
The provision of end-of-life care by medical-surgical nurses working in acute care: A literature review

JUDITH GAGNON M.SC.N, R.N., AND WENDY DUGGLEBY, PH.D., R.N., A.O.C.N.

Edmonton Clinic Health Academy, University of Alberta, Edmonton, Alberta, Canada

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ABSTRACT

Objective: Caring for terminally ill patients is complex, stressful, and at times distressing for nurses. Acute care hospitals continue to be the predominant place of death for terminally ill patients in most Western countries. The objective of the present literature review was to explore and gain an in-depth understanding of the experience of providing end-of-life (EOL) care by medical-surgical RNs working in acute care hospitals, to identify knowledge gaps, and to recommend future research.

Method: A comprehensive literature review was conducted using the following electronic databases: CINAHL, MEDLINE, and PsycInfo (from 1992 to October 2012).

Results: The findings from the 16 reviewed studies suggest that nurses felt a strong commitment to help terminally ill patients experience a good death. Nurses reported feeling deeply rewarded and privileged to share the EOL experience with patients/families. Organizational and individual factors influenced nurses' experience. Important challenges were associated with managing the divergent needs of a mixed patient load (i.e., curative and palliative care patients) in a biomedical culture of care that is heavily oriented toward cure and recovery. In this culture, nurses' emotional work and ideals of good EOL care are often not recognized and supported.

Significance of results: Managerial and organizational support that recognize the centrality of emotional work nurses provide to dying patients is needed. More research exploring ways to improve communication among nurses and medical colleagues is essential. Finally, a critical examination of the ideological assumptions guiding nurses' practice of EOL care within the context of acute care is recommended to help reveal their powerful influence in shaping nurses' overall understanding and experience of EOL care.

KEYWORDS: End of life, Medical nurses, Surgical nurses, Acute care, Hospital

INTRODUCTION

Acute care hospitals continue to be the predominant place of death for terminally ill patients in most Western countries (Jacobs et al., 2002; Sorensen & Iedema, 2011), and nurses are key players in the provision of end-of-life (EOL) care. Considering their continued presence at the bedside, nurses are expected to care holistically for terminally ill patients/families while they adjust to and live through the trajectory of the terminal illness (Fitzgerald, 2007).

However, the high-tech acute care environment of hospitals has been recognized as suboptimal for EOL care (Jacobs et al., 2002; Sorensen & Iedema, 2011), and in such a context a comprehensive approach to care can be very difficult for nurses to accomplish due to: (a) the very fast pace of the environment, (b) the biomedical culture focused on active treatment and cure (Summer & Townsend-Rocchiccioli, 2003), and (c) the cultural reluctance to discuss sensitive issues surrounding dying and the death itself (Willard & Luker, 2006; O'Gorman, 1998). In that regard, the perceived cultural norms in acute care settings can have a strong influence on staff behaviors, attitudes, and beliefs toward dying patients (Wilson & Kirshbaum, 2011), even

Address correspondence and reprint requests to: Judith Gagnon, Faculty of Nursing, Level 3, Edmonton Clinic Health Academy, University of Alberta, 11405 87th Avenue, Edmonton, Alberta, Canada T6G 1C9. E-mail: jgagnon2@ualberta.ca

more so when these norms ignore the consequences and suffering that caring for dying individuals can create in healthcare professionals (Willard & Luker, 2006).

In a literature review focused on the effect of death on nursing staff, Wilson and Kirshbaum (2011) noted that much of the knowledge development on EOL care reports on the experience of patients and their relatives. Furthermore, research on EOL has mostly explored the experience of nurses working on specialty units, such as oncology, palliative care, and critical care (Wilson & Kirshbaum, 2011). The medical-surgical nurses (or generalist nurses) represent an important group of nurses involved in the provision of EOL, yet no review to date has explored such specific experience in providing EOL care within an acute care environment. According to the Canadian Association of Medical Surgical Nursing, medical-surgical nurses are considered the largest group of practicing nurses and have been referred to as “the foundation of our healthcare system” (CAMSNS, 2008). Considering the valuable role these nurses play in supporting many of the dying patients in our acute healthcare institutions, the aim of this literature review is to explore and gain an in-depth understanding of this experience, identify knowledge gaps, and recommend future research. We will attempt to answer the following questions: How is the experience of providing EOL care described by nurses? What are potential factors that influence nurses’ responses and adjustment to provision of EOL care? What future research is needed in this area?

METHODS

Search Criteria

Inclusion Criteria

The sample inclusion criteria for the review were as follows. Published and peer-reviewed articles of empirical research reporting the experience and/or perceptions of acute care nurses regarding provision of EOL care in an acute care hospital, in a context other than critical intensive care units. Studies were limited to adult acute care where medical-surgical nurses were on staff. Studies including other areas of nursing practice or other healthcare professionals’ perceptions and experiences were considered as long as the data attributed to the medical-surgical nurses were clearly identifiable. All study designs were included, based on the belief that combining through data from different types of research could potentially increase the depth and breadth of our conclusions (Whittemore, 2005). Studies that repor-

ted exclusively on critical care and ICU nurses, oncology, or palliative care nurses were excluded.

Literature Search

The first author conducted the literature search during September 2012 using the CINAHL, MEDLINE, and PsycInfo databases, from 1992 to October 2012. The search criteria included the terms end-of-life, palliative care, terminal care, death and dying, nurs*, medical-surgical, acute care, hospita*, and tertiary care. Reference lists of key papers were reviewed to identify additional relevant references.

