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A Qualitative Study of Norwegian Care Institutions Health Care Workers' Experiences of Ad Hoc Ethical Reflection During the Workday

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Background/Objectives: The objective of the study was to explore experiences related to ad hoc ethical reflection and how ethical reflection might be structured. There has been limited research on the topic in the context of nursing homes and health care centres. Reflection is an ongoing practice in healthcare, often linked to problem-solving and clinical decision-making.

Methods: The study has an exploratory design with a qualitative approach. The researchers conducted four group interviews. The data were analysed with systematic text condensation, which entails condensing meaning units following development of code groups.

Results: When health care workers (registered nurses, auxiliary nurses, or care workers) encounter ethical uncertainty or ethical issues, they may perceive these situations as challenging. Occasionally, they take the initiative to conduct ad hoc ethical reflection, where they discuss different perspectives and make decisions collectively. Hence, ethical reflection contributes to collaboration. The structure of ad hoc ethical reflection appears to be shaped by two key components: problem-solving and consensus-building, while also addressing, to some extent, the values involved. Furthermore, ethical reflection often led to health care workers supporting each other.

Conclusion: Ad hoc ethical reflection can improve decision-making and foster moral awareness among nursing home health care workers. Moreover, the study identifies a need to implement practices of ad hoc ethical reflection through training programs, such as simulation training. Future research, preferably observational, may provide deeper insight into the prerequisites, structure and performance of ad hoc ethical reflection, and how its conclusions are implemented.

Keywords: ad hoc ethical reflection, clinical decision making, nursing home, health care centre

Introduction

A fundamental aspect of ethics in nursing is the desire to do the best for the person who receives care, and reflection is an ongoing activity in care.[1] Care organisations operate in societal and regulatory contexts and have several organisational levels, and many actors and stakeholders, all of which hold different values and preferences. It is therefore nearly inevitable that individuals receiving long-term care (such as those in nursing homes) and their relatives/carers will experience ethical uncertainties and ethical issues.[2] In long-term care, in which individuals often have a reduced capacity for speaking for themselves, relatives/carers must cooperate with the health care team and are crucial partners for good-quality care of the individual.[3]

Ethical behaviour is indispensable from good quality nursing and presuppose ethical competence that comprises moral sensitivity, ethical knowledge, ethical reflection, ethical decision making and ethical action.[4] Ethical reflection on the part of health care workers (registered nurses, auxiliary nurses or care workers) might contribute to moral sensitivity and better understanding of the person and the situation because the health care workers take into consideration significant values and what is at stake in the specific situation for the individual. Furthermore, moral sensitivity is necessary for moral agency.[5,6] An individual health care worker might reflect on their own, or

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ethical reflection might be performed as a group with (primarily) health care workers from different professions[3,7,8] along with relatives/carers and the person in need of care.[3] Ethical reflection is also an ongoing ad hoc activity that can be used to sort out ethical uncertainties[9,10] and as a part of clinical decision making.[11] Ad hoc ethical reflection can be described as spontaneous and not planned reflections in "here and now" situations, often when it is urgent to decide on which action to take in performing health care. Ethical reflection involves examining prevailing views and assumptions about a specific situation and individual persons.[12] Gaining a deeper understanding of the situation, the person, and the relevant values positively influences care practices and collaboration among healthcare workers. The individual along with what matters most to them and what contributes most to their quality of life—becomes the focal point of care,[3] ultimately enhancing their sense of dignity[13] Consequently, quality of care may be indirectly affected positively. Furthermore, through ethical reflection, the health care team developed a common view of quality and significant goals and developed a shared language of care.[9] However, previous studies have not reached clear conclusions regarding whether or how ethical reflection affects quality of care.[3]

