

Ethical Conflicts Experienced by Physicians in Community-Based Practice

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Abstract

Background: The ability to understand, examine, and make decisions related to morally difficult situations differs from one medical specialist to another depending on the clinical situation and circumstance. With a further understanding of the ethical conflicts experienced by physicians in community-based practice comes the ability to better support physicians and ethics committees in the future.

Purpose: The purpose for this research practicum was to conduct a qualitative research study to gain confidence as a qualitative researcher through the process of applying knowledge, principles, and skills of qualitative inquiry and qualitative data analysis.

Methods: To meet the objectives: 1) literature was reviewed related to ethical conflicts, a qualitative, exploratory design, and discussion related to issues qualitative recruitment were identified and, 2) one physician was recruited to interview utilizing an inductive approach to data analysis.

Results: Preliminary findings is that primary care physicians do experience ethical conflicts within their daily community-based practice. The categories identified by the interviewed physician were: (1) ethical conflicts from the type of care provided to patient/family, and (2) ethical conflicts from the role of living and working in a rural community.

Conclusions: The research presented contributes to a larger study and the understanding of the experience of ethical conflict and supports needed. Describing successes and challenges of recruitment strategies may contribute to a dialogue about best practice for qualitative recruitment.

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Research Practicum Introduction

In this report, I present my research practicum entitled *Ethical Conflicts Experienced by Physicians in Community-Based Practice*, undertaken in partial fulfillment of the requirements for the degree of Master of Nursing from Memorial University of Newfoundland. The findings from my research project will contribute to a larger study entitled *Clinical Ethics Committees and Ethical Conflicts in Community Health Care* that explores the ethical issues of physicians, nurses, and patients along with the availability of ethics supports and services.

Background

Clinical settings are complicated, diverse, and ever evolving, and as such, providing care can be challenging and make the likelihood of ethical conflicts a strong possibility. Researchers have primarily focused on ethical conflicts in the hospital setting and little is known about how physicians working in the community setting manage ethically difficult situations. More extensive medical services are expected to be provided in the community setting as opposed to the acute care hospital setting, which means health care is shifting, with a focus on the aging population as well as increased fiscal responsibilities (Pavlish, Brown-Saltzman, Hersh, Shirk, & Rounkie, 2011). Physicians are facing a number of challenges in the workplace including limited resources for consultation, end of life care dilemmas, increased patient load, increased burden of documenting, and a decreasing scope of practice (Okie, 2012). The implications of these increased burdens can lead to burn out, mental health issues, and stressful work environments which impacts the physician and other staff, patients, and personnel.

The rationale for the larger study is multi-faceted; however, the primary investigators believe that client care and client safety may be interlinked with the health professional's ability to manage ethical conflicts. The focus of my research practicum project was ethical conflicts in community-based care, specifically ethical conflicts experienced by physicians. For the purposes of this practicum project ethical conflict was defined as the health professional experiencing a clash between their values and their perceptions of how patients are cared for and treated (Gaudine, LeFort, Lamb & Thorne, 2011).

Through semi-structured interviews with physicians I obtained data about types of ethical conflicts faced, along with information about how these ethical conflicts were managed. With a further understanding of the ethical conflicts experienced by physicians in community-based practice comes the ability to better support physicians and ethics committees in the future.

Goal and Objectives

For this practicum project, my overall goal was to develop my skills as a researcher through practical hands-on experience. I hoped to gain confidence as a qualitative researcher through the process of applying knowledge, principles, and skills of qualitative inquiry throughout my research practicum project. To achieve these goals, I worked towards the following objectives:

1. To gain an understanding of ethical conflicts experienced by physicians in community-based practice;
2. To better understand qualitative content analysis;
3. To develop semi-structured interviewing skills;
4. To develop skills in the collection and analysis of qualitative data; and

5. To demonstrate Advanced Nursing Practice competencies.

Practicum Methods

I utilized the following method objectives to guide me in the achievement of my practicum objectives and research based objectives.

1. Conduct a comprehensive literature review;
2. Complete a review of the methodology;
3. Conduct semi-structured interviews;
4. Analyze and report the results of my findings; and
5. Give a presentation of my findings.

I utilized an inductive, exploratory qualitative research approach which put an emphasis on the phenomena with a focus on the subjective experiences of the participants. Adopting a general perspective on the complexities of the work is the definition of a paradigm. That is, a paradigm for human inquiry consists of the ways in which a person responds to basic philosophical questions related to their experiences of their reality. For the purpose of this practicum project, a constructivist (naturalistic) paradigm was most appropriate. When aligning with a constructivist paradigm one believes that reality is subjective and multi-faceted and not based on a cause and effect reality (Polit & Beck, 2012); Streubert & Carpenter, 2011).

My initial goal for my project was to conduct my data collection in Nova Scotia. I encountered recruitment issues which led to my project being conducted in Western Newfoundland. Further information about the difficulties encountered during recruitment will be presented in this report. I received ethical approval from the Health Research Ethics Authority in Newfoundland and Labrador. Through purposive sampling utilizing a

recruitment poster I recruited one participant to conduct a semi-structured interview with. Data analysis was completed and a presentation of my findings was completed for faculty and colleagues of the School of Nursing. I completed an additional research literature review on recruitment challenges (See Appendix B).

Literature Review

One of the methods I implemented to achieve my practicum goal was a literature review. I reviewed the literature to increase my knowledge on the subject of ethical conflicts in community-based practice as well as to identify any gaps in the current literature. The process of reviewing the literature involved a comprehensive literature search focused on ethical conflicts experienced by physicians. The literature search began at Memorial University Health Sciences Library online database, utilizing the “OneSearch” online tool. All of the nursing related databases were part of the search strategy. CINAHL, Pubmed, Google Scholar, and Cochrane databases yielded the most results. The inclusion criteria were full text online, within last 10 years, peer-reviewed, research-based, English text, and human subjects. I utilized the following search terms individually or in multiple combinations: *ethics, moral, conflict, conflict, dilemma, physician, primary care, provider, community practice, community health, home care, and ethics committees*. I utilized differing combinations of the key search terms: for example, the word *ethics* was combined with *dilemma, conflict, issue, and problem* while adding *community health, primary care, and physician*. I also hand searched the cited references from relevant articles for additional studies in both PubMed and CINAHL. I was looking for appropriate article titles as well as key words listed in the abstract.

Medical ethics is a relatively new area of study so it was not surprising to yield a small number of articles. The five articles retrieved were highly relevant to my research topic (Gaudine et al., 2011; Hurst et al., 2007; Leuter et al., 2017; Orłowski, Hein, Christensen, Meinke, & Sincich, 2006; Sorta-Bilajac et al., 2011). There were four quantitative and one qualitative research studies which incorporated ethical conflicts, physicians, and community practice. It was evident from the review of the literature that ethical conflicts experienced by physicians in community-based care have not been thoroughly explored. Ethical conflicts have mostly been explored in a hospital setting and often related to the nurse's experience of ethical conflict. The review of literature revealed that physicians are facing specific conflicts related to end of life care, decisions around estimating the odds of patient survival, and professional disagreements with the ever-changing practice guideline. Results of my review indicate that: 1. ethical conflicts are cross-cultural; 2. physicians and nurses need basic and continued education related to ethics; 3. ethical consultation services are needed; and 4. professional collaboration will aid in ethical conflict resolution for physicians. The critical appraisal of the quantitative articles was completed using the Public Health Agency of Canada's Critical Appraisal Toolkit (PHAC, 2014). The comprehensive literature review and literature summary tables can be found as Appendix A.

Ethical Conflicts: A Cross-Cultural Experience

The articles reviewed revealed that ethical conflicts could be found not only across various medical fields but also across cultural boundaries. Several articles included discussion of ethical conflicts related to treating patients with impaired or uncertain decision-making, disagreements among caregivers, limiting self-sustaining treatment, and

euthanasia. In addition several authors concluded that physicians across cultures require more collaborative support from other professionals when they are experiencing ethical difficulties (Gaudine et al., 2011; Hurst et al., 2007; Leuter et al., 2017; Orłowski, et al; Sorta-Bilajac et al., 2011). Collaborative support implies that there is shared decision making among several disciplines or health care providers to facilitate the resolution of the ethical conflict. Sorta-Bilajac et al. noted that ethical dilemmas were observed across medical specialties and Hurst et al., too, noted that ethical difficulties were found in the clinical practices that were observed in their study.

Basic and Continued Ethics Education

Leuter et al. (2017) concluded that providing both physicians and nurses with basic and continued education related to ethical situations would provide a valuable continuing education opportunity. By reviewing examples of ethical conflicts experienced by other physicians (e.g., end of life care; interpersonal issues; patient or family conflict related to medical decisions) could help to generate ideas regarding their professional ethical conflict resolution. The concept of interdisciplinary ethical education was highlighted and supported by the literature (Gaudine et al., 2011; Leuter et al.). An interesting finding by Leuter et al. was that the fact that nurses had a much better appreciation for their own knowledge than physicians did. Although physicians identified more ethics related education during their training, nurses substituted a lack of educational training with utilizing their own clinical experiences to guide their ethical decision making process (Leuter et al.). The fact that consultation between colleagues was more likely for nurses and less likely for physicians is a distinct area of difference between professions.

Ethical Consultations

Hurst, Hull, DuVal, and Danis (2005) utilized a survey to explore the types of ethical dilemmas faced by European doctors, how they ranked these dilemmas, their satisfaction with the resolution of a recent dilemma, and the types of help they found the most useful. The authors concluded that physicians face ethical difficulties daily, however, they infrequently seek ethical consultation to facilitate the management of the situations. This conclusion was also found in a study by Hurst et al. (2007) which noted that physicians identified the importance of professional reassurance related to their decision making related to an ethical dilemma. However, they did not seek guidance when faced with an ethical situation in their own practice. Leuter et al. (2017) concluded that an ethical consulting service could have benefits for both physician and nurse. Ethical consultation could actually facilitate communication rather than impede it.