In all, 650 references were found and reviewed, considering the title and abstract first. A total of 16 studies met the inclusion criterion. Studies were from developed countries and included the United States (4), Canada (2), United Kingdom (2), Sweden (2), Ireland (1), Australia (3), Singapore (1), and Japan (1). In all but two studies (Davidson et al., 2003; Thacker, 2008), the authors specified that the majority of participants were female. The age of the nurses and years of experience varied across studies, but this information was not always available. The included studies employed qualitative designs (9), mixed methods (1), and quantitative designs (6) (see Table 1; also marked with an asterisk in the reference list below). Two separate publications reported findings from one original study (Hopkinson et al., 2005; Thompson et al., 2006b). Most studies focused exclusively on registered nurses (RNs). Two quantitative studies also included nurse participants from other areas of practice: oncology, cardiology, pulmonary, and cardiac care (Cramer et al., 2003; Thacker, 2008). These were included since nurses’ experience according to area of practice was identifiable. One study combined data from nurse participants working in the community, in home care, and on medical-surgical units in a hospital (Wallerstedt & Andershed, 2007). The specific experience of medical-surgical nurses was not singled out, but the authors suggested that their findings reflect a commonality across settings. One study also included nurse students and support workers who experienced EOL care on medical-surgical wards (Clarke & Ross, 2006), but, again, specific comments from those nurses were identifiable.

Analysis

This narrative review was conducted as per the following steps: (1) identification of the topic, (2) search of the literature, and (3) reading and critique of the sources, followed by (4) an in-depth analysis of the sources “to identify systematically the main recurrent and/or most important (based on the review questions) themes and/or concepts across multiple

Table 1. Summary of the studies included in the review

Authors/ Year/Country	Purpose/Study Design/Method	Sample/Setting	Findings/Results	Themes
Smyth & Allen (2011) Australia	Purpose: To explore and describe how nurses define spirituality and incorporate spiritual care into their clinical practice Study design: Mixed methods; explanatory descriptive design	Sample: N = 16 nurses Female: N = 14 RN: N = 12 Enrolled: N = 4 YOP [3–8 years]: N = 7 YOP [20–37 years]: N = 9 Faith: N/A Setting: Regional rural hospital; acute care medical ward	Spirituality is an essential part of being a nurse. It is incorporated into the care but follows a less prescriptive approach; listening; observing and communicating. Organizational constraints — lack of privacy, hamper spiritual care. Mix staff; differing idea of spirituality. Nurses experienced tensions from a focus on cure and acute care vs. the spiritual needs of dying patients.	Organizational constraints: Biomedical culture of care Nurse factors: Clinical experience
Johansson & Lindahl (2012) Sweden	Purpose: To describe the meanings of generalist RNs' experiences of caring for palliative care patients on general wards in hospital Study design: QUAL Phenomenology (Ricoeur's philosophy) Method: Narrative approach	Sample: N = 8 Female RNs YOP: [3–32 years] Faith: N/A Setting: Two hospitals Medical/surgical care	Seven themes: (1) Being grateful to be able to share in the end of another's life (2) Being touched by physical and existential meaning (3) To exist in place and space (4) To give and receive energy (5) Being open in relation to patients and colleagues (6) Being in embodied knowledge (7) Time that does not exist By being an embodied knowledge nurses referred to the "intuitive quiet knowledge within the nurses that operates as nurses are moving between rooms, back and forth between both worlds (curative and palliative patient) & within the nurse." Spoke of a transformation & transition within nurses.	Organizational factors: Constraints of time & mix load of patients Nurse factors: Experience
Bjarnason (2010) Religion United States	Purpose: to explore influence of healthcare providers' religiosity on the care they deliver to patients Study design: exploratory quantitative study Method: Cross-sectional survey	Sample: N = 494 RN Female: N/A YOP: 2 years + Faith: N/A Education: N/A Setting: Medical-surgical acute care hospitals	Religiosity may be influencing how nurses address EOL discussion with patients and what nurse may be avoiding based on her religion.	Nurse personal factor: Religiosity

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Table 1. Continued

Authors/ Year/Country	Purpose/Study Design/Method	Sample/Setting	Findings/Results	Themes
Roche-Fahy & Dowling (2009) Ireland	Purpose: To explore the lived experience of nurses who provide comfort to palliative care patients in acute setting in small urban hospital Study design: qualitative Gadamerian hermeneutic phenomenology	Sample: $N = 17$ Female RNs Ed: n/a YOP: 7–40 years Faith: N/A Education: N/A	Four major themes (with subthemes). Time (privacy, place of care, space, and dignity). Emotional cost to the nurse: emotional labor engagement and detachment; advocacy. Holistic approach in the provision of comfort (attending to spiritual, family and physical needs). Role of education and expert team in providing comfort (communication skills and palliative care team involvement).	Organizational constraints: Biomedical culture of care.
Rice et al. (2008) United States	Purpose: To determine the prevalence of moral distress in medical-surgical nurses Study design: Quantitative prospective cross-sectional survey (response rate: 92%)	Sample: $N = 260$ RNs Female: n/a Age: 21–61 years; median: 34 years YOP: median 6 Faith: N/A Ed: Diploma nurses: 29% BScN: 62% MN: 4% Setting: Adult tertiary care hospital	Moral distress was uniformly high across the following six categories: (1) Physician practice, fear and incompetence; (2) Nursing practice: lack of experience and staffing; (3) Institutional factors (time); (4) Futile care; (5) Deception; (6) Euthanasia.	Organizational constraints: Biomedical culture of care; communication and collaboration with MD
Thacker (2008) United States	Purpose: To reveal acute care nurses' perceptions of advocacy behaviors in EOL nursing practice Examining difference between novice experienced and expert nurses Study design: Qualitative comparative descriptive design (response rate: 33%)	Sample: $N = 317$ Age ($n = 305$): 20–73 years Faith: N/A Ed: Diploma nurse = 47.1% BScN = 21.2% Setting: Three regional hospitals in moderately sized urban areas Med/Surg: 47.5% Critical care: 23,9 %	Significant difference between novice, experienced and expert nurses in advocacy education; area of practice; primary employee status and educational level. Three most frequent barriers common across to advocacy: (a) Physician; (b) Patients and family; (c) Fear of speaking up. Nurses also reported barriers to EOL nursing practice in terms the following categories: a lack of communication; lack of knowledge; lack of time; lack of hospital support.	Biomedical culture of care; collaboration and communication with families and with MD Nurse factors: Professional experience

