CE Ethics Series

1 ANCC Contact Hour

Making Sense of Moral Distress Within Cultural Complexity

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The aim of this study was to explore nurses' experiences working on a chronic ventilator-dependent unit with a predominance of elderly Orthodox Jewish patients at the end of life. Little is known about how cultural complexity creates differences between nurses' and family's expectations for patient care at the end of life. A qualitative study of 27 nurses was conducted using focus groups. Early interviews led to the expansion of the original question to include exploring nurses' moral distress. Content analysis revealed 3 categories of themes, one of which is highlighted in this article. The main finding was an incongruence of perspectives, described as depth-of-field dissimilarity, in which the focus and depth of perspective depend on the person doing the looking. This study suggests that depth-of-field dissimilarity can be used to develop educational strategies, clinical interventions, and research to address moral distress and cultural complexity.

KEY WORDS

bioethics, culture, end-of-life issues, ethics, moral distress, nurses, nursing

A qualitative study was conducted to explore the experience of mostly non-Jewish nurses caring for a population of mainly elderly Orthodox Jewish patients with chronic ventilator-dependent respiratory failure, who were nearing the end of life. Many of these patients were Holocaust survivors, which increased the complexity of decision making at the end of life in an already difficult situation. Although nurses commonly encounter patients and families with values different from their own, the nursing unit selected for this study was unique because among an otherwise diverse population was the predominance of one culture, elderly Orthodox Jewish patients. Conflicts of values among health professionals, patients, and families can be a pathway to the experience of moral distress.

An Orthodox Jew's choice to use life-sustaining treatment is informed by his/her religious beliefs, particularly regarding the sacredness of life. The unit population presented the challenge of routinely caring for patients and families whose goals are to support life, even when significant improvement is unlikely. The average age of patients on this 30-bed unit was 82 years. Most patients were unresponsive because of dementia, anoxic encephalopathy, or other conditions, and nearly all were mechanically ventilated. Some patients required sedation to tolerate mechanical ventilation, and most required complete care. Palliative extubation, sometimes referred to as terminal weaning, is an infrequent practice within this particular patient population. Most patients die while remaining on a ventilator or are discharged to a skilled nursing facility on a ventilator. The care of patients on this unit can be physically and emotionally demanding for nurses and others even when there are no cultural differences.

The complexity of care, morbidity and mortality, and the cultural considerations informed the main research question: "What were the specific challenges of nurses caring for this population?" This question expanded to include whether the nurses experienced psychological, emotional, or moral distress because of the issues they encountered.

BACKGROUND

Maimonides Medical Center located in Brooklyn, New York, has a high concentration of Orthodox Jewish patients. According to the United Jewish Federation 2011 Jewish Community Study,[1] is home to 562 000 Jews. This represents more than one-third of the 1.5 million Jews (36%) in the metropolitan New York city area. New York and its surrounding areas has the most populous Jewish community outside Israel.[1] A qualitative study designed by the first and third authors used focus groups with staff nurses to understand their experience of working with elderly, chronic, ventilator-dependent patients near the end of life. The main purpose of the

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study was to describe challenges and concerns so that supportive strategies for nurses could be developed. Specific study aims were to (1) determine whether nurses experienced distress related to the care they provide and, if so, (2) determine contributing factors and consequences of that distress, and (3) identify nurses' coping strategies. Ideas for addressing any distress identified in their practice environment were also elicited.

THE ORTHODOX JEWISH PERSPECTIVE

Being an observant Jew means maintaining Jewish laws and customs dictated by the *Torah* (the first 5 books of the Bible). Jewish identity is complex because it is composed of religious tradition, ethnicity, and cultural practice. There are also differences in levels of observance across the continuum of Orthodox, Conservative, Reform, and non-affiliated Jews.

