Postpone death?
In memory of Peter Sjökvist, research colleague and friend
1957–2003

"Every path we take leads to fantasies about the path not taken."
HALCON
Mia Svantesson

POSTPONE DEATH?
Nurse-physician perspectives on life-sustaining treatment and ethics rounds
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Title: Postpone death? Nurse-physician perspectives on life-sustaining treatment and ethics rounds

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ABSTRACT

The starting point of the present thesis is nurses’ reported experiences of disagreements with physicians for pushing life-sustaining treatment too far. The overall aim was to describe and compare nurses’ and physicians’ perspectives on the boundaries for life-sustaining treatment and to evaluate whether ethics rounds could promote mutual understanding and stimulate ethical reflection.

A mixed methods design with qualitative and quantitative data was used, including interviews and questionnaires. The health-professionals’ experiences/perceptions were based on known patients foremost from general wards, but also intensive care units, at four Swedish hospitals. The first two studies treated the perspective on boundaries for life-sustaining treatment and the last two evaluated philosopher-ethicist led ethics rounds. Analysis of data was performed using a phenomenological approach and content analysis as well as comparative and descriptive non-parametric statistics.

In the first study, the essence of the physicians’ decision-making process to limit life-sustaining treatment for ICU patients, was a process of principally medical considerations in discussions with other physicians. In the second study, there were more similarities than differences between nurses’ and physicians’ opinions regarding the 714 patients studied. The physicians considered limited treatment as often as the nurses did. The ethics rounds studies generated mixed experiences/perceptions. It seemed that more progress was made toward the goal of promoting mutual understanding than toward the goal of stimulating ethical reflection. Above all, the rounds seemed to meet the need for a forum for crossing over professional boundaries. The most salient finding was the insight to enhance team collaboration, that the interprofessional dialogue was sure to continue. Predominating new insights after rounds were interpreted as corresponding to a hermeneutic approach. One of nurses’ negative experiences of the ethics rounds was associated with the lack of solutions. Based on the present findings, one suggestion for improvement of the model of ethics rounds is made with regard to achieving a balance between ethical analyses, conflict resolution and problem solving.

In conclusion, the present thesis provides strong evidence that differences in opinions regarding boundaries for life-sustaining treatment are not associated with professional status. The findings support the notion of a collaborative team approach to end-of-life decision-making for patients with diminished decision-making capacity. There is an indication that stimulation of ethical reflection in relation to known patients may foremost yield psychosocial insights. This could imply that social conflicts may overshadow ethical analysis or that ethical conflicts and social conflicts are impossible to distinguish.

Keywords: Clinical ethics, life-sustaining treatment, end-of-life decisions, attitudes, nurses, physicians, inter-professional relations, ethics consultation, ethics rounds, reflective ethical practice
The present thesis is based on the following studies:


II. Svantesson M, Sjökvist P, Thorsén H, Ahlström G. Nurses’ and physicians’ opinions on aggressiveness of treatment for general ward patients. Nursing Ethics 2006 13(2):147-161


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INTRODUCTION

As a graduate nurse 20 years ago, I remember one day on the surgical ward when Tora (assumed name) was the last patient for the afternoon round. She had been an inpatient for months due to a ruptured bowel, secondary to radiation for ovarian cancer. Again, she had a high fever and the senior consultant suspected a new ruptured bowel and ordered an X-ray. He left the room, but I stayed with Tora. She started to weep and said “I don’t want to, I can’t take it any longer”. This made me run after the doctor who was just about to leave the ward. Completely out of breath I shouted, “Dr X”. Seeming a bit irritated, he stopped. I told him that Tora could not take it any more and did not want the X-ray. Furious and without a word, he turned on his heels and left the ward. Now you may think that this doctor was not very nice. On the contrary, his patients loved him and I know he wanted the best for them. Wanting the best for Tora seemed to imply pursuing life-sustaining treatment. On the other hand, maybe you think I was a naive nurse thinking short-sightedly. I also wanted the best for Tora – to relieve her suffering. This meant palliative treatment. Who was right?

This is the point of departure for my thesis: nurses in industrial countries who are frustrated with physicians for pushing life-sustaining treatment too far. When treatment only seems to extend suffering and postpone the foreseeable death, care sometimes feels demoralizing. The phenomenon under study is the disagreement over whether to continue or limit treatment. The stakeholder perspective is that of nurses’ and physicians’, parties concerned in end-of-life decision-making. The first step was to understand how physicians reason and to compare nurses’ and physicians’ opinions. The second step was to find a way to improve end-of-life decision-making.

BACKGROUND

Problems associated with stakeholders in end-of-life decision-making

Continuing or limiting life-sustaining treatment is the paramount ethical issue in hospital care.56,88,121 The ability to stretch the limits through technology has led to difficulties in determining when it is appropriate to accept that a patient is dying. Prognosis may be uncertain, and knowing when to stop when the benefit is no longer in prospect is difficult. The decision is not solely medical, since consideration must be taken both to the effectiveness of treatment and the meaningfulness.141 Effectiveness refers to measures that lead to prolonged life and meaning-
fulness to the ethical dimension, the subjective assessment that continuing treat-
ment is meaningful. Thus, decision-making combines medical considerations with 
the values and beliefs of multiple stakeholders.⁶

A simple definition of life-sustaining treatment is “drugs, medical devices, or pro-
cedures that can keep individuals alive who would otherwise die within a foresee-
able, but usually uncertain, time period”.¹⁹³ Life-sustaining treatment includes 
mechanical ventilation and advanced cardiac life support, exclusively used in in-
tensive care. Other life-sustaining treatments that may also be used in general 
wards are renal dialysis, cardio-pulmonary resuscitation, surgery, chemotherapy, 
antibiotics, nutritional support, hydration.⁹¹ Depending on the intention, a treat-
ment can be life-sustaining or palliative, i.e. relieving symptoms to improve qual-
ity-of-life.⁶²,²⁰² For example, a blood transfusion can be life-sustaining, but also 
palliative in that it decreases symptoms of fatigue.

The patient

Although the patient is a key stakeholder in end-of-life decision-making, studies 
show low patient involvement.¹⁴,²⁷,³⁹,⁶¹,⁷⁸,⁸³ However, problems have been reported 
concerning patient involvement: physicians’ avoidance behavior to talk about 
death with the patient,¹²⁴ patients’ lack of decision-making capacity accompanied 
by lack of advance directives,⁶²,¹⁸⁴ as well as patients’ reluctance towards involve-
ment in end-of-life decision-making⁸²,⁸³,¹⁴⁴,²⁰⁴ or to assume an active role in their 
own care.⁵⁴ Other studies have shown that patients want to be involved in such 
decisions.⁷⁸,⁹⁶,¹¹⁵,¹⁵³ If asked, the majority of severely ill patients want life-
sustaining treatment⁴⁴,⁷⁰,¹¹⁷,¹³¹ including cardiopulmonary resuscitation (CPR).¹²⁷, 
¹³⁴,¹⁵²,²⁰⁴ Studies also show that older people overestimate the efficacy of CPR.¹²³ In 
connection with this, in two studies, patients’ were asked about their wishes be-
fore and after informing them of the low prognosis of survival after CPR.¹²⁸,²⁰⁴ In 
one study, most of the patients then did not want CPR¹²⁸ while those in the other 
study still did.²⁰⁴

Dying a high-technology death with suffering and lack of control is frightening,²⁸ 
but studies show that severely ill patients want life-sustaining treatment. Though 
there are reports of suffering and distress from former ICU patients,¹¹¹,¹¹² the ma-
jority are positive toward renewed ICU stays.⁷⁰ In a study outside the present the-
sis, European co-researchers and I found that half of the former ICU patients val-
ued life itself as a supreme value over quality-of-life and wanted renewed ICU 
stays, even if this only gave an extra month’s survival.¹⁷⁴ The will to live is re-
ported to be strong for patients with cancer recurrence\textsuperscript{49} and even in the final course of the illness,\textsuperscript{183} but it is also reported to vary considerably.\textsuperscript{32} This may imply that a critical ill person and with a strong will to live may request life-sustaining treatments that the physician views as futile.\textsuperscript{48,138}

Next-of-kin
Next-of-kin or the family is also a paramount stakeholder in the decision-making process, especially when the patient has diminished decision-making capacity. There are reports that patients view the family’s role as central to decision-making,\textsuperscript{82,158} but complications also occur when advocating the patient’s best interests. Studies have shown that few families know the patient’s preferences regarding life-sustaining treatment\textsuperscript{40} and that some have inaccurate ideas about the patient’s wishes.\textsuperscript{103,143} Health care professionals have reported moral distress situations when families want to continue aggressive treatment\textsuperscript{118,168} against the patients’ wishes.\textsuperscript{148} When families wanted everything done, they were experienced as having too much power over decision-making\textsuperscript{167} and as acting solely in their own interests.\textsuperscript{135}

Society: guidelines
In Sweden, there are no laws regulating decisions concerning life-sustaining treatment, only guidelines.\textsuperscript{172,176,177} According to the Swedish National Board of Health and Welfare, physicians may limit life-sustaining treatment and have the sole decision-making responsibility.\textsuperscript{172} The focus of national and international guidelines is however not on when to limit, but on the stakeholders in the decision-making process. The physician should be guided by the patient’s wishes, or if incapacitated, by advance directives or what the next-of-kin believe to be the patient’s wishes.\textsuperscript{19,150,172,176,177,185} Most guidelines also stress the importance of discussion and taking into account the views of other health professionals concerned.\textsuperscript{19,172,176,185} In the Swedish Society of Medicine’s guidelines on CPR,\textsuperscript{176} allied health professionals are one of the stakeholders, but in other guidelines on withholding and withdrawing life-sustaining treatment, allied health professionals are not mentioned.\textsuperscript{177}

All guidelines protect the patient’s rights of autonomy, but only as negative rights, implying that the patient only has the right to refuse treatment. This makes the involvement of patients in decisions of CPR especially complicated. The patient cannot demand CPR, as this is limited by the physician’s clinical judgment.\textsuperscript{62,190}
This brings us to the problem of social justice. Ineffective treatment of a particular individual may consume resources better spent on treatment of others. The Swedish Health and Medical Services Act was influenced by the report of the Swedish Parliamentary Priorities Commission. According to the commission, three basic ethical principles guide the distribution of care. They are, in order of decreasing importance: the principle of human dignity, the principle of need and solidarity, and the principle of cost-effectiveness. There has been criticism, however, against ranking the principle of need before the principle of cost-effectiveness. For patients with serious diseases, belonging to the group with the highest degree of urgency, this means that the higher the degree of ill health, the lower the claim on cost-effectiveness. This may imply that the terminally ill patient has the greatest need for life-sustaining treatment, but that the treatment may not be cost-effective, i.e. poor chances of survival or poor quality-of-life. However, guidelines only consider groups of patients, and cost-effectiveness only considers methods. There are few systematically open priorities, especially regarding life-sustaining treatment, though guidelines for recommended treatments for different groups of diseases have been put forward. In conclusion, societal guidelines support physicians regarding their possibility to limit life-sustaining treatment and give consideration to stakeholders, but not regarding when to limit, that is, how to apply guidelines to prioritization on the individual patient level.

**Healthcare professionals**

Stakeholders are physicians, nurses, nurse’s assistants and allied professionals. The healthcare professionals most often reported to experience ethical problems regarding end-of-life decision-making are the physicians and nurses. Traditionally, physicians are seen as the sole stakeholder in the decision-making process and nurses only as the executors of the decisions, as most studies report low nurse involvement. According to previous studies, nurses experience frustration with physicians regarding the decision-making process (Table 1). Nurse’s assistants’ experiences of ethical problems have also been described, but their stories did not concern the decision-making process, instead their relationship with patients and patients’ families.

**In summary: Problems associated with stakeholders**

Problems of patient/family involvement and lack of societal guidance concerning when to limit life-sustaining treatment seem to entail great power and responsibility for the physicians in the decision-making process, but to also affect the executors of these decisions, the nurses. There are reports of nurses’ disagreements with
physicians regarding the decision-making, and thus, it would seem to be important to study nurse-physician perspectives.

**Nurse-physician perspectives on end-of-life decision-making**

**Nurses-physician experiences in relation to each other**

Though the core ethical problem for both nurses and physicians regarding end-of-life issues is the overtreatment of dying patients, nurses seem to experience more disagreements and frustration than physicians do regarding end-of-life decision-making. Qualitative findings on nurses’ moral outrage against physicians are presented in Table 1. According to the sociologist Chambliss, this may be described as one of nursing’s systematic ethical problems, in that the same problems recur time and again in various settings and different countries. Of 230 Australian intensive care unit (ICU) nurses, 95% reported disagreements, daily to at least once a month, with physicians regarding their decisions to inappropriately initiate and continue life-sustaining treatment. In an American study of nurse-physician perspectives on the care of dying patients in ICUs, 75% of nurses experienced frustration about end-of-life communication with the physicians, whereas none of the physicians had recognized the nurses’ frustration. At the same time, harmony between nurses concerning this issue has been reported. In some studies showing nurses’ negative judgments of physicians’ behavior, nurses could nevertheless acknowledge the difficulty of the physicians’ situation and were also aware that severely ill patients occasionally survive against all odds.

Fewer studies have looked into physicians’ experiences of end-of-life decision-making, and when this has been studied, both nurses’ and physicians’ experiences are often explored. In interviews with physicians, nurses seldom appear in their stories and disagreements with nurses are hardly recognized. Physicians report more satisfaction with end-of-life decision-making processes than nurses do. In one study, physicians indicated communication with nurses regarding aggressiveness of treatment for 34% of the patients, while the nurses agreed with this in 3%. In another large study on conflicts in end-of-life decision-making, nurses experienced conflicts with the physicians, while physicians experienced conflicts with other physicians higher in the hierarchy. There are, however, reports indicating that physicians believe nurses are keener to stop treatments and sometimes feel pressured by them to stop. Physicians felt nurses lacked medical knowledge and could not remember the miracles that do occur. According
to two other studies’ descriptions of physicians’ experiences, physicians felt that nurses wanted to participate in decision-making, but did not want to share the decision-making responsibility.\textsuperscript{194,200} There are reports of physicians missing communication and support, but from other physician colleagues. They experience both little room for discussion\textsuperscript{182} and fear of discussing ethical difficulties and uncertainties. It was perceived as easier to continue treatment, as this would save them from being criticized.\textsuperscript{168,178,181,182}

Comparing nurses’ and physicians’ experiences, nurses narrate more pessimism about prognosis than physicians do\textsuperscript{84,194} and they narrate more certainty that patients are going to die.\textsuperscript{43,194} When nurses cite problems of overly aggressive treatment, physicians are more likely to cite reflections on uncertainty about how to decide\textsuperscript{18,182,194} or on agonizing about whether they have made the right decision.\textsuperscript{135} In essence, when nurses question physicians, physicians question themselves\textsuperscript{135} or physicians higher in the hierarchy.\textsuperscript{17} Let us see in the next section how nurse/physician experiences of each other correlate with their attitudes and opinions.
Table 1 Nurses’ experiences of end-of-life decision-making in relation to physicians

<table>
<thead>
<tr>
<th>Disagreement over too much treatment</th>
<th>Country</th>
<th>Authors</th>
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<tbody>
<tr>
<td>Initiation and continuation of overly aggressive or meaningless treatment</td>
<td>Australia</td>
<td>Bucknall 1997&lt;sup&gt;22&lt;/sup&gt;</td>
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<tr>
<td></td>
<td>Norway</td>
<td>Torjuul 2006&lt;sup&gt;191&lt;/sup&gt;</td>
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<td></td>
<td>Sweden</td>
<td>Udén 1995&lt;sup&gt;195&lt;/sup&gt;</td>
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<td></td>
<td>USA</td>
<td>Brett 2002&lt;sup&gt;18&lt;/sup&gt;</td>
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<td></td>
<td>Sweden</td>
<td>Udén 1992&lt;sup&gt;194&lt;/sup&gt;</td>
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<tr>
<td>Delayed decisions</td>
<td>Canada</td>
<td>Oberle 2001&lt;sup&gt;135&lt;/sup&gt;</td>
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<td></td>
<td>Finland</td>
<td>Kuuppelomäki 2002&lt;sup&gt;98&lt;/sup&gt;</td>
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<tr>
<td></td>
<td>Finland</td>
<td>Hildén 2004&lt;sup&gt;81&lt;/sup&gt;</td>
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<td></td>
<td>Australia</td>
<td>Bucknall 1997&lt;sup&gt;22&lt;/sup&gt;</td>
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<td></td>
<td>Norway</td>
<td>Bunch 2000&lt;sup&gt;23&lt;/sup&gt;</td>
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<td></td>
<td>Norway</td>
<td>Hov 2007&lt;sup&gt;84&lt;/sup&gt;</td>
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<td></td>
<td>Sweden</td>
<td>Udén 1992&lt;sup&gt;194&lt;/sup&gt;</td>
</tr>
<tr>
<td>Not allowing old patients to die</td>
<td>Canada</td>
<td>Bucknall 1997&lt;sup&gt;22&lt;/sup&gt;</td>
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<td></td>
<td>USA</td>
<td>Redman 2000&lt;sup&gt;148&lt;/sup&gt;</td>
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<td></td>
<td>Sweden</td>
<td>Cronqvist 2004&lt;sup&gt;43&lt;/sup&gt;</td>
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<th>Frustrations over physicians’ characteristics</th>
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<th>Authors</th>
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<tr>
<td>Fear of making end-of-life decisions</td>
<td>Finland</td>
<td>Hilden 2004&lt;sup&gt;81&lt;/sup&gt;</td>
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<td></td>
<td>Sweden</td>
<td>Silén 2008&lt;sup&gt;167&lt;/sup&gt;</td>
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<tr>
<td>Heterogeneous attitudes and contradictory orders</td>
<td>Norway</td>
<td>Torjuul 2006&lt;sup&gt;191&lt;/sup&gt;</td>
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<td></td>
<td>Sweden</td>
<td>Silén 2008&lt;sup&gt;167&lt;/sup&gt;</td>
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<td>Sweden</td>
<td>Udén 1995&lt;sup&gt;195&lt;/sup&gt;</td>
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<th>Frustration over communication</th>
<th>Country</th>
<th>Authors</th>
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<tr>
<td>Do not listen</td>
<td>Canada</td>
<td>Oberlee 2001&lt;sup&gt;135&lt;/sup&gt;</td>
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<td></td>
<td>Sweden</td>
<td>Silén 2008&lt;sup&gt;167&lt;/sup&gt;</td>
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<td></td>
<td>Sweden</td>
<td>Silén 2008&lt;sup&gt;167&lt;/sup&gt;</td>
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<tr>
<td>Lack of meetings</td>
<td>France</td>
<td>Ferrand 2003&lt;sup&gt;52&lt;/sup&gt;</td>
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<td></td>
<td>Norway</td>
<td>Hov 2007&lt;sup&gt;84&lt;/sup&gt;</td>
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Nurse-physician attitudes and opinions about aggressiveness of treatment

Most studies on this issue have focused on ICU staff’s attitudes in general or are based on hypothetical patients. In surveys on nurses’ and physicians’ attitudes toward level of aggressiveness of treatment for hypothetical patients, there were no differences associated with professional status.²⁹,⁶⁰,¹⁶⁹ Findings from two studies on opinions based on real patients showed conflicting results, in one nurses were less aggressive than physicians were⁶⁰ and in the other there were no differences between them.⁵⁰

Regarding attitudes and opinions influencing decisions on aggressiveness based on both hypothetical and real patients, few differences have been found between nurses and physicians. Closed-ended items most commonly used for both hypothetical and real patients were the patient’s wishes, age and quality-of-life. Studies have shown that these are the most important rationales.⁵,³⁶,⁶⁰,¹³³,¹⁵¹,¹⁶⁹ Medical aspects were also commonly used, but were described in other ways, such as likelihood of survival, premorbid illnesses, futility and prognosis.⁶⁰,¹³³,¹⁶⁹

In summary: Nurse-physician perspectives

Few studies have gone beyond nurses’ and physicians’ experiences to exploring their reasoning and opinions in actual clinical practice with real patients. Physicians’ reasoning has been less explored than nurses’ has, and to my knowledge no study has explored physicians’ reasoning regarding actual end-of-life decisions. Few studies have compared nurses’ and physicians’ opinions regarding aggressiveness of treatment, especially for general ward patients, and the findings show conflicting results. Furthermore, nurses’ reported disagreements with physicians seem to be closely connected with feelings of frustration, especially over lack of communication.

How to improve end-of-life communication between nurses and physicians

Promoting mutual understanding

Starting from nurses’ experiences of disagreement over too much treatment and frustration over communication with physicians, a limited understanding of each other’s role,³⁶,¹³⁵,²⁰⁰ and lack of communication are seen as major causes for conflicts regarding life-sustaining treatment.¹⁷,³⁰,⁶³,¹⁹⁴ A collaborative team approach is called for and advocated with regard to end-of-life decision-making.⁴,⁶,³⁸,⁶²,⁷⁶,¹¹³,¹⁷⁵,²⁰⁰ Katzenbach and Smith⁹² defined a team as “a small number of people with complementary skills who are committed to a common purpose, perform-
Compared to other areas such as psychiatry, which has a well-established system of interprofessional teamwork, teamwork in the care of critically ill hospital patients does not seem to be generally established. Several studies have shown that collaboration in interprofessional teams generally lead to more efficient work, timesaving and reduced costs compared to efforts from a lone profession. However, objective valid outcome measures are difficult to find, and in one review study, only 11 of 2000 studies qualified as good research. Thylefors concluded that the superiority of interprofessional teams has not been proven. In a scientific report on interprofessional teamwork, Blomqvist also found studies that do not support teamwork. Teamwork may lead to more conflicts due to profession-related differences and to overly time-consuming decision-making processes.

Improved communication through use of daily goals for care in ICUs led to decreased length of stay. Within the area of end-of-life decision-making, some studies support the notions that improved physician-nurse collaboration leads to improved quality of care and earlier transition to palliative care. Bunch found that in situations where team organizations were established, nurses and physicians made consensus agreements on limiting treatment. In more hierarchical places of work, physicians made decisions themselves, which nurses sometimes felt was not the most ethical decisions.

One Swedish study evaluated an intervention involving ethical discussion groups intended to improve the climate in interprofessional work between social and nursing staff in special houses for elderly and disabled people. The goal of the discussions was to promote mutual understanding between the professional groups. Scales of job satisfaction, sense of coherence and burn-out were used for the intervention and control group as well as qualitative interviews about their experiences. The only findings showing positive changes of the intervention were those from the qualitative part. The interviews revealed that the discussion groups had helped the staff groups come closer, and subtle changes were seen in their attempts to understand colleagues’ perspectives and to view them as less of a hindrance.
Therefore, together with nurses’ experiences of overtreatment and lack of communication, there appears to be an incentive to improve end-of-life decision-making by creating an arena for dialogue concerning severely ill patients. An important intermediate goal to improve decision-making would be to promote mutual understanding between nurses and physicians.

**Stimulating ethical reflections**

Improving dialogue alone may not improve end-of-life decision-making, as there still remain the difficulties of determining when and how to limit life-sustaining treatment. Kalvemark referred to previous research on health staffs’ lack of support to deal with ethical problems.

**Ethics consultation**

In North America, dealing with clinical ethical problems through ethics consulting (EC) has been in practice since the 1970s and is offered in most hospitals today. A consensus conference in Chicago 1995 led to following definition: “**Ethics consultation is a service provided by an individual consultant, team, or committee to address the ethical issues involved in a specific clinical case. Its central purpose is to improve the process and outcomes of patient care by helping to identify, analyse, and resolve ethical problems**.” There are, however, reports on the high degree of variability in EC services and its tasks, goals and effects are a source of ongoing debate. A recent major survey exploring EC goals in hospitals throughout the U.S. showed that the most common goals are to protect patient rights, improve care and resolve conflicts. A less common goal is to educate staff about ethical issues. The majority of consultations are one-to-one discussions with health care staff or the patient/family, resulting in recommended courses of action. The main reason for contacting EC services is end-of-life decision-making. North American ethics consultants, so-called ethicists and foremost members of clinical ethics committees, come from a variety of professional backgrounds: They are physicians, nurses, priests, lawyers, social workers or philosophers. However, in a recent study of EC practices, ethicists were primarily clinicians without formal ethics education and less than 5 % of them were philosophers. The authors saw the lack of ethics education as a cause for concern. Meyers defended the philosopher as ethicist, arguing that they have skills of reasoned arguing and that there is an expectance of impartiality. No study has examined the
role of only using philosophers as ethicists. Furthermore, there is also disagree-
ment over the role of ethicists, concerning whether they should only clarify the
circumstances or give recommendations, i.e. whether they should assume a fa-
cilitative or authoritative role.

Subjective evaluations of ethics consultation have shown high staff satisfaction,
also among physicians, regarding help in identifying, analyzing and solving ethical
problems as well as issues of ethics education. Objective evaluations of EC in
intensive care have shown positive outcomes of reduction in non-beneficial treat-
ment and costs, through earlier decisions to limit life-sustaining treatment com-
pared to the control group. One of these studies involved 550 patients at
seven hospitals. The EC went through the following steps in this study: reviewing medical records, interviewing those involved in the patient’s care, formulating an ethical diagnosis, improving communication between those involved from team meetings to formal conferences involving an ethics committee, facilitating resolu-
tion and follow-up support.