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Table 1. *Continued*

Authors/ Year/Country	Purpose/Study Design/Method	Sample/Setting	Findings/Results	Themes
Yin et al. (2007) Singapore	Purpose: To explore the relationship among demographic variables and nurses' attitudes toward the dying patients Study design: Quantitative descriptive Method: Survey (response rate: 77.9%)	Sample: <i>N</i> = 96 Nurses RNs = 71.9 % Female = 94,8% Age: 18–29 years = 79.2% YOP = N/A Faith: Christian = 11.7% Buddhist = 24.0% Muslim = 20.8% Ethnicity = N/A Setting: General surgical ward and medical oncology ward within same hospital in Singapore	Staff from both wards felt exhausted taking care of dying patients; both reported feeling of helplessness. Caring for dying patients enhance reflection about life and death and make them treasure life more. Significant difference: RN staff working in general surgical floor were 4.49 times more likely to feel frightened toward taking care of dying patients (<i>p</i> = 0.006); oncology staff more likely to think of their own mortality as compared to surgical nurses. Religion: Buddhists felt more fulfilled than Christians. Gap between ambition (ideal) and reality. Nurses felt a sense of responsibility to ensure dying patients good death. Cooperation among team members was essential to good EOL care. Doctors' insecurity affects cooperation; doctors' relations are more demanding. Nurses reported that EOL care provided greater insight about life; provided them with an opportunity to give to patient; to care for the whole person; allowed for personal growth and happiness/ Nurses reported forbidden feelings such as: feeling of inadequacy; frustration; sorrow; loss & no longer having the strength to cope. Nurses reported little understanding for the work commitment and their physical and mental health in such culture of care.	Organizational constraints Nurses factors: Religion; professional and personal experience
Wallerstedt & Andershed (2007) Sweden	Purpose: To describe nurses' experiences in caring for gravely ill and dying patients outside special palliative care settings Study design: Qualitative/phenomenology	Sample: 9 RNs Female: N/A Age: 30–65 years YOP: 10–39 years Faith: N/A Setting: Home care community & medical-surgical ward	Gap between ambition (ideal) and reality. Nurses felt a sense of responsibility to ensure dying patients good death. Cooperation among team members was essential to good EOL care. Doctors' insecurity affects cooperation; doctors' relations are more demanding. Nurses reported that EOL care provided greater insight about life; provided them with an opportunity to give to patient; to care for the whole person; allowed for personal growth and happiness/ Nurses reported forbidden feelings such as: feeling of inadequacy; frustration; sorrow; loss & no longer having the strength to cope. Nurses reported little understanding for the work commitment and their physical and mental health in such culture of care.	Organizational constraints: Biomedical culture of care; communication and collaboration with MD. Nurse factor: Clinical experience

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Table 1. Continued

Authors/ Year/Country	Purpose/Study Design/Method	Sample/Setting	Findings/Results	Themes
Clarke & Ross (2006) United Kingdom	Purpose: To explore nurses' perceptions and experiences regarding listening and talking to older people about issues relating to the EOL Study design: QUAL Method: Focus groups and one-one interviews	Sample: $N = 24$ Age: N/A Faith: N/A Medical wards: RNs: $N = 11$ Student nurse: $N = 1$ Support workers: $N = 2$ Palliative care ward: Student nurse: $N = 3$ Support workers: $N = 3$ Setting: Medical wards: $n = 2$ Palliative care ward: $n = 1$	Factors influencing nurses' communication with older people included: (1) Nurses' perceptions and experiences of talking and listening to older people; (2) Learning from other members of the multi-professional team; (3) Environmental and organizational constraints such as time; privacy; and the culture of care; and a perceived difference between the values of nurses and those of doctors and patients' families. Medical nurses expressed the need for more support in these areas	Organizational: Biomedical culture of care; time and privacy; communication and collaboration with MD
Thompson et al (2006a) Canada	Purpose: To examine the nursing behaviors and social processes inherent in the provision of quality EOL care. Study design: QUAL grounded theory	Sample: Generalist female RNs: $N = 10$ Age: [18-65] years YOP = 11.5 years Faith: N/A Setting: two university-affiliated hospitals; four adult inpatient medical units	Overarching theme: "Creating a safe passage for heaven" with the following sub-processes: facilitating an maintain lane change; Getting what's needed; "Being there." Main barriers identified by nurses: (1) medical factor was a significant barrier resulting in delayed transition from curative to palliative; complicated by episodic and fluctuating nature of chronic illness; (2) patient and family factors: changing lanes affected by patients' age, lack of patient and family knowledge about palliative care and with resultant unrealistic treatment expectations, and misunderstanding about illness; (3) organizational factor: lack of privacy; Increase frustration and absence of palliative care philosophy or dependant on the great variability of physician present on unit; (4) professional factor: divergent professional paradigms espoused by nurses and doctors: nurses critiquing the medical model predominance over nursing's holistic model of care. Facilitators: (1) Patient and families having a clear understanding of the nature and prognosis of the illness; when end-of-life discussions occur while the patient is still capable of participating in decision making; and (2) nurses' level of experience.	Organizational: Biomedical culture of care; time and privacy; communication and collaboration with MD

