How to succeed with ethics reflection groups in community health care? Professionals' perceptions

Introduction

Studies from community health care show that health care personnel often experience ethical challenges in their practice (1-6), and that such challenges can contribute to moral stress if they are not addressed or handled properly (7,8).

In Norway, community health care (often also termed primary health care) is performed in the municipalities, of which there are 426 as of January 2017. Community health care includes nursing homes, home-based care, sheltered housing/assisted living facilities, mental health and substance abuse care, school health services, maternal-child and adolescent health stations, and the services of primary care physicians (general practitioners) (9). This part of health care consists of many complex services that require competence in several fields as well as inter-service cooperation. The services often experience challenging situations where different values and arguments are emphasized. Some studies have demonstrated that ethics reflection has a positive role in supporting the staff in difficult decision-making processes (8-11).

Dealing with ethical challenges may take many forms, but in Norway, the most common is the use of ethics reflection groups (ERG) (9) or clinical ethics committees

(CEC). In this study we use the term ERG because in our view, the ERG can also involve the discussion of other topics, such as clinical-ethical values or other general topics. Other authors use terms like ethics case reflection (ECR) (12) or Moral case deliberation (MCD) (10,11,13). A study of doctors who had brought a case to a hospital Clinical ethics committees, showed that clinicians found it useful to discuss ethical problems, and that they appreciated the depth of the discussion (14).

A government white paper (15) suggests that municipalities ought to carry out ethics training and implement ethics reflection for health care staff, but not much is said about how to do it.

From 2007 to 2015, 243 municipalities participated in a government sponsored, national ethics project – hereafter referred to as the ethics project – led by The Norwegian Association of Local and Regional Authorities (KS). The project aimed to enhance ethics competence in Norwegian community health care. Most of the participated municipalities have implemented ERGs, wherein a group of colleagues come together to reflect on ethical challenges or topics, discussions typically being led by an ethics facilitator (1,5,7).

Evaluation of the project was carried out both while it was in progress (7, 16) and after its completion (5, 9, 17). The last evaluation has consisted of a quantitative study based on two questionnaires sent to all participating municipalities' contact persons and

facilitators (9, 17), and a qualitative study based on focus group interviews with staff from a strategic selection of municipalities (5). The qualitative study intended to investigate staff experiences concerning the content and significance of ethics reflection The first paper from this study indicates that the ethics project has made considerable contributions to perceived quality and competence development, and is seen by most informants as a meaningful initiative towards better handling of ethical dilemmas (5).

The present article, based on qualitative data from the same study, seeks to shed light on the following question: What does the staff experience as promotors or as barriers to successful ethics reflection?

Previous studies

Health care staff experience ethical dilemmas as complex and find that it is often difficult to separate medicine, ethics, and law (5). ERG helps employees to increase their sensitivity to ethical problems, and they find that they are not alone in the difficult situations they face (2,5,7). Staff, facilitators and management agree that systematic ethics work increases the quality of care, for instance by focusing on user participation, and increasing professionals' ability to identify alternatives and better decisions. It may also have a positive impact on the work environment (2, 5, 7, 18).

There are few studies that explore in-depth what the participants of ERG find to be criteria for success. Two Norwegian studies explored the view of "resource persons"

responsible for running the local ethics projects (7, 16). Results indicate that the longevity of the ethics activities depend on organizational support and the facilitator's skills, and that the absence of systematic work seems to have influenced the municipalities that don't succeed with ERGs (7). The importance of using specific situations and stimulating a reflection process where both professional skills, value questions and attitudes are taken into account was highlighted (16). S staff members find that it is valuable to use dilemmas from their own practice, rather than constructed cases (1, 5). Evaluation studies show that despite a willingness to succeed, ethics support in community healthcare is dependent upon local enthusiasts, and that organization, resources and prioritization are often found to be lacking (6, 19).

There are no clear answers how to best organize ERGs, but resource persons in the municipalities find that it is important that ethics reflection is well organized (7). We want to map out what the participants in ERG find to be beneficial arrangements and what they consider to promote or hinder ethics reflection.

