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

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

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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 to 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.[1] Subjective evaluations of ethics consultation have shown high staff satisfaction.[2 3]

Although ethics consultations similar to those in the American model have been reported from Europe,[4–6] it seems that supporting healthcare teams in dealing with ethical problems through reflective practice[i] are more commonly advocated[7–11] and practised.[8 11 12] 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.[13 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.[16]

Questionnaire

Evaluation of the stimulation of ethical reflection was operationalised in terms of comparing the

[i] The term moral deliberation might also be used but seems more to be associated with decision-making.

Table 1 The content of the two questionnaires

Questionnaire 1, before the ethics rounds number answered = 186	
1. Do you believe that an ethicist can help give you insights into the ethical problems in the care of the patient in question?	Closed-ended question
2. Describe the ethical problems that you perceive in the care of the patient in question.	Open-ended question
3. Describe how you think the team should try to solve the ethical problems.	
Questionnaire 2, after the ethics rounds number answered = 189	
4. Have you gained any insights during the ethics rounds regarding what the ethical problems are in the care of the patient in question?	Closed-ended question
5. Have you gained any insights into how the team should try to solve the ethical problems?	
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.	Open-ended question
7. If you answered "None" or "Low level" to question 4 or 5, please describe what the reasons might be.	
8. Indicate to what level the ethicist facilitated your insights.	Closed-ended question
9. Indicate to what level the participating staff facilitated your insights.	

rating of expectations of gaining new insights versus reported insights and comparing descriptions of reasoning about the ethical problems before and after the ethics rounds. Based on the literature[3 17] and two pilot tests, two study-specific questionnaires were developed with both open and closed-ended questions (table 1). For the closed answers a five-point adjective scale was used to measure the rating of expectation about gaining insights and new insights: none (1); low (2); moderate (3); rather high (4) and high (5). Insights were defined in this study as new thoughts, new angles of approach or increased knowledge about an ethical problem.

RESPONDENTS AND DATA COLLECTION

The sample comprised all staff at the three nephrology departments. They were informed of the opportunity to participate in the rounds during departmental meetings. Of 200 available personnel, 103 persons attended one to four rounds of a total of 12 ethics rounds, resulting in 194 attendances (table 2) and a median of 14 participants per round. Selection was non-random mainly because the staff working the day of the rounds had the opportunity to participate, on average 20 persons. Not being familiar with the patient and time constraints were reported as reasons for not attending. The first questionnaire was handed out immediately before each session and the second directly afterwards. The internal drop-out was nine not answering the first questionnaire and five the second. For separate questions it ranged from 1% to 24% (mean 4%).

Analysis

Qualitative analysis

First, the open-ended answers in the questionnaires were analyzed through inductive content analysis with co-assessment.[18] The text was divided into meaning-units and preliminary subcategories were generated by constant comparison using the software NVivo.[19] 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",[20] 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).[21] The third and fifth author examined these approaches to use as 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[21] and might resolve the ethical problem.[22] 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 problematical situation.[21] Boyd[21] 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[22] and implies interpretation through openness to different perspectives, which may lead to awareness of one's prejudices and a new shared perspective among individuals.[21 22]

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.[23] To detect any effect of respondents attending more than one ethics round, a subgroup analysis was made with

Table 2 Professions of respondents and the number of rounds attended

	No of respondents				
Professionals	**1 Round**	**2 Rounds**	**3 Rounds**	**4 Rounds**	**Total respondents**
Nurses	24	18	14	3	114
Doctors	5	1	6	1	29
Nurses assistants	15	3	4	1	37
Others*	5	1	1	1	14
Total respondents	49	46	75	24	194

*Four students, two social workers, one physiotherapist, one occupational therapist.

