

**COMMUNITY ISSUES IN HOSPITAL ETHICS CONSULTATIONS  
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**By**

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## **Abstract**

Clinical ethics committees are developed to attend to the ethical issues surrounding patient care and clinical practice. The members of these committees support and guide healthcare professionals when dealing with these issues. Unfortunately, there has been limited research on ethics committees/services in the community with the majority of research focusing on the hospital setting. In this report I describe a qualitative research study that I conducted as part of a larger study on community ethical issues and services being conducted by my practicum supervisor. The purpose of my study was to identify ethical issues related to the community in the summaries of ethics consults submitted to a large, regional health authority. Prior to initiating this study I reviewed the literature and found that there is a need to explore what ethical issues exist that have implications for care in the community, and how these issues are currently being managed.

In this report I outline the findings of a content analysis of 47 ethics consults. Included is a summary of issues from these consults as well as a description of the main themes identified pertaining to ethical issues in the community. These themes include: (1) Lack of resources to meet patient/client needs; (2) Family requesting futile interventions/treatment; (3) Respect for patient/client wishes; (4) Patient's/client's behavior harmful to self and/or others; (5) Timely communication; (6) Patients/clients participating in unsafe behavior; (7) Patient's/client's needs unable to be met in current setting; (8) Perception that unethical care is being provided; (9) Legally prevented from helping; (10) How to protect patients'/clients' rights; and (11) Rights of a patient/client versus rights of others.

The findings of the study are discussed and implications for practice, education and research are reviewed. I conclude this report with a discussion on the advanced practice nursing competencies used to complete this practicum. The data from this study will be included as part of a larger qualitative research study of ethical services and ethical issues related to the community.

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Over the years, most Canadian hospitals have developed ethics committees as a means of dealing with ethical issues. This is in response to a standard set out by accreditation guidelines (Gaudine, Lamb, LeFort, & Thorne, 2011a). As today's population continues to age, and as hospital stays become shortened, clients are receiving more care in the community. Ethical issues have also grown in complexity in response to advances in healthcare. These advances have led to patients in acute care that are sicker than they have ever been, lives being saved beyond previous capabilities, and illness and disease being treated by the overwhelming advances in modern medicine. Ethics committee members need to prepare themselves to address these complex ethical issues.

It is important to identify those ethical issues that are related to community care so as to promote quality patient/client care. Many community health care organizations in Canada may not have their own ethics committee, and ethical issues related to the community may be evident in the consults completed when the patient receives hospital care. The study for this research practicum included a review of ethics consults that have been received by the ethics service of a large regional health authority and that pertain to care of clients/patients. The data analysis that I performed helps to bridge the gap in knowledge that exists with regard to ethical issues in the community and to identify themes among these issues.

This qualitative research study began as a means of meeting the requirements of the Master of Nursing program at Memorial University of Newfoundland. I learned that Dr. Alice Gaudine was seeking a graduate student to assist in a larger research project and this practicum provided the opportunity not only to complete my master's degree but also to work with an experienced nurse researcher on part of a larger study. Consultation



with Dr. Gaudine and the director in charge of ethics for the region took place prior to beginning this study to determine what the best method of contributing to the larger research project would be. Various areas were explored and narrowed down based on the scope of possible smaller projects and taking into account the time frame within which this smaller project would have to be completed.

As a staff nurse working with critically ill neonates in the intensive care unit, ethical issues often arise surrounding the care of these tiny miracles. While the focus of this particular study is on clinical ethical issues within the community, many of the underlying issues and resulting recommendations may also have implications within the hospital setting. I have not had much experience with regard to ethics services, but I serve on the Neonatal Quality Family-Centered Care Committee for the neonatal intensive care unit where I am employed. The members of this committee focus on quality patient care for the babies and families in our unit. Sometimes issues may arise of an ethical nature and this has always peaked my interest. This interest and the void in the literature identified by Dr. Gaudine made for an interesting research project which has helped me to meet the requirement for the Master of Nursing program.

In addition to the information provided by Dr. Gaudine, I reviewed the literature and this helped me conclude that further research was necessary to investigate the types of ethical issues arising that pertain to care in the community and the use of ethics committees in the community to address these issues.

Throughout the literature there are many definitions of ethical/moral distress and this distress usually stems from some form of ethical moral uncertainty. According to Kälve mark, Höglund, Hansson, Westerholm, and Arnetz (2004) an ethical/moral

dilemma is a situation in which “two or more principles or values conflict” (p. 1077). Ethical/moral dilemmas can in turn lead to ethical/moral distress. Ethical/moral distress has been described by a number of authors and researchers. One definition that I find clear is one by Epstein and Delgado (2010), which states that moral distress occurs when an individual knows which action is best to take in an ethical situation but feels helpless to take that action. In their article they discuss how to understand and address moral distress, and they explore the phenomenon of moral distress as described by Andrew Jameton in 1984. Jameton (1984) distinguishes between ethical dilemmas in which there are more than one seemingly possible action to take, and moral distress where an individual feels constrained from taking the action that they know to be appropriate. I found Epstein and Delgado’s (2010) and Jameton’s (1984) definitions of moral distress useful when examining the data to determine what ethical issues were appropriate to this study.

In this report I summarize the activities undertaken during my research practicum, beginning with an outline of the practicum objectives followed by a review of literature pertaining to ethical conflicts/dilemmas, ethical/moral distress and ethics committees and ethical issues in the community and then a presentation of research findings. I conclude with a discussion of study limitations and possible recommendations for further research, education, and practice. Lastly I present a breakdown of the advanced practice nursing competencies that were utilized throughout this research practicum.

This study was a great opportunity for me as a novice researcher to work with an experienced researcher and gain an in-depth understanding of the research process and how to perform a research study. I was able to utilize my supervisor’s vast research

experience and learn about each of the steps required from proposal writing and ethics approval to data analysis and report writing. This experience has certainly prepared me well for any future research endeavors I may encounter.

This study has also given me insight into an array of ethical issues related to health care. Some, such as end of life decision-making and respect for patient wishes were familiar to me, but others, such as timely communication and treatment of non-compliant patients were new to me.

### **Practicum Objectives**

The overall goals for this research practicum were to discern how a research project is conducted, to complete a qualitative research study, and to contribute to a larger research project. The main objectives for the research practicum included:

- (a) To review a grant proposal for a larger research project;
- (b) To review the relevant literature to support the need for this study on ethical issues within the community setting;
- (c) To successfully obtain research ethics and organizational approval to conduct this study;
- (d) To complete this qualitative descriptive research study;
- (e) To learn how to complete a content analysis; and
- (f) To disseminate the findings of this study in a written report and presentation.

The main purpose of the research study was to identify themes of ethical issues in the community identified in the summaries of ethics consultations conducted in a regional health authority. Specifically, the research question for this study was “What are the

ethical issues related to the community that are brought to a regional health ethics service for consultation?” An additional purpose was to identify the implications of the study’s findings for quality patient/client care and nursing practice within the community.

The activities for this research study were:

- (a) To review summaries of the most current 40 to 50 ethics consults from a regional health authority;
- (b) To develop a list of ethical issues related to the community setting based on a content analysis of a collection of summaries of ethics consults submitted in 2013;
- (c) To identify themes from the list of ethical issues in the community setting; and
- (d) To determine what implications the identified themes have for the community setting.

### **Literature Review**

When completing a literature review for this study I explored the available research pertaining to ethical issues occurring in or having implications for the community as well as definitions of the concepts of ethical conflicts/dilemmas and ethical/moral distress. I used the findings of this literature review to support the need for further research in this area and for this study.

Although an extensive literature review was conducted, to the best of my knowledge, studies that specifically address ethical issues in the community setting are somewhat limited. Despite the limited literature, the research on ethical issues in acute care settings has relevance for community settings. In this section of the report I explore the concepts of ethical conflicts/dilemmas, moral distress, ethics committees and ethical

issues in the community, ethical issues in the hospital setting, ethical issues that cross different settings, and ethics committees and services.

