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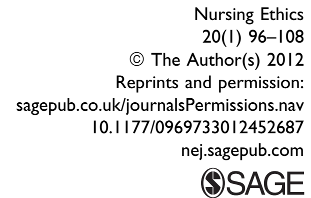

Ethical challenges and how to develop ethics support in primary health care

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Abstract

Ethics support in primary health care has been sparser than in hospitals, the need for ethics support is probably no less. We have, however, limited knowledge about how to develop ethics support that responds to primary health-care workers' needs. In this article, we present a survey with a mixture of closed- and open-ended questions concerning: How frequent and how distressed various types of ethical challenges make the primary health-care workers feel, how important they think it is to deal with these challenges better and what kind of ethics support they want. Five primary health-care institutions participated. Ethical challenges seem to be prominent and common. Most frequently, the participants experienced ethical challenges related to scarce resources and lack of knowledge and skills. Furthermore, ethical challenges related to communication and decision making were common. The participants welcomed ethics support responding to their challenges and being integrated in their daily practices.

Keywords

Ethical challenges, ethics support, primary health care

Introduction

Ethical challenges are prevalent in health-care services, and there is a growing interest in the field of health-care ethics. Clinical ethics support has been established in the United States, Canada, Australia and in quite a few European countries over the last decades, for example, through ethics committees, smaller teams, ethics consultants or moral deliberation groups.[1–8] Ethics support services often include ethics education for the employees, the development of policies and guidelines and case consultation or deliberation (typically when health-care professionals face specific moral dilemmas). However, the development of ethics support seems to have been much sparser in primary health-care services compared to the hospitals and more specialized medical care.[9]

Empirical studies from nursing homes and in other types of primary health-care services indicate that ethical challenges are prevalent, significant and complex and that there is a need for ethics support and structured ethical reflection.[10–15] Many nursing home patients have multiple and severe diseases, while the available resources, for example, funding and professional training, are generally more limited.[9,16] Not

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surprisingly, inadequate treatment, or not being able to attend to and care for the patient in a proper way due to lack of resources, is reported as one of the most prominent ethical challenges in nursing homes and home care services.[9,11,16] Reduced decision-making capacity represents another central ethical challenge to clinicians' attempt to respect the patients' autonomy,[9,17] and various kinds of restraints are frequently used in nursing homes.[18] Finally, end-of-life care represents many prominent ethical challenges and sometimes conflicts.[11,19] Informal discussions among colleagues seem to be the primary way clinicians solve ethical challenges in their everyday practice.[9]

Thus, there seems to be a great need to develop ethical competency and to deal more systematically with ethical challenges also in primary health care. However, to adequately meet this need, to reach out to those most affected by the ethical challenges and to make an impact on the health care provided, what should we do and how should we do it?

Recent literature reviews indicate that quite a few empirical studies have been published on ethics in primary health care.[9,10,13] However, most previous studies focus on selected issues (e.g. autonomy) or selected informants (e.g. nurses) within a particular context (e.g. nursing homes or end-of-life care). Furthermore, there is a lack of systematic evaluation of the various measures taken to deal more systematically with ethical challenges in primary health care. Thus, there is a need for further research to implement ethics support and systematic reflection on a broader basis in primary health care, both concerning what the most prominent ethical challenges are and how to deal with such challenges.

In Norway, specialized health services are provided in hospitals (including in-patient and out-patient departments), organized as health trusts. Local and less specialized health and welfare services are municipal health services, such as nursing homes, home care and residential settings for persons with learning disabilities. Norway has a population of about 5 million people. The country is divided into 435 municipalities. There are 4 regional health authorities and 23 health trusts. This article presents the results from a study on ethical challenges and the need for ethics support, in which all types of employees working in various types of primary health-care services in a Norwegian municipality participated with their own opinions and experiences.

Methods

In 2007, we were asked to assist one urban municipality located in the South-Eastern part of Norway in developing ethics support services for two nursing homes, two home care units and one residential care home for people with learning disabilities.

We knew that there were many distressing ethical challenges the health-care workers were facing and that there was a need to do something about this. However, we also knew that many clinical ethics support services in the hospitals report that they are relatively rarely used in specific cases and struggle to become visible and integrated in the hospital.[1,7,20–22] Thus, we wondered, could there be other or supplementary ways to develop ethics support and competency? To avoid developing ethics support that did not respond to the employees' needs and that was too far removed from their practices, we wanted to include all the employees and to answer some of the following basic questions:

1. How frequent and prominent are various types of ethical challenges in primary health care?
2. How important do the primary health-care workers think it is to deal better with these challenges and what kind of ethics support do they want?

