Ethical Conflicts in Community-Based Health Care

by © Sarah E. Messervey

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Abstract

In this practicum report, I describe my research practicum focused on ethical conflicts experienced by community-based nurses working in the province of Newfoundland and Labrador. This research-based practicum project is situated within, and will contribute to, a larger grounded theory study entitled *Clinical Ethics Committees and Ethical Conflicts in Community Health Care* (Dr. Alice Gaudine and Dr. Caroline Porr, co-principal investigators). My overall goal was to conduct a qualitative research project to gain valuable experience with qualitative research methodology, namely interviewing and analyzing qualitative data. Five nurses were interviewed about ethical conflicts encountered in community-based health care. I employed the technique of qualitative content analysis to sort through and analyze the qualitative data derived from my interviews with community-based nurses. Several predominant categories emerged from the data: types of ethical conflicts, strategies used to manage conflicts, supportive factors, and barriers. I discuss these categories in detail within this report, including theoretical conjecture based on Greenberg and Edwards' (2009) *Voice and Silence in Organizations*. I also put forth recommendations for nursing research, practice and administration based on my project findings. Finally, I discuss the advanced nursing practice competencies achieved through completion of this research practicum project.

Acknowledgements

I would like to take the opportunity to recognize and extend my heartfelt gratitude and appreciation to my practicum supervisor, Dr. Caroline Porr. I cannot thank you enough for your support and guidance throughout my practicum experience. You are truly a one-of-a-kind individual, who has gone above and beyond what I ever expected from a supervisor. You are an amazing asset to the profession of nursing and I could not have done this without you.

I am also forever grateful to Joanne Smith-Young, Nursing Research Unit Coordinator at the Memorial University School of Nursing, for her assistance and guidance throughout this practicum. You have provided me with fantastic resources and additional support. You are a fantastic nurse researcher!

A special thank you to the community health and public health nurses who gave me their time and input for my inquiry. You are strong client advocates, and the nursing profession is lucky to have you. Your insight into ethical conflicts in community care has seen eye-opening, and I could not have completed this practicum without you.

Finally, I would like to thank my parents, Lorne and Kathy Messervey, for their continuous love and support. Without you both, I could never have gotten this far. I am so proud to share my accomplishments with you.

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Practicum Context

> Ethics is not definable, is not implementable, because it is not conscious;
> it involves not only our thinking, but also our feeling.
>
> --V. W. Setzer, 1998

In this report, I outline and discuss the details of my research-based practicum project entitled *Ethical Conflicts in Community-Based Health Care*, undertaken in partial fulfillment of the requirements for the degree of Master of Nursing from Memorial University of Newfoundland. This practicum project is situated within, and will contribute to, a larger grounded theory study entitled *Clinical Ethics Committees and Ethical Conflicts in Community Health Care.* I describe my project, including objectives and outputs; study background, purpose and methodology; and, how I achieved advanced nursing practice competencies through the completion of this practicum project.

I chose to complete this research-based practicum project because I have had a keen interest in research dating back to my undergraduate studies. I sustained a career altering injury in 2014, which left me out of clinical practice for several years. It was during this time that I replied to a message sent out to the Master of Nursing class, seeking research assistance for an ethics study. The topic immediately caught my attention. Ethics and ethical conflicts within health care, namely nursing, have been severely under researched, but it is my experience, and that of colleagues, that ethical conflicts can adversely affect the delivery of health care, and can contribute to dissatisfaction with nursing practice. I met with one of the co-principal investigators (Dr. Alice Gaudine) of the larger grounded theory study and indicated my interest in participating by taking on the topic as a research practicum project.

Rationale

The climate of health care is shifting, focusing on fiscal responsibility and the increased care needs of rapidly aging populations with many comorbidities. As a result, many changes have been made to how health care is provided within Canada and worldwide (Asahara et al., 2013; Pavlish, Brown-Saltzman, Hersh, Shirk, & Rounkie, 2011). The length of stay for in-hospital treatment has significantly decreased, with many care activities moved to outpatient settings, such as community clinics, or the home. Combined with rapidly aging populations, this means that a large percentage of health care is now provided by community-based nurses across a broad geographical range. Community-based nurses are faced with a number of challenges in the workplace, including scarcity of resources, disagreement with organizational policies, conflicts of interest with clients and families, and lack of respect for the profession (Gaudine, LeFort, Lamb, & Thorne, 2011). However, because this area has not been extensively researched, we know very little about what types of ethical conflicts exist in the community setting, and how community-based nurses manage these conflicts. Traditionally, research has focused on the acute care setting (e.g., palliative care, oncology, intensive care) when examining ethical issues for nurses. However, many ethical issues experienced by acute care nurses are also experienced by community health nurses as well.

When ethical conflicts occur within the confines of a hospital, nurses have the opportunity to access ethics committees or additional ethics services, however, in the community setting this is less likely (Moore, 2000). Nurses working in the community setting may feel isolated and alone, without formal support such as ethics committees, or

informal support such as colleagues and other nurses. It is essential we understand the ethical conflicts nurses face in the community setting, what strategies (if any) they employ to manage these conflicts, and what kinds of supports should be recommended to improve quality of work life for nurses working in this field.

Practicum Objectives

For this practicum project, my overall goal was to actively participate in a research study to gain valuable experience with the qualitative research methodology, namely conducting interviews and analyzing qualitative data. To achieve these goals, I completed the following objectives:

1. Obtain ethics approval to interview participants, as a graduate research assistant with the larger grounded theory study, from the Health Research Ethics Authority.
2. Recruit a minimum of five study participants.
3. Conduct a minimum of five semi-structured interviews with eligible study participants to gain competence with interviewing skills
4. Transcribe and analyze interview data following completion of interviews.
5. Submit an interim report of practicum progress at the end of the fall semester and complete a final practicum project report at the end of the winter semester.
6. Contribute to the manuscript for publication when the larger grounded theory study has concluded (date yet unknown).

Additionally, I presented my interim research findings alongside my practicum supervisor, Dr. Caroline Porr, at the Nursing Education and Research Council 12th Annual Research Symposium on May 12th, 2016. Presenting at the research symposium

was an excellent opportunity to develop oral presentation skills and to disseminate my findings to a broad audience.

Literature Review

A broad search of the literature was conducted using the CINAHL, Pubmed and Cochrane databases (see Appendix C). Search terms included *ethics, ethical conflict, ethical dilemma, community health, community health nursing, public health nursing,* and *nursing ethics*. These search terms were used alone and in combination with one another in the search for scholarly articles pertaining to ethics, ethical conflict and community-based health care. In the last ten years, approximately 342 multidisciplinary articles were written on the topic of ethics in community-based health care. Nursing-specific articles comprised 110 of the 342. Unfortunately, many of these articles were informative or opinion articles, rather than research studies. The literature covering ethical conflicts and nursing ethics was based primarily in the acute care setting. Little attention has been paid to ethics within the community setting, nor has the literature comprehensively examined ethics and ethical conflict among community-based nurses. While both quantitative and qualitative studies were retrieved, the majority of studies were descriptive studies using a qualitative research design. This is not surprising given that the topic of ethical conflicts, specifically in community-based health care, is a relatively new topic for researchers. Most of the quantitative studies examining ethical conflicts were cross-sectional studies that sought to develop tools for empirically testing ethical and moral distress among nurses. Key themes that emerged from the multidisciplinary literature include: nursing ethics; ethical issues in practice (hospital setting, community setting); ethical dilemmas;

stress and burnout; and, implications of the current ethics literature for future nursing research, administration, and, practice.

Nursing Ethics

Nurses are guided in practice by personal values and beliefs about what is right or moral. These personal values and beliefs comprise each nurse's sense of morality, consequently influencing their decision-making capabilities and their reaction to problems. While morality refers to individual values and beliefs, "ethics" may be used to describe moral issues in a broader sense. Nursing ethics is based on both professional and personal commitments, including rights, duties and responsibilities. Such ethics lay down the values and principles that regulate the conduct of nurses in relation to their clients, colleagues, other professions and nursing organizations (Kangasniemi, Pakkanen, & Korhonen, 2015). The aim of nursing ethics is to protect clients and give nurses the guidance they need to practice competently and in the best interests of clients and their families. Ethics in nursing is often articulated in codes of ethics (i.e., the Canadian Nurses Association Code of Ethics for Nurses) which reflect shared international values. The ethical principles, or rules guiding the practice of nursing, include nonmalificence, beneficence, autonomy, and justice (Beauchamp & Childress, 1979). These principles are reflected in virtually every nursing code of ethics the world over.

Traditionally, nurses have been responsible for acquiring professional ethics through education and clinical practice; however, nurses are increasingly voicing difficulty in practicing ethically due to limited resources, increased workloads and inadequate supports (Kangasniemi, Pakkanen, & Korhonen, 2015). Nurses who provide

community-based health care services must uphold the same ethical principles and standards for practice as those working in the hospital setting, yet community-based nurses are faced with unique challenges such as coverage of broad geographical areas, poor resource allocation, working alone or in isolation, and intrusion of privacy when care is provided in the client's home. It is imperative that ethical issues in the community setting be closely scrutinized so that we gain a deeper understanding of how to better anticipate these issues, and provide sufficient support to community-based nurses.

Ethical Dilemmas

Ethical dilemmas occur when there are conflicting values or beliefs about what is the right or best course of action in a given health care situation. Conflict may transpire between two or more of the ethical principles, and it is likely that any possible solution to the conflict may result in undesirable outcomes for those involved (Ham, 2004). According to Beauchamp and Childress (1979), ethical dilemmas exist in two forms. Firstly, an ethical dilemma exists when a nurse is faced with an act that can be considered both morally right and morally wrong, and where there is questionable evidence for either choice. Secondly, an ethical dilemma exists when a nurse feels morally obligated to perform two or more nursing actions, but is unable to do both at the same time. The nurse must choose what to do first as a priority, but the "best course" of action may be unclear. Ethical dilemmas have become increasingly common in today's health care setting. Many nurses may be unaware of the subtle ethical conflicts existing in everyday practice (Varcoe et al., 2004). Nurses become increasingly tense and frustrated with their practice, experiencing low job satisfaction and compromised work relationships with both co-

workers and clients. Many nurses feel powerless when confronted with ethical dilemmas (Pavlish et al., 2011), leading to frequent stress and eventual burnout (Wlodarczyk & Lazarewicz, 2011). The need for quality nursing research that examines nurses' voices in ethically conflicting situations cannot be understated.

Moral Distress

Moral distress was initially coined by Jameton (1984), who defined the term as a disequilibrium experienced by an individual when he or she feels that they are forced into taking an action that they know to be inappropriate. The Canadian Nurses Association (2003) defines moral distress as that which arises "when one is unable to act on one's ethical choices, when constraints interfere with acting in the way one believes to be right" (p. 2). Moral distress can be related to the experience of an ethical dilemma, for which there is no foreseeable option that satisfies one's moral principles (Cohen & Erickson, 2006; Kopala & Burkhart, 2005). As previously indicated, ethical dilemmas occur when one's personal values or beliefs conflict with the available choices for action in a given situation. In such cases, nurses are required to examine the available courses of action from an ethical perspective, in order to determine whether or not a given action is the best choice. Moral distress occurs when the nurse is unable to carry out his or her chosen ethical action, due to any number of constraints (Kopala & Burkhart, 2005). Experiences of moral distress do not need to be verbalized. They can be apparent in an individual's actions or inactions, or in one's overall emotional state. There may be emotional or physiologic symptoms associated with moral distress, such as tension, frustration, depression and anger (Brown, 2015; de Veer, Francke, Struijs, & Willems, 2013). Moral

distress can be further exacerbated by lack of perceived support, time constraints and legal issues. Moral distress can be directly attributed to nursing burnout and turnover (Wlodarczyk & Lazarewicz, 2011).

Stress and burnout. Research indicates that the immediate and ominous consequences of moral distress include blame; self-criticizing; feelings of anger, guilt, remorse, frustration, sadness; withdrawal from clients and colleagues; avoidance behaviors; powerlessness; and, aggression (Dahl, Clancy, & Andrews, 2014; Edwards, Burnard, Coyle, Fothergill, & Hannigan, 2000; Ives & Melrose, 2010; McTiernan & McDonald, 2015; Samuelson, Willén, & Bratt, 2015; Solum & Schaffer, 2003; Sturm, 2004; Wlodarczyk & Lazarewicz, 2011). When nurses' values and beliefs conflict with the realities of the job, they experience distress (Nathaniel, 2006). This distress may linger for many years, contributing to loss of nurses' integrity and dissatisfaction for the work that they do. It is no surprise, then, that moral distress also causes issues with client care delivery, affecting the quality, quantity and cost of nursing care (Corley, 1995; Hamric, 2000; Redman & Fry, 2000).

Ethical conflict is an important topic within health care because the experience may lead to adverse outcomes for individuals, organizations, professions and society as a whole. The adverse outcomes of ethical conflict include nurse burnout and turnover, and decreased morale. These concepts have been studied in the nursing literature for some time (Gaudine & Thorne, 2000; Yarling & McElmurry, 1986). More recently, a longitudinal study of Canadian nurses found that experiencing ethical conflict in the workplace was associated with increased stress, absenteeism, and turnover intent

(Gaudine & Thorne, 2012); however, there is little documentation of how ethical conflict affects community-based nurses. This represents are area towards which future research efforts should be directed.

Methods

Qualitative inquiry as a research method has been gaining ground since the 1990s as an alternative to the traditional quantitative, or scientific, method of inquiry. Quantitative methods are rooted in the postpositivist perspective (Creswell, 2003), where investigators employ strategies of inquiry (i.e., cause and effect, hypotheses and variable measurement, theory testing, experiments) which yield statistical, scientific data. However, the quantitative method is inappropriate for gaining an understanding of the meanings of individual or group experiences, nor is it appropriate for exploring new, emerging phenomena for which the literature offers insufficient information.

In contrast to the quantitative approach, qualitative research entails the use of strategies of inquiry such as narratives, phenomenologies, enthnographies, or case studies (Creswell, 1998). Investigators involved in qualitative research studies do not propose hypotheses or establish variables to be manipulated or measured. Qualitative research methods are concerned with the understanding of subjective human experiences using non-statistical methods of analysis (Crowe, Inder, & Porter, 2015). Qualitative research is linked to naturalistic inquiry, exploring the multitude of complex experiences of human beings. Researchers conducting qualitative studies seek to establish the meaning of a given phenomenon from participant experiences (Creswell, 2003). To do this, researchers must identify a particular group to be examined, for example, community-based nurses.

Four basic types of information may be collected from participants in a qualitative study: observations, interviews, documents, or audio-visual data. The type of information, or data, collected will depend on the qualitative approach used.

Many strategies exist for qualitative inquiry, ranging from basic, exploratory studies to more complex, multi-faceted qualitative studies. A basic, exploratory design does not aim to provide final or conclusive answers to research questions, but merely explores the research topic with varying levels of depth (Polit & Beck, 2012). As a beginning researcher examining a topic which has seen little attention in the multidisciplinary research, an exploratory design was the most appropriate to address my research questions. I used a qualitative, exploratory research design situated within the aforementioned larger study, using semi-structured interviews to collect the data required to address my research questions.

Setting

This project was centered on community-based nurses working in Newfoundland and Labrador. Interviews were conducted in participants' homes, offices, or in one case, a local coffee shop. All interviews were conducted in-person, though the option of a phone interview was provided. Participants chose the time and place for the interview, based on personal preference and availability. For two of the interviews, I drove out of town to a rural community health office to meet with participants.

Participant Selection, Sampling and Recruitment

Purposive sampling was used to recruit participants for this practicum project, an exploratory inquiry of ethical conflicts in community-based health care. The purposeful

selection of participants represents a distinctive process in qualitative research (Creswell, 1998). The objective of purposive sampling is to *purposefully* select participants who will provide the researcher with the best understanding of the research phenomenon, and who can provide the necessary data to address the research question(s). In this exploratory inquiry, eligible participants must have experienced ethical conflict over the course of their practice. Otherwise, they would have been unable to provide me with sufficient data to answer the research questions: "What types of ethical conflicts exist in community-based health care?" and "What strategies, if any, are used to manage ethical conflicts in community-based health care?"

