The Nature of Ethical Conflicts and the Meaning of Moral Community in Oncology Practice

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Oncology nurses encounter ethical questions in their daily clinical practice and often experience the moral uncertainty and dilemmas that accompany critical ethical concerns, such as informed consent, quality-of-life considerations, and disagreements at the end of life. These dilemmas can ripen into ethical conflicts with potentially harmful and far-reaching consequences. Much has been written about ethical conflicts that critical care nurses experience (Azoulay et al., 2009; Danjoux Meth, Lawless, & Hawryluck, 2009). However, fewer studies on oncology nurses' experiences of ethical conflicts have been published. This gap seems particularly important given the research that indicates oncology nurses experience ethical dilemmas and moral distress more often than nurses in other specialty areas (Ferrell, 2006; Rice, Rady, Hamrick, Verheijde, & Pendergast, 2008; Shepard, 2010). Medland, Howard-Ruben, and Whitaker (2004) identified the potential for burnout that often accompanies the emotional and task-intensive work of oncology nurses.

This article focuses on the types of ethical conflicts that oncology nurses experience as they care for patients with life-threatening conditions and their families. These data are part of an ethnographic study that explored the context in which ethically difficult situations arise. In the study, the authors learned that oncology nurses work toward three goals: relieving patient suffering, being honest with patients, and contributing meaningfully to patient improvement and stated goals (Pavlish, Brown-Saltzman, Jakel, & Rounkle, 2012). However, nurses also reported challenges, such as administering treatments that cause suffering, being honest without removing hope, and considering the risks of speaking up, that often thwarted the goals of care. Within those challenges, nurses described specific situations that illustrated ethical conflicts with other healthcare providers and families. In the current article, the authors detail the nature of those ethical conflicts and describe the type of environment that may prevent those conflicts from occurring.

Purpose/Objectives: To explore ethical conflicts in oncology practice and the nature of healthcare contexts in which ethical conflicts can be averted or mitigated.

Research Approach: Ethnography.

Setting: Medical centers and community hospitals with inpatient and outpatient oncology units in southern California and Minnesota.

Participants: 30 oncology nurses, 6 ethicists, 4 nurse administrators, and 2 oncologists.

Methodologic Approach: 30 nurses participated in six focus groups that were conducted using a semistructured interview guide. Twelve key informants were individually interviewed. Coding, sorting, and constant comparison were used to reveal themes.

Findings: Most ethical conflicts pertained to complex end-of-life situations. Three factors were associated with ethical conflicts: delaying or avoiding difficult conversations, feeling torn between competing obligations, and the silencing of different moral perspectives. Moral communities were characterized by respectful team relationships, timely communication, ethics-minded leadership, readily available ethics resources, and provider awareness and willingness to use ethics resources.

Conclusions: Moral disagreements are expected to occur in complex clinical practice. However, when they progress to ethical conflicts, care becomes more complicated and often places seriously ill patients at the epicenter.

Interpretation: Practice environments as moral communities could foster comfortable dialogue about moral differences and prevent or mitigate ethical conflicts and the moral distress that frequently follows.

Key Words: ethics; qualitative nursing research; workplace issues

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Background

Ethical conflicts currently are increasing for several reasons, including extended life spans, increased technology, the public's unrealistic expectations of medical care, greater cultural and religious diversity, more emphasis

on patient rights, shifts in healthcare financing, and limited resources (Morris & Dracup, 2008; Schlairet, 2009). Barsky (2008) defined ethical conflicts as "crisis in interaction in which each party becomes wrapped in self-interest, fails to see other sides, and feels victimized, hurt, or disempowered" (p. 166). Conflict emerges "when patients, surrogates, or clinicians perceive that their goals related to care and outcomes are being thwarted by the incompatible goals of others" (Edelstein, DeRenzo, Waetzig, Zelizer, & Mokwunye, 2009, p. 342). For example, McClendon and Buckner (2007) identified critical care nurse conflicts with families who demanded aggressive treatment despite unlikely benefit. Other researchers have identified nurses having conflicts with physicians about aggressive treatments or with families who override patient decisions (Hamric & Blackhall, 2007; Peter, Lunardi, & Macfarlane, 2004). In addition, ethical conflicts quickly can flame into contentious arguments, emotional outbursts, and disruptive behaviors that result from the use of defensive coping (Agich, 2011). These defense mechanisms often complicate or impair communication, collaboration, and ethical reasoning, which can escalate the ethics conflict (Danjoux Meth et al., 2009; Reilly, 2010).