Since there were several hundred employees to be included, we decided to answer these questions through a survey, using a questionnaire. However, due to the nature of the questions and the topic (ethics) to be studied, we considered a mixture of open-ended and closed-ended questions to be most fruitful. Although there are various previous empirical studies exploring similar questions through questionnaires, validated questionnaires are lacking and most questionnaires have been developed for different or narrower purposes.

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Thus, we decided to develop a new questionnaire for this study, while using already developed questionnaires as an inspiration. Furthermore, we conducted two focus group interviews in the participating primary health-care services; one group interview with directors and leaders/management, and the other group interview with key members of the staff whom we knew had a special interest in ethics. The dialogue of these two groups, focusing on the participants' experiences, thoughts and views on ethics, ethical challenges and the need for ethics support, was valuable in the development of the questionnaire used in this study.

A preliminary version of the questionnaire was discussed and modified in collaboration with other researchers in the field, to assess face validity. Then, a pilot survey consisting of a total of 25 employees, 5 from each of the 5 participating health-care services, was carried out. Their answers indicated that the questionnaire was understandable for the participants, and the pilot testing led to only minor changes in the questionnaire. For example, in the pilot questionnaire, at the end of Question 1, there was an open-ended question asking if the participants had other ethical challenges than what was listed through the closed-ended questions. Yet, none of the participants in the pilot study reported that they had other ethical challenges. Furthermore, the following questions (Questions 2 and 3) also gave the participants the possibility to describe any ethical challenges in their own words. Thus, the question at the end of Question 1 was removed.

The developed questionnaire included the following three main areas (an English version of the questionnaire available on request):

1. Ethical challenges in the respondents' work day (Questions 1–4), types, frequency and how distressed the ethical challenges make the respondents feel. The participants were asked to answer closed-ended questions with various response options (Question 1), to describe (in their own words) situations they had experienced as ethically challenging and to describe the most difficult ethical challenges in their work day. Furthermore, they were asked to assess the extent to which these challenges were experienced as a burden in their work day.
2. An assessment of how these challenges are dealt with, and the respondents' skills to classify, think through, discuss and deal with ethical challenges (closed-ended questions; Questions 5–7).
3. How important the respondents think it is to deal more systematically with ethical challenges and to increase knowledge and skills in ethics, and how this should be done (both closed-ended and open-ended questions; Questions 8 and 9).

Finally, we also asked for some general information about the respondents (age, gender, profession, etc.; Question 10).

When studying ethical challenges, a methodological challenge is that there is no universally accepted definition of 'ethics' or 'ethical challenges'. At the same time, most, if not all, health-care employees have some pre-understanding of what ethics and moral dilemmas are. However, our experience with ethics-teaching and research in health care is that this pre-understanding is often implicit and that it may vary considerably. This also seems to be the case among 'experts' on health-care ethics. Nevertheless, how ethics is defined can influence the results of this kind of study and be of importance when deciding what the tasks of ethics support services should be, how such services should function and in deciding what ethical competence and expertise are.[23]

In this study, we decided not to choose one theory or definition of ethics and rather asked the respondents to describe ethical challenges in their own words so as to avoid defining ethics in advance and thereby excluding the participants' views on what ethical challenges are. Furthermore, we attempted to formulate the closed-ended question in a similar way to how health-care personnel often express their ethical challenges (as expressed in previous research and the focus groups) rather than using more academic or theoretical ways of describing or defining ethical challenges. However, to give the participants some idea in

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advance of what we wanted to study, and to avoid confusion, we included the following description of the purpose of the study and of 'ethical challenges' in the invitation letter that was given to the participants along with the questionnaire:

> An important aim of this project is to strengthen the employees' and leaders' abilities to reflect upon and deal with ethical challenges in their work day. Ethical challenges may arise when we cannot do what we think ought to be done, or when there is doubt or disagreement about what is right or wrong.

Participants

The participants included health-care workers, nursing assistants, auxiliary nurses, care workers, laundry workers, doctors, kitchen staff, mercantile staff, nurses, physiotherapists, service managers, social educators and social workers, as well as department managers. All employees within the participating health-care service sites (two nursing homes, two home care units and one residential care home for people with learning disability) were invited to participate in this study, including permanent as well as hired staff. No exclusion criteria were used. In total, 323 questionnaires were distributed.