A person-centred approach is recognized as a strategic priority within healthcare policy and professional practice.[14] Person-centredness can empower individuals by involving them in decision-making processes, enhancing their sense of control and autonomy, and uphold the dignity of the person by valuing their experiences and perspectives.[14] This approach also encourages health care workers to focus on the individuals' experiences and needs, as well as to engage more sensitively with their perceptions and objectives.[15,16] Finally, a person-centred approach can lead to more ethically sound decision-making because it fosters a reflective practice in which health care workers continually assess and adapt care based on individual needs and preferences.[17]

Ethical reflection is more than simple problem solving and requires structure. "The 6-steps model for ethical deliberation in health and care services" (henceforth "the 6-steps model")[18] was claimed to provide structure and systematisation of reflection and is mostly used in Ethics Case Reflection rounds, also known as Moral Case Deliberation.[3,7] The 6-steps model emphasises articulating the ethical problem, investigating relevant facts, the involved partners and how they are involved, the values at stake, and ethical principles and legislation. Furthermore, the 6-steps model balances the values at stake and lets those values help to choose a justifiable course of action.[18] Elements of the "6-steps model" may be used in ad hoc ethical reflection, and the ad hoc ethical reflection has the potential to be systematic.[9] Recent research highlights the effectiveness of the "6-steps model" in structuring ethical deliberation, which enhances clinical decision-making and promotes consistent value-driven practices in healthcare settings.[3,9,18] The studies show that this model improves moral sensitivity and collaboration among healthcare teams, underscoring its potential to support ad hoc ethical reflection. Furthermore, it seems reasonable to contend that the ad hoc ethical reflection may contribute to better clinical decisions and improved person-centred care in "here and now" situations where actions must be taken without delay.

There is a substantial body of research on formal ethical reflection, but it seems to be scant about ad hoc ethical reflection and how it might be structured in the context of nursing homes and health care centres. The authors wanted to know more about ad hoc ethical reflection and how it might be structured. To start investigating these issues, the aim of this study was to explore experiences related to ad hoc ethical reflection and how ethical reflection might be structured.

Materials and Methods

Design

Because we wanted to learn from the health care workers' experiences, we chose an exploratory design with a qualitative approach.[19] Furthermore, research about ad hoc ethical reflection that takes place during the workday seems to be limited. We used group interviews to collect data because these can potentially give richer data and better reveal variation in data than individual interviews.[19]

Data Collection

The sampling of participants was purposeful. Criteria for participation were working as Registered nurse, auxiliary nurse or care worker and having received brief training in formal, planned ethical reflection and how to use the 6-steps model. Both the nursing home and the healthcare centre had a resource nurse in palliative care who had completed a one-day training course that included education on the 6-steps models and simulation-based ad hoc ethical reflection training. The resource nurse's colleagues had received brief education on the 6-steps models and practical exercises in applying them in formal, planned ethical reflection.

The first and second author developed an interview guide that included questions about what the interview participants and their colleagues do when they face ethically challenging situations, who participates in ad hoc ethical reflections. We asked if they had used the 6-steps model, and how it might be useful, and the interview guide also included questions about what an ad hoc ethical reflection may yield regarding understanding of others, communication, cooperation, and quality of services. The interviews were conducted by the first author. To avoid misunderstandings during the interviews, we occasionally verified whether our understanding was accurate.

In total, four semi-structured group interviews were conducted over a five-month period in 2022–2023 at one nursing home and one health care centre in a county in south-eastern Norway. The interviews were conducted at the nursing home and at the health care centre where the interview participants worked. In nursing homes and healthcare centres in Norway, cultural and organisational norms are quite similar. These norms are primarily shaped by legal regulations.[20,21]

The ward leaders contacted the relevant interview participants face-to-face. The size of the groups varied from three to five participants (A total of 12 participants – six Registered Nurses, five auxiliary nurses and one care worker). The age of the participants varied from 18 to 62.