An Orthodox Jew is committed to Halacha (the collective body of Jewish law) as delineated by the *Shulchan Aruch* (codex of Jewish law). Halacha, which includes biblical text as well as Talmudic and rabbinical interpretation of Jewish law, means "to walk," and as such, it serves as a guide for walking through life. Halacha guides all aspects of Jewish daily life, religious practices, rituals, and customs, including health care–related decisions. It is the role of a rabbi to guide the interpretation of Halacha and its related texts. A rabbi who specializes in interpreting Halacha is called a *posek*. Orthodox Jews consult a rabbi or *posek* before making most major life decisions, including matters of health care.[2]

Judaism is grounded in the belief of the supreme sanctity of life. Safeguarding and preserving human life are of utmost importance. This principle, "*pikuach nefesh*," defined as the duty to restore health and wellness of a fellow man, takes precedence over all other religious duties, including keeping the Sabbath (Deuteronomy 22:1). There are many facets of this obligation, especially with regard to medical decision making. It is this important value that is often misunderstood in contemporary health care. This sanctity-of-life concept is important in the context of the study unit because the patients' families typically follow the directive of their rabbi or *posek* regarding the continuation of life-sustaining measures.

LITERATURE REVIEW

Moral distress has had various definitions since the concept was introduced in the nursing literature by Jameton.[3] The initial definition stipulates an "inability to act" due to institutional constraints as a necessary condition of moral distress. This has been called into question because sometimes actions are taken that are not successful in resolving the situations that cause moral distress. Fourie[4] proposed redefining moral distress as "a psychological response to morally challenging situations such as those of moral constraint or moral conflict or both."[4(p7)]

Many scholars have identified contributors to and consequences of moral distress. Futile care, or the perception of patient pain and suffering, has been identified as an important factor contributing to moral distress.[5-7] The nurse's sense of being complicit is included in this perception of futility.[8] However, nurses' definition of futile care varies and reflects the subjectivity of personal judgments, based on emotions, beliefs, and culture.[9]

McAndrew and Leske[10] specifically studied end-of-life decision making in intensive care units, describing it as a balancing act. Factors contributing to balance included a team approach with shared goals, understanding perspectives of those involved, and knowing one's own beliefs. Moral distress occurred when there was an imbalance caused by factors such as uncertainty, feelings of powerlessness, difficult family dynamics, and recognition of suffering.

Consequences of moral distress included psychological responses and stress reactions that negatively affect the emotional health of nurses, sometimes leading to physical symptoms, including physical exhaustion.[6,11] Feelings of frustration, anger, depression, guilt, and powerlessness were prevalent. Nurses sometimes engaged in avoidance behaviors, which contributed to decreased job satisfaction and an unhealthy work environment affecting quality of care and patient satisfaction. An organization is adversely affected when nurses change jobs or leave the profession.[11]

The effects of unresolved moral distress and poor ethical climate on nurse turnover have been explored, and important relationships identified (Figure).[12] Later studies also described important relationships between moral distress, the ethical climate of health care settings, and staff retention.[13] Hamric et al[14] found an inverse correlation between moral distress and the perception of a positive ethical climate.

METHODS

Institutional review board approval was obtained prior to conducting the study. The principal investigator met with registered nurses on the study unit to describe the research and invite their participation. Written informed consent was obtained from participants, and no identifying information was collected. Data were accessible only to the investigators, and security was maintained throughout the study. All related ethical standards were upheld.

Demographic data collected from nurses included age, tenure on the unit, highest level of nursing education, and certification status. Although religious affiliation was not ascertained, this question was asked, "Do you have any spiritual/religious beliefs that influence your nursing practice?" Just slightly more than a quarter of the participants responded affirmatively, without choosing to elaborate in the space provided. Differences between