Patients, families, healthcare providers, and healthcare organizations suffer the consequences of ethical conflicts (McCullough, 2012). In a concept analysis, Russell (2012) identified competing loyalties, some of which related to ethical conflicts, as an attribute of moral distress. Another study documented an increase in moral distress intensity with a decrease in nurse-physician collaboration (McAndrew, Leske, & Garcia, 2011). Moral distress also has been linked to decreased job satisfaction and work productivity, burnout, intentions to quit, and leaving the nursing profession (Balevre, Cassells, & Buzaianu, 2012; Elpern, Covert, & Kleinpell, 2005; Manojlovich, 2005; Pendry, 2007; Schluter, Winch, Holzhauser, & Henderson, 2008; Storch & Kenny, 2007; Winland-Brown, Chiarenza, & Dobrin, 2010). A recent study in the United States associated staff burnout with an increase in costly healthcare-associated infections (Cimiotti, Aiken, Sloane, & Wu, 2012). Nelson, Weeks, and Campfield (2008) identified other financial burdens of ethical conflicts, such as increased operational, public relations, and legal costs.

Ethical conflicts also can compromise relationships (McAndrew et al., 2011; Rosenstein & O'Daniel, 2005) and disrupt teamwork (Austin, 2012; Campbell & Cornett, 2002; Coomber & Barriball, 2007; Danjoux Meth et al., 2009; Maiden, Georges, & Connelly, 2011; Page, 2004; Van Soeren & Miles, 2003). Among nurses in Poland, Wlodarczyk and Lazarewicz (2011) found a positive association between professional burnout and frequency of ethical conflicts. Fragmented care and patient suffering also can result from ethical conflicts (Boyle, Miller, & Forbes-Thompson, 2005; Varcoe, Pauly, Storch, Newton, & Makaroff, 2012; Wiegand & Funk, 2012). Compromised relationships and fragmented care threaten patient safety and increase patient mortality and morbidity, which causes unnecessary suffering and can be costly (Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Estabrooks, Midodzi, Cummings, Ricker, & Giovannetti, 2005). Efforts to prevent or mitigate ethical conflicts could decrease these negative and far-reaching consequences. However, research on the nature of ethical conflicts is needed. Hamric (2012) noted a need to study root causes of ethical conflicts and moral distress to develop initiatives that prevent the potentially dangerous experiences, which could benefit providers, patients, families, and the healthcare system.

Framework and Methods

The authors adopted a socio-ecologic framework to study the context in which individuals experience and cope with ethically challenging situations. Focusing on complex and multilevel factors that influence human interactions, social ecology explores relational networks and practices that occur within a specific context (Richard, Gauvin, & Raine, 2011). For the current study, the authors used an ethnographic design that provided deep understandings about everyday practices and customs. Ethnography yields context-specific insights that offer descriptions of participant experiences (Streubert, 2011). Although findings cannot be transferred automatically to other contexts, readers are sensitized to concepts and experiences that may apply to their own settings. Ethnography particularly is suited to the study of ethical conflicts because conflicts cannot be isolated from the culture and settings in which they occur. The Office of the Human Research Protection Program at the University of California, Los Angeles approved the current study.

Data collection and analysis details of this study have been reported previously (Pavlish et al., 2012) and are summarized in the current article. An oncology clinical nurse specialist, bioethics center co-director, nurse academic, and student research assistant formed the research team. The team used flyers and emails to recruit oncology nurses from southern California chapters of the Oncology Nursing Society and conducted six focus groups with 30 nurse participants. All nurses were working in acute and clinic-based oncology settings. In addition, the authors recruited via email and interviewed 12 key informants in California and Minnesota: five clinical ethicists, three nurse executives and managers, two oncologists, one nurse academic who taught in a bioethics program, and one oncology clinical nurse specialist. Data were collected over a six-month period from November 2010 to April 2011. Key informants worked in academic medical centers

and community hospitals in southern California and Minnesota. In focus groups and interviews, the authors solicited patient situations that participants considered ethically difficult. The authors then explored the nature of the conflicts and how they developed. The authors also examined contributing factors and actions to address the conflicts.

The team recorded and transcribed all focus group and interview sessions. Using ATLAS.ti, version 5.2, researchers inductively coded and sorted research text into five structural categories. Researchers then subdivided into teams, separately detail coded within each category, and met regularly to discuss codes. As agreement was reached on the level of abstraction, the authors created a team-based codebook and logged the analytic decisions regarding the clustering of detail codes into concept categories and themes (MacQueen, McLellan-Lemal, Bartholow, & Milstein, 2008). The team separated focus group from key informant coding structures throughout most of the analytic process, which allowed the authors to consider and compare how each coding structure evolved from the raw data. The coding structure for oncology nurses was reported previously (Pavlish et al., 2012). In the final analytic step, the authors merged coding structures from key informants with focus groups to determine themes for the current article, which reports on ethical conflicts within the clinical situations that were described and the key elements of healthcare environments that prevented or mitigated their occurrence.