Ethics reflection models

Different reflection models are used in ERG. We choose to divide them into two main categories: simple and structured models. What we call simple models are often used for conversations about a topic or concept, but may also focus on experienced or constructed cases. Although these methods are based on a small set of simple principles, they may very well lead to complex discussions which it is no simple matter to lead for

the ethics facilitator. Examples of these kinds of models are sequential conversation (the "fish bowl" method (6,7)), the traffic light method (6), or the use of reflection cards (20). Structured models are based on discourse ethics. They usually elicit facts, stakeholders' views, values, ethical principles and laws involved, and the arguments for and against preferred courses of action in concrete situations. Two examples are the dilemma method (10,20) and the CME model (21) (see Table 1).

Table 1. The Centre for Medical Ethics (CME) model for ethics reflection.

1. What is the ethical dilemma in this case?
2. What are the relevant facts (medical and psychosocial)?
3. Who are the involved parties in the case, what are their views and interests?
4. Which ethical principles, virtues and values are at stake, and what are the relevant laws and guidelines?
5. Which courses of action are possible, and which arguments justify these?
6. Which solution is preferable?

Design, material and method

This study is based on data from focus group interviews with staff in community health care who have participated in ERGs. Focus group interviews are well suited for studying experiences, attitudes, and opinions (22), and can produce richer data than individual interviews. The group process may contribute to comprehensive knowledge (22-24), and this approach was chosen in order to access different points of view (25).

An interview guide that the participants had been sent in advance was used. This included the following open questions:

Which situations have been discussed in ethics reflection in your workplace? What did the ethics reflection mean to you, to your work, and to the work environment? Have you experienced including patients and/or relatives in ethics reflection? Which factors have, in your experience, promoted or hindered the ethics reflection? The last question is the focus of this paper.

Selection and recruitment

Wanting to assess the experiences of municipalities that had succeeded with ERG, we chose 11 municipalities that had been nominated for the Ethics Award[1]. Ten municipalities accepted the invitation to participate, and the study is based on ten focus group interviews, involving a total of 56 professionals. Group size varied from three to eight participants, including several professions: nurses, nurse's aides, social workers, occupational therapists, managers as well as unskilled assistants. The participants worked in nursing homes, home-care units, assisted living facilities, addiction and mental health units, and senior activity centers. More than 90% of participants were

[1] The Ethics Award is annually awarded to a municipality by the national ethics project led by KS. The objective is to make systematic ethics activities more visible, using the following criteria: strengthening users' sense of dignity and integrity, strengthening the ethical competence of management and staff, and strengthening practice and increasing the quality of services: http://www.ks.no/fagomrader/helse-og-velferd/etisk-kompetanseheving/etikkprisen/utlysning-av-etikkprisen-2015/

women, their work experience ranging from a few years to over 30 years. Their experience with participation in ERG varied from only a few times to weekly over several years. Eight of them were themselves ethics facilitators;[2] even though they were not the targeted group for the interviews, we chose to include them. The facilitators supplied some views based on their experiences as facilitators, but since they also had experiences as participants in ERG we decided to include them as informants based on their general participation in the ERGs.

Data collection

The interviews were scheduled by the first author and the municipality's ethics coordinator. The coordinator invited the participants to the interviews, based on volunteering, and relayed information about the study. The coordinators did not participate in the interviews. Interviews lasted between 60 and 90 minutes, and were audio recorded. With the exception of one interview, the first author (HK) took part in all the interviews, and the first author conducted one interview alone. In the others, a co-moderator was present (LL or EG or MM or IS). The moderators led the discussion, posed questions, and assessed the validity of statements by mirroring and follow-up questions. Audio recordings were transcribed verbatim.

[2] Different names are used for the person responsible for facilitating ethics reflection: ethics supervisor, resource person, facilitator or local enthusiast. For simplicity, we will refer to them as facilitators.