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Table 1. *Continued*

Authors/ Year/Country	Purpose/Study Design/Method	Sample/Setting	Findings/Results	Themes
Thompson et al. (2006b) Canada	Purpose: Reports on finding that generated a conceptual model of the nursing behaviors and social processes	Sample: <i>N</i> = 10 Generalist female RNs Age: 18–65 years YOP = 11.5 years Faith: N/A Setting: two university-affiliated hospitals; four adult inpatient medical units	To provide high-quality care on acute medical unit is a complex process involving many factors related to the patient, family, healthcare providers and the context in which provision of end-of-life care takes place. Nurses are striving to provide high-quality EOL care on acute medical unit while being pulled on all directions.	Nurse factors: Personal ideal of care; clinical experience & personal experience
Hopkinson et al. (2005) United Kingdom	Purpose: Report of phenomenological study from Hopkinson et al (2003) Study Design: Qualitative phenomenology. Method: One-on-one interview	Sample: 28 RNs Age: N/A Female: <i>N</i> = 27 YOP: [<2 months> 3 years] Faith: N/A Setting: 8 acute medical wards	Relationships: give and receiving care; approach that is inconsistent with patient centered care. Nurses used a structured approach to overcome some of the difficulties from not knowing what to say. Nurses were controlling involvement otherwise they would experience distress, which would detract them from the care of other patients. Nurses need to establish a balance between emotional involvement care vs. emotional distance. Learning from experience: experiential knowledge is what really helped nurses to care for dying people; nurses' studies were of little importance. Nurses' personal comfort with EOL care & personal history influenced the experience, which also help with nurses' revision of ideal way to die.	
Borbasi et al. (2005) Australia	Purpose: Explore nurses' perceptions of the care provided to ESHF patients in community and hospital settings Study design: In-depth, open-ended interviews	Sample: <i>N</i> = 12 RNs Age: N/A YOP: N/A Faith: N/A Setting: Three acute care sites & five community nursing	Nurses reported that “good death” requires open communication with interdisciplinary members & palliative care involvement. “Bad death” was often the result of a conspiracy of denial; lack of consultation with palliative care team; fear of discussing death; failing to manage symptoms lack of resources., imposition of healthcare professionals values. Lack of communication was more present in medical units and had a profound effect on nurses; nurses identified a greater process of medicalization of death leading to “bad death.”	

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Table 1. *Continued*

Authors/ Year/Country	Purpose/Study Design/Method	Sample/Setting	Findings/Results	Themes
Hopkinson et al. (2003) United Kingdom	Purpose: Develop an understanding of care for dying people in hospital from the perspective of newly qualified nurses Study design: Qualitative phenomenology study Cross-sectional interview-based study Method: Nondirective open style of interviewing	Sample: <i>N</i> = 28 RNs 28 RNs Female: <i>N</i> = 27 YOP: <2 months> 3 years Faith: N/A Setting: 8 acute medical wards	Six essences of taking care of the dying: (1) personal ideal; view of how dying people ought to be cared for; (2) the actual; “part of your job”; (3) the unknown; the humanly unknown and the personally unknown; (4) the alone; others do not appreciate the personal meaning of the experience; (5) the tension: is inevitable; one must learn to deal with tension, and nurses are feeling inadequately prepared to do so; (6) the anti-tension: emotional distance enables nurses to continue caring for EOL patients. Nurses’ expectation and preparation are important for personal comfort.	Organizational factors: Biomedical culture of care; collaboration and communication with MD Nurse factors: Personal ideal of care
Davidson et al. (2003) Australia	Purpose: To examine the perceptions of palliative care among cardiorespiratory nurses Study design: Qualitative content analysis Method: Focus groups	Sample: <i>N</i> = 35 RNs YOP: months to 25 years Faith: N/A Setting: Coronary care, medical cardiology, respiratory units	Four major theme identified: (1) searching for structure and meaning in the dying experience of patents with chronic disease; (2) lack of treatment plan and lack of planning and negotiation; (3) discomfort dealing with death and dying; (4) lack of awareness of palliative care philosophies and resources. New graduate understood palliative care as pain management only. Nurses identified a lack of fit/ integration between palliative care philosophy and acute care. Facilitating factor: Collegial support: both formal and informal.	Organizational factors: Biomedical Culture of care Communication and collaboration with MD
Cramer et al. (2003) United States	Purpose: To describe characteristics, attitudes and communications of nurses regarding hospice and caring for terminally ill patients. Study design: Quantitative cross- sectional survey design	Sample: RNs: <i>N</i> = 30 Female: 94.8% Faith: Roman Catholic: 65.5% Deep faith: 67.2% YOP = mean of 12.3 years Setting: 6 Connecticut Hospitals; Cardiology, medical, pulmonology, and oncology units	Nurses’ attitudinal characteristics such as greater comfort with initiating hospice discussion and greater perceived added benefit of hospice were significantly associated with nurses increased discussions of hospice. Internal medicine nurses had the lowest percent of nurses having discussed hospice with terminally ill patients and families. Hospice training was insignificant when adjusted for religiousness, education, practice characteristics and personal experience.	Nurse factors: Individual characteristics and experience as nurses