Findings

Nurse participants included 19 staff nurses, 4 clinical educators, 4 advanced practice nurses, and 3 administrators with an average of 12.7 years of oncology experience. Key informants came from a variety of fields, including clinical ethics, nursing, and medicine, and they averaged 25.5 years of clinical practice.

During focus group discussions, nurses detailed 51 ethically difficult situations, and 63% of those situations were described as conflict-laden, end-of-life situations (see Table 1). Key informants discussed 11 specific cases, and 73% pertained to decisional capacity and authority concerning treatments toward the end of life. Conflict permeated all ethically difficult situations and occurred between all types of stakeholders. Sometimes conflicts simmered quietly over time. Nurses described "murmuring among themselves," "shaking their heads," or "walking slowly to codes" in what they perceived to be overly aggressive treatment situations. Conflicts also could erupt suddenly when the situation reached a "boiling point" or when stakeholders "hit the wall." A nurse recounted a seriously ill patient whose condition deteriorated over a weekend. The on-call physician discussed options with the family and then ordered comfort care and documented a do not resuscitate order. When the pulmonologist returned on Monday, he was livid, blamed the nurses, and resumed the more aggressive treatment. The nurse blamed the pulmonologist for protecting his research more than the patient. Disrupted relationships that are difficult to repair frequently resulted from ethical conflicts during the study.

Table 1. Types of Ethically Difficult Cases Described by Nurse Participants (N = 51)

Type of Case	n
End-of-life situations with futility as a major concern	18
End-of-life situations with patient autonomy as a primary issue	9
Fidelity to RN obligations but medical team not listening	6
End-of-life situations with honesty about prognosis as concern	5
Patient capacity to provide informed consent for clinical trial	3
Pain management when drug-seeking behavior is suspected	3
Adolescent patients with cancer who turn 18 years old, but parents continue to make all decisions	3
Mental health patient capacity to manage complex treatments	3
Justice issue with insurance company refusal to cover treatment	1

Ethical Conflicts

Three factors in ethically difficult situations tended to foster conflict. First, delaying or avoiding difficult conversations about poor prognosis or end-of-life care options occurred. Many nurses expressed frustration with healthcare providers who avoided honest conversations about prognosis with patients and families. A nurse described a situation with a seriously ill child who was on maximum doses of vasopressors. When the physician told the family that the patient seemed better, the nurse interjected that the patient was not improving and required maximum medications to maintain her blood pressure. The physician reacted angrily and "dragged the nurse outside [the room]. . . . The nurse was actually saying what was really going on, but she got into a lot of trouble. It was a big deal, and the manager had to speak with her. The child died that night." Other nurses claimed that some physicians and nurse managers "jump down [their] throat," "slap [them] around," or "dismiss [them]" when they raised ethical questions

such as code status. One nurse described discussing end-of-life options in response to a seriously ill patient's questions. However, the physician reprimanded the nurse by saying, "It was not your responsibility or business to discuss that with my patients." Another nurse was told by her nurse manager to be "more wifely" when making suggestions to physicians.

Several key informants and nurses noted the challenge of honest conversations when patients and families were treatment-focused. One nurse commented that, in those circumstances, providers often opt for the easier approach, which is to foster hope rather than acknowledge the possibility that treatments could fail. Action-oriented patients and families look for what's next rather than experience the uncomfortable helplessness of waning treatment choices. The result can be a "churning plan" of treatments rather than a goals-of-care discussion and patient education about uncertainty and other options such as watchful waiting, palliative care, or hospice. A clinical ethicist noted the tendency to delay end-of-life conversations and emphasized the importance of "proactive guidelines," such as ensuring advance directives and surrogate decision makers are in place and that goals of care are documented and updated regularly.

Delayed conversations with patients and families often reflected nurses' fears that treatments actually were harming patients. For example, a nurse stated,

> You just want their end of life to be as quality as possible. I feel so guilty sometimes when I hang platelets on someone with 2,000 platelets and hemoglobin is 6. We know they're not going to make it, and we're pumping all these blood products in them, and then the doctor writes an order for chemo, and you think, "Oh my God, what's ethical about this situation?" We're not saving them, and it's not even for palliative care. Where do you draw the line?