Table 3 Descriptions of the ethics rounds

No/hospital/ethicist/participants (n)	Patient and the primary issue	Representative quotation of insights gained
Round 1 Hospital 1/Ethicist 1/(27)	♂, age 67 years, several diseases and complications affecting quality of life; suffering connected with continued dialysis	"An already complicated question was proved to be even more difficult. What I reflect mainly over is the lack of discussions between professional groups."
Round 2 Hospital 1/Ethicist 2/(15)	♀, age 41 years, dialysis since age 16 years, late complications, psychosocial problems; non-compliance with medical regimen	"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."
Round 3 Hospital 1/Ethicist 3/(14)	♂, age 55 years, non-Swedish-speaking, suicidal, confused, has deportation order; suffering	"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."
Round 4 Hospital 1/Ethicist 1/(11)	♂, age 63 years, non-Swedish speaking, investigated for kidney transplant, cooperation difficult; non-compliance with medical regimen	"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."
Round 5 Hospital 2/Ethicist 2/(19)	♂, age 61 years, deceased, rotted away; gangrene in extremities and genitals; suffering connected with continued dialysis	"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."
Round 6 Hospital 2/Ethicist 1/(11)	♀, age 89 years, deceased, pain, anxiety, confusion; suffering connected with continued dialysis	"Neither we nor anyone else could do anything. Moral stress is a good explanation for how we all felt. It is difficult to prevent it from happening again."
Round 7 Hospital 2/Ethicist 2/(7)	♂, age 71 years, feebleness; distress over patient's decision to discontinue dialysis	"The thoughts I got 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 is to ask. Then I always need to ask myself how my own part influences the decision."
Round 8 Hospital 2/Ethicist 4/(14)	♂, age 61 years, deceased, not informed about malignant disease; truth-telling about bad news	"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."
Round 9 Hospital 3/Ethicist 4/(26)	♂, age 62 years, expresses a desire to die, aggressive, cooperation difficult; non-compliance with dialysis regimen	"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."
Round 10 Hospital 3/Ethicist 1/(14)	♂, age 61 years, skips dialysis, sometimes wants to discontinue it, does not appreciate information; non-compliance with dialysis regimen	"In some way this person must be helped to gain awareness of his illness. The staff as a whole must also set joint boundaries."
Round 11 Hospital 3/Ethicist 4/(16)	♀, age 88 years, deceased, feebleness; family wanted dialysis to be continued, suffering connected with continued dialysis	"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."
Round 12 Hospital 3/Ethicist 2/(20)	♂, age 62 years, skips dialysis, refuses admission to hospital, cooperation difficult; non-compliance with medical regimen	"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."

random selection of all participants from a collective list of all ethics rounds (n = 103). Factors from the interview study[16] suspected to affect perceived insights were profession, department and philosopher. These were tested using Kruskal–Wallis and then Mann–Whitney tests,[23] 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.[16] 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 35% 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 meaning-units); 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.

Table 4 Reported new insights compared with expectation of gaining insights

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

*From high or rather high expectations; †from moderate or low; ‡22 could not decide about expectations.

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 principles 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).

Table 5 Ethical problems and solutions perceived before rounds

Boyd's approaches (%*)	Main categories	Subcategories	Meaning-units (n)	Representative meaning-units from the most frequent subcategory
Ethical problems			n = 208	
Principles (74%)	Patient participation problematical	Doubt about decision-making capacity	33	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.
		Ambiguous responsibility for decision	29	
		Lack of adequate information	19	
		Doubt about in whose interest to continue treatment	8	
	Exposure to suffering	Burdensome situation	21	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.
		Debasing treatment	16	
		Doubt whether it is right to continue treatment	19	
	Allocation of resources	Consideration of other patients	9	Is it fair to the other patients to give him a kidney when he is so non-compliant? What resources are reasonable to expend, which are then taken away from other patients?
Persons (12%)	Personal responsibility	Insufficiency as carer	14	The woman screamed and was in pain. Nothing helped. I felt powerless. Other patients heard her screams. It was frustrating not being able to help her.
		Uncertainty about mental posture towards the patient	11	
Perspectives (14%)	Difficult to understand the patient	Difficult to know patient's thoughts	17	Do we know if the patient is hunger striking just to stay in the country or wants to quit dialysis because he wants to die or is he doing it for the family or because he is psychotic and can't keep it together?
		Double messages from patient regarding death	12	
How to solve			n = 209	
Principles (30%)	Promote patient participation	Inform patient/family about treatment	28	Explain to the family more exactly what dialysis involves and how difficult it is for the patient.
	Alleviate suffering	Help the patient decide	26	
		Decide to withdraw treatment	8	The physicians should have tried to decide how and if the patient was to be treated at an earlier stage.
Persons (14%)	Be brave	Question the doctors	20	That we look to the patient's best interest and not to the prestige of the medical profession or be afraid of going against someone else's decision.
		Dare to speak out	10	
Perspectives (56%)	Enhance team collaboration	Request for interprofessional dialogue	43	Discuss together, doctors and nurses. Easier to understand why the treatment continues despite the patient's condition.
		Reach a consensus for care	24	
	Enhance patient/familycontact	Give psychological support	41	Help the patient take an active part in his care. In some way help the patient cope with the situation and take care of himself and his health.
		Try to understand the patient	9	

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

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.