Sorta-Bilajac et al. (2011) discovered that among the participants of their study, nurses or physicians were not using clinical ethics consultations. The ability to incorporate these types of consultations into ethical decision making could help to facilitate shared decision making within the healthcare team (Gaudine et al., 2011; Leuter et al., 2017; Orłowski et al.; Sorta-Bilajac et al.).

Interprofessional Collaboration

In three of the five articles there was a comparison between how nurses and physicians manage and identify ethically challenging situations. When the professions were compared as it relates to decision-making in ethically charged situations the hierarchical nature of the relationship between nurse and physician played a major role (Orłowski et al., 2006; Sorta-Bilajac et al., 2011). Physicians were noted to take on more responsibility

themselves to resolve the issues including relying on their own experience, consulting literature on the topic, or communicating with the family directly. Leuter et al. (2017) introduced the idea that the “subordination of nurses to physicians implies that nurses have a lower self-perceived need for ethics support” and will leave the physician the responsibility of the ethical decision with them (p. 2). Due to the fact that the physician is often responsible for the final medical decision in the clinical setting physicians often rely on their training and own analysis of the situation instead of reaching out for collaborative ethical support (Leuter et al.; Orłowski et al.; Sorta-Bilajac et al.). Researchers in the five studies reviewed concluded that a collaborative approach to managing ethical conflicts would provide significantly more support than simply managing the situation without any support (Gaudine et al., 2011; Hurst et al., 2007; Leuter et al., 2017; Orłowski et al., 2006; Sorta-Bilajac et al., 2011).

Although research studies to date have only been descriptive, researchers have explored ethical difficulties in the hospital setting, compared ethical conflict management between physicians and nurses, as well as identified the types of conflicts physicians encounter. Little is known about the physicians’ experience with ethical conflicts in the community-based setting and why the physician does not seek support to manage ethical situations with more frequency. The way in which to implement these supports is by developing a deeper understanding of the physician’s identified needs. This can be accomplished by first exploring with physicians what the ethical conflicts they encounter in the community-based setting are, ways in which they have managed these situations in the past, and any the recommendations they have for ways to encourage physicians to access clinical ethical supports.

Synopsis of Research Findings

I chose a qualitative exploratory design for my research practicum project utilizing an inductive approach to data analysis. Using this approach facilitated an emphasis on the subjective experience of the physician interviewed. Qualitative researchers investigate phenomena in-depth and holistically using emergent and flexible research designs (Creswell, 2012; Polit & Beck, 2012).

For my practicum project I had several recruitment challenges. Since I encountered these challenges in recruitment I decided to explore how other researchers faced recruitment challenges. I completed a literature review in an attempt to answer my questions about why recruitment was so challenging. I concluded there were challenges specific to recruiting clinical personnel and related to small-scale qualitative research recruitment. I feel the most useful tool for future researchers would be to present the recruitment section like the methods or findings sections of a research report. This would provide more detail that could include a full description of time committed, tools utilized, and successes or limitations of attempted recruitment methods. Due to the fact that recruitment strategies will vary from project to project, it is not possible to present one recruitment strategy for researcher use. However, if recruitment were described in research articles, then other researcher may be more apt to consider their recruitment timelines and possible barriers to recruitment at the beginning of their project. As Hysong et al. (2013) noted the more stable the estimates of recruitment time, the more researchers can plan based on the experiences of other researchers. After a number of research publications included a description of recruitment, it would be valuable to do an updated literature review on recruitment methods and compile an

expanded list of successful and unsuccessful recruitment methods to build on the work of Jessiman (2013).

I was only able to recruit one physician to interview. The physician was in his/her mid-thirties and practicing as a community-based physician for approximately 10 years. The semi-structured interview was conducted via videoconference after written consent was obtained. The data and transcript of the interview were stored on an encrypted USB in a locked home office. The interview transcript data was analyzed using an inductive approach, going from a general view of the data to more a more specific view, which yielded several preliminary findings. Utilizing a credible research method, such as narrative interviews, enhanced the trustworthiness of my research. By discussing my transcripts, research findings, and other relevant aspects of the data analysis process with my supervisor, I reduced the risk of bias and increased the validity of the findings (Byrne, 2001; Creswell & Miller, 2000). A preliminary finding from this interview was that primary care physicians do experience ethical conflicts within their daily community-based practice. I will discuss the two major categories of ethical conflicts noted from the data collected. Further discussion of the methods, recruitment challenges, and research findings can be found in the research report; see Appendix B.

Types of Conflicts

Two major categories emerged from the data analysis regarding the types of ethical conflicts encountered in community-based medical practice. The categories are: (1) ethical conflict from the type of care provided to patient/family, and (2) ethical conflicts from the role of living and working in a rural community.

Ethical Conflict Encountered in Community-Based Medical Practice.

This type of clinical ethical conflict can be defined as a health professional experiencing a clash between one's values and one's perception of how patients are cared for and treated (Gaudine et al., 2011). Examples of clinical ethical conflict noted in the data are "designating a patient as incompetent" and "taking away their livelihood". The physician noted that "taking away someone's independence or livelihood" was never a decision that was made lightly and it was deemed to be a difficult internal ethical conflict.

Ethical Conflict from the Role of Living and Working in a Rural Community.

Although the clinical conflicts tended to illicit a deeper ethical uncertainty for the physician, conflicts related to living and working in a rural community were a more frequent occurrence in his/her practice. Therefore the physician has to figure out how to manage these conflicts mostly through "trial and error". One type of conflict that occurred frequently for the physician was "treating family and friends". The interviewee found this particularly difficult in the early years of his/her practice as many family and friends would feel a clinical issue was something simple when it was in fact more complicated. He/she noted that he/she would "try to help as much as I could" to figure out the presented situation. The fact that his/her patients would show him/her a mole in the grocery store and he/she would be asked at the soccer pitch "what do you think about this rash doc?" caused significant stress in the first five years of his practice. He/she noted that he/she began to get used to this after some time passed and now simply attempts to be discrete with these discussions. Finding support to aid with the ethical conflicts was not something the physician had every accessed. An area that was discussed significantly during the interview was the role of other professionals (e.g., physicians, registered nurses, social workers etc.) to

facilitate discussions and provide a forum for ethical consultation. This interprofessional collaboration will be discussed next.

Interprofessional Collaboration

One of the key findings from my research was the gap in support related to interprofessional collaboration. According to the literature, when nurses and physicians were compared as it relates to decision making in ethically charged situations, the hierarchical nature of the relationship played a major role. Due to the fact that the physician is often responsible for the final medical decision in the clinical setting, physicians often rely on their training and own analysis of the situation instead of reaching out for collaborative ethical support (Leuter et al., 2017; Orłowski et al., 2006; Sorta-Bilajac et al., 2011).

Similar findings were noted from the interview however the physician noted that he/she would be interested in a more collaborative approach to ethical decision-making. The literature was supportive of this, noting that a collaborative approach to managing the ethical situation provided significantly more support than managing the situation without any support (Gaudine et al., 2011; Hurst et al., 2007; Leuter et al., 2017; Orłowski et al., 2006; Sorta-Bilajac et al., 2011).

The aforementioned larger study, with the contribution of my study, could lead to the implementation of improved organizational structures. These improvements could lead to better management of ethical conflicts faced by physicians in community-based practice and further aid in the development of ways to manage these conflicts. The information related to recruitment issues could help further the discussion on qualitative recruitment issues by facilitating a dialogue among researchers.

Advanced Nursing Practice Competencies

According to the Canadian Nurses Association (CNA) (2008) *advanced nursing practice* is a term utilized to describe an advanced level of clinical nursing practice that maximizes the use of graduate educational preparation. This includes in-depth nursing knowledge and expertise in meeting the health needs of individuals, families, groups, communities, and populations. Those with the advanced nursing practice designation are guided by core competencies based on a graduate-level nursing knowledge. The framework outlined by the CNA (2008) separates these competencies into four categories: clinical, research, leadership, and consultation and collaboration. In completing a research based practicum I worked towards developing my research and consultation and collaboration competencies.

Research

Completing a research based practicum helped to contribute to my knowledge on “generating, synthesizing, and using research evidence” to conduct and analyze my research data (CNA, 2008, p. 23). I feel I accomplished the research competencies by demonstrating my ability to collaborate with members of a research team including the research coordinator, co-authors of the research project, and other support staff. Through my comprehensive literature review and analysis I was able to gain insight and evaluate knowledge regarding ethical dilemmas faced by physicians in community-based practice. This review of the literature also helped me to work on my skills of critiquing, interpreting, and applying evidence-based to guide my research process. This provided a platform for knowledge generation and the data gained through this interview will help in contributing to the aforementioned larger study, which has the potential to alter the way ethical dilemmas

are managed and how physicians, nurses, patients/families are supported when facing an ethical dilemma.

Due to the limitation in my sample size it is difficult to say if my research findings will contribute to any organizational or administration changes however, it is my hope that what I am contributing will be utilized towards improving the supports in place for community-based physicians.

Consultation and Collaboration

The effective collaboration with other members of the health care team became an integral part of this project. I feel this was accomplished through the initiation of timely and appropriate consultation with other health care providers; my ability to apply theories related to roles and organizations I collaborated with; and the participating in a collaborative project with an academic institution.

I collaborated with the Memorial School of Nursing, my supervisor, Dr. Caroline Porr, and Joanne Smith-Young, Nursing research Unit Coordinator at the Memorial University School of Nursing in a timely and respectful manner. I feel these collaborations were vital to my success as a novice researcher and facilitated my knowledge acquisition regarding qualitative research. During the challenges related to ethical approval in Nova Scotia, as well as my recruitment difficulties, both Dr. Porr and Joanne Smith Young were great mentors and dynamic research leaders. The three of us collaborated to share ideas about how to manage the challenge of delayed ethical approval. This collaboration helped to facilitate the process of ethical approval in Newfoundland and the completion of my project.

Concluding Remarks

I set out to complete this practicum research project to the best of my ability and to acquire as much knowledge related to conducting a research project as I could. I had not anticipated learning so much about my skills and myself as a nurse researcher. Nursing research is an area I would never have imagined myself working in however, I will now actively seek opportunities in research instead of avoiding them. I found the research to be exciting, the barriers to be a challenge I was willing to work through, and the final project to be something different than I set out to achieve, but something I am immensely proud of.