Participants in this project were limited to community-based nurses. A recruitment flyer was distributed throughout Easterners Health locations in the St. John's region. Contact information was provided on this flyer and any community-based nurses interested in participating in my practicum project were encouraged to call the number located on the flyer. However, I found that the distribution of flyers was ineffective in recruiting nurses. Instead, I sought help from my practicum supervisor, Dr. Caroline Porr. Dr. Porr put me in contact with a nursing manager in the community who distributed a recruitment message by electronic mail that I had drafted. This resulted in approximately ten nurses responding with interest in participating. My goal was to recruit five to ten participants, fitting into the larger study participant total of 30 to 40 individuals. I found recruitment to be the most challenging part of this practicum project.

"Assertive tracking" (Patel, Doku, & Tennakoon, 2003, p. 235) is a technique where researchers, essentially, do not "give up" after an initial unsuccessful attempt to

recruit a potential participant. This technique posits that all attempts to recruit participants should be followed up on, using various methods of communication (e.g., telephone, electronic mail, word of mouth). Initially, there were ten potential participants who had expressed interest; however, five out of those ten were unsuccessfully recruited after multiple attempts. One of the five who had initially expressed interest cancelled the interview at the last minute on several occasions, and eventually did not respond to any of my follow-up attempts to reach her. Another one of the five later indicated that she did not wish to participate, and the remaining three were unable to participate at the present time but allowed me to pass on their contact information for the future.

Recruiting participants is described as an "emotionally turbulent and maturing experience for a junior researcher" (Patel et al., 2003, p. 236), and I wholeheartedly agree with that statement. It was frustrating and exhausting at times, especially when potential participants cancelled at the last minute when I had prepared for the interview, booked an interview time and space, and took time out of a busy workday to accommodate their schedule. However, with the five completed interviews, I believe I was able to obtain the necessary data, and more, to adequately address the research questions. This entailed long drives out of town to meet with participants in rural areas, and even longer nights spent listening to interview data, transcribing the interviews, and reading and rereading transcripts. However, I am eternally grateful to those community-based nurses who provided me with thoughtful insight into the ethical challenges of their practice.

Ethical Considerations

Ethics approval for any research project must be sought prior to initiation. In the province of Newfoundland and Labrador, ethics approval is granted by the Health Research Ethics Authority (HREA). An amendment to the ethics approval for the *Clinical Ethics Committees and Ethical Conflicts in Community Health Care* study was submitted to the HREA, which included myself as a "graduate research assistant." The amendment was approved by the HREA in October 2015, allowing me to begin recruitment of eligible participants. Additionally, ethics approval must also be obtained from the governing health authority where eligible participants are employed. Ethics approval from Eastern Health was also obtained by the *Clinical Ethics Committees and Ethical Conflicts in Community Health Care* research team.

Many potential ethical issues can arise when conducting research. Researchers must be aware of the potential ethical issues, and have a plan in place to manage these issues should they occur. It is required that all researchers develop an informed consent form for eligible participants. Such consent forms must include the following points (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada, 2014; Creswell, 2003):

- participation is voluntary and participants may be able to withdraw from the study at any time;

- the purpose to the research study must be clearly stated, so that participants can understand the nature of the research and its potential impact on them should they choose to participate;
- the data collection procedures must be clearly stated, so that participants can anticipate what to expect;
- participants must be aware of their right to ask questions, obtain copies of results, and to have their privacy protected;
- both potential risks and benefits of participating in the study must be clearly outlined; and,
- signatures for both participants and those overseeing the consent process must be included.

The consent form used for this project can be found in Appendix A. Provisions for the protection of participant data must also be considered when conducting research (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada, 2014; Creswell, 2003; Whiting, 2008). For my project, the following safeguards were put in place, keeping with the standards set out by the HREA:

- all members of the research team will be briefed on their responsibility for privacy protection;
- all members of the research team will sign an oath of confidentiality;
- no names, addresses, or telephone numbers will be recorded on paper or requested in data files;

- any data-sharing agreements between the researcher and other researchers and/or institutions will be signed prior to providing or obtaining access to data;
- consequences for breaches of confidentiality will be clearly stipulated to the research team;
- all computer files pertaining to the study will be password protected; and,
- all paper abstract forms and printouts of electronic files will be kept in secure storage (specifically, the locked filing cabinet of my supervisor).

Data Collection

Semi-structured interviewing. Qualitative interviewing is paramount in qualitative inquiry, allowing researchers to obtain first-hand accounts of participant experiences with the research phenomenon. While several interviewing strategies exist, a semi-structured interviewing approach was chosen for my project. Semi-structured interviews can be differentiated from unstructured interviews in several ways (DiCicco-Bloom & Crabtree, 2006). Semi-structured interviews are:

- scheduled in advance at a designated time;
- generally located outside of everyday events;
- organized around a set of *predetermined* questions (other questions emerge from the interview dialogue); and,
- generally run from 30 minutes to several hours in length.

All semi-structured interviews completed with participants were audiotaped with a handheld, digital recording device. All five interviews were conducted in person with five different community-based nurses. The interviews were conducted using a preconceived

interview script developed by the research team from the *Clinical Ethics Committees and Ethical Conflicts in Community Health Care* study (see Appendix B).

Semi-structured interviews are commonly used by nurses (Whiting, 2008). Such interviews are personal encounters, during which researchers are able to pose open, direct, and sometimes personal, questions which are then used to elicit rich, detailed narratives of the experiences of participants. To examine the topic of ethical conflicts in community-based health care, semi-structured interviews proved to be an excellent method to elicit thick, rich, detailed descriptions of both the existing types of conflict, and potential management strategies employed by community-based nurses. The data obtained through the interviews that I have completed with participants are compelling, allowing me to gain invaluable information about the types of ethical conflicts faced by community-based nurses and how such conflicts are managed or resolved.

Semi-structured interviewing was chosen as the primary source of data collection because keeping participants "on track" in the interview process is essential in order to obtain the required data (Whiting, 2008). The use of preconceived questions in semi-structured interviewing has been very beneficial to a beginning researcher, such as myself, as all interviews are conducted in the same manner and the preconceived questions serve as prompts to keep both researcher and interviewee focused.

Phases of semi-structured interviewing. There are several phases in conducting semi-structured interviews: building rapport, apprehension, exploration, cooperation, participation, and, conclusion (DiCicco-Bloom & Crabtree, 2006; Whiting, 2008). Essentially, the interviewer begins with attempting to establish rapport with the

interviewee. Nurse researchers generally have an affinity for this stage in the interview process, but it is important to be open, understanding, approachable and compassionate to help interviewees feel. Throughout the course of my inquiry, I was able to appropriately build rapport with participants and the interviewing process resembled more of an easy conversation between friends or colleagues, rather than a structured interview process between interview and interviewee.

Apprehension refers to the feelings of strangeness and vulnerability that interviewees may experience. To ameliorate such feelings, interviewers may pose "ice breaker" type questions or engage in general conversation prior to the initiation of the formal interview. In general, I did not find it difficult to engage participants in the interview process. Moreover, I found that engaging in conversation as I went through the process of obtaining consent did help participants feel more comfortable and prepared them for the interview process.

Exploration begins when interviewees become comfortable engaging in the interview with ease, and divulge in-depth descriptions of their experiences. This is where predetermined questions become increasingly important, so that interviewees are focused. The use of predetermined interview questions will maintain interaction and lead to the generation of knowledge. Probing questions, such as "Can you tell me more about that?" or "How did that make you feel?" may be used to gain further insight into interviewees' experiences. There were times when participants did feel that the questions posed during the interviews were "tough," but allowing them time to reflect on their answers was a strategy that I employed that helped elicit further detail.

Cooperation and participation are reached when the interviewee and interviewer are engaged, and, the interview becomes an enjoyable experience for both parties. There is no worry of offending one another, and the interviewee may even become a "guide" to the interviewer. However, due to time constraints or researcher inexperience, the participation phase may not always be reached. The conclusion phase is self-explanatory. Both parties should be comfortable and feel ready to finish the interview. If possible, the interview should be concluded on a positive note, and it is appropriate to thank the interviewee for his or her time. I received an overwhelmingly positive response from all participants that I interviewed. While a Tim Horton's card was provided as incentive, most participants said that they did not even need the incentive and instead thoroughly enjoyed speaking with me about their experiences.

While interviewing is a great way to elicit research data, conducting interviews can prove to be challenging. As a novice researcher, I am limited in my knowledge of qualitative interviewing, and as such, I was sure to be prepared for any issues that could arise during the data collection procedure. There is potential for any number of field issues to occur, ranging from technical difficulties with audiotaping, to handling emotional outburst from participants. However, I was lucky enough to have completed five interviews without encountering any difficulties. I have had senior researchers available throughout my research practicum who have served as excellent resources, namely my supervisor Dr. Caroline Porr and Memorial University School of Nursing Research Unit Coordinator Joanne Smith-Young.

Data Analysis

Sound qualitative research "uses a systematic and rigorous approach that aims to answer questions concerned with what something is like (such as a client experience), what people think or feel about something that has happened, and it may address why something has happened as it has" (Seers, 2012, p. 2). Qualitative data analysis, or QDA, is often described as a series of processes by which a researcher is able to extract relevant data to form an explanation, understanding, or interpretation of human experiences (Chowdhury, 2015). Qualitative researchers are able to produce rich, detailed descriptions of study phenomena that are interpreted through the coding, sorting, and sifting of data. The rich, detailed descriptions derived from qualitative data may then lead to significant findings, contributing to both theoretical knowledge and practical use (Bryman, 2006). Qualitative researchers generate results using creativity and plurality of thought (Creswell, 1998). QDA, therefore, is an open-ended process requiring the researcher(s) to remain flexible and inductive in their exploration of human meanings in the context of their own making (Chowdhury, 2015).

Limitations of qualitative data analysis. Unfortunately, QDA is often compared and contrasted with quantitative research techniques that reduce phenomena to empirical facts and figures that may be quantified or correlated in an attempt to generate results (Bryman, 2006). Critics of QDA often target the inherently small sample sizes of most qualitative studies, indicating a lack of representativeness of the broader population. Dixon-Woods et al. (2006) argue that the results of QDA cannot be generalized outside of the study context, nor can they be authenticated in the same way as quantitative data

results. Additionally, QDA is further criticized for an apparent lack of rigor and for the heightened possibility of researcher bias (Atkinson, Coffey, &, Delamont, 2003).

Atkinson et al. (2003) also argue that it is impossible to determine whether participants of qualitative research studies actually tell the truth when they are being interviewed; thus, how can the results obtained from the analysis of qualitative interviews be accurate and representative? Unlike quantitative research, qualitative research is not concerned with large sample sizes that produce statistical data and analyses to accept or reject hypotheses; however, because of this, QDA is often scrutinized as being weak or unscientific.

Strengths of qualitative data analysis. While there is much criticism in terms of the strength, accuracy, and reliability of QDA, there also exists a plethora of irrefutable evidence which undermines such criticism. A "significant amount of empirical and theoretical evidences can be presented to show the authenticity, robustness, validity, and capacity of qualitative research" (Chowdhury, 2015, p. 1138). For example, QDA requires extensive engagement in both data collection and analysis, as well as requiring immense intellectual, practical, physical, and emotional effort on the part of the researcher.

The primary goal of qualitative research is to enhance the understanding of a particular phenomenon (Byrne, 2001), rather than produce empirical data inherent in quantitative research. In quantitative research, concepts such as "reliability" and "validity" are used to evaluate the strength of research; however, in qualitative research, the concept of "credibility" is preferred. Credibility may be established in qualitative

research by any number of strategies built into data collection and analysis. Interviewing in qualitative data is viewed as a "credible" data collection technique (Byrne, 2001), and to provide credible research findings it takes considerable effort and dedication. Audiotaping qualitative interviews and transcribing them verbatim is another strategy that may be used to enhance credibility. All five interviews that were completed for my practicum project were audiotaped using a handheld recording device, and were subsequently transcribed verbatim into Word documents.

Other strategies for enhancing credibility of qualitative data include using peer debriefers and member checking (Byrne, 2001). Joanne Smith-Young, the Nursing Research Unit Coordinator from Memorial University School of Nursing, was heavily involved in peer debriefing of the data that I obtained from my interviews. That is, she would listen to all the taped interviews, and compare them to the verbatim transcriptions that I had completed. In doing so, she was able to ensure accurate representation and offer a fresh perspective for the analysis of interview data. Additionally, once the audiotaped interviews were transcribed and the transcripts reviewed by Joanne, I would then send by electronic mail encrypted transcripts to allow participants opportunity to confirm my transcription and interpretation of the data, which is referred to as "member checking" (Byrne, 2001).

*Transferability***.** Unlike quantitative research, qualitative researchers do not endeavor to generalize results. Instead, the term "transferability" is applied to determine whether findings can be applied outside of the study context. To achieve transferability, thick descriptions and purposive sampling are employed. "Thick descriptions" refer to the

richly detailed data that provide the research audience with adequate information to judge emergent themes, categories or constructs (Byrne, 2001). The researcher provides contextual information on the setting details, participant demographics, and the situation or circumstances surrounding the phenomenon. Thus, the audience is able to determine whether it is appropriate to apply the findings from a particular qualitative research study to other settings. To enhance the richness of descriptive qualitative data, quotes from participants' interviews are often included in the body of the text. In the findings section, I have included a number of quotes obtained from participant interviews that allow for a comprehensive view of the research phenomena.

I also used purposive sampling to recruit eligible participants, as was required to explore the topic of ethical conflicts in community-based health care. To answer the research questions "what are the types of ethical conflicts faced by community-based nurses?" and "what strategies are used by community-based nurses to manage ethical conflicts?" it was necessary to recruit community-based nurses who had experienced an ethical conflict within their clinical practice. As such, all five community-based nurses who were interviewed were able to provide the necessary information to answer the research questions, and to adequately address the purpose of the study.

Confirmability. In order to determine "confirmability" of a qualitative research study, it is imperative for researchers to produce an audit trail (Byrne, 2001). An audit trail refers to the specific documentation accumulated throughout the qualitative data collection and analytic procedures. An audit trail can allow an independent researcher to follow the decision-making process and steps taken by previous researchers that enabled

them to arrive at the study results. An audit trail consists of the original study data (i.e., audiotaped interviews and interview transcriptions), early data interpretation or analysis (i.e., coding, sorting of data), research reports, and communication with peer debriefers and research participants. As indicated, I have kept all audio and transcription files on my personal USB device. They may be requested by independent researchers as necessary. My coding framework and handwritten analysis are also available for anyone interested in reviewing my process of analysis.

Qualitative Content Analysis

Despite the many and varied approaches to qualitative data analysis of interview data, all methods are essentially based on a common set of principles: (1) transcribe the interview data; (2) immerse oneself in the data "to gain detailed insights into the phenomena being explored" (Noble & Smith, 2014, p. 3); (3) develop a coding framework; and, (4) further abstract codes to form overarching concepts or categories (Noble & Smith, 2014). The most important feature of QDA, therefore, is the identification of recurrent or significant categories whereby interview data is methodically examined in order to recognize patterns occurring in the textual data that can provide the researcher with a revealing description of a particular phenomenon (Noble & Smith, 2014).

Qualitative content analysis is a method often used in nursing research (Graneheim & Lundman, 2004), and may be applied to a variety of data at varying levels of interpretation. It is a way of analyzing written, verbal or visual communication messages, and is often used in public health studies (Elo & Kyngäs, 2007). By using

qualitative content analysis, it is possible for researchers to reduce many words into fewer content-related categories. The aim is to reach a condensed, broad description of the phenomenon under study, and the outcome of content analysis is a set of concepts or categories that describe the particular phenomenon.

Qualitative content analysis, as previously stated, is often used in nursing research. This method offers several benefits to the novice researcher, namely its flexibility in terms of research design (Elo & Kyngäs, 2007). Content analysis can be used in quantitative, qualitative and mixed methods research, and can be applied to any number of research designs, including a qualitative, exploratory design. For this practicum project, I chose to combine both the steps for generic QDA (Bogdan & Biklen, 1998; Creswell, 1998, 2003), and the steps for qualitative content analysis (Schreier, 2014) as outlined in the *SAGE Handbook of Qualitative Data Analysis.*

Step One

Organize and prepare the data for analysis. This step involves the transcription of raw interview data verbatim from pre-recorded audiotapes. Transcripts should be complete, including the questions asked by the interviewer, not leaving out anything, including that which may seem unimportant while transcribing.

I transcribed three interviews in total, with Joanne Smith-Young completing two out of the five transcriptions for me. I listened to the audiotaped interviews first to get a general sense of the interview. Then, I transcribed each interview word-for-word into Word documents. Each transcription took anywhere from five to eight hours for me to

complete, as transcription was a new skill that I had to learn throughout the course of this project.

