would always acknowledge how hard this time is." Aanya, p. 15, l. 246-252 "sometimes it's hard to hide these things from how you feel like on your face, ….." Aanya, p. 16, l. 252-257 "I think it's hard to *pretend* that you are 'matter of fact' and 'it's all fine'. …."Aanya, p. 16, l. 257-262
PET7: Being looked at as someone who is in control and fixes things	**Being looked at as the people in control and making things ok**	"And also, I think with some hope that we would be able to fix… what was going on." Aanya/p. 6. l. 97-103 "I think he looked at the medical team as the people who were in control. And we are going to make this OK. Erm. When he himself and his world were out of control." Aanya, p. 11, l. 195-199
	Experiencing a lot of pressure as doctor to fix everything	"And they are much more involved as caregivers, whereas doctors in the hospice setting tend to step in, and make a plan and step out. They have a lot of pressure on the doctor to make… to be the person who's going to fix everything.."(Aanya/p.53/l.804-811)
	Needing to take professional hat off in personal life	"And I think in terms of my personal life, I am. I sometimes have to remind myself when I'm not at work, so I'm not at work. (Aanya/p.113/l.1888-1892) "And I have to remember to just listen and just let my friend… grieve and not try to fix it.…. need to just be there. "(Aanya/p.112/l.1900-1908) "So yeah, I have to remember to turn my 'hat off' when I'm met, when I hear about death and dying outside of work… I have to remember ….(Aanya/p.113/l.1913-1917)

PET8: The anticipatory grief – Aanya grieving with them on their journey and not so much after	**Aanya grieving with them on their journey and not so much after**	"But I don't, I think we grieve with them, whereas families grieve afterwards and for a periods of time" Aanya, p. 32, l. 444-448 "So, yes, it's, I feel like *I grieve with* them on their journey and not…. Not so much after [big sigh… sigh of relief], although I do *remember* them." (Aanya, p. 37, l. 520-524)
	No time to grieve after – moving on	"I think because we see so much death. We are stretched and we have to move straight on to the next person that's coming in. Aanya, p. 33. L. 449-452
	Ambivalent what grieving	"it's like we do that journey with them. Whereas the families are grieving, what they are losing. We grieve… kind of, I think." Aanya, p. 33, l. 452-460 "Erm. I think, in a way, yes, because I think, I don't know if I ever kind of think about how I do it." (Aanya, p. 37, l. 530-533).
	Remembering vividly hard conversations about dying	"He, he did… understand that he was dying. Erm. And we had to have those conversations. And he knew that, you know, it was a hard conversation. I remember quite vividly" Aanya, p.13, l. 201-206
	Sad for people who weren't accepting	"I think I feel especially *sad* for the people who, who weren't at peace with what was happening to them, who weren't accepting." (Aanya, p. 36/l. 506-510)
	Finding it hard to anticipate the death of a younger patient – glad for not seeing it happen	"We had a really good rapport. I really got on well with him and his wife. …. I, I did feel grief in that I wouldn't see him again… not because I was going to miss him, but *because I inputted so much*. Aanya/p.100/l.1668-1693) "And I always wanted to be there when he died, ….". (Aanya/p.100/l.1668-1693) "And I felt sad if I wouldn't be able to see him have the death that he wanted."(Aanya/p.100/l.1668-1693)
PET 9: Aanya feeling relieved not needing to carry that emotion anymore	**Aanya's relief of not needing to carry that emotion anymore**	"And I, sometimes, there's… there is a relief when someone does pass and dies, because actually….in a way, you don't have to carry that emotion so much anymore. Aanya, p. 31-32, l. 432-442 "I could sort of put myself in his shoes and think, "Gosh, that's so hard". […] seeing him suffer so much… in his processing and his disease was awful." Aanya, p. 33-34, 462-472
	Not missing the person but being relieved the suffering ended	"Erm, when he did die, I was relieved for him. I was relieved that he didn't suffer anymore. I didn't *miss* him, so to speak, because…he, he wasn't personally in my life. But, I was grateful that he, he did pass. Aanya, p. 34, 471-475 "…. you know, I don't wish him dead, but I, I was grateful that his suffering had ended." Aanya, p. 34, l. 480-484
PET10: Aanya learning from personal life bereavement experiences	**Aanya's relating differently due personal bereavement having massive impact**	"I think it's massively impacted the way I work as a doctor. …. doctors who have been bereaved…. *tend* to relate differently. ……, can relate more to the relative who's going … that. … I can feel her. I can, because I know what she's about to go through. And I feel, I feel sad for her. (Aanya/46/l.654-679).
	Aanya gaining more empathy	"I think it gives me a deep empathy… for what…. that person is suffering. So I think as well, we often forget that the person suffering is not just in the bed. It's those around them." (Aanya/p.47/l.686-691) "My personal grief from… my bereavement does help me to relate on a better level… with relatives. But it also can be confusing. …." Aanya/p.47/l.693-702 "I think… now that I'm more experienced and I've had more time in this environment, I, I, it doesn't tend to surprise me how people grieve. (Aanya/p.47/l.704-708)"
	Gaining experience and maturity helping to understand different aspects grief	"I think… now that I'm more experienced and I've had more time in this environment, I, I, it doesn't tend to surprise me how people grieve. (Aanya/p.47/l.704-708)" "But, you know, you might have someone who would grieve in a totally different way to how you personally grieve. And that can strike a chord." (Aanya/p.48.l.710-714) "And I remember thinking that was just a bit…. strange. But actually, now I've had more experience. I see that's quite normal. Actually, that's, that's just that person's personal way of grieving." (Aanya/p.49/l.731-736). "I've seen it from different aspects, I guess now. As someone who has grieved, what do people grieve, so I see other people like other professionals' grief, like manage grief." (Aanya/p.49/l. 741-746) "Ultimately…everyone has a very unique grief experience, whether it's professional, [..]." (Aanya/p.50/l.754-758) "So because, as I said, I think if you've been bereft, you do understand grief differently." (Aanya/p.131/l.2090-2092)
PET11: Aanya putting mental boundaries: "where you let yourself go and where you won't"	**Hard taking on someone else's grief – holding a skill that is learned**	"And it can be hard hearing, like… it… taking on someone else's grief. Aanya, p. 23, l. 372-373 "And I think it's holding a skill that's…learnt… over time…how you process" Aanya, p. 374-375
	Paradoxical learning – gets easier with the time but harder the longer one does it **Putting mental boundaries where you let/won't let yourself go** **Long term impact – a worry of becoming cold or withdrawn**	"It certainly, eh, in a way it's easier the longer I do it. But at the same time it's harder, the longer I do it." Aanya, p. 24, l. 380-383 "I say easier because you learn to mentally put in… emotional boundaries where you let… yourself go and where you won't." Aanya, p. 24, 385-388 "But at the same time, it's… hard as you get… as you do that because you… I sometimes worry, am I becoming cold or withdrawn? I hope not. My husband tells me I'm not *[saying this in a cheery way]*. But you do have to sort of separate yourself." Aanya, p. 25, l. 395
PET12: Aanya setting boundaries between work and home by "Throwing emotions out of the window"	**Aanya's 'sorting time' to process emotions needed** **Setting boundaries – throwing emotions out** **Emotions permeating personal life – "hitting the heart"**	"One of the things for me is I have quite a long commute to work. … But I use that time to process my day. And I kind of use it as like a sorting time to sort my thoughts out, to process my emotions." Aanya, p. 25, l. 396-344 "So certainly I pretend that I throw them out of the window on the way home to kind of *[laughing]*. To kind of … Erm. So I don't take that the day home with me." Aanya, P. 26, l. 344-349 "Some patients that just …kind of hit you in the heart, it's really hard to, to not carry that home." Aanya, p. 27, l. 351-354 "No *(physical reactions)*, …., I get nightmares. Not, not frequently. Yeah, I dream quite vividly. [..]." Aanya, p.101-102, l, 1716-1722
PET13: Aanya learning how to do the job from seniors – seeing how they are in response to grief – space and permission	**Learning how to relate to grief from seeing how seniors are in response to grief** **Being encouraged by senior to explore feelings and being affected - getting the permission to grief**	"Learning how to do this job from seniors is really important. And seeing how they are…. in response to grief… It helps you to realise what the boundaries are. (Aanya/p. 122l/l.2067-2072.) "And I would say the general theme is that they encourage… exploration of your feelings and how it affects you. […]And actually feeling privileged to be part of it and witness that, and always be feel like you're given permission to do the same." (Aanya/p.123/ l. 2080-2096) "… I've felt like: "Phew" [*sound of a deep sigh]* "This is hard…." [… I hope to handle it decently like that. I try to acknowledge it. But knowing that it's OK to do that is, is helpful. I don't think I've ever been shown that in other settings…. because we're so busy doing our jobs." (Aanya/p. 125/l.2099-2114)