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Appendix A

Literature Review

A Literature Review of Ethical Conflicts in Community-Based Practice Experienced by Physicians

The focus of my research practicum project is ethical conflicts in community-based care, specifically ethical conflicts experienced by physicians. The study of medical ethics or bioethics has been an aspect of allopathic medicine since ancient times. The ability to understand, examine, and make decisions related to morally difficult situations differs from one medical specialist to another depending on the clinical situation and circumstance (Gillies, 2009). Clinical settings are complicated, diverse, and ever evolving and providing medical care in these diverse situations can be complex. More medical care is expected to be provided in the community setting as opposed to the hospital setting which means health care is shifting, with a focus on the aging population as well as increased fiscal responsibilities (Pavlish, Brown-Saltzman, Hersh, Shirk, & Rounkie, 2011). Physicians are facing a number of challenges in the workplace including limited resources for consultation, end of life care dilemmas, increased patient load, increased burden of documenting, and a decreasing scope of practice (Okie, 2012). For the purposes of this practicum project ethical conflict will be defined as the health professional experiencing a clash between their values and their perceptions of how patients are cared for and treated (Gaudine, LeFort, Lamb & Thorne, 2011).

The literature review and critical appraisal of current literature is essential when beginning a research-based project. The proposed research project will seek to gain insight into the types of ethical conflicts physicians experience and how they are managed in a

community-based practice. By conducting this qualitative study examining the ethical conflicts experienced by physicians in community-based practice, a contribution will be made to fill the gap in the literature.

In this integrative literature review, I first describe my literature search methods and the results with discussion of major themes. I also include critical appraisal of the relevant research articles. From my review I discovered that generally, medical ethics has been addressed in the hospital setting and physicians identify ethical conflicts related to disagreement with clinical practice guidelines, estimating odds of survival, balancing merit of survival with disability in an infant and child, as well as of life medical care decisions (Gaudine et al., 2011). Several major themes were identified from the research based articles that focused on ethical conflicts experienced by physicians, which included: ethical conflicts experienced by physicians across cultures; that physicians require basic and continued ethics education; ethical consultation; and interprofessional collaboration has benefits that could be a key strategy for ethical conflict management. Finally, I conclude with the implications of my results for my research practicum project.

Literature Search Methods

As aforementioned, I was interested in the literature on the topic of ethical conflicts in community-based care, specifically ethical conflicts experienced by physicians. The process of reviewing the literature involved a comprehensive literature search focused on ethical conflicts experienced by physicians. The literature search began at Memorial University Health Sciences Library online database, utilizing the “OneSearch” online tool. All of the nursing related databases were part of the search strategy. CINAHL, Pubmed, Google Scholar, and Cochrane databases yielded the most results. The inclusion criteria

were full text online, within last 10 years, peer-reviewed, research-based, English text, and human subjects. I utilized the following search terms individually or in multiple combinations: *ethics, moral, conflict, conflict, dilemma, physician, primary care, provider, community practice, community health, home care, and ethics committees*. I utilized differing combinations of the key search terms: for example, the word *ethics* was combined with *dilemma, conflict, issue, and problem* while adding *community health, primary care, and physician*. As an example I used *ethical conflict AND physician* in CINAHL and 45 articles resulted; the articles were related to ethics of organ trafficking; ethically challenging situation avoidance; trust and transparency of physicians; conflicts of interest; and end of life care decisions. In PubMed I utilized the MeSH terms *ethical conflict* and *physician* (applying inclusion criteria) and 541 articles resulted. I added *primary care* and 8 articles resulted. I went back to the 541 results page and found the articles were related to human trafficking; ethics and transparency of physicians and the pharmaceutical industry; refusal of physicians to participate in ethical consultations; religion and values. I also hand searched the cited references from relevant articles for additional studies in both PubMed and CINAHL. I was looking for appropriate article titles as well as key words listed in the abstract.

I was able to identify 10 articles from the search terms listed above and the hand searching process. Five of these articles were deemed relevant because they covered ethical conflicts in community-based care experienced by physicians and/or health care professionals. The studies chosen were four quantitative designs and one qualitative in design. These articles incorporated ethical conflicts, physicians, community practice, some were robust while others identified gaps in the current literature.

Medical ethics is a relatively new area of study so it was not surprising to yield a small number of articles. However, the five articles were highly relevant. The key details of each study and relevant critical appraisal are summarized in the literature summary table found in Appendix A.

Critical Appraisal of Literature

The critical appraisal of research-based articles is best facilitated by utilizing the Public Health Agency of Canada's Critical Appraisal Toolkit (PHAC, 2014). I used the Toolkit as a guide to provide myself with the tools to critically analyze the quality of relevant quantitative research studies retrieved to support key themes and conclusions drawn from my literature review. The PHAC outlines seven steps to critical appraisal with a ranking that ranges from weak to strong (high), based on specific criteria including for example the study design, assessing internal validity, participant recruitment process, data collection process etc. The seven steps of appraisal are:

1. Identify the purpose for reviewing the article to ensure the focus remains on the articles relevant for your research question(s).
2. Read the methods section of the study for an overview of the research methods used.
3. Name the study design and choose the appropriate critical appraisal tool (i.e. analytic, descriptive, or literature review)
4. Describe the study's content in an appendix utilizing a literature summary table.
5. Critically appraise the study utilizing the appropriate criteria.
6. Include the critical appraisal results and any comments in the last column of the literature summary table.

7. Summarize the nature of the studies and conclusions relevant to your key questions to form the basis of recommendations. (PHAC, 2014, p. 4).

It was evident from the review of the literature that ethical conflicts experienced by physicians in community-based care have not been thoroughly explored. Ethical conflicts have mostly be explored in a hospital setting and often related to the nurse's experience of ethical conflict. The review of literature revealed that physicians are facing specific conflicts related to end of life care, decisions around estimating the odds of patient survival, and professional disagreements with the ever-changing practice guideline. Results of my review indicated that: 1. ethical conflicts are cross-cultural; 2. physicians and nurses need basic and continued education related to ethics; 3. ethical consultation services are needed; and 4. professional collaboration will aide in ethical conflict resolution for physicians. This review of the literature aided in my understanding of the importance of a comprehensive literature review. I was able to note that there were not many articles on the topic of ethical dilemmas experienced by physicians in community-based practice and that they are all descriptive in nature; however, the articles did provide a foundation for further research.

Ethical Conflicts: A Cross-Cultural Experience

The articles reviewed revealed that ethical conflicts can be found not only across various medical fields but across cultural boundaries. Several articles included discussion of ethical conflicts related to treating patients with impaired or uncertain decision-making, disagreements among caregivers, limiting self-sustaining treatment, and euthanasia. In addition several authors concluded that physicians across cultures require more collaborative support from other professionals when they are experiencing ethical difficulties (Gaudine, LeFort, Lamb, & Thorne, 2011; Hurst et al., 2007; Leuter et al., 2017; Orłowski, Hein,

Christensen, Meinke, & Sincich, 2006; Sorta-Bilajac et al., 2011). Collaborative support implies that there is shared decision making among several disciplines or health care providers to facilitate the resolution of the ethical conflict. Sorta-Bilajac et al. noted that ethical dilemmas were observed across medical specialties and Hurst et al., too, noted that ethical difficulties were found in the clinical practices that were observed in their study.

Ethical dilemmas affect physicians in different ways, for example: some choose to talk to others, some choose to seek ethical consultations, some discuss the situations with patients, and some feel they have the moral ground to decide what to do on their own (Hurst et al., 2007; Leuter et al., 2017; Orłowski et al., 2006; Sorta-Bilajac et al., 2011). Hurst et al. concluded that cultural differences did influence how physicians perceived ethical conflicts however, the type of help needed was not markedly different. I am interested to discover if this will be a similar result within my project participants.

My practicum project will help to develop a better understanding of the way in which ethical conflicts are experienced and what supports are needed within the population studied in Nova Scotia.

Basic and Continued Ethics Education

Leuter et al. (2017) concluded after exploring nurses' and physicians' knowledge in the ethical field and experience with ethical conflicts that providing both physicians and nurses with basic and continued education related to ethical situations would provide a valuable continuing education opportunity. By reviewing examples of ethical conflicts experienced by other physicians (e.g., end of life care; interpersonal issues; patient or family conflict related to medical decisions) could help to generate ideas regarding their professional ethical conflict resolution. The idea of interdisciplinary ethical education was

highlighted and supported by the literature (Gaudine et al., 2011; Leuter et al.). An interesting finding by Leuter et al. was the fact that nurses had a much better appreciation for their own knowledge than physicians did. Although physicians identified more ethics related education during their training, nurses substituted a lack of educational training with utilizing their own clinical experiences to guide their ethical decision making process (Leuter et al.).

Leuter et al. (2017) concluded that providing both physicians and nurses with basic and continued education related to ethical situations would provide a valuable continuing education opportunity. The inter-professional nature of this education could facilitate a platform for collaborative discussion on cases where both physicians and nurses are involved. Physicians were not apt to consult with nurses; they were more apt to consult with other physicians or draw conclusion on their own (Gaudine et al., 2011; Leuter et al., 2017). The fact that consultation between colleagues was more likely for nurses and less likely for physicians is a distinct area of difference between professions.

Ethical Consultations

Hurst, Hull, DuVal, and Danis (2005) explored the types of ethical dilemmas faced by European doctors, how they ranked these dilemmas, their satisfaction with the resolution of a recent dilemma, and the types of help they found the most useful. The authors concluded that physicians face ethical difficulties daily, however they infrequently seek ethical consultation to facilitate the management of the situations. This conclusion was also found in a study by Hurst et al. (2007) which noted that physicians identified the importance of professional reassurance related to their decision making related to an ethical dilemma. However, they did not seek guidance when faced with an ethical situations in their own

practice. Leuter et al. (2017) concluded that an ethical consulting service could have benefits for both physician and nurse. Ethical consultation can actually facilitate communication rather than impede it.