### **Ethical Conflicts/Dilemmas**

Ethical conflicts/dilemmas have been defined by Jansky, Marx, Nauck, and Alt-Epping (2013) as situations that arise when two or more principles and/or values differ. These conflicts occur frequently in healthcare as patients/clients and families are dealing with sensitive circumstances such as illness, pain, suffering, and sometimes death. As Pavlish, Brown-Saltzman, Jakel, and Fine (2014) discuss, changes in healthcare have led to longer life spans, more extensive treatment, and greater care expectations. When ethical conflicts occur, those involved may experience moral distress. This can apply to patients/clients, families, and even healthcare providers. As a result relationships between these parties can be affected (Pavlish et al.).

While there are numerous ethical conflicts/dilemmas, I will discuss three to illustrate what an ethical conflict/dilemma is: a) the duty to warn vs. confidentiality; b) the patient's/client's wishes and well being at end of life vs. substitute decision maker's wishes; and c) balancing hope and autonomy with truth. I selected these three ethical conflicts/dilemmas because I believe they occur frequently and that they may occur or have implication for the community.

One ethical issue identified in the literature is the duty to warn. Shah et al. (2013) discuss the parameters of the duty to warn and what it entails. These parameters include taking into account whether or not disclosure will cause harm to the patient or family. Shah et al.'s article includes a case presentation of a family who are facing possible genetic risks, but who may not be aware that these risks exist. The issue lies with

disclosing information regarding possible genetic mutations while maintaining confidentiality of other family members. There may be circumstances when the duty to warn outweighs the desire to maintain confidentiality. In this particular situation, upon disclosure, family members can make informed decisions about whether or not to have genetic testing done on themselves or their children (Shah et al.). This particular ethical issue can occur in a number of different settings, including the community. The duty to warn applies not only to medical information that may affect or harm other family members or members of the community, but also issues surrounding safety and well-being that may require intervention by health care staff to protect not only the patient but also others who may be involved. There is certainly a need to determine whether or not this is an issue that is arising in the community setting and address it as needed.

Other ethical issues arise at the end of life. Hawryluck, Sibbald, and Chidwick (2013) performed a qualitative study to examine decision-making at the end of life. This Canadian study involved a search of an online database and a purposive sample of 29 decisions surrounding life-sustaining treatments was taken from 1486 cases submitted to the Consent and Capacity board in Ontario, Canada over the past seven years. When end-of-life care decision must be made it is initially the responsibility of the physician to determine what treatments, if any, are appropriate for the individual patient. These treatments must not only support the necessity to do no harm, but must also coincide with the patient's wishes surrounding end-of-life care. When substitute decision makers (SDMs) are involved, physicians must ensure that these individuals are indeed acting in the best interests of the person they are representing. The majority of cases reviewed in this study involve situations where physicians determined that the treatment in question

was not beneficial to the well-being of the patient. Through examination of the individual cases it was also determined that end-of-life decisions must be reviewed on a case-by-case basis and that recommendations may change based on the status of the patient's condition (Hawryluck, et al.). The findings from this study are limited as data is solely from the province of Ontario. It would be useful to determine if ethical issues surrounding end-of-life care are being addressed in the same way and if physician beliefs surrounding this end-of-life care is the same in other parts of Canada and the world, and in what settings these issues are most prevalent.

One ethical dilemma identified in the literature by Sarafis, Tsounis, Malliarou, and Lahana (2014) is balancing hope and autonomy while disclosing the truth about a patient's health or condition. These researchers attempted to decipher whether or not trends exist worldwide surrounding this dilemma. Practices have changed over the past number of decades and globally patients are provided with more information. Despite this change, non-disclosure remains a reality as physicians and nurses become stressed by the need to disclose information to their patients (Sarafis et al.). As sicker patients are being discharged into the community, patient autonomy must be encouraged when and where possible. Given that this study included a review of worldwide trends in this area, it would be interesting to note whether or not a balance between patient autonomy and the hope associated with disclosure of health care information is prevalent to the community setting. Also, is the lack of disclosure of health information as common in the community as in the hospital setting and are the reasons for this lack of disclosure similar across healthcare settings?

No matter what the ethical issue may be, the effect on those involved may be substantial and moral distress may be experienced.

### **Moral Distress**

One of the earliest authors to identify moral distress in nursing was Jameton (1984). He defined moral distress as the disequilibrium that an individual experiences when they feel constrained in taking an action that they know to be appropriate. Since that time, other authors have continued to refine the definition. For example, Hanna (2005), who performed a study to help define the concept in universal terms to include use in clinical practice, found valuing to be the foundation of the concept. Hanna refined the definition of moral distress and the resulting definition is the “perception of harm to an objective good” (p. 119). The Canadian Nurses Association uses the term ethical/moral distress to provide a more generalized definition of moral distress. This organization defines ethical/moral distress as a distress that “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).

While there is increasing reference to moral distress in the nursing literature, Kopala and Burkhart (2005) noted that there are no North American Nursing Diagnoses Association diagnoses that address ethical dilemmas and moral distress. In their article, Kopala and Burkhart distinguish between moral and non-moral conflicts. This is important to the study of ethics and ethical issues as not all conflicts that make individuals feel unsure or cause them to be uncomfortable are moral or ethical in nature, thus not every issue requires the consultation of an ethics committee.



Ethical dilemmas occur when choices and values conflict. In these cases healthcare providers must examine the choices from an ethical standpoint to determine whether or not a given action is the best alternative given the circumstances. Moral distress is the result of inability to carry out a chosen ethical action due to constraints (Kopala & Burkhart, 2005). Experiences of moral distress can be verbalized by individuals or may be evident through the person's actions or inactions. There may also be emotional or physiologic symptoms associated with this distress that may need to be addressed. Moral distress may be exacerbated by lack of support, time constraints, or legal concerns surrounding the associated ethical conflict or dilemma. These are all important concepts to consider when providing care in sensitive situations and with individuals who may be experiencing moral distress.

### **Ethics Committees and Ethical Issues in the Community**

Given the increase in care being provided in the community, it is a reasonable assumption that ethical issues exist among community clients, residents, families, and healthcare providers. While there is little known about community ethics committees and services, a few articles have focused on rural ethics services and ethical issues. Cook and Hoas (2008) reviewed ethics in rural healthcare from eight studies they conducted over nine years in the United States. In their studies they explore how ethical services in urban areas have advanced while those in rural areas have seen minimal changes. In a six state survey performed by Cook and Hoas (2000) as cited in Cook and Hoas (2008) it was found that only 41% of rural hospitals have ethics committees and these ethics committees have been found to be used for staff education as opposed to expected roles such as patient advocacy or the development of policies or procedures (Cook & Hoas,

2000). Staff in rural areas often look to their peers for guidance in ethical decision-making. Decisions are often emotionally laden, and staff is unsure if specific issues are truly ethical in nature. While Cook and Hoas' (2008) studies were in rural hospitals and communities, their finding that rural hospitals have fewer ethical services than acute care hospitals suggests the need to study what ethical services are available in the community.

Bolin, Mechler, Holcomb, and Wiliams (2008) wrote an opinion article in which they discuss the resolution of ethical dilemmas in rural healthcare, stating that these dilemmas are no less common in the rural setting than they are in the urban one. The researchers do point out that there may be difficulty in resolving these dilemmas, as healthcare workers may feel conflicted if they know clients and their families outside of their professional relationship. They discuss the Texas A&M Health Science Center's use of a virtual peer review committee made up of peers to monitor and evaluate the quality of care given in rural hospitals (Bolin et al.). They introduce the idea of a virtual ethics committee that is made up of peers and helps caregivers to solve ethical dilemmas in the rural healthcare setting. The functions of a virtual committee could include consultation on ethical issues, policy development and review, and continuing education specifically focused on ethical issues. This type of strategy could certainly prove useful in other settings where an ethics committee has not already been formed such as community settings.