Data Analysis

We audiotaped, transcribed verbatim, and analysed the interviews with systematic text condensation,[22] a method that requires condensing meaning units following development of code groups and subgroups. Microsoft Excel was to some extent used to manage the data. In the first step of the analysis, we read the transcribed text many times and tried to set aside our preconceptions. All the authors have been teaching nursing ethics. The first author was a member of the National Council of Nursing Ethics. The themes were derived from the data. The process resulted in the identification of ten temporary themes. In the second step, we conducted a thorough examination of text elements in the transcription that could contribute to answering the research question.

We next processed the ten preliminary themes into two main code groups and seven subgroups, and we coded the meaning units using the code groups and subgroups. Next, we categorised distinct phenomena in different codes, and we categorised facets of the same phenomenon in the same code. We then reflected upon similarities and differences between and within the code groups and subgroups. Meaning units that seemed not to fit in a code group or subgroup stimulated questions and decisions about changing categorisation throughout the analysis. In the third step of analysis, we gathered and processed coded text elements belonging to each subgroup into new condensed texts. In the next step, we recontextualised the text into a single coherent text that reflected the meanings of the participants through writing an analytical text based on condensed texts. At this point, we read the analytical text several times and reflected about code groups and code group labels, which resulted in restructuring of the analytical text. Finally, to ensure that the analytical text entailed the meanings of the participants, we inspected the original transcriptions and looked for meaning units that could contest the analytical text. This final step resulted in some minor corrections to the analytical text. See Table 1 for a sample of the analytical process.

Ethical Considerations

The Norwegian Agency for Shared Services in Education and Research (SIKT) has approved the study (registration number 461057). Participants were briefed on the study's purpose both verbally and through written documents prior to the interviews, emphasising that their participation was entirely voluntary. Each participant signed a written consent form

Table 1 Example of Systematic Text Condensation

Transcribed text	**Identifying and Sorting Meaning units Subgroup 1A *Being Aware that a Situation is Ethically Challenging***	**Condensation**	**Analytical Text**
Interviewer: *What happens with you when you observe next of kin act in a way that harms the patient?* Interviewee: *First, we want to protect the patient … it is a bit about a basic conscience … it can be different from person to person what triggers the conscience …. It is about a gut feeling, looking a part from theory and experience, but to think if it feels right or wrong*	My response is based on my conscience. A response can be different from person to person. I rely on my gut feeling (divided from both theory and experience) to decide what is right or wrong.	Feeling whether something is right or wrong is based on conscience, which differs among people.	The participants said that ethical reflection process is about a conscience that differs from person to person. They rely on their gut feeling about what is right or wrong.

Table 2 Results

Code Group 1	**Ethical Uncertainty and Ethical Issues**
Subgroup 1A	Being aware that a situation is ethically challenging
Subgroup 1B	Taking initiative and conducting ethical reflection when needed
Subgroup 1C	Speaking up and dealing with disagreements
Code group 2	**Creating Collaboration**
Subgroup 2A	Making use of different perspectives
Subgroup 2B	Making a decision collectively
Subgroup 2C	The challenge with documentation
Subgroup 2D	Taking care of each other

and actively participated in discussions to ensure their understanding of confidentiality. The participants informed consent included publication of anonymized responses/direct quotes.

Results

The two identified main code groups, with seven corresponding subgroups, appear above (Table 2).

Ethical Uncertainty and Ethical Issues

Being Aware That a Situation Is Ethical Challenging

The participants explained that when they feel the need for ethical reflection, they are during an ethically challenging situation, which are typically characterised by complexity and conflicting values, that leaves them feeling frustrated and uncertain about their next steps. This situation could also have involved actions that contradict their professional values. For the participants, the primary concern was to protect the individual receiving care. The participants said that moral sensitivity is about a conscience that varies from person to person. They relied on their gut feeling about what is right or wrong. *"(We) consider whether it feels right or wrong"* (first interview at the health care centre). Two recurring ethical problems as a part of daily work were when an individual's wishes conflicted with safety or what is professionally sound, and when coercion had to be used to secure what was in the individual's best interests. Another recurring ethical problem was when an individual's person's wish conflicted with the wishes of that person's relatives/carers.