It was also concluded that shared decision making can improve the confidence of the patient and family that are involved in the ethical conflict (Orlowski et al., 2006). The presence of a consulting service and valid support in the area of ethical conflicts was evident as a need in all five articles reviewed. Sorta-Bilajac et al. (2011) discovered that among the participants of their study, clinical ethics consultations were not being used by nurses or physicians. The ability to incorporate these types of consultations into ethical decision making could help to facilitate shared decision making within the healthcare team (Gaudine et al., 2011; Leuter et al., 2017; Orlowski et al., 2006; Sorta-Bilajac et al., 2011).

Interprofessional Collaboration

In three of the five articles there was a comparison between how nurses and physicians manage and identify ethically challenging situations. When the professions were compared as it relates to decision-making in ethically charged situations the hierarchical nature of the relationship between nurse and physician played a major role (Orlowski et al., 2006; Sorta-Bilajac et al., 2011). Physicians were noted to take on more responsibility themselves to resolve the issues including relying on their own experience, consulting literature on the topic, or communicating with the family directly. Leuter et al. (2017) introduced the idea that the “subordination of nurses to physicians implies that nurses have a lower self-perceived need for ethics support” and will leave the physician the responsibility of the ethical decision with them (p. 2). Due to the fact that the physician is often responsible for the final decision in the clinical setting, the physician will often rely on their

training and own analysis of the situation instead of reaching out for collaborative ethical support (Leuter et al., 2017; Orłowski et al., 2006; Sorta-Bilajac et al., 2011).

Researchers in the five studies reviewed concluded that a collaborative approach to managing ethical conflicts would provide significantly more support than simply managing the situation without any support (Gaudine et al., 2011; Hurst et al., 2007; Leuter et al., 2017; Orłowski et al., 2006; Sorta-Bilajac et al., 2011).

Implications for Research

Overall, from the review of the literature related to ethical conflicts experienced by physicians in community-based practice, only five descriptive studies contributed to the knowledge that ethical conflicts are present in everyday medical practice, physicians are often facing these conflicts on their own, and supports are not readily utilized. Although these conclusions can be noted it is also clear that more research needs to be conducted to fully understand why physicians are not seeking ethical consultation services, why physicians do not rely more on their colleagues during times of ethical uncertainty, and how to utilize the knowledge gained through this practicum and literature review to better support community-based physicians. The articles reviewed do provide insights on the topic of ethical conflicts in community-based care as it pertains to physicians. Researchers recommend providing physicians the ability to access ethics supports (e.g., an ethics committee and/or ethics consultant). A deeper understanding in regards to the barriers to seeking ethical decision making support, how to engage physicians in collaborative education opportunities, and what these supports could be in the community setting is needed (Gaudine et al., 2011; Hurst et al., 2007; Leuter et al., 2017; Orłowski et al., 2006; Sorta-Bilajac et al., 2011). Although my practicum project will not answer all of these

questions, I hope it will provide an answer to what ethical conflicts are present within Southwestern Nova Scotia and why do or don't physicians seek ethical decision-making support.

Missing in the literature is research pertaining to community-based ethical conflicts faced by physicians, barriers to seeking support during ethically difficult encounters, and what types of supports would be useful to the physicians interviewed. I will begin to address the gap in our understanding by utilizing qualitative inquiry to explore ethical dilemmas through semi-structured interviews (Creswell, 2012).

Conclusion

In conclusion, to date researchers have explored ethical difficulties in the hospital setting, compared ethical conflict management between physicians and nurses, as well as identifying the types of conflicts physicians encounter. Little is known about the physicians experience with ethical conflicts in the community-based setting and why the physician does not seek support to manage ethical situations with more frequency. The way in which to implement these supports is by developing a deeper understanding of the physician's identified needs. This can be accomplished by first exploring with physicians what the ethical conflicts they encounter in the community-based setting are, ways in which they have managed these situations in the past, and any the recommendations they have for ways to encourage physicians to access clinical ethical supports. By contributing to the aforementioned larger study there could be improved organizational structures implemented. These improvements could lead to better management of ethical conflicts faced by physicians in community-based practice and further aide in the development of ways to manage these conflicts.

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Literature Summary Tables

Qualitative Study- Gaudine et al.

Name, Author, Date, Study Objective	Sample/Groups (Size, Setting, Characteristics)	Design and Methodology	Key Results/Findings	Strengths/Limitations	Conclusion and Rating
<p>“Clinical ethical conflicts of nurses and physicians” Gaudine, et al., 2011</p> <p>Objective: To identify themes of hospitals nurses’ and physicians’ clinical ethical conflicts that cut across the spectrum of clinical speciality areas</p>	<p>Sample: -34 clinical nurses, 10 nurse managers, and 31 physicians -convenience sampling to reflect different types of clinical ethics committees</p> <p>Setting: -four different university teaching hospitals located in Atlantic and Central Canada -participants worked in a wide variety of clinical settings</p>	<p>Methodology: -qualitative descriptive study -semi-structured interviews were conducted -part of a larger investigation, nurses and physicians were interviewed about their ethical conflicts in clinical situations, with the organizations, and their perceptions of barriers to consulting the clinical ethics committees -this article presented the results from the discussion of ethical conflicts from clinical situations</p>	<p>Key Findings: -nine themes of clinical ethical conflict were common to both hospital nurses and physicians -three themes of clinical ethical conflict were specific to physicians (disagreement with national guidelines, estimating odds of survival, & balancing merit of survival with disability) -identified similarities in between physician and nurses related to clinical ethical conflicts -all themes reflecting the core theme: <i>striving to do what is best for the patient</i></p>	<p>Strengths: -identified themes of ethical conflict that span clinical specialities, patient diagnoses, and specific treatment -relatively large number of participants for qualitative study -identifying similar themes between professions has positive implications for professional education</p> <p>Limitations: -results could differ in other areas of Canada or other countries -not generalizable</p>	<p>Conclusion: -study provides a framework for continuing education related to ethical conflicts in the clinical setting -the study provides a platform for future research on resolution of ethical conflicts, as well as way to mitigate conflict in clinical settings -facilitates a platform for studying other professionals in order to create interprofessional guidelines for resolution of ethical conflicts</p>

Literature Summary Table 2-Hurst et al.

Name, Author, Date, Study Objective	Sample/Groups (Size, Setting, Characteristics)	Design and Methodology	Key Results/Findings	Strengths/Limitations	Conclusion and Rating
<p>“Ethical difficulties in clinical practice: experiences of European doctors” Hurst, et al. (2007)</p> <p>Objective: To explore the types of dilemmas faced by European doctors, how they ranked the difficulty of these dilemmas, and their satisfaction with the resolution of an ethically difficult case.</p>	<p>Sample: -n-656 physicians (response rate 43%) -sample ranged from 28-82 years old</p> <p>Setting: - Physicians were practicing in Norway, Switzerland, Italy, and the UK. -All countries offer universal healthcare access</p> <p>Characteristics: -physicians specialized in general practice, or as general internists. -averaged 25 years in practice -random sample of 400 physicians from each country (proportional between specialties) -consent was received</p>	<p>Design and Methodology: -survey instruments were adapted, Ethics Experience Scale and Usefulness of Help Scale, to explore the types of ethical dilemmas faced. -questionnaire was piloted with a convenience sample and again with full sample. -questionnaire was self-administered.</p>	<p>Key Findings: -cultural difference may influence how physicians perceive ethical difficulties - the type of help needed did not vary markedly - ethical difficulty most often reported was uncertain or impaired decision-making capacity (94.8%) -as well as disagreement among caregivers (81.2%) and limitation of treatment at end of life (79.3%). -help Id’d: professional reassurance about decision (47.5%), specific advice (41.1%), weighing outcomes and clarifying issues (~36%).</p>	<p>Strengths -sample size produced significant findings related to ethical difficulties -opened up a discussion of cultural difference related to ethical difficulties -identified the need for increased support in the community healthcare setting -generalizable results to similar settings</p> <p>Limitations: -sample 84% men -physicians of European decent only -societal norms could influence male perspective on ethical difficulties</p>	<p>Conclusion: -ethical difficulties can be found in clinical practice in all of the countries surveyed - differences were noted in the kinds of dilemmas and their perceived difficulty -the kinds of help that physicians considered useful varied less -study concluded that outpatient medicine requires increased ethical support. - further development of clinical ethics committees need to consider outpatient practitioners.</p> <p>PHAC Rating: -Medium quality (B1 & B5) with no weak ratings</p>

Literature Summary Table 3- Leuter et al.

Name, Author, Date, Study Objective	Sample/Groups (Size, Setting, Characteristics)	Design and Methodology	Key Results/Findings	Strengths/Limitations	Conclusion and Rating
<p>“Ethical difficulties in healthcare: A comparison between physicians and nurses” Leuter, et al. (2017).</p> <p>Objective: To analyse knowledge in the ethical field and experience with and the propensity for using ethics consultations by nurses and physicians.</p>	<p>Sample: -351 nurses and 128 physicians</p> <p>Setting: -four central Italian Hospitals (ranging from a 40 bed to 317 bed capacity). -ethics approval received</p>	<p>Design: -a cross-sectional observational study was conducted on. A non-probabilistic sample.</p> <p>Methodology: -a validated semi-structured questionnaire was used -4 sections of questionnaire included: demographic information, knowledge in ethics field, experience in ethical issues, and propensity for ethics consultation -Descriptive analyses was performed for all data</p>	<p>Key Findings: -new technologies and new care methods have generated changes in health organizations -physicians face more relationship problems with increased medical decision making requirements -knowledge in ethics fields was better for physicians than nurses however nurses were found to have better judgement</p>	<p>Strengths: -first Italian study comparing nurses and physicians regarding ethical difficulties -highlights a need for more ethics specific training for physicians and nurses -highlights need for ethics consulting services to support field of care decision making</p> <p>Limitations: -non-probabilistic sampling -not generalization to a national stage -limited sample size</p>	<p>Conclusion: -results suggests that a consulting service could be valuable for both physician and nurse -basic and continued education related to the ethical fields would benefit both nurse and physician</p> <p>PHAC Rating: -High with no weak items noted</p>

Literature Summary Table 4-Orlowski et al.