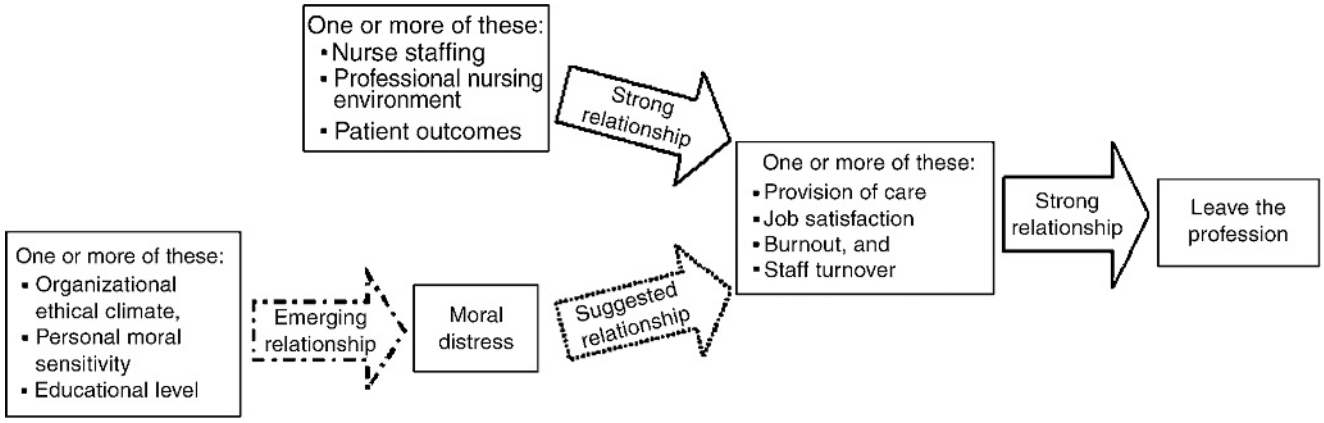

FIGURE. Influences and effects of moral distress on nurses' intention to leave the profession. Adapted from Schluter et al.[12]

Jewish and non-Jewish nurses caring for patients on this unit were not explored.

Night staff nurses were younger, with twice as many nurses younger than 40 years when compared with day staff, and they had attained more years of formal nursing education than the more experienced day-shift nurses. However, day-shift nurses had a higher certification rate, more than twice as many average years of nursing experience, and almost twice as many years of unit tenure.

Eleven focus groups were conducted over approximately 6 weeks in the spring of 2014 for an exploratory qualitative study. All nurses practicing on the unit were invited to participate, and all interested nurses were enrolled. There were 27 nurse participants from a staff of 39, evenly divided between day and night shifts. The reasons why 12 nurses did not volunteer were not explored.

Most participants took part in focus groups of 2 to 4 nurses. Two nurses requested individual interviews. Although focus groups typically have 6 to 10 participants to reap the benefits of stimulating discussion through diversity of ideas,[15] it was not feasible in this study. The unit was usually staffed with 7 to 8 nurses, and only half the staff could participate at a time so that the other half could provide direct patient care. Focus groups were conducted using a semistructured interview format (Table 1). Each focus group of 45 to 60 minutes was audiotaped and transcribed. The first question was intended to invite the nurses to enter into discussion. Once the discussion was underway, focus was shifted to discuss challenges and concerns. Next, the effects of these challenges on the nurses and their coping strategies were explored. The discussion closed with eliciting recommendations for improvement.

Although data saturation was reached after 5 groups, the focus groups continued until all volunteers had participated. This was done since the investigators had a general sense that staff needed more opportunities to talk about their experience with each other and with someone outside their unit.

The authors read and reread all the transcripts many times and discussed them together on several occasions. Content analysis provided consensus regarding categories and themes. A great deal of redundancy was evident across the 11 transcripts, with participants repeating the same points in almost the same words. The third investigator was brought into the study at this point and recommended determining which transcripts provided the most salient and representative data. This was an adaptation of Bazely's[16] recommendation to select a transcript typical or representative of the whole group or one that is "rich" in its details to begin the analysis, because this will affect how the remaining categories and themes are developed. Two of the most representative transcripts were selected by the authors and uploaded into NVivo 10 (QSR International Pty Ltd, Melbourne, Australia) for analysis. Twenty-one categories were generated during open coding. These codes were reduced to 3 thematic categories.

RESULTS

Three categories of themes emerged from the data: (1) themes universal to all nurses, (2) themes common to

TABLE 1 Focus Group Questions

Topic Explored	Focus Group Question
Invitational question	What are the positive aspects working on this unit?
	What helps you perform your job well?
Probing the concerns	What are the challenges working on this unit?
	How does work stress affect you?
Exploring resilience	What coping of self-care strategies do you use?
Recommendations	What ideas do you have for improving care on this unit?