Taking Initiative and Conducting Ethical Reflection When Needed

Ethical reflection is often a continual part of the situations encountered by participants and taking a moment to weigh individual autonomy and other considerations is crucial, the participants said. Participants said that they engaged in

reflection continuously, albeit they did not always recognise it as ethical reflection. According to one participant, they often asked questions about what to do, rather than using the 6-steps model for ethical reflection in health care services.

Well, maybe we do use the model. In that case, it is somewhat unconscious (second interview at the nursing home).

Nevertheless, the participants demonstrated ethical reflection when they talked about a conversation with a physician: "We discussed if it was ethically right or wrong to send the patient to the hospital so that x-rays could be taken" (first interview at the health care centre). When asked about which values were at stake if they sent a seriously ill person to the hospital for taking x-rays, the participant said that the value was "do no harm".

The participants trusted and preferred certain colleagues when it came to having ethical reflections. They acknowledged the significance and importance of ad hoc ethical reflection, for instance, in a situation when there was uncertainty about whether an individual receiving care should be admitted to the hospital, but no doctor was available to discuss the situation.

After an ethical decision was made, for instance, to admit a person to the hospital, they often asked themselves "Was that the right decision?" and "How did it go?" Some of the participants said that they kept on thinking about the decision when they got home, hoping that the decision was right or wondering whether they should have handled the situation differently. Ad hoc ethical reflection commonly took place during breaks, between shifts, and after significant events. The ward nurse often joined in these ad hoc ethical reflection sessions.

Quotation illustrating 1a. and 1b.: Interviewer: What kind of situation during patient care might make you think that you should reflect together

Interviewee: For example, if there is restlessness during care—what should we do now? What is causing it? Should we implement environmental measures, or is there a need for calming medication? If the patient is in pain, we, of course, ask them, but when they are unable to respond, we have to discuss it among ourselves. But perhaps that is not ethical reflection?

Another Interviewee: Yes, it is.

Another Interviewee: The patient's well-being is the priority (First interview at the nursing home).

Speaking up and Dealing with Disagreements

The participants mentioned that colleagues frequently have different opinions and to speak up, they needed to have confidence in themselves and their colleagues. For someone to speak up, it required confidence in their observations and understanding of a situation, as well as the ability to explain and justify a position professionally (not only in terms of their feelings). Furthermore, the participants stated they required an open-minded response and follow-up after speaking up. If they encountered rejection, they would be likely to become silent in future situations. The participants emphasised that the opinion of all professional groups is equally significant, and novices' observations and opinions ought to be taken seriously.

It's tough to stand alone with an opinion—that's the risk we take. Even though discussions are usually not too big or intense, it's important to feel secure with your colleagues, to actually be able to say, You know what, I don't quite agree with you, can we talk about it a bit more? or I have a different opinion. You need to feel somewhat secure with your colleagues and yourself (first interview at the health care centre.

To unite around a common stance before having a conversation with an individual receiving care and their relatives/carers, the participants emphasised the importance of the nursing team and physician to conduct ethical reflection in advance. The team members did not necessarily need to agree, but they did need to stand united behind the decision. If health care workers and the physician held different positions when informing the person receiving care and relatives/carers, it could lead to frustration and insecurity. Additionally, the participants talked about the challenge of involving colleagues in part-time positions in collectively made decisions, explaining that if certain employees were not involved, the person receiving care and their relatives/carers might receive conflicting or ambiguous information. The participants said that, on occasion, relatives/carers to the individual receiving care were included in ethical reflection, most often when treatment goals were unclear or when there was a disagreement about treatment. Often, these reflections resemble

informational discussions more than ethical reflection, said the participants. The participants were concerned that relatives/carers participating in ethical reflection would witness conflicting opinions among health care workers and that relatives/carers would then strongly support the stance they preferred without further dialogue or through further reflection. The participants mentioned that there had been occasions on which relatives/carers strongly disagreed with the goals of treatment. Occasionally, cultural and religious issues and difficulties regarding language made it difficult to get relatives/carers to understand the situation and what were acceptable actions. If a situation is deadlocked and the conflict is persistent, there needs to be ethical reflection in a larger arena, said the participants.