		"… that when you see your senior stepping into someone else's shoes, it sets the example that it's okay… to do that. … So. So I think the learning from your seniors is, it allows space and permission. Like an 'unsaid permission'. Aanya, p. 126-127l. 2116-2131
PET14: Aanya modelling to Junior Doctors how to manage the burden of grief	**Witnessing Junior Doctors finding emotional things hard**	"I often see with… we get a lot of junior doctors rotating through here. ….And they find it very hard on the emotional side of things." Aanya, p. 27, 356-359
	Aanya allowing it to be hard	"And I guess one of the things I try and remind them is that 'it's okay for it to be hard' and they need to talk about it. And we will openly talk about it… in the hospice, in the maybe in the doctor's office or with the nurses in the office." Aanya, p. 27, l. 366-373
	Aanya initiating and modelling conversations **Preferring talking than bottling it up**	"…. "So, you know what, I found that really hard today. Had really tough that the patient is this and that." …..and then it opens up conversation for people to talk." Aanya, p. 375-383 "I tend to find that talking about it is easier than bottling it up." Aanya, p. 29, l. 384-385
	Making space for everyone who is struggling with the burden of grief can be tricky	"So, I think, yeah, making space for myself, making… enough space for others, supporting my Juniors can be quite tricky. The more junior doctors, especially the ones who are rotating through and do… really struggle sometimes with the burden of grief that they're seeing. Erm. (Aanya/p.57/l.884-892).
PET15: Medical training not preparing Aanya for emotional aspects – learning in the job	**Medical training not preparing for emotional aspects to deal with loss, death and dying** **Learning in the job – learning through experience** **Realising that training not teaching how to not burn out** **Hospice different from other specialties: time and space to look after wellbeing**	No, I don't think it does… at all. I don't think any of my medical training prepared me" (Aanya/p.82-83/l.1313-1316 "Erm. Because I, I think actually five years at medical school is actually a really short time……Erm. And I don't think it teaches you how to be emotionally resilient." (Aanya/p.81-82/l.1319-1327) "I think that's something that's learnt on the job. And I think you can't teach it. I think you have to learn it …through experience. …." (Aanya/p. 82/l.1329-1339). "And I definitely think there've been times in my career where I thought, I don't know how long, I can do this for, ….had no time off and I have been burned out, but they don't teach you how to… stop yourself burning out." (Aanya/p. 84/l.1366-1375) "[..] But, erm, I do think it's something that you learn and I don't think our working environment is conducive to looking after yourself, …." (Aanya/p.84-85/l.1377-1390) "… not having space to…to actually look after your well-being. (Aanya/p.86/l. Whereas in the hospice is different. You have the space, you have the time. And if you personally can't do it, you don't have your your capacity is full. There are people who can." (Aanya/p.87/l.1432-1437)
PET16: Aanya hiding feelings behind a professional stance	**Putting on a professional stance and hiding feelings: "you don't see it"- you are not showing it** **Although considering acceptable to cry because of patients – would not share it/show it**	**"**I think a grieving doctor looks like any doctor. I don't think you would see it, erm, on the surface anyway. (Aanya/p.87/l/1447-1452) "I think doctors are very good at putting on a professional stance and hiding often how they feel. And I think you tend to see it more behind closed doors ,erm….. You don't see it. [..]." (Aanya/p.54/l.1454-1465) "[…]I think it's very acceptable to cry and to be tearful or upset or stressed, grumpy *[chuckle]* at work when you're struggling with your personal or professional grief, griefs. But I don't think most people share it." (Aanya/p.90-91/l. 1511-1523)
	Aanya trying to remain professional: wanting to go and have a good cry but not in front of everyone else	"I'm actually… still trying to remain professional. It's quite hard sometimes when you work because the hospice is quite a close knit community as, as a team. And yes, it's completely fine to express how you're feeling, but sometimes you don't want to in front of everyone else. Sometimes you just want to go and have a good cry." (Aanya/p.58/l.894-893)
	Hard to be hiding grief due to being constantly bombarded with grief **Putting barriers up – keeping grief private**	"I think grief is very hard. [..]., I think it is very hard to be in this palliative care environment, erm, because you're then constantly being bombarded with grief and then it would be hard for it not to see around the edges, even if you're trying to hide it. " (Aanya/p.89/l.1489-1509) "She was a bit tearful, but then.. it was, "let's do this job, barriers up, let's do our job", …she's an excellent consultant, but she probably wanted to keep her grief private." (Aanya/p.91/l.1528-1534)
PET17: Managing everyone else's grief: Aanya's experience of grief becoming secondary and no time/space to grieve	**Carrying a responsibility to listen and not wanting to burden**	"…because erm, I think we carry a responsibility… to… listen to how they're feeling and how their families are coping and not wanting to burden them with our pain." Aanya, p. 14. L. 226-230
	Doctors' grief secondary: Aanya's grief not being recognised	"I think in death, patients become very, in a way, selfish in thinking about themselves and their immediate world. But then they can't almost acknowledge anyone else (the doctor)." Aanya, p. 17, l. 267-272
	Aanya feeling her grief not equal to patient's grief	"Actually, if your doctor looks, is looking sad and I'm not sure they would actually equate it to what they're going through." Aanya, p. 18, l. 284-287
	Aanya managing everyone else's grief a big part/responsibility	"the first thing *[in terms of challenges]* that comes to mind is managing everybody else's grief." (Aanya/p.52/l.785-787)
	Aanya supporting colleagues instead of giving space for her emotions	"… And I think one of the things I find quite hard is I'm quite often trying to support my colleagues. I don't actually give myself the space to think about how it's affecting me." (Aanya/p. 53/l. 813-821). "She [*a nurse colleague]* just broke down in tears. .. And she, all she needed was to talk about it, just to process it. But I didn't have chance to even process how it made me feel because I felt so bad for her *[nervous chuckle]* and I wanted to comfort her and allow her space. So I think that can be a challenge is in trying to support everyone around you that you forget sometimes to look after yourself. Which is why my commute time is great for processing personally *[subtle laughter]."* (Aanya/p. 58/l.832-848)
	Aanya attending to others' needs	"I think that's why it's really important to try and get time alone with your patient. as well as getting time alone with the family members. ..." Aanya, p. 19, l. 297-308
	People opening up to Aanya in the unique setting	"I think it's helpful to step out with a person, allow them space…"and people do open up to us, here at the hospice, …" Aanya, p. 308-326 "… And I took her into one of our relatives rooms to have conversation. She just broke down and she'd been bottling it all up,." Aanya, p. 351-358 "…, it's finding the right environment, for the person that needs to talk." Aanya, p. 367-370