Analysis

Thematic content analysis (26) was used to process the data. The audio recordings were listened to several times, and the first author wrote short summaries of the main points that emerged in the conversations. The research group (the authors) went through the summaries and preliminary topics were identified. The transcribed material, which totalled 441 pages of text, was the basis of the further analysis. All interviews have been read and discussed by the first author and at least one of the co-authors. The first author continued by writing summaries of all the interviews based on the transcriptions, which then were discussed in the research group. The analysis has several phases, and the audio recordings were listened to several times, with and without the transcribed material. We developed a table to systematized and categorized findings in main and sub-categories (26,27). In the course of analysis three main categories were developed: organization of ethics activities (broadly defined), significance of ethics activities for service practicethe services, and significance of ethics activities for the work environment. This article focuses on the first main category and its sub categories, the other s main categories are being described in another article (5). The categoriezing gave a meaningful overview of the findings (26) , and an idea of what the staff experienced as promotors and hinders to ethics reflection . Some illustrative examples that represent the participants' experiences and views are used in this paper.

Research ethics

The data collection was based on the participants' informed consent, and the information about the study was given both orally and written. The participants signed a consent form before the interviews, and the moderator started the interviews by reminding everyone of mutual confidentiality. During the interviews, a respectful attitude and positive interactions between the participants was emphasized. In this way, we achieved good and nuanced group discussions. In accordance with the Norwegian system for research ethics, the study did not need approval from the Regional Committees for Medical and Health Research Ethics, but was evaluated and approved by the Data Protection Official of the Norwegian Centre for Research Data (project number 41968).

Findings

Several organizational factors were highlighted by the participants as crucial to succeed with ERG. They pointed out internal factors such as developing competence to facilitate ethics reflection, , facilitator's role, and how to organize ERG in the workplace. Amongst external factors they pointed to organizational support and organizational instabilities in their workplace. The participants expressed great enthusiasm and willingly shared their experiences. There were differences between the municipalities, but also within a single municipality, especially regarding organization and

implementation of ERGs. The participants expressed both positive experiences and some things they struggled with. In the following we will highlight some of the factors they experienced as promotors for ethics reflection. Their opposites – or the absence of such factors – were experienced to inhibit ethics reflection.

Factors promoting ethics reflection

Internal factors

Ethics competence

Ethics competence was seen as a crucial factor by the participants. The content and extent of municipally-sponsored ethics training for staff members varied. Many had been offered a «kick-off» meeting at the start of the ethics project. Several participants mentioned that they wished there had been more follow-up. In their view, ethical competence developed through courses and ethics reflection would increase the quality of their work, and such competence was important for successful ERG.

In about half of the focus groups interview, the participants told us that their municipality had offered a step-by-step course program when they started the ethics project: an introductory course in ethics, followed by advanced ethics courses and training in ethics reflection for facilitators specifically. The other half did not know anything about what the municipality offered. Regardless of the training offered, all the participants experienced a need and a strong wish for more ethics training, and for

ethics training to be repeated. Several of them experienced a need for training courses that targeted both new employees and those who had more experience.

Facilitators need extra training

All the participants stated that they had a facilitator to guide their ERG. Because some facilitators also participated in the focus group interviews, we discovered that there was variation in facilitators' training, ranging from systematic teaching of some theory and practical applications, to a more superficial and brief seminar about what ethics and ethics reflection is. The participants who had received the latter kind of training expressed that the training was inadequate and that the initial phase of ERG had been based on trial and error. There was consensus among the participants that they experienced that the facilitator had an important, but difficult role: *"... I think that the facilitator has an important role,... and can make [ERG] to a good or bad [event]".*

Enthusiastic facilitators were felt to create better reflections, and the participants had experienced that a good facilitator needed to ask for and use knowledge that contributed to highlighting the ethical problem. *«A good facilitator is important. Someone who keeps to the structure, and in a way, directs the conversation through the [structured] model»*. The facilitator's ability to stimulate reflection and at the same time challenge the staff was experienced as a beneficial contribution to ethics reflection, and thereby to competence building.

The facilitators who participated in the focus group interviews expressed a wish for follow-up and renewed training. Several other participants supported this, and said that taking care of the facilitators' need for more competence was important. Participation in a network of facilitators for shared experiences, and renewed training were considered as a good way to take care of the facilitators. The participants experienced that having a designated person with overall responsibility for ethics in the municipality was another good initiative, one who could contribute when they needed support, to maintain enthusiasm and continuity in ethics work: *.."(name of the person)* [the fasilitator] *has been a success ... ...she is a driving force".*

Understanding ethics and ethics reflection

Many participants found it difficult to pinpoint what ethics is, and struggled to differentiate ethics reflection from more general reflection on practice. Some had experienced that clarifying the terms could be useful at the beginning of ethics reflection:

> …it's just that there are so many difficult words that not everyone understands… that make it scary, that make it incomprehensible. Ethics is a very difficult word, what is ethics, really? What is reflection? Values, what are values? …I mean, these are words that require some reflection.