The second factor in ethically difficult situations was that nurses felt caught between competing obligations. For example, one nurse questioned the meaning of family-centered care when describing an unhappy 18-year-old patient whose mother directed all care decisions. The nurse stated,

> The parents leave and [the patient] is crying her heart out to us. What do we do? We're stuck in the middle [of family disagreements]. The mother calls and says, "Remove [the patient's] phone. I don't want her talking to this person." I can't ethically do that. I mean, she can't even order her meals if I take the phone away.

Another nurse described caring for an 18-year-old patient with cancer whose mother threatened to discontinue insurance if the patient moved out of the house. The mother said, "You'll just have to die at that point." The nurse wondered how to advocate and stand up for her patient while keeping everybody happy. She said, "I see a whole lot of issues between parents and adult children." Another pediatric nurse described a mother who forced her 18-year-old son to "sign over the rights for her to make decisions," and then required the nurses to call her every time the patient requested anti-anxiety or pain medications. The nurse said, "This causes a lot of problems because we are not able to manage his care properly. He is perfectly capable of making decisions." The consternation of competing obligations seemed to occur frequently and often led to uncertainty and inaction.

The third factor was that conflicts tended to emerge from the silencing of different moral perspectives. In those situations, patients often were a quiet presence between splintering parties extending their best efforts in difficult circumstances to implement the ideal plan. Describing a situation of reintubating a dying patient, a nurse said,

> The pulmonologist got so angry with us [nurses] and even with the intensivist who asked, "What are we doing here?" [The pulmonologist] stomped off and said, "You don't understand. [The patient] is still good and wants to live." And the idea was, yeah, everyone wants to live but [the patient] had never been presented with opportunities to choose a different pathway.

A clinical nurse specialist noted that ethical conflicts often emerged from "differences of opinion." For example, the nurses may go to an oncologist who wants to be very frank with the patient and family, but the private doctor may say, "No, I've known these people for years and if you say the word 'cancer,' they're going to give up hope." Noting the uncomfortable position when moral perspectives differ, a nurse said, "What do we do then? The family is insistent and the oncologist doesn't want to step on the attending's toes. We believe it's wrong."

Clinical ethicists provided insight on moral disagreements. One ethicist related dissimilar perspectives to different "moral identities" accompanied by diverse conceptions of what it means to be a good nurse, oncologist, parent, or patient. The contrasting perspectives emerged from deeply held views on professional, family, cultural, and personal identities that must be taken into account. One ethicist said, "If you are working with people who have this particular understanding, then you know right away that you're going to have these tensions over what gets defined as the best thing to do in a situation." Another ethicist asserted that some conflicts are not resolvable and healthcare providers need to accept that "sometimes the result you like will not happen . . . that what you

believe with all your heart is wrong, someone else cannot accept as wrong. There can simply be moral disagreement, and people can base it on very sound values and good moral reasoning."

Differing moral perspectives were particularly evident in cross-cultural situations. Describing a cross-cultural situation in which the patient's family prevented diagnostic disclosure and insisted that nurses explain they are giving "vitamins" when administering chemotherapy, a nurse said,

> In my mind, I think [the patient] knows and is playing along because she doesn't want to hurt the children. And the children don't want to hurt the mother, but this woman is watching, looking at me, and her eyes are saying, "I understand everything, and I'm going to play along so nobody gets mad at me." Isn't that terrible?

An oncologist also detailed a cross-cultural situation where a daughter directed all care for her elderly mother with metastatic colorectal cancer. The oncologist said,

> When we discussed a biopsy with the patient [through translator] in the presence of her daughter, the patient became very tearful and seemed like she did not want another biopsy because it would cause additional pain. But her daughter encouraged her very strongly to undergo the biopsy and minimized her mother's concerns about discomfort. It was very difficult to discern [the patient's] wishes in those circumstances.

Cross-cultural care is more challenging when translators are needed. For example, commenting on the difficulty of having serious conversations through a translator, a nurse said,

> We were explaining all the terrible side effects of a drug, and I knew enough Spanish to hear the translator say, "You might have a little bit of a headache," as opposed to, "The blood counts could go so low, you will be in the hospital for a long time." . . . You really are at the mercy of your translators.

That poses a challenge for telling the truth to patients and can lead to ethical conflicts if decisions are made based on inaccurate or incomplete information.

Characteristics of a Moral Community

Participants painted a robust picture of how healthcare providers and clinical ethicists defined an ethically sensitive and responsive environment, often described as a moral community (see Figure 1). Each theme has a unique description, but participants also noted how themes interrelate.