Data collections

In June and July 2008, the questionnaire was distributed to the participants within the five health-care services participating in this study. Questionnaires were distributed during staff meetings or delivered to the employees by the local project collaborators. Survey return as well as reminder of questionnaire submission was used. In September 2008, data collection was completed.

Ethical considerations

In the invitation letter and orally when possible, all participants were informed that participation was voluntary. The questionnaires were returned to the researchers in sealed envelopes, and confidentiality and anonymity were ensured.

Approval for the study was obtained from the Norwegian Social Science Data Services (NSD). NSD is the Data Protection Official for Research for all the Norwegian universities, university colleges and several hospitals and research institutes. This means that the Data Inspectorate has delegated part of its responsibility to NSD in relation to the Personal Data Act and Health Register Act.

The Regional Research Ethics Committee in Norway must pre-approve medical and health science research projects, general and thematic research biobanks and exemptions from the duty of confidentiality for any other type of research. Since we did not collect any identifiable patient information, and all the participants were health-care personnel and not patients, the study was exempted from the Regional Research Ethics Committee requirement of study's pre-approval.

Analyses

The results from the survey are mainly described by descriptive statistics. To compare the answers from various groups of respondents, we used cross tabs and chi-square tests. The following groups of respondents were compared: Those working closer to the patient (nursing assistant, auxiliary nurse, care worker/health-care worker, doctor, nurse, department manager/middle manager, occupational therapist/physiotherapist, social worker and social educator) versus those working further away from the patient (service manager, mercantile staff, cleaner/laundry worker and kitchen staff). Furthermore, the biggest professional groups were compared (nurses vs. auxiliary nurses and nursing assistants); the latter two groups were clustered.

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SPSS, version 16, was used to do the statistical analyses. Data from the pilot study are included in the analysed material. In the presentation of the responses, some of the response options are clustered, for instance 'daily' and 'weekly' are clustered to 'frequently', while 'less often' and 'never' are clustered to 'less than weekly'. Furthermore, some of the questions and answers were largely overlapping (Questions 1j and 1l and Questions 1i and 1k). Thus, the responses to these questions are also clustered in the presentation. In the clustering and recoding of the answers on these overlapping questions (i.e. Questions 1j and 1l and Questions 1i and 1k), we did the following: If a respondent answered 'frequently' to at least one of these questions, the clustered answer was coded as 'frequently'. If the respondent answered 'less than weekly' on one of these questions and not relevant to the other questions, the clustered answer was coded as 'less than weekly'.

A qualitative content analysis was used to analyse the respondents' answers to the open-ended questions. The process included interpretations, extracting meaningful units, condensation and creating themes and subthemes. To avoid haphazard interpretations, both authors first analysed the qualitative material on their own and then discussed what the most adequate themes and subthemes were and how to group the various meaningful units according to these themes.[24] In the process of naming the themes, emphasis was on preserving the content of the respondents' descriptions. Many of the respondents answered quite similarly to two of the open-ended questions (i.e. Questions 2 and 3), and many others answered only one of these questions. Thus, the answers on these two questions were clustered and analysed together.

Results

In total, 159 of 323 questionnaires were returned (response rate: 49%).

How frequent and prominent are various types of ethical challenges in primary health care?

Eighty-two per cent of the respondents reported that they frequently (i.e. daily or weekly) experience at least one of the ethical challenges listed in the questionnaire in their work. Ethical challenges associated with inadequate attention to the patients' needs for social contact, physical activity or self-expression and ethical challenges related to information, communication and shared decision making were experienced most frequently (see Table 1). Ethical challenges related to different cultures, use of coercion, confidentiality, palliative treatment and life-prolonging treatment were experienced less frequently.

Those working closest to the patient generally experienced the various ethical challenges more often than those working further away from the patient (see Table 2). The differences between the largest professional groups, nurses versus auxiliary nurses and nursing assistants (the latter two groups were clustered), were smaller (see Table 3). However, when looking at ethical challenges related to unsatisfactory care, the nurses tended to experience these kinds of ethical dilemmas more often. No significant differences were found when comparing health-care workers in institutions and home care services.