Step Two

Read through the transcribed interview data, gaining a general sense of the information presented and reflecting on the overall meaning. Researchers may ask themselves "What general ideas are presented?" or "What is the tone conveyed in the transcripts?" It may be beneficial to write notes in the margins, or begin recording general impressions about the data in the form of preliminary codes.

I read through each transcribed interview several times, highlighting passages that I thought could represent some potential codes. I made queries and notes in the margins when needed, and began to develop an initial coding framework with some preliminary codes.

Step Three

Begin a detailed analysis with a coding process. The coding frame is at the heart of the content analysis method. The coding frame comprises the majority of analysis and can be time consuming, depending on the amount data for analysis. In total, there were 80 single-spaced, typed pages of textual data which I had to analyze.

Coding consists of at least one main category and at least two subcategories (Schreier, 2014). Main categories represent those aspects of the data about which the researcher would like more information, and subcategories specify what is said in the data with respect to these main categories. Coding frames should meet a number of requirements. Firstly, main categories should cover only one aspect of data (requirement of

unidimensionality). Secondly, subcategories within one main category should be created so that they are mutually exclusive (requirement of mutual exclusiveness). It is important to see this requirement in the context of the entire coding frame. It does not imply that any one unit can be coded only once, rather, it implies that any unit can be coded only once under one main category. Finally, all relevant aspects of the data must be covered by a category (requirement of exhaustiveness). This is to make sure that all parts of the data are equally accounted for within the coding frame. In practice, this requirement is easily met by introducing residual categories; however, there should not be too many of these and they should not be used too often, or the frame will not be sufficiently valid (Schreier, 2014).

Qualitative research generally involves large amounts of data. Because of this, and to avoid cognitive overload, not all data may be used in building the coding frame. The first step in building a coding frame, then, is to select a suitable amount of data for analysis. It is recommended researchers engaged in qualitative content analysis break the data down into smaller chunks, and build the coding frame one chunk after another (Schreier, 2014).

Structuring and generating are the next steps in building the coding frame. Structuring refers to creating main categories, and generating refers to creating subcategories for each main category. “Subsumption” (Schreier, 2014) is a useful strategy for generating subcategories once main categories have been established. This involves examining one transcript after another, going through the following steps: (1) Reading the data until a relevant concept is encountered; (2) Checking whether a subcategory that covers the concept has already been created; (3) If so, mentally ‘subsuming’ this under the

respective subcategory, and if not, creating a new subcategory that covers the concept; and, (4) Continuing to read until the next relevant concept emerges. This process of subsumption is then continued until a point of saturation is reached. "Saturation" refers to the point where no additional concepts can be extracted from the data (Schreier, 2014).

Step Four

Use the coding framework to generate descriptions of study participants, as well as the categories for analysis. Codes may be generated for the description. Then, coding may be used to generate a small number of categories, ideally five to seven for a research study. These categories will be those appearing as major findings in the qualitative study, and are stated under specific headings located in the findings section of the study report. These main categories should contain multiple perspectives from study participants, and should be supported by diverse quotations or specific evidence (i.e., subcategories). Subcategories under each main category should be mutually exclusive. Extensive definitions, including a name, description, and example, should be generated for all subcategories in the coding frame. For main categories, a brief description of the scope of the category is usually sufficient (Schreier, 2014).

Step Five

In a pilot phase, the coding frame is attempted on a small segment of the data. This is a crucial step for recognizing and modifying any shortcomings in the frame before the main analysis is carried out. The pilot phase consists of the following steps: selecting unit(s) for analysis; the trial coding; and, evaluating and modifying the coding frame.

Data chosen for the pilot phase should be selected so it covers all types of data and data sources in the data. The categories from the coding frame are then applied to the data during two rounds of coding, following the same procedure that will be used during the main coding. This can be done by two coders working independently of each other, or by one person coding and recoding the data within approximately 10 to 14 days. If the definitions of subcategories are clear and straightforward, and if the subcategories are found to be mutually exclusive, then the units of coding will usually be assigned to the same subcategory during both rounds of coding (Schreier, 2014).

Step Six

The main analysis phase begins, where all data is coded. Initially, the researcher begins with dividing the data into coding categories. Developing a coding system involves several steps: searching through the data for regularities and patterns or topics covered in the data, and then writing down words or phrases to represent these topics and patterns (Bogdan & Biklen, 1998). The words or phrases then become coding categories. They are a way of sorting the data so that particular segments can be separated from others. Some coding categories may arise as a result of data collection, and should be made note of for future use. A crucial step in qualitative content analysis is developing a list of coding categories after all data has been collected and is ready to sort.

It is during this step that the role of theory in qualitative research is considered, though it is often where novice researchers reach difficulty. A theoretical framework does not necessarily mean that generating data is way of "filling in the blanks," but rather helps guide researchers to be informed about what they are looking at, and to make

inferences as necessary (Bogdan & Biklen, 1998). *Voice and Silence in Organizations* (Greenberg & Edwards, 2009) provides the theoretical lens through which I have explored the reasons why nurses in the community may or may not access ethics services. The results of the content analysis coding process are interpreted through *Voice and Silence*. Meanings were derived from a comparison of the findings with the information gathered from the theories presented in *Voice and Silence*.

Step Seven

Accuracy, or validation, of findings occurs through the rigorous research process involved in content analysis. As previously indicated, validity is not implied in the same sense for qualitative research as it is for quantitative research, nor are the concepts of reliability and generalizability (Creswell, 2003); however, validity is a strength of qualitative research when it used to determine whether the findings are accurate from the view of the participants. This is referred to as "member checking," where the final research report (or specific descriptions or categories) are taken back to participants to determine whether the participants agree that the findings are, indeed, an accurate representation of what they conveyed through the interview process.

Member checking has been an integral aspect of my inquiry to ensure study validity, and to strengthen research findings. Once each interview was transcribed, I electronically mailed the password protected Word files to participants so that they were able to verify the accuracy of the information, and also to allow them the opportunity to remove information presented in their interviews for the final analysis. Only one

participant wished to have data removed from the interview transcript; however, it was limited to several singular words and did not adversely impact the analysis process.

Findings

An overview of the research findings for this practicum project is presented, organized around each of the four major categories: types of ethical conflicts encountered in community-based health care, strategies employed to manage ethical conflicts, supportive factors, and barriers. In general, most community-based nurses verified understanding of the concept of "ethical conflict," and were able to provide accurate definitions of the concept. Although all five participants reported having experienced ethical conflicts in their practice in the community, each revealed unique perspectives with relation to the types of conflicts experienced, how such conflicts are managed, and what are considered to be supportive factors and barriers in managing such conflicts.

Demographics

Five community-based nurses participated in this project, with a mix of both community health and public health nurses. All five participants were female. The average age for participants was 44 years, ranging from 35 to 51 years. The average tenure, or length of time with the organization, was 20 years, ranging from 12 to 30 years. All participants currently practice in the province of Newfoundland and Labrador and Labrador, and all were employed by the same health region. However, all participants practiced in different areas of the particular health region.

Types of Ethical Conflicts

Three major subcategories emerged from the data regarding the types of ethical conflicts encountered in community-based health care. These subcategories are: (1) internal conflict, (2) external conflict, and, (3) interpersonal conflict. The most commonly cited conflicts were external and interpersonal, with the most distressing being external conflicts associated with wait times, cutbacks, and funding.

Internal conflict. Internal conflict, subcategorized as "struggling with the decision to act (or not act)" was cited by four out of five participants as being a type of ethical conflict encountered in community-based health care. For example, one nurse said, "You ask yourself before you get on that bus, is this a battle I want to fight? How important is it to me?" (P1) This is in reference to the internal struggle that community-based nurses may feel when they are faced with an ethical conflict, but are unsure how to act. This indecision can be associated with either making decisions related to client care, or to conflict with system-related issues such as inadequate staffing or dissatisfaction with organizational policies. Another nurse actually stated that "most of the conflicts [encountered in community-based health care] are within" (P4), meaning that for her, the majority of ethical conflicts were situated internally and to resolve them would entail an internal struggle about what is the right, or best, course of action.

External conflict. Under this category, two subcategories emerged: (1) wait times, and (2) cutbacks and funding. All five participants indicated having experienced external ethical conflicts. External ethical conflicts were predominantly discussed as being the most distressing and difficult to manage. Most nurses felt that their concerns

were not adequately addressed, because of the hierarchal structure of the health region in which they worked. They referenced "people at the top" (i.e., regional coordinators/managers, CEOs and top tier officials) as not caring about the detrimental effects that issues, such as wait times and cutbacks, can cause in terms of providing care to clients and assuring community-based nurses are equipped with all the necessary supports. One nurse said, "Somebody at the top made the decision based upon a desire to standardize things, disregarding the…you know, the needs of a population." (P1)

Wait times. All five participants referenced wait times as an ethical conflict, or challenge, in community-based health care. In general, lack of family physicians and availability of services were the most frequently associated with the issue of wait times. One nurse said, "You'll run into waits for scans, you'll run into waits for intervention. And even a family doctor for God's sake." (P4) While another said, "Because of staffing issues there are people who need our services and we can't accommodate the services as quickly as we would like." (P5)

There is a clear ethical conflict between wanting to provide the best possible services for their clients, while at the same time, not having sufficient resources to provide those services. More often than not, nurses expressed that they felt powerless in being able to amend external conflicts given their position in the hierarchal structure of the employing organization. This leads nurses in the community to question the efficacy of their role, as one nurse said, "When that wait list is 12 months, 14 months, 16 months…you know…yeah, you kind of think, really, what benefit am I really, how much am I really helping here?" (P1)

The lack of family physicians, and availability of services in the community, were both cited as leading to adverse effects for clients and their families. For example, one nurse said, "…therefore then that child then had to go back on the waitlist, or go back into this pile or whatever the wait time is, and it's a delay in service for that child. So that child would be close to school entry before she actually receives any services. And it's very…I think that's very unfortunate for that child…" (P2)

Wait times were associated with delays in treatment and services for clients, some of whom were in dire need. It is frustrating and upsetting for nurses knowing that they have clients in need of treatment or services, but being unable to coordinate the necessary treatment or service due to constraints such as wait times. Two participants cited the issue of wait times in reference to the palliative care program, indicating a lack of availability of beds in the palliative care unit for dying clients. One nurse said, "You've told them ahead of time that, "Okay, you're palliative care. You're pre-approved for palliative care should this happen, you know, and you want to go." But when the time comes to go, there is no bed available. And, I'm not sure if you see that really as an ethical conflict. But I kind of do, because everything you've told them is not balanced anymore." (P4)

Community-based nurses, then, find it ethically conflicting when they know that clients who require services, such as in-hospital palliative care, cannot access them in a timely manner. The lack of family physicians also has a negative impact on the care that clients in the community can receive. For example, lack of family physicians can impede clients from getting referrals to much needed services, such as wound care. Additionally, the lack of family physicians has resulted in community-based nurses having to take on

additional roles, such as having to pronounce death of a palliative client in the home. One nurse describes it as, "…you know there's not enough physicians because, ideally, it would be done by a physician. […] So you have this strange nurse who has never met this family and you're going into their house when their loved one has died to pronounce death and I just don't think it's appropriate…" (P5)

Additionally, another nurse referenced the lack of family physicians as directly impacting the issue of wait times, "So, it impacts wait times because you're not getting your first line. You're not seeing your first health care line, which is your family physician, to make your referral or to follow you up and whatever." (P4)

Cutbacks and funding. All five participants referenced cutbacks, or lack of funding, as being a significant external ethical conflict in community-based health care. Cutbacks to services were referenced, as well a lack of funding to support increased numbers of community-based nurses. Community-based nurses are in a unique position to offer a wide array of services to clients and their families. This is particularly important in rural areas, where access to services is limited and family physicians are scarce. One participant, who practiced in a rural setting, said, "And we would do satellite clinics. There was a need! There was very low cervical screening rates in a lot of these rural areas, so, we did the clinics. We did the diabetes education. People got used to that service. And then, she decided that because it's not a service that's offered, you know, across the board, and nurses in (city location) are not offering that service, we're going to dissolve, we're going to take that service away." (P1) Another nurse, also working in a rural setting, said, "We have very limited services in this area, and, I guess that can

encounter then some ethical conflict too as well, especially with children, parents' low income, no transportation…" (P2)

Without sufficient access to necessary services for their clients, community-based nurses can often be limited in terms of the care that they can provide to clients in need. Lack of adequate staffing was also frequently cited as an ethical conflict in community-based health care. For example, one nurse cited having to "fight and scratch" to get any added resources, in the form of additional staff. For one particular nurse, the majority of ethical conflicts encountered in community-based practice stem from "time constraints" and "limited resources." For example, the pressure from management to reduce the use of supplies, or to use cheaper supplies even when they are less effective, was cited as an ethical conflict.

Another significant ethical conflict, as it relates to cutbacks and funding, is the lack of additional staff. Most nurses interviewed reported being unable to provide the caliber of service that they would have liked to provide due to inadequate staffing levels. For example, one nurse stated, "There are always cut backs with staff and lack of staff. Right now, all our casual nurses in community health are actually in positions, so like at our office now today and tomorrow, there are five nurses off and so we can't accept referrals from the hospital. So, like, there are people who need services and we can't provide them because of lack of staff." (P4)

Inadequate staffing, cutbacks, and lack of adequate resources impede the ability of community-based nurses to provide the standard of care that they believe their clients

are entitled to, which leaves these nurses frustrated, overworked, and less than satisfied with their current working conditions.

Interpersonal conflict. Interpersonal ethical conflicts can occur in several different forms: between nurse and client, between nurse and colleague, and, between family members. In general, most interpersonal ethical conflicts occur between nurses and clients. For example, parents may not wish to have their child immunized, yet, in their role as community or public health nurse, the nurse is a strong advocate for immunization. The conflict, then, exists between the nurse's beliefs and parents' beliefs. One nurse referenced ethical conflicts as occurring "when I'm strongly encouraging a parent to do something which they don't feel is good for their child." To manage such situations requires thoughtfulness and tact, something which all participants demonstrated throughout the interview process.

A unique ethically challenging situation referenced by one nurse dealt with social media, namely the Facebook website. This nurse felt that if a client tried to add a nurse to a social media site, such as Facebook, that it would "definitely be an ethical conflict because you're providing services to someone you're going to be, you know, social with." While this issue was only addressed by one participant, it is likely to become a frequently occurring situation with the advancement of the role of social media in society today. When dealing with clients and families in the community, rather than in an institutional setting such as a hospital, it seems plausible that lines can become blurred and how clients and families may think that it is okay to pursue their community-based nurses on social media sites. Being in the community, living in proximity to the clients

and families for whom they care for, community-based nurses are in a unique predicament. One nurse reported, “And sometimes I feels like I don’t want to go to a birthday party, or the mall, or, you know, because I don’t want anyone to talk to me about work outside of work.” (P2)

Interpersonal conflict, as indicated, can also occur between nurse and colleague, though this was only reported by two of the five nurses interviewed. In general, conflict with colleagues involved colleagues not sharing responsibilities for care, and colleagues who had negative attitudes towards work. For example, one nurse referred to some of her colleagues as the “Eeyores” of the world, referencing a character from the Winnie the Pooh series who was known for complaining and having a negative outlook towards life. What she meant was that some colleagues were prone to complaining about work, and this had a negative impact on relationships with colleagues and how they were perceived in the office. Another nurse, in reference to colleagues not taking on shared responsibilities, said, “…the other people are not stepping up to the plate.” And “I mean, if you worked in emerg, and someone said “You have to learn how to put in this particular type of IV,” you don’t get to say “Well no, I’m not doing it.” (P3)

So, when colleagues display negative attitudes towards work, or when they are unwilling to take on shared responsibilities, this can have an adverse effect on the quality of work life for other nurses working in the community.

One of the five participants referenced interpersonal conflicts occurring between members of the same family as being ethically challenging. For example, when nurses are involved with a palliative care program client whose family members are in

disagreement about treatment options or the plan of care. The nurse described the conflict as, "…you get a client who wants to die at home, but the family members and the caregivers are really torn because they don't think they can deal with the whole. […] But ultimately, it's the family, really, when it comes to clients dying at home, who's got to be the one to take on the responsibility." (P4)

It can prove to be challenging for community-based nurses to come into the homes of their clients, and have to work through various family dynamics. As one nurse stated "See, the thing is, is you are there for the client. But, it's a whole family unit, really."