In Europe, EC similar to those in the American model have been reported, but Reiter-Tell et al. conclude that empirical research of this topic remains un-
derdeveloped. In Sweden, the moral philosopher Brülde introduced a form of ethics consulta-
tion in clinical practice as a non-scientific project during 2002, on commission by
the Swedish Association of Local Authorities and Regions. Thereafter, a national
network of philosophers was established, assisting health care professionals with
clinical ethical problems. Brülde found that the staff wanted help in identifying
and analyzing ethical problems, but not help with solving them. Some skepticism
has been expressed about using ‘expert’ help to solve ethical problems. Pellegrino
pointed out the risk that an outside expert could remove responsibil-
ity from the person formally in charge of decision-making. Contrary to American
ethics consultation, the European literature seems to show that support for health
care teams in dealing with ethical problems through reflective practice is more
commonly advocated and practiced. Thus, it would seem ap-
propriate to support Swedish staff by stimulating ethical reflection, that is by
helping them identify and analyze ethical problems, but not by helping them to
solve such problems. This stimulation may prepare staff for solving ethical prob-
lems on their own in the future.
Models of ethics rounds

Stimulating ethical reflection involves a pedagogic component. WHO advocates shared learning between different professional groups in healthcare, which implies learning with, from and about each other to improve collaboration and the quality of care. Regarding ethics education, there is a gap between theory and practice and case-based teaching is advocated. One pedagogical challenge is to discuss patients known to the participants. The social context is taken into account, which brings realistic complexity into the discussion, preventing simple solutions, as compared to hypothetical scenarios. Furthermore, as regards using the case method, studies show more effective learning when an actual critical situation from clinical practice is involved.

One form of reflective ethical practice is ‘ethics rounds’. The term has been previously mentioned in North American literature, usually in association with the teaching of medical ethics to students and practicing professionals by means of case discussions. No scientific evaluation has been found. In a Swedish model initiated by Hansson, an ethicist leads discussions with staff concerning a particular patient case. The ethicist’s role is to facilitate a democratic dialogue. No one is an expert, and the ethicist helps to bridge any gaps and alleviate tensions due to workplace hierarchies so as to focus on the matter on hand. By listening to each other’s perspectives, participants can become aware of alternative perspectives and multiple values related to clinical practice. Hansson stressed that the ethicist may give valuable input with regard to the weighing of values at stake for the patient, but the moral responsibility for decision-making still rests with the staff.

One study evaluating the above-mentioned ethics rounds model, using scales of moral distress to indicate improved ethical competence and another evaluating ‘moral case deliberation’ using responsive evaluation were published after the present research project had been finished.

In summary: How to improve end-of-life communication

To help nurses, physicians and allied health professionals improve end-of-life communication, it seems important to promote mutual understanding and to stimulate ethical reflections using a model of ethics rounds. To my knowledge, no study illuminating and evaluating reflective ethical practice regarding known patients has been published at this stage.
AIMS OF THE THESIS

The overall aim of the present thesis was to describe and compare nurses’ and physicians’ perspectives on the boundaries for life-sustaining treatment and to evaluate whether ethics rounds could promote mutual understanding and stimulate ethical reflection.

This is presented in four studies with the following specific aims:

I. To explore how admitting-department physicians reason when they make end-of-life decisions for ICU patients.

II. To describe and compare nurses’ and physicians’ opinions regarding level of life-sustaining treatment for their patients and the rationales on which their opinions were based.

III. To describe and evaluate one ethics rounds model, by describing nurses’ and physicians’ experiences from the rounds. An additional aim was to describe their opinions of how ethical discussion should be conducted.

IV. To describe and evaluate whether the ethics rounds stimulated ethical reflection.

With respect to the aims of the studies, the term evaluate is used in the sense of ‘formative evaluation’. It provides description of patterns of strengths and weaknesses so that improvements can be recommended. Guba and Lincoln referred to this as second-generation evaluation as opposed to first-generation, which determines effectiveness through measurement. The studies exist in a context and attention is paid to the local situation, without the possibility to control conditions.
METHOD

Design
The present research project had a mixed methods design including both qualitative and quantitative data. The nature of the research questions, accompanied by pragmatic assumptions about the different methods’ strengths in terms of data collection and analysis, has guided the choice of methods rather than any philosophical assumptions. Greater weight has been given to the qualitative approach, as it is useful when the subject under study is relatively unexplored and when investigating individual experiences as well as in capturing complex social processes. Two of the studies (Study I and III) were exclusively qualitative, whereas the two others involved mixed methods (Table 2). The three first studies had an inductive approach and the last a deductive approach, as patterns started to emerge in the inquiry.

Setting
The setting was intensive care units (Study I) and general wards (Study II-IV) at four Swedish hospitals (Table 2).

In Study III and IV, a model of ethics rounds was applied that was inspired by the ethics rounds model by Hansson in combination with the goal established by the American Task Force on Standards for Bioethics Consultation, to identify and analyze the ethical problem, excluding the solving component. Four philosopher-ethicists, rotating between departments, led interprofessional care conferences regarding particular dialysis patients. The philosophers were recruited from the recently established national network. They held different ethical theories – consequentialist, realist, particularist and the fourth held no particular theory. The goals of the rounds were to promote mutual understanding and stimulate ethical reflection. The rounds were held regularly every other month, in total four times at each hospital, and each session lasted one and a half hours. The head nurse chose the patient to be the subject of the ethics rounds, in accordance with the advice of the nurses and in consultation with the physicians. It was the most moving cases that were chosen. See further description in Study III and IV.
<table>
<thead>
<tr>
<th>Study</th>
<th>Design Settings</th>
<th>Selection Participants</th>
<th>Drop-out/ internal drop-out</th>
<th>Patients as source for data collection</th>
<th>Data collection</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Qualitative</td>
<td>Consecutive, studying a continuous series of end-of-life decisions</td>
<td>17 physicians from admitting department, in charge of 17 intensive care patients</td>
<td>0/- 17 ICU patients, with decision to limit life-support. Deceased or alive</td>
<td>After end-of-life decisions. Interviews with phenomenological approach</td>
<td>Inductive Phenomenological according to Giorgi</td>
</tr>
<tr>
<td>II</td>
<td>Quantitative/Qualitative</td>
<td>Comparative</td>
<td>107 nurses and 65 physicians</td>
<td>During duty. Structured interviews with closed- and open-ended questions</td>
<td>Inductive Descriptive and comparative statistics Content analysis</td>
<td></td>
</tr>
<tr>
<td>III</td>
<td>Qualitative</td>
<td>Evaluative</td>
<td>11 nurses, 7 physicians</td>
<td>After the end of all rounds. Semi-structured interviews</td>
<td>Inductive Manifest and latent content analysis</td>
<td></td>
</tr>
<tr>
<td>IV</td>
<td>Qualitative/Quantitative</td>
<td>Evaluative</td>
<td>59 nurses, 23 nurse’s ass, 13 physicians, 8 allied prof. participating in 1-4 ethics rounds at 3 nephrology departments</td>
<td>Before and after each ethics rounds. Ethical discussions with medical residents and nurses</td>
<td>Deductive Directed content analysis Descriptive and comparative statistics</td>
<td></td>
</tr>
</tbody>
</table>

Table 2 Methods Study I - IV
Participants
Of the stakeholders in end-of-life decision-making, the present perspective was mainly limited to the nurse-physician perspective (Study I-IV) (Table 2). Most of the participants were female nurses and male physicians. Other professionals such as nurse’s assistants, social workers, physio- and occupational therapists participated in one of the studies (Study IV), but their part will not be separately analyzed. Different selection strategies were used in the studies (Table 2).

Data collection
All data collection was based on patients, where the majority were general ward patients (Study II-IV) in current treatment and the minority ICU patients (Study I) (Table 2).

Interviews
In Study I, the interviews with physicians applied a phenomenological approach with one single question (Table 3) and without interrupting the physicians. In Study II, two research nurses and I asked nurses and physicians structured questions (Table 3) and an open-ended question. When answers seemed unclear, the interviewers asked for clarification. In Study III, a co-researcher who is a physician interviewed the physicians and I as a nurse interviewed the nurses (Table 3).

Questionnaires
In Study IV, a self-reporting pre-/post-questionnaire for the ethics rounds was used (Table 3). Inspiration in formulating the questions was derived from Thorsén’s decision model of ethical problems and from Schneiderman et al.’s follow-up questions regarding helpfulness of ethics consultation. In the pilot test of the first questionnaire, staff answered on the basis of ethically problematic patient situations. All answers were rich and no misunderstanding was detected. In the second pilot test, including both questionnaires, a philosopher led an ethics round at another nephrology department. The answers after the rounds were less rich than the answers before rounds. A discussion afterwards with the participants resulted in reformulations into simpler language.
Table 3 Questions in the interviews and the questionnaires

**Study I** (interview with phenomenological approach)

<table>
<thead>
<tr>
<th>Question</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can you give a description of the time when you first learned of the patient to when the decision was made to forego life-sustaining treatment?</td>
<td>Open-ended question</td>
</tr>
</tbody>
</table>

**Study II** (structured interview)

<table>
<thead>
<tr>
<th>Question</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expectation of survival for your patient?</td>
<td>Closed-ended question*</td>
</tr>
<tr>
<td>In your opinion, what level of life-sustaining treatment is appropriate for your patient?</td>
<td>Closed-ended question**</td>
</tr>
<tr>
<td>The rationale for your opinion?</td>
<td>Open-ended question</td>
</tr>
</tbody>
</table>

**Study III** (semi-structured interview)

<table>
<thead>
<tr>
<th>Question</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please, describe how you experienced the ethics rounds.</td>
<td>Open-ended question</td>
</tr>
<tr>
<td>How would you like discussions about ethical problems at your workplace to be conducted in the future?</td>
<td>Open-ended question</td>
</tr>
</tbody>
</table>

**Study IV** (questionnaire)

**Questions before the ethics rounds**

<table>
<thead>
<tr>
<th>Question</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you believe that an ethicist can help you insights into the ethical problems in the care of the patient in question?</td>
<td>Closed-ended question***</td>
</tr>
<tr>
<td>2. Describe the ethical problems that you perceive in the care of the patient in question.</td>
<td>Open-ended question</td>
</tr>
<tr>
<td>3. Describe how you think the team should try to solve the ethical problems.</td>
<td>Open-ended question</td>
</tr>
</tbody>
</table>

**Questions after the ethics rounds**

<table>
<thead>
<tr>
<th>Question</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Have you gained any insights during the ethics round regarding what the ethical problems are in the care of the patient in question?</td>
<td>Closed-ended question***</td>
</tr>
<tr>
<td>5. Have you gained any insights into how the team should try to solve the ethical problems?</td>
<td>Open-ended question</td>
</tr>
<tr>
<td>6. Follow-up question from 4 and 5: If you experienced gaining new insights regarding the care of the patient in question, please describe these insights.</td>
<td>Open-ended question</td>
</tr>
<tr>
<td>7. If you answered “None” or “Low level” on Question 4 or 5, please describe what the reasons might be.</td>
<td>Open-ended question</td>
</tr>
<tr>
<td>8. Indicate to what level the ethicist facilitated your insights.</td>
<td>Closed-ended question***</td>
</tr>
<tr>
<td>9. Indicate to what level the participating staff facilitated your insights.</td>
<td>Closed-ended question***</td>
</tr>
</tbody>
</table>

* Alternatives: Less than one month, less than one year, greater than one year or not predictable

**Alternatives: Full life-sustaining treatment, limited life-sustaining treatment or uncertain about level of aggressiveness.

*** Adjective scale: none (1), low (2), moderate (3), rather high (4) and high (5).
Qualitative analysis

Phenomenology
In Study I, phenomenology was chosen to minimize my influence on the informants and the analysis, owing to preconceptions about end-of-life decision-making. A descriptive phenomenological approach by Giorgi was implemented (Table 2). The phenomenologist’s purpose is to discover the essence of and variation in a phenomenon, as given by the subjects. Using the phenomenological method entails as strong an effort as possible to disregard preconceived ideas that might prevent researchers from participating in experiences of the subjects – experiences that are the subjects’ preferential rights.67,68 The analysis proceeded in four steps:
1. Reading through the whole experience several times to get a grasp of the whole.
2. Breaking the text down into meaning units, which seem to be connected in meaning, focusing on the phenomenon of the decision-making process.
3. Analyzing every meaning unit separately through a process of reflection and “imaginative variation”66 with emphasis on the phenomenon, without changing the meaning.
4. Synthesizing the transformed meaning units into a consistent statement about the structure of the phenomenon, including its essence and variations.66

Content analysis
Content analysis was chosen to facilitate utilization of descriptions on both the manifest (the visible and obvious) and the latent level (the underlying meaning).47 The theoretical assumptions are based on communication theory197 and structuralism,12, 73 but are scarcely described in papers. Choice of the content analysis method depended on how comprehensive and deep the available data were: almost manifest level (Study II)80, more manifest than latent (IV)87 and more latent than manifest (Study III)73 (Table 2). Although there were different levels of depth, the analysis process followed similar systematic steps. Each step was scrutinized and discussed by all the co-researchers, especially in Study II and IV:
1. All data were read several times to obtain a sense of the whole.
2. The text was divided into meaning units and thereafter condensed and more or less abstracted depending on the depth of data (less in II).
3. Similar abstracted meaning units were grouped together and labeled as preliminary subcategories/subthemes. The text for each subcategory/subtheme was read again and the label was refined in light of the whole dataset.
4. The subcategories/subthemes were then compared with each other, and those that shared similar meaning were collapsed, sorted and abstracted into main categories/themes/dimensions/approaches.

In Study IV, the content analysis was carried out using the software NVivo\textsuperscript{132} to facilitate sorting. After the inductive steps described above, this analysis was transformed into a deductive ‘Directed content analysis’,\textsuperscript{87} because of the discovery of a pattern in the answers. This pattern seemed to be in line with a theoretical framework presented in a guide for practical ethical analysis by Boyd.\textsuperscript{15} This implied using Boyd’s principles, persons and perspectives approaches (see beneath) as coding categories. The approaches were used as operational definitions for each category. Step 4 above was repeated, with new categorization and sorting into these three approaches. This involved a comprehensive process of moving between the empirical data and the framework in a continuous process of refining categories and sorting data.

**Principles, persons, perspectives**

Principles approach: principle-based, primarily deontological and teleological ethics, including the four principles of respect for autonomy, nonmaleficence, beneficence and justice.\textsuperscript{15}

Persons approach: focus on the moral agent. It is referred to as virtue ethics, which is concerned with the best kind of person to be.

Perspectives approach: focus on the case, which implies understanding of a problematic situation and being context sensitive. It is referred to as a hermeneutic approach, which considers multiple contexts, such as psychological and social.\textsuperscript{15} This approach seeks to highlight complexities\textsuperscript{104} and implies interpretation through openness to different perspectives, which may lead to awareness of one’s prejudices and a new shared perspective among individuals.\textsuperscript{15, 104}

**Statistical analysis**

The data were ordinal and analyzed using descriptive and comparative non-parametric statistics in Study II and IV. For the answers from the closed-ended questions in Study II, comparisons regarding agreement for level of aggressiveness were calculated as the difference between paired proportions.\textsuperscript{1} In Study IV, for the comparison between expectation of gaining insights about ethical problems and
reported new insights, the Sign test was calculated.\textsuperscript{1} The qualitative categorizations of answers from the open-ended questions in Study II and IV were quantified. In Study II, the rationales for aggressiveness were then compared by calculating the difference between two independent proportions.\textsuperscript{130} For the comparison between nurses and physicians regarding the rationales, confidence intervals for the difference between two independent proportions were calculated.\textsuperscript{130}

Subgroup analyses were performed in both Study II and IV. In Study II, nurses’ and physicians’ uncertain answers and patients with an expected survival of more than a year were treated separately. This was done because being uncertain was not considered as disagreement with full or limited treatment, and because some patients were not ill enough to elicit the question of need for limited life support. In Study IV, a subgroup analysis was made with random selection of all participants from a collective list of all ethics rounds to detect any effect of respondents attending more than one ethics round. From this subgroup, factors of profession, department and philosopher thought to affect perceived insights were tested using Kruskal-Wallis and then Mann-Whitney tests.\textsuperscript{1}

**Ethical considerations**

Research Ethics Committees approved all research projects, except Study I for which approval not was sought. In Study I, the interviewed physicians were not in a state of dependence on me as a subordinate nurse. The interviews took place after the decisions about limiting life-sustaining treatment had already been made and therefore could not affect patient care. However, at the time of the interviews (1997-1998), the issue of limiting life-sustaining treatment seemed tense, which I experienced from some of the physicians. In one interview a colleague physician participated as support, but none of the physicians seemed upset after the interviews.

The research participants were informed that confidentiality was guaranteed. Informed consent was based on written information regarding the study and voluntary participation. In Study II, the head of the departments approved of the study well in advance. The participants, however, did not receive information until the day of participation, which implied less time for consideration of consent. This did not seem to pressure the participants, although a few physicians did show some distress over being asked about their rationales for their opinions about *full* life-sustaining treatment.
Two major ethical issues in Study III and IV were considered. One issue in the ethics rounds was the non-participation of patients, most of whom were not informed about being the subject for the rounds. Excluding patients as participants was not considered ethically wrong, as ethical problems were not to be solved during the rounds. As the ethics rounds constituted a sort of supervision, the tradition in Swedish healthcare is to discuss patient cases without their presence. The other ethical issue was the emotionally charged issue of end-of-life, which may cause distress for staff during and after the ethics rounds. Regarding the potential distress for these participants, the head nurses were prepared to arrange psychological help if needed. Emotional distress was noticed in one of the participants especially. The interview situation afterwards seemed to provide some relief, and I also followed up the contact.
KEY FINDINGS

Only the key findings for each study will be presented in this section, and in the next, the findings will be expanded in connection with considerations.

Study I

End-of-life decisions in the ICU: How do physicians from the admitting department reason?
The physicians’ reasoning during the decision-making process to limit life-sustaining treatment for ICU patients involved great individual variation in attitudes. However, two major approaches were found. One approach was focused on saving life and considering limiting life-sustaining treatment only after realizing that the patient was going to die even with treatment. The other approach was also about saving life, but at the same time keeping in mind the option of limiting treatment. A pattern of five phases in the process emerged: defining role and contact with the patient, knowledge of the patient, evaluation and action, turning point and decision-making. The essence of the physicians’ decision-making process consisted principally of medical considerations in discussions with other physicians. Patients, next-of-kin and nurses did not seem to play an important role as stakeholders.

Study II

Nurses’ and physicians’ opinions regarding aggressiveness of treatment for general ward patients
There were more similarities than differences between nurses’ and physicians’ opinions about the 714 patients studied. There was 86 % agreement between their opinions regarding full or limited treatment. Agreement was lower for patients with a life expectancy of less than one year (78 %), but the disagreement was not associated with professional status. The hypothesis that nurses would consider limiting treatment for a greater number of patients than would physicians was not verified. The physicians considered limiting life-sustaining treatment as often as the nurses did (support for similarity 95 % CI -3 to 3 %). For the majority of patients, medical rationales were used, and age was important in one-third of the patients. When considering full treatment, nurses used quality-of-life rationales for 42 % of the patients compared to physicians’ 24 % (99 % CI 11 to 26 %). Respect for patient’s wishes was mentioned for few patients.
Study III

**Learning a way through ethical problems – Swedish nurses' and doctors' experiences from one model of ethics rounds**

The nurses and physicians described mixed experiences from the ethics rounds. The goals of the ethics rounds – to promote mutual understanding and stimulate ethical reflection – seemed to be partially achieved. Positive experiences included stimulation to broadened thinking, a sense of connecting between nurses and physicians, strengthened confidence to act, insight of moral responsibility and emotional relief. Negative experiences were associated with a sense of unconcern and resignation that change is not possible. Nurses were frustrated with the lack of solutions. In some rounds, there were also experiences of a sense of alienation between nurses and physicians as well as in relation to the philosopher. The main response to the additional question about how ethics discussions should be conducted in the future was that interprofessional team conferences were sure to continue, as this was more important than continued ethics rounds.

Study IV

**Interprofessional ethics rounds concerning dialysis patients: Staff's ethical reflections before and after rounds**

The goal evaluated here, to stimulate ethical reflection, was not completely achieved. Seventy-six percent of the respondents reported a moderate to high rating regarding new insights into the ethical problems. But the ethics rounds did not stimulate the ethical reflection that respondents had expected ($p < 0.001$). Two major issues were experienced with regard to the selected patients; end-of-life issues and non-compliance to medical treatment. The pattern discerned in the answers concerning perceptions of ethical problems before rounds and insights gained after could be sorted into the principles, persons and perspectives approaches (see p.30). The ethical problems described before the rounds were foremost sorted into the principles approach (74 % of the meaning units): problematic patient participation and exposing for suffering. The most prevalent insights concerning identification of ethical problems after rounds were sorted into the perspectives approach (72 %). This was illustrated by an extended perspective on the patient and increased awareness of relations to other professions. Regarding the persons approach, some answers both before and after rounds concerned reflections over personal responsibility. Concerning the insights into how to solve the ethical problems, the request to enhance team collaboration including reaching a consensus for care and further inter-professional dialogue predominated.
EXPANDED FINDINGS WITH CONSIDERATIONS

The phenomenon under study in the present thesis – disagreement over whether to continue or limit treatment – unfolded to an understanding of physicians’ difficult role in end-of-life decision-making, but also their shared opinions with nurses. This led to the realization that nurses and physicians should be brought together to share both their experiences of disagreement and their similar opinions. Ethics rounds were applied in order to promote mutual understanding and stimulate ethical reflection. These goals seemed to be only partially achieved. The findings suggest that the rounds primarily met the need for a forum for crossing over professional boundaries, but did not stimulate the kind of ethical reflection that was expected. The negative findings led to considerations about improvement of the ethics rounds model. Finally, considerations emerged over what kind of insights may be gained from ethical analysis concerning known patients. The four following sections illustrate further the findings in the present thesis.

Physicians’ perspective compared with nurses’
This section will focus on findings from Study I and II. According to the physicians in Study I, they were the key stakeholders in the decision-making process to limit life-sustaining treatment. Nurses were not described as stakeholders. The only time they were mentioned was in connection with patient care conferences, which however the participating physicians expressed great appreciation for.

Physicians’ professional behavior and personal beliefs
Although Study I concerned the decision-making process to limit life-sustaining treatment, the physicians’ reasoning was about continuing treatment until reaching the point of no return. The focus was on medical considerations, predicting the prognosis and survival. In Study II, when asking about opinions of aggressiveness of treatment, these physicians used similar reasons as the nurses did, medical and quality-of-life reasons, as also shown in previous studies.\[5, 36, 133, 151, 169\]

They also considered limited treatment for the same number of patients as the nurses did. This agreement is supported by one small American study on real patients\[50\] and others on hypothetical patients.\[29, 36, 169\]

To understand the discrepancy between previously reported disagreement over too much treatment (Table 1) and shared opinions about aggressiveness of treatment (Study II), the findings may be viewed from the physicians’ perspective –
their professional behavior and personal beliefs. This reasoning is partly based on Udén et al.'s papers on nurses’ and physicians’ narratives about ethically difficult end-of-life care episodes. The nurses and physicians were interviewed twice. First, the physicians narrated about scientific knowledge and preserving life, emphasizing atomism, while nurses emphasized holism. In the following interview, the physicians and nurses reflected on their previous narratives and then the physicians narrated about similar experiences as the nurses did – experiences of meeting death and seeing care as holistic. The physicians’ first narration was interpreted as their professional experiences and the subsequent narration as their personal experiences. Transferring this to Study I, the physicians seemed to narrate based on their professional behavior, in their role as decision-maker and their assumed responsibility for saving lives. In Study II, not being in the decision-making role when answering the questions, some of the physicians might have responded based on their personal beliefs, not based on how they would act. Thus, with regard to the discrepancy between nurses’ previously reported disagreement over too much treatment and physicians’ reported willingness to consider limited treatment to the same extent as the nurses in Study II, there seems to be a discrepancy in what some physicians actually do and what they believe should be done. This is confirmed by an unpublished finding in Study II, showing that 49 % (95 % CI, 41 to 56 %) of patients for whom physicians considered limited treatment did not have a limitation order. This is also supported by a previous survey in which 80 % of European ICU physicians felt that do-not-resuscitate orders should be applied, but only 58 % reported using such orders. In another study, physicians reported having acted against their conscience in providing overtreatment for their patients.

**Physicians’ individual attitudes toward limiting treatment**

The findings, however, showed discrepancies in opinions about aggressiveness of treatment, though this was not associated with professional status. The reported agreement of 78 % in Study II for patients with a life expectancy of less than one year held for the answers ‘full’ or ‘limited’ treatment. When also including the answer ‘uncertain’, meaning disagreement between uncertain and full or limited treatment, the agreement was only 63 % between nurses and physicians. There was still no association with professional status. The different choices seemed rather to be associated with individual differences, which is supported by a previous study. This may illustrate how incredibly difficult end-of-life decisions are and how both individual nurses and physicians have different attitudes toward aggressiveness. The physicians in Study I also revealed different attitudes regard-
ing willingness to limit treatment. This may primarily suggest that nurses’ frustrations are related to individual physicians’ reluctance to limit treatment. This may be one explanation of nurses’ previously reported frustrations over physicians’ heterogeneous attitudes toward aggressiveness of treatment (Table 1). This heterogeneity is also supported by previous studies revealing arbitrary end-of-life decision-making processes, based on physicians’ own biases and values.

In summary: Physicians’ perspective compared with nurses’
The present findings suggest that physicians share opinions with nurses concerning the boundaries for life-sustaining treatment, when physicians are not in the decision-making role. The difference between physicians’ and nurses’ perspective seems to be physicians’ burden of having to make the decisions to limit treatment and nurses’ burden of living with the fact that the decisions are not made. This suggests that physicians and nurses both need support in the decision-making process.

Partially achieved goals of ethics rounds
The focus will now be on the findings from Study III and IV.