PET18: Space and time away from hospice necessary to Aanya to cope – being constantly on fire	**Helpful to have space away from the hospice – enough distance** **Risk of work eating into personal life – Aanya feeling strict about processing work**	"Yeah. Having, having space and time. ….. I find that really helpful to have space away from the hospice. …it *does eat into my personal life…* and it can affect me. … " Aanya, p. 55-57, l. 853-882 *"erm,* and I'm quite strict about processing it and making sure that I talk about it with colleagues here. I find it difficult to talk to my husband and family about it because they're not medical, and they don't work in this field[…]" Aanya, p. 55-57, l. 853-882
	Aanya finding it important to have space and time away	".. they are very encouraging you to take time out. So making sure… we need to take our annual leave or a holiday and… not just taking days here and there, but taking blocks of time off because I think having a day annually doesn't relax. It doesn't give you enough space away." Aanya, p.60, l.925-935
	Aanya's experience of being like in the fire constantly	"[…] think you need to sometimes… it can get 'hot', bit…. It's like being in the fire constantly, sometimes you need to remove yourself from the.. from it. And it helps to get some perspective." (Aanya/p.59-60/l.918-923)
PET19: Managing the grief: Aanya turning inwards	**Aanya doing "Talking to herself", self-processing in mind** **Noticing/learning no one way to professionally manage grief – Aanya not always getting upset**	"… I guess, a *[heavy sigh].* I think I do a lot internalising. But not internalising but self processing. Talking to, talking myself down and talking and processing it in my mind. Not kind of, because I do process it. Erm. (Aanya/p.101/l. 1687-1693 "I think sometimes I surprise myself that I don't get upset. Erm. And it makes me worry that… I'm becoming disillusioned or cold." (Aanya/p. 104/l.1753-1758); "And there's not a one size fits all when it comes to professionally managing your grief. […] (Aanya, p.107/l.1800-1812)
PET20: Experiencing subconscious stress: Aanya getting nightmares and dreams	**Poignant thing that patients affecting Aanya: nightmares stemming from subconscious stress**	"…a certain patient that's kind of emotionally affecting me, I get nightmares. […] So if I start dreaming about my work, I *know* that I need to take some time to process. For me, it's a cue that things are getting too much. *It's like a kind of subconscious stress.*" Aanya, p. 101-102, l. 1716-1732 "Erm. So, that's, that's quite a poignant thing personally for me, that if I dream any aspect of workbecause I know that I'm burning out, I just need a bit of space. And that works for me. " Aanya, p.103, l. 1734-1744
PET21: Importance of sharing and feeling normal: "sense everyone feeling this way"	**Talking through helpful for Aanya** **Verbalising with a colleague who understands but careful about this** **Relief from grief by sharing the pain with the team – contributing to feeling normal** **Support systems available but best grieving times spontaneous over 'a Cup of tea'** **Being surrounded by public grief – seeing so much of it**	"We are also really, really lucky here…erm, that we get clinical supervision. …either one to one or small groups at two or three to one. Erm. Discussion around difficult cases that we've experienced and help us to process the emotions around that. " "And it's not just for doctors, it's for…al staff. But I find that quite helpful just to talk through… some really ha-, hard cases." Aanya, p. 29-30, l. 387-410 "I do sometimes process it with a colleague though, and verbalising how I am feeling is helpful. ..not necessarily with the same patient, but has had the experience of feeling a certain way. (Aanya/p. 100/l. 1698-1706) "I am… grateful that the teams I've always worked in happily share between each other… how they're feeling, which is, is helpful." Aanya, p. 15, l. 232-236 "Patient related grief is talked about openly, because I think it is, the environment is conducive for that and it, .. It's okay to express how it makes you feel. We also have these things called 'Schwartz rounds' do you know? … very good space for people… to share about personal and professional grief. But I think the best grieving times come over a cup of tea … (Aanya/p.93-94/l.1564-1576) "We're surrounded by grief so much. .. every bereavement that happens here *is so public.* But grief is actually really *personal* to that person. ….." (Aanya/p.91/l.1536-1544).
PET22 Aanya growing and excelling- sense of meaningful work	**Professionally wanting to excel and giving her best** **Growing and being present for patients**	"I think it's changed me enormously….erm. Professionally…It's made me want to be excellent. […] feel that my patients deserve the best of me." (Aanya/p.108/l.1827-1831) "So I want my work to be.. excellent in what I do, I don't want. I hope I don't take shortcuts, …[..] my patients deserve to see me at my best. Erm. Not kind of like scruffy." (Aanya/p.109/l.1833-1843 "I, certainly in the hospice, I take more time with my patients and their relatives. It doesn't matter to me if I have to stay a bit late." (Aanya/p.111/l.1868-1871) "[…] And I think really, people need more than anything else is just time. Especially when they don't have much time. Well, their time is short. …but it's they go through the biggest costs of their lives. " (Aanya/p.111/l.1873-1884) "[…] but also to acknowledge how things have changed in my career and how I've grown… and changed the way I do things over time. (Aanya/p.128/l.2131-2147)
PET23: Aanya's awareness of mortality giving new perspective on life	**Aanya gaining perspective – there is more to life than job** **Aanya becoming more spontaneous and seeing more opportunities**	"looking at it for just, just taking that step back and working in this environment and seeing so much death and grief. It's just… like… it gives you perspective." (Aanya/p.114/1932-1936) "Over time, I have realised that there is more to life than my job. …"" (Aanya/p.115/ l.1944-1953) "And you see so much in the hospice.. … life crept up on them and ended. And I don't, I don't want to live that way with regrets. .. I want to kind of enjoy what I've got." (Aanya/p. 118/l.1993-2001) "[…]. And I said, why don't you just do it now? *[laughing/smiling]* So I joined a wine club just because I could. …. And it was just something very spontaneous. ..I got my scuba diving licence. […] life is short and. […] having children and not firstly everything about career and having time for family, and embracing the life that you have because it can just change." Aanya/p.116-118/l.1967-1991
PET24: Aanya's normality and reality not understood by outside world	**Aanya feeling grateful to be part of someone's journey: passionate about providing space for good death** **Outside hospice people can't really understand professional experience of grief** **Guarding oneself/needing to be guarded – Aanya not wanting to pass distress**	"… I'm grateful to be part of someone's journey at the last stage so that I can… allow them that space to have… a good death." Aanya, p. 34/pp. 489) "…..there is something about… providing space for a good death. And that's something I'm quite passionate about. And a, and a good death that's different for everyone." Aanya/p. 35/l. 488-502) "People, I think people don't think about grief and dying a death in their day to day. And I think that's normal. …Whereas I deal with death, dying. […]Erm. Whereas most people don't really talk about it because it's still 'a taboo'. We don't like to talk about death. [..] (Aanya/p. 67/l.1045-1059) "Whereas I see it daily and I know that *[laughing voice]* they will die at some point. So I face that reality. {Aanya/p.68/l.1061-1063) "So I think working in a hospice is a very helpful environment to process the enormity of death and dying, you see. Because I don't think anyone else really understands. […] But I don't think people really fully…. Can immerse themselves in that unless they've either experienced grief at work. […] And they are different." (Aanya/p.69/l.1080-1094) "But …I guess in a way you have to be quite guarded when you talk about it, because you have to be respectful, even though we're outside of work […]And I don't want to pass distress…. people around me." (Aanya/p. 68/l. 1065-1075)