Name, Author, Date, Study Objective	Sample/Groups (Size, Setting, Characteristics)	Design and Methodology	Key Results/Findings	Strengths/Limitations	Conclusion and Rating
<p>“Why doctors use or do not use ethics consultation”</p> <p>Orlowski, J. P., Hein, S., Christensen, J. A., Meinke, R., & Sincich, T. (2006)</p> <p>Objective: To determine factors that may influence doctors to request or not request ethics consultation.</p>	<p>Sample and Setting: -121 physicians at the University Community Hospital in Tampa, Florida</p> <p>Characteristics: -Demographic data was similar among respondents</p>	<p>Design and Methodology: -a survey questionnaire was developed and distributed to consenting physicians -two questionnaires were developed: one for physicians who used ethics consultation and one for those who did not -questions were arranged in a 5 pt Likert scale (from “strongly agree” to “strongly disagree” -data was analysed with the Wilcoxon test</p>	<p>Key Findings: -ethics consultations are used by doctors who believe in shared decision making. -doctors who did not use ethics consultations felt it was their responsibility to resolve issues with patients and families -those who did not use consultations also noted that they were proficient in ethics -non users felt it would be difficult for “outsiders” to fully grasp the ethical situation presented</p>	<p>Strengths: -first study to attempt to quantify and directly asses factors influencing ethics consultation -statistically significant findings</p> <p>Limitations: -response rate was modest -complicated questionnaire set up leading to difficult statistical analyses -slightly out of date (>10 years ago)</p>	<p>Conclusion: -this study brings to light the notion that shared decision making can increase the confidence of the patient and family involved in ethical conflicts -ethical consultation facilitated communication rather than impeding it</p> <p>PHAC Rating: -High with no weak ratings -statistically significant findings</p>

Literature Summary Table 5-Sorta-Bilajac

Name, Author, Date, Study Objective	Sample/Groups (Size, Setting, Characteristics)	Design and Methodology	Key Results/Findings	Strengths/Limitations	Conclusion and Rating
<p>“How nurses and physicians face ethical dilemmas- the Croatian experience” Sorta-Bilajac, et al. (2011)</p> <p>Objective: To assess nurses’ and physicians’ ethical dilemmas in clinical practice.</p>	<p>Sample: -survey included 140 physicians and 392 nurses (n=364, 68% response rate)</p> <p>Setting: -Clinical Hospital Centre Rijeka, Rijeka, Croatia</p> <p>Characteristics: -participants worked in Internal Medicine, Anaesthesiology and Intensive Care, and the Institute for Radiotherapy and Oncology -selection process intended to incorporate a variety of specialties in the survey</p>	<p>Methodology: -quantitative research -an anonymous questionnaire was used as the main survey tool -participants were clearly informed and the authors distrusted and collected the questionnaires -part one contained privacy and data confidentiality statement, part two was composed of questions on ethical dilemmas, part three was socio-demographic data -several scales were utilized to compile data -statistical significant findings P< 0.05</p>	<p>Key Findings: -primary ethical issue raised was related to <i>limiting life-sustaining therapy</i>, and <i>euthanasia and physician-assisted suicide</i> -Men tended to have higher satisfaction with resolution of the case -physicians sought support by obtaining more information about patient (50%) and clarifying ethical issues (39%) -nurses were similar however statistically significant difference related to nurses: more apt to talk through ethical issues with patients (30% vs. 21%) -Croatian health system still regards nurses as subordinates to physicians and this affects moral decision making</p>	<p>Strengths: -generalizable results to the mentioned specialization in Croatia -sample size produced statistically significant findings -identified ethical dilemmas present in every day practice</p> <p>Limitations: -not generalizable to other fields of practice or geographic areas -the attitude regarding status of nurses as subordinates may have affected results -questionnaire was designed with physicians as main respondents, could have alienated nurses -low response rate (39%)</p>	<p>Conclusion: -study yielded significant finding related to ethical dilemmas in every day practice -offered data to prove that clinical ethical consultations (CEC) are not being utilized by nurses or physicians -the use of the CEC would be indispensable to aide in ethical decision making -further work could be done to assess nurses and to facilitate a more integrated health team approach</p> <p>PHAC Rating: -High(B1 medium) -higher response rate needed</p>

Appendix B

Ethical Conflicts Experienced by Physicians in Community-Based Practice:

Practicum Research Report

For my practicum research project I developed and implemented a qualitative study to gain insight into the types of ethical conflicts physicians experience and how these are managed in a community-based practice. In this report, I present my research practicum project entitled *Ethical Conflicts Experienced by Physicians in Community-Based Practice*, undertaken in partial fulfillment of the requirements for the degree of Master of Nursing from Memorial University of Newfoundland. The findings from my research project will contribute to a larger study entitled *Clinical Ethics Committees and Ethical Conflicts in Community Health Care* that explores the ethical issues of physicians, nurses and patients along with the availability of ethics supports and services.

By conducting this qualitative study examining the ethical conflicts experienced by physicians in community-based practice, I made contributions toward filling the current gap identified in the literature. In this research report I will present the research process and the findings of this practicum research project. I will present the findings of my interview as well as a discussion specific to the challenges faced in qualitative research participant recruitment. This paper will begin with background information regarding the chosen research design and approach to the phenomena of focus.

Research Design

I selected a qualitative research design for my practicum research project; the use of qualitative inquiry as a research design ensures researchers can "...direct their attention to human realities rather than to the concrete realities of objects" (Streubert & Carpenter, 2011,

p. 20). In contrast to quantitative research, in which researchers use a rigorous and controlled design to investigate phenomena that can be precisely measured and quantified, qualitative researchers investigate phenomena in-depth and holistically using emergent and flexible research designs such as ethnography, phenomenology, descriptive, or grounded theory studies (Creswell, 2012; Polit & Beck, 2012).

Adopting a general perspective on the complexities of the world is the definition of a paradigm (Polit & Beck, 2012). That is, a paradigm for human inquiry consists of the ways in which a person responds to basic philosophical questions related to their experience of their reality. For the purposes of this practicum project, a constructivist (naturalistic) paradigm is most appropriate. When aligning with the constructivist paradigm one believes that reality is subjective and multi-faceted and not based on a cause and effect reality (Polit & Beck; Streubert & Carpenter, 2011). Utilizing an inductive, exploratory qualitative research approach puts an emphasis on the phenomena with a focus on the subjective experiences of the participants. By utilizing a small, information-rich sample with a narrative, semi-structured interview design the focus remains on the process as well as an in-depth understanding of the participants' experiences. The exploratory methodology is best utilized to facilitate the understanding of a "little-understood" phenomenon (Polit & Beck, p. 18).

Setting and Participants

This project was focused on community-based physicians working in Western Newfoundland. My intention was to recruit three to five participants with whom to conduct semi-structured interviews and collected data related to ethical dilemmas experienced by community-based physicians. I faced many challenges during recruitment, which I will

discuss within the body of this paper. As a result, I conducted only one interview prior to the required finish date for my practicum project. The interview was conducted, at a time convenient to the participant, via videoconference and was audio recorded.

My initial goal for my project was to conduct my data collection on the South Shore of Nova Scotia. I worked towards this goal with the assistance of Dr. Caroline Porr and Joanne Smith-Young throughout N6660 and into N6661. Although it ultimately would have been possible, the timeline for my practicum courses did not allow for the completion of this process. It was decided that my population of interest would be sufficiently comfortable with a videoconference interview.

Ethics Approval

The Health Research Ethics Authority (HREA) in Newfoundland and Labrador grants ethical approval for research projects. Ethical approval was then sought in Western Newfoundland. An amendment to the ethics approval for the *Clinical Ethics Committees and Ethical Conflicts in Community Healthcare* study was submitted to the HREA. The amendment received approval on June 20, 2017.

Participant Selection, Sampling, and Recruitment

Participants were recruited using purposive sampling. This is a method where the researcher selects participants based on their potential contribution to the research project (Polit & Beck, 2012). This method of recruitment is most appropriate for an exploratory research approach because it ensures the participants will in fact have an experience with the phenomenon being explored. For this practicum research project the participants must have experienced some type of ethical conflict while working in a community-based setting. My

goal as the researcher was to develop a rich or dense description of the culture or phenomenon of interest.

Upon receiving ethics approval from the HREA the recruitment process began. I distributed recruitment posters to participants via the mailboxes located in Western Regional Memorial Hospital (see Appendix A). Contact information was provided on the poster for community-based physicians to contact me if they were interested in participating. Thirty posters were distributed with only one response. Dr. Caroline Porr and a colleague located in Western Newfoundland reached out to their professional contacts with the poster. I did not receive any further interest from their recruitment efforts. I then contacted Judith Strickland (faculty member, Western Regional School of Nursing) who is a research assistant for the larger study to which my research practicum will contribute. Professor Strickland distributed the poster to two physicians as well as emailing the physicians' clinic secretaries directly. This effort did not yield any participants.

I feel I utilized all the recruitment approaches available to me and I found this process of my research project to be the most difficult. I had hoped to recruit at least three participants and found the inability to meet this low number very disappointing. Due to the fact that I only obtained interview data from one participant. I included in this paper a section about recruitment issues in qualitative research. Through my review of the literature on the topic of recruitment difficulties it can be concluded that my issues with recruitment are not a solitary case and this is pervasive issue in qualitative research.

Data Collection

Semi-structured interviewing. Researchers who use qualitative methods use several types of interview methods to collect data including unstructured interviews, semi-

structured interviews, focus group interviews, and joint interviews. Each method has different goals and potential outcomes associated with it (Polit & Beck, 2012). I used a semi-structured method for the interview as opposed to an unstructured or structured interview. Semi-structured interviews are used when a researcher wants to ensure a specific topic is covered with a topic guide while enabling the participants to speak freely and in their own words (Polit & Beck). My project was best suited to a semi-structured interview style because this allowed me to guide the session with a focus on the ethical conflicts faced by the physician. I also focused on how he/she managed these conflicts and moved from general to more specific questions. This interview method allowed the physician to share his or her story, experiences, perspectives, and to speak freely during the interview.