Others found that ethics was an integrated part of their profession, and that all interaction between patient and health care staff was colored by ethics. Yet others saw ethics and ethics reflection as looking into why we do what we do, and what is right to do. *«We experience ethical dilemmas, plain and simple. What are the laws and rules, what is the boundary for where you should get involved? There can be things you see in people's private homes…»*

Some of the participants experienced uncertainty with regard to what topics could be brought to an ERG, while others said that ethics was about respect, behavior and attitudes. Notably, the latter had often used simple models in their ERG, relying more on discussion of concepts (e.g., "respect") than on concrete, experienced cases as the basis for ethics reflections. Participation in ERG where situations from practice are discussed was experienced as particularly helpful by a majority of the participants. The result could be that they became aware of several new aspects of the situation, or that the values at stake became clearer. There was a clear difference between those participants who had mainly reflected upon value concepts, and those who had reflected upon experienced dilemmas from their practice. The difference was both in the way they expressed their understanding of ethics, in the content of the ethics reflection, as well as how the participants distinguished between ethical, organizational, legal and medical questions. One participant said that ethics reflection contributed to more professional awareness, as well as the realization that without ethics reflection,

traditional (and poorly justified) routines can guide a ward. *«We easily resort to routines in our work, and if we stop reflecting, our work will suffer…»* Discussing experienced dilemmas was seen as an important contribution to sharing experiences and building competence among the colleagues.

Clinical ethics committees (CEC)/Ethics council

Some municipalities had established clinical ethics committees (CEC), sometimes called ethics councils. The participants from these municipalities had experienced the CEC to be beneficial for competence building, as well as a help in discussing «the bigger cases», as they said. A few of the participants had participated in a CEC discussion, and found hearing the views and suggestions of outsiders to be helpful. The discussion brought out the depth and breadth in the reflection, and was experienced as inspiring, engaging and informative. Some CECs offered regular ethics courses for municipal staff, which the participants found to be helpful.

Participants' experiences with ERGs organizing

Time and frequency for ethics reflection varied among the municipalities and workplaces. Some told us that they spent 10 minutes, others as much as 90. Some held the reflection weekly, others every six weeks. Notably, there appeared to be a correlation between the time set aside and the reflection method employed: Those who spent little time (e.g., 10 minutes) were more likely to talk about ethics more generally. More time gave a higher likelihood for using a structured reflection model, and that the

reflection was systematic.The topic for the reflection was often a concrete dilemma experienced by the participants. Time, often lacking in the health sector, was experienced as a scarce resource in this study too. One of the participants said: *«You don't have time you have to take the time. Because this takes time.»* This person followed up by pointing to the importance of setting aside enough time, at least an hour, in order to carry out thorough reflections that would be meaningful for practice. This person said: "*Superficial and too brief discussions are a waste of time".*

Some had an external facilitator. This person would come at a set time, had ethics competence, and was often a priest. The participants of these groups more often experienced that their reflection groups were prioritized. According to their experience, when a person came from outside, it would send negative signals if the staff did not show up. On wards that had internal facilitators, participation was experienced to be more varying. Here it was more common that colleagues did not finish their work on time to participate. In such cases, ethics reflection had to be postponed, start without the full group, or be cancelled. Still, about half of these municipalities managed to carry out ethics reflection according to plan. The other half ended up cancelling it at times, often blaming lack of time, or lack of prioritization by management or colleagues. Good planning, cooperation, solid structures and systematics were seen as important elements of success.

> I think good organization is the key, and that the ward manager has a positive attitude towards it, and wants it on the ward. That it is scheduled regularly, put on the semi-annual plan, and that it is carried out systematically regarding time and place – that it is predictable.

One municipality paid the employees to participate in ERG when the sessions fell outside of regular work hours, during the project period. However, when the project ended, this arrangement ended too. The result was less participation in ethics reflection.