	Comparing experiences to ‘horrible child protection’ – can’t relate but the feelings overlap to be able to process together **Seeing beauty in palliative care – a privilege to sitting the patient down**	“I have got a friend who works in child protection, which is horrible [*nervous chuckle]*. And although I can’t relate specifically to what she’s going through and vice versa, …the feelings overlap. So it’s quite helpful to process together.“ (Aanya/p.65/l.1011-1019) “And I think… the beauty of palliative care is that you can actually sit your patient down and say what's important to you. And it's actually a privilege to do that[…]” (Aanya/p.69-69/l.1248-1263) “A[..] And allowing them space to say what they want is really is a joy is a privilege because you're empowering a patient then to make, I guess it's putting them back in the driver's seat at a time where life is out of control. (Aanya/p.80-81/1287-1306)
OUT –> NOT A HOSPICE EXPERIENCE) ***PET25– Making sense from first shocking experiences of dying patient to Aanya not getting fazed anymore***	***Feeling utterly bereft of first experience of patient dying – unexpected*** ***Shocking – difficult to comprehend and struggling to process***	*“My first day, my first patient died. Erm. And I wasn't expecting it. It was an unexpected death in the hospital. And I had to go and verify that they had died and see this dead body. And I remember thinking, they are live one minute and they are dead now.. That is weird. That's quite hard. And I remember crying on my way home from work and and really sobbing and just…. I felt, I felt bereft for my patient and for his family. I didn’t even know him. I was, but I felt utterly bereft. (Aanya/p. 70/l.1107-1121)* *“And I think as well shocked that I'd seen a dead body. But he had been alive. It wasn't like in medical school when you are seeing dissection of bodies because they've only ever been dead to you. Whereas someone who was living and then died. And I really struggled for a couple of days…erm, just processing… Erm.” (Aanya/p. 59/l. 1123-1132)*