A number of authors have identified ethical issues in the community. For example, issues related to end of life, palliative care, managing patient/client suffering, and responding to questions from clients and families may have ethical issues (Karlsson, Roxberg, Barbosa da Silva, & Berggren, 2010). Instances where mental health patients do

not receive quality care in the community have ethical issues as well. Pomerantz (2009) discusses the ethical issue of overlapping relationships among health care providers who, outside of their clinical position, are also friends or family members of the individuals they are caring for. These clients may live in the same community as the health care provider and see this individual outside of the clinical area. In this setting there may be a struggle to develop adequate boundaries to ensure that ethical standards are being maintained and to ensure that personal relationships do not affect professional/clinical relationships. Other ethical issues that were discussed by Pomerantz included (a) physician's family gaining unfair advantage; (b) choosing between loyalty to the hospital or to the patient; and (c) breaching confidentiality to prevent possible harm.

In another article, Bell (2003) discusses wound care in the community and the ethical issue of forcing clients/families to be autonomous when they may or may not be ready. Clients/families may not have the supplies needed to perform dressing changes appropriately. This may then make the client/family appear non-compliant when in actual fact they have not been provided with enough information, or financial support, and there may be confusion about what they are required to do. If families are uncomfortable or unprepared to provide wound care in the home they may be faced with strange workers and strange equipment in their home, sometimes even into the night. Another ethical issue related to wound care in the community is the dilemma that nurses are faced with when clients do not have the financial means of continuing with the dressing changes that are recommended. Do they chart improperly so that supplies continue to be provided? This financial burden makes it very difficult to provide individualized care. Clients/families should be provided with the information necessary to make an informed

decision about the care that they will be responsible for providing and they should then be permitted to make a decision based on what they have learned (Bell). These ethical issues are likely unique to the community setting as clients/families would not typically be faced with this insistence to become autonomous, and if the client/family were in acute care there would likely be supports in place to help the client/family make decisions and perform those tasks that the client/family were uncomfortable with.

### **Ethical Issues in the Hospital Setting**

A wide variety of ethical issues in acute care settings have also been identified. In this section I provide several examples to illustrate these issues such as ethical conflicts that exist among nurses and physicians and the hospital organizations in which they work, clinical ethical issues experienced by nurses and physicians in hospitals, and barriers and facilitators to those consulting hospital ethics committees. As well, I identify several ethical issues experienced by physicians and families in palliative care and intensive care.

While some ethical issues from the community have been identified in the literature, the majority of ethical issues identified pertain to acute care or the hospital setting. Gaudine, LeFort, Lamb, and Thorne (2011b) explored the ethical conflicts that exist among nurses and physicians and the hospital organizations in which they work. These conflicts exist because nurses and physicians want to provide a certain standard or level of care and this conflicts with the type of care that they are able to provide within the organization. They identify themes of nurses and physicians' ethical conflict with hospitals including lack of respect for professionals, insufficient or scarce resources impacts on work life and patient care, not agreeing with organizational policies,

administration turning a blind eye, lack of transparency or openness of the organization, lack of investment in nurses' professional development, and lack of preventative focus. The issues of ethical conflict with the organizations where a health professional works may be especially concerning in community care because many of the conditions that patients face are out of the staff's control. Further research is required to identify health professionals' ethical issues with community settings and to identify if patients are receiving the care they require.

Gaudine, LeFort, Lamb, and Thorne (2011c) also explored the clinical ethical conflicts experienced by nurses and physicians in hospitals. They identified a core theme, which was 'striving to do what is best for the patient.' Some of the other themes identified include respect for patient wishes, end-of-life care, safe and quality care, and knowing the right thing to do. From my personal experience these issues can and may be applicable to any clinical area, however research is needed about ethical issues in the community to see if similar themes are identified.

Gaudine, Lamb, LeFort, and Thorne (2011c) also explored barriers and facilitators faced by those who consult hospital ethics committees. Some of the barriers identified in the study by Gaudine et al. include lack of knowledge about the community, lack of experience or expertise in managing ethical issues, and lack of formal and informal supports. I feel that these barriers are important to consider when identifying ethical issues in the community setting as well and determining how and why these issues are or are not being addressed.

Specific areas of healthcare may struggle with ethical issues more so than others. Palliative care and intensive care are two of these areas. Jones, Contro, and Koch (2014)

explored the care being provided by physicians to pediatric patients in palliative care. When caring for pediatric patients, family members are often active participants of the care team. Despite the intention of having a truly family-centered approach, this approach may not be implemented. The authors identify that physicians have a responsibility to not only care for the sick children, but also for their families. Ethical issues exist when families feel abandoned by the healthcare team after patients have passed away. In the hospital setting this can often be avoided because physicians can call on other members of the healthcare team to help in care of the family (Jones, et al.). This support may or may not be available in the community setting.

Numerous studies have discussed ethical issues related to intensive care. For example, Swetz and Mansel (2013). The focus of their article is patients in the cardiovascular intensive care unit (CICU). According to the authors, ethical issues occur frequently in the CICU. Some of the ethical issues identified in this article include advance care planning and shared decision-making, poor communication, and futility. The authors discuss guidelines set out by the American Heart Association and stress the importance of physicians considering all treatment options and outcomes, minimizing harm while maximizing good, and promoting patient autonomy throughout. Swetz and Mansel also discuss the importance of maximizing communication while supporting patients and their families, physically, emotionally, and spiritually. These concepts are all important no matter what the healthcare setting and the ethical issues identified are likely applicable not only in other palliative care units but also in the community setting.

## **Ethical Issues that Cross Different Settings**

Some ethical issues may stretch across different healthcare settings. A study was designed by Guedert and Grosseman (2012) to identify in which setting physicians in Brazil experienced specific ethical issues when caring for pediatric patients. Their aim was to determine what aspect of the physicians' practice is associated with these ethical problems. The study consisted of a questionnaire, which identified 210 ethical problems from 88 physicians. The ethical problems identified were categorized into five areas, which included end-of-life care and physician-patient relationships, among others. Guedert and Grosseman identify that some of the ethical problems identified pertain solely to the hospital setting, while others pertain to primary care. The broad array of settings in which these problems occur justifies the need for specific education for these physicians to appropriately handle ethical problems that arise in their particular setting. This study is helpful in identifying that a number of ethical issues related to acute care may also occur during community care.

An Israeli survey performed by Wagner and Ronen (1996) examines the extent of ethical dilemmas experienced by nurses following publication of the Israeli Code of Ethics for Nurses in 1994. The response rate was 89% for their self-administered questionnaire and it was found that the major determinant of this experience was the work setting, i.e. hospital vs. community. The researchers found that most nurses were not even aware of the code's existence and often based their ethical attitudes on the familial beliefs. They were also likely to seek support from their peers to addressing ethical concerns. Some of these ethical concerns included conflict between patient and family needs, providing treatment of questionable value, and giving treatment that was

perceived as mistaken or wrong. The results of Wagner and Ronen's survey were meant to serve as a baseline for a new program being developed aimed at providing knowledge and coping skills to nurses surrounding the concept of ethical dilemmas in the workplace (Wagner & Ronen). All of the ethical issues that were identified in this study could pertain to different areas of healthcare and thus have implications for both the acute care and community care settings.

### **Ethics Committees and Services**

No matter what the healthcare setting, ethical issues must be addressed to optimize patient/client and family health and to mitigate ethical conflict. Oftentimes these issues are addressed by formal ethics committees or ethics services. Gaudine, Thorne, LeFort and Lamb (2010) outline the evolution of clinical ethics committees (CECs) in Canadian hospitals. The committees included in the survey varied in structure and provided ethics support in a number of ways, including discussion of issues, formal consultations, and providing counseling for patients and their families. The researchers provide a table listing areas where CECs should be involved. Some of these areas include life and death issues, resource allocation, and termination of treatment. All of these issues are likely applicable to care in the community as well as the hospital setting as sicker patients are being cared for at home and in community healthcare facilities.