Strategies Employed to Manage Ethical Conflicts

In general, the participants in this project managed their ethical conflicts by either (1) speaking out, or (2) remaining silent. Speaking out entails several strategies: approaching management; being a client advocate; and, networking. Remaining silent entails either "just dealing with it," or struggling to cope.

Speaking out. Participants in this project spoke out about their ethical concerns in several ways, as indicated. They would approach management with concerns; they would act as an advocate on behalf of the client and/or family; or, they would network with other colleagues and disciplines.

Approaching management. In general, most participants in this project felt comfortable expressing work-related concerns to their immediate supervisors (i.e., managers). Participants described their managers as "open," "receptive," "approachable," and "respectful." Approaching management proved to be an effective strategy to manage

most significant ethical conflicts that negatively impacted the ability to provide safe, competent, and ethical care to clients in the community. One nurse stated, "…any ethical issues that I've encountered, or anything…questions I've had, I can ask my manager…that's no problem. […] My manager is an excellent support to us." (P2)

Being a client advocate. Most participants referenced advocating for clients as being a strategy used to manage ethical conflicts. Nurses in the community go above and beyond the realm of regular duties to support their clients and to provide the best possible care, oftentimes given limited resources. Nurses working in the community develop close connections with the clients and families they care for, and there is a strong desire to provide their clients and families with as much support and encouragement as possible. As one nurse said, "Sometimes I do create more work for myself and see the clients probably more often than I probably should and make my list a little bit more extensive just because I know the family member is struggling." (P5)

Another nurse discussed a lack of attention given to sexual health, especially amongst the teenage population. This nurse was advocating for more services by spear-heading a pilot project. She said, "I had worked with health promotion and our manager to come up with an STI pilot project. …that particular program has basically been an answer to a lot of my ethical concerns…" (P1) Without taking the initiative to become a strong advocate for the sexual health of residents in her area, it is unlikely that the ethical issues related to sexual and reproductive health would have been effectively addressed, given the clawing back of services and lack of adequate funding.

A third nurse reported finding ways to bypass wait times so that clients in her area could avail of particular services. By strongly advocating for her client, she was able to help save a client from losing a limb. This nurse took it upon herself to coordinate services for a client in need when the system was working against her. She took it upon herself to go above and beyond, even visiting the family physician's office to pick up a referral and physically drop it off to the wound care clinic just so that client could be seen in a timely manner.

Networking. Networking was referenced by all five participants as being a means of managing ethical conflicts in the community. Networking refers to several strategies used by nurses in the community to deal with ethical conflicts: debriefing with colleagues; serving on committees; and, interdisciplinary collaboration. Debriefing with colleagues was an effective way to gain insight into how other nurses working in the community perceive ethical conflicts, and what ways to address them so that client care is not negatively impacted. For example, one nurse referenced drawing on the experience of "senior" nurses in her office who would often assist her in managing ethically challenging situations. Additionally, another nurse referenced debriefing with colleagues during the lunch hour, as it provided other nurses in her area with the opportunity to discuss work-related issues in a relatively relaxed environment.

Serving on committees was a strategy proposed by one of the five participants, but proved to be highly effective for her in managing ethical conflicts experienced in the community. She said, '"[On] committees, you have people who are great resources. If I need the palliative care physician or team to come in and see the client, I would call the

physician whom I'm on the committee with. She said "I got no team, but I can come if you can come with me." I said "I can do that." (P4)

Drawing on additional human resources, such as clinical coordinators, clinical nurse specialists, and bereavement counsellors was also referenced as being a strategy to manage ethical conflicts in the community. Additionally, interdisciplinary collaboration (e.g., social work, Child, Youth and Family Services, medicine) was also referenced as an effective strategy when managing ethical conflicts in community-based health care. One nurse said, "So, I kind of had to go and seek that. Child, Youth and Family Services were very helpful in that, and the social workers, they were very helpful to and for me…" (P2)

Remaining silent. In some instances, participants chose to remain silent rather than assert their voice and speak up about ethical conflicts in community-based practice. For example, one nurse referred to it as "put up or shut up." Interestingly, another nurse stated, "So, you've got to be careful of how far you're going to take things…especially in ethical conflicts, because with ethical conflicts…that may be just internal." (P4) This may signify a conscious decision to remain silent due to the fear that colleagues or the organization will not perceive ethical conflicts in the same way, and that sometimes, the nurse may think that the conflict is not realistic, but is internal in the mind of the nurse.

Supportive Factors

In general, supportive factors for addressing ethical conflicts in community-based health care according to the participants were management and coworkers. Specifically, managerial characteristics reported as supportive included openness, receptivity, advocacy, and approachability. Colleagues were also reported as being a strong

supportive factor. “Senior” nurses who have practiced in the community setting for a long time were viewed as strong supports for managing ethical conflicts as they likely had experienced the conflict to some degree in the past. Several participants referenced taking coworkers along with them on home visits when safety may have been an issue. Nurses working together, collaborating and forming a working group, was mentioned by participants as a supportive factor. This may assist community-based nurses in asserting a collective voice when managing challenges, including ethical conflicts. One nurse stated the following, “I think more issues are going to come about and then I think, you know, you’ll see groups of nurses actually form together to try to make some policy changes or at least to advocate for the clients…” (P5)

Another participant referenced “power in numbers,” meaning that, in the community setting, a collective voice is likely to have a stronger effect than the individual. In the hospital setting, there is a higher number of nursing staff, combined with a number of other accessible resources, such as ethics committees. However, in the community, it appears that nurses rely on each other and have a much higher degree of autonomy. Thus, a collective voice is both a unique and necessary support for managing ethical conflicts as they are encountered in the community setting.

Barriers

Many barriers were reported by participants as impeding the ability to effectively manage ethical conflicts in community-based health care. Predominantly, lack of funding and wait times were referenced as the most significant barriers; however, other barriers reported include: fear of repercussions, geography, lack of education, time constraints,

and lack of open communication between disciplines. In general, nurses reported more barriers to addressing ethical conflicts than supportive factors, which is troubling. Most participants referenced wait times and lack of funding as negatively impacting client care, and these barriers were the most difficult to bypass for nurses in the community. Even after approaching management, sometimes ethical concerns were not resolved. For example, one nurse said, "So the management is aware, but I guess she has financial constraints and budgets to contain with…" (P5), which indicates that although management can be supportive, there are system-wide factors, such as funding and wait times that, while they can be quite ethically challenging, cannot be addressed at the middle management level. This is even more troubling given the harsh economic climate the province of Newfoundland and Labrador is currently facing. It is likely that there are to be further cutbacks, clawing back of services, and lack of resources for community-based nurses. It will be interesting to see how these hard economic times impact frontline staff in community-based health care.

The hierarchal nature of health regions in this province is also a predominant barrier for managing ethical conflicts in community-based health care, according to participants interviewed for my project. It seems that top tier officials in health care in this province are too far removed from the community setting to gain an accurate picture of the importance of community-based health care, the challenges inherent in community-based health care, and the impact that cutbacks, lack of funding, and clawing back of services has on both the overall population and nurses in the community setting.

Discussion

In general, the participants in this project managed their ethical conflicts by either speaking out, or remaining silent. Employee voice has been defined as "the discretionary communication of ideas, suggestions, concerns or opinions about work-related issues with the intent to improve organizational or unit functioning" (Morrison, 2011, p. 375). Conceptually, this describes voice as a behavior that is constructive and is intended to bring about organizational improvements, even though it may be challenging because it threatens the status quo, meaning that voice carries with it a degree of risk. It can also be conceptualized as a form of Organizational Citizenship Behavior (OCB), which is referred to as a helping behavior above and beyond the requirements of a particular job role (Organ, 1988), and is challenging rather than affiliative in nature, similar to altruistic and courteous behaviors . This suggests that voice is unlike other manifestations of OCB, such as dependability, cooperation, and teamwork, and that it may not always be welcomed because it is challenging to those who receive it (i.e., management). This is more likely to result in an employee being silenced rather than choosing to remain silent (Fast, Burris, & Bartel, 2014), and this has implications for power dynamics in the workplace, where an individual who chooses to remain silent holds on to a degree of power but an individual who is silenced has power taken away.

The main features of this definition of voice are that it is a self-initiated and promotive behavior targeting the organization to bring about change or to cease a current practice. It is also focused on and directed towards the immediate manager, or to one's coworkers. Employee voice is, therefore, directly related to the concept of employee

silence. Some debate exists as to whether voice and silence are distinct constructs, or whether they are simply opposite ends of the same spectrum. Greenberg and Edwards refer to employee silence as a "conscious withholding of information, opinions, suggestions, or concerns about potentially important organizational issues" (2009, p. 112). This choice is determined, at least in part, by organizational norms and a "climate of silence", which leads employees to conclude that speaking out is not worth the effort and could, in some instances, be risky as it might attract retaliation. In *Voice and Silence*, this is referred to as "deaf ear syndrome," where an organizational norm exists where employees are discouraged from speaking up or speaking out about their dissatisfaction with work-related issues (Greenberg & Edwards, 2009). In this sense, employees feel as though speaking up will only fall on "deaf ears" and thus, for them, it seems pointless to bring concerns to leaders (i.e., managers) when they are not going to be taken seriously. Tenets of *Voice and Organization* were strongly evidenced in interviews with community-based nurses throughout this project. Employees referenced "putting up or shutting up" or having their professional credibility at risk by voicing concerns. This indicates that there may be a climate of silence within the community-based health care setting.

An ethical or unethical management style also seems to have an impact on employee voice. Ethical leadership is defined as "the demonstration of normatively appropriate conduct through personal actions and interpersonal relationships, and the promotion of such conduct to followers through two-way communication, reinforcement and decision-making" (Brown, Trevino, & Harrison, 2005, p. 120). An ethical leadership

style can be strongly linked to personality traits such as agreeableness and conscientiousness, and this management style can help to promote employee voice, in part by creating a climate of psychological safety where employees feel comfortable in speaking out (Detert & Trevino, 2010; Fast et al., 2014). Managers, however, are faced with the decision about whether to act upon voiced concerns (Milliken & Lam, 2009). Organizational learning is likely to take place when staff gives voice to real concerns and managers act upon these concerns; however, if managers act upon insignificant concerns, this will likely be seen as a waste of resources. Managers may therefore be more apt to do nothing because of the risk of punishment. Instead, they may decide that the problem presented is not of sufficient importance to merit further action, disregarding the negative impact this might have on the job satisfaction and productivity of the employee who chose to use their voice. There is also a real possibility that managers may choose to disregard the voice of those who speak out too frequently on the same issue, particularly if the message is perceived as too challenging or change-oriented (Greenberg & Edwards, 2009). The nurses interviewed for this project did, indeed, indicate that they were oftentimes unwilling to speak out about concerns due to fears about being perceived negatively by management and the organization, and losing their professional credibility.

In general, most participants in this project felt comfortable expressing concerns to their immediate supervisors (i.e., managers) when required. Most participants described their managers as "open," "receptive," "approachable," and "respectful." However, while participants agreed that they would approach management with concerns and that they felt they were adequately supported by management, this did not always

lead them to actively speaking out. For example, several participants referred to speaking up as being negative. For example, one nurse said, "Nobody wants to be the one that's always complaining about something" (P1), while another said, "You don't want to be the one who's beating the drum all the time. Because if you are that one, then when you really need somebody to come, you may not get it" (P4).

This indicates a strong fear of repercussions based on an organizational climate where speaking up or speaking out is generally viewed as being negative, rather than an effective means to ameliorate organizational issues. However, it has been shown that having a chance to voice concerns or be heard actually increases employees' perceptions of organizational fairness (Greenberg, 2000; as cited in Greenberg & Edwards, 2009). According to Greenberg (2000), in some instance where issues directly impact the ability to provide proper nursing care to clients, employees are more likely to voice concerns to management. In reference to approaching management with concerns, one participant stated, "If it's not that significant, I'll just put up and shut up, but if it gets to the point that something is, you know, you really think this is impacting quality of care, or this, you know, your job satisfaction or just the, like, inefficiency, or whatever…" (P1).

It has been proposed that the psychology of leaders can significantly shape opportunities for employees to express their voice, whether voice will make a difference or not, and the extent to which employees feel that the benefits of voice outweigh the costs attached to it. It is believed that approachable, accessible, supportive, and open leaders will increase staff perception that they can express their voice (Greenberg & Edwards, 2009). All participants in this project referenced managerial characteristics that

made it easier for them to approach management with concerns when necessary. For example, regarding her manager, one participant said, "She has a great ability to deal with people. […] Like, she…she doesn't get angry. She doesn't get irritated. She listens to your side of things. And more often than not, she has your back" (P4)**, w**hile another participant said, "Our manager is really, really good. We have an excellent manager here who is very approachable" (P2).

So it seems that managers who are open, receptive, and approachable are more likely to have employees who are comfortable with asserting their voice when appropriate. However, it is important to note that even when employees perceive management to be effective and approachable, this still does not necessarily make them more inclined to assert their voice as often as they should. Most participants reported that they would only approach management with concerns when there was a direct impact on ability to provide safe, competent, and ethical care. For example, one nurse stated, "…for us that was a bit of a concern, going and showing up on someone's doorstep unannounced. So that got brought to management and I think there was even professional practice got involved with that. Anyways, that's not the case anymore, like we don't go out and do unannounced home visits anymore" (P3).

This indicates that a willingness to approach management with concerns surrounding safe and ethical care can have positive end results. However, participants also reported struggling internally with ethical issues and whether to bring them to the attention of management at all. The fear of repercussions was strong amongst participants in this study. One nurse even stated, "Your professional credibility means a lot, so you've

got to be careful to keep that in tact…keep the integrity of that together. […] So you've got to determine within yourself how far to take this, and how effective is it going to be if I tell" (P4).

Greenberg and Edwards (2009) refer to "ostracism" as "any behavior, real or perceived as such, whereby a group or individual ignores and excludes another group or individual" (p. 247). It is likely that community-based nurses fear ostracism as a repercussion of asserting their voice in the workplace. Voice was referenced by several participants as being a "battle to face" or "being the town crier," alluding to a more negative connotation. Because of the isolation involved in working in community-based health care, community-based nurses rely heavily on the support of their colleagues to address ethical issues encountered in practice. Speaking with colleagues, sitting on committees, and interdisciplinary collaboration were all cited as being supportive factors in managing ethical conflicts in community-based health care. Therefore, it is not surprising that community-based nurses are less likely to assert their voice in the workplace due to fears of colleagues and coworkers viewing them negatively, and thus being less likely to support them when faced with ethical conflicts or ethically challenging situations.

Overall, it is concerning that nurses practicing in the community are only likely to report concerns when there is a direct, negative impact to clients, or their ability to effectively care for their clients. While management and coworkers were noted as being supports, the overall organizational structure and hierarchy, and a general climate of

silence, impede community-based nurses from actively pursuing ethical concerns as they arise.

Recommendations

Research

Through conducting this practicum project, I have highlighted some important areas for future research. There were no male participants in this study. It would be interesting, and prudent, to actively select a number of male participants in the future. Male participants may offer a unique view of the types of ethical conflicts encountered in community-based health care, as well as different strategies used to manage ethical conflicts in the community setting. It would also be prudent to gain insight into how nurse managers in the community setting perceive ethical conflicts, and how they are able to manage such conflicts, in the face of cost containment and organizational structure. Future research efforts should be directed towards recruiting male participants and nurse managers in the community setting. Additionally, interviewing more community-based nurses would help to either enhance or refute the findings of this project.

Practice

In general, nurses practicing in the community setting exert a much higher level of autonomy than their hospital nursing counterparts. However, with this increased autonomy comes increased potential for ethical challenges and conflicts. Nurses working in the community setting should be supportive of one another, and should be encouraged to come together to assert a collective voice when ethical issues or conflicts arise that may be detrimental to their ability to provide safe, competent, compassionate nursing

care. In the community setting, there are no real 'formal' supports, such as an ethics committee. Therefore, nurses practicing in the community setting should recognize that their colleagues, including those from various other disciplines, are able to provide a unique perspective when it comes to dealing with ethical conflicts, and are more often than not there to assist them when needed. Interdisciplinary collaboration in the community setting cannot be understated. Becoming familiar with other nurses from various disciplines is likely to benefit nurses practicing in the community, and may offer additional supports when faced with ethical issues or conflicts.

