at the request of a patient with capacity to make the relevant decisions.

These SPCT members work at a large specialist cardio-respiratory hospital and are often involved in discussions and decisions about, and the act of, withholding and withdrawal of treatment including oxygen and non-invasive ventilation.

This was the first occasion where team members specifically articulated distress, including moral distress, following their involvement in treatment withdrawal. Moral distress can be described as the 'psychological disequilibrium associated with knowing the ethical/appropriate action but being unable to take that action.'

Initial explorations of the distress identified only that this case 'felt different' to other withdrawal scenarios and team members used different vocabulary to describe their experiences and their impact. Within ethical literature, 'felt moral difference' is not considered to be a reliable guide to ethical conduct but nonetheless is important to address.

One team member used the American '4A's Approach to Moral Distress' (Ask, Affirm, Assess, Act) to help better understand their experience.

Relevant individual case factors included the very high flow rate of oxygen involved and the time-bound nature of the request. Analysis revealed different weights that individuals (patient and staff members) placed on autonomy and non-maleficence as a source of tension. Furthermore, there were different views and values about individual and wider harms, including how these were explored and managed.

A combination of open communication, self-directed learning and reflection, enabled SPCT members to understand the source of their distress more clearly. Moral distress and a felt moral difference can impact on wellbeing, team functioning and ability to undertake specific work tasks. It is hoped this experience will enable the team to better articulate ethical dilemmas and understand their own perspectives.

75 DO ETHICAL BARRIERS EXIST IN PROVIDING PALLIATIVE CARE TO THE HOMELESS, AND CAN THESE BE ADDRESSED WITH EXISTING HEALTHCARE SERVICES AND PROVISIONS?

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Background Average life expectancy in the homeless population is 47, and rates of homelessness are increasing significantly. With a high disease burden, these patients may benefit from palliative input, but historically there have been barriers to effective care.

Methods From consequentialist, virtue, and care ethics perspectives, two questions are addressed. Firstly, whether a coercive approach can be justified in a population who are traditionally reluctant to seek medical help, but may benefit greatly from treatment. Secondly, whether existing palliative services are appropriate for this group, or if there is ethical justification for a bespoke service, separate from mainstream healthcare.

Results Homelessness can be shown to effect the ability to make informed choices. Although there is ethical precedent for paternalistic approaches to health in such cases, for this population cultural capital, and so informed decision making, can be improved. We should therefore aim to increase the agency of homeless people, rather than further diminishing their rights.

Homeless people are often reluctant to engage with health services, and the care they receive is sub optimal. We should therefore avoid over medicalising end of life for this population, and focus on community based measures of care, which may emphasize social and psychological support over medical treatments.

Conclusion The homeless have not seen many of the health benefits of improved public health and primary prevention measures, and as such their life expectancy has remained static while others has improved. We frequently talk about a biopsychosocial model to health, but the focus is primarily on a biological approach. In this population, the focus should be reversed, with an emphasis on maintaining important social relationships and the psychological burden of disease in their situation.

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76 'WE TRY TO TRANSMIT PSEUDO STRENGTH TO OUR KIDS; IF WE ARE BROKEN, THEY WILL BE BROKEN AS WELL': NATURE OF THE DIALOGUE BETWEEN MOTHERS, GRANDMOTHERS AND CHILDREN WITH LEUKAEMIA IN PALESTINE

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Background Mothers of children with life-limiting illnesses describe facing challenges such as sometimes finding it difficult to communicate with their children, for example when their children become irritable due to their illnesses. This study explored the experience of communicating regarding the care of children with cancer, from the perspective of physicians, nurses, mothers, grandmothers and children in Palestine. This paper reports on the perceptions of the mothers and the grandmothers.

Methods This study employed an ethnographic, collective, qualitative case study approach. It was conducted in one oncology unit in a Palestinian hospital. Two data collection methods were employed: participant observation and semi-structured interviews.

Results The study generated 70 hours of observation and 35 interviews; physicians (n=5), nurses (n=11), children aged 6–18 (n=6), mothers (n=7) and grandmothers (n=6). Findings: The mothers and grandmothers stated that they pretended to be strong in front of their children to prevent them from feeling distressed by witnessing their mother's suffering and grieving. Protecting children from seeing their mothers' distress was thought to be essential to help children face their illness and their own suffering. Mothers talked to their children about their children's strengths rather than the deprivations caused by their illnesses. Although they did not feel strong, the mothers tried to transfer their own strength to their children to strengthen them and protect them from being broken.

Conclusions Being the mother of a child with cancer is clearly distressing and they suffer along with their child. Their maternal role drives them to conceal their own grief and their conversations with their children are strengths-based. There is clearly a role for nurses caring for families of children with cancer to support mothers and give them the opportunity to express and share their grief and distress.