When asked to describe the most difficult ethical challenges in their own words, the most frequent challenges reappeared as important main themes (lack of resources and undermining of professional responsibility). In Table 4, condensed examples of common answers are presented according to main themes and subthemes. Coercion and end-of-life ethics also appeared to represent particular ethical challenges for many of the respondents. Many of the described ethical challenges indicate that the staff, the patients and the relatives are faced with very serious and complex ethical challenges. Some of the situations described may also represent violation of the law, such as illegal use of coercion due to lack of resources.

The majority of the respondents (65%) experience ethical challenges as a strain in their working day to some degree or to a large/very large degree. Those working closer to the patient and the nurses

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Table 1. Ethical challenges in the respondents' work day ($N = 148–155$).

How often in your work day do you experience ethical challenges or conflicts associated with:	Frequently (%)	Less than weekly (%)	Not relevant (%)
Patients' needs for social contact, physical activity or self-expression are not adequately met (Questions 1j and 1l)	62	36	2
Information and communication with patients and relatives (Question 1a)	53	41	5
How many patients and relatives should decide (Question 1b)	53	38	9
Being unable to carry out your job in a satisfactory way (Question 1h)	48	50	2
Patients receiving unsatisfactory health care (lack of care, psychological support/treatment, rehabilitation or palliative treatment) (Questions 1i and 1k)	46	49	5
Different cultures, religions or philosophies of life (Question 1g)	27	68	5
Professional secrecy and the duty of confidentiality (Question 1d)	27	60	13
Use of coercion (Question 1c)	25	62	13
Unsatisfactory palliative treatment (Question 1f)	24	56	20
Withdrawing or initiating life-prolonging treatment (Question 1e)	23	60	18

Table 2. Working closer to the patient – percentage of respondents who answer 'frequently' ($N = 134–141$).

	Further away from the patient (%)	Closer to the patient (%)	p value[a]
Patients' needs for social contact, physical activity or self-expression are not adequately met (Questions 1j and 1l)	43	65	0.06
Information and communication with patients and relatives (Question 1a)	32	58	0.02[b]
How many patients and relatives should decide (Question 1b)	32	60	0.01[b]
Being unable to carry out your job in a satisfactory way (Question 1h)	27	51	0.04[b]
Patients receiving unsatisfactory health care (lack of care, psychological support/treatment, rehabilitation or palliative treatment) (Questions 1i and 1k)	14	51	0.00[b]
Different cultures, religions or philosophies of life (Question 1g)	27	29	0.90
Professional secrecy and the duty of confidentiality (Question 1d)	5	32	0.01[b]
Use of coercion (Question 1c)	14	29	0.13
Unsatisfactory palliative treatment (Question 1f)	5	30	0.02[b]
Withdrawing or initiating life-prolonging treatment (Question 1e)	5	26	0.03[b]

[a]For the 2×2 tables (chi-square tests).
[b]Statistically significant difference (< 0.05).

experienced the ethical challenges as more burdensome ($p = 0.017$ and 0.063, respectively (chi-square test)).

How are ethical challenges dealt with?

Informal discussions among colleagues are the most common way of dealing with ethical challenges (86% answer that this 'fits well' or 'to some degree'). Also various types of regular meetings in the units are used to discuss these kinds of challenges (74% answer that this 'fits well' or 'to some degree'). However, quite a few respondents also report that ethical challenges are often not discussed, left to the individual or that their opinion has little importance (58%, 65% and 51%, respectively, answer that this 'fits well' or 'to some degree').

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Table 3. The largest professional groups – percentage of respondents who answered 'frequently' ($N = 85–91$).

	Nursing assistant and auxiliary nurses (%)	Nurses (%)	p value[a]
Patients' needs for social contact, physical activity or self-expression are not adequately met (Questions 1j and 1l)	62	79	0.13
Information and communication with patients and relatives (Question 1a)	55	68	0.28
How many patients and relatives should decide (Question 1b)	62	60	0.87
Being unable to carry out your job in a satisfactory way (Question 1h)	42	72	0.011[b]
Patients receiving unsatisfactory health care (lack of care, psychological support/ treatment, rehabilitation or palliative treatment) (Questions 1i and 1k)	48	67	0.13
Different cultures, religions or philosophies of life (Question 1g)	21	44	0.03[b]
Professional secrecy and the duty of confidentiality (Question 1d)	33	24	0.39
Use of coercion (Question 1c)	29	36	0.53
Unsatisfactory palliative treatment (Question 1f)	24	54	0.01[b]
Withdrawing or initiating life-prolonging treatment (Question 1e)	23	33	0.35

[a]For the 2×2 tables (chi-square tests).
[b]Statistically significant difference (<0.05).