The goal of promoting mutual understanding
This goal seemed to be achieved to a greater extent than the goal of stimulating ethical reflections and focus is here on the positive experiences from the rounds. The findings cannot confirm conclusively that mutual understanding was achieved, but they do suggest that the ethics rounds primarily met the need for a forum for crossing over professional boundaries. Experiences of connecting (Study III) and increased awareness of relations to other professions (Study IV) confirm this. The most salient finding from both studies was the insight to enhance team collaboration and that interprofessional dialogue was sure to continue. The nurses felt the physicians listened to them, something the same nurses reported was lacking when they were interviewed before the ethics rounds; lack of listening was also reported in another study. But according to the physicians, the rounds seemed to mainly serve the purpose of defending and explaining their rationales for continuing life-sustaining treatment (Study III).

Attempts at mutual understanding could be seen in the expressed understanding for the difficulties inherent in each other’s professional role. The nurses expressed
an understanding of the physicians’ loneliness and sense of powerlessness in making the right decision (Study III and IV). This may have contributed to improved understanding concerning the delayed decisions previously reported (Table 1). Likewise, the physicians expressed understanding for nurses’ feelings of being bound by their closeness to long-term patients (Study III and IV) and for how frustrating physicians’ heterogeneous attitudes toward life-sustaining treatment could be (Study III).

The findings showing crossing over of professional boundaries, including attempts at mutual understanding, correspond with previous evaluations of reflective ethical practice, such as coming closer to each other, understanding each other’s perspective better and changing attitudes toward each other. This is also in agreement with a large evaluation of interprofessional education interventions, mostly involving nurses and physicians. Major positive outcomes of the studies were changes in attitudes/perceptions toward other professions and improved understanding of their roles and responsibilities.

The philosopher-ethicists seemed to have an important role in promoting the crossing over of professional boundaries. They were described as facilitating an open climate (Study III and IV) when they actively led the discussions, distributing speaking time fairly and promoting mutual understanding by turning accusations into ways of seeing things from a different perspective (Study III).

**The goal of stimulating ethical reflections**

In Study III, there were experiences of stimulation to broadened thinking, which was very much connected with the role of the philosopher-ethicists. This emerged foremost in Study III, but also as additional findings in Study IV. The philosopher-ethicists were appreciated for giving clarifications (Study III and IV), stimulating to brake from habitual ways of thinking (Study III) and seeing things from different perspectives (Study III and IV). However, the quantitative part of Study IV revealed that the ethics rounds did not stimulate the ethical reflection that the respondents had expected. This corresponds with the results from an evaluation questionnaire of a Dutch project, in that the expectations of the goal of moral deliberation were higher than the goal perceived to be reached. The participants in present project may have expected to gain principle-based insights into the reported problems of patient participation and suffering. Instead they gained insights that did not fit into traditional ethics (often referred to as principle-based ethics, but also virtue ethics), and these insights were interpreted as corresponding
to a hermeneutic approach. This was illustrated as an extended perspective on the patient, gained from others’ perspectives and knowledge, finding the problems more complex, but also as gaining an increased understanding of the patient. There were also descriptions of increased awareness of relations to other professions, which was also one of the main findings of Study III, as described above. Leder pointed out that the hermeneutic approach opens up for interpretations, but does not distinguish between right and wrong. Thus, hermeneutic approach cannot provide quick solutions to problems, which are what clinical practice seems to demand. Further ideas about what kind of insights may be gained are discussed under ‘Theoretical considerations of ethical analysis concerning known patients’.

Aspects that obstruct mutual understanding and ethical reflection

Compared to the positive remarks in Study III and IV, the negative remarks in the interviews and questionnaires were fewer in number, but not lower in intensity. Negative findings are important to report, because there is a lack of negative qualitative descriptions in previous studies on reflective ethical practice and interprofessional education. The findings of nurses’ frustration with the lack of solutions will be discussed later. Some of the other negative experiences were described as conditions outside the rounds, such as lack of time for further reflection and discouragement of colleagues’ lack of commitment. A large part of the negative findings, however, seemed to be associated with individual- and group-related aspects during the rounds. A new categorization of subthemes from Study III and subcategories from Study IV will illustrate this as in Figure 1:

The group of professionals: Relationships between workmates seemed to influence experiences to a great extent. A deadlock between nurses and physicians was experienced when nurses felt that physicians did not listen to or understand them, and the physicians felt criticized (Study III). In Study IV, a gap between the professionals was perceived, which confirmed their pre-understanding of how far physicians and nurses stand from each other. Some lacked new input from workmates; they felt they had already heard it all before.

The philosopher-ethicist: The philosopher seemed also to have a great influence on experiences. When the philosopher was too passive, participants could experience the rounds as polemical and filled with unleashed emotions. Worthless input was associated with failure to make the knowledge applicable to the real world. A few participants also experienced that the philosopher influenced the round too
much with his own opinions, and they found this coercive and that it inhibited the discussion.

*The patient:* Unmoving patient cases were experienced as negatively affecting the overall feeling. This could occur when the patient was unknown or the problem was perceived as being neither emotionally moving nor ethically relevant.

*The individual professional:* Perceptions of already knowing the answers and being morally secure about values, possible actions and the solving of the problem gave feelings of indifference. There was also a feeling of insoluble classical problems, such as nurses feeling it is impossible to influence physicians and physicians believing that nurses will never understand the difficulties connected with the decision-making responsibility.

**Figure 1** Group- and individual aspects contributing to negative experiences/perceptions during the ethics rounds

- **The group of professionals**
  - Deadlock between nurses and physicians (III)
  - Gap between the professionals (IV)
  - Already heard it all before from other staff members (IV)

- **The philosopher-ethicist**
  - Too passive (IV)
  - Worthless input (III)
  - Inflicted value judgments (III)

- **The individual professional**
  - Already morally secure (III)
  - Already knowing the answers (IV)
  - Resignation of insoluble classical problem (III)
  - Powerless to affect decisions (IV)

- **The patient as subject for the round**
  - Unmoving patient cases (III)
  - Not familiar with the patient (IV)
Several of the aspects that seemed to obstruct mutual understanding and ethical reflection are in line with Sarvimäki and Stenbock-Hult’s descriptions of hindrances to ethical dialogue, such as lack of time, perception of ethical problems as insoluble, other’s predominating attitude and leaving decision-making to others.

**In summary: Partially achieved goals of ethics rounds**

It seemed that the goal of promoting mutual understanding was achieved to a greater extent than the goal of stimulating ethical reflection. Insights into ethical problems did not fit into traditional ethics, but could rather be interpreted as corresponding to a hermeneutic approach. The findings support the notion of a collaborative team approach to treating severely ill patients. However, individual- and group-related aspects should be taken into consideration as possible hindrances to mutual understanding and ethical reflection.

**Improvement of the model of ethics round**

**Critical considerations of the model**

There are at least four concerns regarding the model of ethics rounds in the present thesis: the leadership of the rounds, the timing of them, the selected patients and the goals. Because it is unusual for Swedish philosophers to be involved in everyday clinical practice, only two of the four philosopher-ethicists had experience of ethics discussions in connection with clinical practice. A series of pilot rounds may have been beneficial for the inexperienced philosophers. Reported reasons for the lack of moving cases were the scheduled ethics rounds and the criterion that staff members from both the dialysis unit and the ward were to be familiar with the patient. Additionally, at least five of the patients’ problems were of long duration and seemed difficult to solve. This may indicate the need for ethics rounds proactively, i.e. to anticipate ethical problems before they become severe and to be able to arrange ethics rounds in critical situations. The fourth concern, the expectation of solving the ethical problems is dealt with in the next section.

**Adding solving to the model**

When deciding about the goals of the ethics rounds in the present thesis, the decision was taken to exclude the idea of finding solutions of the ethical problems. This decision was based on European ethical literature, which advocates supporting healthcare teams through reflective ethical practice rather than through expert solutions. This, however, must be reconsidered. The negative findings...
from Study III and IV revealed that nurses expected solutions to the ethical problems, lacking a formal decision that would direct future actions. Some wished for an answer book and became impatient when theoretical reflections were discussed instead of practical solutions. Also in the Dutch study of moral case deliberation, respondents missed concrete suggestions and consensus for solving.\textsuperscript{126}

In a few of the present rounds, however, alternatives of action were offered, which was appreciated by the nurses (Study III). The approach these philosopher-ethicists used in present project appears to be similar to the facilitation approach used in American ethics consultations, where attempts are made to facilitate consensus building among health-care professionals. Schneiderman et al.\textsuperscript{160} showed that the help ethics consultants provide with identifying and analyzing ethical problems yielded high staff satisfaction. This may be due to the simultaneous help with problem-solving, which also was ranked high.\textsuperscript{160}

The nurses’ frustration should be taken into consideration. This would imply adding a further goal to the ethics rounds: to promote solving ethical problems. See Figure 2 for the proposed model. In this model, the addition entails letting the ethicist help the participants in the rounds in their analysis of different courses of action and, after the rounds, arranging an interprofessional team conference aimed at solving the problems at hand. One should keep in mind here the importance of allotting sufficient time to analyzing what the ethical problems actually are.

Because the goal of the ethics rounds in the present thesis did not include solving ethical problems during the rounds, it was not considered ethically wrong to exclude the patients as participants. But adding the goal of promoting problem-solving, there is a major ethical concern about the non-participation of patients and next-of-kin. It could be argued that the proposed model further strengthens the powerful group of health professionals in relation to the already weak group of patients and next-of-kin. Let us analyze the lack of patient autonomy in end-of-life decision-making and how interprofessional team conferences or ethics rounds may serve as a source of trust for the patient.
Figure 2 From Study III. A model based on findings illustrating one possible way of dealing with ethical problems in patient care

A model of interprofessional team dialogue about the care of the severely ill patient

Interprofessional team conference

Health-care staff engaging in a dialogue about the goal of the care

Awareness of an ethically complicated situation

Consensus about the goal and what course of action to take, followed by patient/family involvement

Ethics rounds with an ethicist

First phase: Ethicist helps staff to identify and analyse the ethical problem as well as to deal with any relational conflicts

Second phase: Ethicist facilitates problem solving by helping to analyse different courses of action

Interprofessional team conference

Only health-care staff engaging in a dialogue with the aim to suggest what course of action to take

Decision together with patient/family
Ethics rounds serving as a source of trust for patients with diminished decision-making capacity

Although respect for autonomy, in addition to human dignity, appears to be the paramount ethical principle in health-care,\textsuperscript{48,64} Study I and II confirm the results from previous studies showing low patient involvement in end-of-life decision-making.\textsuperscript{14,39,61,78,83} Compared to previous survey results revealing that healthcare professionals view patients’ wishes as important,\textsuperscript{5,60,151,169} this was rarely mentioned in Study II. In previous studies, patients’ wishes may have been a socially desirable option, being one of several closed-ended options in contrast to the open-ended question in the present study.

For patients with decision-making capacity,\textsuperscript{62} refusing treatment does not seem to be controversial. Yet even if measures are taken to improve patient involvement, there will still be quite a few patients with lack or fluctuating capacity\textsuperscript{185} to make rational choices.\textsuperscript{48} In Study IV, the predominating perceived ethical problem for the patients as subjects for the ethics rounds was problematic patient participation. The respondents felt that several of the severely ill and non-compliant patients lacked decision-making capacity.

For patients who have diminished decision-making capacity of various origins, who have not given advance directives\textsuperscript{62,184} and who have no sensible next-of-kin,\textsuperscript{118,148} the physicians have great moral responsibility to determine what is best for the patient. They must, besides determining the effectiveness of the treatment, also make a subjective assessment of the meaningfulness. I am aware that most of the physicians in the present thesis did not explicitly ask for support in decision-making. Rather they realized that the interprofessional dialogue should be continued in order to meet the need of the nurses. However, adding a problem-solving part to the ethics rounds model implies a team approach to the assessment of meaningfulness in end-of-life decision-making. Interprofessional team conferences or ethics rounds may serve as a support and basis for the physician’s decision, by providing the perspectives of several professions and a more integrated and holistic view of the patient, as shown in Study III and IV. Together with help from an ethicist in analyzing the problem and courses of action (still without giving recommendations), this may lead to better ethical decision-making, preventing reported arbitrary decision-making.\textsuperscript{33,34,36,102,146,162}

Competent patients who do not wish to assume an active role in their own care\textsuperscript{54} or be involved in end-of-life decision-making\textsuperscript{82,83,144,204} and patients who do not
have a physician they trust may leave their autonomy in the hands of ethics rounds, which then may serve as their source of trust. Trust has been defined as “the reliance on others’ competence and willingness to look after rather than harm things one cares about which are entrusted to their care”. This, however, presupposes continuity in care by nurses and allied healthcare professionals.

In summary: Improvement of the model of ethics rounds
Findings from Study III and IV show the need for short-term help in solving ethical problems. This may be possible in patient team conferences or ethic rounds regarding patients with diminished decision-making capacity or competent patients who entrust their autonomy to the team. A balance should be found between ethical analyses, conflict resolution and problem-solving.

Theoretical considerations on ethical analysis concerning known patients
The mixed findings in Study III and IV concerning whether the ethics rounds stimulated ethical reflections caused me to reflect further on what kind of insights may be gained from reflective ethical practice regarding known patients. The insights gained here suggest that these kinds of insights are different from those expected when analyzing hypothetical or disguised patient cases with insufficient context, which is most commonly the case in traditional ethics teaching.

Is it possible to distinguish between ethical and psychosocial reflections?
It seems difficult to distinguish pure ethical reflections from psychosocial reflections. At first glance at the questionnaire answers in Study IV, most perceived insights after rounds concerning identification of the ethical problems appeared to be psychosocial reflections about communication and how the dialogue of the ethics rounds worked, and could be argued not to be ethical reflections. The request to the respondents in Study III to describe experiences of the ethics rounds revealed answers of a cognitive, social and psychological nature. The respondents in Study IV may have answered based on their broader experience of ethics rounds and not based on the apparently narrow question of insights into the identification of the ethical problems. On the other hand, the respondents may not have been clear about what is meant by ethical reflections. In Study III, experiences of the philosopher-ethicists’ structuring of the thinking into steps were appreciated, but only one of the respondents could explicitly describe insights into this. Previous studies have also reported that nurses did not articulate traditional ethical concepts and were unable to give examples of ethical situations.
Contemplating how to analyze the questionnaire answers in Study IV, my co-researchers and I decided at last to give the respondents the preferential right to define ethical problems and insights. The pattern that emerged in the answers led to Boyd’s\textsuperscript{15} three approaches to practical ethical analysis, where the hermeneutic approach was added to principles and virtue ethics.

**Hermeneutic approach in relation to other context-sensitive approaches**

In philosophical literature, discussions about which theories/approaches are appropriate to use in ethical analysis appear to be blurred with the actual *method* of analysis, such as a Democratic, Socratic dialogue or Moral case deliberation. Two different accounts of approaches to ethics appear. One emanates from general principles for seeking answers in the particular ethical case. The other emanates from the particular ethical case or situation and pays close attention to the rich complexity that exists, so-called *context-sensitive* theories.\textsuperscript{104,129,186} These may either deny the significance of principles or view context-sensitive knowledge as a complement to principles.\textsuperscript{156} Because ethics rounds constitute a kind of method of analyzing a particular case, you may regard this as circular reasoning, ending up in the context-sensitive hermeneutic approach. As a comparison, however, there are other context-sensitive theories such as casuistry,\textsuperscript{90} moral particularism,\textsuperscript{189} narrative ethics,\textsuperscript{77,125} situation ethics\textsuperscript{186} and imaginative ethics.\textsuperscript{77} They all share with the hermeneutic approach a focus on details, interpretation and self-reflectiveness in the situation.\textsuperscript{104} However, these approaches do not seem to deal with the prejudices, social structures and behaviors of those involved in the communicative act. Imaginative ethics appears to best resemble the hermeneutic approach, formulated by Hansson\textsuperscript{77} and based on his experience as an ethicist in ethics rounds (the model of inspiration in the present thesis). Imaginative ethics deals with the diversity of perspectives on the case. By listening to other perspectives, alternative perspectives and multiple values may be imagined. The focus appears to be on the values at stake, but Hansson\textsuperscript{77} acknowledged that he had no scientific basis for the nature of ethical reflection during rounds. As a comparison, in Study III and IV, one of the main features of the ethics rounds was the connecting that occurred between nurses and physicians, who were trying to understand each other’s perspective. According to Leder\textsuperscript{104}, ethical problems do not arise only from the complex details of the situation. The diverging perspectives of stakeholders may provoke “interpretive” conflicts.
Is it possible to distinguish between ethical conflicts and social conflicts?

When analyzing the case of a known patient, the question is whether it is possible to distinguish between ethical and social conflicts? In two previous studies evaluating ethics consultation qualitatively, the conclusion was that what appeared to be ethical problems were instead interpreted as a breakdown in communication and relational problems. Kelly et al. found that traditional ethical concepts were not relevant, instead there appeared to be interpersonal, cultural and professional factors involved, such as differences in the professional cultures of medicine and nursing. In Study III, it was expressed that the ethical analysis was overshadowed by relational conflicts. The sociologist Chambliss meant that ethical problems in healthcare are an expression of interest group conflicts, such as professional clashes between nurses and physicians. Thus, an ethical conflict may not only be a conflict between values, but also between different stakeholders. According to Leder, an ethical dilemma can be recognized when consensus breaks down. In this respect, a breakdown in communication could be interpreted as a type of ethical problem. A major portion of American ethics consultation seems to deal with mediating social conflicts in healthcare.

In conclusion, there is an indication that a major part of clinical ethical analysis regarding known patients concerns the social and the communicative act. Therefore, it seems difficult to distinguish ethical reflections from psychosocial reflections as well as to distinguish ethical conflicts from social conflicts. Yet, the ethical inquiry still remains: What is it one ought to do?

Philosophers as ethicists

The choice of ethicists for the present ethics rounds fell on philosophers, due to my preunderstanding that ethical analysis constitutes analyses of the values at stake, conflicts of interest and the weighing of pros and cons. Based on the insights described after the ethics rounds (Study IV), one might not assume that the ethicists were philosophers. If the ethicists in the present thesis had been chosen from professional groups such as nurses, physicians or social workers, as suggested by research colleagues, it may have been more natural to interpret the insights gained after the rounds as solely psychosocial.

Owing to both the study design and the findings of the present thesis, support for choosing philosophers as ethicists in clinical practice cannot be offered. The interviewees in Study III had little to say regarding from which profession the ethicists in future rounds should be drawn, being more concerned with the ethicists’ char-
acter and competence. This is in accordance with the American Task Force on Standards for Bioethics Consultation.2,165

The philosopher-ethicists in the present thesis appeared to have different abilities in group-process skills, such as handling the power balance between the nurses and the physicians. Maintaining control over the discussions seemed important to the respondents (Study III). Given the value-laden subject of end-of-life, losing control over the discussion seemed dangerous. In Kelly et al.’s53 ethnographic study of ethics consultation, in contrast to the physician-ethicists, the philosophers and social workers distributed the time more equally and stimulated more discussion. The role of the philosopher and social worker as ethicist should be further studied.

Finally, connecting the ethicist’s role with the hermeneutic approach, Leder104 proposed that from being an “answer” person, the ethicist may instead become a facilitator; “fostering mutual understanding and respect” as opposed to pro and con perspectives. Boyd15 considered that the ethicist may help by asking relevant questions, but the answers need to come from the participants.

In summary: Theoretical considerations on ethical analysis
Analyzing ethical problems in relation to known patients seems to produce psychosocial insights. This could imply that social conflicts may overshadow ethical analysis or that ethical conflicts and social conflicts are impossible to distinguish.
CRITICAL METHODOLOGICAL CONSIDERATIONS

In analyzing and measuring how well the design, data and analysis processes have addressed the intended focus, credibility and dependability as well as internal validity and reliability will be described below. They are described together because they are intertwined: There can be no dependability without credibility and no internal validity without reliability. But first some considerations of the difficulties of designing the studies III and IV.

Designing the ethics rounds studies

The initial ambition was to evaluate the goals of promoting mutual understanding and stimulating ethical reflections by measuring impact and outcomes according to Gubas and Lincoln’s term ‘first generation evaluation’. To my knowledge, no previous study has evaluated these goals in reflective ethical practice, and consequently no validated instrument was found. Furthermore, previous studies using instruments with control groups to evaluate reflective ethical practice could not detect any long-term impact. In one of the research projects, only positive changes of the intervention emerged from the qualitative findings, and there were methodological reflections over the quantitative design’s inability to measure complex social processes. When purely quantitative designs are used to study psychosocial processes, there seems to be a problem of excluding the contextual perspective and of controlling conditions. As it appears, when interventions are aimed at a long-term instead of short-term impact, such as solving ethical problems for particular patient situations (American ethics consultation), valid outcome measures are difficult to find.

Thus, in the present thesis, the most realistic approach was to illuminate how ethics rounds were conducted as well as to evaluate the strengths and weaknesses of both goals with a view to improvement. Guba and Lincoln described this as ‘second generation evaluation’. Looking back at this point, ‘responsive evaluation’ may have been a better alternative for finding evaluation criteria and for better understanding of the weaknesses and strengths of conducting the rounds. Guba and Lincoln described this as ‘fourth generation of evaluation’. Responsive evaluation was used in a Dutch 4-year moral deliberation project, which was published after the present research project had been finished. The Dutch project implied that the evaluation criteria were derived from the stakeholders such as the management’s and staff members’ expectations of moral deliberation. They became active and equal partners in the research process and also the researchers.
participated themselves as ethicists and in regular work activities. Mixed methods were used to gather information on group dynamics and the actual learning process, as well as the implementation process.\textsuperscript{125,126} Regarding implementation, none of the departments in the present research project and in the other ethics rounds study\textsuperscript{99} have continued with the reflective ethical practice. Kälvemark concluded: “A deeper understanding is needed of why methods such as this are not put into practice after the enthusiastic first phase”.\textsuperscript{99} p.50 In light of the above, in the present research project, management and staff members should have been involved regarding the expectations of the ethics rounds. The present research project cannot offer support for the superiority of ethics rounds in promoting mutual understanding and stimulating ethical reflection. But the findings from the mixed-method approach have provided a broad spectrum of strengths and weaknesses serving as a knowledge base for improvement of reflective ethical practice. Several findings from Study III and IV confirm each other, and the combination of different data collection methods may be seen as representing a triangulation approach,\textsuperscript{42,108} which strengthens the trustworthiness.

**Credibility and dependability in the qualitative parts**

**Data collection**

The appropriateness of the inquiry in Study I may be challenged. The question posed to the physicians may not have completely captured the decision-making process in a phenomenological sense: ”Can you give a description of the time from when you first learned of the patient to when the decision was made to forego life-sustaining treatment?” A more phenomenological question for capturing the lived experience might have been “Can you give a description of the experience to be in the decision-making process?” Owing to weakened credibility, the phases may not have captured the essence of the decision-making process, but rather represented a reconstruction of memories of the process. However, the physicians were interviewed without interruption, giving them the preferential right to decide what they considered as important in the decision-making process.

Using two interviewers in Study III may have constituted a threat to dependability. My co-researcher and I used somewhat different interview techniques, a conversational style as opposed to a probing technique.\textsuperscript{136} I may have been too focused on the research questions, thereby keeping the nurses from offering new ideas. My co-researcher did not follow up some interesting reasoning, but the relaxed interview atmosphere may have encouraged the physicians to be more open. This,
however, was taken into consideration, as both manifest and latent analysis were performed, depending on the nature of the statements.

It could be argued that the question in Study IV regarding description of new insights into the ethical problems (Table 3) may not have captured ethical reflections, as discussed above. Using a questionnaire for these kinds of questions may have been a too superficial method. There could also be difficulties in formulating insights immediately after the rounds. However, the broad question of experiences of ethics rounds in Study III, when rounds were distant in time, also did not capture ethical reflections in the traditional sense. Another consideration is whether the other goal, to promote mutual understanding, influenced the answers regarding insights.

Analysis
In establishing credibility, the data have been subject to co-assessment from co-authors and peer debriefing during seminars, which helped me be “honest” when co-authors and seminar participants played the devil’s advocates. Biases have been proved and the basis for interpretation clarified. However, the different levels of data in the present thesis have made this varyingly possible. For the data consisting of short answers (Study II and IV), the strength was the rigorous co-assessment. But the interpretation and categorization were sometimes difficult, involving struggling with what the informants actually meant owing to the lack of rich description. Contrary to the studies with short answers, the longer descriptions from the respondents (Study I and III) made deeper interpretation possible, owing to the rich context. However, co-assessment seemed more problematic due to the co-researchers’ reduced possibility to obtain a sense of the whole data, a problem pointed out in the literature.
Internal validity and reliability in the quantitative parts

Data collection
The confidence of the finding in Study II showing that nurses and physicians considered limited treatment for the same number of patients is high. This due to the large sample size, and the difference was only 0.5 % with a narrow 95 % confidence interval around 0 (-3 to 3 %). The reliability of this finding seems high, as the data were collected during separate years, with no differences detected between the time periods. The sample size in Study IV may seem inadequate, because there were few possibilities to perform extensive statistical calculations and subgroup analysis, especially of different professional groups. The goal of the quantitative data collection was, however, to capture the group of participants’ subjective evaluation of the stimulation of ethical reflection, not to find causal explanations.

Analysis
When comparing possible differences between the nurses and physicians, it could be argued that consideration of gender is important. One limitation, especially in Study II, was that it was impossible to separate the professional role from gender, as the majority of nurses were female and the majority of physicians male. Chambliss considered that it is impossible to distinguish the effect of gender (female) from profession (nursing), because they are so highly correlated. According to him, comparing male and female nurses is like comparing unconventional men with quite conventional women.