Semi-structured interviews are quite often the main source of data collection for a qualitative research project. They can be used in a one-on-one format or a group format (DiCicco-Bloom & Crabtree, 2006). In qualitative research this type of interview style focuses on a list of topics and/or open ended questions rather than a specific list of predetermined questions to ask. I prepared the interview guide and encouraged the physician to speak freely on the topic of ethical conflicts experienced in his/her community-based practice. The interview guide can be found in Appendix B. Utilizing this method of interviewing allowed the physician to tell about his/her experiences with ethical conflicts in his or her own narrative. Fully engaging in this type of interview method allowed for the best outcomes in the interview process. As the researcher I had an obligation to have a good understanding of the topic of ethical conflicts as well as be prepared with *probes* to facilitate the interview process (Hsieh & Shannon, 2005; Polit & Beck; Streubert & Carpenter, 2011). Examples of these types of probes that could be utilized are “Can you tell me how that made

you feel?” and “Can you tell me more about that experience?” By utilizing both open-ended and probing questions the physician had the opportunity to provide rich and detailed answers about the phenomenon under study, in this case ethical conflicts in their medical practice.

Consent. The consent form used in this project can be found in Appendix C. All data were stored on a password protected USB and were kept in a locked home office during the data analysis process. The consent form was created to ensure the participants were informed of the nature of the research, any potential impact on them, the procedure for data collection, any risks or benefits of participating, and the fact that they had the right to withdraw from the study at any time. Both the researcher and the participant read and signed this form prior to the interview.

Building Rapport. An essential aspect to this process was my ability to develop rapport with participants during the interview process. Rapport building involves developing trust and respect while also creating a space that is safe and comfortable for personal sharing (DiCicco-Bloom & Crabtree, 2006). This process of trust building will encourage honest and open sharing during the interview process (Streubert & Carpenter, 2011). DiCicco-Bloom and Crabtree offer several stages to rapport building. The stages are:

- 1. Apprehension:** I began the interview with the physician participant by posing broad and open-ended questions with a non-threatening tone. Follow-up questions were considered carefully during the rapport building stages with a focus on “unselfconsciously” sharing “in his or her words” (p. 317).

- 2. Exploration:** During the exploration phase I encouraged an environment of sharing, learning, and listening. I encouraged participant to become fully engaged in an in-depth description of their experiences with ethical conflicts.
- 3. Cooperation:** During this phase the goals are increased comfort and knowledge of one another. The more sensitive topics were explored during this third phase. I also utilized this time to clarify or probe further into some of the participant's descriptions in order to deepen my understanding of the participant's experiences.
- 4. Participation:** Depending on the interview and the process of rapport building this phase of "participation" may or may not be achieved. The participation phase demonstrates the deepest form of rapport building and at this point the physician participant may take on the role of guiding and teaching myself.

I recognized that as a novice research this type of interviewing and rapport building might not be fully accomplished. Acknowledging this fact I did attempt to create a safe and trusting environment during my interview. As a novice researcher, I prepared for the interview with DiCicco-Bloom and Crabtree's (2006) recommendations in mind and with the support and knowledge of my supervisor, Dr. Caroline Porr and support from Joanne Smith-Young, research coordinator (Memorial School of Nursing).

Qualitative Data Analysis

The purpose of qualitative data analysis (QDA) is to "organize, provide structure to, and elicit meaning from data" (Polit & Beck, 2012, p. 556). In exploratory qualitative research, data analysis begins with repeatedly reading all data to achieve immersion and achieve a sense of the whole. The researcher starts to identify common themes and concepts embedded within the narrative data. This process can take an extended period of time and is

identified in the literature as labour intensive (Chowdhury, 2015; DiCicco-Bloom & Crabtree, 2006; Hsieh & Shannon, 2005; Polit & Beck, 2012; Streubert & Carpenter, 2011). When using an exploratory research design, the researcher has the responsibility to describe and analyze the raw data to aide in the further understanding of a particular under-studied phenomenon (Polit & Beck; Streubert & Carpenter).

Although there are critiques of QDA, especially related to validity and reliability, it is important to note that if the qualitative researcher focuses on telling the story of the participants with “truthfulness and an attention to context and power” the evidence will be presented with authenticity, robustness, and validity (Chowdhury, Streubert & Carpenter, p. 52). One main strength of QDA is that, when done correctly, it has the ability to produce a “rich, detailed, and valid process data that usually leave the study participants’ perspectives intact with contextual consideration” (Chowdhury, p. 1138). This produces trustworthy and rigorous findings that aid in the validity of the results produced.

The interview was audio taped after the consent form was reviewed and signed by the participant. A verbatim account of the interviewee including “um” and “uh” or other such sounds during the interview was transcribed. When transcribing the interview and observations into text, I took note of any silence, sighs, laughter, posture, gestures and so forth, as these may influence underlying meanings (Graneheim & Lundman, 2004; Schreier, 2013). In order to ensure accuracy of transcription, I listened and re-listened to the interview while reviewing my notes and my written transcript. One suggestion I implemented was to add in notes to the transcriber “inaudible” or “go back to this section” to ensure I did not make errors or *accidental alterations of the data* (Polit & Beck, 2012). All data collected were stored on a private, password protected USB and kept in a locked office while data

analysis was being completed. I have also kept a copy of my handwritten notes and my coding process throughout the analysis process. In the next section I will review several common terms and strategies used to substantiate and evaluate research methods and findings as outlined by Byrne (2001).

Credibility. Another strength of QDA is the ability to demonstrate the credibility of the research findings. Byrne (2001) described the techniques to ensure credibility or rigour: first, researchers must be transparent with their qualifications, experiences and any bias that may have influenced interpretation of the data. Utilizing a credible research method, such as narrative interviews, also enhanced the trustworthiness of my research. By discussing my transcripts, research findings, and other relevant aspects of the data analysis process with my supervisor, I reduced the risk of bias and increased the validity of the findings (Byrne; Creswell & Miller, 2000).

Transferability. In quantitative research the generalizability, the ability to apply the results from a sample population to the population at large, of the research results is a common goal; however, in qualitative research, transferability, the extent to which the findings can be applied to other contexts, is used to predict the extent of the findings application to other settings (Byrne, 2001). To achieve transferability thick descriptions and purposive sampling are best used. To achieve a thick description the data must be richly detailed and the research audience must be able to adequately judge the emergent themes, categories, or constructs (Byrne, 2001). I utilized a purposive sampling method to recruit the physicians for this study. With my preliminary findings I hope to contribute to a deeper understanding of ethical conflicts experienced by physicians in community-based practice.

Confirmability. Byrne (2001) further describes techniques for ensuring rigour including confirmability or dependability by employing an *audit trail*. An audit trail will allow an independent examiner to examine all of the decisions made throughout the research process. Therefore the researcher must keep all data, transcripts, reports, and communication with peer debriefers and research participants organized and easily accessible. With only a small amount of data collected and analyzed this process was done on a smaller scale for my project.

Triangulation. Creswell and Miller (2000) note that validity can be further increased through the process of triangulation. This process involves searching for a “convergence among multiple sources of information to form themes or categories in a study” (p. 126). This type of data triangulation is an especially important step when it is the researcher who is responsible for both data collection and analysis.” (Creswell & Miller; Polit & Beck, 2012). Since my data analysis process did not involve extensive data, the process of triangulation was not utilized.

In this next section I present my use of qualitative content analysis to further delve into the analysis of my data.

Qualitative Content Analysis

Qualitative content analysis is a flexible method for systematically analyzing text data in a qualitative study when there is not a lot of knowledge on a phenomenon being studied (Elo & Kyngäs, 2007; Hsieh & Shannon, 2005; Schreier, 2013). Researchers Elo and Kyngäs’ approach was utilized to help guide and further explore my process for content analysis. Content analysis is the process of analyzing written, verbal, or visual communication. It has a long history of use in communication, journalism, sociology,

psychology, and business and has shown steady growth in use over the last few decades (Elo & Kyngäs). Content analysis can be utilized in both qualitative and quantitative data analysis. Schreier (2013) further defined the characteristics of qualitative content analysis as a way to reduce the data in a systematic and flexible manner.

The process of content analysis utilizing an inductive approach means that I took the data from the specific to the general; particular findings are observed or noted and then combined into a larger whole or general statement on the area being studied (Elo & Kyngäs, 2007). I used a conventional approach to content analysis which is best utilized within an exploratory study design and when literature is limited on the phenomenon. I utilized the phases of content analysis outlined by Elo and Kyngäs with further justification provided by Hsieh and Shannon (2005). The three phases for inductive conventional data content analysis are: preparation, organizing, and reporting. Each of these stages will be discussed in turn.

Phase One: Preparation

During the preparation phase there was a focus on data organization. It was important to ensure the transcript was complete and reviewed for errors during the preparation phase. The unit of analysis must be decided upon, and for the purposes of this project I utilized the whole interview to provide context during the analysis process. I examined latent content (e.g., sighs, silences, laughter, posture) to help me consider the underlying meanings within the words in my initial phase of content analysis as well as manifest content (words of the interview). During this phase I attempted to make sense of the data and attempted to completely immerse myself in the written transcript. Without this complete immersion into the data it would have been difficult to make sense of the data (Elo & Kyngäs, 2007).

Phase Two: Organizing

I utilized an inductive approach to content analysis, and therefore the organization phase began with *open coding*, *creating categories*, and *abstraction*. Open coding is a process of making hand written notes and headings during the reading of the transcribed text. These headings written in the margins of the transcripts were collected and put onto coding sheets. Categories were then created from these headings on the coding sheets and based on the different codes appropriate links were created (Hsieh & Shannon, 2005). These sub-categories were then grouped and put into generic categories so I could begin to describe the phenomenon and further my understanding of the topic. Ideally, there would be around 10 to 15 clusters to keep the clusters broad enough to sort a large number of codes (Creswell, 2007). Abstraction means that a general description of the research topic will be created through the generation of categories. Each category will be named using a content-characteristic word related to the broader categories. Next, sub-categories with similarities will be grouped together and then further grouped until main categories are established (Elo & Kyngäs, 2007; Hsieh & Shannon). Due to the fact that qualitative research often involves a large amount of data, this process requires diligence because all relevant aspects of the material must be included in a category. If necessary, a residual category, introduced to ensure all relevant material is covered by a category may be utilized; however, this should not be used often as it will decrease the validity of the findings (Schreier, 2013).

