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Extending awareness of healthcare ethics at Cabrini Health: Junior clinicians' perspectives

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Introduction

Good clinical practice encompasses practitioners' attitudes, expert skills and knowledge, and is increasingly dependent on clinicians' abilities to exercise critical and reflective thought. Current complexity in clinical decision making now demands that nursing and medical staff abide by both professional codes of conduct and ethical codes to ensure good healthcare is delivered through principles of right action (Medical Board of Australia, 2014; Nursing and Midwifery Board of Australia 2002). "Ethics" however, may be interpreted through many lenses. Whilst many practitioners simply consider ethics synonymously with regulations, accountability and risk management (Jennings et al. 2007), ethical principles from religious traditions may stem from fundamentally different viewpoints. Catholic ethics for example, whilst adhering to regulatory stipulations as above, additionally asks the question of *what it is to be truly human* and as such provides practitioners with a framework within which to practice the healing art of medicine (Fisher 2012).

In Australia, one in 10 hospitalized patients are cared for by Catholic organizations, including in 21 publically and 54 privately funded hospitals and 550 aged care facilities (Catholic Health Australia 2013). Catholic healthcare also encompasses the largest group of non-profit healthcare services in the United States (Pellegrino 2004). Catholic healthcare organizations specifically regard their ministry as encompassing health preservation, restoration, and spiritual service (United States Conference of Catholic Bishops 2009). Core values encompass: "respect for human dignity, promotion of the common good, care for the poor and vulnerable, stewardship of resources, and acting on behalf of justice" (Catholic Health Association of the United States 2014, p. 5). A comparison of Catholic and secular approaches to healthcare ethics is provided in Table 1. Given that dealing with human

well-being is essentially an ethical endeavor, Catholic ethical principles should thus pervade Catholic clinical care, organizational activities, and broader community responses.

INSERT TABLE 1 HERE

Catholic healthcare organizations can however find it challenging to remain connected with the identity and integrity of core values when needing to economically survive and employ staff unfamiliar with its moral teachings (Catholic Health Australia 2001). Although articulation of an organization's identity and culture through mission and values statements helps to maintain employee cohesion, integrity and supports strategic endeavors; additional articulation of guiding moral faith-based sources and values may further "attribute conscience to an institution" (Pijnenburg et al. 2008, p. 80). As such, the Ethical and Religious Directives for Catholic Health Care Services (United States Conference of Catholic Bishops 2009) and the Code of Ethical Standards for Catholic Health and Aged Care Services (CES) (Catholic Health Australia 2001) were published in the United States and Australia respectively to guide ethical health care practices in Catholic hospital and residential aged care settings.

Despite the availability of the above documents, there are no known published studies that have evaluated awareness and use of Catholic code of ethics in Catholic organizations. This study was prompted by a clinical staff survey (n = 70) conducted by a Catholic organization in Australia, which found that 37% were not aware of the CES. We aimed to examine junior nursing and medical staff views about the CES delivered via a brief Catholic healthcare approach to ethics (CHAE) education intervention. Specifically, we sought to: examine how junior clinicians

approached healthcare ethics, understood Catholic healthcare ethical principles and considered how Catholic healthcare ethics awareness could be improved.

Methods

The study used a qualitative descriptive design with grounded theory overtones (Sandelowski 2000). The Consolidated Criteria for Reporting Qualitative Research (COREQ) were used to ensure quality of the research process (Tong et al. 2007), except data analysis was not returned for participant confirmation because, arguably, research participants' interpretations evolve and cannot be revisited (Taylor and De Vocht 2001). The core research team consisting of an experienced qualitative researcher (CO), Director of Mission (JT) and a clinician experienced in Catholic bioethics (NM) developed a framework to be used in interviews and focus groups (Table 2).

INSERT TABLE 2 HERE

Setting and Participants

The study was conducted at a private, not-for-profit Catholic healthcare service in Melbourne, Australia. The Organization serves as a clinical educational facility, annually training approximately 55 first year graduate nurses/midwives, and 24 doctors completing specialist training. Following ethical approval from X Health Human Research Ethics Committee (Number: 05-30-03-15), participants were recruited via convenience and limited purposeful sampling, ensuring diverse information to address the study aims. Graduate nursing/midwifery students, advanced medical trainees and early career consultant staff who had been employed by the Organization for a minimum of 3 months were eligible. The study was

conducted May to September 2015

Data Collection

Study explanation and participant invitations were emailed electronically and displayed in study areas. Doctors were also invited face-to-face to ensure perspectives from administrative and clinical sectors. Participation was voluntary and consent was implicitly granted through attendance and participation in interviews/focus groups (implied consent).