A study of clinical ethics services in acute care was performed by Racine and Hayes (2006) in Quebec, Canada and the researchers note that clinical ethics services are common in acute care, but the presence of these services in non-acute care is minimal, with only five percent of the 74 identified healthcare ethics committees being in health care service centers that offer community health services. The authors suggest that a



focus on crisis and emergency have prevented the establishment of these types of committees in the community. These researchers developed a survey which was handed out to each healthcare worker at one specific center and four other surveys were sent to the director of professional services in other centers in Montreal to be handed out to a nurse, social worker, doctor, and healthcare administrator. The surveys were sent to explore the relevance of an ethics service, what types of services should be provided, what the structure should be, and where priorities should lie. With a response rate of thirty percent, ninety-five percent of respondents believed that the establishment of ethics services in the community would address a need in non-acute care, with consultation and education being the most sought after services. Survey respondents preferred an interdisciplinary approach with assistance from an ethics consultant and believed that staff should be consulted when policies were being established. Respondents were asked which ethical issues the ethics committee should lend priority to. Among these issues were respect for autonomy and for patients, confidentiality and privacy, resource allocation, quality of life, and disclosing medical errors.

In the literature there is support for education as a strategy to improve ethical decision-making in the community. Asahara, Kobayashi, Ono, Omori, Todome, Konishi, and Miyazaki (2012) surveyed a group of public health nurses (PHNs) in Japan. They had a response rate of 3493 questionnaires were returned which resulted in 31.1% of useable data. The survey addressed ethical issues in practice, and supports the need for education of nurses on ethical decision-making in practice. These researchers indicate that there is need for further research to identify what factors influence ethical issues for PHNs to help establish educational programs to help PHNs feel more competent in addressing ethical

issues. The proposed study would help to bridge this gap in knowledge enabling programs that could be developed to address the ethical issues arising in the community with community health professionals.

### **Literature Review Conclusion**

While various aspects of ethics, ethical conflicts/dilemmas, moral distress, clinical ethics committees, and ethical decision-making are discussed in the literature, there are relatively few studies that focus on ethics and ethical issues in the community. I was unable to locate any articles that included discussion of an ethics committee that examines ethics issues strictly in the community. Further research is certainly necessary to bridge this gap in the knowledge.

The benefit of clinical ethics committees in acute care is obvious as is discussed in the literature. It is difficult, however, to determine how effective this type of committee would be in the community because no research seems to exist to support or deny this. My study will address this gap in the literature by looking at ethics consults that have been done by an ethics service for a health authority that includes acute care and community services, by identifying community issues from consults submitted by community services, and by identifying ethical issues related to clients in the community that may be identified when the patient enters acute care or when planning for discharge from the hospital setting.

### **Conceptual/Theoretical Framework**

The research method used in this study was an inductive one. Since there has been such limited research done in this area, and since I am looking for themes of ethical

conflict related to the community, I thought this would be most appropriate, as I did not want to prematurely impose a theory. My work in this area will add to what is currently known about ethical conflicts and ethical distress in this setting.

Given the nature of this research study and my own limited experience with ethics in the community, I identified the need of performing a literature review. Some researchers recommend not doing a literature review prior to data collection and analysis to avoid biasing the study's results. Walls, Parahoo, and Fleming (2010) actually dispute this idea, stating that a researcher who chooses to conduct a study "without any relevant interest and background might therefore lack the necessary theoretical sensitivity to conduct the research rigorously" (p. 11). This literature review allowed me to identify existing gaps in the literature and helped me to justify why I should perform my study. From the literature review I was able to generate research questions and study objectives and then use the data provided to help answer those questions and meet those objectives.

Next I was able to analyze the data repeatedly to break it down into smaller pieces. Backman and Kyngäs (1999) discuss how these smaller pieces are then "conceptualized and put back together in new ways" (p. 149). Backman and Kyngäs also talk about the importance of discussing the organization of the data with another person or researcher. During this study, I was able to discuss all data analysis and organization with my supervisor to ensure that my ideas were on track. Initially this was confusing for me, which according to Backman and Kyngäs is a common issue for new researchers using this method. It was difficult to understand the different ideas that could exist about the same data set. Working through the data with my supervisor allowed new ideas to

emerge through discussion and helped to clarify existing ideas that we both had, thus leading to the concepts, categories, and themes that finally emerged.

## **Methodology**

### **Setting**

The setting of this study was a large multi-site urban teaching health region in Atlantic Canada. There is currently no ethics committee assigned to address ethical issues that occur directly in the community setting. The acute care ethics committee often receives ethics consults at the point of transition from acute care to the community or from community into acute care. There is also an ethics committee that addresses ethical issues in long-term care and consults from that committee and the resulting issues have not been included in this study.

### **Procedure**

I requested de-identified copies of the most recent 40 to 50 summaries of ethics consults that had been done at the health authority used for this study. The director in charge of ethics at this health authority provided me with a copy of 47 de-identified summaries of ethics consults that covered a ten-month period in 2013. Physicians, nurses, support staff, patients/clients, and/or families of patients/clients could have requested these ethics consultations.

### **Ethical Considerations**

I submitted a research ethics application and an application to perform this study from the research approval committee at the health care authority where the data was

collected. Research ethics approval was received in October 2013 followed by formal approval in November 2013, and approval from the health care authority was received in November 2013. A copy of the research ethics application and the approval from the research ethics authority and the health care authority were also provided to the director in charge of ethics. I also provided the ethics director with a written request for the data.

All consults provided to me by the director were de-identified. These de-identified summaries of ethics consultations were only reviewed by me and my study supervisor. The examples provided in the discussion have been reviewed by the director of ethics for the region to establish that clients and cases remain unidentifiable.

Any information pertaining to the study stored on my computer has been password protected and the data provided by the director has been stored in a secure location and is accessible only to me and my practicum supervisor.

### **Data Analysis**

Throughout the analysis it was my aim to identify ethical issues in the community. In this study I used an inductive methodology, which is a method often associated with qualitative research that begins with specific observations, in this case the ethics consult summaries, and moves to more generalized ideas or theories, in this case the categories and themes which I identified through content analysis. In order for inductive research to be implemented properly the researcher must keep an open mind and be as objective as possible.

Data for this study was analyzed using content analysis. Cole (as cited in Elo & Kyngäs, 2007) defines content analysis as a method that is used to analyze data, which is

written, verbal or visual. Content analysis allows the researcher to take the information in the communication, interpret what they have read, and break it down into categories and themes that have like meanings. Graneheim and Lundman (2004) identify the most suitable units for this type of analysis to be those that are “large enough to be considered whole and small enough to be possible to keep in mind as a context for the meaning unit” (p. 106). Hsieh and Shannon (2005) identify that not needing a specific theoretical perspective or a set of preconceived categories is one of the benefits of using content analysis in qualitative research.

Both my supervisor and I reviewed each summary of an ethics consultation separately. We identified any issues within each consult that contained ethical issues related to the community. If the summary had an issue related to the community, I reviewed the summary again and applied a post-it note to the first page with possible ethical issues. Next I read each consult for a third time and highlighted text indicating possible ethical issues.

I then met with my supervisor and we discussed the issues we had identified. We decided to separate the issues into three main categories: (1) Ethical issues occurring in the community; (2) Ethical issues occurring in acute care but having implications for the community; and (3) Ethical issues occurring in acute care but that could have occurred in community.

My supervisor and I then analyzed the ethical issues in each of these three categories for possible themes of ethical issues. Initial themes were identified by reading through the ethical issues and conceptualizing the issue. The various conceptualizations were then reviewed to determine which ones were related and were possible subthemes. I

then discussed these themes and subthemes with my supervisor at three additional meetings. We crosschecked the themes with the data and came to an agreement on the themes.