It may be argued that the Sign test should not have been chosen in Study IV to compare the expectation of gaining insights into ethical problems with reported new insights. This is because the questions posed before and after the rounds were not worded identically, one concerning expectations of whether an ethicist could provide insights and the other concerning any insights gained after the rounds (Table 4). However, there was also a question about insights that came specifically from the ethicist, and this result did not differ from overall insights gained.

External validity/transferability
The finding of physicians considering limited treatment as often as the nurses did (Study II) may be generalized to hospital ward settings in Western Europe and North America. This because respondents and patients were included from differ-
ent wards, and because of the total selection criteria, low attrition (Table 2) and narrow statistical confidence limit. Despite naturalistic inquiry, the essence of physicians’ decision-making process in Study I, which entailed medical considerations in discussions with other physicians, may be transferable to other ICU settings in Western Europe. This due to the manifest findings, consecutive nature of selection and because the study comprised half of the decisions made during one year in each hospital. The findings in Study III and IV are context specific, owing to the model of ethics rounds, workgroup cultures and the fact that there were only 12 patients as subjects for the ethics rounds. Therefore, thorough descriptions are presented to enable the readers to judge the transferability.
CONCLUSIONS AND IMPLICATIONS

First, the present thesis provides strong evidence that differences in opinions regarding boundaries for life-sustaining treatment are not associated with type of profession. Physicians want to limit life-sustaining treatment as often as nurses do, and there is an indication that some physicians want to limit treatment for more patients than they actually do. Accordingly, this suggests that some physicians need support regarding when to limit. Furthermore, the findings on shared opinions may contribute to improved understanding and collaboration between nurses and physicians regarding end-of-life decision-making.

Second, several of the findings support a collaborative interprofessional team approach to end-of-life decision-making. Using a team approach may be seen as self-evident, but not for the Swedish Society of Medicine. Their guidelines regarding withholding and withdrawing life-sustaining treatment,\textsuperscript{177} seem to indicate that this is an affair between physicians and the patient/family only. One suggestion here is to add to the guidelines a recommendation for the team approach for patients with diminished decision-making capacity. The Swedish National Board of Health and Welfare may also wish to emphasize this further when revising their old guidelines.\textsuperscript{172}

Third, the present thesis indicates that stimulation of ethical reflection in connection with known patients may yield other insights than those gained from traditional ethics reflections. These insights may be interpreted as corresponding to a hermeneutic approach. The kind of ethical analysis that is most beneficial to clinical practice concerning particular patient cases should be furthered explored. Furthermore, it would be interesting to capture the learning process associated with the kind of ethics that is beneficial to everyday clinical practice.
SVENSK SAMMANFATTNING (SUMMARY IN SWEDISH)

"Uppskjuta döden? Sköterske- och läkarperspektiv på livsuppehållande behandling och etikronder"

Utgångspunkten för denna avhandling är sjuksköterskors upplevelser av att livsuppehållande behandling drivs för långt. Syftet var att beskriva och jämföra sjuksköterskors och läkares perspektiv på gränsdragning för livsuppehållande behandling och att utvärdera om etikronder kunde främja ömsesidig förståelse och stimulera etisk reflektion. Både kvalitativa och kvantitativa metoder har använts, i form av intervjuer och enkäter. För analys av resultaten har fenomenologi, innehållsanalys samt statistik använts.


Studie II: I jämförelsen mellan sjuksköterskors och läkares åsikter om nivån på livsuppehållande behandling fanns fler likheter än skillnader för de 714 patienterna i studien. Samstämmigheten var 86 % avseende full eller begränsad behandling. För patienterna med en förväntad överlevnadstid under 1 år var samstämmigheten lägre, 78 %, men oenigheterna hade inte något samband med yrkestillhörighet. Hypotesen att sjuksköterskorna skulle vilja begränsa behandling för fler patienter än läkarna verifierades alltså inte. Sjuksköterskorna och läkarna motiverade också sina åsikter om att begränsa eller fortsätta behandling på liknande sätt. De anförde medicinska skäl för majoriteten av patienterna, därefter livskvalitetsskäl, för en tredjedel åldersskäl och hänsyn till patientens vilja för en minoritet.

Studie III och IV: För de två sista studierna anordnades 12 etikronder på tre njursektioner. Det innebar att filosofer ledde vårdkonferenser angående etiska problem i vården av särskilda dialysepatienter, där främst sjuksköterskor, läkare och undersköterskor deltog. Målet för ronderna var att främja ömsesidig förståelse mellan yrkeskategorierna och att stimulera etisk reflektion. Filosofernas uppgift var att hjälpa vårdpersonalen att identifiera och analysera de etiska problemen, men inte ge förslag på lösning. Utvärdering skedde dels genom intervjuer om upp-
levelserna av ronderna och dels genom enkäter om uppfattningar om de etiska problemen före rond och eventuella nya insikter efter rond.


Slutsatser: Resultaten från de två första studierna tyder på att läkares och sjuksköterskors åsikter om gränsen för livsuppehållande behandling är lika, när läkarna inte har den beslutsfattande rollen. Skillnad i inställning beror inte på yrkestillhörighet. Resultaten från de två sista studierna styrker uppfattningen om en mångprofessionell teambaserad inriktning till beslutsfattande i livets slutskede. Etisk reflektion kring en patient som är känd för personalen verkar ge andra insikter än vid traditionell etikundervisning. Reflektionen verkar främst ge psykosociala insikter, vilket antingen kan betyda att sociala konflikter överskuggar den etiska analysen eller att det helt enkelt inte går att skilja mellan etiska och sociala konflikter. Sjuksköterskornas frustration över utebliven lösning i etikronderna har givit anledning till ett förslag att ändra modellen, för att hitta en balans mellan etisk analys, konflikt- och problemlösning (Figur 2).
TILL SIST VILL JAG TACKA FölJANDE PERSONER FÖR ALLA STÖD OCH SÄLLSKAP PÅ VÄGEN MED AVHANDLINGSARBEDET.

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End-of-life decisions in Swedish ICUs
How do physicians from the admitting department reason?

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Objective: To study how physicians from the admitting department reason during the decision-making process to forego life-sustaining treatment of patients in intensive care units (ICUs).

Design: Qualitative interview that applies a phenomenological approach.

Setting: Two ICUs at one secondary and one tertiary referral hospital in Sweden.

Participants: Seventeen, admitting-department physicians who have participated in decisions to forego life-sustaining treatment.

Results: The decision-making process as it appeared from the physicians’ experiences was complex, and different approaches to the process were observed. A pattern of five phases in the process emerged in the interviews. The physicians described the process principally as a medical one, with few ethical reflections. Decision-making was mostly done in collaboration with other physicians. Patients, family and nurses did not seem to play a significant role in the process.

Conclusion: This study describes how physicians reasoned when confronted with real patient situations in which decisions to forego life-sustaining treatment were mainly based on medical—not ethical—considerations.

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KEYWORDS: Decision-making; Professional ethics; Critical care; Intensive care units; Life support care.

Introduction

Modern intensive care has been increasingly effective in providing life support that allows many patients’ lives to be saved. Increased possibilities to maintain life have also created ethically problematic situations (Soderberg & Norberg 1993). Sometimes use of life-sustaining technology merely prolongs the process of dying, rather than returning the patient to a meaningful life. A major problem is to define the turning point, when meaningful treatment becomes futile (Soderberg et al. 1997; Sorlie et al. 2000, 2001; Oberle & Hughes 2001).
For care to be beneficial, it must be both effective and meaningful (SOU 1995). In this context, “effective” refers to medical and caring measures that lead to prolonged life, and “meaningful” refers to the ethical dimension, that is, the subjective assessment that continuing treatment is meaningful. We believe that physicians are experts in effectiveness of treatment but not in its meaningfulness. This implies a dilemma: The effectiveness role is built into the physician’s professional competence, while the physician takes on (assumes) the meaningfulness role.

European physicians often make decisions that limit life support for incompetent patients without participation of next-of-kin or other professionals (Sjökvist et al. 1998; Vincent 1999; Nyman & Sprung 2000). Two studies have shown that there are Western European intensivists, who view end-of-life decisions to be the responsibility of physicians and essentially based on medical factors (Vinay 1996; Vincent 1999). This is contrary to our earlier findings, which indicated that the general public, nurses and physicians would often prefer input from others with justified interest in these decisions (Sjökvist et al. 1999a,b,c). Studies show that intensive care unit (ICU) nurses disagree with physicians regarding appropriate level of treatment that is provided to patients (Bucknall & Thomas 1997; Baggs & Schmitt 2000) and that overall disagreement exists among health care professionals concerning decisions (Cook 1997; Breen et al. 2001). Several authors argue for collaborative, interdisciplinary decision-making in which physicians with different specialties, nurses and other health care professionals participate. Decision-making is shared, and all those involved are charged with acting as the patient’s advocate (Vinay 1996; Corley 1998; Baggs & Schmitt 2000; Dean 2001; Miller et al. 2001; Baggs 2002; Stroud 2002).

In Sweden, as in many other countries, responsibility for intensive care patients is shared between the intensivist and the physician from the patient’s admitting department. This includes, for example, surgeons, internists and neurologists.

Several studies investigated attitudes of intensivists and ICU nurses regarding the foregoing of life support within the ICU (Asch et al. 1995; Cook et al. 1995; Sjökvist et al. 1999a,b,c; Vincent 1999). Intensivists and ICU nurses care for patients in situations when 90% of the patients are viewed as incompetent (Sprung & Eidelman 1996; Luce 1997), whereas physicians from admitting departments would be more likely to have met their patients awake and competent before they entered an ICU.

Other surveys explored attitudes of physicians from admitting departments regarding end-of-life issues, including those in the ICU (Caralis & Hammond 1992; Steinberg et al. 1997). To our knowledge, no study specifically explored how these physicians reason in real ICU cases and few studies reach beyond physicians’ attitudes to physicians’ practice (Asch et al. 1995; Hall & Rocker 2000; Cook et al. 2001).

Previous authors have advocated use of qualitative methods in this field (Kendrick & Cubbin 1996; Bucknall & Thomas 1997; Jones & FitzGerald 1998). Some qualitative studies explored physicians’ and nurses’ experiences of ethically difficult situations. The situations are almost without exception about end-of-life decisions and experiences of too much treatment (Udén et al. 1992; Söderberg & Norberg 1993; Sorlie et al. 2000, 2001).

This study’s purpose was to explore how admitting-department physicians reason when they make end-of-life decisions for ICU patients. Consequently, we studied a continuous series of clinical decisions rather than specifically asking about ethically difficult situations.

Method

This study implemented a phenomenological approach according to Giorgi. The phenomenologist is interested in the everyday world, as perceived by the individual. Human experience is understood as something holistic. Each individual has his/her own perception of a phenomenon, which means that different conceptions can be the result of one and the same phenomenon. The phenomenologist’s purpose is to discover the structure and variation of a phenomenon, as given by the subjects. Using the phenomenological method entails as strong an effort as possible to disregard preconceived ideas that might
End-of-life decisions in Swedish ICUs

Prevent researchers from participating in experiences of the subjects—experiences that are the subjects’ preferential rights (Giorgi et al. 1975; Giorgi 1989).

Setting
The setting was two general ICUs in one tertiary (14 beds) and one secondary (10 beds) referral hospital in central Sweden. In the 14-bed ICU, 40 decisions were taken to limit life support and in the 10-bed ICU, 20 decisions were taken during the year of the study (1997/1998–1999).

Participants
Seventeen physicians from admitting departments were selected: 10 from the tertiary referral hospital and 7 from the secondary referral hospital. All had participated in consecutive end-of-life decisions concerning ICU patients. The physicians were chosen chronologically, according to when the decisions were documented in a special protocol (Sjökvist et al. 1998). Several patients were not included in the study because the physician was on leave after the decision, and this made it impossible to arrange an interview within a reasonable period. So these physicians were not asked to participate. In this special protocol, admitting-department physicians were referred to as the patient’s primary physician. Of the 17 physicians who participated in this study, 14 were senior consultants and 3 were residents (13 men and 4 women). An introductory letter was sent to the physicians; all physicians, who were approached, agreed to participate.

Interviews and analysis
The interviews were carried out 1 day–3 weeks (mean = 8 days) after the decisions were made. One of the authors (M.S.) did the interviews. The physicians were asked just one question: “Can you give a description of the time from when you first learned of the patient to when the decision was made to forego life-sustaining treatment?” They were allowed to describe their experiences without interruption. The only additional questions were to clarify circumstances, such as who was being referred to when physicians used the word “we”. The interviews were recorded; lengths varied between 15 and 40 minutes. They were transcribed verbatim and analysed according to the phenomenological method advocated by Giorgi (1985). In the analysis, we used a caring-ethical perspective, which means focusing on a holistic view of the patient and on ethical aspects of the decision-making process. By “ethical aspects”, we mean descriptions of value conflicts and interest conflicts, such as the sanctity and quality of life, respect for the patient’s autonomy and interests of others.

Approval
At the time of the interviews (1997–1998), the praxis in Sweden was not to seek ethical approval from an ethics committee when health care professionals participated in studies. When we started the study we acquired approval from the head of the Departments of Anaesthesiology and Intensive Care Clinic in both of the hospitals. We believe that the physicians were not in a state of dependence on the first author (the interviewer who is a nurse). Neither the physicians nor the patients can be identified. The interviews took place after the decisions of limiting life support had already been made and could therefore not affect the care of the patients.

Results
Table 1 displays the physicians’ specialties, the patients’ diagnoses and ages and decisions taken. The time between the physicians’ first contact with the patients and decisions to forego life-sustaining treatment varied. Some physicians met their patients the same day that the decision was taken at the ICU, whereas others had seen their patients for several years as outpatients. In other words, the physicians either met the patient before intensive care or for the first time at the ICU. The process that led to a decision to forego life-sustaining treatment, as expressed through the physicians’ experiences, was complex and involved great individual variation. The physicians displayed different attitudes and
Table 1 Characteristics of physicians and patients combined with 17 cases of end-of-life decisions

<table>
<thead>
<tr>
<th>Physician's specialty</th>
<th>Patient's diagnosis</th>
<th>Age</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haematologist</td>
<td>Leukaemia</td>
<td>64</td>
<td>Withdrawing all life support</td>
</tr>
<tr>
<td>Cardiologist</td>
<td>Post-cardiac arrest</td>
<td>72</td>
<td>Withholding inotropes and CPR*</td>
</tr>
<tr>
<td>Cardiac surgeon</td>
<td>Status post-coronary bypass</td>
<td>79</td>
<td>Withdrawing all life support</td>
</tr>
<tr>
<td>Surgeon</td>
<td>Colitis</td>
<td>82</td>
<td>Withdrawing all life support</td>
</tr>
<tr>
<td>Cardiologist</td>
<td>Post-cardiac arrest</td>
<td>59</td>
<td>Withholding CPR if asystole</td>
</tr>
<tr>
<td>Internist</td>
<td>Septic shock</td>
<td>84</td>
<td>Withholding CPR</td>
</tr>
<tr>
<td>Internist</td>
<td>Neurological disease, pneumonia</td>
<td>68</td>
<td>Withholding ventilator</td>
</tr>
<tr>
<td>Neurologist</td>
<td>Intracerebral bleeding</td>
<td>80</td>
<td>Withholding ventilator and CPR</td>
</tr>
<tr>
<td>Pulmonologist</td>
<td>Respiratory insufficiency</td>
<td>67</td>
<td>Withholding ventilator</td>
</tr>
<tr>
<td>Cardiac surgeon</td>
<td>Status post-coronary bypass</td>
<td>71</td>
<td>Withholding CPR and surgery</td>
</tr>
<tr>
<td>Surgeon</td>
<td>Post-operative abdominal abscess</td>
<td>75</td>
<td>Withholding CPR and surgery</td>
</tr>
<tr>
<td>Internist</td>
<td>Pulmonary fibrosis</td>
<td>71</td>
<td>Withdrawing all life support</td>
</tr>
<tr>
<td>Vascular surgeon</td>
<td>Ruptured abdominal aortic aneurysm</td>
<td>80</td>
<td>Withholding CPR and dialysis</td>
</tr>
<tr>
<td>Internist</td>
<td>Pneumonia, sepsis</td>
<td>70</td>
<td>Withholding dialysis</td>
</tr>
<tr>
<td>Rheumatologist</td>
<td>No diagnosis, multiorgan failure</td>
<td>76</td>
<td>Withholding CPR</td>
</tr>
<tr>
<td>Surgeon</td>
<td>Multitrauma</td>
<td>83</td>
<td>Withholding dialysis</td>
</tr>
<tr>
<td>Nephrologist</td>
<td>Renal and heart failure</td>
<td>72</td>
<td>Withholding CPR</td>
</tr>
</tbody>
</table>

*Cardio pulmonary resuscitation.

approaches. No special differences were detected between male and female reasoning. However, two major approaches were expressed. One approach focused on saving the patient’s life and considered limiting life support only after realizing that the patient was going to die despite use of it: “... then we contacted a plastic surgeon, who performed a special operation. It was a major operation, and we did it to give the patient a chance, as a last resort. We want to do what is the best for the patient. We want to use all resources available, but unfortunately the patient did not improve, so we had to give up the battle”. —Cardiac surgeon

The other approach was to save life, while keeping the option of limiting life support in mind: “… what I thought one should do was to try to operate, take him to the ICU and to the extent that he showed signs of pulling through, one should help him but not take any advanced measures, instead everything should as it were, be left to take its natural course”. —Vascular surgeon

Another difference involved the descriptions of how active the physicians were in the decision-making process. Some physicians visited the patient frequently in the ICU and described themselves as the person most responsible for taking the final decision. Other physicians described their part as less active, visiting the patient in the ICU only on the request of the intensivist and describing their role as peripheral regarding the final decision. Despite individual differences and the fact that physicians met the patients in different situations and under different conditions, there still seems to be a pattern in the process. The common features in the process appeared principally as five phases; see Fig. 1. The process was not always linear. Some reasoning occurred back and forth, particularly between phases 2 and 3, and the expressed importance of every phase varied among the physicians.

Phase 1: Defining their role and contact with the patient

In phase 1, the physicians started by defining their role toward the patient. The role seemed to be important, and the descriptions varied from a primary responsibility to a consultative role. Primary responsibility could mean that the physician was responsible for the patient in the ward or had maintained long-term contact with the patient during outpatient treatment. Some physicians, who had primary responsibility, described this responsibility as a task given to them to save the patient’s life, which seemed to affect decision-making. One surgeon was asked by another department to perform a life-saving colectomy on the patient. He expressed will to save the patient’s life throughout the decision-making process and expressed defeat to be forced to limit life support.
Physicians who expressed that they were not responsible for the patient described their role as consultative. This could mean being called to a ward or an ICU by another physician to examine the patient without any special request.

Most physicians had met the patients before their arrival at the ICU. Despite these earlier contacts, patients were described in a detached way, and verbal communication with patients was rarely mentioned. The focus was on patients' medical conditions. One physician had a patient for several weeks on the ward. No verbal contact with the patient was mentioned. Another physician first met the patient in shock, with a ruptured abdominal aortic aneurysm, in the emergency room. He had repeatedly tried to establish verbal contact on the way to the operating room:

"... It was possible to make contact with him, and he probably understood at least something of what was going on. But I know I sat on the stretcher for a while trying to talk to him...".

—Vascular surgeon

**Phase 2: Knowledge of the patient**

In phase 2, the physician's knowledge of the patient was described. The knowledge came from physicians' memories of meeting the patient before, from medical records, clinical examinations and from other physicians. Knowledge gained from the patient's family was described, but this did not seem to appear further in the physician's reasoning during the rest of the process. Knowledge described as especially important was the patient's present and former physical status. The concept *quality of life* appeared, although not significantly and was mostly interpreted to mean functional ability: "A 200 meters' walk, no more, would make him out of breath. He has not been able to go outdoors lately. Limited by weakness of his heart. Life has been very burdensome for him, and he has survived against all the odds".

—Cardiologist

**Phase 3: Evaluation and action**

In phase 3, the physicians evaluated the patient's condition and possible choices of action. This evaluation took up a large part of the physicians' descriptions. They either centred on the difficulty of coming to a prognosis or focused only on life-saving actions such as surgery or medicine. Prognosis evaluation included collecting more
knowledge about the patient’s physical condition, discussions with other physicians and diagnostic procedures.

Different degrees of uncertainty were expressed. Uncertainty was expressed through thoughts about the cause of the patient’s deterioration or fluctuating condition or about other colleagues’ opinions concerning prognoses. One physician met a patient in a ward on a consultative basis. When he read the medical record, he reflected about whether reasonable judgements had been made earlier concerning the level of care: “Something that struck me was that he ended up in an ICU the same year, and I wondered about the level of care then, but it must have been quite likely his condition must have been reversible...yes, it was probably obvious that he would be helped by intensive care then. But in the medical records, you can read that the level of care was discussed with respect to the patient’s underlying neurological illness. In addition, he had a heart condition, but note he had gone through heart surgery as late as 1993 and then one would expect that some kind of assessment was made about the patient’s condition, which is slowly deteriorating”.

-Internist

Certainty was expressed as certainty about prognosis and diagnosis:

When I saw this man and remembered his medical history, I agreed with my colleague’s judgement that cardio-pulmonary resuscitation was not justified. He was an 80-year-old man who was seriously ill and considering his circulatory failure and the fact that he looked tired and miserable, couldn’t react to pain but had pupils that reacted.... In other words he was neurologically alive but comatose, so I believed that the earlier judgement was correct.

-Neurologist

Phase 4: Turning point

After evaluation, a turning point was finally reached, mainly through discussions with other physicians. The discussions were mostly described as being unanimous. A common feature through the entire process was the use of “we” when referring to other physicians. A few physicians mentioned disagreements with the intensivist about gate-keeping, balance of power or different opinions about the turning point. All of this was expressed in mild terms: “...there was, probably earlier than I accepted it, a certain pressure, maybe I shouldn’t call it pressure but there was, I would say, a request from the intensivists about limiting this treatment”.

-Surgeon

The dominating determining factors for the decision were short-term survival or a bad prognosis.

“The patient’s condition had deteriorated during the night. A deterioration in the liver and the coagulation blood test, continued high fever and even more circulatory instability, despite inotropes, forced us to revalue the situation.”

-Haematologist

Other factors besides these, which were also mentioned by a few physicians, included poor quality of life, old age and life without dignity.

Phase 5: Decision-making

In phase 5, a decision was reached. There were varying descriptions of the discussions that led up to the formal decision. Discussions with other physicians dominated, but some physicians did not mention discussions and said that the decision was theirs and theirs alone.

The patient did not appear to be a participant in the decision-making phase. But some physicians reflected on the problem of asking the patient about his own wishes: “Should you discuss death with a patient you are treating? It’s an extremely delicate task, psychologically difficult. Should you ask a human being who struggles to breathe, how he wants to die? The patient had clearly expressed that life was hell, but we had not discussed if and how he was going to die”.

-Cardiologist
Descriptions of contact with the patients’ families varied. The dominating result was that the physicians either did not mention the family or just informed them about decisions that were made. But there were some descriptions of physicians seeking support from the family for a preliminary decision that was made: “The family probably understood what we said and thought of course that it was sad that things had taken this turn for their mother. At the same time, they did agree and realised that their mother was seriously ill. In connection with all this, we told them that we considered that the treatment that we were now administering would gradually be withdrawn, because she had not responded to treatment, so we thought it was futile to only prolong her suffering further. . . . And the relatives also agreed that it was absolutely OK, for they had known for a long time that their mother did not want, so to speak, to be kept alive by mechanical means . . . .”

-Surgeon

One of the hospitals had recently introduced interdisciplinary conferences about patients in an organised form, in which nurses and other professionals participated. This was the only time that physicians mentioned nurses. Nurses’ opinions did not emerge. But the physicians expressed great appreciation regarding these group discussions.

Physicians were described as taking the final decision to forego life-sustaining treatment. They described their own role in varied ways. Either they took the decision on their own, shared the decision with intensivists and/or other physicians, shared the decision with others during an interdisciplinary conference or only expressed a recommendation.

“Because I am the primary physician everybody expects me to make the decision. Nobody else is very willing to make such a decision before me, so it is really very much my own personal decision.”

-Cardiac surgeon

“. . . I think it is very important that when one takes this kind of decision it is natural that it is not just one single person who does it. It is not a decision which one makes immediately, instead it is a kind of process, where one gradually reaches the decision and in these kind of cases it is a discussion between the surgeon and the intensivist.”

-Surgeon

“\[In my opinion, the intensivists who are the experts on intensive care can make these decisions, without actually involving the primary physician.\]”

-Internist

At the end of the interview, after the descriptions of the decision-making process, some ethical reflections emerged. These reflections concerned ethical issues in general, rather than issues connected with the actual patient and the decision-making process. Those ethical reflections that did concern the actual patient were about respecting the patient’s autonomy and questioning the meaningfulness of continued treatment: “After all, I still thought that she would pull through without the ventilator, and I don’t quite know what decision I would have arrived at if I had been convinced that she would die without the ventilator. In that case I might have come to another decision. But owing to the fact that the patient expressed a negative attitude toward use of the ventilator, I might have been influenced but just a little . . . . I could have placed her on it without considering her own wishes . . . .”

-Pulmonologist

“Then I do wonder if it’s really meaningful, a patient lying like a vegetable for us to treat in the ICU . . . . then there would be no reason for us to take part in this kind of care, but I don’t like this when there is no progress during an entire month despite the treatment we have given.”

-Cardiac surgeon

**Discussion**

In this study, 17 physicians were asked to describe authentic end-of-life decisions. A pattern of five phases emerged in the decision-making process. The interviews revealed a process that on the whole can be described as a medical one that involved only few ethical reflections. The focus was on medical facts, predicting prognosis and survival. The process was mostly carried out in collaboration with other physicians—without discussions with patients, next-of-kin or nurses. However, a minority of physicians contributed an ethical dimension to the process. There were some descriptions of a holistic view of the patient, descriptions of the patient and family as participants and reflections about what is best for the patient.