Table 4. Ethical challenges (main themes and subthemes and condensed examples).

Resources and professional responsibility	Patient autonomy, privacy and the role of relatives	Coercion	End of life
1. Lack of time and staff Having to downgrade the users' opportunities to go outside and have some fresh air due to workforce shortage When users are forgotten When the user receives inadequate assistance due to resource problems 2. Lack of competence Too much responsibility for unskilled workers When there is a predominance of foreigners on extra shifts Misunderstandings in the patient's reports may harm the patient	1. Patient autonomy Can we decide how much the user is allowed to eat in order to prevent obesity? 2. Lack of capacity When the patient lacks mental capacity, who should then decide, us or the patient's relatives? 3. Privacy When we talk privately with the patient and others can listen 4. The role of relatives When relatives decide without awareness of/ regard to the user's needs	1. Forced feeding Giving a drink with the drug/medication when he will not open his mouth 2. Forced care When a patient resists personal hygiene and we use force to do it 3. Forced medication We crush and mix drugs in the jam and put on their sandwich when the patients do not take drugs 4. Preventing free mobility Patients are tied to their chair to prevent falls, when staff is lacking	1. Treatment intensity How much should you treat? 2. Disagreements When relatives want treatment not beneficial to the patient When relatives want the doctor to give antibiotics and other medication to the patient even when the patient refuses treatment How much treatment should be initiated? What is the patient's desire? Is it right to give antibiotics when the patient is dying?

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Table 5. How to handle ethical challenges and increase ethical competence.

	Yes (%)	No (%)	Uncertain (%)
Someone who can give guidance:	76	12	13
A colleague with skills in ethics	66	20	14
An ethics committee	57	19	24
A lawyer	29	42	29
Meeting place for systematic ethics discussions	64	15	21
More time for ethical discussion	63	16	21
Ethical guidelines	59	16	25
Internet-based teaching	24	45	31

How important is it to deal with ethical challenges better and how should this be done?

Nearly, all of the respondents think it is significant to work more systematically with ethical challenges and to increase the ethical competence of their workplace (94% when clustering 'very important' (66%) and 'quite important' (28%)). A large majority of the respondents (89%) think that all members of the staff should increase their ethical competence. Furthermore, most of the respondents want more time for ethical discussions and meeting places where ethical challenges can be discussed systematically (e.g. reflection groups or ethics committees) (see Table 5). Management and key members of the staff are regarded to be important target groups for ethics training by most of the participants (84% and 80%, respectively), and most of the staff members want the possibility to seek advice when needed from a colleague with skills in ethics or from an ethics committee (see Table 5).

When asked about what the content of ethics education should be (open-ended question), the answers indicate that the respondents most of all would like to have ethics training that gives them an opportunity to reflect on, and discuss more systematically, specific ethical challenges emerging in their working day. Second, they want the possibility to discuss more general ethical challenges such as the following:

- How to handle end-of-life care situations
- The relationships with patients and their families
- How to manage the relationship with frail elderly patients when the question of autonomy and the risk of coercion is apparent (e.g. care and personal hygiene, medical treatment and setting limits when the patient has reduced decision-making capacity).

As shown in Table 5, ethical guidelines are also wanted by most of the respondents. When asked what kind of guidelines they wanted (open-ended question), the answers indicate that the staff members want guidelines that can be helpful in dealing with specific ethical challenges rather than more general guidelines or value documents.

Discussion

The purpose of this study was threefold: First, to identify the frequency of ethical challenges and how distressed the various types of ethical challenges make the primary health-care workers feel; second, how

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important health-care workers in primary health care think it is to deal better with these challenges; and third, what kind of ethics support they want. The findings in the present study show that health-care workers in primary care frequently experience varied and complex ethical challenges in their work. The way these specific challenges are dealt with by health-care workers means a lot not only to patients, next of kin and colleagues but also to the staff themselves. This is in accordance with other studies.[9,11] Furthermore, those working closer to the patients generally experience these ethical dilemmas more often and as more burdensome than those working further away from the patients. These kinds of variations are also supported by earlier research in nursing homes and other health-care facilities.[11,16,25] Interestingly, the nurses experienced ethical challenges related to unsatisfactory care more often and also reported the ethical challenges to be more burdensome than the other large professional groups working closest to the patient. This may be related to their level of education and knowledge, that is, experiencing something as unsatisfactory, and more generally experiencing moral distress, may be related to the level of competence of health-care workers. If this is the case, one may argue that a certain level of competence and moral distress is probably unavoidable in assuring a satisfactory level of care and that a lack of perceived ethical challenges among staff is in itself no proof of good care. However, further research is needed to explore these findings and their possible relations and explanations.