## Findings

### Ethical Issues Identified

The ethical issues related to the community are summarized in Table 1. Thirty-six consults out of the forty-seven consults analyzed for this study were found to have issues related to the community. Table 1 identifies the thirty six ethical situations, some of which included more than one ethical issue.

Table 1

*Ethical Issues Identified in Ethics Consults*

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1. Implications of charging (legal charge) vs. not charging a mental health patient (for patient, family & society).
2. Staff unclear on responsibility to make contact with and to provide treatment to a client refusing treatment but who continues to make contact with treatment center; team unable to do home visits due to client history of violence; unsure if client meets criteria for services.
3. Right to take placenta home.
4. Lack of resources for bariatric patient.
5. i) Interference of family in-turn interferes with care of patients; ii) Family potentially giving meds not prescribed and not disclosing to staff; Daughter requesting futile treatment.

6. Would family want staff to contact son to see if he agrees with being the SDM.
7. Timely communication of acute care information to community settings. (Same issue identified twice).
8. Wife requesting futile treatment and not respecting patient's/client's wishes.
9. Liability of staff nurses caring for patient who might use medical devices inappropriately; patient/client using drugs and may cause harm in the community; treatment of noncompliant patient who is actively participating in behavior that is counterproductive
10. Admission due to an ethical issue; family and community services unable to provide safe care at home and client's needs are not being met; client refusal of community services.
11. Patient's/client's needs unable to be met in a private care home and patient/client refusing to go where care is possible.
12. Searching resident's belongings and taking inventory without permission.
13. Unable to determine if patient is suffering; family requesting futile treatment and refusing DNR; conflict of what to do in best interest of the patient to reduce suffering.
14. i) Unable to get adequate support in the community so admitted to acute care; ii) Difficulty finding appropriate placement due to past inappropriate behavior; duty to inform residential care.
15. i) Patient using drugs and undermining treatment plan; treatment of noncompliant patient who is actively participating in behavior that is counterproductive; ii) medications being crushed and added to food and beverages.
16. i) Physician intentionally mislead patient with inaccurate information about transfer after discharge; ii) Lack of effective advocacy by SDM surrounding patient's wishes.



17. Clients smoking while using home oxygen; noncompliance with safety regulations putting others at risk; duty to provide care; duty to respond to known risk; duty to warn.
18. Daughter wants futile invasive treatment for her incompetent mother despite her mother's refusal of treatment; family disagreeing with treatment plan.
19. Patient wants to hasten death with medication; nursing staff uncomfortable with the high doses of morphine prescribed and administered, as patient is not actively dying; concern that meds may hasten death; disagreement of staff with amount of morphine required for illness.
20. Futile care
21. Resident having sexual conversations via chat rooms over the Internet.
22. Non-smoking policy interfering with client retention in treatment programs; possibility of exemption of program from smoke-free policy to increase therapy effectiveness; residential guidelines versus patient or client's compliance with treatment and receiving the care they need.
23. Concern that incompetent patients able to vote in election; family upset with caregiver's support of patient's rights.
24. Management of patient/client distress while avoiding futile intervention.
25. Family want client to go to LTC but client wants to remain in community with husband; family members think it isn't safe for relatives to stay at home.
26. Appropriate and timely disclosure to family.
27. Approval of resident to visit mother at a nearby facility via motorized wheelchair; staff concern for client safety.
28. Family conflict interfering with client's best interest; inappropriate exposure of patient to hostile family behavior.

29. i) Inability to provide necessary care to patient in rural hospital; ii) respect for patient's wishes regarding refusal of treatment; iii) appointment of an SDM.
30. The use of restraint for patients who are unwilling to wash, and who disrobe, urinate and defecate in public places.
31. i) Patient has lack of insight into current condition and disagreement with physician's assessment; possible forced nutritional treatment via NG without patient consent; ii) patient used to work on treatment unit and staff having difficulty maintaining objectivity during treatment.
32. i) Patient is an elopement risk and is a risk to self; ii) risk to other patients.
33. Staff knows client is safe but parents unaware of client's whereabouts; staff wants to protect client's privacy but want to reduce emotional distress of the parents.
34. Resources not available to meet unique patient/client requests (how should resources be allocated?)
35. Providing services that are less effective and may be harmful due to patient's increased weight; right to withhold fertility services to obese patients; withholding treatment based on client behavior.
36. Forcing treatment on someone to keep him or her alive; patient refusing treatments that staff feel and know is life saving.

Further analysis led to the development of three categories: a) ethical issues occurring in the community; b) ethical issues occurring in acute care but having implications for the community; and c) ethical issues occurring in acute care but that could have occurred in the community. Table 2 shows each of the ethical issues identified in Table 1 and what category they fall under.

Table 2

*Categories of Ethical Issues as Pertaining to the Community*

Ethical issues occurring in the community	Ethical issues occurring in acute care but having implications for the community	Ethical issues occurring in acute care but that could have occurred in community
	Staff unclear on responsibility to make contact with and to provide treatment to a client refusing treatment but who continues to make contact with treatment center; team unable to do home visits due to client history of violence; unsure if client meets criteria for services.	Implications of charging (legal charge) vs. not charging a mental health patient (for patient, family & society).  Right to take placenta home.  Lack of resources for bariatric patient.  Interference of family in-turn interferes with care of other patients; family potentially giving meds not prescribed and not disclosing to staff; daughter requesting futile treatment.  Would family want staff to contact son to see if he

agrees with being the SDM.

Timely communication of acute care information to community settings.

Wife requesting futile treatment and not respecting patient's/client's wishes.

Liability of staff nurses caring for patient who might use medical devices inappropriately; patient/client using drugs and may cause harm in the community; treatment of noncompliant patient/client who is actively participating in behavior that is counterproductive.

Admission due to an ethical issue; family and community services unable to provide safe care at home and client's needs are not being met; client refusal of community services.

Client's needs unable to be met in a private care home and client refusing to go where care is possible.

Searching resident's belongings and taking inventory without permission.

Timely communication of acute care information to community settings.

Unable to determine if patient/client is suffering; family requesting futile treatment and refusing DNR; conflict of what to do in best interest of the patient/client to reduce suffering (what is the right treatment?)

Unable to get adequate support in the community so admitted to acute care; difficulty finding appropriate placement due to past inappropriate behavior; duty to

inform residential care.

Patient using drugs and undermining treatment plan; treatment of noncompliant patient who is actively participating in behavior that is counterproductive; medications being crushed and added to food and beverages.

Physician intentionally mislead patient with inaccurate information about transfer after discharge; lack of effective advocacy by SDM surrounding patient's wishes.

Clients smoking while using home oxygen; noncompliance with safety regulations putting others at risk; duty to provide care; duty to respond to known risk; duty to warn.

Daughter wants futile invasive treatment for her incompetent mother despite her mother's refusal of treatment; family disagreeing with treatment plan.

Patient wants to hasten death with medication; nursing staff uncomfortable with the high doses of morphine prescribed and administered as patient is not actively dying. Concern that meds may hasten death; disagreement of staff with amount of morphine required for illness.

Futile care

Resident having sexual conversations via chat rooms over the Internet.

Non-smoking policy interfering with client retention in treatment programs; possibility of exemption of program from smoke-free policy to increase therapy

effectiveness; residential guidelines versus patient or client's compliance with treatment and receiving the care they need.

Concern that incompetent patients able to vote in election; family upset with caregivers support of patient's rights.

Management of patient distress without futile intervention.

Family want client to go to LTC but client wants to remain in community with husband; family members thinking it isn't safe for relatives to stay at home.

Appropriate and timely disclosure to family.

Approval of client to visit mother at a nearby facility via motorized wheelchair (Client had made prior suicidal statements but not currently deemed suicidal); staff concern for client safety.

Family conflict interfering with client's best interest; inappropriate exposure of patient to hostile family behavior.

Inability to provide necessary care to patient in rural hospital; respect for patient's wishes regarding refusal of treatment; appointment of an SDM.