Appendix K: A Table of PETs for all Participants

Aanya	Rachel	Helen	Mary	Jeanne	Harry
PET 1: Aanya's experience of being affected: relating to patients as more than patients PET2: Aanya's grief reactions unpredictable PET3: Difference between professional and the personal grief – grief present in different lives (Aanya) PET4: Aanya in a job mode - there to do a job PET5: Aanya's grief tied to professional boundary holding her back PET6: Aanya hiding personal feelings PET7: Being looked at as someone who is in control and fixes things PET8: The anticipatory grief – Aanya grieving with them on their journey and not so much after PET 9: Aanya feeling relieved not needing to carry that emotion anymore PET10: Aanya learning from personal life bereavement experiences	PET1: Reacting to them as whole people: Rachel feeling piece of their humanity and that gets in PET2: Rachel's quality of sadness towards patients: "not deep or long lasting" like dust but inevitable - feeling grief generally PET3: Rachel's Anticipatory reactions to upcoming deaths PET4: Rachel Learning to do awkward and difficult conversations in the anticipatory phase PET5: Different levels of grief hard for Rachel: general existential grief and being exposed to mortality every day depressing PET6: Rachel being triggered by personal grief and loss experiences PET7– Rachel dealing with "Survivor's guilt" instead of grief and feeling stupid about it PET 8: Treating the whole room – relatives' high emotions making it 'really real'	PET1: Helen's experience of the specialness of the environment: "Working in a family atmosphere" PET2: Helen's Sense of going through it together: forming deeper attachments with patients "getting under your skin" PET3: Forming deeper attachments both meaningful and painful for Helen: "can't let everyone in PET4: Helen's fear of being judged as unprofessional if showing attachment but all being affected PET5: Helen making sense of the overwhelm and mixed feeling of responsibility PET6: Helen's complex feelings: it wasn't fair but it was also very beautiful and very peaceful PET7: Shared sense of achievement with the staff in addition to sadness PET8: Temporal aspects of momentary sadness –	PET1: There is something within it that has resonated – Mary being emotionally affected PET2: Mary trying to be equal in her emotional responses to patients PET3: It is unexpected and surprise – for whatever reason making Mary sad PET4: Mary feeling oddness for not remembering the patient's death: there is sadness but memories more colored by the joy of her PET5: Mary balancing the personal relationship and the clinical care: two different responses to situation existing together PET6: Controlled reactions: traditional expressive grief reactions less frequent PET7: Muting responses and putting things into pockets to be able to work PET8: Mary surrendering to subconscious working grief	PET1: Jeanne becoming conscious about feelings towards patients PET2: Jeanne's realisation needing to be careful about feelings toward patient – being profoundly affected by patient's death PET3: The anticipation: Jeanne feeling torn and not wanting the patient to die PET4: Always sadness but sometimes a sense of relief for Jeanne PET5: Life-affirming impact even years later – continuing bonds (Jeanne) PET6: Jeanne putting profound sadness aside – "this is your job, you need to get on with it" PET7: Jeanne learning grief coming and going PET8: Suppressed grief finding its' way out in "weird" situations and time and space PET10: Jeanne being 'knocked sideways': overwhelmingly exhausted	PET1: Everyday event but variation in how Harry being affected PET2: Harry trying to rely on logical approach but surrendering to emotions taking over: seeing someone actually die PET3: Anticipatory grief hard for Harry: you sort of see it coming and the hard bit is seeing it coming. PET4: Harry's sense of resolution and relief and mixed feelings PET5: Harry's ambivalence re. what is an appropriate response to a patient's death : feeling of oddness PET6: The challenge of Harry's professional grief: life doesn't stop and you've got to get onto next one PET7: Needing to find a way to process emotions slightly differently - quicker PET8: Recognising own preferences and needs for processing emotions: spending time alone and
PET11: Aanya putting mental boundaries: "where you let yourself go and where you won't" PET12: Aanya setting boundaries between work and home by "Throwing emotions out of the window" PET13: Aanya learning how to do the job from seniors – seeing how they are in response to grief – space and permission PET14: Aanya modelling to Junior Doctors how to manage the burden of grief PET15: Medical training not preparing Aanya for emotional aspects – learning in the job PET16: Aanya hiding feelings behind a professional stance PET17: Managing everyone else's grief: Aanya's experience of grief becoming secondary and no time/space to grieve PET18: Space and time away from hospice necessary to Aanya to	PET9: Supporting grieving relatives – awkwardness of words not feeling right or enough PET10: Rachel "Shutting doors" and recognising part of "being closed off" to protect herself from being affected PET11: Rachel keeping it suppressed: putting down "a big steel shutter" to not allow others to see her deep emotions PET12: Rachel separating and drawing boundaries PET13: Grief woven itself into all of Rachel's life – trying to leave it as their grief PET14: The professional role inhibiting expressing 'being human' PET15: Sense of Responsibility – Rachel's internalised ideas of not being able to let guard down PET16: Rachel's emotional tiredness in the body PET15: The process of unlearning the culture of hospital medicine –	needing to suppress grief reactions to move on PET9: Helen suppressing for professional responsibilities: no time to grieve PET10: Dynamic grief: as if no control of Helen being transported back into that space three years later PET11: Supporting families/others in their grief: big part of the job PET12: Feeling unentitled to grieve PET13: Sharing and validating grief with a family member "helped both of our grief over him" PET14: Public expectations: hiding professional grief PET15: "An arena for being emotional" – Public vulnerability and crying experienced as embarrassing PET16: Reflecting and re-experiencing valued despite emotionally vulnerability difficult	PET9: Mary recognising different layers of mixed emotions existing PET11: An echo of all the people that are lost – personal losses getting transmitted to professional loss reactions PET12: Learning about emotional self to be healthier and better as a doctor PET13: Mary's anxiety about expressing emotions: learning to deal with vulnerability PET14: Being profoundly influenced by patient as a human being and as a professional – learning from the patient PET15: Identity shift from 'hero that saves lives' to being part of a subgroup that accepts death as an entity PET16: Mary on a mission as a senior doctor and educator: encouraging new generation to be healthier with emotional responses PET17: Mary's challenge to break down the stigma about hidden and not	PET11: Jeanne compartmentalising as a coping method to not wanting to feel PET12: Jeanne's fear of 'unlocking the box': not knowing what to do with the consequences PET12: Jeanne putting barrier on herself: Not getting 'job head' and 'personal head' 'mishmashed' PET14: Struggling with 'the cross-over' of how to feel as a professional and feel as a person – not knowing how to integrate PET15: Jeanne's doctor's professional identity shifting from being the 'coper' to 'human part' being more open PET16: Jeanne learning about herself: Becoming more aware of herself as a human as opposed to 'a functioning machine' PET17: Recognising own struggles with vulnerability: "I am vulnerable and I don't know how to manage that."	preferring one-on-one support PET9: Harry's struggle of finding space and time to relieve emotional burdens and dealing with the next one: fear of burnout PET10: Increased self-awareness helping with coping: burden of grief building up PET11: Being part of the dying moment: the last breath feeling like a privilege and making cry PET12: Public expectations towards assisted dying changing: more control over dying for people but how will the grieving look like? Harry's concern PET13: Holding all up: it is just not your grief, it is managing the grief of others PET14: Being expert for colleagues modelling integrating loss and coping with death necessary competence PET15: Hard to take 'professional hat' off in personal life