Open, respectful team relationships: Every interview and focus group session emphasized the centrality of relationships in healthcare environments. An ethicist said, "Systems will facilitate or hinder good group relationships, which are, by far, the most important aspect for navigating a moral community." Participants described ideal relationships as those built on trust and mutual respect, and those that foster open dialogue and intentional collaboration between patients, families, healthcare providers, and administrators. In addition, participants identified egalitarian, interdisciplinary relationships as the most important aspect in ethics-related discussions, particularly in the context of moral disagreement. For example, an ethicist suggested providers must acknowledge "the fact that people have different values, and if we're going to live peaceably, we need to live in a manner that respects other values, plus having our own values respected." Another ethicist commented on the healthcare provider focus on problem solving that is sometimes to the detriment of simply listening to one another.

> I think it's wrong to assume that there will always be a solution and that the solution will be the one you want . . . the one that relieves your moral distress. The relief of one person's moral distress can generate moral distress in someone else. In fact, if it didn't do that, the conflict was only superficial.

The ethicist indicated that the key to working through moral differences is provider willingness to listen and engage in dialogue with one another about perspectives and not just about "my" or "your" solution.

Processes for timely, honest, planned communication: Participants asserted that ethically sensitive institutions emphasized holistic, patient-centered care and developed processes that value continuity. An ethicist stated, "It is critical to approach the patient as a whole being whether you're a nurse or physician." However, examples of the failure to achieve that ideal were common, including situations such as neglecting patient and family psychosocial needs, communicating poorly within healthcare teams, avoiding honest discussion about prognoses with patients and families, and lacking a standard mechanism for assessing and articulating goals of care with patients and families. Some participants were aware of those lapses and addressed them directly. For example, an ethics expert described a nurse who said,

> So I get really upfront to that patient's family and say, "Look at me. Your mother, sister, whatever, is very, very sick." It's often a very different kind of message than they get from the physician, so without actually countering them, I start to offer the possibility of another picture in an attempt to give the big picture, which is often missing. That's what I take my responsibility to be.

Success in implementing honest, planned communication included regular documentation of patients'

Open, respectful team relationships

Ethicist: I received a call from a unit nurse manager. The night nurses were having a lot of moral distress around the goals of treatment that didn't make sense. I did a debriefing with nurses and also invited the lead physician to come. He was very open and flexible and recognized what the issues were. So that was an opportunity to learn.

Staff nurse: If you can sit down and communicate, where there's a care plan in place, where everybody is a team and knows that this is being addressed and taken care of . . . and you have a multidisciplinary scenario, it works very well, and to me that eases the burden and discomfort of having communication barriers because you know who to go to. You know who is responsible and accountable.

Processes for timely, honest, planned communication

Ethicist: I was recently called by the nurse manager in one of the baby units. A critical number of nurses felt that this particular baby was being flogged to death, and the doctors didn't see it that way. The manager wanted me to come and just talk. This doctor is a very gentle, kind person who did have a different view of this particular baby, which was also shared by his colleagues. The purpose of the sit-down was for people to express how they felt and why they felt that way and what they thought was the right thing to do and why, but also to listen to why people thought differently.

Ethicist: So the first thing I normally ask in those circumstances [nurse calling an ethics consultation] is, "Have you spoken with the doctor?" Why do I do that? Because it seems to me if these things are ever to change, if we are to surmount the apparent disconnect between how nurses perceive a situation and how doctors perceive a situation, the only way is to be talking to each other and not talking to someone else. If there is a solution, it is to generate honest conversations and a sharing of one's perceptions, one's feelings, one's convictions.

Accessible, strong, ethics-minded leadership

Oncology clinical nurse specialist: I think it's important that we have leadership and that staff observes leaders being assertive, professional, and resolving conflicts to the nurse's comfort level. I think mentoring is important, and maybe it'll help nurses feel more comfortable bringing up issues by themselves.

Ethicist: So the nurse manager has to have a good relationship with staff nurses and also take seriously the concept of the healthcare team. If you don't have that view, then you create a lot of disgruntled, downtrodden, emotionally and ethically exploited nurses on your team.

Routine, readily available, systemwide ethics resources

Ethicist: So we're working with that unit to say you need to document goals of care. Every week, this person needs a goals-of-care conversation. So it's like a process improvement plan for an ethics issue.

Director of bioethics center: We're starting a pilot for preventive ethics that has to do with goals of care conversations in the intensive care unit and developing practice guidelines about what kind of conversation it should be and how often and what they're looking for.