Administration

Throughout this project, the role of management was reported as being generally supportive and was viewed positively by community-based nurses. However, the same cannot be said for the overall organization. The organizational hierarchy was oftentimes referenced as being troublesome. There is a large disconnect between frontline staff and those in positions of power. Middle management should serve as a direct link between frontline staff and top tier executive staff; however, there is little understanding of how middle management is able to address the concerns of frontline staff while abiding by organizational policies and procedures. It is my opinion that a reactive, rather than proactive, organization is likely to miss the mark when it comes to supporting best practices and increasing the efficacy of programs and services. It is imperative that organizations find a way to bridge the gap between frontline staff and executive staff. Committees may be one way in which community-bases nurses, middle managers, and executives can come together to approach issues relating to community-based health care.

Additionally, workshops for executives that promote employee engagement and fostering supportive practice environments for frontline staff should be considered.

Advanced Nursing Practice Competencies

According to the Canadian Nurses Association (CNA), *advanced nursing practice* describes an advanced level of clinical nursing practice that maximizes the use of graduate-level educational preparation (i.e.,, in-depth nursing knowledge and expertise) in meeting the health needs of individuals, families, groups, communities and/or populations (CNA, 2008). Advanced nursing practice is characterized by several core competencies based on graduate-level nursing knowledge, which include theory and research, and may be enhanced by clinical experience. By completing a research-based practicum, I achieved two of the overarching advanced nursing practice competencies – namely, research, and consultation and collaboration.

Research

"Generating, synthesizing, and using research evidence is central to advanced nursing practice" (CNA, 2008, p. 23). By completing a research-based practicum project, I was able to meet the research competency for advanced nursing practice by completing the following objectives (CNA, 2008):

- conduct and support research that enhances or benefits nursing practice;
- evaluate current practice at individual and system levels in light of research findings;
- critique, interpret, apply, and disseminate evidence-based findings; and,

- contribute to nursing and the health care system by disseminating new knowledge through formal and informal channels, including presentation at the local level.

I was able to present my research findings, alongside my supervisor, at the 12th Annual Eastern Health Nursing Research and Education Symposium, held during National Nurses' Week on May 12th, 2016 at the Health Sciences Centre. Nurses from across the province were in attendance, and my presentation was warmly received by audience members.

Consultation and Collaboration

"The ability to consult and collaborate with colleagues across sectors and at the organizational, provincial, national, and international level is a characteristic of nurses in advanced practice" (CNA, 2008, p. 26). By completing a research-based practicum project, I was able to meet the consultation and collaboration competency for advanced nursing practice by completing the following objectives (CNA, 2008):

- initiate timely and appropriate consultation with other health care providers;
- apply theories related to group dynamics, roles, and organizations; and
- participate in collaborative projects with academic institutions.

My research-based practicum project was undertaken in collaboration with the Memorial University School of Nursing. I collaborated with my supervisor, Dr. Caroline Porr, as well as Joanne Smith-Young, the Nursing Research Unit Coordinator at the Memorial University School of Nursing. Both Dr. Porr and Joanne were great mentors to a novice researcher, like myself. I was able to learn so much about conducting qualitative research, especially how to conduct a semi-structured interview, how to transcribe

interview data, and how to recruit participants. When recruitment proved challenging, my supervisor was able to put me in contact with a nurse manager in the community. I consulted with this nurse manager, and she was able to assist me in recruiting participants via electronic mail. This nurse manager was also in attendance when I presented at the Research Symposium, and was very interested in my project.

By applying the theories presented in *Voice and Silence* (Greenberg & Edwards, 2009) to the qualitative interview data gathered through my project, I was able to interpret the findings from my project in a way that relates to group dynamics, roles, and organizations. While it is too early in the study to determine whether the findings from my project will be used to bring about organizational changes, it is my hope that the work I have completed will be put towards improving practice in the community setting.

Conclusion

In conclusion, by conducting this research-based practicum project, I was able to identify a number of ethical conflicts experienced by nurses working in the community setting. By interpreting the findings from my inquiry through a unique theoretical lens, *Voice and Silence*, I was able to relate the ethical conflicts experienced by community-based nurses to organizational and system-wide issues that have a direct impact on the ability to provide safe, competent, ethical care. The findings from my inquiry should direct future research efforts, with the hope of creating further understanding of how ethical conflicts are encountered, perceived, and managed in community-based health care.

This practicum project presented an excellent opportunity to gain invaluable research experience, and also to examine an area which I have always felt to be under researched. It has been a fantastic learning experience. The knowledge and skills that I have gained include: research proposal writing; submitting an application for research to the Health Research Ethics Authority; conducting qualitative interviews; transcribing and analyzing qualitative research data; and, writing research reports. My newly acquired knowledge and skills have allowed me to expand my career focus, and to further my nursing education. These have always been important goals for me, so to have had this opportunity is truly a blessing.

This research-based practicum project has also allowed me to develop interpersonal and networking skills. I have learned how to recruit participants for a research study, and have had to learn how to troubleshoot the challenges inherent in participant recruitment. I have learned how to facilitate trust and openness when conducting qualitative interviews. As well, I have learned how important it is for nursing professionals to come together as a collective voice in advocating for improvements in the delivery of nursing care.

References

Asahara, K., Ono, W., Kobayashi, M., Omori, J., Momose, Y., Todome, H. & Konishi, E. (2013). Ethical issues in practice: A survey of home-visiting nurses in Japan. *Japan Journal of Nursing Science, 10*, 98-108.

Atkinson, P., Coffey, A. & Delamont, S. (2003). *Key themes in qualitative research: Continuities and changes*. Walnut Creek, CA: Altamira Press.

Beauchamp, T. & Childress, J. (1979). Principles of Biomedical Ethics. New York: Oxford University Press.

Bogdan, R. C. & Biklen, S. K. (1998). *Qualitative research for education*. Needham Heights, MA: Allyn & Bacon.

Brown R. B. (2006). *Doing your dissertation in business and management: The reality of research and writing*. London, UK: Sage Publications, Ltd.

Brown, G. (2015). Ethical and moral courage is distress among professional nurses: A workplace issue. *ABNF Journal, 26*(3), 63-64.

Brown, M. E., Trevino, L. K., & Harrison, D. A. (2005). Ethical leadership: A social learning perspective for construct development and testing. *Organizational Behavior and Human Decision Processes, 97*, 117–134.

Bryman, A. (2006). Integrating quantitative and qualitative research: How is it done? *Qualitative Research, 6*(1), 97-113.

Byrne, M. M. (2001). Evaluating the findings of qualitative research. *AORN Journal, 73*(3), 703-706.

Chowdhury, M. F. (2015). Coding, sorting and sifting of qualitative data analysis: Debates

and discussion. *Quality & Quantity, 49*(3), 1135-1143.

Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada. (2014). *Tri-council policy statement: Ethical conduct for research involving humans.* (Catalogue No: RR4-2/2014E-PDF) Ottawa, ON.

Canadian Nurses Association. (2003). Ethical distress in health care environments. Retrieved from https://www.cna-aiic.ca/en/on-the-issues/best-nursing/nursing-ethics/ethics-in practice.

Canadian Nurses Association. (2008). *Advanced Nursing Practice: A National Framework.* CNA, Ottawa: Ontario.

Cohen, J. & Erickson, J. (2006). Ethical dilemmas and moral distress in oncology nursing practice. *Clinical Journal of Oncology Nursing, 10*(6), 775-782.

Corley, M. C. (1995). Moral distress of critical care nurses. *American Journal of Critical Care, 4*(4), 280-285.

Creswell, J. (1998). *Qualitative inquiry and research design*. Thousand Oaks, CA: Sage.

Creswell, J. (2003). *Research design* (2nd ed.). Thousand Oaks, CA: Sage Publications, Inc.

Crowe, M., Inder, M., & Porter, R. (2015). Conducting qualitative research in mental health: thematic and content analyses. *The Australia and New Zealand Journal of Psychiatry, 49*(7), 616-623.

Dahl, B., Clancy, A., & Andrews, T. (2014). The meaning of ethically charged encounters and their possible influence on professional identity in Norwegian

public health nursing: A phenomenological hermeneutic study. *Scandinavian Journal of Caring, 28*(3), 600-608.

de Veer, A., Francke, A., Struijs, A. & Willems, D. (2013). Determinants of moral distress in daily nursing practice: A cross sectional correlational questionnaire survey. *International Journal of Nursing Studies, 50,* 100-108.

Detert, J. R., & Treviño, L. K. (2010). Speaking up to higher ups: How supervisor and skip-level leaders influence employee voice. *Organization Science*, 21, 249–270.

DiCicco-Bloom, B. & Crabtree, B. F. (2006). The qualitative research interview. *Medical Education, 40*(4), 314-321.

Dixon-Woods, M., Bonas, S., Booth, A., Jones, D. R., Miller, T., Shaw, R. L., . . . Young, B. **(**2006). How can systematic reviews incorporate qualitative research? A critical perspective. *Qualitative Research, 6,* 27-44

Edwards, D., Burnard, P., Coyle, D., Fothergill, A. & Hannigan, B. (2000). Stress and Burnout in community mental health nursing: A review of the literature. *Journal of Psychiatric and Mental Health Nursing, 7*, 7-14.

Elo, S. & Kyngäs, H. (2007). The qualitative content analysis process. *Journal of Advanced Nursing, 62*(1), 107-115.

Fast, N. J., Burris, E. R. & Bartel, C. A. (2014). Managing to stay in the dark: Managerial self-efficacy, ego defensiveness, and the aversion to employee voice. *Academy of Management Journal, 57*(4), 1013-1034.

Gaudine, A. & Thorne, L. (2000). Ethical conflict in professionals: Nurses' accounts of

ethical conflict with organizations. *Research in Ethical Issues in Organizations, 2*, 41-58.

Gaudine, A., LeFort, S., Lamb, M. & Thorne, L. (2011). Clinical ethical conflicts of nurses and physicians. *Nursing Ethics, 18*(1), 9-19.

Graneheim, U. H. & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Rn Education Today, 24*, 105-112.

Greenberg, J. & Edwards, M. (Eds.) (2009). *Voice and Silence in Organizations*. Bingley, UK: Emerald Group Publishing Ltd.

Ham, K. (2004). Principled thinking: A comparison of nursing students and experienced nurses. *Journal of Continuing Education in Nursing, 35*, 66-73.

Health Research Ethics Authority. (2014). *General application for research ethics review*. Retrieved from http://www.hrea.ca/getdoc/d489b0dd-c845-418c-8005 0960be3e6523/General-Application-Form-Jan-2014.aspx.

Hamric, A. B. (2000). Moral distress in everyday ethics. *Nursing Outlook, 48*(5), 199 201.

Ives, M. & Melrose, S. (2010). Immunizing children who fear and resist needles: Is it a problem for nurses? *Nursing Forum, 45*(1), 29-39.

Jameton, A. (1984). *A nursing practice: the ethical issues.* Englewood Cliffs, NJ: Prentice-Hall.

Kangasniemi, M., Pakkanen, P. & Korhonen, A. (2015). Professional ethics in nursing: an integrative review. *Journal of Advanced Nursing, 71*(8), 1744-1757.

Kopala, B. & Burkhart, L. (2005). Ethical dilemma and moral distress: Proposed new NANDA diagnoses. *International Journal of Nursing Terminologies and Classifications, 16*(1), 3-13.

McTiernan, K. & McDonald, N. (2015). Occupational stressors, burnout and coping strategies between hospital and community psychiatric nurses in a Dublin region. *Journal of Psychiatric and Mental Health Nursing, 22*, 208-218.

Moore, M. L. (2000). Ethical issues for nurses providing perinatal care in community settings. *Journal of Perinatal and Neonatal Nursing, 14*(2), 25-35.

Noble, H., & Smith, J. (2015). Issues of validity and reliability in qualitative research. *Evidence-Based Nursing, 18,* 34-35.

Patel, M. X., Doku, V., & Tennakoon, L. (2003). Challenges in recruitment of research participants. *Advances in Psychiatric Treatment, 9*(3), 229 – 233.

Pavlish, C., Brown-Saltzman, K., Hersh, M., Shirk, M. & Rounkie, A. (2011). Nursing priorities, actions, and regrets for ethical situations in clinical practice. *Journal of Nursing Scholarship, 43*(4), 385-395.

Polit, D. F. & Beck, C. T. (2012). *Nursing research*. Philadelphia, PA: Lippincott Williams & Wilkins.

Redman, B. K. & Fry, S. T. (2000). Nurses' ethical conflicts: what is really known about them? *Nursing Ethics, 7*(4), 636-650.

Samuelson, S., Willén, C. & Bratt, E-L. (2015). New kid on the block? Community nurses' experiences of caring for sick children at home. *Journal of Clinical Nursing, 24,* 2448-2457.

Schreier, M. (2014). Qualitative content analysis. In *The SAGE Handbook of Qualitative Data Analysis* (pp. 170-184). London, UK: SAGE Publications Ltd.

Seers, K. (2012). Qualitative data analysis. *Evidence-Based Nursing, 15*, 2.

Solum, L. & Schaffer, M. (2003). Ethical problems experienced by school nurses. *Journal of School Nursing, 19*(6), 330-337.

Sturm, B. A. (2004). Ethics and care: An ethnographic study of psychiatric community health nursing practice. *Archives of Psychiatric Nursing, 18*(3), 106-115.

Varcoe, C., Doane, G., Pauly, B., Rodny, P., Storch, J. L., Mahony, K. et al. (2004). Ethical practice in nursing: Working the in-betweens. *Journal of Advanced Nursing, 45*(3), 316-325.

Whiting, L. S. (2008). Semi-structured interviews: Guidance for novice researchers. *Nursing Standard, 22*(23), 35-40.

Wlodarczyk, D. & Lazarewicz, M. (2011). Frequency and burden with ethical conflicts and burnout in nurses. *Nursing Ethics, 18*(6), 847-861.

Yarling, R. & McElmurry, B. (1986). The moral foundation of nursing. *Advances in Nursing Science, 8*(2), 63-73.

Appendix A

Consent Form

Consent to Take Part in Research [Hospital employees]

TITLE: Clinical ethics committees and ethical conflicts in community health care

INVESTIGATOR(S): Drs. Alice Gaudine, Sandra LeFort, Caroline Porr, Creina Twomey, and Kevin Woo
You have been invited to take part in a research study. Taking part in this study is voluntary. 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, what risks you might take 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 researchers will:

- discuss the study with you
- answer your questions
- keep confidential any information which could identify you personally
- 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. As well, few studies have included clients 'and family members' ethical concerns. More health care is being provided in the community rather than hospital, and therefore it is important to identify ethical issues in the community. It is also important to describe the role of ethics committees and services in the community.

2. Purpose of study:

The purpose of this study is to describe the ethical conflicts of clients, family members, and nurses related to health care in the community. Another purpose is to look at the role of ethics committees and services in helping people to manage ethical conflicts.

3. Description of the study procedures:
If you agree to participate, you will meet with a researcher in a private setting. You will be interviewed for 1 – ½ hours. You are free not to answer any question or to stop the interview at any time. Several months after this interview, we will meet with you again either in person or by telephone, to verify the information in your interview and possibly ask you additional questions.

4. Length of time:
You will be expected to participate in two interviews over the next six months at a place of your convenience. Each interview will last 1-1/2 hours.

5. Possible risks and discomforts:
A potential risk is that you may become upset when discussing ethical conflicts. If this occurs, we will stop the interview and if you wish, we will help you to contact your family physician or go with you to a medical clinic or a hospital Emergency Room.

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 or agencies 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

<u>Access to records</u>
The members of the research team will see study records that identify you by name. Other people may need to <u>look</u> 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.

<u>Use of your study information</u>
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 study interviews

Your name and contact information will be kept secure by the research team in Newfoundland and Labrador 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 kept for five years after the publication of the study in a journal article(s).

If you decide to withdraw from the study during your first interview, the information collected up to that time will not be used by the research team. We will verify your typed interview with you, and at that time you may request information to be removed. After that time, the interview data will continue to be used even if you decide to withdraw from the study. 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 and Labrador. Joanne Smith-Young (Nursing Research Unit Coordinator) is the person responsible for keeping it secure.

<u>Your access to records</u>
You may ask the study researcher [Alice Gaudine in Newfoundland and Labrador and Labrador; Kevin Woo in Ontario] 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: [Alice Gaudine in Newfoundland and Labrador and Labrador; Kevin Woo in Ontario].