CO, an experienced qualitative researcher, led focus groups/interviews, with CHAE education input from JT. Brief opt-in follow-up telephone interviews conducted two months later asked participants about their ongoing views about the CHAE. Focus groups/interviews were audiotaped, transcribed and analyzed with support of ATLAS/ti (ATLAS.ti Scientific Software Development, version 7, 2012) qualitative data management software.

Data analysis

Data was inductively coded, comparable codes categorized, and comparable categories grouped into themes and statements. CO conducted initial data analysis with an inter-rater reliability strategy integrated to promote rigor. Inter-raters (JT, MS and EP) discussed data and analysis until all reached agreement with the final representation of findings.

Results

Eighteen nurses (participant numbers 1-18) and 4 doctors (participant numbers 19-22) initially participated in focus groups (n=20) and interviews (n=2), with 9 nurses and 4 doctors participating in the follow-up interviews. Most participants worked in inpatient areas and 11 nurses and one doctor had previously a completed student

rotation at X Health. Further background information is in Table 3.

INSERT TABLE 3 HERE

Data were condensed into three themes, clarified below.

Catholic Code of Ethical Standards Seldom Inform Ethical Approaches

Graduate nurses' descriptions of a clinical ethics approach emphasized patient-centered care with values based stances. This included the promotion of patients' dignity through advocacy, being respectful, non-judgmental, and confidential. They viewed good ethical practice as acknowledging and learning from mistakes, accepting patients'/families' treatment decisions even when disagreeing with them, and "providing the best care possible within your scope" (Participant 10).

Nurses believed that different ethical issues arose in different parts of the hospital and that related policies and procedures should support ethical practice.

Working ethically also:

...feels really good to do like, you know, because you don't feel like you're just there doing your medications and, you know, your dressing and stuff.

You're actually doing a service to your patients. (Participant 15)

Doctors depicted examples of ethical approaches as considering non-invasive treatment when care was futile, "doing no harm", ensuring patient autonomy, or seeking ethical consultation when needed. Three doctors described "grey areas" with no right or wrong medical decisions. One stated, "Sometimes there are a bit grey areas ... I don't think in those examples there is a true right or wrong answer" (Participant 21).

Another doctor stated that being ethical is morally and culturally based, and another stated, "I think, just constantly think of the ethics and values and just make

sure that what you are doing fits that” (Participant 21).

Nurses’ ethical approaches were mostly informed by personal and moral beliefs education, observations of others’ work practices, the Organization’s mission and Code of Conduct (presented in hospital orientation) and occasionally, university ethics. Many were often aware of the nursing code of ethics, but only two knew of the CES. One recognized the CES material but added, “We never actually looked at this book (CES)” (Participant 6).

Doctors’ ethics approaches were hardly informed by formal ethical principles, with recollections of negligible ethics training in medical schools. One said, “I remember having to do an essay as a medical student and the aim was to throw in as much ... values as possible” (Participant 21).

Doctors also struggled to recall ethical frameworks that informed their work. Three unsuccessfully tried to name the *Georgetown Mantra* (Beauchamp and Childress, 2012) of biomedical ethics. When asked if any code of ethics informed her practice, one stated, “I can’t think of any at the moment. I think there must be”, and later in the interview recalled a code of ethics for doctors (Participant 19).

Two doctors had not heard about the CES while the other two had read the CES after receiving it from Catholic healthcare colleagues. One of these doctors, however, indicated that the CES offered limited insight into appropriate practices:

I suppose there might be a lot of misassumptions out there that, you know, Catholics are against contraception or against abortion at any cost. ...

(but) there are a lot of nuances in there (CES) that, then again, I don’t fully comprehend (Participant 19).

Some doctors commented that the Organization’s/ Catholic ethics information was gained by “osmosis” or ad hoc discussions rather than formal learning. Two had

previously worked at other Catholic hospitals where senior doctors had described Catholic healthcare approaches but not the CES: “They tell us the big things, about the IVF, the contraception, the termination, those are the main principles and it’s easy for us” (Participant 22).

The other doctor only thought “the pill” distinguished Catholic to non-Catholic healthcare despite being told by senior (obstetric/gynecological) colleagues, “...it’s a Catholic hospital and, these are the values and things that we should continue to think about and make sure we abide by those” (Participant 21).

Two doctors familiar with the CES indicated the need to tailor their work to fit Catholic requirements. However, many believed there was no difference between Catholic and public hospital ethics, stating that the principle of patient-centered care transcended distinctions between these healthcare settings

Endeavoring to Master Ethical Quandaries within Remit

Nurses’ described ethical quandaries that they had been involved in or observed, including when patients and families diverged on care goals, resuscitating seriously ill patients, dealing with a Jehovah’s Witness parent who declined a blood transfusion for their child, and maintaining confidentiality of a minor patient who disclosed concerning behaviors. Some also mentioned perceptions of unethical staff behaviors. One participant remained concerned about being told by a manager during a student placement to ignore a palliative care patient’s “trouble(d) breathing” because the treatment was considered futile yet the patient had not signed a “not for resuscitation” order and his family were indecisive about his “situation”. She said, “It doesn’t sit well with me like to just walk out and pretend I didn’t see something” (Participant 6). Some questioned systemic ethical issues related to patients’ limited care options due to finite healthcare resources.