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Table 1. *Continued*

Authors/ Year/Country	Purpose/Study Design/Method	Sample/Setting	Findings/Results	Themes
Sasahara et al. (2003) Japan	Purpose: To investigate the difficulties encountered by nurses who have cared for terminally ill cancer patients at general hospital Study design: Quantitative cross-sectional study. (response rate: 70.1%)	Sample: <i>N</i> = 375 nurses RNs: 94% Female: 97% YOP: Mean 5.5 years Faith: N/A Setting: Three general hospitals near Tokyo;	Nurses experience a high degree of difficulty overall while caring for the dying, particularly with communication with patients and families. Areas creating “very much” difficulties were the following: communication with patients (62%) and their families (55%) and personal issues such as immaturity with myself (56%). Unique features of this study young nurses with little experience.	Communication and collaboration with MD Nurse factors: Clinical experience and personal experience.
Oberle & Hughes (2001) Canada	Purpose: To identify and compare doctors’ and nurses’ perceptions of ethical problems in EOL decisions. Study design: Qualitative descriptive approach Method: One-on-one structured interviews	Sample: <i>N</i> = 21 Female RNs: <i>N</i> = 14 MDs: <i>N</i> = 7 Female: <i>N</i> = 1 Male: <i>N</i> = 6 Faith: N/A Setting: Acute medical-surgical units	The defining features of uncertainty around end-of-life decision present in both doctors and nurses. Differences between doctors’ and nurses’ ethical concerns were primarily related to their perceived mandates as caregivers. Key differences are that doctors are responsible for making decisions and that nurses must live with these decisions. Yet, moral distress was experienced in both disciplines Scarce recourses: doctors concern about resources distribution and decisions about one patient impacting another. Nurses’ concern mainly due to inability to provide quality care because of financial constraints and staffing cutbacks. Contextual features influenced ethical decisions such as: competing values between doctors and nurses and hierarchical processes.	Organizational factors: Biomedical culture of care; communication and collaboration

Notes: N/A = not available; YOP = years of practice; MD = medical doctor.

studies” (Pope et al., 2007, p. 109). Data extracted from original studies were summarized with respect to sample characteristics, settings, methods, and key factors reported as influencing nurses’ experience of EOL care within acute medical-surgical units (see Table 1).

RESULTS

Overall, the experience of acute care nurses providing EOL care within a hospital environment was challenging, but for some it was a time of personal satisfaction and growth. Several factors were identified as influencing the medical-surgical nurses’ experience of caring for individuals at the end of life. These are detailed further below grouped as followed: 1) factors related to organizational constraints, 2) factors related to nursing and its professional ideal of a good death, 3) factors related to collegial collaboration and communication, and 4) factors related to nurses’ personal experience and personal resources factors.

Organizational Factors

Culture of Care, Time and Privacy

The organizational factors were considered part of the working environment and not within nurses’ control. Several studies addressed the difficulty associated with nurses caring simultaneously for both curative and palliative patients (Hopkinson et al., 2003; Johansson & Lindahl, 2012; Smyth & Allen, 2011; Thompson et al., 2006a; 2006b; Wallerstedt & Andershed, 2007). Nurses were aware of the need to establish meaningful relationships with dying patients, but, given the task-oriented culture of medical units, they felt they had to give priority to meeting the physical needs of the acute patients (Clarke & Ross, 2006). As an example, nurses frequently reported that the spiritual needs of the dying were often given lesser attention than the more pressing and objective tasks to be accomplished for acute care patients (Roche-Fahy & Dowling, 2004). Furthermore, time taken to sit down and talk with patients was hard to justify as actual work (Davidson et al., 2003; Roche-Fahy & Dowling, 2004).

Even when time could be found, nurses identified important physical constraints from their working environment, such as the lack of privacy and lack of space, further limiting possibilities for spiritual and emotional care (Clarke & Ross, 2006; Sasahara et al., 2003; Smyth & Allen, 2011; Roche-Fahy & Dowling, 2004; Thompson et al., 2006a). However, nurses also recognized that a lack of time and practical tasks were at times helpful strategies employed to avoid talking with dying patients (Clarke & Ross,

2006). The difficulty involved in the emotional work of the dying was also contrasted with the ease and the comfort nurses felt toward providing physical care to active patients, which did not require as much emotional involvement (Roche-Fahy & Dowling, 2004). Caring for patients receiving active treatments offered nurses the chance to gather the strength and energy needed to care for dying patients (Johansson & Lindahl, 2012).

These cultural, physical, and time constraints were not without consequences for nurses who experienced tensions caused by their practice. They often described feelings that had negative connotations: feeling “physically and spiritually split between work with terminally ill patients and those suffering acute illness” (Johansson and Lindahl, 2012, p. 2038); feeling “helplessly torn between competing demands on their time” (Hopkinson et al., 2003, p. 529); feeling inadequate from being unable to give dying patients and their loved ones what they needed (Johansson & Lindahl, 2012); and feeling hopelessness (Thompson et al., 2006a). Nurses often perceived that the acute care environment did not encourage sharing these feelings (Wallerstedt & Andershed, 2007) and that caring for dying people was something that nurses had to accept as “part of the job” or something “you get used to” (Hopkinson et al., 2003, p. 528).

Having to learn to deal with it on their own, nurses perceived a risk attached to identifying and developing closeness with dying patients, mostly in terms of a difficulty in letting go at the end of their shift and taking work home with them (Wallerstedt & Andershed, 2007). To cope with the emotional demands EOL care placed on them, nurses in several studies spoke of the need to balance their engagement and detachment (Hopkinson et al., 2005; Johansson & Lindahl, 2012; Roche-Fahy & Dowling, 2009). This balancing act helped make it possible to care both in the present and on a long-term basis (Hopkinson et al., 2005).

Lack of Recognition of the Emotional Dimension of EOL Care

As just described above, attending to the emotional needs of dying patients created dissonance within acute care nurses who felt constrained to do so within an acute care environment that did not recognize the emotional dimensions of care. Yet, despite being demanding work, when nurses were able to meet the emotional needs of dying patients, they described the caring experience as rewarding and gratifying (Johansson & Lindahl, 2012; Roche-Fahy & Dowling, 2009). Nurses in several studies spoke of the work satisfaction they derived from being able to care for

the whole person and also from their relationship with families (Johansson & Lindahl, 2012; Hopkinson et al., 2005; Wallerstedt & Andershed, 2007). Johansson and Lindahl (2012) reported that nurses were grateful for being able to share in the end of another's life. Nurses viewed "their caring practice as a privilege and felt compelled to give back by involving themselves deeply in their work, in a 'totally comprehensive way'" (p. 2038). Nurses acknowledged the opportunity that this deep involvement provided for self-knowledge, which was conceptualized as "finding oneself, both as a person and as a professional nurse" (p. 2038).