Among the most prominent of this study's findings is the fact that many of the most frequently experienced ethical challenges are not given much notice in traditional medical and health science ethics and are not even regarded as ethics by many. Two important examples are the frequently reported ethical challenges related to communication, and the ethical challenges employees experience when not being able to do their job properly due to lack of resources, for example, being short on staff, and insufficient knowledge and competence. Not only does it lead to a reduced quality of the work, as reported by the staff, but it also leads to mistakes being made and to illegal use of coercion against the patients. Some might argue that this is a matter of priorities, but traditional theories and ethics of priority settings (for instance, accountability for reasonableness or the Norwegian criteria for priority: seriousness, usefulness and cost efficiency) are likely to be of lesser relevance in handling the challenges resulting from the limited resources.

Perhaps, most of all, it is a matter of how to do a good job and retain motivation, meaning and professional integrity, as well as relations to users, next of kin and colleagues, within the given framework conditions. In regard to the relatively ample resources available in Norwegian primary health care, and perhaps especially in the region the study took place, this may seem paradoxical. If instead, it is seen in relation to the fact that possibilities increase, more than the finances allow, it is less surprising. Nor is it hard to understand that communication and information often become ethically challenging if one feels that there is no time for more than the bare minimum, or if the staff frequently offer help of a lesser quality than they would like.

In the staff member's own descriptions of especially difficult ethical challenges met in their work day, we see the prominence of the more traditional ethical challenges, for instance, ethics at the end of life and the use of coercion. This coincides with earlier studies,[11] which show that even if these are not the most frequently experienced ethical challenges, they are some of the most challenging. The questions of intensity of treatment and the timing of ending life-prolonging treatment are central. In addition, next of kind's role, participation specifically tied to end-of-life circumstances and more generally, is seen as an ethically challenging question in this study as well.

The staff member's description of ethical challenges caused by lacking resources is worrisome, especially considering the fact that the study was carried out in a municipality that has more resources than most others. Compared to the other municipalities in Norway, this one has a higher percentage of college-trained staff members and a lower percentage of unskilled staff members. The numbers indicate that staff members in Norway's other municipalities are unlikely to experience this less than the participants in this study. The staff member's descriptions of ethical challenges contain everything from unfortunate to incompetent

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communication, for instance in relation to persons with dementia, forced feeding, forced medicating and forced care of patients who resist. Due to lack of time or lack of competence, alternative solutions are not tried. In the busy work day, attending to the patient's primary needs is prioritized, even when the patient objects.

The staff members see improvement of the methods for handling ethical challenges as vital. In accordance with other studies,[9] informal conversations between staff members are the most common way of dealing with the ethical challenges of the work day. This is seen as unsatisfactory, and the staff sees the need for increased ethical competency. A prominent finding in this regard is that increased ethical competency is wanted for *all* the employees, also for management.

It is in the close face-to-face relations that the ethical challenges are most prominent, and therefore, perhaps, the staff member's specification of the need for increased ethical competency for all can be explained as an acknowledgement that their own ethical competency is too fragile to properly handle patients with severe needs and their next of kin. In addition to increased competency, the participants point to the need for time and a place where staff can discuss ethical dilemmas. In Norway, it is a fact that many of the traditional arenas for discussion are removed for efficiency reasons. For example, collegial meetings where the nursing home staff members can discuss the patients' problems together are substituted with the individual responsibility of staff members to learn about the patients alone. Instead of an interdisciplinary meeting where care and treatment of the individual patient are discussed, each health-care worker has the individual responsibility to get acquainted with the written documentation available about each patient. Many health-care workers describe ethics as an integrated part of their profession and of their work day, it is in the conversations about the practice that ethics are reflected. When the arenas for conversations about the practice disappear, the room for ethical reflection is reduced to an individual responsibility. The findings of this study point to a need to reinstate natural interdisciplinary arenas for discussion. One way to do this is by creating reflection groups that systematically discuss ethical challenges. This study, however, suggests that it is not enough to give the staff members the time and the opportunity to reflect on ethical challenges. The reflection seemingly needs to be close to practice, grounded in specific problems, offer new and better solutions, be feasible to carry out during the work day and involve everyone.[26]

In their wish for ethics support, the participants point to a colleague with ethical competency, not to an external ethics consultant. This finding seems to be in accordance with the other findings; the ethical challenges are an integrated part of the staff's work day, and it is there they feel the need for a boost. Perhaps, a colleague with ethical competency can be the one to lead the ethical reflection that the staff wish for in their work day. This finding seems to oppose a move towards using ethics consultants or ethics experts to aid the health-care workers.