Limited examples of doctors' ethical experiences were noted. A doctor believed that patient care needed to be moral, legal, reflect collaborative staff-patient-family decision-making, and include an ethics moderator if needed. Many nurses and doctors also stated that they accepted the hospital's ethical standards, and patients', substitute decision makers', and senior managers' decisions, even when disagreeing with them, because, "many people have different views of what is acceptable" (Participant 16), and "if you work in the organization you have to... follow the rules" (Participant 22). One nurse asked. "Do we ethically support those patients or do we support the doctors knowing that that was the treatment that's going to save them even though the patient doesn't want them (sic)? So I think it's very subjective" (Participant 6).

A doctor was also concerned about determining treatment futility due to what he perceived as the Catholic ethical context of a "very fine line" between maintaining ventilation and "ending (someone's) life in suicidal way" through its withdrawal while there is a chance that the person could remain alive (Participant 22).

Participants described developing their ethical approaches through witnessing others' daily work. A nurse witnessed a doctor's "frustration" that a person from Jehovah's Witness background declined a blood transfusion, stating, "There's not much (doctors) can do even though it's the right thing, but you have to understand where the patient's coming from, ethically, patient centered care. ...I can understand the (doctor's) frustration that it is their cultural belief" (Participant 4).

Participants also described learning ethical behaviors through observing seniors, who were perceived as also "struggling" when dealing with a family who wanted futile life extending treatments for a patient. Two doctors described learning that there was a need to present arguments/reasons for a course of action to

patients/families, and to allow time for discussion and processing to reach an acceptable course of action.

In general, participants indicated they would take significant ethical concerns to supervisors/managers and contrasted this support with “not much” comparable guidance available in public hospitals.

CHAE may Improve Knowledge and Promote Confident, Respectful Practice

Participants generally found the CHAE education interesting, useful and well presented. One nurse stated that she developed a better understanding of CES nuances. Another found the CES message that “everyone has the right to flourish” affirming. One stated, however, that CHAE education did not offer sufficient information to assist specific quandaries and that additional information relevant to their areas of practice would help. One nurse and one doctor were surprised by the care principle of unity of the body and spirit.

Many participants anticipated that CHAE education would assist their confidence working in Catholic hospitals and with Catholic patients in general. Nurses imagined that the CES could be a backup to justify ways of caring to patients, family members and the team, including agency staff. Even when one does not believe in a principle/practice one can state, “As a hospital we believe this” (Participant 8). The CES could further be a resource to assist understanding/learning about how to approach specific care situations and provide supportive means “to process” difficult work situations. One stated, “If you’re faced a situation where you’re torn.... What is the best like thing for this situation or whatever? I can see myself looking at this” (Participant 7). Some nurses also valued knowing that they could approach a hospital ethics consultant to discuss ethical issues that they would feel uncomfortable discussing with a supervisor.

Doctors thought that the CES would be a good starting point for framing issues surrounding medical decisions in Catholic healthcare, and a resource to reduce fear and support confidence in medical decision making. It can also support a more considered approach when dealing with people who desire active treatment, which the doctor considers futile. One stated, “It’s always better to have some guidelines so then, you know, that you can fall back on them” (Participant 20). She also speculated that all Christian patients, “probably abide by some similar codes and principles which I will now have to think about” (Participant 20).

Two months following the study, many participants recalled feeling surprised to hear that Catholic healthcare was distinguishable from other healthcare services through the CES. Virtually all participants still thought it helpful to receive the introduction and many asserted that they could consult the CES in future if needed.

Discussion

This study characterizes views amongst clinical staff on the CES and the brief CHAE approach to ethics education. It focuses on the challenges that may arise with *implementation and integration* of CES, rather than questions about its *legitimacy*. Findings demonstrate heterogeneity among the responses of participants but a number are particularly noteworthy and discussed below.

Firstly, our findings suggest that whilst staff remain thoughtful about values based patient-centered care, they seldom consider formal ethical codes or frameworks in their daily work-lives. Furthermore, a significant number regarded the CES as barely distinguishable from good quality general healthcare. Staff though particularly affirmed the CHAE education segment and related discussions and felt supported

through knowing that decisional-based support existed, even when they held beliefs that conflicted with CES teachings such as showing solidarity in suffering and death and a respect for life at all stages (Catholic Health Australia 2001). However numerous recommendations made by participants to extend awareness of Catholic healthcare ethics were not distinguishable from those made for advancing nurses' and doctors' general ethical competence. These included development of hospital ethical policies and standards; staff ethics discussions and education; time for ethical decision-making; and support for reading ethics articles and codes (Poikkeus et al. 2014). The above responses suggest a possible lack of discernment amongst staff of what made the CES truly unique; through its emphasis on the relationship between God and human persons and on the service of life, particularly human life (Fisher 2012). Discernment in this context calls for practitioners to have within them a keenness of perceptions and sensitivities, as well as demonstrable capacity for empathy, subtlety, and imagination (Gula 1989).