The use of restraint for patients who are unwilling to wash, and who disrobe, urinate and defecate in public places.

Patient has lack of insight into current condition and disagreement with physician's assessment; possible forced nutritional treatment via NG without patient consent; patient used to work on treatment unit and

Staff knows patient is safe but parents unaware of patient's whereabouts; staff wants to protect patient's privacy but want to reduce emotional distress of the parents.

staff having difficulty maintaining objectivity during treatment.

Patient is an elopement risk and a risk to self; patient is aggressive and a risk to other patients.

Resources not available to meet unique patient/client requests (how should resources be allocated?)

Providing services that are less effective potentially harmful due to patient's increased weight; right to withhold fertility services to obese patients; withholding treatment based on client behavior.

Forcing treatment on someone to keep him or her alive; patient refusing treatments that staff feel and know is life saving.

## Themes Within Ethical Issues and Implications for Patient/Client Care

Eleven themes of ethical issues were identified and are shown in Table 3. In the following section a description of each theme is presented.

Table 3

### *Themes Among Ethical Issues in Community Care*

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Lack of resources to meet patient/client needs  
Family requesting futile interventions/treatment  
Respect for patient/client wishes  
Patient's/client's behavior harmful to self and/or others  
Timely communication  
Patients/clients participating in unsafe behavior  
Patient's/client's needs unable to be met in current setting  
Perception that unethical care is being provided  
Legally prevented from helping  
How to protect patients'/clients' rights  
Rights of a patient/client versus rights of others

#### **Lack of resources to meet patient/client needs**

The first theme is lack of resources to meet patient/client needs. Examples of the lack of resources include alternative storage facilities for samples, possible treatment of health concerns that arise as a result of a specific service, and additional health equipment specific to patient/client needs.

#### **Family requesting futile interventions/treatment**

This theme is related to a family wanting treatment for their relative when the health providers believe this treatment is futile. An example of this theme is a situation



where a family member was requesting unnecessary and invasive testing. Further, this family member was administering medications to the patient that were not prescribed by the attending physician but did not disclose this to staff caring for the patient. When the staff discovered this, they were concerned about possible adverse reactions from mixing medications or overdosing.

### **Respect for patient/client wishes**

A number of consults included ethical issues surrounding respect for patient/client wishes. This theme includes differing opinions of staff and patients/clients when it comes to treatment options. Staff did not wish to force treatments on patients/clients, yet they felt conflicted if they knew they could provide life-saving treatment but they were unable to do so. This theme is also related to when family members did not wish for patient/client preferences for treatment to be respected. In other cases, staff and/or family may wish to respect patient/client wishes but did not know what these wishes were.

### **Patient/client behavior harmful to self and/or others**

The theme patient/client behavior harmful to self and/or others was identified from ethical issues such as patients/clients with lung cancer who continue to smoke, patients/clients with heart disease who continue to eat poorly and fail to exercise, and patients/clients with indwelling intravenous lines who use them for illicit drug use. Not only are these clients at risk for self-harm but also in the case of illicit drug use, they may be a risk to harm others. Staff were concerned that /clients who smoked, did not exercise, or engaged in other behaviors were not being helped by medical treatment, making staff wonder if the care they provided was futile.

Another example of this theme is a client who was noncompliant with attendance at a treatment facility but who continued to make contact with that facility. Staff questioned if they should cease follow-up with the patient/client because he was not compliant with attending, or if they should continue to spend time encouraging treatment.

### **Timely communication**

This particular theme, as it applies to the consults being analyzed, captures situations where clients or health professionals were not communicated information as soon as they, or others, believed the information should have been communicated. One example in the consults was the transfer of test results from the acute care to the community setting. Another example is timely disclosure of information to patients/clients and their families, such as information about administration of the wrong medication or breach of privacy or confidentiality. Patients/families were told this information, but staff believed the delay in transmitting this information was an ethical issue.

### **Patients/clients participating in unsafe behavior**

Despite extensive education patients/clients may continue to participate in unsafe behavior. The ethics consults analyzed include a number of these unsafe behaviors including smoking while on home oxygen therapy, and entering chat rooms on the Internet and participating in conversations of a sexual nature. These behaviors may not only pose a threat to those directly involved but may also affect family members, other patients/clients, and those who are living or working nearby.

### **Client's needs unable to be met in current setting**

This theme captures ethical issues related to not being able to meet a patient's/client's needs where they are located, and asking a patient/client to relocate when he/she does not wish to do so. The ethical issues that are captured by this theme include a patient's/client's refusal to enter long term care despite the family's concern that the patient/client is unable to remain at home, a patient's/client's refusal of community care, and a patient's/client's admission to acute care due to inadequate support in the community.

### **Perception that unethical care being provided**

Staff may feel conflicted in providing patient/client care if the care they are providing conflicts with their own beliefs and values. One example from the data is a patient who requested increasing doses of morphine and whose pain does not appear to correspond with the doses being requested. Staff nurses feared that this patient wished to hasten his death. A second example is the deliberate lack of disclosure by the health professional to a patient about relocation to long-term care. In this example, the health professional misled the patient causing her to believe that she would be discharged to her own home.

### **Legally prevented from helping**

This theme captures situations where staff wanted to help patients/clients or their families but was unable to do so because of legalities. In one example, staff knows of an adolescent's location but was unable to tell the adolescent's parents who were worried about where he/she was. The staff's knowledge about the adolescent's location and safety

provided a conflict in that they legally needed to protect the adolescent's privacy but they wanted to minimize the emotional distress of the family. Another example of this theme is the request from a patient to take home her placenta after giving birth. Staff understood the patient's perspective but were also aware of their legal obligation.

### **How to protect patient's/client's rights**

This theme is related to situations where health professionals did not know the right thing to do. In some situations, health professionals did not know who to consider as the patient, or whose rights they should protect. An example of an ethical situation that is captured by this theme is a mental health patient who was being physically abusive toward staff. The mental health patient is the patient, however does this restrict the responsibility to protect the staff within the organization? Charging and convicting a patient who is mentally incapable of knowing the difference between right and wrong also seems inappropriate, but staff have the right to not be harmed at work. In situations such as this one, the rights of the patient/client conflict with the rights of the staff.

Another example of this theme is a client who wished to visit his mother in a nearby facility via motorized wheelchair. In doing this, the client would have to cross a street. Staff was unclear if it would be safe to let the client do this, despite the client being fully competent.

### **Rights of a patient/client versus rights of others**

Staff may be faced with the issue of balancing the rights of a patient/client with the rights of other patients/clients or persons, or with the rights of society at large. In one particular example, family members expressed concern that incompetent patients/clients

were allowed to vote in the federal election and that staff were supporting them to do so. This ethical situation is related to the rights of an incompetent patient/client versus the rights of society to have a democratic election.

Another example related to this theme is the use of restraints to protect an individual from hurting him/herself, staff and other patients. On the one hand, the patient and others are protected, but on the other hand the patient loses his/her right to the freedom of movement.

### **Discussion**

The purpose of this study was to answer the research question that I had developed. This research question is: “What are the ethical issues related to the community that are brought to a regional health ethics service for consultation?” In the literature there are many studies in which researchers focus on ethical issues in a variety of settings, but primarily the focus is on acute care settings. Despite the possibility of shared implications from these studies’ findings for community settings, there was certainly room for further exploration to determine what, if any, ethical issues are specific to community care, and what implications these issues may have for client care and healthcare in that specific setting.

Ethical conflict may also exist when there is uncertainty of what to do when protecting patients’/clients’ rights. Sometimes when we encourage a patient’s/client’s autonomy we may be faced with a potential threat to his/her safety. In the ethical situation of the patient who wished to visit his/her mother via wheelchair independently, the patient’s right to visit his/her mother may give him/her support and pleasure.

However, the associated risks, such as being hit by a car, may be greater than the benefits of the visiting.