The results do not predict how physicians may decide in these questions, but it gives a
pre-understanding of how physicians may reason during the process leading up to a decision. The strength of the study is that the physicians were interviewed about real cases and that they narrated their own experiences without interruption. The decision-making process was described in its context, which made it possible for the physician's holistic experience to become visible.

As no additional questions were raised for further reflections, this probably led to descriptions presented on a medical and technical level of reality. In the Lindseth et al. (1994) study, physicians distinguish between professional and personal experiences in narrations about “ethically difficult care episodes”. Narrating from a professional experience perspective, the physicians emphasised atomism (opposite of holistic view), scientific knowledge, paternalism and the principle of preserving life. When asked to reflect once again on their experiences, they instead narrated about meeting death and seeing care as something holistic (Udén et al. 1992; Lindseth et al. 1994). The aim of this research was to study real clinical situations and the physicians' professional experiences. According to the phenomenological method, we invited the physicians to give a descriptive account, to describe as freely and spontaneously as possible. We assume, according to the phenomenological method that the descriptions in this study cover what the physicians spontaneously considered as important for decision-making. That, which was omitted, i.e. ethical considerations, we assume was seen as peripheral. If we had asked them questions to encourage a reflective account, there may have been a risk of rationalisation concerning decision-making. This might have led to a construction of ethical reasoning. Because the descriptions were on a surface level, they may therefore be regarded as a result. This might indicate that in real life, professional experience may explain the physicians' actions and not their personal reflections and theories. However, we consider it important to study reasoning on the surface level (medical and technical level of reality) and on the internal level (goodness on an ontological level) (Soderberg 1999), both of which may influence decisions.

It may be debated if phenomenology was the best method for analysing these interviews because the emotional part of decision-making did not emerge. Because of the resulting lack of intentional depth, content analysis may have been a better choice. But content analysis may not have given the physicians their right to interpret (preferential right), which is something that phenomenology offers.

In an earlier phenomenological study that explored intensivists' and intensive care nurses' experiences of decisions about withdrawing life-sustaining treatment, the physicians viewed the final decision as medical (Vinay 1996). In a survey of Western European intensivists by Vincent, 42% of the respondents said that ethical issues in effect were medical issues. Vincent also stated that there is a difference between what a physician actually does and what he or she believes should be done (Vincent 1999). The present study demonstrated what physicians actually did and that which emerged as the dominating common feature was that the decision was described as a medical decision. In his paper, Vincent indicated that with his low response rate (39%), the answers may have been "furnished by the most motivated physicians" and that questionnaires in general rely on pre-formulated answers.

In our study, the primary decision-maker was not clearly specified, i.e. whether the person was the admitting-department physician or the intensivist. Personal characteristics of the physicians involved seemed to be decisive for the balance of power.

In the earlier phenomenological study, the intensivists experienced the greatest conflicts with physicians from the admitting department. The dissonance centred on power and control over decision-making (Vinay 1996). In two Scandinavian studies, which concerned ethically difficult situations, the physicians experienced a lack of dialogue with colleagues and that communication was on a superficial level. They experienced few opportunities for discussing their uncertainties. It was easier to continue treatment, as this would save them from being criticised (Soderberg 1999; Sorlie et al. 2000). In another study, male physicians praised a good collegial atmosphere, but their
narratives reflected a lack of support among colleagues and a fear of opening a dialogue about ethical difficulties (Sorlie et al. 2001). Our study, which mostly displays unanimity between admitting-department physicians and the intensivists, has probably captured communication on a superficial level. But the earlier studies focused on ethical problems, while we studied continuous sequences of real decisions. Our study suggests that a decision to limit life support is possible only when physicians agree with each other. If not, life-sustaining treatment continues. This implies that it would be interesting to study when decisions to continue treatment are made.

Swedish health care is largely hospital-based. This means that many patients do not have long-term outpatient contact with a physician. One effect of this is that when a patient is admitted to the hospital, ward physicians are responsible for the medical care. A dominating feature in our study was that the physicians made decisions about patients whom they did not know. The physicians were named in the special protocol as the patient’s primary physician, but in reality more than half of the physicians who participated in decisions were not the patients’ primary physicians. The differences in the time periods of when the physicians had met the patients for the first time reflect this. This study implies that a system in which the primary physician is appointed to the patient at admittance to the hospital does not work, because it entails problems with physician continuity.

The decision-making process was about patients, but as our study showed, patients did not appear to play an active role. Similar to an earlier study, it was regarded as difficult to discuss preferences with patients (Cook 1997). The physicians felt that their objective was to save patients’ lives and give them hope. However, several studies show that patients do want to talk with their physicians about end-of-life issues (Miles et al. 1996; Heffner & Barbieri 2000; Lofmark & Nilstun 2000), although the opposite view has also been presented (Hofmann et al. 1997). In this study, physicians described their patients in a detached way. This agrees with Sorlie’s study in which male physicians explained it as important to be able to keep problems at a distance, to protect themselves from being too emotionally involved and consequently, to be unable to cope with their work (Sorlie et al. 2001).

According to the earlier survey, about 50% of Western European intensivists involved the patient’s family in decisions (Vincent 1999). But it is not clear if “involve” meant that physicians sought support for their decision or that the family really participated in decisions? By the phrase “seeking support” we mean seeking support for a decision already made by physicians. By “participation” we mean discussions with family before any decision is made. In our study, involving family seemed to mean only seeking support for a decision that was already made.

In this study, the physicians did not mention discussions with nurses. This is similar to most findings in earlier studies, which show low involvement of nurses in end-of-life issues (Udén et al. 1992; Baggs & Schmitt 1995, 2000; Kennard et al. 1996; Viney 1996; Puopolo et al. 1997; Reckling 1997; Costello 2002; Stroud 2002). Although some studies report participation of nurses in decision-making. In a Finnish survey of community health centre nurses, 87% reported discussions with physicians about starting terminal care (Kuuppelomaki 2002). In an American survey of ICU nurses, most nurses thought that communication about end-of-life decisions with physicians was “somewhat effective” (Puntilla et al. 2001). In a review of Baggs, she notes that ICU nurses’ involvement in end-of-life decision-making, has seldom been described, and the area needs further exploration (Baggs 2002).

The physicians in our study, who participated in interdisciplinary conferences, did not mention discussions with nurses, but they mentioned their participation. They expressed great appreciation to be able to sit down and work together in group discussions. Kennard et al. recommends “joint grand rounds” for physicians and nurses to make collaboration between them easier (Kennard et al. 1996). Hohenleitner (2002) emphasises education in communication skills for these discussions.
Conclusions

In conclusion, we found that the decisions, which are expected to be based on ethical considerations, were in reality made on medical grounds and were made by physicians. The physicians mainly provided descriptions of effectiveness, in other words, if it was possible to prolong life. At the same time, they assumed the role of being experts on the larger issue of meaningfulness, because they described themselves as the sole decision-makers.

The only expert on the meaningfulness of an individual's life is the patient. Roles of patients and their next-of-kin have been thoroughly discussed in the literature and at conferences. In this study, it was found that physicians from the admitting department, made end-of-life decisions without patient or family participation. This might be an acceptable practice when, despite life-sustaining treatment, it is obvious that the patient is going to die, but in most cases, the prognosis has at least some degree of uncertainty.

We believe that in cases with an uncertain prognosis or when advance directives are not known, it is important to involve different kinds of participants early in the decision-making process. For example, family involvement should mean discussions before any preliminary decision is made. Nurses may play an important role in finding out whether the patient has expressed advance directives to his/her next-of-kin or earlier caregivers.

Besides this, nurses often know a lot about the level of suffering that patients may be going through during their time in intensive care. The nurse may act as an advocate for the patient (Hohenleitner 2002). This study indicates that a stricter organisation of interdisciplinary conferences would enable nurses to participate in decisions. The nurse's knowledge of the patient (continuity of care granted) may complement a medical decision, which may because of this, become an ethical decision for a patient who is incompetent. To be prepared for the consequences of an ethical decision (i.e. withdrawal of life support), it is time for ICU nurses to develop a curative and a palliative approach to the delivery of care (Miller et al. 2001; Truog et al. 2001; Stroud 2002).

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Nurses’ and Physicians’ Opinions on Aggressiveness of Treatment for General Ward Patients

Mia Svantesson, Peter Sjökvist, Håkan Thorsén and Gerd Ahlström

Key words: attitudes; do not resuscitate; end-of-life decisions; ethics professionals; providing life-sustaining treatment; withholding life-sustaining treatment

The aim of this study was to evaluate agreement between nurses’ and physicians’ opinions regarding aggressiveness of treatment and to investigate and compare the rationales on which their opinions were based. Structured interviews regarding 714 patients were performed on seven general wards of a university hospital. The data gathered were then subjected to qualitative and quantitative analyses. There was 86% agreement between nurses’ and physicians’ opinions regarding full or limited treatment when the answers given as ‘uncertain’ were excluded. Agreement was less (77%) for patients with a life expectancy of less than one year. Disagreements were not associated with professional status because the physicians considered limiting life-sustaining treatment as often as the nurses. A broad spectrum of rationales was given but the results focus mostly on those for full treatment. The nurses and the physicians had similar bases for their opinions. For the majority of the patients, medical rationales were used, but age and quality of life were also expressed as important determinants. When considering full treatment, nurses used quality-of-life rationales for significantly more patients than the physicians. Respect for patients’ wishes had a minor influence.

Introduction

When patients do not participate in decisions to be made at the end of their life, it may be difficult to know what is best for them and whether to continue or limit life-sustaining treatment. Several previous studies show low levels of patient involvement in end-of-life decisions, with contradictory findings regarding their attitudes towards this involvement. Some studies have found that the majority want to participate in such decisions, while others have shown the opposite. This

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places great responsibility on the health care professionals who make end-of-life decisions, so studying their opinions on these issues is essential.

In addition, different aspects have been studied regarding ethical considerations in end-of-life care. One aspect is health care providers’ experiences of ethical problems in the daily care of their patients and another is their attitudes and opinions in general towards limiting life-sustaining treatment. Opinions are different from attitudes in that attitudes are often referred to in the literature as arising from more complex unconscious thought processes and beliefs than opinions. Several studies have described nurses’ experiences of being in disagreement with physicians regarding the decision-making process and the appropriate level of life-sustaining treatment. Other studies have reported agreement on their attitudes regarding limiting life-sustaining treatment. One American opinion survey based on real patients in a small rural hospital showed, however, that nurses were more willing than physicians to limit treatment. The attitudes of health care professionals regarding the limiting of life-sustaining treatment have previously been studied mostly by postal surveys. Several of these studies involved hypothetical patient scenarios investigating the rationales concerning when to limit life-sustaining treatment. Few have enquired about the rationales regarding real patients. In all the studies nurses and physicians responded to a limited number of preformulated options comprising between eight and 17 items. The items most commonly used for both hypothetical and real patients were patient wishes, age and quality of life. These have been perceived as being the most important rationales. Medical aspects were also commonly used, but were described in other ways, such as the likelihood of survival, premorbid illnesses, futility and prognosis. Only a few study reports describe how the rationales were generated. Cook and colleagues constructed a list of factors after carrying out a literature review and from semistructured interviews with 30 intensive care unit physicians and nurses. Frampton and Mayewski asked general ward staff members which factors were perceived as important for the generation of rationales. In the other studies no explanation was given of how the rationales were generated.

In nearly all of the previous studies the focus was on rationales for limiting life-sustaining treatment. Dramatic advances in lifesaving treatment and technology have increased the ability to prolong life, so there has been a simultaneous rise in health care costs, which has led to health resource allocation problems. For these reasons rationales for decisions to continue treatment also deserve investigation. We have found one study carried out in a small rural hospital in which nurses and physicians were also asked to give rationales for considering full life-sustaining treatment. The nature of the underlying disease was equally important for considering either full or limited life-sustaining treatments, but quality of life and age were ranked highly much more often for patients thought to warrant full treatment. In summary, there is little literature available on studies of nurses’ and physicians’ opinions regarding aggressiveness of treatment for general ward patients. In addition, no comprehensive study was found that used an inductive approach to identify opinions regarding the aggressiveness of treatment. On the basis of the literature, it was hypothesized that nurses would consider limited treatment for a greater number of patients than physicians. The aim of this study therefore was to evaluate the level of agreement between nurses’ and physicians’ opinions regarding full or
limited life-sustaining treatment for their patients, and to investigate and compare the rationales on which their opinions were founded.

Method

This study had a descriptive and comparative design using both qualitative and quantitative approaches. The interviews conducted were based on actual general ward patients because it can be expected that most of these patients will be competent and able to participate in decision making. Ethical approval was obtained from the regional research ethics committee. Written information was provided regarding the study and the voluntary nature of participation was based on informed consent.

Participants and setting

Nurses and physicians working in 10 wards of a university hospital in Sweden were invited to participate. Dealing with end-of-life issues was highly relevant in daily practice in these wards because of the severe nature of the patients’ illnesses. Heads of departments from three wards declined to take part, resulting in the inclusion of seven wards from the departments of surgery (gastrointestinal and vascular), internal medicine (renal, endocrine and gastrointestinal), cardiology, neurology, gynaecology and ear, nose and throat. A total of 107 registered nurses and 65 physicians participated. Ten physicians were residents and 55 were specialists. All the nurses agreed to participate, but six of the physicians declined, mainly owing to time constraints. The majority of the nurses interviewed were women (94%) with a median of 5 (quartile 1 (Q1) 1; Q3 12) years’ professional experience as a nurse, while the majority of the physicians were men (78%) with a median of 19 (Q1 10; Q3 28) years’ professional experience.

Data collection

The data were gathered on 24 separate days over a two-year period. Pairs of nurses and physicians who were caring for the same patients on data-collection days were interviewed regarding all patients in their care, including those in which limited treatment was not a consideration. There were three interviewers (MS and two research nurses), all using the same technique. On each interview day, year of birth, gender and any documented decisions regarding limited life-sustaining treatment were registered for all the patients on the ward. Contact was then made with the nurses and physicians in charge of those patients in order to schedule an interview on the same day. Some participated in two or three interviews because they had relevant patients in their care on more than one occasion. Of the 801 patients discussed, there were 132 interviews with nurses and 92 with physicians. Paired nurse–physician interviews were completed with regard to 714 patients. Dropouts in the paired interviews resulted from physicians’ inability to remember sufficiently the specifics of each patient, transfers of patients from general to intensive care or patients’ deaths, and the six physicians who could not participate. The mean number of patients discussed in each interview was six for nurses and nine for physicians.
Interviews

The structured interviews began with a question regarding the diagnosis and if the patient’s expected survival was less than one month, less than one year, greater than one year or not predictable. Expected survival data were necessary in order to identify severely ill patients. The main question asked was: ‘In your opinion, what level of life-sustaining treatment is appropriate for your patient?’ The life-sustaining treatment envisaged was mainly cardiopulmonary resuscitation, but it also included any possible eventual need for intensive care or other life-sustaining treatments such as dialysis or chemotherapy. The closed answer alternatives were: full life-sustaining treatment, limited life-sustaining treatment, or uncertain about the potential level of aggressiveness. The interviewers made certain that the respondents understood the definitions of full and limited life-sustaining treatments. The nurses and physicians were then asked an open-ended question about the rationale they used to formulate their opinion on the level of care considered. When the answers were unclear, the interviewers asked for clarification: ‘What do you mean by . . . ?’ The answers were recorded verbatim. Each interview lasted approximately 15 minutes.

Qualitative analysis

Content analysis was used to investigate the rationales for full or limited life-sustaining treatment. The approach was inductive, inspired by a multistage method for analysing open-ended questions. Initially, the first author read through the text once. Similar responses were grouped together and labelled into preliminary subcategories. The text was read again and refined in the light of the data as a whole. This resulted in a list of 98 preliminary subcategories. In the next stage, the second author read the raw data and then coded the responses independently, using the subcategory list developed by the first author. Coding agreement between the first and second authors was 90% and the remaining 10% were further discussed with input from the third author. These subcategories were modified into broader subcategories, from which main categories emerged. In the third stage, all the authors performed repeated checking of the plausibility of the content of the categories. The main categories were validated and compared with previous research. Finally, in the fourth phase, all authors discussed the four dimensions that emerged from the main categories.

Quantitative analysis

The evaluation of nurse–physician agreement on the level of aggressiveness of treatment was accomplished by using the paired frequency distribution of the aggressiveness level categories. Disagreement was expressed as confidence intervals (CI) for the differences between paired proportions. After the rationales for the level of aggressiveness were categorized, the data were quantified by computing the main category frequencies. More than one rationale for the same patient could be coded into the same main category. The main categories were counted once per patient in order to prevent statements from the more verbal nurses and physicians affecting the result. For the comparison between nurses and physicians regarding rationales for the opinions, CIs for the difference between two independent proportions were calcu-
In order to adjust for multiple tests and to keep an overall significance level of 5%, each hypothesis test was regarded as significant when $P < 0.01$ and the 99% CI was calculated.

An initial subgroup analysis was performed to separate the patients about whom the nurses and physicians were uncertain with regard to full or limited treatment from those about whom they were certain. From the latter group, an additional subgroup analysis was made by dividing the patients who were expected to survive for more than one year into one group and the patients expected to survive less than one year or assessed as unpredictable in the other group. This was performed so that those patients who were not ill enough to elicit the question of need for limited or full life support could be separated from the others.

**Results**

The paired nurse and physician interviews were based on 714 patients, whose most common medical problems are shown in Table 1.

**Agreement between nurses’ and physicians’ opinions regarding level of aggressiveness of treatment**

Table 2 presents nurses’ and physicians’ opinions about life-sustaining treatment for the same patients. Of the entire group of 714 patients, the same level of treatment was chosen by both physicians and nurses for 553 (77%). The nurses were uncertain about 4.6% more patients than the physicians (99% CI 1.4–8), a significant difference. In most cases when the nurses or physicians replied ‘uncertain’, the patients were described as being severely ill and were eligible for both limited and full treatment. Some nurses were uncertain because a do not resuscitate (DNR) order had not yet been decided on or they felt too inexperienced to form an opinion. After separating out the patients for whom uncertainty was expressed, the percentage of agreement between nurses and physicians was 86% for the remaining 637 patients.

For 207 of these 637 patients (32%) a nurse and/or a physician expected survival to be less than one year or unpredictable and there was 78% agreement between them.

**Table 1** Characteristics of the 714 patients assessed\(^a\)

<table>
<thead>
<tr>
<th>Type of medical problem</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>168 (24)</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>146 (20)</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>128 (18)</td>
</tr>
<tr>
<td>Neurological</td>
<td>96 (13)</td>
</tr>
<tr>
<td>Kidney</td>
<td>57 (8)</td>
</tr>
<tr>
<td>Ear, nose, throat</td>
<td>40 (6)</td>
</tr>
<tr>
<td>Endocrine</td>
<td>30 (4)</td>
</tr>
<tr>
<td>Respiratory</td>
<td>12 (2)</td>
</tr>
<tr>
<td>Other</td>
<td>37 (5)</td>
</tr>
</tbody>
</table>

\(^a\)Median age, 70 years (Q₁ 55; Q₃ 79); 372 women (52%).
concerning treatment. For the 431 (68%) patients expected to survive for more than one year, agreement was 90% (difference 12%; 99% CI 3–20).

In the opinion of both the nurses and the physicians, limited life-sustaining treatment was considered most appropriate for 25% of the total 714 patients. For 8.5%, the physicians’ opinion was for full treatment or they were uncertain, while the nurses chose the limited treatment option. This situation was reversed for a further 8%, for whom the physicians chose limited treatment and the nurses were uncertain or opted for full treatment (difference 0.5%; 95% CI –3 to +3), an insignificant difference.

Rationales for opinions regarding level of aggressiveness of treatment

The nurses and physicians provided between one and six rationales for each patient in response to the open question concerning the reason for considering either full or limited life-sustaining treatment or rationales for their uncertainty. The answers were either succinct, such as: ‘young, good prognosis’, ‘vital, good quality of life’, ‘elderly, heart disease’, or more detailed: ‘Seriously ill, being poorly from underlying illness, bedridden, poor circulation, pressure sores, long history of suffering. Would be nice if she could just go in her sleep. Hardly a life for a human being.’

The content analysis generated four dimensions: medical, quality of life, age and autonomy. The rationales for full and limited life-sustaining treatments were similar, but expressed in opposite ways such as good prognosis and poor prognosis, or satisfaction and dissatisfaction (Table 3). Thus only quotations for the rationales for full treatment were selected for further presentation.

Medical dimension

For medical condition, the expression ‘not seriously ill’ was commonly used, as well as ‘healthy’ or ‘no serious disease’. ‘No premorbid disease’ was mostly used to describe a healthy state prior to the present condition. Having a benign disease most often implied it was not cancerous, but also that it was not life threatening. Whether the condition was benign or malignant seemed to be of importance: ‘Elderly man, but the disease is not malignant.’ Good prognosis was described as being curable to expecting

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Table 2  Nurses and physicians’ opinions regarding the level of life-sustaining treatment for the same patients

<table>
<thead>
<tr>
<th></th>
<th>Physicians</th>
<th></th>
<th></th>
<th>Totals for nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Full life-sustaining treatment</td>
<td>Uncertainty about level of treatment</td>
<td>Limited life-sustaining treatment</td>
</tr>
<tr>
<td>Nurses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full life-sustaining treatment</td>
<td>426</td>
<td>12</td>
<td>36</td>
<td>474</td>
</tr>
<tr>
<td>Uncertainty about level of treatment</td>
<td>30</td>
<td>6</td>
<td>22</td>
<td>58</td>
</tr>
<tr>
<td>Limited life-sustaining treatment</td>
<td>54</td>
<td>7</td>
<td>121</td>
<td>182</td>
</tr>
<tr>
<td>Totals for physicians</td>
<td>510</td>
<td>25</td>
<td>179</td>
<td>714</td>
</tr>
</tbody>
</table>
only some improvement in severe conditions (Table 3). The disease was often expressed as being treatable: ‘The medication the patient has been treated with has given a good result. Believe the patient will improve even more.’

The ongoing procedures category included only rationales for full life-sustaining treatment (Table 3). If the patients were undergoing certain procedures, this was a reason for not considering limited treatment at that time. In the diagnostic phase, the diagnosis was still undetermined due to ongoing procedures or pending test results. The treatment phase implied that the patient had just begun treatment, had recently completed treatment or was waiting for elective surgery or other treatments such as pacemaker insertion, chemotherapy or dialysis: ‘Aortic aneurysm surgery planned. Waiting for a stent to be sent from Belgium.’ Some rationales included full treatment, which temporarily superseded future consideration of a more palliative approach: ‘Is

Table 3  Rationales for full and limited life-sustaining treatment

<table>
<thead>
<tr>
<th>Main category</th>
<th>Subcategory: rationale for full life-sustaining treatment</th>
<th>Subcategory: rationale for limited life-sustaining treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical dimension</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical condition</td>
<td>Not seriously ill</td>
<td>Seriously ill</td>
</tr>
<tr>
<td></td>
<td>No premorbid disease</td>
<td>Premorbid disease</td>
</tr>
<tr>
<td></td>
<td>Benign disease</td>
<td>Malignant disease</td>
</tr>
<tr>
<td>Prognosis</td>
<td>Cured/curable</td>
<td>Incurable</td>
</tr>
<tr>
<td></td>
<td>Reversible condition</td>
<td>Irreversible condition</td>
</tr>
<tr>
<td></td>
<td>Long-term survival</td>
<td>Short-term survival</td>
</tr>
<tr>
<td></td>
<td>Unpredictable prognosis</td>
<td>Failure to respond to treatment</td>
</tr>
<tr>
<td>Ongoing procedures</td>
<td>Diagnostic phase</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Treatment phase</td>
<td></td>
</tr>
<tr>
<td>Quality-of-life dimension</td>
<td>Good physical function</td>
<td>Poor physical function</td>
</tr>
<tr>
<td>Functional status</td>
<td>Functional independence</td>
<td>Functional dependence</td>
</tr>
<tr>
<td></td>
<td>Good cognitive function</td>
<td>Poor cognitive function</td>
</tr>
<tr>
<td></td>
<td>High motivation/abilities</td>
<td>Low motivation/abilities</td>
</tr>
<tr>
<td>Satisfaction/dissatisfaction</td>
<td>Joy in life</td>
<td>Distraught</td>
</tr>
<tr>
<td></td>
<td>Feeling well</td>
<td>Suffering</td>
</tr>
<tr>
<td></td>
<td>Expected to feel well</td>
<td>Expected suffering/inhumane life</td>
</tr>
<tr>
<td>Existential aspects</td>
<td>Will to live</td>
<td>Lack of will to live</td>
</tr>
<tr>
<td></td>
<td>Perceives self as healthy</td>
<td>Ready to die</td>
</tr>
<tr>
<td>Social circumstances</td>
<td>Intact nuclear family</td>
<td>Living alone</td>
</tr>
<tr>
<td></td>
<td>Good social network</td>
<td>Lack of social network</td>
</tr>
<tr>
<td></td>
<td>Consideration for family</td>
<td>Consideration for family</td>
</tr>
<tr>
<td>Age dimension</td>
<td>Young</td>
<td>Old</td>
</tr>
<tr>
<td>Autonomy dimension</td>
<td>Patient’s wishes unknown</td>
<td>Expressed acceptance to die</td>
</tr>
<tr>
<td>Respect for patient’s wishes</td>
<td>Expressed a will to live</td>
<td>Expressed a will to die</td>
</tr>
</tbody>
</table>
in a postoperative phase with the standard recovery plan. Then with regard to his cancer, one should not be too aggressive.’