Phase Three: Reporting

The results of the coding process can be described as the contents of the categories (Elo & Kyngäs, 2007). Creating these categories can be both an empirical and a conceptual challenge. This required that I, as a novice researcher, formed categories that reflected the

ethical conflicts experienced by physician. The credibility of these findings will be demonstrated by how well the categories represented the data collected (Elo & Kyngäs, 2007). Documentation is crucial for the process of data analysis so the findings are consistent with the experience of the physician interviewed and that findings are consistent with the purpose of the research project. The knowledge generated from content analysis is based on the physician participant's unique perspectives and grounded in the data collected during the interview.

Research Practicum Project Findings

Since the recruitment process yielded only one interview, my findings are preliminary. A preliminary finding is that primary care physicians do experience ethical conflicts within their daily community-based practice. I will review the major categories identified during data analysis for my interview.

Sample Characteristics

The participant, aged in his/her mid-thirties, had worked in a community-based general practice for approximately 10 years in rural Newfoundland.

Types of Ethical Conflicts

Two major categories emerged from the data analysis regarding the types of ethical conflicts encountered in community-based medical practice: (1) ethical conflict from the type of care provided to patient/family, and (2) ethical conflict from role of living and working in a rural community.

Ethical Conflict Encountered in Community-Based Medical Practice. This type of clinical ethical conflict can be defined as the health professional experiencing a clash between his/her values and his/her perception of how patients are cared for and treated

(Gaudine, LeFort, Lamb, & Thorne, 2011). Examples of the type of clinical ethical conflict experienced in community-based medical practice are “designating a patient as incompetent” and “taking away their livelihood.” The interviewee noted that “taking away someone’s independence or livelihood” was never a decision that was made lightly and it was deemed to be a difficult personal (internal) conflict. This type of internal struggle was often experienced in solitude without the consultation of others. The physician noted that it was sometimes easier for the family if he/she was the “bad guy” instead of the family being involved in these highly emotional ethical situations.

The interviewee also noted that although they often makes these decisions without the consultation of others, he/she does feel that they can use a monthly medical journal club gathering to access his/her peers for further discussion on these challenging personal conflicts. For the ethical conflict examples noted, this discussion did not change the outcome of the clinical decision. However, it was noted that reassurance for decisions made or a different perspective for future personal conflicts were achieved through discussion with peers.

Ethical Conflict from the Role of Living and Working in a Rural Community

Although the clinical conflicts tended to elicit deeper ethical uncertainty for the physician, conflicts related to living and working in a rural community were a more frequent occurrence in his/her practice. Therefore the participant had to figure out how to manage these conflicts mostly through “trial and error.” One type of external conflict that occurred frequently in the small town where the physician’s clinic is based was “treating family and friends.” The interviewee found this particularity difficult when starting his/her practice as many family and friends would feel a clinical issue was something simple when it was in

fact more complicated. He/she stated he/she would “try to help as much as I can” and would say things like “I don’t know for sure but I can guide you or maybe ask a friend” to take them on as a patient. He/she noted that “if I saw something that I really thought was urgent...I would probably get the right professions involved because I have the ability to do that.” He/she noted that building rapport with other professionals in the community makes a huge difference during some of these situations.

Another subcategory identified was “dealing with medical questions in non-clinical settings.” The interviewee refereed to being shown moles in the grocery store and being asked at the soccer pitch “what do you think about this rash, doc?” He/she noted “I found the first five years really tough” however “the funny thing is you get used to it as long as they don’t mind, I always listen”. He/she would tell individuals a more confidential space could be provided for discussion if they made an appointment; sometimes they wanted to and sometimes they said they didn’t mind. A particularity difficult ethical case was described when a client came up to him/her at the gym and asked “Did you get the result back of my mammogram?”. He/she had received the result and it was in fact cancer. In that situation the physician did not feel it appropriate nor morally responsible to provide the truthful response and said “no, I do not know the result yet.” In some ways this example presented both an external and internal conflict as the interviewee had to make a decision that was best for his/her patient and considered his/her own moral compass as well.

Supports for Conflict Resolution

When asked “if there was a support person for ethical situations” or “if he/she had ever access the support of an ethics committee” the physician stated “no, and that he/she didn’t know” and he/she had never really asked anybody or inquired about an ethics

committee. The interviewee did note that the support of his/her peers during monthly meetings as well as some key members of the interdisciplinary community provides him/her with a small platform for ethical consultation. The physician stated that he/she has relied on public health nurses and social workers to discuss the management of certain cases. However, the physician did note that he/she was ultimately still making the final decision related to each ethically challenging situations.

Interprofessional Collaboration

One of the key findings that was noted in the literature review was a gap in support related to interprofessional collaboration. Several articles reviewed noted that when the professions are compared, as it relates to decision making in ethically charged situations, the hierarchical nature of the relationship between nurse and physician played a major role. This was noted in the literature review that physicians would take on more responsibility themselves to resolve the ethical issues including relying on their or experience, consulting literature on the topic, or communicating directly with the family. Due to the fact that the physician is often responsible for the final medical decision in the clinical setting, physicians often rely on their training and own analysis of the situation instead of reaching out for collaborative ethical support (Leuter et al., 2017; Orłowski et al., 2006; Sorta-Bilajac et al., 2011).

Similar findings were noted by the physician during the interview however, the physician noted that he/she would be interested in a more collaborative approach to ethical decision-making. The literature was supportive of this, noting that a collaborative approach to managing the ethical situation provides significantly more support than managing it without any support (Gaudine et al., 2011; Hurst et al., 2007; Leuter et al., 2017; Orłowski et

al., 2006; Sorta-Bilajac et al., 2011). When I mentioned some of the examples of an interdisciplinary team meeting to discuss ethically challenging situations and ways to manage them, the interviewee noted this would be very welcome in his/her practice and he/she would most certainly access this service.

I have presented the most significant findings from my interview above. I will now present a comprehensive discussion on the challenges in participant recruitment in qualitative research.

Research Practicum Project Discussion:

Recruitment Challenges

Recruitment of participants is a major component of conducting a research study. Recruitment requires significant effort and resourcefulness however, there appears to be very little guidance for researchers, especially novice researchers like myself (Hysong et al., 2013; Jessiman, 2013). I set out to recruit three to five participants for my small scale, qualitative research study. To be quite honest, it did not occur to me that I would have difficulty recruiting such a small number of participants in my local community. Due to issues with ethical approval in Nova Scotia and the timelines of the program, I decided to complete my study in Newfoundland. I felt the recruitment would be completely feasible from a distance and could rely on a colleague to help distribute my posters. After a month of active recruitment as reviewed above, I was only able to recruit one participant and complete one interview. These difficulties prompted me to examine the literature on the topic of recruitment challenges faced in qualitative research. I was surprised to find that the literature backed up my experiences and thoughts regarding my difficulties recruiting physicians. Jessiman also noted that there needs to be more discussion on recruitment

difficulties to better support researchers during the recruitment phase of a small-scale qualitative research project. Since ninety percent of patient contact is occurring in a primary care setting, primary health care settings are an important setting for research. Without effective recruitment strategies, primary health care will remain an under-studied area of health care (Jessiman).

I will discuss my findings related to recruitment for small-scale qualitative research and then discuss my findings related specifically to recruitment of clinical personnel for qualitative research. I will conclude with a discussion about what could be done in the future to ease the burden of this process for researchers.

Recruitment Challenges: Small-Scale Qualitative Research

In order to increase my knowledge regarding qualitative recruitment, I reviewed the participant, discussion, and limitation sections of approximately 10 research articles utilized for my literature review. There were a variety of different sized participation groups however, very little was written about the recruitment process. Many of the studies described the participants in great detail including demographics and other specifics depending on the population and research study. I found no descriptions of the recruitment process itself and no information regarding difficulties in recruitment except a mention of sample size as a limitation of the findings of three of the studies.

Until this review of the participant sections of 10 studies, I had not realized that issues with recruitment in qualitative research are not often discussed. Researchers need to be more aware of the issues that could arise during the recruitment component of their study (Jessiman, 2013). By beginning this discussion related to these issues I hope to help my colleagues to have a more successful recruitment process especially as novice researchers.

Jessiman presented a study that aimed to review the strategies for successful recruitment by exploring methods used in a variety of different studies. Jessiman felt practical guidance for researchers could help them to devise a more efficient strategy for an effective recruitment process. I noted that the studies reviewed for the author's article also found that recruitment challenges were seldom reported nor were approaches of recruitment that were particularly successful. If more information about recruitment were presented in qualitative research publications, researchers would be able to benefit from the descriptions of either successes or failures of certain recruitment strategies. From my perspective it would seem appropriate to include this in the recruitment/participant section of the research article or even in the discussion or limitation section. By discussing these challenges the same mistakes and frustrations could be avoided for future researchers.

Jessiman (2013) was interested in recruitment for small, qualitative studies. However, she concluded that her paper raised broader issues about the recruitment of participants in all types of research. Considering the fact that recruitment has a direct implication on the trustworthiness and dependability of the data and findings of all research projects, it only makes sense that researchers share these experiences with one another. Jessiman recommended researchers include a formal evaluation of their recruitment strategies in the body of their research report. In the next section, I will continue with a discussion on recruitment issues specific to clinical personnel.

Challenges Recruiting Clinical Personnel

Hysong et al. (2013) and McKinn, Bonner, Jansen, and McCaffery (2014) presented two very relevant articles on the topic of recruiting clinical personnel for qualitative research studies. The recruitment of clinicians for qualitative studies is vitally important to continue

to improve healthcare quality, however enrolment of clinicians, specifically physicians, can be very difficult. Hysong et al. noted that clinical personnel are important sources of data but in addition they are also vital stakeholders and resources for the implementation of interventions based on research evidence. Clinicians' time is increasingly limited and researchers need to realistically think about their access to a population that is often stressed. In particular, physicians who are paid for each service they provide and are not on salary may be particularly reluctant to participate in research. Hysong et al. reported the results of one study conducted by Solberg (2006) that proposed seven factors that researchers must keep in mind to maximize participation by entire medical groups; however, achieving a 100% participation rate requires "herculean efforts not often included in the timeline or budgets of research proposals" (p. 2).