cope – being constantly on fire PET19: Managing the grief: Aanya turning inwards PET20: Experiencing subconscious stress: Aanya getting nightmares and dreams PET21: Importance of sharing and feeling normal: "sense everyone feeling this way" PET22 Aanya growing and exceling- sense of meaningful work PET23: Aanya's awareness of mortality giving new perspective on life PET24: Aanya's normality and reality not understood by outside world	Rachel's loss of the doer identity PET 16: Rachel becoming more empathetic – Rachel learning to sit with people's distress PET 17: Rachel Witnessing Junior Doctors struggling with not being able to fix things PET18: A Process of learning to be comfortable with dying and accepting it as part of life PET19: Recognised as normal that all cry but 'off the ward': moving the grief to different space PET20: Experiencing ALL FEELING THE SAME THING BUT Rachel requiring 'bravery' to show vulnerability PET22 Relating to outside world – polishing the reality that is 'unfine' PET23: Acknowledging the reality suddenly hit her – not noticing struggling PET24: Maturing and growing through grief experiences and loss	PET17: Helen stepping away and needing silent reflection away from workspace to grieve PET18: Between colleagues - emotions openly and honestly reflected PET19: Learning to separate personal and professional grief triggers PET20: Learning to oscillate back and forth – "an adjustment thing" PET21 – Containing grief in the workspace – Helen needing boundaries and time away PET22: Reconstructing professional identity: "Not doing what you are trained for" PET23: Professional identity both protecting and hindering empathy outside work PET24: Grief helping individuation process: more clarity on one's unique self-identity and values	spoken grief as a medical educator PET18: Mary's disconnected realities: Living in a sanitised world where death doesn't happen but death and dying reality in hospice PET19: Mary's duty of care and responsibility to support colleagues PET20: Senior role support lacking emotional support – non-healthcare professionals don't understand PET21: Mary learning flexibility and adaptability to try to meet people's individual needs – a challenge PET22: Catalyst for Individuation and clarity	PET18: Jeanne almost dying: a hugely difficult thing to think about people around Jeanne grieving her PET19: Learning to relate to vulnerability differently but preference to avoid it PET20: Learning from other people how to deal with sadness and grief PET21: Putting yourself aside and feeling the 'ultimate responsibility' to support others PET22: Feeling helpless in relation to hopelessness – who would support a senior doctor? PET23: Supporting Junior Doctors: 'feeling torn' in different directions PET24: A shared experience of emotionally challenging work: grief being understood and validated even when can't be expressed PET25: Jeanne in between realities of 'A funny place to be in': 'this is what I do' reality vs. being judged 'that is awful' reality	PET16: The challenging patriarchal aspect in the medical culture where "work is doing, not work is feeling" PET17: Carrying grief is heavy and tiring: Harry being pulled down PET18: Being taught to be a professional - Not Being taught to grieve: holding it in PET19: A challenge of being part of 'a system:' Becoming a professional and being also a human being PET20: Lost in disconnection: outside hospice context relating to the experiences: seeing horror and 'people in business' don't talk to each other

				PET26: Grieving patients teaches to live life – life-affirming impact	
OUT (not hospice experiences): PET6: Jeanne's first experiences of death – from feeling panicked to learning to be 'in a job mode' PET25: Making sense from first shocking experiences of dying patient to Aanya not getting fazed anymore PET12: Public expectations towards assisted dying changing: more control over dying for people but how will the grieving look like? Harry's concern					

Appendix L: A Table of GETs and PETs

GET1: The Relational tension
Subtheme: Being affected in relational bonds: "Reacting to them as whole people" (Helen, Jeanne, Rachel, Aanya, Mary, Harry)
PET1: The specialness of the environment: Helen working in "a family atmosphere" PET2: Helen's Sense of going through it together: forming deeper attachments with patients "getting under your skin" (overlapping) PET1: Jeanne becoming conscious about feelings towards patients PET1: Reacting to them as whole people: Rachel feeling piece of their humanity and that gets in PET1: Aanya's experience of being affected: relating to patients as more than patients, as persons PET14: Being profoundly influenced by patient as a human being and as a professional – learning from the patient (Jeanne) (overlapping) PET2: Jeanne's realisation needing to be conscious about feelings toward patient – being profoundly affected by patient's death (overlapping) PET1: Everyday event but variation in Harry being affected
Subtheme: It is "unpredictable": "there is something within it that has resonated" (Mary, Aanya, Jeanne, Helen, Harry, Rachel)
PET2: Harry trying to rely on logical approach but surrending to emotions taking over: seeing someone actually die PET2: Aanya's grief reactions unpredictable PET1: Rachel reacting to them as whole people: feeling piece of their humanity and that gets in PET2: Helen's sense of going through it together: forming deeper attachments with patients "getting under your skin" PET1: There is something within it that has resonated – Mary being emotionally affected PET3: It is unexpected and surprise – for whatever reason making Mary sad PET 1: Aanya's experience of being affected: relating to patients as more than patients, persons PET2: Jeanne's realisation needing to be conscious about feelings toward patient – being profoundly affected by patient's death PET11: Being part of the dying moment: the last breath feeling like a privilege and making cry (Harry)
Subtheme: Resisting being affected: "you can't let everyone in" (Helen, Mary, Jeanne, Aanya, Rachel, Harry)
PET4: Helen's fear of being judged as unprofessional if showing attachment but all being affected PET2: Mary trying to be equal in her emotional responses to patients PET2: Jeanne's realisation needing to be careful about feelings toward patient – being profoundly affected by patient's death PET6: Mary balancing the personal relationship and the clinical care: two different responses to situation existing together PET1: Reacting to them as whole people: feeling piece of their humanity and that gets in. (Rachel) (overlapping) PET4: Aanya keeping professional boundary: holding her back from fully connecting PET 2 – Aanya making sense of the difference between professional and the personal grief – grief present in different lives PET3: Anticipatory grief hard for Harry: you sort of see it coming and the hard bit is seeing it coming. [Resisting and keeping it as a professional relationship aspect]
GET2: Making sense of the complex emotional layers related to grief
Subtheme: Anticipatory grief: "the hard bit is seeing it coming" (Harry, Jeanne, Rachel, Aanya)
PET3: Anticipatory grief hard for Harry: you sort of see it coming and the hard bit is seeing it coming. PET3: The anticipation: Jeanne feeling torn and not wanting the patient to die PET3: Rachel's Anticipatory reactions to upcoming deaths PET4: Rachel Learning to do awkward and difficult conversations in the anticipatory phase PET6: Aanya's anticipatory grief – grieving with them on their journey and not so much after
Subtheme: Mixed feelings from overwhelm to relief: "different levels of grief hard" (Harry, Helen, Aanya, Rachel, Mary)
PET5: Helen making sense of the overwhelm and mixed feeling responsibility PET4: Always sadness but sometimes a sense of relief for Jeanne PET 9: Aanya feeling relieved not needing to carry that emotion anymore (overlapping) PET4: Harry's sense of resolution and relief and mixed feelings PET5: Harry's ambivalence re. what is an appropriate response to a patient's death: feeling of oddness PET5: Different levels of grief hard for Rachel: general existential grief and being exposed to mortality every day depressing PET7: Rachel dealing with "Survivor's guilt" instead of grief and feeling "stupid" about it