TABLE 2 Illustrative Quotes

Thematic Categories	Illustrative Quotes
Themes universal to all nurses Workload, desire for acknowledgment of nature, and intensity of work	• *And with the staffing also, they just look at the numbers; they're not thinking about the unit and the time that is needed.* • *It's hard work, but it's brutal work when you're understaffed.* • *The last 6 months our staffing has been really terrible. So I feel like, I feel more overworked than I used to in be the past.* • *A lot of people don't realize how much the level of care gets cut when we're short-staffed.* • *If one day they get great care, and then the next day I have them, and we're short-staffed, it looks like I'm not as good as a nurse, but it's just because I have extra patients that day.* • *What would it be every once in a while to have a lunch given, or bagels in the morning, or something?*
Themes common to nurses caring for patients at end of life Concerns about medical treatment without potential to improve a patient's overall condition, providing unrealistic hope to patients and families Emotional responses to distress, depersonalization, desensitization, disempowerment, and depression	• *At times I'm saying, ''What am I doing?'' But if I don't do it, who else will? Someone has to care for them.* • *You know, I just don't see any benefit from it, so it's discouraging. I pretty much know no one is going to get better. I just say to the families, ''We will pray.''* • *That's how I feel. It's hard to explain to the family. They want to do the best for the patient—we do too, but at the same time, blood should be for people who really need it.* • *''Fine'' is not a word that should be used on this unit.* • *It makes me feel useless.* • *I have no stories to go home and tell anymore.* • *I don't have anything worthwhile to talk about.*
Themes unique to this study The concept of depth-of-field dissimilarity	• *There are peaceful ways for this [dying] to happen. There are options, but people don't always seem to understand that.* • *I'm missing the satisfaction of knowing that I did a good deed.* • *One of the challenges is working with these families. Hasidic (one form of Orthodox) Judaism is so alien to me—I have never encountered anything like it …and have limited understanding of how to help them; it feels like everything I've said doesn't make sense to them.* • *We should make them understand the value of treatment—it's not going to be helpful for this condition, for this situation.* • *Sometimes, the family, they don't understand. We try to educate the family as much as possible, but they're not understanding.* • *They have to accept the education that we give them.* • *We understand how they feel; we respect their feelings, but sometimes, it's so difficult to make them understand—they want the patient to get more (vasopressors) to keep the patient alive—we don't know how to deal with the situation.*

nurses caring for patients at end of life, and (3) themes unique to this study. Illustrative quotes of each thematic category are included in Table 2.

Universal themes included nurses' perception of their workload and the desire for acknowledgement of the nature and intensity of their work. These data revealed concerns of nurses who practice in a variety of different clinical settings but are not the emphasis of this article. Themes common to other nurses who engage in palliative care, such as futility, were also noted and will be discussed later.

The unique theme found in the data related to a difference of worldview found among nurses, patients, and families. This theme will be discussed through a metaphor called *depth-of-field dissimilarity,* adapted from a photographic term, *depth of field*. Depth of field refers to the zone of clarity in front of and behind the point of focus in a photograph. For example, in simple handheld cameras, depth of field is established with a single, fixed focus with a limited view. More sophisticated cameras with greater depth-of-field capability have adjustable telephoto lenses. The focal point and the depth of field around that focal point can be adjusted as needed. Photographic clarity relates to the degree of sophistication of the camera and its lens. This metaphor can be applied to understand the depth and breadth of the nurse's skill level in therapeutic presence. Having a broad, holistic, and nonjudgmental perspective allows nurses to be more effective patient advocates. In contrast, nurses with a more limited perspective provide more limited therapeutic effect. The focus and depth of field depend on the person who is doing the looking.

Discussions about the transcripts led the authors to realize that clinical situations were understood with different levels of insight and clarity, depending on the person's underlying worldview, education, and experience. The transcripts revealed that the religious doctrine that formed the worldview of patients and families was foreign to some nurses' understanding. The views of Orthodox Jewish patients who uphold the sacredness of human life through its preservation often conflict with common health care practice and the nurses' own views. The concept of depth-of-field dissimilarity provided a way to understand these data.