Choosing a model for ethics reflection

The participants had experienced the use of different reflection models. Some found that lack of time limited their options. Free reflection upon a topic was used by some, but this approach will not be discussed further in this article.

Simple models

Some facilitators told us that they used simple models initially in order to make ethics reflection less intimidating and make it easier for the participants to be active. *«First we gave some information about ethic,s then we presented how we planned to do it, and what the goal was. Then we used the fish bowl...»* (Facilitator, referring to the "fish bowl" (sequential conversation) models of ethics reflection).

Staff and facilitators differed in their views on the usefulness of reflection models in ERG. Several of the facilitators experienced that starting with the simple models was

useful. Some kept using these models, whereas others gradually moved on to more structured models as they gained experience. The ERG participants were generally more critical of these simple models than the facilitators were, and some described the fish bowl method as "phony", "childish", or "rigid". One went so far as to say that she felt ridiculed when using the fish bowl method, and therefore avoided participating in ERG. Others were more content with the model and found that it helped their colleagues listen. The traffic light model and reflection cards were used by some, but no one experienced these as especially useful; the latter was often used if the colleagues did not have a case of their own to reflect on.

Structured models

Among participants who used structured models, The CME model was used by most (see Table 1). This model was experienced as useful because it contributed to good structure, allowed for a broader scope of reflection, as well as not being too time-consuming. Precisely the breadth and systematics of the model were seen as instructive and stimulated reflection upon the participants' own practice. They experienced that the model challenged them to formulate the ethical problem in a precise manner. Participants also found that the model stimulated the invention of novel solutions and better handling of ethical dilemmas. One of the participants who had several years' experience using the model in ERG said that the systematic approach contributes to heightened reflection in the colleague group, but also on the ward as a whole.

Several participants pointed out that they had experienced 45 minutes as a minimum for a successful reflection, and that structured reflection models required more competent facilitators than the simple models. The participants said that they learned more from the structured models, because they were challenged to use both their own and their colleagues' knowledge, and to acknowledge medical, ethical, and legal arguments in their discussion. Reaching a conclusion about a solution, was seen as important. Such tangible outcomes made the staff more enthusiastic about ethics reflection, but also about their job in general. The opposite, when no solution was found, less enthusiasm or interest, and some stated that ethics reflection was a waste of time.

External factors

Organizational support

The participants experienced that the organizational support for ERG varied, but solid support such as demand, facilitation, cooperation and prioritization from all the three groups (among staff, department management and municipal management) was felt as a clear factor for success:

Among staff: Participants experienced that ERG was not prioritized by colleagues who did not see the importance of ethics reflection. Important prerequisites for support among staff members were information and participation. The participants considered that colleagues needed to be well-informed about the content of the initiative, what the

activity entailed, and how it would be carried out. It was felt to contribute to enthusiasm and interest for ethics in general, for clinical-ethical questions, and for ethics reflection in particular. One of the participants said: *«Ethics is something the facilitators deal with»*. She felt that she had neither received information nor been involved in the ethics project. The participants emphasized the necessity of a joint effort, which was positive for collegial cooperation and sense of companionship. Involving the staff was seen as an ongoing process. The participants didn't think that it was enough to inform about the ERG in the beginning and then expect it to run itself. To sustain enthusiasm among the staff, they experienced it was important to evaluate and talk about the initiative continually.

Department management: There was consistent agreement that the department management has a key role as a driving force, organizer, and as someone who actively expects results from the ethics reflection. This was experienced as a positive force for the activity, and contributed to enthusiasm among colleagues, even in busy times. *«It is important that time is set aside for it, that we have a manager that can see that we need it, and that we feel that it is useful, of course…».* Without managerial prioritization and legitimization of the ERG, the activity was experienced to wither away. Cooperation between the department management and facilitators regarding planning, organizing and implementation of ethics reflection was experienced as a promoting factor.

Municipal management: Some municipalities had been given instructions by municipal management or political leaders that ethics and ethics reflection should be prioritized. The underlying motivation was often a distressing situation that had received media attention. However, regardless of the municipal management's motivation for emphasizing ethics reflection, support from municipal management was felt as a promoting factor. Yet, it was experienced as less important than collegial and department support. Ethics reflection were mainly sustained by collegial and department management's enthusiasm and interest.