Principal Investigator's Name and Phone Number

Alice Gaudine
Tel: 709-777-6529
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: [for persons interviewed]

1) Interview at beginning of study
2) Interview several months later

After signing this consent you will be given a copy.

Signature Page

Study title: Clinical ethics committees and ethical conflicts in community health care

Name of principal investigator:
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 **Joanne Smith-Young** and he/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
- without affecting my future care [for clients]
- without affecting the future care of my family member[for family members]

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 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

Appendix B

Interview Guide

Semi-structured interview guide

Background information:

- Gender
- Age (or range)
- Province
- Name of employing organization
- Tenure in organization
- Position in organization

Interview probes:

1. Please describe an ethical conflict you've had within your clinical practice?
    - How did you manage that conflict?
2. Please describe an ethical conflict you've had with organization's values, policies, procedures, regulations, etc.
    - How did you manage that conflict?
3. We are interested in conflict associated with wait times for example, you have conducted an assessment or screening and made a referral but there is a lengthy wait time. Please tell about your experience.
    - How did you manage that conflict?

Appendix C

Literature Review

This literature review is presented in order to meet the requirements of the Master of Nursing Program course N6660 at the Memorial University School of Nursing. The N6660 course is the first of two practicum courses for which I have proposed a qualitative nursing research study to determine the types of ethical conflict in community-based health care, as well as any strategies employed by community-based nurses to manage ethical conflict. This study will be incorporated into a larger study examining the role of clinical ethics committees and how ethical conflict is managed in community health care.

Ethical conflict in the nursing profession is an interesting topic, and one that is relevant across all areas of practice. While some researchers advise against conducting a literature review prior to the initiation of a research study, Creswell (1998) indicates that conducting a literature review prior to the initiation of qualitative research may be beneficial in both framing and substantiating the research problem. Considering this, and the fact that I am limited in my knowledge of community-based health care, this literature review is warranted.

In this paper I present a thorough review of the literature regarding ethical conflicts in nursing, paying particular attention to what is currently known about ethical conflicts in community-based health care. I begin with explanation of the literature search methods, then in accordance with coverage in the literature, I provide a description of nursing ethics, with a focus on the ethical issues in both the hospital and community

settings. This is followed by examination of ethical conflict, specifically moral distress, stress, and burnout. Finally, I discuss the potential implications, based on my literature review that ethical conflict may have for nursing practice, administration and research.

Literature Search Methods

A broad search of the literature was conducted using the CINAHL, Pubmed and Cochrane databases. Search terms included *ethics, ethical conflict, ethical dilemma, community health, community health nursing, public health nursing,* and *nursing ethics*. These search terms were used alone and in combination with one another in the search for scholarly articles pertaining to ethics, ethical conflict and community-based health care. In the last ten years, approximately 342 multidisciplinary articles were written on the topic of ethics in community-based health care. Nursing-specific articles comprised 110 of the 342. Unfortunately, many of these articles are opinion pieces, rather than research studies. The literature covering ethical conflicts and nursing ethics were based primarily in the acute care setting. Little attention has been paid to ethics within the community setting, nor has the literature comprehensively examined ethics and ethical conflict among community-based nurses. While both quantitative and qualitative studies were retrieved, the majority of studies included in this review are qualitative, descriptive research studies using qualitative study designs. This is not surprising given that the topic of ethical conflicts, specifically in community-based health care, is a relatively new topic for researchers. Qualitative studies were generally ranked as either strong or moderate based on the Public Health Agency of Canada's criteria for critical appraisal (PHAC, 2014). Quantitative studies examining ethical conflicts were inherently weaker, cross-

sectional studies that sought to develop tools for empirically testing ethical and moral distress among nurses. Key themes emerging from the multidisciplinary literature include: nursing ethics; ethical issues in practice (hospital setting, community setting); ethical dilemmas; stress and burnout; and, implications of the current ethics literature for future nursing research, administration, and, practice.

Critical Appraisal Tools

In order to critically appraise the literature, I used the Public Health Agency of Canada's Critical Appraisal Toolkit (PHAC, 2014). While the purpose of critical appraisal is to assess study quality, there are no perfect studies and critical appraisal is not an exact science. However, this toolkit provides enough guidance to identify relevant issues to be discussed and allows for the reviewer's discretion in applying the proposed critical appraisal criteria.

According to the PHAC, there are seven steps to critically appraising the literature. The seven steps for appraising each article are:

1. Identify the purpose for reviewing the article. Focus on the methods and outcomes relevant to your research question.
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, literature review).
4. Describe the content of the study in the literature summary tables.
5. Critically appraise the study using the appropriate tool.

6. Include critical appraisal results and comments in the last column of the literature summary tables.
7. Summarize the nature of the studies and conclusions to form the basis of recommendations/implications.

As previously indicated, the majority of studies included in this review are qualitative. The purpose of qualitative studies is to describe a particular topic. Research questions ask *how* or *what* rather than *why*. Qualitative studies are unique in that they present a detailed exploration of topics without establishing relationships or manipulating conditions to achieve anticipated results (Creswell, 1998). Articles in this review are ranked from weak to strong, based on the PHAC appraisal criteria.

Nursing Ethics

Nurses are guided in practice by personal values and beliefs about what is right or moral. These personal values and beliefs comprise each nurse's sense of morality, consequently influencing their decision-making capabilities and their reaction to problems. While morality refers to individual values and beliefs, "ethics" may be used to describe moral issues in a broader sense. Nursing ethics is based on both professional and personal commitments, including rights, duties and responsibilities. Such ethics lay down the values and principles that regulate the conduct of nursing professionals in relation to their clients, colleagues, other professions and nursing organizations (Kangasniemi, Pakkanen, & Korhonen, 2015). The aim of nursing ethics is to protect clients and give nurses the guidance they need to practice competently and in the best interests of clients and their families. Ethics in nursing is often articulated in codes of ethics (i.e., the

Canadian Nurses Association Code of Ethics) which reflect shared international values. The ethical principles, or rules guiding the practice of nursing, include: nonmalificence, beneficence, autonomy, and justice (Beauchamp & Childress, 1979). These principles are reflected in virtually every nursing code of ethics the world over.

Traditionally, nurses have been responsible for acquiring professional ethics through education and clinical practice; however, nurses are increasingly voicing difficulty in practicing ethically due to limited resources, increased workloads and inadequate supports (Kangasniemi et al., 2015). Nurses who provide community-based health care services must uphold the same ethical principles and standards for practice as those working in the hospital setting, yet community-based nurses are faced with unique challenges such as coverage of broad geographical areas, poor resource allocation, working alone or in isolation, and intrusion of privacy when care is provided in the client's home. It is imperative that ethical issues in the community setting be closely scrutinized so that we gain a deeper understanding of how to better anticipate these issues, and provide sufficient support to community-based nurses, especially nurses.

Ethical Issues in Nursing

The climate of health care is shifting, focusing on fiscal responsibility and the increased care needs of rapidly aging populations with many comorbidities. As a result, many changes have been made to how health care is provided within Canada and worldwide (Asahara et al., 2013; Pavlish, Brown-Saltzman, Hersh, Shirk, & Rounkie, 2011). The length of stay for in-hospital treatment has significantly decreased, with many care activities moved to outpatient settings, such as community clinics, or the home.

Combined with rapidly aging populations, this means that a large percentage of health care is now provided by community-based nurses across a broad geographical range. Community-based nurses are faced with a number of challenges in the workplace, including scarcity of resources, disagreement with organizational policies, conflicts of interest with clients and families, and lack of respect for the profession (Gaudine, LeFort, Lamb, & Thorne, 2011). However, because this area has not been extensively researched, we know very little about what types of ethical conflicts exist in the community setting, and how community-based nurses manage these conflicts. Traditionally, research has focused on the acute care setting (e.g., palliative care, oncology, intensive care) when examining ethical issues for nurses. However, many ethical issues experienced by acute care nurses are also experienced by community health nurses.

The Hospital Setting

As previously indicated, while some ethical issues from the community have been identified in the literature, the majority of ethical issues identified in this literature review pertain to the acute care or hospital setting. Gaudine, LeFort, Lamb, and, Thorne (2011b) explored the ethical conflicts that arise when nurses' and physicians' values differ from those of the hospital organizations in which they work. These conflicts exist because nurses and physicians want to provide a certain standard of care, which often conflicts with the type of care that they are able to provide within the organization given the available resources. The researchers identify several themes of nurse and physician ethical conflict with hospitals, including: lack of respect for professionals; insufficient or scarce resources; disagreement with organizational policies; inattentive administration;

lack of organizational transparency; lack of investment in nurses' professional development; and, lack of preventative efforts (see Table 1). When considering community-based health care, potential ethical conflict with organizational values or policies may be especially concerning given that the community setting is far removed from the acute care hospital setting. Community-based nurses experiencing ethical conflict in practice may perceive increased difficulty finding support or accessing services to alleviate their ethical issues. Further research is required to identify nurses' ethical issues in the community setting, and to identify if they are receiving adequate support to deal with complex client care issues and ethical or moral distress.

Gaudine, LeFort, Lamb, and Thorne (2011a) also explored the clinical ethical conflicts experienced by both nurses and physicians within the hospital setting. They identified a core theme, "striving to do what is best for the client." Some of the other themes identified include: respect for client wishes; end-of-life care; safe and quality care; and, knowing the right thing to do. While these issues may be applicable to any clinical area, further research is needed into ethical issues in the community to determine if similar themes are identified.

Gaudine, Lamb, LeFort, and Thorne (2011c) explored barriers and facilitators faced by those nurses who decide to consult with hospital ethics committees. Some of the barriers identified in the study include: lack of knowledge about the community; lack of experience or expertise in managing ethical issues; and, lack of formal and informal supports. These barriers are important to consider when seeking to identify ethical issues

in the community setting. Also of importance is both how and why ethical issues may or may not be addressed.

Specific areas of health care may struggle with ethical issues more so than others. For example, palliative care and intensive care are two areas where research indicates a high level of ethical issues among nurses. Falcó-Pegueroles, Lluch-Canut, Roldan-Merino, Goberna-Tricas, and Guàrdia-Olmos (2015) examined the level of exposure to ethical conflict among professional nurses in critical care units, and the relationship between the level of exposure and the types of ethical conflict. Using a descriptive-correlational design, the researchers were able to determine that the most frequently occurring ethical conflicts were related to administering treatments or carrying out procedures without being consulted, and whether clients had an advanced care directive or living will. Most problematic for nurses were situations involving ineffective pain control and working with incompetent colleagues. Most of these situations involved caring for clients at the end of life, and nurses felt responsible for relieving clients' suffering but were constrained by not being able to act in the most ethical fashion.

Table 1. Literature Summary: The Hospital Setting

Author, Date	**Methods & Outcome Measures**	**Results**	**Strengths, Limitations, Conclusions**
Gaudine, LeFort, Lamb, & Thorne, 2011a	34 Clinical nurses 10 Nurse managers 31 Physicians 4 Canadian hospitals Semi-structured interviews, 1 hour in length (audio-taped and transcribed)	9 themes of ethical conflict common among nurses and physicians: disagreement about care decisions; not respecting client's wishes; sub-par quality of end of life care; client or family behaviors preventing safe or quality care for self or others; client or	Strong qualitative study. Research question focused and clearly stated. Data analysis completed by 3 team members to ensure validity.

		family not having informed consent or full disclosure; not knowing "the right thing to do"; system deficit or deficiency preventing quality care; nurse or physician values conflict with client values or lifestyle choices; and, possible or perceived deficiencies in care owing to nurse/physician competency. 3 themes among physicians only: disagreement with national clinical practice guidelines; estimating odds of survival and futility of treatment; and, balancing merit of survival with disability in infant or child. Overarching theme: "striving to do what is best for the client"	Interview transcripts reviewed by participants to ensure accuracy. Discussed potential limitations. Did not use random sampling to select participants but participants worked in multiple areas of practice. Findings applicable only to Canadian context.
Gaudine, LeFort, Lamb, & Thorne, 2011b	34 Registered nurses 10 Nurse managers 31 Physicians 4 Canadian hospitals Semi-structured interviews, 1 hour in length (audio-taped and transcribed)	5 themes of ethical conflicts with organizations experienced by both physicians and nurses: lack of respect for professionals; insufficient or scarce resources impacts on work life and client care; disagreement with organizational policies; administration turning a blind eye; and, lack of transparency/openness of the organization. 1 theme specific to nursing: lack of investment in nurses' professional development.	Strong qualitative study. Methodology appropriate for research question. Data analysis completed by 3 team members to ensure validity. Interview transcripts returned to participants to ensure accuracy. Discussed potential limitations. Research question not clearly stated. Did not use random sampling to select participants but

		1 theme specific to physicians: lack of preventive focus.	participants worked in multiple areas of practice. Findings applicable only to Canadian context.
Gaudine, LeFort, Lamb, & Thorne, 2011c	34 Nurses 10 Rn Managers 31 Physicians 4 Canadian hospitals Semi-structured interviews, 1 hour in length (audio-taped and transcribed)	Barriers to nurses' and physicians' use of hospital ethics committees: lack of knowledge about committee; lack of expertise in managing ethical issues; reactions of others (e.g., fear of repercussions); it is my responsibility (i.e., one should be able to manage clinical situations independently); lack of expertise on committee; fear of others intervening with client/family; not my role; problematic process for ethics consultations; and, lack of informal and formal supports. Facilitators to nurses' and physicians' use of hospital ethics committees: support within unit and hospital; available information within organization about HEC; ethics education; speedy consultation; interest of organization in ethical issues; knowing a committee member; knowing consultation would not "sideline" them; increasing expertise on committee; and, accepting that one may need help to manage clinical situations oneself.	Strong qualitative study. Research question focused and clearly stated. Data analysis completed by 3 team members to ensure validity. Interview transcripts reviewed by participants to ensure accuracy. Discussed potential limitations. Did not use random sampling to select participants but participants worked in multiple areas of practice. Findings applicable only to Canadian context.

Falcó-Pegueroles, Lluch-Canut, Roldan-Merino, Goberna-Tricas, & Guàrdia-Olmos, 2015	203 nurses from critical care units 2 hospitals, one city (Barcelona, Spain). Ethical Conflict in Nursing Questionnaire – Critical Care Version (ENCQ-CCV) developed by researchers used. Questionnaire distributed by nursing department heads, or completed individually by participants and dropped into a sealed box.	Index of exposure to ethical conflict = 182.35. Most significant sources of ethical conflict were situations involving analgesic administration and end of life care. Most frequently occurring situations causing ethical conflict (occurring at least once a week): "administering or carrying out procedures without having been able to participate in decision making" and "caring for a client without knowing whether he or she had a living will."	Moderate quantitative study. Research question clearly focused and stated. Reliability of tool noted to be Cronbach's α = 0.882. Appropriate statistical tests used. Effect size calculated. No random sampling used. 69% response rate for questionnaire (203 of 292 eligible). Construct validity estimated via exploratory factor analysis (appropriateness of main factors responsible for 33.414% of variance). Findings cannot be generalized (critical care only included; only one city in one region included).

The Community Setting

In terms of community-based health care, there are two different areas of interest. Firstly, general community-based health care deals with providing health services to clients in their home, for example, palliative care. Secondly, there is the field of public health which deals with health promotion and disease prevention, and focuses on areas such as perinatal care and school nursing.

Community health. The most frequently occurring practice situation causing ethical conflict for nurses practicing in community health is end of life care. End of life care represents an area extensively researched in the literature when considering ethical conflicts. It is no surprise that ethical issues abound when caring for clients who are near death (Webb, Passmore, Cline, & Maguire, 2014). The shift in care from the hospital setting to the community means that increasingly, clients are able to die in the comfort of their home. However, this presents unique ethical challenges for community-based nurses caring for these vulnerable clients. To be able to effectively deal with ethical problems involving difficult choices, such as with end of life care, nurses need to be present for the client while also being able to distance themselves. This is no easy task, and presents an area where community nurses need adequate support and resources. Karlsson, Roxberg, Barbosa da Silva, and Berggren (2010) found that nurses practicing in the community experienced powerlessness, frustration and concern in relation to ethical issues encountered while providing end of life care in the client's home (see Table 2). Nurses felt powerless when they considered themselves to be doing everything possible, but yet the client's family continued to place higher demands on them that they were unable to fulfill. Nurses became frustrated when the client's family were mistrustful with regards to pain control, or when there were disagreements with co-workers regarding client's suffering. Nurses need to be able to meet both the physical care needs and the emotional needs of clients and families in the community setting. Dying at home is every client's right, and while having to deal with families may add unwanted strain to this care situation, the client's home is their own and nurses need to be able to be respectful of

clients' and families' wishes (Karlsson et al., 2010; Karlsson, Karlsson, Barbosa da Silva, Berggren, &, Söderlund, 2012; Piers et al., 2012).