All health care professionals should strive to provide quality patient/client care. This provision of quality patient/client care addresses the themes of respect for patients' wishes and the struggle of how to protect patients'/clients' rights. This becomes ethically challenging when competency is being disputed or when patients become incapable of making decisions for themselves. Sometimes patients/clients choose a substitute decision-maker, but other times health may deteriorate rapidly or there simply may not be anyone available to fulfill this role. Staff may find this need for respect frustrating when they know that the treatment they can provide will be life-saving, as for example, when a person with an eating disorder refuses to eat. Staff recognize if they feed the person via a nasogastric tube, survival is very likely and long term effects to her health may be minimal. However, should this person be able to make the decision to refuse treatment or is the person with an eating disorder considered competent?

In respecting patient/client wishes staff may be faced with unfamiliar requests such as different treatment options and a more homeopathic, natural means of healthcare that reflects on different beliefs and values. These requests support the themes of respect for patient/client wishes and possible legalities associated with care. The request to bring home a placenta is one such example. In a situation such as this one, staff may side with the law, however, staff also wants to support cultural beliefs, and therefore there is an ethical conflict.

The use of SDMs may also help address the theme of how to protect patients'/clients' rights. However, for family member's acting as SDMs, how much

power is too much? Should one individual be given the capacity to make such huge decisions when the rest of the family feels differently? One particular example in the consults showed a patient being exposed to hostility because the family disagreed on what the plan of care should be. This is an unfortunate situation to find oneself in as an SDM and in turn places pressure on staff to know what is truly in the client's best interest and who is actually looking out for this best interest.

In an effort to protect the patient's/client's best interest it is important to recognize that unfortunately there are times when a patient's/client's current location is not the most appropriate one in which to provide quality patient/client care. Sometimes the resources simply are not available to support a patient to live in his/her own home or even in an assisted living facility. To help address the themes of lack of resources to meet patient/client needs and patient's/client's needs unable to be met in current setting, these patients/clients should be encouraged and supported in choosing a care environment that is appropriate and safe given their health needs and their need for support. This may be an emotional decision for patients/clients and their families and each party may not always be in agreement.

Situations may also arise when caring for patients/clients poses a threat to others. This becomes a source of ethical conflict as caregivers struggle with the theme of rights of a patient/client versus others. When patients/clients are a danger to themselves or others, the need to find alternative strategies to manage behavior may need to be explored. This may involve the use of restraints to protect an individual patient's/client's safety while at the same time protecting caregivers and other patients who are living with the patient/client.

In an attempt to improve quality of care health professionals can educate patients/clients but patients/clients may not follow this health advice in the community. What they do with this education once they are discharged is up to them. When a patient/client does not follow health advice, health professionals cannot enforce it because this violates patient rights. This issue supports the theme of how to protect patients'/clients' rights. In the example of patients/clients receiving oxygen therapy in their home who have chosen to continue smoking, this has safety implications. If staff believe that there is a risk for continued smoking in the home, they have a duty to disclose that this is taking place because this is not only a risk to the patients/clients receiving oxygen therapy, but also to the others in the area. For health professionals in this study, observing patients/clients acting in ways to harm themselves and/or others was a source of ethical conflict. Also it is not sufficient to disclose information. The disclosure of information to patients/clients, families, and other health professionals needs to be timely. In disclosing this information, those caring for the patient/client are helping to protect the patient and others from unnecessary harm.

Addressing ethical issues is important no matter where they occur. It is especially important to address those issues that may arise in an area where there is no formal committee that exists to address them. Existing literature suggests that healthcare staff often fail to report ethical issues or engage in ethical consults with an ethics committee because they feel it is their professional responsibility to address the issue themselves or via consultation with co-workers (Gaudine, Lamb, LeFort, Thorne, 2011a). This can lead to increasing levels of moral distress. If this is the situation in acute care, where ethics committee are actively working to address ethical concerns, it is possible that moral



distress may be an unrecognized issue in the community because there are fewer resources to address it. In the health authority that was the data source for this study, the community ethical issues that were identified were mostly identified at the point of admission or discharge from acute care. In consults analyzed for this study, very few were issues only occurring in the community. However, the absence of an ethics service in community settings may lead to under reporting of ethical issues in these settings. Alternatively, it may be that the community ethical issues that are addressed successfully at the point of care are during acute care admissions. Until further research occurs, the answer to these questions remains unknown.

Through content analysis I have identified three categories of ethical conflicts in the summaries of consultations from a large health authority that are related to where the ethical situations occur. By analyzing all of the data within these three categories, I have identified eleven themes. The identification of these themes make a contribution to what had been previously known about ethical issues in the community. After reviewing the data it has become evident that some ethical issues are strictly community issues, for example, the issue of relocation due to inability to receive/provide adequate care in the current setting. The majority of the ethical issues identified are not unique to the community setting. Many of the issues occurring in acute care are issues that could have occurred within the community such as, the respect for patients'/clients' wishes and family requesting futile intervention/treatment. Other issues that occur in acute care certainly have implications for care in the community. An example of this is timely communication and treatment of non-compliant patients/clients participating in behaviors counterproductive to care.

Most, if not all, of the ethical issues and themes identified in this study are related to the concept of patient/client well-being and what is in the best interest of the patient/client. This links closely to the central theme of “striving to do what is best for the patient” that I identified in my literature review. Over the past number of decades, patient and family expectations have increased when it comes to healthcare. They expect more treatment options, more pain control, more care. Unfortunately, despite advances to healthcare, sometimes resources simply are not available or sometimes what is available just is not enough. This may lead to ethical/moral distress for patients/clients, families, and healthcare providers. A better understanding of the types of ethical issues that exist in the community setting will hopefully help health care professionals to identify and manage these situations.

### **Strengths and Limitations**

One of the strengths of this study was the use of printed copies of the ethics consults/consult summaries. This allowed for frequent review of the same written data and ensures that others wishing to continue with further research will have access to the identical data used for this study.

A second strength of this study was the cross-examination of data by two researchers, an experienced researcher and I. This was followed by discussion of each ethics consult and agreement on existing issues and possible categories and themes within the data. The use of two researchers enriches the dependability and credibility of the findings of this study.

In addition to strengths, this study did have limitations. One such limitation is that the study was limited to ethics consults and did not include data from interviewing the

director in charge of ethics for the region. All of the data was de-identified and I did not conduct further exploration of the situations in the ethics consults.

Another limitation would be that the data used was only collected from across one health region in Atlantic Canada. This may limit the ability to transfer findings to other areas of the province or country, because there is the potential for different types of ethical issues in more rural or more urban areas, and in areas with residents from different cultures, or with different health needs.

### **Implications for Practice, Education and Future Research**

The study of ethical issues certainly has implications for nurses and physicians no matter what clinical area they may be working in. As a result, many of the themes identified in this study are pertinent to the study of ethics and ethical issues. Given the advances in technology and healthcare and the ability of medicine to cure or extensively treat what was once incurable or untreatable, the healthcare system may find it is actively caring for those patients/clients that are sicker than they have ever been. With these advances come expectations, some that are realistic and some that are not. Families sometimes grasp at glimpses of hope and request that physicians, nurses, and support staff do everything physically possible to save their loved one, despite the fact that these interventions or treatments may be futile. An attempt to save a life may lead to unnecessary pain and/or suffering, decreased quality of life, and hastened death. Advances in technology have also led to the ability to provide treatment for infertility, to plan ahead for patients to conceive children following cancer treatment, and to handle the needs of bariatric patients. The issue is providing this specific care to the minority when resources simply are not available.

Staff, patients/clients, and their families need to be introduced to the availability of existing ethics committees and informed of the type of issues that are appropriate for ethics consultations. This is not only important in acute care settings, but also in community healthcare settings. When ethics committees are consulted and recommendations are made, these recommendations should be reviewed by staff providing care to the patient/client to ensure that all staff understands the plan of care. It is possible that this should also be discussed with the patient/family to make the patient/family aware of staff concerns. Situations need to be discussed on a case-by-case basis as the risks to one patient/client may differ greatly than the risk to another.