Provider awareness and willingness to use ethics resources

Ethicist: Some nurses have been involved in, for instance, setting up a regular change-of-shift time in which I go and listen to what has happened in the last three months. If there's some sort of systems-level ethics issue you would like to raise, we have a set time to do it. We're trying to find different ways to address and define what ethics resource means and how to approach ethics in our environment.

Ethicist: One of the things that an ethicist can do is help people conceptualize and verbalize both [ethical concern and a sense of moral responsibility] by giving [healthcare providers] the space to speak and also the vocabulary to speak about things in a moral way, to translate raw emotion or just the bad issues out of a situation into something that is an articulate ethical stance.

Figure 1. Sample Quotes for Characteristics of a Moral Community

personal care-related goals, patient and family education, thorough communication of patients' unique needs to all providers, and referral to multidisciplinary resources and staff to properly address those needs. A nurse leader said,

> We all need to be on the same page. The whole bad-mouthing occurs if we don't have an understanding of what's going on with the plan of care and goals of treatment, so it's easy to say, "I disagree." But sometimes we're not privy to discussions that the physician and patient and family have had, and rather than jumping to a conclusion, nurses need to talk with physicians to see what's going on and why they are doing this.

The benefits of timely, honest, and planned communication included more awareness and focus on patients' psychosocial needs that were often at the heart of ethical conflicts. In addition, participants noted that planned communication minimized conflicting goals, promoted openness, allowed for the correct staff and resources to be involved in a timely manner, and prevented important patient care and ethical issues from being overlooked, particularly during hand-offs or care team transitions.

Accessible, strong, ethics-minded leadership: Throughout the narratives on ethical conflicts, nurses and key informants described the importance of leadership. Several situations exemplified strong nursing leadership, such as nurse managers who noted staff distress and invited the clinical ethicist to the unit for conversations about how to address ethically difficult situations. One ethicist described a unit manager who

supported a weekly ethics seminar for nurses, which would pay nurses for their attendance and include ethics handbooks for skill building.

Leaders also were noted for their positions as role models. One nurse said,

> Having a role model that you can talk to—a clinical educator, a clinical nurse specialist, somebody in the nursing profession that you trust, that you can really confide in and have them help you—it's very important in these situations.

Participants suggested that leaders need to be action oriented and team based. An ethicist said,

> It's troubling if the nurse manager doesn't have sufficient backbone in their unit, if they're not prepared to tell doctors that there's trouble at the mill, as they would say in Britain. . . . They also need to say, "I am not only telling you this, but we also need to do something about it."

Routine, readily available, systemwide ethics resources: Participants recognized that an efficacious ethical environment must include the availability of appropriate tools and resources, such as formal and informal ethics consultations and training. An ethicist recommended developing a systemwide ethics infrastructure and said, "It's really about engaging leadership in recognizing that something in the infrastructure needs to change. Otherwise, you do a lot of dog paddling." Another ethicist described adopting a systemwide integrated ethics approach and claimed, "We've brought ethics out of the closet because it used to be . . . it was like Las Vegas, 'Whatever happens in ethics, stayed in ethics.' And now we are much more visible." Suggesting that ethics resources should be visible and routinely used, a staff nurse said, "It would be nice to offer all-inclusive support [to providers]. I long to see the day that we know where to turn, what [ethics] resources are there for us, the patients, and the physicians."

Provider awareness and willingness to use ethics resources: Ethics resources must be accompanied by capable and willing providers who intend to use the resources and by supervisors who incentivize their use. As one clinical ethicist said, "It's about connecting the dots [between willingness and availability]." Many participants suggested that providers are not always aware of their institution's ethics resources or may be unwilling to use the available resources. Nurses seemed particularly hesitant to solicit ethics consultations for fear of retribution or hesitance to "kick up too much dirt." In addition, several key informants and a few nurses mentioned some provider inability to articulate ethical dilemmas using vocabulary that pinpoints ethical concerns and moral responsibilities. A clinical ethicist said,

> Nurses have an internal drive about ethics because they know, I mean, nurses have great intuition, but often they don't know how to capture it and use their voice in a way that gets action, and I think that's as much a cause of moral distress as anything.