PET2: Rachel’s quality of sadness towards patients: “not deep or long lasting” like dust but inevitable - feeling grief generally
PET6: Helen’s complex feelings: “it wasn’t fair but it was also very beautiful and very peaceful”
PET7: Helen’s shared sense of achievement with the staff in addition to sadness
PET10: Mary recognising different layers of mixed emotions existing
PET4: Mary feeling oddness for not remembering the patient’s death: there is sadness but memories more coloured by the joy of her
PET8: Controlled reactions: traditional expressive grief reactions less frequent (Mary)

Subtheme: Carrying grief in the body: withdrawing and physical exhaustion
(Aanya, Harry, Jeanne, Rachel)

PET17: Carrying grief is heavy and tiring: Harry being pulled down
PET10: Jeanne being ‘knocked sideways’: overwhelmingly exhausted
PET16: Rachel’s emotional tiredness in the body
PET23: Acknowledging the reality suddenly hit her – not noticing struggling (Rachel)
PET5: – Different levels of grief hard for Rachel: general existential grief and being exposed to mortality every day depressing
PET9: Aanya Feeling relieved not needing to carry that emotion anymore
PET10: Increased self-awareness helping with coping: burden of grief building up (Harry)

Subtheme: Just like the weather: “grief coming and going”
(Jeanne, Helen, Mary)

PET7: Jeanne learning: grief coming and going: feeling it in the body but not sorted out in head
PET8: Jeanne’s suppressed grief finding its’ way out in “weird” situations: time and space
PET10: Dynamic grief: as if no control of Helen being transported back into that space three years later
PET8: Temporal aspects of momentary sadness: Helen needing to suppress grief reactions to move on
PET8: Mary surrendering to subconscious working grief

Subtheme: Personal grief intertwined with professional experiences
(Mary, Rachel, Jeanne, Aanya, Helen)

PET11: An echo of all the people that are loss: Mary’s personal losses getting transmitted to professional loss reactions
PET6: Rachel being triggered: personal grief and loss experiences
PET18: Jeanne almost dying: a hugely difficult thing to think about people around Jeanne grieving her
PET10: Aanya learning from personal life bereavement experiences
PET6: Aanya hiding personal (experiences) feelings
PET18: Helen learning to separate personal and professional grief triggers

GET3: Managing grief tied to professionalism

Subtheme: “Being in the job mode”
(Jeanne, Helen, Aanya, Harry, Mary)

PET5: Jeanne putting profound sadness aside – “this is your job, you need to get on with it”
PET9: Helen *s*uppressing for professional responsibilities: no time to grieve
PET3: Aanya in a job mode – there to do a job
PET6: The challenge of Harry’s professional grief: life doesn’t stop and you’ve got to get onto next one
PET9: Harry’s struggle of finding space and time to relieve emotional burdens and dealing with the next one: fear of burnout
PET2: Mary trying to be equal in her emotional responses to patients (‘moving’ on part)

Subtheme: Hiding grief: “putting down a big steel shutter”
(Aanya, Mary, Rachel, Jeanne, Helen, Harry)

PET10: Rachel “Shutting doors” and recognising part of “being closed off” to protect herself from being affected
PET11: Rachel keeping it suppressed: putting down “a big steel shutter” to not allow others to see her deep Emotions
PET5: Aanya’s grief tied to professional boundary holding her back
PET7: Muting responses and putting things into pockets to be able to work (Mary)
PET12: Jeanne’s fear of unlocking the box – not knowing what to do with the consequences
PET16: Aanya hiding feelings behind a professional stance
PET14: Public expectations: hiding professional grief (Helen)
PET18: Being taught to be a professional holding it in (Harry)
PET11: Aanya putting mental boundaries: “where you let yourself go and where you won’t”
PET11: Jeanne compartmentalising as a coping method to not wanting to feel