**Quality of life dimension**
The term ‘quality of life’ was sometimes used without explanation, especially when referring to a poor quality of life. Good quality of life could also be described as living a good or satisfactory life. Other descriptions were more specific. The following quotation as a rationale for full life-sustaining treatment contains three of the categories: functional status, satisfaction and existential aspects: ‘Active woman, employed, content with life. Accepts and understands her condition, complies with treatment regimen, wants to live.’

In the functional status category, good physical function and functional independence seemed important. Good physical function was mainly depicted as being active and vital. Functional independence was described as having a high level of ability in the activities of daily life, being able to take care of himself or herself, or not requiring home health care services. Good cognitive function implied for the most part being alert and orientated. High motivation/abilities were described as complying with the medical care or rehabilitation programme: ‘Well informed about his illness; believe the patient will take perfect care of himself.’

The satisfaction category was perceived as still having joy in life or feeling well, which could imply the absence of pain or that they were expected to feel well: ‘Has prospect for a decent life.’ Existential aspects were mainly perceived as the will to live, but could also be described as ‘still fighting’. ‘Perceives the self as healthy’ could include statements such as patients being unaware of their illness. The ‘right to live’ could be interpreted as everything should be done for the patient and that no resources should be spared: ‘Worth our efforts.’ Social circumstances included rationales that were considered for patients with intact nuclear families, especially including young children and/or with a good social network, which could imply receiving good support from their partner and/or relatives or having many friends: ‘The illness is of a cancerous origin, but he still has a worthwhile family life.’ Consideration for the family could be interpreted as the family demanding or appealing for treatment.

**Age dimension**
Most of these rationales were short and concise and contained words such as ‘young’ or ‘not so old’ or ‘relatively young’. They were sometimes accompanied by remarks such as ‘he is in the prime of his life’. These remarks, however, mainly accompanied rationales for limited treatment such as that it is natural to die of old age.

**Autonomy dimension**
In the respect for patients’ wishes category, only those answers in which the nurses and physicians referred to what the patients had themselves expressed were included. This is different from nurses’ and physicians’ perceptions of patients having a will to live (existential aspects). ‘Patient’s wishes unknown’ could imply that they were not yet familiar with the patient or that the patient had not expressed a wish for no further treatment. The words ‘expressed a will to live’ could mean that the patient wanted treatment: ‘The patient has himself chosen to have the operation today in an effort to beat the cancer. The patient has made this decision in consultation with the rest of the family.’
Comparisons of nurses’ and physicians’ rationales

Table 4 presents the distribution of the dimensions from the rationales generated by the content analysis, which were computed from the number of patients that were considered for full or limited treatment by the nurses and physicians. When considering full treatment, nurses used quality-of-life rationales for significantly more patients than the physicians (Table 4). Figure 1 gives the distribution and comparisons between the nurses and the physicians for the main categories of rationales. Both groups viewed medical condition, prognosis and functional status as most important. The physicians cited prognosis significantly more often when considering full life-sustaining treatment than the nurses, while nurses viewed functional status and social circumstances as significantly more important than physicians. Considering reasons for limited treatment, patient dissatisfaction was of greater significance for the nurses than the physicians.

Table 4  Distribution of dimensions comparing nurses and physicians for total patients ($n=714$) (multiple rationales were often given, so total dimensions are greater than 100%)

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Full treatment: no.%</th>
<th>P-value</th>
<th>Limited treatment: no.%</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nurses (474 patients)</td>
<td>Physicians (510 patients)</td>
<td>Nurses (182 patients)</td>
<td>Physicians (179 patients)</td>
</tr>
<tr>
<td>Medical</td>
<td>355 (75)</td>
<td>408 (80)</td>
<td>NS</td>
<td>153 (84)</td>
</tr>
<tr>
<td>Quality of life</td>
<td>199 (42)</td>
<td>122 (24)</td>
<td>$P &lt; 0.01^*$</td>
<td>69 (38)</td>
</tr>
<tr>
<td>Age</td>
<td>142 (30)</td>
<td>122 (24)</td>
<td>NS</td>
<td>62 (34)</td>
</tr>
<tr>
<td>Autonomy</td>
<td>14 (3)</td>
<td>10 (2)</td>
<td>NS</td>
<td>11 (6)</td>
</tr>
</tbody>
</table>

NS, $P > 0.01$ (not significant).

*99% CI 11–26.

Discussion

The findings suggest that there are more similarities than differences between the opinions of nurses and physicians regarding life-sustaining treatment. Surprisingly, contrary to previous findings of nurses describing their experience of physicians giving too much treatment, the physicians in this study considered limiting life-sustaining treatment as often as the nurses. After excluding the ‘uncertain’ answers the agreement was good (86%) regarding the level of treatment aggressiveness. This agreement was however lower when the entire sample, including those answers with uncertain opinions, was analysed. Nevertheless, we do not consider being uncertain as actually being in disagreement with full or limited treatment because, for most of the uncertain answers, the nurses and physicians had rationales for both limited and full treatment. For patients with an expected survival of less than one year or an unpredictable life expectancy, agreement was lower (77%). This was not associated with professional status because the physicians chose limited treatment when the nurses considered full treatment or were uncertain and vice versa for an almost equal number of patients. The 95% CI ($-3\%$ to $+3\%$) for this difference ($0.5\%$) is so narrow.
that it should exclude any relevant differences in the clinical setting. One previous opinion survey of similar design carried out by Eliasson et al.\(^3\) was found to be in accordance with our result. In this study, nurses and physicians were asked on a daily basis about their opinions regarding DNR issues for each patient in one intensive care

**Figure 1** Percentage distribution of main categories of rationales comparing nurses and physicians (patients \(n = 714\)): ■, nurses; □, physicians; *\(P < 0.01\)

...
unit. There were no significant differences in the timing of when DNR was considered appropriate between nurses and physicians.\textsuperscript{34}

In our study and the one mentioned above,\textsuperscript{34} the physicians were not in a decision-making role when answering the questions. It is however one thing to have an opinion and another to take the responsibility and to act on it. The results suggest that health care professionals may have similar opinions regarding the limiting of life-sustaining treatment, but it is the physicians who must assume the responsibility to act and take the legal, social and personal consequences. For some physicians, the decision to limit life-sustaining treatment may for this reason be so difficult that they hesitate, which may explain nurses’ experience of doctors giving too much life-sustaining treatment. The data from these two opinion studies support the findings of agreement found in other studies regarding attitudes to forgoing life-sustaining treatment.\textsuperscript{17-21,34}

It may seem controversial to be asking for rationales for considering full treatment. It is our experience that, in the traditional way of thinking, reasoning for full life-sustaining treatment is not needed; it is taken for granted. However, the results indicate that there is a substantial number of severely ill hospitalized patients when considering that, for 40\% of the patients, a physician and/or a nurse was uncertain or considered limited treatment (Table 2). This high percentage would imply that, on wards with many severely ill patients, the administration of full treatment should never be taken for granted. It should therefore be standard procedure to assess all patients on admission for their eventual need for life-sustaining treatment.

Among the rationales that were not found in earlier studies were ‘ongoing procedures’ and ‘existential aspects’.\textsuperscript{17-19,21,25,28,29} The use of ongoing procedures as a reason for full life-sustaining treatment for some patients included situations that temporarily superseded what may be a more palliative approach in the future. When procedures were ongoing, such as perioperative care, it did not seem acceptable to choose limited life-sustaining treatment. In this study, existential aspects as a reason for full life-sustaining treatment were mainly described as a will to live. Structured interviews with elderly people in a study from Israel revealed that self-esteem and fear of death were the strongest predictors of the will to live. The correlation between the will to live and the patient’s wish to prolong life by the use of life-sustaining treatment was statistically significant, but rather low.\textsuperscript{35} Apart from the previous study, there seems to be a lack of existential aspects in the literature in relation to life-sustaining treatment. One reason may be that earlier studies have focused on rationales for limited treatment rather than full life-sustaining treatment. Furthermore, in other studies,\textsuperscript{28} existential aspects may have been described as the patients’ wishes but may in reality have been confused with the health professionals’ perceptions of the patients’ wishes. Cook \textit{et al.} examined the clinical determinants associated with the withdrawal of life-sustaining treatment in intensive care, the strongest of which was the physician’s perception that the patient preferred not to receive life-sustaining treatment.\textsuperscript{28} In intensive care, where most patients are incompetent, this must imply that the authors studied existential aspects not autonomy.

Contrary to previous findings that patients’ wishes were one of the most commonly used rationales,\textsuperscript{18,19,21,22} this was rarely mentioned in the present study. In our previous Swedish study, patients’ wishes were viewed as one of the most important factors.\textsuperscript{18} In that study, nurses and physicians were asked about their attitudes towards hypothetical patients whose wishes were one of many preformulated options. In the present study the interviews concerned real patients and participants were asked to
state their rationales in answering an open-ended question. The patients’ wishes in the previous study may have been a socially desirable option. To respect patients’ wishes may be an ideal, but may not necessarily correspond with reality. The results of this study agree with the majority of previous studies regarding low levels of patient involvement in end-of-life decisions.\textsuperscript{1,2,5,36}

Except for patients’ wishes, our study was in accordance with previous studies\textsuperscript{17–19,21,22,29} showing medical, age and quality-of-life factors as being the most important. It is noteworthy that Swedish law prohibits using chronological age alone as a factor in determining medical care.\textsuperscript{37,38} In spite of this, age was cited in the present study as the sole rationale for 92 (13\%) of the patients and the first mentioned rationale for 248 (35\%) when multiple rationales were given. There were few reflections regarding such opinions and it seemed natural to view age as a decisive factor. This non-adherence to the law is evident, if not common, in medical practice.\textsuperscript{39,40}

The nurses and physicians based their rationales on similar factors, which is in agreement with previous attitude studies.\textsuperscript{17–19,21,22} However, when considering full life-sustaining treatment, the nurses used significantly more quality-of-life rationales than the physicians. No significant difference was found between the nurses and the physicians for the number of patients for whom they used quality-of-life rationales when opting for limited treatment. However, owing to the relatively low number of patients chosen for limited treatment, a larger sample may have detected a significant difference. The main categories under the quality-of-life dimension in our study corresponded with four of the five domains into which quality of life is usually divided. The fifth dimension, economic standard of living,\textsuperscript{41} was not mentioned by the nurses or the physicians. However, the meaning of the term ‘quality of life’ varies depending on the theoretical perspective and the empirical field of application.\textsuperscript{42} In the literature a distinction is usually made between health-related quality of life and quality of life in general, the former being based wholly on health domains that can be easily measured and quantified. Quality of life may consist of a much broader range of elements, many of which are generally unrelated to the factors monitored by health care professionals.\textsuperscript{43} The nurses’ and physicians’ perceptions of the patients’ quality of life seemed to be evident when there was no knowledge regarding the patients’ wishes (ie interpreting the wishes of the patients). As several studies have revealed, health care professionals often underestimate patients’ perception of their quality of life,\textsuperscript{44,45} which may lead to arbitrary judgements being made by others.

**Methodological considerations**

Contrary to several other studies using hypothetical patient scenarios,\textsuperscript{17,18,21,23–26} this study focused on real patients, which implied a more complicated context. Some of the authors of previous studies concluded that interpretation of the results might have been limited because of the hypothetical character of the scenarios, which may diverge from real world circumstances.\textsuperscript{21,24,26} In this study every patient who was on the ward on the day of data collection was included, even those who were not severely ill. Nevertheless, if we had included only those who were assessed to be ill enough, there might have been a risk of excluding patients for whom physicians and nurses had diverging opinions; this could have led to selection bias, for example, when the rationale was age rather than illness.
In the present study the approach was inductive, which generated a broad spectrum of rationales. A description of how the earlier instruments were developed seems to be lacking in the literature.\textsuperscript{14,21,24,29} To our knowledge, no study has previously used quantitatively generated rationales based on an inductive approach using such a large number of patients. Ferrand \textit{et al.} stated that closed-ended questionnaires preclude new input from respondents.\textsuperscript{14} Another limitation of previous designs could be that respondents would be more apt to give socially desirable responses when these are among predetermined items such as respecting patients’ wishes.

In the present study, the short response time the nurses and physicians had may have influenced the results. It may be argued however that this produced spontaneous answers. Having more time to reflect before answering may result in more socially desirable responses. It may also be argued that taking a stand on an ethical issue requires time for reflection. Nevertheless, this study, which was performed on a superficial level, may reflect the superficial clinical practices on the wards. Surprisingly, despite the short time available, the assumed complexity of this issue, and the fact that participants were encouraged not to take a stand if they were hesitant, few nurses and even fewer physicians chose the uncertain answer alternative.

One strength of this study was the rigorous co-assessment carried out during the development of the categories. The data were more manifest than latent (ie describing mostly the visible and obvious components of communication)\textsuperscript{46} so this co-assessment was possible. Coding agreement between the first and second authors was 90%, so reliability was high.\textsuperscript{46} Working together while grouping the categories enabled discussion on different interpretations of the data, which we believe also increased the reliability of the result. The first author used a panel of experts (co-authors) to establish category production, which ensured high content validity.\textsuperscript{46}

In summary, the hypothesis that nurses would consider limited treatment for a greater number of patients than physicians was not proved. Instead, this study revealed few differences between the opinions of nurses and physicians compared with the results of previous studies in which nurses reported experiencing such differences.

**Implications of the results**

Asking for someone’s experience regarding end-of-life decision making seems to generate a different sort of knowledge to asking for their opinions or attitudes. There seems to be more disagreement when enquiring about experiences and more agreement with opinions and attitudes. Further studies, including meta-analyses, are recommended to increase the knowledge of how the various aspects correlate with and differ conceptually from each other.

Medical rationales dominated the reasons given for choosing both full and limited life-sustaining treatment. In addition, the nurses and physicians also cited quality of life and age as relevant factors for one third of the patients. This implies that they had opinions not only about the effectiveness of treatment but also about its meaningfulness. Meaningfulness of life-sustaining treatment refers to an ethical dimension, namely the subjective assessment that continuing treatment would be meaningful.\textsuperscript{3} Ethical competence as well as continuity in patient care are prerequisites when making these assessments, especially when patients are not involved in the end-
of-life decision making. For these reasons, this study may indicate a need for reflective ethical practice, in clinical work and during professional education. There should be an obligation to prepare students for predictable ethical dilemmas. This could be achieved by discussing ethical problems experienced during their clinical training. An ethicist could contribute to determining students’ values and opinions. One way of facilitating reflective ethical practice in the clinical setting would be through interdisciplinary team meetings including an ethicist by means of so-called ‘ethics rounds’. Health professionals would then have assistance in dealing with questions of meaningfulness. Physicians and nurses could also come together with their experiences of disagreement and share their opinions in order to achieve a common goal for patient care.

Acknowledgements

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Mia Svantesson and Gerd Ahlström, Örebro University, and Örebro University Hospital, Örebro, Sweden.

Peter Sjökvist, Huddinge University Hospital, Stockholm, Sweden (deceased).

Håkan Thorsén, Örebro University, Örebro, Sweden.

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9 Fuchalski CM, Zhong Z, Jacobs MM et al. Patients who want their family and physician to make resuscitation decisions for them: observations from SUPPORT and HELP. Study to


Learning a way through ethical problems: Swedish nurses’ and doctors’ experiences from one model of ethics rounds

M Svantesson,1 R Löfmark,2 H Thorsén,3 K Kallenberg,4 G Ahlström5

ABSTRACT
Objective: To evaluate one ethics rounds model by describing nurses’ and doctors’ experiences of the rounds.
Methods: Philosopher-ethicist-led interprofessional team ethics rounds concerning dialysis patient care problems were applied at three Swedish hospitals. The philosophers were instructed to promote mutual understanding and stimulate ethical reflection, without giving any recommendations or solutions. Interviews with seven doctors and 11 nurses were conducted regarding their experiences from the rounds, which were then analysed using content analysis.

Findings: The goal of the rounds was partly fulfilled. Participants described both positive and negative experiences. Good rounds included stimulation to broadened thinking, a sense of connecting, strengthened confidence to act, insight into moral responsibility and emotional relief. Negative experiences were associated with a sense of unconcern and alienation, as well as frustration with the lack of solutions and a sense of resignation that change is not possible. The findings suggest that the ethics rounds above all met the need of a forum for conflict resolution and problem-solving. A model based on content analysis.

Conclusion: When assisting healthcare professionals in learning a way through ethical problems in patient care, a balance should be found between ethical analyses, conflict resolution and problem-solving. A model based on ethics rounds may be one way of providing training in moral reasoning and reflective practice beneficial for future ethical decision-making or it may also provide urgent support regarding patient care problems. In addition, there appears to be a social incentive, a need to gain mutual understanding among the different professions. Several studies have described disagreements nurses have with doctors over not making the decision to limit life-sustaining treatment.3–5 Other studies have, however, shown that they do actually in theory share the same opinions as to when treatment should be limited.3–5 A lack of communication is seen as a major cause for conflicts regarding life-sustaining treatment.6,7

The term “ethics rounds” has previously been described in north American literature usually in association with the teaching of medical ethics to students and practising professionals by means of case discussions. The use of “ethics consultation” seems to be more common in north America, where one of the purposes has been described as educational but foremost it seems to imply short-term help to solve particular patient care problems. This help involves health personnel, patients and their families. According to the American Task Force on Standards for Bioethics Consultation, the goal is to identify, analyse and resolve value-laden issues concerning particular patients.8,9 Studies involving ethics consultation in intensive care have shown positive outcomes in terms of satisfaction with conflict resolution and ethics education, as well as a reduction of non-beneficial treatment and costs.10 There have, however, been reports of a high degree of variability in ethics consultation services.12 There is disparity over the role of the ethicist as to whether they should only clarify the circumstances or give recommendations,13 i.e., to assume an authoritative or a facilitative approach.14

In European countries, some clinical ethics committees have begun giving support regarding particular patient care cases10 but no systematic evaluation of this support has been found. The practice of ethics rounds has been reported from one hospital in Sweden. Here an ethicist led a discussion with healthcare staff from one ward concerning a particular patient case. The ethicist’s role was to facilitate a democratic dialogue.17 Through listening to each other’s perspectives, the participants can become aware of alternative horizons and of the multiplicity of values related to clinical practice.17

In the present study, we have chosen to apply a model inspired by the previously mentioned Swedish rounds and the goal established by the American Task Force, to identify and analyse the ethical problem but excluding the solving component.10 This was in order to decrease the risk that an outside expert would remove responsibility from the person with the formal decision-making responsibility.13 Discussing known patients has two motives. First, the social context is taken into account, which brings realistic complexity into the discussion.1 Second, by using the case method, more effective learning is provided because it involves a critical situation from clinical practice.19

From a review of the literature, it seems that Europeans are beginning to develop the structure of clinical ethical discussions. Nurses and doctors are two of the main professional actors involved in ethical problems associated with inpatient care. Therefore, the main aim of this study was to evaluate one ethics rounds model, by describing
nurses’ and doctors’ experiences from the rounds. An additional aim was to describe their opinions on how ethical discussion should be conducted.

**METHOD**

This interview study was part of a larger evaluation project concerning ethics rounds. This included interviews before the first round and after the last, as well as questionnaires before and after each round. Ethical problems surrounding the patients and the perceptions of all the professionals participating in the rounds have been explored using a questionnaire and will be presented elsewhere.

**Model for ethics rounds**

From 2004 to 2005, interprofessional team discussions were led by a philosopher-ethicist that dealt with the ethical problems surrounding the care of patients from the nephrology departments (one ward and one dialysis unit) of three hospitals. Dialysis patients were selected because the nature of their long-term life-sustaining treatment could provide an opportunity for the care providers to get to know them rather well (see characteristics of patients involved in table 1). Four male practical philosophers were recruited from a recently established national network that assists healthcare professionals with clinical ethical problems. One of the philosophers is a co-author (HT), the others had no relation to the authors. Three philosophers participated at each hospital. The participants were informed that the goal of the rounds was to imulate ethical reflection and promote mutual understanding between the professional groups. The philosophers were instructed to help identify and analyse the ethical problems but not to make any recommendations or offer solutions. The healthcare staff were informed that they were to seek solutions on their own after the rounds.

The head nurse chose the patient to be the subject of the ethics rounds, in accordance with the advice of the nurses and in consultation with the doctors. It was the most moving cases that were chosen. Two major problems were experienced with regard to the 12 patients before the ethics rounds, non-compliance and end-of-life issues (see table 1). Four of the patients had died when the rounds took place. The meetings occurred in conference rooms at the hospitals. They were held regularly four times every other month at each hospital and each session lasted one and a half hours. Participation in the ethics rounds was voluntary but the doctors were urged to participate in the light of the aim to promote mutual understanding. Of the 194 participants in the 12 rounds (median 14 participants, range 7–27), 58% were nurses, 16% doctors, 17% healthcare assistants and 9% were others, such as social workers and occupational/physiotherapists.

**The philosophers’ descriptions of the rounds**

The philosophers were asked after each round to describe briefly how they structured the round and how they perceived their role. A manifest content analysis with the aid of the computer program N Vivo was used to sort the data. The philosophers’ descriptions showed that they structured the rounds in similar ways but perceived their roles differently in different rounds. In some rounds they perceived their role to be that of a discussion leader with a low profile, mostly listening while at the same time seeing that everyone had a chance to be heard. In other rounds they perceived their role as being more authoritarian, steering the discussion and helping to focus on ethical analysis and bringing ethical concepts into the discussion. The predominant structure was this: the philosopher started by defining what an ethical problem is, then a doctor presented background facts about the patient. A large amount of the time was then spent on identifying the ethical problems together. Some of the rounds resulted in analyses of different choices of action. Finally, the philosophers made a summary of the discussion.

**Participants in the research**

Of the 11 total nurses from the dialysis units and nephrology wards, six volunteered to be interviewed and five were purposely asked to participate by the head nurses as they were

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**Table 1** Characteristics of the patients and the perceived related ethical problems reported before the ethics rounds, followed by characteristics of the interviewees

<table>
<thead>
<tr>
<th>Patients</th>
<th>n = 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, mean (range)</td>
<td>66 (41–89)</td>
</tr>
<tr>
<td>Women/men, n</td>
<td>3/9</td>
</tr>
<tr>
<td>Deceased when the rounds took place, n</td>
<td>4</td>
</tr>
<tr>
<td>Type of ethical problem attributed the patients, n</td>
<td></td>
</tr>
<tr>
<td>Patient non-adherence to dialysis regime</td>
<td>5</td>
</tr>
<tr>
<td>Suffering connected with continued dialysis</td>
<td>4</td>
</tr>
<tr>
<td>Professional distress over patient’s decision to discontinue dialysis</td>
<td>1</td>
</tr>
<tr>
<td>Truth-telling about bad news</td>
<td>1</td>
</tr>
<tr>
<td>A suicidal patient with a deportation order</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nurses</th>
<th>n = 11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, mean (range)</td>
<td>45 (23–58)</td>
</tr>
<tr>
<td>Women/men, n</td>
<td>9/2</td>
</tr>
<tr>
<td>Years of professional experience as a nurse, mean (range)</td>
<td>13 (1–26)</td>
</tr>
<tr>
<td>Years of work experience in nephrology, mean (range)</td>
<td>12 (1–31)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Doctors</th>
<th>n = 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, mean (range)</td>
<td>53 (47–67)</td>
</tr>
<tr>
<td>Women/men, n</td>
<td>1/6</td>
</tr>
<tr>
<td>Years of professional experience as a doctor, mean (range)</td>
<td>23 (17–39)</td>
</tr>
<tr>
<td>Years of work experience in nephrology, mean (range)</td>
<td>17 (8–35)</td>
</tr>
</tbody>
</table>
known for their willingness to verbalise opinions. Among the 11 doctors that participated in at least one ethics round, seven agreed to be interviewed. See characteristics in table 1.

**Teaching and learning ethics**

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Positive experiences of ethics rounds expressed in themes and subthemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stimulus to broadened thinking</td>
<td>Sense of connecting</td>
</tr>
<tr>
<td>Getting clarifications</td>
<td>Open climate</td>
</tr>
<tr>
<td>“They wrote the problem on the board, they broke it down, what is the ethical problem, why are we here. They wrote down the points, very good I think. And then they talked based on those points, very structured” Nurse 9</td>
<td>“It was fantastic that the doctors managed to sit there and take our criticism and not become defensive. Instead they said, yea we probably made a mistake there and we were not observant enough and what should we do to make things better” Nurse 8</td>
</tr>
<tr>
<td>Breaking from habitual ways of thinking</td>
<td>Sense of equality</td>
</tr>
<tr>
<td>“The philosophers really got us thinking. Is that how it is? Why do you do it like that? and little thought provokers. Somebody from the outside came and sort of looked into the work group” Nurse 3</td>
<td>“There hasn’t been the usual hierarchical order that is otherwise so prominent in healthcare. But in this case, they probably weren’t familiar enough with the subject and didn’t want to stick their necks out. At the same time, they were actually listening and the nurses opinions were probably worth as much as their own” Nurse 2</td>
</tr>
<tr>
<td>Seeing from different perspectives</td>
<td>Promoting mutual understanding</td>
</tr>
<tr>
<td>“Someone from dialysis had met the patient before he was transplanted, when he had dialysis the first time. He was against it; he didn’t want dialysis at all then. I didn’t know that. I thought that was interesting. Yea, it’s seems that together we know quite a bit about the patients. We have met the same person in different situations” Nurse 7</td>
<td>“It’s really good that we sit down and talk about it. And discuss what we doctors actually base our decisions on. Sometimes I get the impression that the nurses think we haven’t thought at all, that we dialyze the patients as long as they breathe and have a heart beat” Doctor 4</td>
</tr>
</tbody>
</table>

**Ethical considerations**

As ethical problems would not be solved during the rounds, it was not considered unethical to exclude the patients as participants. Withdrawing life-sustaining treatment is an emotionally charged question and the ethics rounds may cause distress for the participants. The rounds could interfere with existing relationships and create new conflicts. The head nurses were therefore prepared to arrange psychological help if needed. The informed consent was based on written information regarding the study and voluntary participation.
Teaching and learning ethics

Findings
A few of the interviewees experienced all the ethics rounds as positive and a few found them negative or they were indifferent to the rounds. The majority, however, had mixed descriptions in which some rounds were experienced as good and others as bad. Compared with the positive statements, the negative statements were fewer in quantity. When no specific occupation is mentioned in the text below, a shared experience by the nurses and the doctors is implied. The five positive and the four negative themes of experiences are illustrated by quotations in tables 2 and 3, under the headings of subthemes.