Discussion

Ethical conflicts usually start as moral disagreements about an issue, the perception of unfairness in the process of dealing with the issue, or an emotional response to a situation (Edelstein et al., 2009). The authors' research evidenced all three types. Some described disagreements about plan of care or disputes with a policy, and others discussed concerns about fair patient or staff treatment. Still others said that their moral concerns, particularly those regarding patient suffering, differed from the moral concerns of family members or physicians. The primary type of ethical conflict described by nurses and key informants occurred in seriously ill patients toward the end of life. Those situations tended to be complex and emotionally charged. Participants described feelings of sadness, anger, guilt, and fear. Emotions often are helpful in identifying important values (Molewijk, Kleinlugtenbelt, Pugh, & Widdershoven, 2011) and can be opportunities for greater clarity and personal growth (Webster & Baylis, 2000). However, during ethical conflicts, emotions often accumulate without recognition or examination and can overshadow the situation, cloud thinking, and accelerate conflict. Describing a crescendo effect that occurs when healthcare providers experience a pattern of ethical conflicts and moral distress and residue, Epstein and Hamric (2009) claimed that providers generally react more strongly to repeated situations. As moral distress and residue accumulate, providers can become emotionally exhausted, morally insensitive (Hamric, 2012), and disengaged from work (Maiden et al., 2011).

Ethical conflicts usually stem from multiple root causes that often overlap and entrench the disagreements that occur (Danjoux Meth et al., 2009; Swetz, Crowley, Hook, & Mueller, 2007). In the current study, participants identified elements of poor communication with some providers not speaking up and others not willing to listen or consider alternative perspectives. In addition, system processes to facilitate good communication often were missing. Without adequate communication, moral differences become more pronounced (Schlairet, 2009) and can result in "tremendous pressure to get along by going along" (Webster & Baylis, 2000, p. 226). In many of the ethical situations described in the authors' research, physicians and nurses were not expected to discuss moral differences and missed the opportunity to understand each other's perspectives.

Patient and family perspectives also occasionally were missed because providers became wrapped in their own internal struggles with the issues at hand. Ho (2009) described the trouble that evolves from deep entrenchment in personal moral perspectives during ethical conflicts and suggested epistemic humility, dialogue, and collaboration as ways to avoid conflict acceleration. In a study with 305 oncology nurses, Friese (2005) found that oncology nurses who reported positive collegial relationships with physicians were twice as likely to report high-quality care. Effective interdisciplinary communication and collaboration are key components of ethical environments.

Many nurses in the current study identified that they were aware of different moral perspectives and the potential for significant disagreements before situations escalated into ethical conflict. Nurses in a critical incident study also indicated early awareness of unfolding ethical conflicts (Pavlish, Brown-Saltzman, Hersh, Shirk, & Nudelman, 2011). In the current study, early warning signs ranged from a sense that something was not right to statements that clearly evidenced contrasting viewpoints. However, a tacit and collective tendency to avoid facing or confronting these differences also was revealed. Other researchers have found evidence of physicians or nurses avoiding communication about moral differences and disparate goals of care (Danjoux Meth et al., 2009; Fassier & Azoulay, 2010; Gaudine, LeFort, Lamb, & Thorne, 2011; Gutierrez, 2005; Wang, 2013). Evidence of cultural differences as a component of ethical conflicts also emerged from this study. The topic remains an understudied aspect of care for seriously ill patients and their families.

Limitations

Limitations to the current study include its small sample size. Ethical conflicts involve many stakeholders, and some of those voices are not represented in this study. Organizational cultures and settings differ significantly. The types and availability of ethics resources also contribute to differences in how ethical conflicts emerge, progress, and are managed. Therefore, the results of the current study cannot be generalized and should be restricted to providing a deeper understanding of issues that may pertain in varying degrees to other oncology settings.

Implications for Nursing

Healthcare providers and clinical ethicists in the current study described their perceptions of ethical environments, often called moral communities. Providers and ethicists spoke congruently about the characteristics of moral communities, with the greatest emphasis on timely, respectful dialogue about moral perspectives and responsibilities. One clinical ethicist said,

> I'm explicit that it's not just within the community of nurses, [difficult situations] actually [have] to be integrated [with] all the care providers. . . . So there actually needs to be a sense of community. That's the precursor of all this, that we actually are in this together. And then the freedom that we can talk explicitly and directly about what we're facing and experiencing as we take care of these patients. That will help ameliorate some of the tensions that develop around these kinds of ethical issues. . . . When you have the dynamic between physician and patient or physician and family about chemotherapy, the fact that nurses and physicians as a community are talking with one another about what's going on is not going to change that. But what it will be able to do is, before it gets to a boiling point or a breaking point, you may have some process interventions that hopefully can resolve whatever the disagreements are or the conflicts or the tensions.