Barriers

In general, factors *promoting* ethics reflection may also be categorized as *barriers* to successful ethics reflection when they are absent. In addition, our analysis found other specific barriers. One significant finding is that ethics activities were started as a project, and when the project came to an end, the activities were supposed to become integrated into the department's regular activities. This transition is critical. Yet, when the project ended, the activities were given less priority by management and colleagues. New projects and initiatives require attention, and several of the participants experienced that in this phase, ethics reflection has often got the short end of the stick.

High turnover of staff and management was experienced as another barrier, because it may inhibit the continuation of existing initiatives. This is experienced as a significant

hindrance because new staff members have not participated in ethics reflection before:

«…and when they haven't participated, they don't know what they are missing…»

Other barriers that were mentioned were new, competing initiatives, high numbers of part-time employees, shift work, sick leave, and understaffing. Another barrier was when the ERG had too many participants (more than 20 persons), especially when these came from different workplaces with different tasks.

Discussion

The participants' varied experiences from ethics reflection indicate some conditions that may increase the chances to succeed with ERG.

Systematic approach

Systematics seems to be a key term in the question of what promotes ethics reflection. This is true in the organization of ERG, in the transition period at the end of a project, and in how ERG is supported in the organization and by employees. But most of all, this is true for the systematics of the actual reflection, in the choice of reflection method. Two studies describe the fish bowl method as being the most common in ethics reflection in Norwegian community health care services (6, 7), but a newer study refutes this (9). Some people find the fish bowl method well-suited for promoting reflection (6), but this goes against the findings of our study; several participants describe this model

as childish and rigid, as a barrier to reflection, and not meaningful for their practice. Structured models were to a higher degree pointed to as meaningful, coinciding with a study of facilitators in the ethics project (17). In the present study, the choice of method mattered for whether ethics reflection was perceived as helpful. Setting aside enough time was considered to be important, and a critical factor for success. While one study suggests that it is enough to set aside five to ten minutes for ethics reflection (6), another says that thirty to sixty minutes is advisable (7). The latter is in concurrence with our findings; several of the informants find it impossible to carry out a meaningful ethics discussion in ten minutes. We found that lack of time was correlated with the choice of a less systematic model. These models could still be experienced meaningful in the starting phase of ERG, when the goal was to get the participants talking, and make it less intimidating to voice your opinions (7). Some groups continued along this track without evaluating or asking their colleagues about their experiences. We think, like the participants, that it is paramount to motivation that the participants of reflection groups learn from the activity; furthermore, there is more learning in using the structured models. If the reflection process could lead to a conclusion, or a suggested course of action, this gave more meaning as a worthwhile activity in their busy workdays.

A small number of municipalities had started both a CEC and ERGs. It is likely that these structures will support each other, and possibly contribute to the creation of a

stronger overall structure for ethics in practice. The ethics project wished to strengthen the staff's ethics skills and ability to handle ethical dilemmas through ethics reflection. This is, among other things, about creating awareness about ethical questions, and contributing to systematic reflection on value questions becoming an integrated element in the workplace. Good organization, solid structures and building competence will likely prevent ethics initiatives from being too vulnerable.

Competence

The study shows that community health care staff understands the terms "ethics" and "ethics reflection" in several different ways. Some say there is ethics in everything we do, and appear unable to separate ethics from medicine, manners and communication (2), while others argue that ethics means more critical reflection on their own and others' practice (28).

One clear premise for successful ERG is knowledge of ethics and competence in leading reflection processes (2, 7). Our findings indicate that some municipalities lack such a foundation, that is, elementary training of facilitators and staff in what ethics is, to separate it from «everything we do». A course package for both new hires and those more experienced would be one way to handle the staff's need for competence (7). The results indicate that if ERG is to be systematic and have staying power, cooperation between facilitators, department management (6), and the staff may increase the

possibility of success. Establishing a solid platform of systematic measures, good planning that secures predictability and organizational support will likely increase the chance of succeeding in using ethics for professional growth. These conditions will contribute to creating a «learning organization» (29) that promotes both collective and personal development and competence.