Factors related to Professional Ideal of a "Good Death"

Nurses' dedication to patient care was motivated by a desire to bring the life of the patient to a good end (Wallerstedt & Andershed, 2007; Borbasi et al., 2005; Thompson et al., 2006a; 2006b). Nurses who were animated by this desire felt an inner reward that positively influenced their work (Wallerstedt & Andershed, 2007). A good death, for nurses, was possible when patients and families: (a) were included in decision making, (b) were kept informed, (c) accepted that death was imminent, and (d) were in an appropriate environment (Borbasi et al., 2005; Thompson et al., 2006a; 2006b). Nurses' ideals around a good death were described in terms of achieving a peaceful and pain-free death (Borbasi et al., 2005; Davidson et al., 2003; Hopkinson et al., 2005). A good death also meant an opportunity for nurses to help prepare and be present with the patient's family members to say their goodbyes (Thompson et al., 2006a; 2006b; Hopkinson et al., 2003). However, some nurses also recognized that death is not always a peaceful phenomenon (Davidson et al., 2003), that problems at the end of life are not always resolvable, and that suffering may very well be inevitable (Oberle & Hughes, 2001; Hopkinson et al., 2003). Nonetheless, despite this awareness, nurses experienced distress from not being able to act on some preventable issues, such as ensuring proper symptom management (Davidson et al., 2003; Thompson et al., 2006a; Rice et al., 2008; Wallerstedt and Andershed, 2007).

Futile Care as a Source of Moral Distress

As discussed earlier, in several studies nurses described the biomedical approach to care (with its curative interventionist focus) as interfering with both their ability to provide high-quality care to the palliative care patients and the process of transitioning patients to palliative care (Davidson et al., 2003; Hopkinson et al., 2003; Rice et al., 2008; Thacker,

2008; Thompson et al., 2006a; 2006b). As a result, nurses spoke of the tension and moral distress they experienced when they provided futile care (treatment without benefit). Moral distress is defined as a painful psychological disequilibrium that results from recognizing ethically appropriate actions, yet not taking them because of obstacles (i.e., lack of time, supervisory reluctance, institutional policy, or legal considerations) (Rice et al., 2008, p. 361). For nurses, the moral distress was related to their perception of providing futile care (Thompson et al., 2006a; Davidson et al., 2003), which has been associated with: (a) unnecessary treatment at the EOL, (b) initiation of extensive life-saving actions that only prolong death, (c) failure to ascertain family/patient wishes regarding these life-saving actions, and (d) communication deficiencies in discussing the implications of life-saving treatments to assure proper understanding on the part of patients and families (Rice et al., 2008; Thompson et al., 2006a; Wallerstedt & Andershed, 2007).

Communication and Collaboration with Medical Colleagues

Poor collaboration and communication with medical colleagues emerged as a strong factor influencing nurses' perceptions of providing futile care (Clarke & Ross, 2006; Davidson et al., 2003; Rice et al., 2008; Sasahara et al., 2003; Thacker, 2008; Thompson et al., 2006a; 2006b). Lack of collaboration was commonly discussed in terms of the personal attributes of physicians that impeded proper EOL care, such as lack of proper prognostication skills and lack of skills and knowledge of palliative care and symptom management (Davidson et al., 2003; Rice et al., 2008; Thompson et al., 2006a; Wallerstedt & Andershed, 2007). Nurses' dissatisfaction and frustration were also considered a direct consequence of nurse-doctor relationships that failed to support and value nurses' caring beliefs and behaviors (Thompson et al., 2006a; Clarke & Ross, 2006). However, both nurses and doctors appeared to lack mutual appreciation of the moral burden carried by each profession in the care practice of the terminally ill patients (Oberle & Hughes, 2001). Alternatively, nurses reported positive experiences in caring for persons at the EOL when collaboration and communication among colleagues was present (Johansson & Lindahl, 2012; Thompson et al., 2006a; Wallerstedt & Andershed, 2007). Collaborative approaches to care were perceived to improve clarity in treatment plans, allowing nurses the time needed to prepare for patient death and further contributed to nurses' positive experience (Thompson et al., 2006a; Clarke & Ross, 2006).

Communication and Collaboration with Patients/Families

Nurses also referred to patients/families “letting go” of curative treatments as another factor that further contributed to their perceptions of futile care (Borbasi et al., 2005; Thompson et al., 2006a). Nurses identified several barriers to patients’ transitioning from curative to palliative care, including: (a) lack of patient/family knowledge about palliative care, (b) unrealistic treatment expectations, and (c) misunderstanding of the illness having progressed to a terminal state. Nurses believed that families’ denial of death brought “false hope” and did not facilitate a “good death” (Borbasi et al., 2005; Thompson et al., 2006a). Nurses also perceived that both patients’ and families’ hopes were very much tied to patients continuing to receive active treatment aimed at a cure (Borbasi et al., 2005; Thompson et al., 2006a).

Individual Factors

End-of-Life Care Knowledge and the Clinical Experience

Although the need for additional palliative education was identified in several studies (Davidson et al., 2003; Sasahara et al., 2003; Yin et al., 2007) mostly in terms of developing necessary knowledge and proper symptom management, it was mostly nurses’ clinical experience that appeared to play a central role in influencing nurses’ comfort around the provision of EOL care. To that effect, several studies highlighted the invaluable knowledge gained from years of practice (Clarke & Ross, 2006; Cramer et al., 2003; Hopkinson et al., 2005; Johansson & Lindahl, 2012; Roche-Fahy & Dowling, 2009; Smyth & Allen, 2011; Thacker, 2008). To that effect, a survey conducted in three general hospitals situated near Tokyo revealed lack of professional experience as an important factor linked to nurses experiencing a high degree of difficulty in terms of communicating with dying patients and families (Sasahara et al., 2003).