> *As healthcare professionals, I believe it is crucial to engage in ethical reflection beforehand if we are uncertain before having conversations with patients and their relatives. It is better to present an united front; otherwise, it can be very confusing for the patient and their family if we provide conflicting advice and recommendations. If we are not aligned or do not share the same perspective, we need to listen to each other's opinions and try to reach a common understanding. It is important to address these differences in an ethical discussion rather than bringing them up in front of the patient* (first interview at the healthcare centre).

Creating Collaboration

Making Use of Different Perspectives

The participants claimed that they had different views of the people receiving care and their situation, because they all had different professional experiences, worked at different hours, and observed differently. Furthermore, some professionals simply had better chemistry with some individuals receiving care than with others. When performing ad hoc ethical reflection, it was possible to achieve a more comprehensive view of an individual receiving care and his or her situation than could be achieved by one single health care worker. Additionally, through ad hoc ethical reflection, health care workers gained confidence that their observations, emotions, and thoughts were valid. Through ad hoc ethical reflection they reached a deeper understanding of each other's views and learned from each other. Consequently, the individual under care received more professional sound assistance, said the participants.

> *They have worked for so many years, and it is nice to exchange experiences, then I, who have not worked for so many years but in other places, can contribute with mine [*ie*experiences] and I feel we are equal and learn from each other* (first interview at the nursing home).

The participants said that among the benefits of ad hoc ethical reflection are better insights, a more clear-eyed view of the individual receiving care, and concerns being taken more seriously. They also emphasised the importance of engaging in conversation with the individual receiving care and that sufficient time must be allocated to facilitate effective communication.

> *Some patients may require additional time to express their concerns, and it is essential to provide them with the opportunity to share their thoughts and feelings* (first interview at the nursing home).

The participants stated that health care workers actively incorporate person-centred care by involving the individual receiving care in assessments, for example, when deciding whether to transfer a person to the hospital. The assessment is more effective when a person receives care, and their careers are included along with a physician.

Making a Decision Collaboratively

Participants said that when they are in a situation that is unclear and difficult to comprehend, they take the initiative by finding a colleague and doing an ad hoc ethical reflection before deciding what to do. A discussed plan that two or more health care workers unite behind will make the health care workers more confident about whether they took the correct action in each situation.

> *It becomes a situation where one reflects on the moment, and then we make a plan* (first interview at the health care centre).

Furthermore, it is easier to follow through on a decision when everybody understands the reason that the decision was made in the first place, even if different workers have different ideas:

It is important that we agree as a workgroup how to deal with… a relative wanting us to use coercion, that we stand united in doing it the same way (second interview at the health care centre).

The participants said that both physicians and health care workers benefited from reflecting on the benefits of being together. The physician is responsible for decisions concerning treatment but may perceive a situation as difficult and needs support from the health care workers. In conversations with relatives, the physician and the health care workers can support each other.

It is usually an observation we make, or something happens to one of our patients that makes us—I feel very secure knowing that we are several people sharing the same thought and decision. Yes, you can do it alone, but it feels better when there are more of us making the decision, figuring it out. That way, we find the solution together (first interview at the health care centre).

The Challenge with Documentation

Most ethical reflections are verbal and so are not always documented in a person's journal, according to the participants:

There is often ethical reflection that takes place, but not all of it is recorded or documented (first interview at the nursing home).

If there are differences of opinion about how to approach an individual receiving care and their relatives/carers, those differences may not be documented, according to one participant. Generally, only the description of the situation and the solution is documented:

We describe the situation or observation and often mention that we consulted with someone and came up with a solution (first interview at the health care centre).