Positive experiences
A good round was found to provide stimulation to broadened thinking, a sense of connecting, a strengthened confidence to act, insight to moral responsibility and emotional relief (table 2).

Stimulation to broadened thinking
The dominating experience was the appreciation of “getting clarifications” with help from the philosophers, which could imply the formulation of thoughts into words. The nurses especially appreciated this. Structuring the thinking into steps was perceived to make the complicated comprehensible. It was found to be a way to uncover the essence of the ethical problem as well as an educational opportunity. When the philosopher actively led the discussions in a structured manner, it was perceived that different perspectives could be envisioned easier. Different notions and other provocative questions were found with “breaking from habitual ways of thinking” and stimulated reflections regarding the nature of the problem (see quotation table 2). Besides being stimulated by the philosophers, stimulation from work mates was also experienced. New information presented about patients offered “seeing from different perspectives” and provided a more integrated and holistic view.

Sense of connecting
The discussion was experienced as having a straightforward “open climate”. Doctors described how they were positively touched by an emotionally tense discussion and experienced the critique as constructive. Nurses expressed admiration for the doctors’ openness about acknowledging errors (table 2). When the philosophers were perceived as actively leading the discussions, the speaking time was experienced to be fairly distributed between the doctors and the other participants. A “sense of equality” had been perceived and was expressed in terms of a diminished hierarchy. Nurses felt they were on more equal ground with the doctors when they experienced the doctors as lacking expertise in ethics. Nurses felt that the doctors and philosophers had listened to them and they could contribute with important information about the patient. The ethics rounds were described as being valuable for “promoting mutual understanding”. The philosophers were perceived as promoting understanding by turning accusations into ways of seeing things from a different perspective. The doctors found the rounds provided an opportunity to elucidate misunderstandings. They tried to make it clear that they had in fact reflected and spoken with the patients about their wishes and tried to explain why the decision to limit life-sustaining treatment had not been made earlier. Doctors told of an improved understanding of the nurses’ frustration over the doctors’ heterogeneous attitudes towards life-sustaining treatment. Nurses understood the doctors’ sense of powerlessness in certain decision-making situations and the difficulty of anticipating the time of death (table 2).

Strengthened confidence to act was associated with “seeing a way out” of a seemingly impossible situation. This especially emerged for nurses when the philosopher gave different alternatives for actions (table 2). They appreciated a straightforward down-to-earth guidance approach for problem solving over a solely theoretical and reflective discussion. The nurses associated “using gained insights” with a more critical attitude, which was thought to give them confidence to act in the future. Some of the patient problems discussed during the rounds were experienced as being recurrent. Being able to see a solution to a problem retrospectively was expressed as being valuable for similar situations in the future.

Insight into moral responsibility
Even though the rounds were felt to be less productive than expected by the doctors, initiating the dialogue alone was considered valuable. The doctors gained an “insight into the need for continued dialogue” with the nurses regarding problematical patients and issues concerning limiting life-sustaining treatment. They realised after the rounds that they had a responsibility to explain their motives for continued treatment better. Another insight came with the discussion of how the ethically difficult situations came about and who was responsible, shedding light on “insight into own and others’ responsibility”. The responsibility was seen as not only lying with the doctor but with everyone involved, even the patients. A discussion that began with the pointing out of a scapegoat ended up with the realisation that ethical problems can be caused by organisational shortcomings. A lack of communication and of doctor continuity in patient care was interpreted as organisational causes that can expose patients to unnecessary suffering.

Emotional relief
Relief was experienced just by having time for reflection, without value judgements and the demand for results. A few interviewees valued “sharing heavy thoughts”, which they felt they usually had to bear alone (table 2). The philosophers were perceived as being sensitive and helpful in sorting out and dealing with feelings. “Feeling of support” could include dealing with patient aggressiveness by interpreting it as a form of ambivalence towards living. The nurses believed the doctors needed these discussions as support to make the decision to limit life-sustaining treatment.

Negative experiences
The negative and indifferent experiences were associated with a sense of unconcern and alienation, as well as frustration with the lack of solutions and a sense of resignation to non-change (table 3).

Sense of unconcern
The rounds themselves were experienced as being worthless or just a “worthless philosopher input” was described. They did not leave an impression beyond that of a discussion leader. A desire for more ethics theory was expressed because some of the reasoning was found to be too complicated. The philosopher was perceived as being unable to make his knowledge applicable to the real world (table 3). There were also experiences that ethical analysis was overshadowed by relational conflicts. “Unmoving patient cases” was experienced as negatively affecting the overall feeling. This could occur when the patient was unknown or the problem was perceived as being neither
emotionally moving nor ethically relevant. Feelings of being "already morally secure" about values and possible actions and the solving of the problem also gave feelings of indifference.

**Sense of alienation**
When the philosopher did not take command over a round, interviewees perceived it as polemical and filled with unleashed emotions. A "deadlock" between nurses and doctors was experienced. Nurses believed that the doctors felt their positions were threatened during such rounds. They felt the doctors took a united front against them, used only medical arguments and did not listen to them. Nurses felt rejected when the doctors did not understand how they felt when the patients were perceived as being exposed to suffering. Doctors had the impression that the nurses used the rounds as an opportunity to criticise them. "Inflicted value judgements" were experienced when the philosopher was felt to influence the round too much with his own opinions and this was found to be coercive and inhibited the discussion (table 3).

**Frustration with lack of solutions**
The rounds were experienced as isolated happenings that had little reference to daily practice. Finding "no direct impact on daily practice" left nurses with a feeling of disappointment. Nurses had expected the rounds to lead to positive changes. They found they became impatient when theoretical reflections instead of practical solutions were discussed. There was a "wish for the answer book" and a feeling that the questions only produced more questions. "No consensus for action" signifies that they missed a formal decision that would direct future actions or compel doctors to be decisive about life-sustaining treatment. They and their non-participating co-workers shared the sentiment that discussions that did not aim to produce solutions were a waste of time (table 3).

**Table 3** Negative experiences of ethics rounds expressed in themes and subthemes

<table>
<thead>
<tr>
<th>Sense of unconcern</th>
<th>Sense of alienation</th>
<th>Frustration with lack of solution</th>
<th>Resignation to non-change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worthless philosopher input</td>
<td>Deadlock</td>
<td>No direct impact on daily practice</td>
<td>Lack of time for further reflection</td>
</tr>
<tr>
<td>&quot;My immediate feeling was that HE actually got more out of it than we did&quot; Nurse 5</td>
<td>&quot;We were hardly getting any steering from the philosopher. Instead it was just us and the doctors, and we were in opposition. And that's when the one that was supposed to steer us would have had a chance to straighten things out and point out the ethical problem&quot; Nurse 7</td>
<td>&quot;The nurses got so fed up just because nothing happens. For some of these patients that we have talked about you had hoped something would have been settled. In my opinion the doctors are such cowards. They are a bunch of slippery eels. They always manage to slither away somehow, there's never ever anyone that will make the decision&quot; Nurse 4</td>
<td>&quot;You get something that makes you stop and think for a moment. But then you let it go or perhaps it's there in the back of your mind. It isn't very often you get a chance to think, instead you're just in the here and now!&quot; Nurse 4</td>
</tr>
<tr>
<td>Unmoving patient cases</td>
<td>Inflicted value judgements</td>
<td>Wish for the answer book</td>
<td>Discouraged by others' lack of commitment</td>
</tr>
<tr>
<td>&quot;What I felt was negative about the rounds was that they didn't touch on any really good ethical problems. They were hardly any problem at all because it was rather obvious what was to be done&quot; Doctor 15</td>
<td>&quot;The philosopher tried to steer us more than he should have for that patient about what was right and wrong. Some things were considered to be more OK than others. That felt overbearing&quot; Doctor 18</td>
<td>&quot;For me it was a bunch of humbug, that there is no answer as to this is the way it is or isn't, and that it's blurred. I would like it a bit more black and white&quot; Nurse 8</td>
<td>&quot;They are at work more or less. It's their kid that's sick or their horse has the sniffles. There are a lot of things that keep a person from really being present&quot; Nurse 2</td>
</tr>
<tr>
<td>Already morally secure</td>
<td></td>
<td>No consensus for action</td>
<td>Insoluble classic problem</td>
</tr>
<tr>
<td>&quot;From the beginning I've had to get used to making these kinds of decisions and that causes one to grow into that kind of responsibility, I have always felt rather sure in that, so personally I've almost never had, well OK some anxiety over a decision, but never fear&quot; Doctor 14</td>
<td></td>
<td>&quot;Even if I think it actually gives something, and you think a little about what the others say and such, but it never really amounts to anything and I think people expect it to lead to something&quot; Nurse 11</td>
<td>&quot;It follows a classic pattern. The nurses always feel that the doctors go too far treating the patients. That's always the theme&quot; Doctor 15</td>
</tr>
</tbody>
</table>

**Evaluation of the ethics rounds' goal**
The goal established for the rounds seemed to be reached in some of the rounds. The theme "stimulation to broadened thinking" corresponds with stimulate ethical reflection. The theme "sense of connecting" describes a broader experience under which promoting mutual understanding constitutes a subtheme. Some interviewees did not explicitly speak of having gained understanding but nevertheless described the ethics rounds as a forum that promoted understanding. In other rounds associated with negative experiences, the goal did not appear to be reached. This was reflected by the view of "worthless philosopher input" and the "sense of alienation". Nurses expressed an expectation that solutions would be reached but that was not part of the original goal. Appreciation was expressed when "seeing a way out" of an ethical problem and "frustration with lack of solutions" from other rounds were noted.
As reported previously from North America, there is a lack of clarity as to whether the ethicist should simply elucidate the issue or should also make recommendations; our study would seem to confirm this finding. Discussing patients currently in treatment probably led to the expectation of solutions. Nurses’ “frustration with lack of solutions” may be caused by unfamiliarity with reflection. On the other hand, it may be a question of pent-up feelings derived from a perceived lack of end-of-life decision-making, which has been reported both in this and in previous studies. This suggests that practice in reflection cannot on its own diminish frustrations. In some rounds, however, the philosopher-ethicists offered different alternatives for action, which was experienced by nurses as instilling a “strengthened confidence to act”. The approach these philosophers used seems similar to the facilitation approach used in American ethics consultations, in which attempts are made to facilitate consensus building among healthcare professionals. In our study design the philosophers were not involved in the clinical practice and did not, for example, speak to patients or their families or access medical records. This design was chosen so that the outside expert would not have too much influence.

The kind of leadership practised by the philosophers in our study seemed to be crucial. When the discussion was perceived to be controlled by the philosopher it was experienced as being democratic and beneficial to the ethical analysis. The philosophers seemed to have different abilities in group process skills, such as handling the power balance between the nurses and the doctors and the individual ability also seemed to fluctuate between rounds. This suggests differences in the climate of collaboration at the work places and a different level of value-laden cases. One philosopher put it this way: “It was a very good discussion today. I felt I had a hold on the conversation and could direct it. It was a drastic contrast to the way it was last time (at another hospital), where I completely lost control.” This was well illustrated in the interviews, in which the interviewees described positive experiences of the later discussion and negative of the earlier. In view of the qualitative design of this study, however, we must be cautious about causal explanations.

The interviewees had little to say regarding which profession the leaders of future rounds should be drawn from, being more concerned with the leaders’ character and competence. This is in accordance with the American Task Force on Standards for Bioethics Consultation, which assigns importance not only to such things as interpersonal and process skills and the capacity to make ethical assessments but also to character. The interpersonal and process skills include an ability to facilitate and structure meetings in such a way that the participants feel free to express their concerns. Nothing is said, however, about the ability to maintain control over the discussions.

One of the most salient findings was the nurses’ and doctors’ polarised descriptions of each other, even with regard to the positively described experiences. It seems that a major portion of the rounds was spent trying to connect with each other, which may suggest that some of the ethical problems were in fact relational conflicts. This is supported by the results found in an ethnographic study of the practice of ethics consultation.

According to the sociologist Chambliss, ethical debates often come about as a result of professional clashes. Ethical issues are embedded in “complexes of routine” and the fact that nurses are subordinates. Complexes of routine can be seen in the present study in terms of the organisational shortcomings such as the lack of patient care continuity as a result of the doctors’

Teaching and learning ethics

Box 1: Opinions regarding desire for competencies of the leader

<table>
<thead>
<tr>
<th>Desired knowledge/experience</th>
<th>Ethics</th>
<th>Philosophy of life</th>
<th>Clinical experience of human care</th>
<th>Life experience with outlook on people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desired qualities</td>
<td>Disciplinarious</td>
<td>Able to set bounds</td>
<td>Able to gain control over balance of power between nurses and doctors</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Analytical</td>
<td>Able to stimulate seeing further</td>
<td>Able to stimulate seeing different solutions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fair</td>
<td>Goal-oriented</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Democratic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Objective</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pedagogy</td>
<td>Able to keep the main thread</td>
<td>Able to maintain structure</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Committed</td>
<td>Able to push the discussion ahead</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Active</td>
<td>Sensitive</td>
<td>Able to integrate with care staff’s real world</td>
<td>Leaves door open for different solutions</td>
</tr>
</tbody>
</table>

Opinions as to how to conduct ethics discussions in the future

In the light of their experience of ethics rounds, the interviewees were asked how ethics discussions should be performed in the future. No differences of opinion between the nurses and the doctors emerged. The majority were of the opinion that interdisciplinary team conferences were bound to be continued in some way. Some wished for team conferences without a leader but the predominant view was that a leader is necessary. Whether a leader was needed could depend upon the severity of the problem. It was preferred that the leader should be a person from outside, in a position to see a problem in a new light. There was no clear opinion as to which profession a leader should be drawn from, it could depend on the type of problem. Philosopher, chaplain and social worker were mentioned but the competence of the person seemed more important (box 1).

Groups with six to 10 participants from different professions were preferred, so that no one would be afraid to speak out. Rounds on a regular basis two to four times a year were desired but also emergency meetings in the case of urgent problems. There was a difference of opinion as to whether the aim should be simply to reflect on problems or also to solve them. The predominant view was that the rounds should lead to some kind of action or decision-making.

DISCUSSION

The ethics rounds in this study seemed to provide training in moral reasoning but, above all, the rounds seemed to meet the needs of a forum for crossing over professional boundaries. Conspicuous was the nurses’ expectation that solutions to the ethical problems would be sought despite explicit instructions to the contrary.
found that nursing’s ethical problems are systematic, whereby the “same problems recur time and again in various settings”. Other, more powerful actors determine nurses’ work. The doctors make the decisions and the nurses have to carry them out. It is the nurse who has to deal hour after hour with the severely ill patient who is not progressing, feeling frustration at the futility of the treatment.

In the rounds experienced as being positive, however, the nurses perceived themselves as being on equal ground with the doctors. The rounds may have brought a sense of having increased influence in accordance with the “degree of influence” scale presented by Granberg. The nurses’ sense of having an influence seemed to advance on the scale from just being informed of a decision to being involved in the deliberation. Melia advocated teamwork when dealing with ethical problems. Doctors are now under pressure to relinquish their dominant professional position and develop a more team-oriented approach. In this study, the doctors acquired an “insight into moral responsibility” to continue the dialogue with the nurses, which suggests a team-oriented approach.

This study offers knowledge of how to learn a way through ethical problems and what ethics rounds may contain regarding cognitive, social and emotional experiences. The positive and negative experiences can provide knowledge about which approaches to the teaching of ethics are desirable in the clinical context. Regarding the cognitive experiences, the philosophers seemed to play an important role in structuring and stimulating reasoned arguments, which seems similar to the approach of the “critical thinking school”. It implies a concern with rational aspects and counteracts an oversubjective approach. Regarding both the cognitive and social experiences, the approach seems to resemble that of the “situation ethics school”. The latter school is distinguished by the attention to the demands of the specific situation and the object with a view to broadening the capacity to empathise with other people and to develop personal insights. This is illustrated in the present study by “sense of connecting” and “seeing from different perspectives”, as well as “understanding of moral responsibility”. Present but not predominant was the emotional experience, “emotional relief”, which resembles the approach of the “ventilatory school”. This school focuses on how people feel about ethical problems and not just on rational considerations. One possible reason why the emotional experiences seemed to be only a minor part is that the male philosophers belonged to the “critical thinking school”, representing a typically male perspective involving a striving for objectivity. Maybe the experiences would have been different with feminist moral philosophers. They are critical of reason being regarded as the supreme principle of morality. They argue that reason is not value neutral and that sound moral deliberation requires an appeal to emotion and intuition as well as reason.

When the rounds in the present study seemed to be of value to the interviewees, they can be conceptualised as a combination chiefly of the approach of the “situation ethics school” and the goal of the American Task Force on Standards for Bioethics Consultation to assist in problem solving. Interviewees’ own suggested means of addressing ethical issues, however, indicating in the first place the establishment of team conferences for the purpose of achieving a common goal in care, seemed to have priority over ethics rounds with an outside leader.

Methodological considerations

The findings may be transferable to other groups of nurses and doctors caring for severely ill patients in Scandinavia and some of the other European countries. In this study only four ethics rounds at each hospital were evaluated, which may be considered more as a systematic evaluation of an application of ethics rounds than as an evaluation of an implemented model. It may generate knowledge about how to conduct future rounds.

The interviewers used somewhat different interview techniques: a probing technique (MS) as compared with a conversational style (RL). In the case of the first technique there may have been too much focus on the research questions whereby the nurses may have been hindered from offering new ideas. When it came to the doctors, some interesting reasoning was not followed up but the relaxed interview atmosphere may have stimulated them to be more open. This was taken into consideration because both manifest and latent analysis was performed, depending on the nature of the statements. We do not consider that it affected credibility. Nor do we consider that the male philosophers belonging to the “critical thinking school” affected credibility or that the first author’s pre-understanding and commitment regarding the idea of ethics rounds steered the analysis towards themes that showed fulfilment of the goal set for the ethics rounds. The open nature of the questions asked, the systematic analysis and the dialogue between all the co-
authors, who come from a diversity of disciplines (nursing, medicine, philosophy and theology), should have prevented this and increased the reliability. The findings revealed mixed descriptions with both positive and negative experiences, which may be a sign of a high level of reliability.

A shortcoming in this study was that two of the philosophers lacked experience of ethics discussions in connection with clinical practice. It is not possible to assess on the basis of our study whether philosophy is a suitable discipline in ethics rounds. A planning limitation may have affected the experience that the patient cases were unmovning. The decision to have regularly scheduled rounds and that staff members from both the dialysis unit and the ward should be familiar with the patient was reported as the reason that the more moving cases were missed.

Implications

The findings suggest that the most important need is the opportunity for interprofessional team dialogue to discuss a common goal for the care of severely ill patients on a regular basis. We have summarised the overall results in a model of how ethical problems may be dealt with through interprofessional team dialogue in fig 1. The basis is team conferences and the readiness to involve an ethicist if participants find the situation ethically complicated. If ethics rounds are to be implemented, it is advisable to find a balance between ethical analysis, conflict resolution and problem-solving. Either one or two rounds may be needed, depending on the severity of the problem. The ethicist leading the discussion may only facilitate problem-solving—the decision as to what course of action to take is to be made without the ethicist, preferably with patient/family involvement. This process may appear time-consuming but can lead not only to an ethical decision but also to improved relations between professionals, as well as serving as a learning experience that may prevent future ethical problems. The model (fig 1) constitutes a tentative, practical suggestion regarding how to arrange interprofessional team dialogue. It needs to be tested in future research before it can be applied to clinical practice for the elucidation and resolution of ethical issues.

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Interprofessional ethics rounds concerning dialysis patients: staff’s ethical reflections before and after rounds

M Svantesson,1,2 A Anderzén-Carlsson,1 H Thorsén,1 K Kallenberg,1,3 G Ahlström4

ABSTRACT

Objective: To evaluate whether ethics rounds stimulated ethical reflection.

Methods: Philosopher-ethicist-led interprofessional team ethics rounds concerning dialysis patient care problems were applied at three Swedish hospitals. The philosophers were instructed to stimulate ethical reflection and promote mutual understanding between professions but not to offer solutions. Questionnaires directly before and after rounds were answered by 194 respondents. The analyses were primarily content analysis with Boyd’s framework but were also statistical in nature.

Findings: Seventy-six per cent of the respondents reported a moderate to high rating regarding new insights on ethical problem identification, but the ethics rounds did not seem to stimulate the ethical reflection that the respondents had expected (p<0.001). Dominant new insights did not seem to fit into traditional normative ethics but were instead interpreted as hermeneutic ethics. This was illustrated in the extended perspective on the patient and increased awareness of relations to other professions. Regarding insights into how to solve ethical problems, the request for further interprofessional dialogue dominated both before and after rounds.

Conclusion: The findings show the need for interprofessional reflective ethical practice but a balance between ethical reflection and problem solving is suggested if known patients are discussed. Further research is needed to explore the most effective leadership for reflective ethical practice.

There are different ways to facilitate ethical decision-making in patient care in Europe and North America. In North America, ethics consultations are offered in most hospitals mainly to help protect patient rights and improve care as well as resolve conflicts. The ethicists are primarily clinicians without formal ethics education. The majority of consultations are one-to-one discussions with healthcare staff or the patient/family, resulting in recommended courses of action. Subjective evaluations of ethics consultation have shown high staff satisfaction.

Although ethics consultations similar to those in the American model have been reported from Europe,1–3 it seems that supporting healthcare teams in dealing with ethical problems through reflective practice4 are more commonly advocated5–7 and practised.8–11 In Europe there is a lack of studies evaluating reflective ethical practice. Two Swedish studies have evaluated long-term effects but neither detected any impact on job satisfaction, burnout or moral stress.12–14 In a Dutch study evaluating “moral case deliberation”, the learning was valued highly and the respondents felt more ethically competent.11

In the present study philosopher-ethicists led interprofessional ethics rounds regarding dialysis patients. Known patients were discussed with real social context,1 which provides for more effective learning through the use of an actual critical situation. The goals were to promote mutual understanding and stimulate ethical reflection by helping to identify and analyse ethical problems,15 but the philosophers were instructed not to offer solutions. The solutions were to be dealt with after the rounds. In a previous study, both goals have been evaluated through interviews with a sample of the ethics rounds participants, which revealed that the goals were partly fulfilled. Positive experiences included stimulation to broadened thinking and a sense of connecting between professional categories; negative experiences were associated with frustration with the lack of solutions.16

In summary, there seems to be a further need of European studies to illuminate reflective ethical practices. The aim of the present study was to evaluate whether the ethics rounds stimulated ethical reflection.

METHODS

This study had a descriptive and comparative design based primarily on qualitative and secondarily on quantitative data.

Model for ethics rounds

Philosopher-ethicist-led interprofessional rounds concerning patient care ethical problems were applied in nephrology departments at three Swedish hospitals. Dialysis patient cases were selected on the basis of their existing life-sustaining treatment and their expected capacity to make decisions. Four philosophers from a national network that assists professionals with clinical ethical problems were recruited. The rounds were held regularly in each department every other month for 8 months and each session lasted 90 minutes. A further description of the model is presented elsewhere.14

Questionnaire

Evaluation of the stimulation of ethical reflection was operationalised in terms of comparing the
The content of the two questionnaires

Table 1

<table>
<thead>
<tr>
<th>Questionnaire 1, before the ethics rounds number answered = 186</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you believe that an ethicist can help give you insights into the ethical problems in the care of the patient in question?</td>
</tr>
<tr>
<td>2. Describe the ethical problems that you perceive in the care of the patient in question.</td>
</tr>
<tr>
<td>3. Describe how you think the team should try to solve the ethical problems.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Questionnaire 2, after the ethics rounds number answered = 189</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Have you gained any insights during the ethics rounds regarding what the ethical problems are in the care of the patient in question?</td>
</tr>
<tr>
<td>5. Have you gained any insights into how the team should try to solve the ethical problems?</td>
</tr>
<tr>
<td>6. Follow-up question from 4 and 5: If you experienced gaining new insights regarding the care of the patient in question, please describe these insights.</td>
</tr>
<tr>
<td>7. If you answered “None” or “Low level” to question 4 or 5, please describe what the reasons might be.</td>
</tr>
<tr>
<td>8. Indicate to what level the ethicist facilitated your insights.</td>
</tr>
<tr>
<td>9. Indicate to what level the participating staff facilitated your insights.</td>
</tr>
</tbody>
</table>

Analysis

Qualitative analysis

First, the open-ended answers in the questionnaires were analyzed through inductive content analysis with co-assessment. The text was divided into meaning-units and preliminary subcategories were generated by constant comparison using the software NVivo. Those subcategories that shared similar meaning were collapsed, sorted and abstracted into main categories. Second, the analysis was then transformed into a deductive “directed content analysis”, because of the discovery of a pattern in the answers. This pattern seemed to be in line with the theoretical framework of the principles approach, persons approach and perspectives approach presented in a guide for practical ethical analysis by Boyd (see below). The third and fifth author examined these approaches to use in coding categories. Then the subcategories were categorised into new main categories and sorted into the three approaches, which involved a comprehensive process of moving between the empirical data and the framework in a continuous process of refining categories and sorting data. All co-authors scrutinised and discussed each step in the analysis process. Finally, the number of meaning-units for each subcategory were counted.