Nurses reported that their clinical experience provided them with valuable and useful knowledge about spiritual care, which came mainly from years of practice and learning from patients and families (Smyth & Allen, 2011). Experience appeared particularly relevant while caring concurrently for both curative and palliative care patients (mixed load, as described above), since it involved a necessary process of inner/psychological movement, whereby a deep knowledge of palliative care encounters and having good self-knowledge and knowledge of others were necessary (Johansson & Lindahl,

2012). Experienced nurses more readily identified other resources that could provide them with support, such as communication skills, relationships with patients, personal beliefs and compassion, and family support (Hopkinson et al., 2005; Thacker, 2008). Experienced nurses were practicing “anti-tension” activities, such as: developing mutually supportive relationships with other nurses or relatives, using assumptions that provided them reasons for decisions and actions, and controlling their emotions so they could continue to care for both their dying patients and other patients (Hopkinson et al., 2005).

End-of-Life Care Knowledge, Personal Experience and Resources

Nurses’ professional experience was also influenced by personal resources such as religion (Bjarnason, 2010; Cramer et al., 2003; Yin et al., 2007), although it is not exactly clear how religion might do so. For example, Bjarnason (2010) pointed out the literature exploring the influence of healthcare providers’ religiosity on the care they deliver to patients at the end of life. The author defined religiosity as “a set of beliefs regarding faith-based activities that are both visible (e.g., church-going) as well as discreet (silent prayer)” (p. 79). In another study, a positive correlation between nurses’ religiosity and level of comfort in educating patients about aspects of EOL care was found. However, a negative correlation was found between nurses’ religiosity and level of comfort with respect to withholding or withdrawing treatment. Cramer and colleagues (2003), looking specifically at hospice discussions among nurses and terminally ill patients, found that greater religiousness was a factor that correlated with nurses being more likely to have discussed hospice with EOL patients/families. However, the authors pointed out other potential contributing variables since these “nurses were also more likely to have discussed hospice when factors such as caring for a greater number of terminally ill patients, having a close family member or friend who had used hospice, and being satisfied with hospice caregivers were present” (Cramer et al., 2003, p. 253). Thus, even though these are correlating variables, they nonetheless highlight the influence that nurses’ personal and professional experience can have on the EOL care they provide.

DISCUSSION

This is the first published review of research studies focusing on factors influencing the experience of medical-surgical nurses in acute care providing end-of-life care. As such, it contributes to our

understanding of this area. Our findings suggest that caring for dying individuals within acute care is complex, demanding, and challenging for nurses and that multiple factors influence nurses' experience.

The Value Placed on Emotional Labor

The organizational factors emerged strongly as factors constraining nurses' provision of good end-of-life care. The acute care environment was often described as unresponsive to nurses' professional assessments in terms of the identified needs of the patients/families, and to nurses' needs in relation to the emotional work they provided to dying patients and their loved ones. The lack of recognition of the emotional labor required in the care of dying patients and their loved ones has been critiqued elsewhere (Sorensen & Iedema, 2009). Emotional labor is defined "as a "deep acting," where a personal exchange takes place and the healthcare professional connects with the patient to feel the emotion that they wish to display" (Sorensen & Iedema, 2009, p. 7). It also involves "managing feelings in both self and others" (Maunder, 2006, p. 28) and is known to exert considerable demands on nurses (Davenport & Hall, 2011; Stayt, 2009; Summer & Townsend-Rocchiccioli, 2003).

In that respect, nurses frequently spoke of a need to balance their emotional involvement to protect themselves and to continue to care for other patients in the present and over the long term. In light of the multiple challenges and constraints to EOL care identified in this review, it is argued that emotional distancing may very well be an inevitable coping strategy nurses use to protect themselves from the suffering that results from by being emotionally involved with EOL care of patient/family may create (Davenport & Hall, 2011). However, despite these organizational constraints, nurses acknowledged gaining intense satisfaction from the relationships they were able to create with their patients.

Caring Ideal and Its Consequences

This satisfaction may be in part related to the professional ideals of nursing that are also influencing nurses' understanding of caring and how they can be fostered in their practice with dying patients and families. Caring in nursing is a core value of the profession around which nursing orients its occupational ideology (Maunder, 2006). In that respect, the caring experience cannot be expressed as an impersonal generalized stance of good will: "it must be lived, communicated intentionally, and in authentic presence" (Boykin & Schoenhofer, 2001, p. 54). Positive experiences of caring for patients at the end of life were described here in terms of contributing to personal

growth, self-knowledge, and greater meaning in life. These findings echoed findings from a review that looked at factors that contributed to job satisfaction in nurses working in hospitals (Utriainen & Kyngas, 2009), which showed that patient care was the major factor impacting on nurse job satisfaction.

Paradoxically, this ideal of caring has been critiqued as potentially contributing to nurses' general sense of inadequacy and to the tensions they have experienced in their practice (Ceci & McIntyre, 2001; Summer & Townsend-Rocchiccioli, 2003). To that effect, Allen (2004) speaks of a "mismatch" between real-life nursing work and the profession's occupational orientation, mandating nurses to develop emotionally intimate therapeutic relationships with the patient. This is further supported by Summer and Townsend-Rocchiccioli (2003), who argued that, in acute clinical settings, "with acutely ill patients requiring an extraordinary level of factual and skill knowledge, the ability to turn on the caring emotion may be difficult if not impossible" (p. 165).