There can also be problems with a lack of continuity. To take a concrete and common example, when someone works on weekends, they usually have Monday off, with the result that the same topic may be taken up in multiple reports. To avoid such situations, some employees that have Monday off nevertheless contact the department head during their weekend to ensure that important information is not lost, said one participant.

Taking Care of Each Other

The participants said that those working in the healthcare sector can experience burnout. Health care workers often bear the brunt of professional challenges and can become frustrated, which can lead to exhaustion. When faced with ethical challenges, debriefing and reflecting on the situation, and receiving support for decisions that were made, is crucial, said the participants.

When you go home, you need to get some sleep and wake up early the next day. Therefore, reflecting on and debriefing after an ethically challenging situation can help you leave work at work and go home with a clear conscience (first interview at the health care centre).

According to the participants, these experiences and challenges in healthcare can take a personal toll, and it is essential to have a space to reflect and discuss the resulting emotions. Sharing thoughts and knowing that others have gone through similar situations can provide validation and support. It is essential to recognise that others may be experiencing similar challenges and may have valuable ideas about how to cope:

It [ethical reflection] allows us to care for each other better and find healthier ways to navigate the challenges we face in the healthcare field (second interview at the health care centre).

There are experiences that can affect you - you can feel sad sometimes because it feels personal. In those moments, it's good to talk about it and maybe hear that someone else has been through the same thing. That's often what we bring up - the cases that are difficult for us, where we are unsure how to handle them. And just being able to talk to others about it can be helpful in itself - to get support and hear that others also find it challenging (second interview at the health care centre).

Discussion

The aim of the study was to explore experiences related to ad hoc ethical reflection and how ethical reflection might be structured. When health care workers become aware that a situation is ethically challenging, which are typically characterised by complexity and conflicting values, they take the initiative to conduct ethical reflection. In this ad hoc ethical reflection, they use different perspectives and make decisions collectively. Additionally, doing ethical reflection appears to help the workers take care of each other.

The results showed that participants regularly experienced difficult and uncertain situations, and that the starting points for ad hoc ethical reflection were situations of uncertainty about what to do and what was right to do. Moral sensitivity has been shown to be important in healthcare for recognising personal vulnerability and ethical issues.[6] The results in this study showed that the impetus to stop and think about the situation over is related to concern about right or wrong decisions or actions. Feelings reveal values,[23] and our results indicate that the most important value for health care workers is that the individual receiving care is cared for properly. The participants said that it could be hard to achieve agreement and reach ethically sound decisions when cultural and religious issues were involved. Participants also admitted to acting against their own beliefs on certain occasions. In the context of assisted living, when values and goals may vary among stakeholders and levels of a care organisation, it is not surprising that people experience difficult ethical situations.[2]

When in difficult or uncertain situations, the participants took the initiative to reflect together with a colleague to help reach a sound decision. Even though uncertainty about what constitutes ethical reflection, the results demonstrated that ethical reflection occasionally is a part of clinical decision-making and problem solving. Recent research indicates that planned ethical reflection in the context of municipal home nursing care contributes to collaborative decision-making.[24] Furthermore, it has been shown that ethical reasoning can be successfully integrated into clinical decision-making, using both ethical principles and the narratives of the person and the relatives/carers.[12] The results indicated that not everybody is aware of the structure inherent in the 6-steps model for ethical deliberation in health and care services,[18] which includes articulating the ethical problem, investigating what is at stake for the involved persons and values related to the concrete situation and the individual. When the participants do not consider the relevant values and what is at stake for the individuals involved, the reflection does not resemble ethical reflection. Conversely, the results indicated that ad hoc ethical reflection tends to be intuitive in nature, with values operating partly as tacit knowledge. The results indicated that the structure of ad hoc ethical reflection is shaped by two key components: problem-solving and consensus-building while also addressing, to some extent, the values involved. Furthermore, the results showed that a structure shaped by problem-solving and consensus-building are mirrored in how the ethical reflection is documented.