A principles approach is a theory-driven approach that focuses on whether a particular act is morally right and might resolve the ethical problem. What makes an act right depends on the moral principle being relied on, such as deontological and teleological theories. A person’s approach focuses on the moral agent, the person who performs the act. It is referred to as virtue ethics, which is concerned with the best kind of person to be and desired virtues, such as justice, kindness or bravery. A perspectives approach focuses on the case, which implies understanding of not just one person but, rather, a problematic situation. Boyd referred this last approach to hermeneutic ethics, which considers multiple contexts such as the psychological and social and acknowledges that multiple interpretive perspectives exist. This approach seeks to highlight complexities and implies interpretation through openness to different perspectives, which may lead to awareness of one’s prejudices and a new shared perspective among individuals.

Quantitative analysis

The closed-ended answers (table 1) were analysed by descriptive and comparative non-parametric statistics. For the comparison between the expectation of gaining insights (question 1) and reported new insights (questions 4, 8 and 9), the sign test was calculated. To detect any effect of respondents attending more than one ethics round, a subgroup analysis was made with...
Table 3 Descriptions of the ethics rounds

<table>
<thead>
<tr>
<th>No/hospital/ethicist/participants (n)</th>
<th>Patient and the primary issue</th>
<th>Representative quotation of insights gained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Round 1 Hospital 1/Ethicist 1/(27)</td>
<td>ð, age 67 years, several diseases and complications affecting quality of life, suffering connected with continued dialysis</td>
<td>“An already complicated question was proved to be even more difficult. What I reflect mainly over is the lack of discussions between professional groups.”</td>
</tr>
<tr>
<td>Round 2 Hospital 1/Ethicist 2/(15)</td>
<td>ð, age 41 years, dialysis since age 16 years, late complications, psychosocial problems; non-compliance with medical regimen</td>
<td>“We must dare to confront the patient. Ask: What do you want out of life? Stand up for your professional integrity and responsibility, and be clear with the patient about what my professional ethics are.”</td>
</tr>
<tr>
<td>Round 3 Hospital 1/Ethicist 3/(14)</td>
<td>ð, age 55 years, non-Swedish-speaking, suicidal, confused, has deportation order; suffering connected with medical care</td>
<td>“It makes a difference who owns the problem, where I should put the focus, what I can do myself and what my own ethical problem is. Don’t expend energy on what is beyond your own problem.”</td>
</tr>
<tr>
<td>Round 4 Hospital 1/Ethicist 1/(11)</td>
<td>ð, age 63 years, non-Swedish-speaking, investigated for kidney transplant, cooperation difficult; non-compliance with medical regimen</td>
<td>“How important communication is and that we must try to find out what the patient actually understands. To get to know the patient better. The philosopher dared to formulate words we had thought but not said.”</td>
</tr>
<tr>
<td>Round 5 Hospital 2/Ethicist 2/(19)</td>
<td>ð, age 61 years, deceased, ratted away; gangrene in extremities and genitals; suffering connected with continued dialysis</td>
<td>“The importance of sitting down all of us together to discuss treatment and get answers from the physicians about their view on the care of the patient.”</td>
</tr>
<tr>
<td>Round 6 Hospital 2/Ethicist 1/(11)</td>
<td>ð, age 89 years, deceased, pain, anxiety, confusion; suffering connected with continued dialysis</td>
<td>“Neither we nor anyone else could do anything. Moral stress is a good explanation for how we all feel. It is difficult to prevent it from happening again.”</td>
</tr>
<tr>
<td>Round 7 Hospital 2/Ethicist 2/(7)</td>
<td>ð, age 71 years, feebleness; distress over patient’s decision to discontinue dialysis</td>
<td>“The thoughts I get are that the patient’s points of view on what is right or wrong are the ones that must be followed. The only way I can find to ask. Then I always need to ask myself how my own part influences the decision.”</td>
</tr>
<tr>
<td>Round 8 Hospital 2/Ethicist 4/(14)</td>
<td>ð, age 61 years, deceased, not informed about malignant disease; truth-telling about bad news</td>
<td>“That everybody is responsible. It is too easy to blame and put the responsibility on somebody else. Information is incredibly important but sometimes difficult to give.”</td>
</tr>
<tr>
<td>Round 9 Hospital 3/Ethicist 4/(26)</td>
<td>ð, age 62 years, expresses a desire to die, aggressive, cooperation difficult; non-compliance with dialysis regimen</td>
<td>“We analysed several ethical dilemmas. I experience even more strongly what an enormous human tragedy it is. I understand the importance of close collaboration regarding this patient. We must go to the bottom of his wish to die.”</td>
</tr>
<tr>
<td>Round 10 Hospital 3/Ethicist 1/(14)</td>
<td>ð, age 61 years, skips dialysis, sometimes wants to discontinue it, does not appreciate information; non-compliance with dialysis regimen</td>
<td>“In some way this person must be helped to gain awareness of his illness. The staff as a whole must also set joint boundaries.”</td>
</tr>
<tr>
<td>Round 11 Hospital 3/Ethicist 4/(18)</td>
<td>ð, age 88 years, deceased, feebleness; family wanted dialysis to be continued, suffering connected with continuous dialysis</td>
<td>“Important to be involved in the decision-making process. To dare stand up for your convictions and listen to others. If you understand why, it is easier to comply and reach a decision. The information to family and patients is super-important.”</td>
</tr>
<tr>
<td>Round 12 Hospital 3/Ethicist 2/(20)</td>
<td>ð, age 62 years, skips dialysis, refuses admission to hospital, cooperation difficult; non-compliance with medical regimen</td>
<td>“I see why care planning is necessary. I see that it is incredibly difficult with this patient, thought that the problem could be solved, but realise that it is extremely difficult.”</td>
</tr>
</tbody>
</table>

random selection of all participants from a collective list of all ethics rounds (n = 103). Factors from the interview study were suspected to affect perceived insights were profession, department and philosopher. These were tested using Kruskal–Wallis and then Mann–Whitney tests calculated on the subgroup of 103. For the open-ended answers subcategories derived from the qualitative analysis were computed according to frequency of meaning-units.

Ethical considerations

Ethical considerations regarding the ethics rounds are published elsewhere. Ethical approval was obtained from the Regional Ethical Review Board in Uppsala, Sweden. The informed consent was based on written information regarding the study and voluntary participation. The questionnaires were returned to a box after the rounds, and confidentiality was guaranteed.

FINDINGS

To illustrate the ethics rounds, descriptions of the patient cases and a representative example of perceived insights are presented in table 3.

The median rating of expectation before the ethics rounds of gaining insight was rather high (4). Forty-one per cent of the respondents reported after the rounds a high to rather high rating (4–5) of new insights and 55% a moderate rating (3). A moderate rating was the median result found for all insights perceived (question 4), insights gained specifically from the ethicists or from other staff members (questions 8, 9). The ratings of reported insights calculated for all insights (question 4) as well as those gained specifically from the ethicist (question 8) were both statistically significantly lower than the expectations of gaining insights (p<0.001) (table 4). After random selection of all participants from a collective list of all ethics rounds (n = 103), there was a higher percentage of dissatisfied respondents (59%, p<0.001). The 45% (24%) that reported a low rating of or no new insights gave the following reasons: they had already heard it all before from other staff members (21%); had expected solutions to the ethical problems (13); the philosopher was too passive (13); they felt they already knew the answers (10) or were not familiar with the patient (7).

Regarding factors hypothesised to affect reported new insights, the median rating (rather high) of reported insights was significantly higher in rounds led by one of the philosophers (p = 0.02). The doctors had significantly lower expectations (moderate) of gaining insights compared with the other professions (p = 0.001). No significant differences were detected between departments.

Perceived ethical problems before and new insights after the rounds

The main findings are presented in tables 5 and 6. Complementary descriptions and comparisons before and after rounds are given below. Each subcategory had representation from an average of six rounds (range 3–11) and from all professions and at least two departments.
Two major problems were experienced with regard to the 12 patients: non-compliance and end-of-life issues (table 3). The respondents described the origin of the problems as similar but with different approaches, which could be sorted into principles, persons and perspectives approaches.

Principles approach
This approach focusing on the act and moral principles dominated before the rounds (74% of the meaning-units) compared with after (10%) (tables 5 and 6). The majority of the ethical problems before rounds related to the principle of respect for autonomy, non-maleficence and justice. Non-maleficence concerned suffering, such as pain, anguish or confusion. It was difficult to know when to withdraw dialysis, considering prolonged suffering and improved health. Respect for autonomy concerned patients whose participation was considered to be problematical because the patient was either too ill to have the capacity or lacked awareness of his/her illness and thus acted in a self-destructive way. There was ambiguity about who had the responsibility to decide about treatment—the doctor, the family or the patient—and in whose interest it was to continue treatment. Lack of adequate information, such as withholding the truth about a poor prognosis or giving false hope, was perceived before rounds as hindering patients’ making important decisions. After the rounds the importance of adequate information was the only principle insight mentioned.

Persons approach
Respondents who reflected on their role as moral agents considered their personal responsibility both before and after rounds (tables 5 and 6). Beforehand they could experience difficulties in helping suffering or aggressive patients, which could arouse feelings of powerlessness, frustration and of tormenting the patients. Nurses wondered about which mental posture to have with non-compliant or suicidal patients, should they be persuasive or forceful. After the rounds the respondents perceived insights of their reactions and how they affected their actions. They also perceived insights about boundaries for responsibility, which could imply either widening or limiting. Limiting could imply insight into the association between what one ought to do and can do. Widening could mean acknowledgement that ethical problems are everyone’s responsibility instead of blaming others. Doctors perceived insights about not being responsible enough.

Perspectives approach
This approach, focusing on the case and the understanding of the situation, dominated after the rounds (72% of the meaning-units) (table 6) in contrast to before (14%) (table 5). Before the rounds there were descriptions of difficulties in understanding the patient, such as why they were being aggressive or expressing a desire to die but still showing up for dialysis. After the rounds respondents extended their perspective on the patient, such as stating they could see aggression as a possible sign of crisis. When the patient conveys death wishes to the nurse but not to the doctor, this might mean a feeling of hopelessness but not wanting to die. The rounds were perceived to produce more questions than answers, giving the insight of more dilemmas and that the right answer was impossible to reach. Respondents realised how little they had understood and questioned their pre-understanding of the situation.

Besides new insights directly connected to patients’ situations, there was an increased awareness of relations to other professions. This implied understanding how other professionals think, especially nurses gaining an increased understanding of doctors. They understood the doctors’ loneliness in trying to make the right decisions. The doctors, on the other hand, learned to understand other staff members’ feelings of powerlessness and emotional connection to long-term patients. There was also an insight that the professionals shared the view of the situation as being difficult, hearing that others have the same thoughts. Others had their pre-understanding confirmed, reinforcing how far doctors and nurses stand from each other.

Perceptions before rounds of how the ethical problems should be solved and new insights afterwards

Principles approach
The principles approach was used about twice as often before rounds as after (tables 5 and 6). At both times, suggestions for problem solving centred primarily on promoting patient participation. Compared with before rounds, the new insights were more specific, such as improving routines for information and documentation and assessing the patient’s decision-making capacity when helping him or her with decisions.

Persons approach
To be brave seemed to be a desired virtue before the rounds. The focus was to become more assertive in relation to the doctors, such as questioning why dialysis treatment continues, but also daring to discuss sensitive issues with staff members. Although some respondents described questioning the doctors after the rounds, the new insights were usually focused on being assertive in relation to the patients. This may be interpreted as being firm rather than brave, as patients are in an inferior position. Respondents received strength from the rounds to confront non-compliant patients about making contracts and drawing clear limits on what is allowed medically.

Perspectives approach
The perspectives approach regarding how to solve ethical problems dominated the other approaches both before and after rounds. The same solutions were described after rounds as before but most came from different respondents. They were either focused on enhancing patient/family contact or staff collaboration (tables 5 and 6).

Enhancing patient/family contact implied giving psychological support, accomplished through close and honest contact. After rounds the additional insights involved helping patients

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Table 4  Reported new insights compared with expectation of gaining insights

<table>
<thead>
<tr>
<th></th>
<th>Higher than expected</th>
<th>As high as expected*</th>
<th>As low as expected†</th>
<th>Lower than expected</th>
<th>Total respondents (n)</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>All reported insights gained (question 4) compared with expectations of gaining insights (question 1)</td>
<td>36 (22%)</td>
<td>22 (14%)</td>
<td>19 (12%)</td>
<td>83 (52%)</td>
<td>160†</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Reported insights gained specifically from ethicist (question 8) compared with expectations of gaining insights (question 1)</td>
<td>34 (22%)</td>
<td>30 (19%)</td>
<td>21 (13%)</td>
<td>71 (45%)</td>
<td>156†</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

*From high or rather high expectations; †from moderate or low; ‡22 could not decide about expectations.
It might be beneficial to speculate about ethical problems and solutions perceived before rounds et al. This may be a sign of n = 209 Schneiderman 2008; J Med Ethics 2008;34:407-413. Reflection that the respondents had expected. Dominating.

**DISCUSSION**

Ethical problems yielded high staff satisfaction. This may be due to the simultaneous help with identify and analyse ethical problems yielded high staff satisfaction. The findings in the present study may, however, not be interpreted as an overall negative result; they might show how ethics works in clinical practice, as new insights did not seem to fit into traditional normative ethics, but was instead interpreted as hermeneutic ethics, such as extended perspectives on the patient and increased awareness of relations to other professions. The request for further interprofessional dialogue to solve ethical problems dominated and this correlates with findings from the ethics rounds interview study. It might be beneficial to speculate about reasons for unmet expectations, as the reasons given were not exhaustive and this may add to suggestions of how to make reflective ethical practice successful.

First, the respondents might have expected to gain principle-based insights about patient participation and suffering. The perspectives approach (hermeneutic ethics), involving gaining new perspectives, does not provide quick solutions or resolutions to problems, which clinical practice seems to request. One of the reported reasons for not perceiving insights was being non-compliant. What resources are reasonable to expend, which are then taken away from other patients? Problems with long-term pain and a lot of problems with daily vomiting, he wants to eat food but it just doesn’t work out. I think they have dragged out the whole thing too long.

**Evaluation of the goal to stimulate ethical reflection**

The goal, operationalised as new insights, was not completely reached. Although 76% of respondents reported a moderate to high rating of new insights, 64% reported insights as low or lower than expected (table 4). Furthermore, reasoning about the ethical problems produced more meaning-units before the rounds than after.

**Table 5 Ethical problems and solutions perceived before rounds**

<table>
<thead>
<tr>
<th>Boyd's approaches (%*)</th>
<th>Main categories</th>
<th>Subcategories</th>
<th>Meaning-units (n) Representative meaning-units from the most frequent subcategory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethical problems</td>
<td>Player participation problematical</td>
<td>Doubt about decision-making capacity</td>
<td>n = 208 The patient is not aware of his illness. He fails to see why he needs dialysis. He often stays away from the dialysis as he feels he doesn’t need it.</td>
</tr>
<tr>
<td></td>
<td>Ambiguous responsibility for decision</td>
<td>Lack of adequate information</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>Doubt about in whose interest to continue treatment</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Exposure to suffering</td>
<td>Burdensome situation</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Debasing treatment</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Doubt whether it is right to continue treatment</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Allocation of resources</td>
<td>Consideration of other patients</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Persons (12%)</td>
<td>Personal responsibility</td>
<td>Insufficiency as carer</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Uncertainty about mental posture towards the patient</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Perspectives (14%)</td>
<td>Difficult to understand the patient</td>
<td>Difficult to know patient’s thoughts</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Double messages from patient regarding death</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>How to solve</td>
<td>Principles (30%)</td>
<td>Promote patient participation</td>
<td>n = 209 Explain to the family more exactly what dialysis involves and how difficult it is for the patient.</td>
</tr>
<tr>
<td></td>
<td>Alleviate suffering</td>
<td>Inform patient/family about treatment</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>Help the patient decide</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Decide to withdraw treatment</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Persons (14%)</td>
<td>Be brave</td>
<td>Question the doctors</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Dare to speak out</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Perspectives (56%)</td>
<td>Enhance team collaboration</td>
<td>Request for interprofessional dialogue</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>Reach a consensus for care</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Enhance patient/familycontact</td>
<td>Give psychological support</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>Try to understand the patient</td>
<td>9</td>
<td></td>
</tr>
</tbody>
</table>

mourn being severely ill or encouraging the healthy person. This also implied trying to understand the patient as a whole human being and understand the non-compliant behaviour.

Regarding staff focus, there were frequent requests for interprofessional dialogue to understand doctors’ reasoning but also to obtain a whole picture of the patient with input from different professions and an opportunity to share different perspectives. After the rounds there was increased insight about the need to enhance the dialogue between doctors and nurses. This was suggested by half of the doctors responding. There were also insights about the need to implement regular team conferences, described similarly before and after rounds. Respondents wished to reach a consensus for care in order to achieve a common attitude towards non-compliant patients and avoid burdensome treatment for the severely ill.
enhanced ethical competence, which might help in solving ethical problems for future patients.

Second, the type of leadership in the ethics rounds seemed to affect reported insights. It might seem controversial to use philosophers as clinical ethicists. It can be defended because of philosophers’ methodological ability to build careful reasoned analysis and because an outsider may bring new perspectives to healthcare professionals, who may be blind to their own prejudices. Comments in this study and experiences from the previous interview study revealed both positive and negative attitudes. Positive experiences in the interview study were associated with the philosopher provoking participants to break from habitual ways of thinking, whereas negative experiences were associated with failure to make the knowledge applicable to the real world.

Positive comments as secondary findings in the present study were associated with the philosophers stimulating critical reflection and clarifying ethical problems; the negative comments concerned passivity. According to Fox et al., fewer than 5% of the ethics consultants in North America are philosophers and they saw the lack of ethics education as a cause of concern. The style of leadership, however, seemed to be more crucial than the type of profession. There was a significantly higher rating of insights from one of the philosophers in this study. This philosopher was admired in the previous interview study and received insights from each other. It could be argued that instead of answering about new insights into ethical problems, many respondents seemed to describe how the dialogue of the ethics rounds worked, a prerequisite for the ethical process. This seems to be in line with the hermeneutic and dialogical ethics method used by Molewijk et al., which involves seeing another persons’ point of view and learning is the result of one’s extended perspective. This was illustrated in the categories “Extended perspective on the patient” and “Increased awareness of relations to other professions”. These reflections could be interpreted as not ethical reflections. We decided not to judge, however, but instead to investigate what the respondents perceived as ethical insights. This led to Boyd’s approach involving adding hermeneutic ethics to the traditional normative approaches of principle and virtue ethics. Hermeneutic ethics is, according to Leder, distinct from other theories such as sociological theories as it sheds light on what should be. As Leder has pointed out, hermeneutic ethics is not in opposition to other ethical discourses but is the very space of dialogue wherein they may be articulated.

This is confirmed by studies showing low patient participation in end-of-life decisions. Reflections about how to make patients comply with treatment occurred frequently in the answers. A new insight was to give psychological support to patients and another, which is not recommended in previous studies, was to make demands on them. Instead, empowering and providing a reward system is recommended. It seems reasonable to assume then that not all insights from the ethics rounds are morally acceptable. There were similar categories before and after rounds, especially on how to solve problems, which would confirm the perceptions of not gaining new insights. The categories were derived mainly from different individuals, however, which might imply that the respondents received insights from each other.

It could be argued that instead of answering about new insights into ethical problems, many respondents seemed to describe how the dialogue of the ethics rounds worked, a prerequisite for the ethical process. This seems to be in line with the hermeneutic and dialogical ethics method used by Molewijk et al., which involves seeing another persons’ point of view and learning is the result of one’s extended perspective. This was illustrated in the categories “Extended perspective on the patient” and “Increased awareness of relations to other professions”. These reflections could be interpreted as not ethical reflections. We decided not to judge, however, but instead to investigate what the respondents perceived as ethical insights. This led to Boyd’s approach involving adding hermeneutic ethics to the traditional normative approaches of principle and virtue ethics. Hermeneutic ethics is, according to Leder, distinct from other theories such as sociological theories as it sheds light on what should be. As Leder has pointed out, hermeneutic ethics is not in opposition to other ethical discourses but is the very space of dialogue wherein they may be articulated.

Methodological considerations

Many of the findings from this study confirm the findings from the previous ethics rounds interview study. The combination

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Table 6 Insights into the ethical problems and solutions perceived following the ethics rounds

<table>
<thead>
<tr>
<th>Boyd’s approaches (%*)</th>
<th>Main categories</th>
<th>Subcategories</th>
<th>Meaning-units (n)</th>
<th>Representative meaning-units from the most frequent subcategory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insights into the ethical problems</td>
<td>Patient participation</td>
<td>Importance of adequate information</td>
<td>n = 130</td>
<td>It is important to give the patient good information that it is possible to withhold treatment and still get good care.</td>
</tr>
<tr>
<td>Principles (10%)</td>
<td>Personal responsibility</td>
<td>Awareness of one’s feelings</td>
<td>12</td>
<td>I realise that I could react from my heart and shout it out to the media.</td>
</tr>
<tr>
<td>Persons (18%)</td>
<td>Extended perspective on the patient</td>
<td>Others perspectives and knowledge</td>
<td>30</td>
<td>I’ve got more facts about the particular situation. That it was not only about the patient having dialysis or not.</td>
</tr>
<tr>
<td>Perspectives (72%)</td>
<td>Increased awareness of relations to other professions</td>
<td>More complex</td>
<td>19</td>
<td>Interesting to learn how those with power (the doctors) also feel vulnerable and find it difficult to reach the patient.</td>
</tr>
<tr>
<td>Increased awareness of</td>
<td>Mutual understanding</td>
<td>14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>perspectives (64%)</td>
<td>Gap between the professionals</td>
<td>13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enhance patient/family</td>
<td>Shared view about the problem</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>contact</td>
<td>Insights into how to solve problems</td>
<td>n = 125</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principles (18%)</td>
<td>Promote patient participation</td>
<td>Improve routines for information and documentation</td>
<td>12</td>
<td>To document the patient’s wishes about the future regarding life-sustaining treatment and if the patient has a different opinion from the doctor.</td>
</tr>
<tr>
<td>Persons (18%)</td>
<td>Be firm</td>
<td>Help the patient to decide</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Perspectives (64%)</td>
<td>Enhance team collaboration</td>
<td>Make demands on the patient</td>
<td>17</td>
<td>From this, I realise a person has the right to make demands on somebody who places demands on you.</td>
</tr>
<tr>
<td></td>
<td>Request for interprofessional dialogue</td>
<td>Question the doctors</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reach a consensus for care</td>
<td>Everyone helps to put the pieces of the puzzle together. You don’t have to be alone with difficult decisions. Find time for dialogue.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Give psychological support</td>
<td>To combine the patient’s concern for his children with the importance of the dialysis regimen.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Try to understand the patient better</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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J Med Ethics 2008;34:407-413
of different data collection modes may be seen as a triangulation approach, which strengthens the trustworthiness.

Even though the ethics rounds were based on only 12 patient cases, the perceived ethical problems involved seem to be in accordance with the dominating problems experienced by nurses in industrial countries. They did not seem to be specific for each patient case, as all subcategories were identified in several rounds. All rounds except one (round 4) seemed to concern life-sustaining treatment, as non-compliance to dialysis treatment is associated with high mortality. The reasoning may therefore be transferable to reflective ethical practice in wards caring for patients with life-sustaining treatment.

The reasoning about the ethical problems produced a smaller number of meaning-units after the rounds than before. This could signal either a lack of insight or difficulties in reflecting immediately after the rounds (which some respondents mentioned). Letting the respondents answer later was considered but was rejected because of the risk of a high dropout rate. The participants were informed that ethical problems would not be solved during the rounds; instead they were to deal with them afterwards. There was, however, a question posed before the rounds enquiring into how ethical problems might be solved, which may have raised the expectation that solutions to problems would be forthcoming.

Neither previous Swedish studies using instruments for evaluating reflective ethical practice showed positive results. There were methodological reflections over the shortcomings of the conduct of the research, applying ethics rounds over too short a time and the chosen scales’ inability to measure complex social processes. These reflections also seem to be of concern in the present study. When ethical reflection is not aimed at solving problems, contrary to American ethics consultations, evaluation measures seem difficult to find.

Despite the strength of the rigorous co-assessment from the co-authors, there were some problems associated with the sorting of Boyd’s approaches. One was distinguishing the principles approach from the perspectives approach, such as in the category “Reach a consensus for care”. With this kind of data it seems impossible to find distinct categories and implies that the frequencies of subcategories cannot be exact. Boyd’s approaches are not really a theory, rather a guide for teaching purposes and in practice not mutually exclusive. Each approach may be useful at different times and in combination.

CONCLUSION AND IMPLICATIONS

Even though the expected ethical reflection was not realised, this study shows the need for interprofessional reflective ethical practice. It may offer an understanding of how ethics might work in clinical reality with known patients that is context sensitive. To make reflective ethical practice successful, we suggest, as in the previous interview study (see model), a balance between ethical reflection and problem solving.

Participants’ expectations of outcomes of ethics rounds might be explored before initiating any further studies. Because both the present and the previous findings suggest that process skills are important, further studies are needed to explore how kind of ethicist leadership is most beneficial for the outcomes. The responsibility for clinical leadership to arrange and motivate ethical reflection is also of interest.

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Ethics approval: Ethical approval was obtained from the Regional Ethical Review Board in Uppsala, Sweden. The informed consent was based on written information regarding the study and voluntary participation.

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