It is the situations that are close to practice, situations that are ethically challenging in one's own work day, that the staff primarily want to reflect upon, discuss and get help to see alternative ways to handle. The participants want teaching and meetings where the focus is systematic discussion of their own specific ethical challenges, and how to find alternative ways to handle these challenges. Their wishes for the content of ethics education indicate that they see ethical competency as the ability to handle specific ethical challenges in a good and systematic way. While ethical theory and general teaching are not sought by many, it seems that the health-care workers see arenas for ethical reflection as a type of collective skill development in ethics, which can help better the way ethical challenges are dealt with in practice.

The wish for Internet-based teaching is minimal and may reflect that the staff has limited access to this, but it can also indicate that they have a view of ethics as dialogue based, since arenas, time and joint discussions are requested so much. Even if this study shows that more than anything the staff wants to discuss ethical challenges with colleagues, they also want to have the option to seek advice from someone with special ethical competency in specific situations. Most of all, they want to seek out another staff member

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with more ethical competency. In the cases where the staff sees a need for external expertise, they point to the need for an ethics committee.

It is a little surprising that so many see ethics committees as a group that they want to seek advice from. Rapports from ethics committees in hospitals[7] show that they struggle with their visibility and that there is little demand for their services. Furthermore, ethics support in the form of ethics committees is still relatively unknown among staff in primary health care in Norway. When the staff still confirm the need for such a measure, it can be an essential signal that the need for ethics support is pressing and that the staff want various forms of ethics support. Perhaps, the establishment of 'close to practice' ethics measures, such as reflection groups, will lead to even more attention to ethical questions and to ethics skill development, which in turn may also increase the use of other types of ethics support, such as ethics committees. More external expertise, such as legal practitioners, are less sought after for handling ethical challenges. It is worth mentioning that while an employee of a hospital rarely has to make decisions and handle difficult situations alone, the reality in primary health care is the opposite. Few doctors and a large number of employees without specific professional training is more the rule than the exception. This is probably an important reason for the reported need for joint discussions and competency building for all staff members.

Limitations

This study did not include all kinds of primary health-care services and only a very limited number of physicians; the response rates were relatively modest, and the validation of the questionnaire could have been more extensive. Compared with other similar studies,[9] the response rate was relatively good and the breadth relatively extensive. We do not know of any formally validated questionnaires developed for this kind of study. On the other hand, the results in our study seem to be consistent with earlier studies where we asked similar questions.[14]

Conclusions

Primary health-care workers who participated in this study reported that ethical challenges occur frequently in their work days. The ethical challenges they describe are closely related to professional and organizational circumstances, with lacking resources as the most prominent, for instance lack of staff and competence. While the staff experience the ethical questions as an integrated part of their practice, others may not see this as ethics at all. Our findings show that the health-care workers' values clash with what they see themselves doing in their practice, such as hiding medication in food, tying patients to the chair or using force to clean the patient. These are the issues that are given less attention than, for example, ethical challenges related to end of life.

A large majority feel that there is a need for ethics support and development of ethics competency in primary health care, and it is emphasized that this should be offered to everyone. The need for more arenas for discussion is pointed out, where common reflection about ethical challenges of the work day could take place. There is a need to set aside time for this. What is most requested, both regarding ethics support and reflection, is that which is close to practice. In addition, a need for more external ethics support is expressed, for example, in the form of ethics committees. More general, external, specialized or theoretical approaches, approaches that do not focus on the specific or practical challenges the staff faces or that are not action-based or problem solving, are seemingly not what the staff wants.

This study suggests that the staff sees ethics competency and ethics support as closely related and that they want it as close to practice as possible. It is also apparent that regardless of which measures are taken (education, guidelines, arenas for discussion and supervision), many workers in primary health care wish to

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have the opportunity themselves to discuss and handle specific ethical challenges along with other staff members in a systematic way.

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Conflict of interest

The authors declare that there is no conflict of interest.

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