Similarly, Austin (2007) suggested that dialogue with "attentiveness to action" (p. 85) is the work of ethics and requires extending beyond an individual's moral agency toward "perpetual responsiveness to others" (p. 86). From that perspective, quality relationships comprise the landscape of moral communities and are the starting point for raising questions, contemplating uncertainty, and examining disagreements. In the current study, the authors found evidence that moral differences and disagreements often were avoided or deferred, so instead of conversation building from moral differences, those differences often stopped conversation, which discouraged collaboration and shared decision making in difficult situations. That seems to suggest that healthcare providers need more skill in working comfortably and not defensively in disagreements and that healthcare systems need to provide opportunities and tools to facilitate ethical conversations.

Webster and Baylis (2000) emphasized the need to address ethical conflicts and moral residue at personal and communal levels, but Hardingham (2004) noted that ethical practice is a shared endeavor to create an ethics-minded culture. The authors' findings indicate that part of creating an ethics-minded culture is sensitizing healthcare providers to early signs of ethical conflicts and preparing providers and structures to respond rapidly, effectively, and efficiently to ethical issues or specific ethically difficult situations. Another aspect of creating an ethics-minded culture is recognizing the collective moral obligations and mutual accountability in transforming systems of care into moral communities where interdisciplinary dialogue, deliberation,

and documentation on ethical considerations becomes expected, comfortable, and routine for complex patient situations.

Nurses need to become more aware of their own moral identities by routinely assessing and clarifying their moral values and obligations. This requires reflective thinking about the core aspects of oncology care. Commitment, education, and accepting accountability also are necessary. Nurse leaders are in a key position to create moral communities by promoting ethical awareness and comfort with ethics-related conversations. Healthcare administrators must consider their role in supporting skill development in ethics. For example, scheduling regular interdisciplinary ethics seminars for case discussion could be incentivized.

Nurses must become more assertive and confident about initiating comfortable, honest conversations in the face of difficult circumstances, such as prognostic uncertainty and moral disagreements. Baer and Weinstein (2013) noted that improving oncology nurses' capacity for having difficult conversations can increase patient satisfaction and positively affect clinical outcomes. Oncology nurses also should look for opportunities to consider goals, values, and preferences with patients and then present and discuss those perspectives with other healthcare providers. Patient and family expectations of treatments should be clarified and documented. This effort seems particularly significant in light of recent research that suggests many patients with advanced cancer have unrealistic expectations of chemotherapy (Weeks et al., 2012) and radiation (Chen et al., 2013).

In the current era of transforming practice environments where the Institute of Medicine (2010) recommended that "nurses should be full partners with physicians and other healthcare professionals in redesigning health care in the United States" (p. 1), nurses must become more proactive in collaborating across moral perspectives and, when necessary, mediating ethical conflicts. Being able to profoundly affect patient and family experiences, nurses should expect to actively participate in team discussions aimed at creating consensus around a patient-centered plan of care (Schlairet, 2009). Nurse managers and staff should develop specific protocols that require interdisciplinary communication and collaboration. For example, holding interdisciplinary goals-of-care conversations within 72 hours of admission for patients with advanced diseases could become standard practice. Developing opportunities for collaborating across positions and differences to frequently update a cohesive plan of care with patients and families could mitigate ethical conflicts.

Creating structures to hold nurses and other healthcare providers accountable for discussing ethics-related issues is needed. For example, nurse leaders and staff could establish specific ethics-related nurse competencies, such as clarifying patient treatment preferences, approaching the medical team to clarify goals of care, or preparing patients and families for family care conferences. In addition, developing specific performance evaluation measures may help to ensure individual accountability and improve system capacity to prevent or mitigate ethical conflicts. Requiring documentation on ethics-related issues also would enhance accountability.

Knowledge Translation

Developing healthcare systems into moral communities where all members are encouraged to illuminate ethical concerns and grapple with them in a manner that promotes trust, shared understanding, and mutual respect is essential.

Research is needed to know how to effectively collaborate across different moral perspectives and avoid ethical conflicts.

Nurses are in a key position to assess for early signs of moral differences and initiate goals-focused discussions with patients, families, and healthcare teams.

Conclusion

Oncology practice continues to become more complex, diverse, and interdependent. Fairchild (2010) noted that caring in the context of complexity requires positive leadership that values the nurse's role in bridging conflict among differing and sometimes competing perspectives. Developing healthcare systems into moral communities where all members are encouraged to discuss ethical concerns in a manner that promotes trust, shared understandings, and mutual respect is necessary in oncology practice. A shared commitment to the "moral good" of high-quality, patient-centered care requires comfortable, honest, evidence- and ethics-based conversations between patients, families, and healthcare teams, as well as within systems of care.

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3. What mechanism(s) do you have to resolve moral dilemmas?
4. How would you go about creating a moral community in your workplace?

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