DISCUSSION

The ethics rounds did not seem to stimulate the ethical reflection that the respondents had expected. Dominating 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.[16] 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.[22] One of the reported reasons for not perceiving insights was expected solutions to the ethical problems, which correlate with nurses' experiences in the interview study.[16] Schneiderman *et al*[3] showed, among other things, that ethics consultation to help identify and analyse ethical problems yielded high staff satisfaction. This may be due to the simultaneous help with solving, which was also ranked high. The findings in the present study may, however, not be interpreted as an overall negative

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

Boyd's approaches (%*)	Main categories	Subcategories	Meaning-units (n)	Representative meaning-units from the most frequent subcategory
Insights into the ethical problems			n = 130	
Principles (10%)	Patient participation	Importance of adequate information	13	It is important to give the patient good information that it is possible to withhold treatment and still get good care.
Persons (18%)	Personal responsibility	Awareness of one's feelings	12	I realise that I could react from my heart and shout it out to the media.
		Boundaries to responsibility	12	
Perspectives (72%)	Extended perspective on the patient	Others perspectives and knowledge	30	I've got more facts about the particular situation. That it was not only about the patient having dialysis or not.
		More complex	19	
		Increased understanding for the patient	10	
	Increased awareness of relations to other professions	Mutual understanding	14	Interesting to learn how those with power (the doctors) also feel vulnerable and find it difficult to reach the patient.
		Gap between the professionals	13	
		Shared view about the problem	8	
Insights into how to solve problems			n = 125	
Principles (18%)	Promote patient participation	Improve routines for information and documentation	12	To document the patient's wishes about the future regarding life-sustaining treatment and if the patient has had a different opinion from the doctor.
		Help the patient to decide	11	
Persons (18%)	Be firm	Make demands on the patient	17	From this, I realise a person has the right to make demands on somebody who places demands on you.
		Question the doctors	5	
Perspectives (64%)	Enhance team collaboration	Request for interprofessional dialogue	36	More collaboration between the different staff groups.
		Reach a consensus for care	20	Everyone helps to put the pieces of the puzzle together. You don't have to be alone with difficult decisions. Find time for dialogue.
	Enhance patient/family contact	Give psychological support	15	To combine the patient's concern for his children with the importance of the dialysis regimen.
		Try to understand the patient better	9	

result; they might show how ethics works in clinical practice, as a time-consuming collaboration. Rather than resulting in a resolution or change in a healthcare provider's basic stance, it may lead towards a richer interpretation.[22] This may be a sign of 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[24] and because an outsider may bring new perspectives to healthcare professionals, who may be blind to their own prejudices.[22] Comments in this study and experiences from the interview study[16] 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.[16] 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*,[1] 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 for being structured and for maintaining discipline as well as balance in power between the nurses and doctors.[16] This perhaps implies that with discipline more voices and thereby perspectives are able to come forth.

Third, some of the patients' problems were of long duration and seemed difficult to solve. This might explain negative perceptions because the respondents felt they had already heard it all before from other staff members and results from the interview study showed a sense of resignation to a lack of change.[16] This may indicate the need for proactive ethics rounds before ethical problems become severe. Furthermore, the insight of promoting patient participation seems obvious and the absence of it perhaps demonstrates how difficult it is to achieve. This is confirmed by studies showing low patient participation in end-of-life decisions.[25] 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.[26] 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*,[11] 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[21] involving adding hermeneutic ethics to the traditional normative approaches of principle and virtue ethics. Hermeneutic ethics is, according to Leder,[22] distinct from other theories such as sociological theories as it sheds light on what should be. As Leder has pointed out,[22] 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.[16] The combination 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.[27] 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.[28 29] 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.[13 14] 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,[3] 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.[21] 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[21] 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),[16] 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[16] suggest that process skills[30] are important, further studies are needed to explore what 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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