As opposed to planned ethical reflection, the ad hoc ethical reflection to some extent is performed under time pressure, and it is not guided by a competent facilitator. It seems reasonable to contend that these factors may weaken the value of ad hoc ethical reflection.

The results indicated that the needs of individuals were emphasised in ad hoc ethical reflections. Having a person-centred focus in these ethical reflections can enhance individualised care by focusing on individual needs, preferences, and experiences.[14] Balancing the need to respect individuals' choices and preferences against the need to follow clinical recommendations and best practice standards can seem easy when issues are discussed; however, the resulting decisions that get made can be considerably more difficult to put into practice.

Because most ethical reflections are verbal, they are rarely documented in a person's medical journal, and it is often not considered necessary to document the ethical reflections that lie behind any given implemented measure. A literature review of nurses' experiences of ethical dilemmas shows that today's healthcare systems are infused by busyness and concerns for efficiency.[25] Working a heavy load under time constraints can result in health care workers not having sufficient time to document ephemeral instances like ethical reflections in the medical record. However, if these reflections are not documented, the assessments underlying health care workers' choices are invisible.[26] There is a risk that the arguments that were central to the individual assessments made by the health care workers will be lost or forgotten and that subsequent health care workers, who were not part of the original ethical evaluations, will not be aware of the basis for the decisions made. Consequently, there is a risk that interventions will be implemented without being

tailored to the individual. Furthermore, it seems reasonable to suggest that leaders should focus on documenting assessments underlying clinical decisions and to suggest that documentation practice should be implemented in competence building programs.

Ethical issues and disagreements are unavoidable in healthcare, which can lead to destructive outcomes including moral distress and staff burnout.[15,27] Our results showed that, by discussing issues with each other, staff can bring out different perspectives and learn to handle disagreements. Not only can health care workers achieve a unified approach to individual care by reflecting ethical issues with each other but such reflections can foster a culture of continuous learning and improvement within the nursing home setting. Maintaining social integrity can be challenging due to time constraints and staffing shortages,[15] but clinical practice with evidence-based guidelines and personal values can lead to professional growth and improved outcomes.[14]

It was clear in our study that, through ad hoc ethical reflection, the participants learned about each other's perspectives, which subsequently contributed to a better understanding of the situation and the individuals involved in each situation. This observation is in line with de Snoo-Trimp et al,[3] which pointed to similar outcomes in the context of planned ethical reflection in a group. In that study, co-workers became more aware of each other's perspectives through ethical reflection and came closer to what was most important for the people receiving care and what contributed most to their quality of life. In other words, quality of care was indirectly improved through ethical reflection. Our results also showed that colleagues united behind a decision after ethical reflection because they understood the rationale for the decision. Other research has shown that, when no ethical reflection had been undertaken, health care workers had less understanding of the decision related to the ethical uncertain situation.[10] Consequently, it seems reasonable to claim that ethical reflection contributes to better cooperation, increased trust, feelings of being supported among colleagues, and a team-based approach to ethical uncertainties.[3] Additionally, our results showed that trust among colleagues is a prerequisite for speaking up and speaking against other viewpoints, and it seems reasonable to think that shared ethical reflection contributes to increased trust among colleagues. Furthermore, supportive colleagues foster empowerment and enhance healthcare workers' ability to deliver care that meets patients' needs.[28]

Our results suggested that it is important to reach a common stance through ethical reflection. If this was not done, there would be a risk of individuals and relatives/carers receiving poorly thought out and conflicting information from different health care workers. Prior research has indicated that ethical reflection helps workers reach a common view of quality and significant goals in care, and staff develop a shared language about care.[9] It has been suggested that a health care worker having ethical reflection together with a physician might broaden the understanding of the situation and the person receiving care beyond the medical perspective.[10] Furthermore, ethical reflection prevents automated, possibly harmful actions in care such as unthinkingly following routines without considering whether the action contributes to quality of life and the person's integrity.[1]