Recruiting clinicians as participants often takes far longer than expected, which can lead to altered timelines further affecting budgets, and occasionally altering research findings. Barriers can exist from gaining entry to clinics or facilities, making contact with busy clinicians, encouraging candidates to participate, and scheduling for interviews or data collection (Hysong et al., 2013). Obviously, tactics for recruitment will vary significantly based on the project, objective, and area of practice of the clinicians. Mentioning a list of barriers does not help in relation to tools and guidance for researchers. I would like to propose a combination of information from the articles to identify what could be done differently in order to more effectively guide researchers in the recruitment process.

Recruitment Strategies Framework

From the articles I reviewed for this discussion, I realize that researchers need the resources to help them recruit participants for qualitative studies. As Jessiman (2013)

concluded “researchers should be encouraged to include a formal evaluation of the recruitment strategies in their studies” (p. 18). Hysong et al. (2013) concluded that a proper framework and metric would provide an “empirical basis for estimating research recruitment timelines, planning subject-recruitment strategies, and assessing the research accessibility of clinical sites” (p. 7). The conclusions drawn by McKinn et al. (2014) were more tangible and noted that mail invitations and in-person physician recruitment were both viable methods of recruitment and more time and cost effective than newsletters and conference satchel inserts.

I feel the most useful tool for future researchers would be to present the recruitment section like the methods or findings sections of a research report. This would provide more detail that could include a full description of time committed, tools utilized, and successes or limitations of attempted recruitment methods. Due to the fact that recruitment strategies will vary from project to project, it is not possible to present one recruitment strategy for researcher use. However, if recruitment were described in research articles, then other researcher may be more apt to consider their recruitment timelines and possible barriers to recruitment at the beginning of their project. As Hysong et al. (2013) noted the more stable the estimates of recruitment time, the more researchers can plan based on the experiences of other researchers. After a number of research publications included a description of recruitment, it would be valuable to do an updated literature review on recruitment methods and compile an expanded list of successful and unsuccessful recruitment methods to build on the work of Jessiman (2013).

Concluding Remarks

In conclusion, by conducting this research practicum project, I was able to make several contributions. I presented a comprehensive review of the literature related to ethical dilemmas experienced by physicians in community-based practice, a detailed methodological approach to my study and my data analysis for the one interview that I was able to conduct. Further, because I faced difficulties with recruitment, I summarized literature on the topic of recruitment for qualitative studies and made the recommendation that qualitative research include a discussion of their recruitment challenges and successes in their publications. I hope that through describing recruitment strategies including recruitment successes and challenges, qualitative researchers will develop knowledge about best practices for recruitment.

This practicum research project led to improvement of my skills as a researcher. The knowledge and skills that I have gained throughout this process will help me as an advanced practice nurse. I have demonstrated through this practicum my ability to write a research proposal, submit an application for ethics approval (via two different ethics bodies), conduct a qualitative interview, transcribe and analyze qualitative research data, and write a report of my findings. As a nurse who had never conducted research, I sought this learning opportunity to increase my knowledge and competence base in research. This knowledge will be an advantage as I expand my career options and work towards a position in nursing education.

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Appendix A



RESEARCH STUDY:

ETHICAL DILEMMAS EXPERIENCED BY PHYSICIANS IN COMMUNITY-BASED PRACTICE

We would like to talk to physicians about ethical concerns they have experienced while providing care in the community setting.

The interview will take approximately 30 minutes and will be conducted via FaceTime or Skype and will be audio-recorded.

If you would like to participate, or want more information about the study, please contact:

Susan Moore, BN, RN, MN (student)

Email: susan.moore@mun.ca

Phone: (902) 456-0059

Appendix B

Interview Guide (for Physicians working in Community Health)

Demographics:

- Gender
- Age
- Province
- Name of employer or organization
- Tenure in organization
- Position in organization

Interview Probes:

- 1) Please describe an ethical conflict you have experienced within your community based practice?
 - How did you manage that conflict?
 - How did you feel when you experienced that ethical conflict?
- 2) Please describe an ethical conflict you have experienced with your organization's policies, values, procedures, or regulations?
 - How did you manage that conflict?
 - How did you feel when you experienced that ethical conflict?
- 3) Do you talk to anyone else about the conflict(s)? If so, how did that help you (or not)?
- 4) Have you ever used an ethics committee to help manage an ethical conflict?
 - How did you find this experience? Was it useful?

Note to interviewer: Describe the process the physician followed – (i.e. self-talk, seeking, mobilizing resources, strategizing...)

Appendix C Consent Form

Consent to Take Part in Research [Community Health Physicians]

RESEARCH PRACTICUM TITLE: Ethical conflicts in community-based health care: A qualitative study of physicians' experiences in providing care within the community

PRINCIPAL INVESTIGATORS: Drs. Alice Gaudine and Caroline Porr

You have been invited to take part in a research study. It is up to you to decide whether to be in the study or not. You can decide not to take part in the study. If you decide to take part, you are free to leave at any time.

Before you decide, you need to understand what the study is for, and if there are risks, and what benefits you might receive. This consent form explains the study.

Please read this carefully. Take as much time as you like. If you like, take it home to think about for a while. Mark anything you do not understand, or want explained better. After you have read it, please ask questions about anything that is not clear.

The researcher will:

- Discuss the study with you.
- Answer your questions.
- Keep confidential any of your information.
- Be available during the study to deal with problems and answer questions.

1. Introduction/Background:

There has been little research on ethical conflicts related to health care in the community. There have also been few studies conducted that have included physicians to investigate if they experience any ethical concerns when providing care outside of the hospital setting. Since more and more health care is being provided in the community, this is an important issue to study.

2. Purpose of study:

The purpose of this study is to describe the ethical conflicts of physicians related to providing health care in the community. Another purpose is to look at what physicians find helpful in dealing with ethical conflicts in the community setting.

3. Description of the study procedures:

If you agree to be in the study, you will participate in an interview via Skype that will be audio-recorded that will last about 45 minutes to 1 hour. You are free not to answer any question or to stop the interview at any time. The interview data collected up to the time you leave the study will be used by the researchers.

4. Length of time:

It is anticipated that the interview will last about 45 minutes to 1 hour.

5. Possible risks and discomforts:

The only anticipated risk is that you may become upset when discussing ethical conflicts. If this occurs, we will stop the interview and continue only when and if you feel ready to continue. At your request, we will assist you to find medical help.

6. Benefits:

It is not known whether this study will benefit you.

7. Liability statement:

Signing this form gives us your consent to be in this study. It tells us that you understand the information about the research study. When you sign this form, you do not give up your legal rights. Researchers involved in this research study still have their legal and professional responsibilities.

8. What about my privacy and confidentiality?

Protecting your privacy is an important part of this study. Every effort to protect your privacy will be made. However it cannot be guaranteed. For example we may be required by law to allow access to research records.

When you sign this consent form you give us permission to:

- Collect information from you
- Share information with the people conducting the study
- Share information with the people responsible for protecting your safety

Access to records

The members of the research team will see study records that identify you by name. Other people may need to look at the study records that identify you by name. This might

include the research ethics board. You may ask to see the list of these people. They can look at your records only when supervised by a member of the research team.

Use of your study information

The research team will collect and use only the information they need for this research study. This information will include your:

- Age
- Gender
- Information from your study interview

Your name and contact information will be kept secure by the research team in Newfoundland and Labrador. It will not be shared with others without your permission. Your name will not appear in any report or article published as a result of this study.

Information collected for this study will be kept for five years after the publication of the study in an academic journal.

If you decide to withdraw from the study, the information collected up to that time will be used by the research team. This information will only be used for the purposes of this study.

Information collected and used by the research team will be stored at the Nursing Research Unit, School of Nursing, Memorial University of Newfoundland, St. John's, NL. Joanne Smith-Young (Nursing Research Unit Coordinator) is the person responsible for keeping it secure.

Your access to records

You may ask the study researchers to see the information that has been collected about you.

9. Questions or problems:

If you have any questions about taking part in this study, you can meet with the investigator who is in charge of the study at this institution. That person is: Dr. Alice Gaudine.

Principal Investigator's Name and Phone Number

Dr. Alice Gaudine
Tel: 709-777-6972
Email: agaudine@mun.ca

Or you can talk to someone who is not involved with the study at all, but can advise you on your rights as a participant in a research study. This person can be reached through:

Ethics Office
Health Research Ethics Authority
709-777-6974 or by email at info@hrea.ca

Study involvement includes:

One interview via Skype that is audio-recorded.
After signing the consent form you will be given a copy.

Signature Page

Study title: Ethical conflicts in community-based health care: A qualitative study of physicians' experiences in providing care in the community

Name of principal investigator: Dr. Alice Gaudine

To be filled out and signed by the participant:

Please check as appropriate:

I have read the consent. Yes { } No { }

I have had the opportunity to ask questions/to discuss this study. Yes { } No { }

I have received satisfactory answers to all of my questions. Yes { } No { }

I have received enough information about the study. Yes { }

No { }

I have spoken to **[the research assistant]** and she has answered my questions. Yes { } No { }

I understand that I am free to withdraw from the study: Yes { } No { }

- at any time
- without having to give a reason

I understand that it is my choice to be in the study and that I may not benefit. Yes { }

No { }

I understand how my privacy is protected and my records kept confidential. Yes { }

No { }

I agree to participate in an interview via Skype that will be audio-taped. Yes { } No { }

I agree to take part in this study. Yes { } No { }

Signature of participant Name printed Year/Month/Day

To be signed by the investigator or person obtaining consent

I have explained this study to the best of my ability. I invited questions and gave answers. I believe that the participant fully understands what is involved in being in the study, any potential risks of the study and that he or she has freely chosen to be in the study.

Signature of investigator Name printed Year/Month/Day