The facilitator's enthusiasm

Like other studies (6,7), our findings indicate that the role as facilitator is a critical factor for success. Those leading the ERG need both elementary skills and follow-up over time to become secure in their role of facilitating ethics reflection at their own workplace (7). That staff to a larger degree participated in ethics reflection when an external facilitator was used, can be explained by the fact that ward management and the staff organized and prioritized ethics reflection when someone came from outside. Alternatively, it can be due to that person's special competence and legitimacy compared to internal facilitators.

Competent facilitators that challenge and support participants and who accept emotions that arise seem to have a significant effect on ERG; maybe even more so than the facilitators were aware of themselves. The participants pointed out very clearly that they wanted progression and development in the ethics work. So it is a paradox that the facilitators, generally speaking, were more approving of the simple models than were the other staff members. Can this be due to facilitators' insecurity in their role, a

perceived lack of competence, underestimation of the staff's capabilities, or lack of feedback from the staff (16)?

A stronger emphasis on training the facilitators, with follow-up and exercises would likely lead to more success (7). The role of facilitator is demanding (6); on the one hand you are to be a kind of leader/supervisor of your own colleagues, on the other you belong to the colleague group. However, establishing meeting places for ethics facilitators to exchange experiences and receive support in difficult dilemmas can be a positive measure that doesn't demand too many resources, and is likely to contribute to the facilitators' competence development, and to creating stronger structures.

Feeling secure is an elementary human need that impacts how a facilitator fills her/his role (30). Feeling secure is likely to be triggered by being invested in, and cared for as a resource.

Organizational instability

Our study also shows that ERGs in community health care are vulnerable. Several participants describe examples of barriers such as understaffing, high levels of sick leave, high turnover among management and staff, shift work, economic hardship, frequent re-organization, and new projects that come and go. It seems that the structures for ethics in the municipalities need robustness to withstand the organizational instability that characterizes many municipalities.

The municipality's increased responsibility for sicker patients (31), along with challenges in funding, personnel, and competence, are challenges of present-day Norwegian community care. In this busy environment, it appears that the medical and most obviously goal-oriented measures will receive top priority. Conversations and keeping the patient/user company (32), as well as «newer» measures like ethics reflection, are likely to receive less priority.

Strengths and weaknesses

This study presents the viewpoints of health care staff in municipalities that have succeeded, and therefore, it is colored by the participants' predominantly positive attitude towards ERG. Participants volunteered to be interviewed, this could also have introduced a bias towards predominantly positive reports from practice. We have not collected data from municipalities who not succeeded.

The participants have differing views based on their experiences in ERG, and our study shows some of the diversity. We have looked for more in-depth knowledge to answer the study's research questions, and the interaction and contact between the participants in the focus group interviews contributed to reflection upon these questions. None of them had the defined responsibility for carrying out the local ethics project, and the participants came from municipalities that had been doing ethics reflection for a while.

They had experience-based knowledge about what supports and hinders ERG in community health care. This is a strength of the study.

The results are based on experiences from a limited amount of informants, and the recruitment and selection of municipalities in this study exclude the 233 other participating municipalities in the national ethics project. We don't know anything about their point of view and experiences related to promotors and barriers to ethics reflection. This is a limitation of the study.

It would strengthen our findings if the study had supplementary observational data, and data about perceived quality of services. This could, for example, be collected systematically before and after implementation of ethics reflection.

A strength is that the results of this study correspond with other evaluation studies that have been carried out (6,7,9,17), and are likely to be relevant to other parts of the health care system.

Conclusion

The study shows that systematics, organization, support, prioritization and competence seem to be crucial elements for succeeding with ERG in community health care. The municipalities' instability is a challenge to this work. This includes constant re-

organizing, new projects and focus areas, instability in group competence, high turnover rates, and underfunding. Additional challenges are high rates of sick leave, shift work, many part-time positions, and increased demands in the form of more and sicker patients as the result of national restructuring of Norwegian health care (31).

One factor emerges as apparently the most important of all: the role and function of the facilitator is essential for the successful establishment and function of an ERG. Being a facilitator is demanding; therefore it is important that the right person is chosen, and that she/he receives sufficient resources and follow-up.

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Declaration of conflicting interests

The authors declare that there is no conflict of interest.

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