The above correlates with research findings that demonstrate that physicians' and nurses' ethical approaches remains underdeveloped. In a study of American internists, 89% remembered a recent ethical dilemma, with common issues including end-of-life care, patient autonomy, justice, and conflicts among parties. The most helpful resolution strategy was speaking with another colleague (42%), however, 14% neither spoke with nor found someone helpful (Du Val et al. 2004). Alternately, nursing ethics research has focussed mostly on the process of ethical decision-making but inadequate training has been shown to limit nurses understanding and use of ethical principles (Poikkeus et al. 2014). Patient-family relationships and team work issues are cited as frequent professional ethical quandaries in research, with clinical staff demonstrating little reflection on how the use of the appropriate ethical

framework, such as the CES, can allow for the more nuanced considerations of complex interpersonal and therapeutic relationships in the workplace (Kockler 2012).

This study also recognized healthcare staff's ongoing struggles with specific clinical issues, particularly perceived treatment futility and equity in Catholic organizations. For example, staff distress related to treatment futility in palliative care supports other findings which state that nurses experience moral disequilibrium through deferring to senior staff recommendations, despite believing they are not best practice nor in patients' best interests (Krautscheid and Brown 2014). Furthermore, given ethical emphasis on just and equitable treatment (Catholic Health Australia 2001), participants suggest further ethical guidance is needed on how best to negotiate families requiring time to comprehend treatment futility whilst staff sustain high cost practices. This may be in addition to acquiescing to patient and family values, which may expect continuing treatments at any cost. In such instances, it may be appropriate for organizations to emphasize through education, the CES principles and traditional teaching on therapeutic proportionality and concepts of *ordinary and extraordinary means* (Catholic Health Australia 2001). Catholic principles recommend the use of ordinary means (the use of medicines, treatments and interventions to provide some benefit, but does not involve excessive burden, pain, or expense) to conserve lives. It is recognized that at some point, the use of medical interventions may no longer be effective and/or because the costs and burdens of such interventions are out of proportion to the life that they are intended to benefit (Congregation for the Doctrine of the Faith 1980). While extraordinary means *may be considered* in the care of a patient, there is no moral obligation to do so.

While some see the unique approach of Catholic providers as a welcome addition to healthcare, others suggest that Catholic providers are unresponsive to

current and broader community needs (Schuklenk and Smalling 2016). Additionally, some question the very acceptability of a public health provider allowing faith-based assumptions to determine their mission and ethos. However, as social and ethical mores are to some extent culturally situated and specific (MacIntyre 1988), it may be appropriate to see Catholic healthcare as an alternative perspective that can enrich our cultural understandings of what constitutes excellence in medicine and patient care (Fisher 2012).

This study reflects 22 junior clinical perspectives from only one Catholic health organization and our findings' relevance to staff in other Catholic healthcare contexts need to be considered with caution. Nonetheless, the findings highlight that the ethical challenges in clinical settings are best appreciated through eliciting the perspectives of key stakeholders. It is possible that only through the interface of Catholic organizations, Mission Directorates, and clinicians, and commitment to ongoing education and dissemination, that the appreciation of the CES can be met. Fundamentally, a more integrated approach to ethical discourse is arguably what is likely to allow patients and families to receive truthful illness information and the best possible care in all, including Catholic, healthcare contexts.

Conclusion

Decision-making processes in healthcare have traditionally considered ethical, clinical, and judicial influences. This includes specific healthcare codes of ethical standards in Catholic contexts. In recent years, Catholic healthcare organizations have integrated pluralist, societal influences and as such, a more creative and pastoral approach to dialoguing Catholic ethics is required. Our findings demonstrate that, in one Australian Catholic healthcare organization, junior clinical staff's ethical approach to care was minimally informed by the CES. They also provide early

insights into challenges that may be faced when considering implementation of religious based ethical codes across religious healthcare organizations. Although CHAE education was valued by the junior healthcare clinician participants, the findings still highlight an important conundrum regarding how best to distinguish Catholic health articulations of promoting human dignity (common good, justice, and person as composite of body and soul) from the standard secular ethical principles.

Compliance with Ethical Standards:

Funding: This study was funded by the Mary Philippa Brazill Foundation

Ethical approval: All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

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