It has been previously shown that an individual receiving care and relatives/carers may experience stress when talking about sensitive matters, and health care workers could be reluctant to include the individual receiving care and relatives/carers for that reason.[10] Similarly, in our study, participants were reluctant to include relatives/carers in any ethical reflection because they feared that relatives/carers had limited capacity to engage in dialogue and generally stuck to their preferred stance. This result conflicts with previous research that has shown that including relatives/carers in an ethical reflection may be successful (but only if the facilitator of the reflection is competent and able to recognise and balance different viewpoints).[3] It seems reasonable to think that performing ethical reflection with the intention to achieve a team-based solution, but without including or informing relatives/carers, may harm trust between staff and relatives/carers. At the same time, our results also showed that some participants had experienced that person-centred care was better when the person and individuals familiar with the person were included in decision-making. This agrees with other prior research that has shown that, in the context of end-of-life decision making, the individual receiving care, relatives/carers and health care workers are partners in the process of decision making.[29]

Strengths and Limitations of the Study

The ward leaders contacted the relevant interview participants face-to-face. Face-to-face contact by ward leaders can enhance trust and boost participation, allowing for immediate question clarification. However, it may risk coercion, as participants might feel pressured to comply, potentially biasing the sample and affecting response authenticity.

Interview groups of 3–4 people can be considered small. However, this type of qualitative method does not require large numbers of participants, instead relying on the collection of rich data.[30] Furthermore, the groups demonstrated a high level of efficacy in eliciting comprehensive and detailed data during the interviews.

We consider it a strength that, in order to avoid misunderstandings during the interviews, we occasionally verified our interpretations with the participants.

Conclusion

This study sheds light on how health care workers use and experience ad hoc ethical reflection during the workday and how ethical reflection might be structured. When health care workers experience ethical uncertainty and ethical issues, the study indicates that they take the initiative to reflect together. The study also indicates that when health care workers articulate the ethical problem, they include different perspectives and values at stake in their reflection. Furthermore, the study indicates that these reflections help to increase trust among colleagues and make it easier to speak up and deal with disagreements. Moreover, the study indicates that reflections might contribute to better cooperation between colleagues and professionals from other disciplines, and the reflections might promote taking care of each other after challenging incidents. The study indicates that the structure of ad hoc ethical reflection is shaped by problem-solving and consensus-building while also addressing, to some extent, the values involved.

The study suggests that it is beneficial to ethical reflection in everyday reflection and clinical decision making. Moreover, the study identifies a need to implement practices of ad hoc ethical reflection through training programs, such as simulation training. Further research, preferably using an observational method, might yield more knowledge about how ad hoc ethical reflection is performed, and how the conclusions of the reflection are implemented. Furthermore, how the structure inherent the 6-steps model might be beneficial for ad hoc ethical reflection, and additionally, prerequisites for implementing the structure of the 6-steps model in ad hoc ethical reflection. Lastly, further research should focus on participation of the person receiving care and relatives/carers in ad hoc ethical reflection. Contextual factors (such as workload, institutional support, culture and organisational and institutional policies) could be explored in further research; how these factors interact with ad hoc ethical reflection and shape professionals' decisions.

Data Sharing Statement

The data are available upon request to the first author to maintain the confidentiality and anonymity of the health care workers taking part in the study.

Public Involvement Statement

There was no public involvement in any aspect of this research.

Institutional Review Board Statement

This study was conducted in accordance with the Declaration of Helsinki[31] and approved by The Norwegian Agency for Shared Services in Education and Research (SIKT) October 21. 2022, registration number 461057.

Informed Consent Statement

The participants were informed verbally and given written information about the study purpose, confidentiality, and voluntariness. The participants were informed that it was possible to withdraw consent to participate. Furthermore, the researchers who conducted the interviews do not have any relation to the interviewees and it should not be any reason to expect power imbalance. Written consent was obtained from all subjects involved in this study.

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Author Contributions

All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

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Disclosure

The authors report no conflicts of interest in this work.

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