In their remarks, nurses emphasized the importance of respecting people from different cultures. They understood that patients and families have a right to treatment in accord with their beliefs and values. Some nurses acknowledged a lack of comprehensive understanding about how the religious beliefs of Orthodox Jews influence health care decision making. Several nurses expressed a desire to learn more in order to provide more sensitive care to families and to feel more competent and effective as nurses.

> One of the challenges is working with these families. Hasidic (one form of Orthodox) Judaism is so alien to me—I have never encountered anything like it—to be working with families… and have limited understanding of how to help them; it feels like everything I've said doesn't make sense to them.

The concept of depth-of-field dissimilarity extends even to nurses, who while they are providing care that is appreciated by the family members could not recognize the merit of their care. For example, 1 nurse said, "I'm missing the satisfaction of knowing that I did a good deed."

Differences in values between nurses and the families of Orthodox Jewish patients about "quality of life" and goals of care were reported by nurses as a source of conflict and stress. This conflict can negatively affect quality of health care decision making and patient care, as well as the satisfaction of providers.[17] It is interesting to note how infrequently culture is mentioned in other studies of moral distress.

Nurses thought the medical treatment was sometimes inconsistent with realistic goals. When implementing plans of care, which they thought caused patient suffering, nurses felt they were "prolonging the inevitable" (eg, performing cardiopulmonary resuscitation on frail, elderly patients with multiple clinical problems). Their motivation to provide outstanding nursing care was very strong, but they sometimes experienced conflicts between patients' values and their own. They also spoke about futility and the use of resources for treatments with little likelihood of patient benefit. For example, 2 nurses said:

> Nurse 1: [Our patients'] prognoses are very poor…. At times I'm saying, "What am I doing?" But, if I don't do it, who else will? Someone has to care for them.
>
> Nurse 2: I feel bad (about the treatments)—sometimes I've apologized.

In another example, a night nurse talked about not knowing how to best support the families for whom she cared.

> There are peaceful ways for this [dying] to happen. There are options, but people don't always seem to understand that. They may not even know what hospice is.

In another focus group, a nurse stated:

> What is the goal for this patient? There need to be a specific goal and care plan. It's about managing expectations.

These statements are clear examples of depth-of-field dissimilarity because in each case the nurse questions why the families do not share the nurse's point of view, without realizing that the family member's values for preserving that life would prohibit the kinds of decisions that the nurses believe should be made.

DISCUSSION

Issues of medical futility have arisen as technology has made life-prolonging treatments more readily available. As seen in this study, nurses experience moral distress when they witness care they think is futile. Because perceived futility can lead to moral, ethical, and emotional conflict, support is needed for nurses providing care for patients at the end of life.[7]

As the authors considered the nurses' statements, it became clear that ideas about technology, futility, and end-of-life decision making reflected an important area of concern. Specifically, there was a mismatch between the ideas that guided many nurses' thinking and the ideas that guided the families' decisions about care. This mismatch or difference in perspective contributed to the nurses' frustration. Peplau[18] wrote:

> Two opposing goals can operate to distort interpersonal relations and to deflect the patient from tasks involved in planning to meet his medical problem. The goals are incompatible with each other, and one or both may not be clearly visualized, the patient acting on goals that operate outside of awareness. The presence of conflict is recognized when a patient shows hesitation, vacillation, and/or blocking and inability to decide on a course of action to be followed."[18(p116)]

What Peplau[18] described as the patient's frustration the authors propose is similar to the nurses' frustration when their beliefs operated outside awareness. They were

unable to clearly consider the patient's personal beliefs that inform decisions nurses would not make themselves. The disparity between the nurses' point of view and those of patients and family members about the same clinical situation brought to mind the concept from photography of depth of field. Using this concept as a metaphor, the focal point in the clinical situation and the zone of clarity around that focal point were different for nurses than they were for patients and family members. Nurses seemed to focus on withholding or withdrawing technology and treatments because these elements symbolized futility of the care being provided. In contrast, patients and families viewed the technology and treatments as signs of care and respect for life. When nurses could not see the family's point of view about the value of this care, nurses expressed frustration about their role and the value of their work. This led nurses to experience moral distress because there was incongruence between the work they were doing and their expectation of being able to provide a different kind of care.