Similarly, in a follow-up study, Karlsson, Karlsson, Barbosa da Silva, et al. (2012) found that nurses demonstrated commitment and a strong desire to "do good" when caring for clients dying at home. However, a consistent theme emerged from the interview data of ten community-based nurses, that of a lack of control. Nurses felt a loss of control over the ethical issues arising from end of life care in the client's home; for example, lack of cooperation from the client's family. However, despite this loss of control, nurses were eager to deliver quality nursing care and engaged themselves with clients and families. The findings from this study indicate the need to consider the perspectives of clients, families and nurses to ensure quality end-of-life care is provided in the home.

In a systematic review of ethical issues and supports within nursing homes and home care Gjerberg, Førde, Pedersen, and Bollig (2010) found many issues arising from scarcity of resources and poor resource allocation, such as the foregoing of life-prolonging medical treatment (i.e., enteric feeding), client neglect, racism and lack of respect for different cultures, as well as a lack of cooperation between professionals and institutions. Of particular concern in their literature review was the lack of ethics support in most nursing homes and home care settings. Due to the lack of research regarding ethical conflicts in the community setting, it is unknown whether there is sufficient support for community-based nurses who are experiencing ethical conflicts. Other ethical

issues in the community setting include issues surrounding advocacy, such as in situations where clients and families may have differing views of treatment options.

Few researchers explore ethical issues in community-based health care. Generally, studies are qualitative in nature, with small sample sizes that do not allow for the generalizability of findings to other areas. What may be encountered in one study may not pertain to all settings. Thus, increased research efforts are required. However, despite the small scale of many qualitative studies, similar findings can be found throughout the existing literature. For example, community-based nurses providing end of life care in the community, in general, are confronted with opposing values. They are pressured to work with limited or inadequate resources based on organizational values or policies, but strive to provide the best possible care to palliative care clients and their families. It is recognized that end of life care can be traumatic and stressful for clients and families; however, the literature indicates that nurses are also experiencing stress, loss of control and uncomfortable feelings when caring for dying clients at home. In order to provide the necessary supports to community-based nurses, in particular, nurses, a deeper understanding of the types of ethical conflicts encountered is required. Additionally, researchers need to understand how nurses manage/resolve ethical conflict, and how the resolution (or lack thereof) impacts their ability to perform competent, ethical nursing care to clients.

Table 2. Literature Summary: The Community Setting

Author, Date	**Methods & Outcome Measures**	**Results**	**Strengths, Limitations, Conclusions**

Karlsson, Roxberg, Barbosa da Silva, &, Berggren, 2010	7 Community-based nurses. Written narrative accounts of ethical dilemmas experienced in practice.	Core themes: powerlessness, frustration, and concern. Nurses were motivated and felt responsible for quality end of life care. They took duties seriously, and wanted to satisfy clients, families and other professionals.	Moderate-weak qualitative study. Sound theoretical framework (Ofstad, 1961). Validity ensured by researchers independently coding and comparing themes. Potential limitations discussed. Good discussion of data analysis techniques and rationale for analysis method used. Small sample size, non-random sample. 7 out of 16 eligible nurses participated. No male nurses included in study.
Karlsson, Karlsson, Barbosa da Silva, Berggren, &, Söderlund, 2012	10 Female Community-based nurses. 5 Swedish communities. Semi-structured interviews, 1-1.5 hours long. Audio-taped and transcribed verbatim.	Emerging themes: uncomfortable feelings, and lack of cooperation. Overarching theme: feelings of loss of control in end of life care in the client's own home. Overall, nurses exhibit commitment to the profession and a strong desire to provide quality care at the end of life, even when experiencing feelings of lack of control.	Moderate-weak qualitative study. Sound theoretical framework (Gadamer, 1989). Trustworthiness of data and analysis discussed. Potential limitations discussed. Good discussion of data analysis techniques and rationale for analysis method used. Small sample size, non-random sample. No male nurses included in study. Findings may not be generalizable outside of the Swedish context.

Gjerberg, Førde, Pederson, &, Bollig, 2010	664 Nurses/Nurse managers. 364 Norwegian nursing homes. Two surveys distributed 7 months apart. Both quantitative and qualitative aspects included.	Inadequate care due to lack of resources and breaches of client autonomy/integrity most frequently occurring ethical issues. Most concerning ethical issues were futility of life-prolonging treatments and disagreements between family's and client's wishes. Also disagreements between staff and family. Nurses desire improved ethics education and more time to reflect on ethical dilemmas. Opportunities to consult with ethics experts also desired.	Moderate-weak mixed-methods study. Questionnaire piloted before use in study, and reviewed by experts in research with revisions made prior to study. 78% response rate. Some missing data (i.e., 60 of 664 respondents did not indicate which nursing home they worked in). Appropriate descriptive statistics used. Potential limitations discussed. Discussion re: data analysis lacking. No indication of validity/reliability of questionnaire. "Framing effect" of questionnaire may have affected responses. Results may not be generalizable outside of Norwegian context.

Public health. In a study by Dahl, Clancy, and Andrews (2014), 23 Norwegian public health nurses were interviewed about their experiences with ethically difficult practice situations. Several themes were derived from the phenomenological hermeneutic analysis (see Table 3). These themes were: feeling responsible; being committed; feeling confident; and, feeling inadequate. Public health nurses voiced concerns over the blurring

of boundaries between their work lives and private lives. Public health nurses felt a strong sense of responsibility for their clients and families, and they found it challenging to leave morally conflicting situations in the workplace. This had a negative effect on their personal lives outside of work; for example, poor sleeping habits. Public health nurses also felt responsible for modeling appropriate behaviors, such as "good parenting" and often felt as though they were under public scrutiny when out in the community. This is particularly concerning in rural areas where community-based nurses live and work in close proximity to their clients and families. From the findings presented in this study, it can be said that public health nurses within the community are committed to providing high-quality nursing care for their clients and families; however, this is increasingly difficult for many nurses who experience ethical challenges in the workplace. It is difficult for public health nurses to separate their work lives and private lives, especially in small or rural communities.

Duncan (1992) was one of the first authors to report on ethical challenges in public health nursing. Her study of 30 public health nurses from British Columbia identified conflict in situations involving client rights, interactions with the health system and nurses' rights. Client rights refer to issues of autonomy, or the right to choose regardless of the risk of harm to self or others. Interactions with the health system pertain to miscommunication among health care providers, or working with limited resources. Nurses' rights are described as conflicts in personal and professional values. Of note in Duncan's study was another source of conflict: working alone, isolated from the opportunity to consult with colleagues and other nurses about workplace issues.

Ives and Melrose (2010) explored the experiences of school nurses with regard to ethical conflict in the workplace, specifically regarding immunization of children who fear and resist needles. Through interviews with six school nurses, several themes revealed the nature of this experience: (1) nurses experience stress when immunizing children who fear and resist needles; (2) the strength of resistant children, combined with the behaviors of some parents or guardians, creates an ethical dilemma for nurses; (3) responses from parents make immunization difficult and unsafe; and, (4) resources to help nurses cope with stressful practice situations are limited or inconsistent. Nurses in this study used strong language indicating the stressful experience of immunizing needle-phobic children, for example, words such as *dread, awful, traumatizing, terror, fear* and *shame* were frequent among the participants' descriptions. Similarly, in the study by Duncan (1992), working alone or lacking the opportunity to consult with colleagues served as an additional stressor for nurses.

When ethical conflicts occur within the confines of a hospital, nurses have the opportunity to access ethics committees or ethical services, however, in the community setting this is less likely (Moore, 2000). As indicated, nurses working in the community setting may feel isolated and alone, without formal support such as ethics committees, or informal support such as colleagues and other nurses. It is essential we understand the ethical conflicts nurses face in the community setting, what strategies (if any) they employ to manage these conflicts, and what kinds of support can be made available to better serve this field.

Ethical Dilemmas

Ethical dilemmas occur when there are conflicting values or beliefs about what is the right or best course of action in a given health care situation. Conflict may transpire between two or more of the ethical principles, and it is likely that any possible solution to the conflict may result in undesirable outcomes for those involved (Ham, 2004). According to Beauchamp and Childress (1979), ethical dilemmas exist in two forms. Firstly, an ethical dilemma exists when a nurse is faced with an act that can be considered both morally right and morally wrong, and where there is questionable evidence for either choice. Secondly, an ethical dilemma exists when a nurse feels morally obligated to perform two or more nursing actions, but is unable to do both at the same time. The nurse must choose what to do first as a priority, but the "best course" of action may be unclear. Ethical dilemmas are more and more common in today's health care setting. Many nurses may be unaware of the subtle ethical conflicts existing in everyday practice (Varcoe et al., 2004). Nurses become increasingly tense and frustrated with their practice, experiencing low job satisfaction and compromised work relationships with both co-workers and clients. Many nurses feel powerless when confronted with ethical dilemmas (Pavlish et al., 2011), leading to frequent stress and eventual burnout (Wlodarczyk & Lazarewicz, 2011). The need for quality nursing research that examines nurses' voices in ethically conflicting situations cannot be understated.

Table 3. Literature Summary: Public Health

Author, Date	**Methods, Outcome Measures**	**Results**	**Strengths, Limitations, Conclusions**

Dahl, Clancy, &, Andrews, 2014	23 Female, public health nurses. Two Norwegian counties. Semi-structured interviews, 60-80 minutes long. Tape-recorded and transcribed verbatim.	Four themes identified: feeling responsible, being committed, feeling confident, and feeling inadequate. Public health nurses exhibit a strong emotional commitment to the well-being of children and families.	Moderate qualitative study. Sound theoretical framework (Ricoeur, 1976). Trustworthiness of data and analysis discussed. Potential limitations discussed. Good discussion of data analysis techniques and rationale for analysis method used. Adequate sample size for methodology chosen. Research question not clearly stated. Non-random sampling. No male nurses included in study. Findings may not be generalizable outside of Norwegian context.
Duncan, 1992	30 Community health nurses. Both urban and rural regions of British Columbia, Canada. Survey with open-ended questions describing clinical situations, emotional responses, and decision-making.	Nurses reported situations involving high-risk parenting as most ethically challenging. Nurses who reported ethical conflict found their experiences difficult, and reported feelings of anger, frustration, guilt, and fear. Working in isolation, and support is lacking or unavailable to effectively manage ethical conflicts.	Weak qualitative study, yet important as it is one of the first studies examining ethical conflict in community health. Research questions focused and clearly stated. Adequate sample size for qualitative study, but no discussion of sampling method. Discussion re: data analysis lacking.

			Low response rate (21%) for survey. No discussion of potential limitations. Findings may not be generalized outside of Canadian (or even provincial) context.
Ives & Melrose, 2010	35 Public health nurses. One Canadian province. Two data sources: survey distributed anonymously via email, and three focus group interviews. Interviews were audio-taped and transcribed verbatim.	Four overarching themes: nurses experience stress when immunizing children who fear and resist needles; the strength of child resistance and some adult behavior creates an ethical dilemma for nurses; some adult responses make immunizing difficult and unsafe; and, resources to help nurses cope with these situations are inconsistent.	Moderate qualitative study. Research questions focused and clearly stated. Multiple data collection methods used. Sound theoretical framework and design (i.e., constructivist theoretical perspective and naturalistic action research design). Trustworthiness established through interaction and member checking with participants. No discussion of sampling technique. No discussion of potential limitations. Findings may not be generalized outside of Canadian (or even provincial) context.

Moral Distress

Moral distress was initially coined by Jameton (1984), who defined the term as a disequilibrium experienced by an individual when he or she feels that they are forced into

taking an action that they know to be inappropriate. The Canadian Nurses Association (2003) defines moral distress as that which arises "when one is unable to act on one's ethical choices, when constraints interfere with acting in the way one believes to be right" (p. 2). Moral distress can be related to the experience of an ethical dilemma, for which there is no foreseeable option that satisfies one's moral principles (Cohen & Erickson, 2006; Kopala & Burkhart, 2005). As previously indicated, ethical dilemmas occur when one's personal values or beliefs conflict with the available choices for action in a given situation. In such cases, nurses are required to examine the available courses of action from an ethical perspective, in order to determine whether or not a given action is the best choice. Moral distress occurs when the nurse is unable to carry out their chosen ethical action, due to any number of constraints (Kopala & Burkhart, 2005). Experiences of moral distress do not need to be verbalized. They can be apparent in an individual's actions or inactions, or in one's overall emotional state. There may be emotional or physiologic symptoms associated with moral distress, such as tension, frustration, depression and anger (Brown, 2015; de Veer, Francke, Struijs, & Willems, 2013). Moral distress can be further exacerbated by lack of perceived support, time constraints and legal issues. Moral distress can be directly attributed to nursing burnout and turnover (Wlodarczyk & Lazarewicz, 2011).

It is commonly accepted that nurses are often confronted with difficult ethical situations. This is evident in the research examining end of life care, in both the hospital and community setting (Cohen & Erickson, 2006; Karlsson et al., 2010; Karlsson, Karlsson, Barbosa da Silva, et al., 2012). Piers et al. (2012) examined nurses' moral

distress with end of life care of the geriatric client. A cross sectional survey of 222 nurses providing geriatric care revealed that the practice situations causing the most moral distress were situations involving futile life support; unnecessary tests and treatments; and, working with incompetent colleagues (see Table 4). Similarly, Asahara et al. (2012) surveyed 1961 home visiting nurses in Japan to identify the types and frequency of ethical issues encountered in practice. Several ethical issues were prominent in the data: concern over respecting clients or relationships with other professionals; differences of opinion in treatment provision or care-taking; and, discrepancy of intention between family and client, or nurse. While these studies were quantitative in nature, and did not report strong response rates for the questionnaires distributed, it is interesting to note that both studies indicate that the work environment has a direct impact on the experiences of ethical dilemmas and moral distress among nurses. While quantitative research can be helpful determining what factors may contribute to the experience of ethical conflict and moral distress, in order to better understand the types of ethical conflict and how these conflicts are managed in the community setting, qualitative analysis of nurses' narratives is required.

Table 4. Literature Summary: Moral Distress

Author, Date	**Methods, Outcome Measures**	**Results**	**Strengths, Limitations, Conclusions**
Piers et al., 2012	222 Geriatric nurses. 20 Nursing homes and 3 acute wards in Flanders, Belgium. Cross-sectional, 18-item self-report survey	Frequency of moral distress 1.1 (mean, range 0-4). Intensity score of moral distress 2.3 (mean, range 0-4). Situations involving futile life-prolonging	Moderate quantitative study. Inherently weak cross-sectional survey design. Moderate sample size, no power calculation.

	adapted from the Moral Distress Scale (Corley, 2001).	treatments, unnecessary tests/procedures, and working with incompetent colleagues were the most morally distressing. Requests for euthanasia and increasing morphine in unconscious clients were the least morally distressing. Factors associated with elevated moral distress include: working in an acute geriatric setting (as opposed to nursing homes); lack of involvement in end of life care decisions; lack of ethical debate; and, specific measures of burnout (i.e., emotional exhaustion and personal accomplishment).	Valid & reliable survey tools used. Response rate fair – 57% Sound conceptual framework presented. Appropriate statistical tests used to analyze data. Potential limitations discussed. Findings likely not generalizable outside Belgian context.
Asahara et al., 2012	1961 Japanese home-visiting nurses. Self-report questionnaire comprised of 139 forced-choice questions and eight open-ended questions.	Frequently encountered ethical issues include: concern over respecting clients or relationships with other professionals; different views of treatment or care among nurse and client, nurse and family, or nurse and other professionals; and, discrepancy of intentions between family and client or nurse. Positive correlations noted between frequency of ethical issues and: current position, duration of home-visiting experience, and type of nursing education (i.e., university, diploma, etc.). Age was negatively correlated	Weak mixed methods study. Appropriate statistical tests used. Large sample size. Potential limitations discussed. Research question not clearly stated. Low survey response rate (23.1%). No discussion of sampling technique. Some data missing/unusable.

		with frequency of ethical issues. Nurses noted continuing education efforts and staff training programs were lacking.	