Hope and Need to Go Beyond Its Medicalization

This literature review clearly indicates that nurses experience a great deal of distress from the perceived futility of the care they provide to dying individuals. This is not unique to generalist nurses and has been abundantly acknowledged as a significant source of stress for critical care nurses (Badger, 2005; Gélinas et al., 2012). It has been argued that the need to intervene until the very end of life may be a response to the healthcare provider's view that this is important to maintain a patient's hope (Abu-Saad Huijjer et al., 2009); however, this view has been critiqued as an incorrect conceptualization of terminally ill patients' hope (Duggleby et al., 2010; Elliott & Olver, 2002; MacLeod & Carter, 1999).

Several studies of the experience of terminally ill patients focused on peace and comfort at the end of life and hope for the families, not on a cure (Duggleby et al., 2010; Elliott & Olver, 2002; MacLeod & Carter, 1999). In relation to nurses striving toward providing dying patients and their families with a good death experience, it can be argued that by using a holistic approach to care nurses are implicitly addressing very important dimensions of hope (Duggleby & Wright, 2005). However, nurses in this review mainly referred to hope in the context of curative intentions and in terms of professionals and patients'/families' "false hopes" and "death denial." The argument developed here is that this discourse emphasizes the medicalization of hope; it is a discourse that is incomplete and insufficient (Elliott & Olver, 2002; Duggleby et al., 2010). As such, it may be necessary for

nurses to expand their discourse of hope for patients at the end of life.

Nurses' Attitudinal Characteristics and Personal Resources

This review highlights the fact that, although formal education is necessary, it is insufficient to help nurses increase their level of satisfaction with the care they provide. In that regard, a nurses' personal attitudes toward death, personal experience as well as professional experience all play a significant role in increasing the level of comfort and satisfaction with EOL care. As such, it may be important in any palliative/EOL educational sessions to consider nurses' personal attitudes and beliefs in terms of the influence these might have on nurses' overall EOL care experience. In fact, training interventions that consider the personal attitudes and beliefs of healthcare providers may be more successful than those focused only on communication skills (Gysels et al., 2004). To that effect, Blomberg and Sahlberg-Blom (2007) concluded that for healthcare professionals to be close and to share in the suffering of another human being, aspects of personal identity — such as self-knowledge, maturity, and security — must be considered in addition to experience and education (Blomberg & Sahlberg-Blom, 2007; Hopkinson et al., 2003).

Collegial Collaboration and Communication

An important struggle faced by nurses was related to the process of transitioning patients/families to palliative care. This is particularly difficult when a collaborative relationship with physicians is lacking. In that regard, medical-surgical nurses are not the only ones; the need to fight to ensure decent conditions for the death of patients has been identified by critical care nurses as the most distressing issue encountered in EOL care (Gélinas et al., 2012). It is argued here that this may be due to medical colleagues also experiencing discomfort and difficulty around timely and appropriate EOL care and decision making.

In fact, a discomfort around end-of-life care in acute care physicians has been well documented (Badger, 2005; Sorensen & Iedema, 2009) along with the use of avoidance strategies to discuss sensitive issues, which are recognized in both doctors and nurses (Bloomer et al., 2011). There is a potent cultural fear of death and a tendency toward denial of death that still prevail in Western societies (O'Gorman, 1998), and healthcare professionals are not immune to these phenomena. Yet, these must be acknowledged if we wish to diminish the suffering experienced by healthcare providers, patients, and families. As findings from this review suggest, when

healthcare professionals ignore their own discomfort, when they think it is not appropriate to display emotions or share the emotions experienced, emotional detachment then develops. This emotional detachment, though at times healthy and necessary, can also result in failure to communicate effectively with patients, subsequently leaving healthcare providers feeling helpless and dissatisfied with the care they have provided (White & Coyne, 2011).

LIMITATIONS

This is a narrative review, and the analysis relies on the interpretation of reviewers (Pope et al., 2007); as such, the two authors crosschecked each other's interpretations of the data from the studies reviewed. Although other interpretations are possible, the strength of this review lies in the commonalities highlighted across studies, which may signal a need to pay closer attention to particular aspects of acute medical-surgical nursing work. A few quantitative studies were cross-sectional survey designs from which correlations were not always easy to interpret. Finally, an additional limitation is a lack of an in-depth interpretation of cultural variation considering that studies came from many parts of the globe; this was beyond the scope of our paper and not one of this review's objectives.

FUTURE RESEARCH

This review identifies important gaps in the research. First, there is a lack of intervention studies specifically aimed at identifying ways to best support medical-surgical nurses in their provision of EOL care and which also consider the limits and particularities of the medical-surgical context of care. In particular, intervention studies considering practical ways to recognize and support nurses' emotional work in such a context are needed. Studies aimed at improving collaboration and communication among healthcare providers are also crucial in that regard. Finally, there is an absence of critical studies of nursing professional discourses, particularly with respect to medical-surgical nurses' practices of EOL care. For example, it may be relevant to conduct future research exploring nurses' discursive practices around the concept of "hope" or "good death" to help reveal dominant ideologies and assumptions influencing nurses' provision of end-of-life care.

CONCLUSION

This review has highlighted that despite the numerous challenges encountered within the hospital environment, generalist nurses want to and are

dedicated to address the needs of patients at the end of life. This culture of care often hinders nurses' capacity to truly engage with patients and thereby threatens an important dimension of nurses' practice of EOL care: the patient–nurse relationship. This relationship is considered a necessary means for nurses to provide high-quality end-of-life care. Administrators and managers must acknowledge the emotional impact that providing EOL care has on healthcare providers and provide resources to support nurses' and other colleagues' emotional work. However, further research is required to develop necessary strategies for achieving meaningful outcomes in this regard.

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