In order to manage ethical issues, staff needs to identify what the patient's/client's wishes are and at the same time what is in the best interests of the patient/client. These wishes and best interests should be discussed with the healthcare team and with the SDM and the family to determine whether or not everyone is in agreement with the plan of care. This plan of care should be discussed with the patient/client when possible to reduce any distress that care decisions may cause. If communication is open then the patient/client may be more likely to agree with the decisions as they know the decisions are being made to protect their best interests and that the staff is aware of and respects the patient's/client's wishes but that those wishes are impossible given their increasing needs for supportive care.

Emotional support and the appropriate referrals are necessary to ensure that these transitions occur smoothly and that patients/clients feel comforted when starting a new phase of their life and their care.

The findings of this study have great educational implications for those who care for patients/clients in today's healthcare system. When it comes to ethical discussions in the classroom of future healthcare providers, including nursing, medicine, pharmacy, social work, etc. ethical issues related to the community setting need to be included. There is also an opportunity to facilitate discussion of possible ethical issues through continuing education in the workplace and encouragement of employees to participate in these programs. Rarely is there only one reasonable action when it comes to ethical issues (Pomerantz, 2009). As a result this increase in knowledge surrounding ethics and ethical issues has the potential to improve the quality of patient/client care, because those caring for patients/clients are better able to recognize and address those issues that are of an ethical nature. Awareness that certain ethical situations exist could be beneficial when communicating and planning care for clients in the community healthcare setting.

The concept of ethics encompasses all areas of healthcare, and there is little research in the area of ethical issues in community health care and ethics committees/services for community health care. Therefore, there are endless opportunities for future research. The health region where I did this study did not have a separate ethics committee for community health services. Research could investigate if community health professionals are satisfied when they bring their ethical issues to a regional ethics committee that is based within an acute care setting. As well, research could investigate the structure of ethics committees and/or services across Canada for community health care.

Research would be also helpful in other health regions, provinces, or countries to determine if the themes identified in this study are similar or different than other areas.

Interviews with staff, families, and clients in the community would also be helpful to determine if they think there are in fact ethical issues in the community, if they have ever reported such an issue, whether they are aware of the existence of an ethics committee that addresses the community's ethical issues, and whether or not they think existing issues are being addressed effectively and appropriately. Finally, a comparison of the ethical themes in community care versus those in acute care to determine if there is, in fact, an extensive difference between the two.

Further research is necessary to determine whether or not resources exist to address ethical issues in acute care, long term care, or community care. Without adequate resources, ethical issues may be missed and staff, patients/clients, and families may suffer the unnecessary stress and duress that is associated with unaddressed ethical issues.

### **Advanced Practice Nursing Competencies**

Hamric, Spross, and Hanson (2009) have identified seven core competencies for advanced practice nursing (APN). These competencies are essential for graduates of a master in nursing program and include: direct clinical practice, expert coaching and guidance, consultation, research, leadership, collaboration, and ethical decision-making. In this study I focused primarily on the research competency but the study has also helped me to demonstrate other APN competencies including consultation, collaboration, and ethical decision-making.

### **Research**

As the importance of accreditation and evidence-based practice increases, the research skills of the advanced practice nurse become vital. The focus of this competency

is on three particular components: (1) participation in research; (2) interpretation and use of findings; and (3) evaluation (Hamric et al., 2009).

During this study, I acted as the primary investigator and collaborated with my supervisor throughout various aspects of the research to ensure that my actions and analysis were appropriate and fitting given the data provided. I completed the necessary research proposal and ethics applications and submitted them for approval of my study. Part of this process involved the development of a research question to guide my study.

The literature review I conducted prior to this study assisted me to interpret and use the research that had already been done. I was able to determine through this literature review that there is a lack of research in the area I was intending on studying and this in turn supported my decision to further explore the area of ethical issues in the community. Given the type of data necessary to learn more about my research question, I chose a methodology in collaboration with Dr. Gaudine. This methodology was a qualitative study using content analysis and therefore I reviewed the literature surrounding this methodology. Following the analysis of the documents I analyzed for this study, I was able to present and discuss my findings in this report, including a discussion of the strengths and limitations of my findings and the implications these findings may have for both future research, practice and education.

I further demonstrated the research competency by disseminating my findings through this written report as well as through a PowerPoint presentation at Memorial University of Newfoundland School of Nursing. I will also approach the ethics department in the health region to determine whether or not they would like a further breakdown of the findings of the study.

## **Consultation**

Consultation is especially evident in this particular study as the focus of the study is on ethics consults within the health authority. Consultation as defined by Caplan (1970) in Hamric et al. (2009) is an interaction between two professionals where there is an exchange of specialized expertise. Prior to the initiation of this study I consulted with both the director of ethics and Dr. Gaudine to decide on the best route to take for this study and what data should be included. The data in this study was provided by the ethics department and is the result of forty seven ethics consults within the regional health authority. The findings of this study may also be presented to the ethics department, thus sharing my expertise on the topic following analysis of the data.

## **Collaboration**

It is an expectation that advanced practice nurses will collaborate with others and also participate in research, whether through interpretation or use of evidence in practice, evaluation of practice, or participation in research (Hamric et al., 2009). In this study I collaborated with the director of ethics to determine the best route to take when exploring the ethical issues and concerns of the health authority, and more specifically the community. I will be presenting the results of this study in order that community health professionals and ethics committee members increase their awareness of ethical issues in the community. This study had allowed me to participate not only in this smaller scale research project but has also allowed me to contribute to a larger research project. The findings of this research project will likely assist those working in the community to make better clinical decisions for their patients. I have collaborated with Dr. Alice Gaudine to develop a research proposal, apply for ethical approval for my research



project to analyze the data provided. I have also sought her assistance in developing this final report for my practicum.

### **Ethical Decision-Making**

Finally there is the advanced nursing practice competency of ethical decision-making, which is a form of decision-making that is required when ethical issues arise and individuals are faced with conflicts to their core values (Hamric et al., 2009). APNs are responsible to help decrease moral uncertainty and moral distress for patients/clients and their families. This can be a difficult responsibility as APNs work in a variety of settings. Patients/clients in each setting have unique needs and thus unique ethical issues arise. In this study I examined ethical issues within a health region and the data that was utilized helped narrow down the ethical issues within the provided consults to determine what ethical issues are most prominent in the community setting. By doing this I was able to develop my skill at identifying ethical issues.

Ethical decision-making is also very important to the research process. I have incorporated ethical decision-making throughout this study. Prior to the initiation of data analysis I completed a research ethics application and an application for approval to conduct research at the health authority used for this study. I also discussed potential ethical issues related to my study with my supervisor and the director of ethics for the region. I took special care to ensure that confidentiality was maintained by requesting that data provided by the ethics department was de-identified before I began using it and I took special care to guarantee that any data being used was stored properly. I will also ensure that the data will be stored in the School of Nursing Research Unit for five years after any publication related to my study.

## **Conclusion**

This study has proven to be a valuable learning experience, specifically of how to conduct a qualitative research study and how to implement content analysis with a data set. It has been interesting to review the consults submitted to the ethics committee and to discover how each of the ethical issues within these consults may or may not have implications for care in the community. The literature review gave great insight into the lack of research in the area I wanted to explore, despite the vast changes that have occurred to hospital ethics committees and the instigation of these committees in acute care settings over the past number of years. The findings of the study have made me more aware of the ethical issues that exist not only in community care but also in acute care, and this awareness will certainly impact the care that I provide to my patients as well as the approach that I take to ethical issues in my own practice.

As outlined in the Implications section, there is room for extensive research to gain understanding of ethical issues in community health care, and the repercussions that these issues have for staff, clients, residents, and their families. As well, future research that identifies ethical issues in the community can lead to better recognition of these issues by health care professionals and improvements in care.

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