Subtheme: Coping by separating grief spaces and drawing boundaries: “It is like being in the fire and you need to remove yourself from it” (Helen, Mary, Rachel, Harry, Aanya)
PET4: Helen’s fear of being judged as unprofessional if showing attachment but all being affected PET17: Helen stepping away and needing silent reflection away from workspace to grieve PET21: Containing grief in the workspace: Helen needing boundaries and time away PET12: Rachel separating and drawing boundaries PET19: Recognising as ‘normal’ that all cry but ‘off the ward’: moving grief to different space (Rachel) PET7: Muting responses and “putting things into pockets” to be able to work (hiding part) (Mary) PET7: Needing to find a way to process emotions slightly differently – quicker (Harry) PET18: Space and time away from hospice necessary to Aanya to cope – being constantly on fire PET12: Aanya setting boundaries between work and home by “Throwing emotions out of the window” PET20 Experiencing subconscious stress: Aanya getting nightmares and dreams PET13: Grief woven itself into all of Rachel’s life: Rachel trying to leave it as “their grief” PET20: Learning to oscillate back and forth – “an adjustment thing” (Helen)
Subtheme: Doctor’s grief being secondary (Rachel, Harry, Jeanne, Helen, Mary, Aanya)
PET17: Managing everyone else’s grief – Aanya’s experience of grief becoming secondary and no time/space to grieve PET7: Being looked at as someone who is in control and fixes things (Aanya) PET 8: Treating the whole room – relatives’ high emotions making it ‘really real’ (Rachel) PET9: Rachel supporting grieving relatives: awkwardness of words not feeling right or enough PET13: Holding all up: it is just not your grief, it is managing the grief of others (Harry) PET11: Supporting families/others in their grief: big part of the job (Helen) PET13: Sharing and validating grief with a family member “helped both of our grief over him” (Helen) PET12: Feeling unentitled to grieve (Helen) PET21: Putting yourself aside and feeling the ‘ultimate responsibility’ to support others (Jeanne) PET23: Supporting Junior Doctors: ‘feeling torn’ in different directions (Jeanne) PET22: Feeling helpless in relation to hopelessness – who would support a senior doctor? (Jeanne) PET20: Senior role support lacking emotional support – non-healthcare professionals don’t understand (Mary) PET19: Mary’s duty of care and responsibility to support colleagues PET21: Mary learning flexibility and adaptability to try to meet people’s individual needs – a challenge PET9: Supporting grieving relatives – awkwardness of words not feeling right or enough (Rachel)
Subtheme: Shared experience: “all going through the same things” (Helen, Aanya, Rachel, Harry, Jeanne)
PET4: Helen’s fear of being judged as unprofessional if showing attachment but all being affected PET15: “An arena for being emotional” – Public vulnerability and crying experienced as embarrassing (Helen) PET3: Forming deeper attachments both meaningful and painful for Helen: “can’t let everyone in PET16: Reflecting and re-experiencing valued despite emotionally vulnerability difficult (Helen) PET18: Between colleagues - emotions openly and honestly reflected (Helen) PET21: Importance of sharing and feeling normal: “sense everyone feeling this way” (Aanya) PET20: Experiencing ‘all feeling the same’ - Rachel requiring ‘bravery’ to show vulnerability PET24: A shared experience of emotionally challenging work: grief being understood and validated even when can’t be expressed (Jeanne) PET8: Recognising own preferences and needs for processing emotions: spending time alone and preferring one-on-one support (Harry)
GET4: A Process of learning to relate to grief
Subtheme: Reconstructing professional identity (Helen, Mary, Jeanne, Rachel, Harry)
PET22: Reconstructing professional identity: “Not doing what you are trained for” (Helen) PET23: Professional identity both protecting and hindering empathy outside work (Helen) PET15: Identity shift from ‘hero that saves lives’ to being part of a subgroup that accepts death as an entity (Mary) PET18: Being taught to be “a professional”: Not Being taught to grieve: holding it in (Harry) PET15: The process of unlearning the culture of hospital medicine – Rachel’s loss of the ‘doer’ identity PET 16: Rachel becoming more empathetic: learning to sit with people’s distress PET17: A challenge of being part of ‘a system:’ Becoming a professional and being also a human being (Harry) PET16: The challenging patriarchal aspect in the medical culture where “work is doing, not work is feeling” (Harry) PET18: A process of learning to be comfortable with dying and accepting it as part of life (Rachel)

Subtheme: Learning grief from others
(Aanya, Jeanne, Mary, Harry)

PET15: Medical training not preparing Aanya for emotional aspects: learning in the job (Aanya)
PET13: Aanya learning how to do the job from seniors – seeing how they are in response to grief – space and permission
PET14: Aanya modelling to Junior Doctors how to manage the burden of grief
PET 17: Rachel witnessing Junior Doctors struggling with not being able to fix things
PET19: A challenge of being part of 'a system:' Becoming a professional and being also a human being (Harry)
PET14: Being expert for colleagues modelling integrating loss and coping with death necessary competence (Harry)
PET16: Mary on a mission as a senior doctor and educator: encouraging new generation to be healthier with emotional responses
PET17: Mary's challenge to break down the stigma about hidden and not spoken grief as a medical educator
PET20: Jeanne learning from other people how to deal with sadness and grief
PET14: Being profoundly influenced by patient as a human being and as a professional – learning from the patient (overlapping) (Jeanne)

Subtheme: Learning about "the emotional self"
(Jeanne, Rachel, Mary, Harry, Aanya)

PET16: Jeanne learning about herself: Becoming more aware of herself as a human as opposed to 'a functioning machine'
PET17: Recognising own struggles with vulnerability: "I am vulnerable and I don't know how to manage that." (Jeanne)
PET15: Jeanne's doctor's professional identity shifting from being the 'coper' to 'human part' being more open
PET19: Learning to relate to vulnerability differently but preference to avoid it (Jeanne)
PET12: Jeanne putting barrier on herself: Not getting 'job head' and 'personal head' 'mismashed'
PET14: Struggling with 'the cross-over' of how to feel as a professional and feel as a person – not knowing how to integrate (Jeanne)
PET13: Mary's anxiety about expressing emotions: learning to deal with vulnerability
PET12: Learning about her emotional self to be healthier and better as a doctor (Mary)
PET14: The professional role inhibiting Rachel expressing 'being human'
PET15: Sense of responsibility: Rachel's internalised ideas of not being able to let guard down
PET14 Hard to take 'professional hat' off in personal life (Harry)
PET19: Managing the grief: Aanya turning inwards

GET5: From disconnection to others to connection with self

Subtheme: The unrelatable reality
(Harry, Rachel, Mary, Aanya, Jeanne)

PET20: Lost in disconnection: outside hospice context relating to the experiences: seeing horror and 'people in business' don't talk to each other (Harry)
PET22 Relating to outside world – polishing the reality that is 'unfine' (Rachel)
PET18: Mary's disconnected realities: Living in a sanitised world where death doesn't happen but death and dying reality in hospice
PET24: Aanya's normality and reality not understood by outside world
PET23: Jeanne in between realities of 'A funny place to be in': 'this is what I do' reality vs. being judged 'that is awful' reality

Subtheme: Expanding life: "taking life in"
(Rachel, Aanya, Mary, Jeanne, Helen)

PET24: Grief helping individuation process: more clarity on one's unique self-identity and values (Helen)
PET24: Maturing and growing through grief experiences and loss (Rachel)
PET22: Catalyst for individuation and clarity (Mary)
PET24: Grieving patients teaches to live life – life-affirming impact (Jeanne)
PET26: Life-affirming impact and continuing bonds even years later: learning from patient's bravery (Jeanne)
PET24: Grief helping Helen's individuation process – more clarity on one's unique self-identity and values
PET22 Aanya growing and excelling - sense of meaningful work
PET23: Aanya's awareness of mortality giving new perspective on life