Yet it seemed from the statements in the transcripts if the nurses could understand that their work was valued by patients and families their moral distress might be transformed to a sense of pride. After multiple discussions of the transcripts, it became clear that for some nurses their sense of purpose and the meaning of their work felt thwarted. They experienced internal conflict from participating in care contrary to their beliefs. Internal conflict can cause suffering and jeopardize self-worth; it also challenges the professional integrity that nurses are explicitly duty-bound to protect according to the American Nurses Association's Code of Ethics for Nurses With Interpretive Statements.[19,20]

How can nurse educators, nurse administrators, and other nurse leaders find ways to strengthen the professionalism of nurses who cannot easily see the perspective of patients and families? Efforts to reduce depth-of-field dissimilarity and to increase nurses' sense of purpose, meaning, and value of their work to comfort and sustain others are an important area for research and knowledge development in end-of-life care.

Although not the focus of this article, study participants emphasized their commitment to teamwork; they shared pride in being part of a supportive and cohesive nursing team. Other positive aspects of their work they included were support received from the nurse manager, clinical knowledge and skills developed through providing care to complex patients, experience gained by caring for patients through the dying process, providing comprehensive physical care, assisting patients achieve comfort, and receiving appreciative feedback from families regarding their care experience on this unit.

This quote from a night nurse illustrates the sense of teamwork:

> The best thing about the respiratory care unit is the people I work with… we work so well together. We give each other moral support. Having a sounding board and knowing we have each other's back make all the difference. Talking to the other nurses validates my feelings.

Themes common to other studies of nurses caring for patients at end of life included concerns about medical treatment without potential to improve a patient's overall condition or as causing pain and other symptoms and providing unrealistic hope to patients and families.[6] Related to this issue are communication patterns between members of the patient care team and families.[21] Nurses reported a lack of thoroughness among some health care providers in discussions about the patient's overall clinical condition, prognosis, goals of care, and treatment options. One effect of inconsistent or incomplete communication is that it puts nurses in the challenging position of communicating a different message or no message at all. Families may not be ready to hear the clinical prognosis, so if different messages are given, they may choose to listen to whomever has the most hopeful outlook.

Nurses provided strong examples of their own emotional responses that correspond to the existing empirical literature.[5,6] These included depersonalization, desensitization, disempowerment, and depression. Some were described as consequences of distress that developed naturally over time; others were described as coping processes developed by conscious choice.

Themes related to nurses' perceptions of their workload are universal and not specific to this unit. Nurses stated that staffing was sometimes not what they wished it would be. Nurses also expressed concern about the level of recognition from organizational leaders regarding their very demanding work and practice environment, and they wished for more acknowledgment of their challenges. These data revealed concerns of nurses in many work settings and although important are not the emphasis of this article.

Nurses also reported their strategies of coping with stress. Sharing feelings with one another and being listened to, understood, and validated were often described as being most supportive. Self-care strategies included listening to music, yoga, baths, massage, prayer, laughter, exercise, participation in hobbies, keeping a journal, having a glass of wine after work, socializing after work, and involvement in religious activities. Other coping strategies mentioned were using unplanned paid time off or knowing they would transition from this unit. Some nurses coped with their moral distress by becoming detached and disengaged from patients and families or exhibiting other emotional responses.

Some study participants described diminished joy in providing nursing care. The focus on physical and technical tasks differed from expectations they had about their role as nurses and left them feeling unfulfilled. Some nurses

expressed interest in acquiring better communication skills in order to have more meaningful conversations with families.

The findings also suggest that nurses with less experience and more formal education may experience more moral distress. Night nurses usually have less opportunity to participate in interdisciplinary rounds and other venues for education and support. Other study findings are conflicted about the impact of educational preparation on moral distress.[22]

Strengths and Limitations

A strength of this study was the high (71%) participation rate. There was also a great degree of openness among the nurses during the focus groups, contributing to rich descriptions. Although nurses were asked keep content of focus group discussions confidential, there might have been some conversations between those who had participated and those who had not yet participated. An unintended benefit of this study was the mutual support among staff nurses that came from their discussions. While these conversations may have been therapeutic, this may also have contributed to "group think," which skews the data to 1 point of view. This possibility was anticipated by the investigator who used open-ended questions and stayed focused on the experience of the participating nurses. Another limitation was that the interviews were conducted during their nursing shift because that limited the number of participants during each session. The small groups might have contributed to some nurses being reluctant to share opinions differing from their peers.