Stress and burnout. Research indicates that the immediate and ominous consequences of moral distress include: blame; self-criticizing; feelings of anger, guilt, remorse, frustration, sadness; withdrawal from clients and colleagues; avoidance behaviors; powerlessness; and, aggression (Dahl, Clancy, & Andrews, 2014; Edwards, Burnard, Coyle, Fothergill, & Hannigan, 2000; Ives & Melrose, 2010; McTiernan & McDonald, 2015; Samuelson, Willén, & Bratt, 2015; Solum & Schaffer, 2003; Sturm, 2004; Wlodarczyk & Lazarewicz, 2011). When nurses' values and beliefs conflict with the realities of the job, they experience distress (Nathaniel, 2006). This distress may linger for many years, contributing to loss of nurses' integrity and dissatisfaction for the work that they do. It is no surprise, then, that moral distress also causes issues with client care delivery, affecting the quality, quantity and cost of nursing care (Corley, 1995; Hamric, 2000; Redman & Fry, 2000).

Edwards et al. (2000) reviewed 30 years of literature on stress and burnout in community mental health nurses. The majority of studies were quantitative in nature, and analysis revealed that stressors inherent in community-based mental health nursing include: increased workload; problems with time management; inappropriate referrals; and, safety issues involving potentially violent clients or those at risk for committing suicide (see Table 5). Similarly, Sturm (2004) also explored the ethical issues among a

group of psychiatric community health nurses. Using an ethnographic design, nine nurses were observed. Semi structured interviews were also conducted with professionals from nursing administration, social work and specialist nursing services. Analysis of the data revealed that all nurses experienced ethical conflict. While these nurses had the desire to provide high quality care to their clients, obstacles were commonly encountered in practice. Such obstacles include: lack of individualized treatment plans; pressure to compromise consistency and quality of nursing services, leading to limited emotional investment in the nurse-client relationship; and, insufficient time available to provide the necessary skills to help community mental health clients improve. Edwards et al. and Sturm discovered in their studies that community-based nursing professionals are faced with increasing obstacles that directly affect how they are able to provide high-quality nursing care. When nurses are unable to provide the quality of nursing care that they feel is needed for their clients, it is no wonder that many succumb to feeling powerless and frustrated. Increased attention must be given to how support can be provided to nurses experiencing ethical conflict in their practice setting, particularly when working in the community.

Ethical conflict is an important topic within health care because the experience may lead to adverse outcomes for individuals, organizations, professions and society as a whole. The adverse outcomes of ethical conflict include nurse burnout and turnover, and decreased morale. These concepts have been studied in the nursing literature for some time (Gaudine & Thorne, 2000; Yarling & McElmurry, 1986). More recently, a longitudinal study of Canadian nurses found that experiencing ethical conflict in the

workplace was associated with increased stress, absenteeism, and turnover intent (Gaudine & Thorne, 2012); however, there is little documentation of how ethical conflict affects community-based nurses. This represents are area in need of further research that cannot be understated.

Table 5. Literature Summary: Stress and Burnout

Author, Date	**Methods, Outcome Measures**	**Results**	**Strengths, Limitations, Conclusions**
Edwards, Burnard, Coyle, Fothergill, & Hannigan, 2000	Narrative literature review of 17 research studies.	Nurses working in the community are experiencing increasing levels of stress and burnout. This is directly related to increasing workloads, increasing administration, and lack of resources. Specific stressors identified in the literature include: increased workload and administrative duties; time management; inappropriate referrals; safety issues; role conflict/ambiguity; lack of supervision; lack of time for education; working conditions; and, lack of funding/resources.	Moderate-strong literature review. Methodology clearly discussed. Research question not clearly stated. All studies included were cross-sectional (inherently weak design). Caution re: interpretation of findings due to design weakness of included studies.
Sturm, 2004	7 psychiatric community health nurses were involved in participant observation by researchers. An additional 2 psychiatric CHNs were interviewed for 15-30 minutes about practice situations. Researchers attended 5 multidisciplinary meetings and semi-	In the context of the American health care system, the overarching finding was that of an ethical dilemma existing of inadequate insurance reimbursement and payment for the much needed therapeutic nursing services provided by psychiatric CHNs.	Moderate-strong qualitative study. Unique study methodology – very few ethnographic studies examine ethical conflicts, especially those in the community setting.

	formally interviewed the administrative director of long-term care, the social work supervisor, the pastoral care counselor, and the psychiatric nurse specialist. Three nursing care coordinators were also interviewed for 30-45 minutes.	Psychiatric CHNs are constrained from providing quality care by a lack of resources, and inadequate support. These nurses are frustrated with the overall health care system that they believe inhibits the proper care of community-dwelling individuals with serious mental illnesses.	Adequate sample size for ethnographic approach. Strong discussion of data analysis procedures (i.e., ensuring trustworthiness). Only one community health care agency observed. Results cannot be generalized outside of the American health care context.
Gaudine & Thorne, 2012	410 nurses. 4 Canadian hospitals. Questionnaire method, with follow-up data re: turnover intention, absence, and actual turnover collected one year after questionnaire completed.	3 aspects of nurses' ethical conflict with hospitals reported: client care values, value of nurses, and staffing policy values. All aspects are associated with stress. "Client care values" is associated with actual turnover. "Staffing policy values" is predictive of turnover intention, and "client care values" is predictive of work absence.	Moderate-strong quantitative study. Longitudinal design strengthens study findings. Sound theoretical framework. Large sample size, however power calculations were not discussed. Tools used were valid and reliable. Appropriate statistical methods employed for data analysis. Research question was not clearly articulated. Findings may not be generalizable outside of the Canadian context.

Implications

Administration and Leadership

Upward communication from employees about the problems or issues of concern encountered in the workplace is critical to organizational performance and success (Greenberg & Edwards, 2009). However, employees are often reluctant to share concerns with management or those in positions of authority. Rather than share their concerns and have their voices heard, they choose to remain silent. The reasons for remaining silent are speculative, however, it can be said that many employees fear the consequences of speaking up (Pavlish, Brown-Saltzman, So, Heers, & Iorillo, 2015). System-related problems such as poor working environments and insufficient resources may result in ethical conflicts for nurses in both the hospital and community setting. These ethical conflicts often result in moral distress, which, as previously indicated, can be directly related to nurse stress, burnout, and turnover intent. The challenge exists for nurse leaders to encourage their subordinates to voice workplace concerns that threaten client safety and quality of care.

Voice and Silence in Organizations (Greenberg & Edwards, 2009) provides the theoretical lens through which I will explore the reasons why nurses in the community may or may not access ethics services. The findings from my proposed study may be used by nurse leaders to encourage employees to voice their ethical concerns to the appropriate individuals or groups. This may lead to improvements in how community-based nurses access ethics services, as well as enhanced understanding of the unique challenges community-based nurses face in practice.

Nursing Research

As indicated in this review, the literature on ethical conflicts and conflict resolution strategies for community-based health care is limited. While the available literature on ethical issues in the hospital setting has some relevancy to the ethical issues experienced by community-based nurses, it is imperative to conduct further research focusing on the community setting.

Traditionally, services such as palliative care and oncology were provided in-hospital; however, with policy changes and reform measures occurring throughout the health care system in recent years, these services are increasingly provided within the community setting. As the research indicates, community-based nurses frequently work alone, with little support from management, coworkers, or formal ethics committees. It is impractical to assume that community-based nurses are able to handle the unique ethical challenges of their work environments by themselves. My proposed research study will provide invaluable information into the types of ethical conflicts encountered in the community, and what strategies are employed by community-based nurses to manage ethical conflicts. There is also a strong need to explore the reasons why community-based nurses may or may not access ethics services. Further research may be geared toward delineating the barriers and facilitators community-based nurses face in terms of accessing ethical services.

Nursing Practice

This review has highlighted the negative effects that ethical conflicts have on nurses both in the hospital and community settings. Throughout the literature, it is noted

that nurses have a strong will and desire to provide high-quality nursing care that meets the needs of clients and families. However, it may be difficult for nurses to voice their ethical concerns, resulting in moral distress. Moral distress is associated with many negative consequences, such as stress, burnout, turnover, guilt, shame, and job dissatisfaction. A better understanding of how ethical conflicts are experienced and managed is essential in order to determine how nurses can be adequately supported. Nurses should be empowered to advocate for better working environments and increased access to resources, in order to provide the best possible client care.

Conclusion

In conclusion, in this literature review I have presented a variety of studies examining ethical conflicts faced by professional nurses. In general, studies into the ethical conflicts faced by community-based nurses are lacking. However, it can be said that nurses are faced with increasing ethical concerns in the workplace, generally, and not enough has been done to understand why this is, or how to increase effective supports to manage these conflicts.

The rationale for conducting my proposed research study has been discussed and strongly supported with findings from my literature review. . By conducting my proposed qualitative study examining the types of ethical conflicts faced by community-based nurses and how these conflicts are managed, I will be able to contribute to the current body of knowledge while also adding important contributions that may have an impact on nursing administration, research and practice.

References

Asahara, K., Ono, W., Kobayashi, M., Omori, J., Momose, Y., Todome, H. & Konishi, E. (2013). Ethical issues in practice: A survey of home-visiting nurses in Japan. *Japan Journal of Nursing Science, 10,* 98-108.

Beauchamp, T. & Childress, J. (1979). Principles of Biomedical Ethics. New York: Oxford University Press.

Brown, G. (2015). Ethical and moral courage is distress among professional nurses: A workplace issue. *ABNF Journal, 26*(3), 63-64.

Canadian Nurses Association. (2003). Ethical distress in health care environments. Retrieved from https://www.cna-aiic.ca/en/on-the-issues/best-nursing/nursing-ethics/ethics-in practice.

Cohen, J. & Erickson, J. (2006). Ethical dilemmas and moral distress in oncology nursing practice. *Clinical Journal of Oncology Nursing, 10*(6), 775-782.

Corley, M. C. (1995). Moral distress of critical care nurses. *American Journal of Critical Care, 4*(4), 280-285.

Creswell, J. (1998). *Qualitative inquiry and research design*. Thousand Oaks, CA: Sage.

Dahl, B., Clancy, A. & Andrews, T. (2014). The meaning of ethically charged encounters and their possible influence on professional identity in Norwegian public health nursing: a phenomenological hermeneutic study. *Scandinavian Journal of Caring*

de Veer, A., Francke, A., Struijs, A. & Willems, D. (2013). Determinants of moral distress in daily nursing practice: A cross sectional correlational questionnaire survey. *International Journal of Nursing Studies, 50,* 100-108.

Duncan, S. M. (1992). Ethical challenge in community health nursing. *Journal of Advanced Nursing, 17,* 1035-1041.

Edwards, D., Burnard, P., Coyle, D., Fothergill, A. & Hannigan, B. (2000). Stress and burnout in community mental health nursing: A review of the literature. *Journal of Psychiatric and Mental Health Nursing, 7,* 7-14.

Falcó-Pegueroles, Lluch-Canut, T., Roldan-Merino, J., Goberna-Tricas, J. & Guàrdia Olmos, J. (2015). Ethical conflict in critical care nursing: Correlation between exposure and types. *Nursing Ethics, 22*(5), 594-607.

Gaudine, A. & Thorne, L. (2000). Ethical conflict in professionals: Nurses' accounts of ethical conflict with organizations. *Research in Ethical Issues in Organizations, 2,* 41-58.

Gaudine, A., LeFort, S., Lamb, M. & Thorne, L. (2011a). Clinical ethical conflicts of nurses and physicians. *Nursing Ethics, 18*(1), 9-19.

Gaudine, A., LeFort, S., Lamb, M. & Thorne, L. (2011b). Ethical conflicts with hospitals: The perspective of nurses and physicians. *Nursing Ethics, 18*(6), 756-766.

Gaudine, A., LeFort, S., Lamb, M. & Thorne, L. (2011c). Barriers and facilitators to consulting hospital clinical ethics committees. *Nursing Ethics, 18*(6), 767-780.

Gaudine, A. & Thorne, L. (2012). Nurses' ethical conflict with hospitals: A longitudinal study of outcomes. *Nursing Ethics, 19*(6), 727-737.

Gjerberg, E., Førde, R., Pedersen, R. & Bollig, G. (2010). Ethical challenges in the provision of end-of-life care in Norwegian nursing homes. *Social Science & Medicine, 71*(4), 677- 684.

Greenberg, J. & Edwards, M. (Eds.) (2009). *Voice and Silence in Organizations*. Bingley, UK: Emerald Group Publishing Ltd.

Ham, K. (2004). Principled thinking: A comparison of nursing students and experienced nurses. *Journal of Continuing Education in Nursing, 35*, 66-73.

Hamric, A. B. (2000). Moral distress in everyday ethics. *Nursing Outlook, 48*(5), 199 201.

Ives, M. & Melrose, S. (2010). Immunizing children who fear and resist needles: Is it a problem for nurses? *Nursing Forum, 45*(1), 29-39.

Jameton, A. (1984). *A nursing practice: the ethical issues.* Englewood Cliffs, NJ: Prentice-Hall.

Kangasniemi, M., Pakkanen, P. & Korhonen, A. (2015). Professional ethics in nursing: An integrative review. *Journal of Advanced Nursing, 71*(8), 1744-1757.

Karlsson, M., Roxberg, A., Barbosa da Silva, A. & Berggren, I. (2010). Community nurses' experiences of ethical dilemmas in palliative care: A Swedish study. *International Journal of Palliative Nursing, 16*(5), 224-231.

Karlsson, M., Karlsson, C., Barbosa da Silva, A., Berggren, I. & Söderlund, M. (2013). Community nurses' experiences of ethical problems in end-of-life care in the client's own home. *Scandinavian Journal of Caring Sciences, 27*(4), 831-838.

Kopala, B. & Burkhart, L. (2005). Ethical dilemma and moral distress: Proposed new NANDA diagnoses. *International Journal of Nursing Terminologies and Classifications, 16*(1), 3-13.

McTiernan, K. & McDonald, N. (2015). Occupational stressors, burnout and coping

strategies between hospital and community psychiatric nurses in a Dublin region. *Journal of Psychiatric and Mental Health Nursing, 22*, 208-218.

Moore, M. L. (2000). Ethical issues for nurses providing perinatal care in community settings. *Journal of Perinatal and Neonatal Nursing, 14*(2), 25-35.

Pavlish, C., Brown-Saltzman, K., Hersh, M., Shirk, M. & Rounkie, A. (2011). Nursing priorities, actions, and regrets for ethical situations in clinical practice. *Journal of Nursing Scholarship, 43*(4), 385-395.

Pavlish, C., Brown-Saltzman, K., So, L., Heers, A. & Iorillo, N. (2015). Avenues of action in ethically complex situations. *Journal of Nursing Administration, 45*(6), 311-318.

Piers, R., Van den Eynde, M., Steeman, E., Vlerick, P., Benoit, D. & Van Den Noortgate, N. (2012). End-of-life care of the geriatric client and nurses' moral distress. *JAMDA, 13*, 80.e7-80.e13

Redman, B. K. & Fry, S. T. (2000). Nurses' ethical conflicts: What is really known about them? *Nursing Ethics, 7*(4), 636-650.

Samuelson, S., Willén, C. & Bratt, E-L. (2015). New kid on the block? Community nurses' experiences of caring for sick children at home. *Journal of Clinical Nursing, 24*, 2448-2457.

Solum, L. & Schaffer, M. (2003). Ethical problems experienced by school nurses. *Journal of School Nursing, 19*(6), 330-337.

Sturm, B. A. (2004). Ethics and care: an ethnographic study of psychiatric community health nursing practice. *Archives of Psychiatric Nursing, 18*(3), 106-115.

Thorne, S. (2000). EBN notebook: Data analysis in qualitative research. *Evidence Based Nursing, **3,*** 68-70.

Varcoe, C., Doane, G., Pauly, B., Rodny, P., Storch, J. L., Mahony, K. et al. (2004). Ethical practice in nursing: Working the in-betweens. *Journal of Advanced Nursing, 45*(3), 316-325.

Wlodarczyk, D. & Lazarewicz, M. (2011). Frequency and burden with ethical conflicts and burnout in nurses. *Nursing Ethics, 18*(6), 847-861.

Yarling, R. & McElmurry, B. (1986). The moral foundation of nursing. *Advances in Nursing Science, 8*(2), 63-73.