Implications for Practice, Education, and Research

It is important to develop a balance between nature, the innate nature of the nurses as professionals, and nurture, the professional work environment within which they contribute their work. Educational strategies are needed that broaden and deepen the professional nurses' depth-of-field perspective. Approaches are also needed to understand the patients' and families' perspectives to reduce the depth-of-field dissimilarity. Clinical nursing interventions could be designed whereby nurses would seek greater understanding of a point of view of their patients and family members, with the explicit intention of providing for the patient's comfort. Research in this area could include studies that focus on the cultural and faith-based perspectives of nurses and their patients as it relates to end-of-life decision making. It may also be beneficial to research end-of-life decision making on chronic ventilator units serving other culturally diverse communities.

Recommendations

Suggestions from staff about improving patient and family care included the need for clear, consistent, and regular communication between the health care team and family members. This can be achieved through consistent interdisciplinary meetings with families and the health care team. Family meetings help establish reasonable expectations and lay the groundwork for ongoing discussions of treatment plans, response to treatment, and evaluation of goals. It is essential for nurses to actively participate in these discussions in order to reinforce information and effectively support families.

Supporting nurses through educational programs and specialty curricula is essential to nurses' professional growth and development. Nurses in this study expressed desire for education to improve communication skills, understanding of cultural and religious issues, and knowledge of hospice and other community resources for families. Nurses at all levels of an organization need to work together to empower bedside clinical nurses to consider and reflect on improving their ethical practice. Bioethics education can be provided through rounds on the unit, clinical ethics consultations, and participation in hospital bioethics committees. Walsh[8] discussed the value of including the emotional experience of moral distress in bioethics education, suggesting that emotional experience is correlated to the nurse's sense of moral agency.

Another strategy is to reevaluate the orientation process for new staff. While our hospital serves a very diverse community, and general training in culturally appropriate care is provided, additional education specific to Orthodox Judaism may foster the development of a greater understanding of this particular community. This recommendation is in alignment with Leininger's[23] concept of cultural accommodation.

Adequate, dedicated time for staff members to discuss their clinical experience is critical. They need support from each other and the nurse manager to help process unresolved issues.[22] Acknowledging the emotional vulnerability of nursing staff is also important. Nurses' responsibility to provide expert, compassionate care to patients and families is very challenging. Their distress can be reframed as evidence of their caring, which can contribute to the development of moral resilience. Compassion satisfaction, for example, nurses being enriched from helping people during a life-threatening crisis,[22] is related to this concept of moral resilience. The opposite and more familiar term, compassion fatigue, is aligned with moral distress. Emotional support can be provided in formalized, regularly scheduled groups, as well as informally.

CONCLUSION

This study explored how nurses felt about working on this unique unit and revealed their experience of moral distress. There was resonance between themes in the existing literature and the findings. As stated, some themes

were universal, and some were common to other studies of nurses caring for patients at end of life. The *theme of depth-of-field dissimilarity is* a new contribution to the literature and scholarship of moral distress.

This study may broaden understanding of moral distress within a particular patient population and clinical area. This research also addresses cultural and ethical considerations in end-of-life care and the need for focused attention to the experience of nurses working in today's complex health care environment.

Nurses want to practice in a work environment where they feel professional satisfaction and pride in the care they deliver. The work environment is meant to nurture its professional staff. Providing care that conflicts with a person's conscience and ethical values may contribute to moral distress. If professional nurses truly believe the statement that "as nurses, we are entrusted with treasuring others in society so that they will be able to treasure themselves,"[24(p311)] then likewise, nurses must create ways to treasure themselves and each other, so that nurses will be able to do important caring work.

Professional nurses bring their own particular "nature" to their work environment. This study shows that the components of nature and nurture must be woven together to reduce depth-of-field dissimilarity and to increase nurses' ability to provide therapeutic care of all patients.

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