Article

Nursing Ethics
2014, Vol. 21(4) 402–413

10.1177/0969733013500806
nej.sagepub.com

Reflections on the ethical dilemmas involved in promoting self-management

Anne Lise Holm and Elisabeth Severinsson
Vestfold University College, Norway

Abstract
Due to their understanding of self-management, healthcare team members responsible for depressed older persons can experience an ethical dilemma. Each team member contributes important knowledge and experience pertaining to the management of depression, which should be reflected in the management plan. The aim of this study was to explore healthcare team members' reflections on the ethical dilemmas involved in promoting self-management among depressed older persons. A qualitative design was used and data were collected by means of focus group interviews. The results revealed one main theme: 'Lack of trust in the community health care system's commitment to bringing about effectiveness and change, based on three themes; 'Struggling to ensure the reliable transfer of information about depressed older persons to professionals and family members', 'Balancing autonomy, care and dignity' and 'Differences in the understanding of responsibility'. Lack of engagement on the part of and trust between the various professional categories who work in the community are extremely counterproductive and have serious implications for patient dignity as well as safety. In conclusion, ethical dilemmas occur when staff members are unable to act in accordance with their professional ethical stance and deliver an appropriate standard of care.

Keywords
Depression, ethical dilemmas, focus group interviews, healthcare team members, self-management

Introduction

Depression is a socially and physically disabling condition associated with poor self-care, adverse medical outcomes, increased mortality and risk of suicide.[1] It is an important cause of disability and was the fourth leading contributor to the global burden of disease in 2000.[2] The rate of depression has increased markedly over the past decade.[3] Patten et al.[4] estimated the rate of depression in a community sample to be nearly twice as high (19.7%) as the lifetime prevalence reported in cross-sectional studies during the same period.

The coordination reform in Norway included several initiatives aimed at making the transition from specialist to community healthcare more effective.[5] It was found that the patients' need for coordinated services was not sufficiently met. Thus, reorganisation is necessary to provide high-quality care. Interdisciplinary

Corresponding author: Anne Lise Holm, Centre for Women's, Family and Child Health, Faculty of Health Sciences, Vestfold University College, P.O. Box 2243, N-3101 Tønsberg, Norway.
Email: anne.holm@hsh.no

work is characterised by each discipline within the team working towards discipline-related goals.[6] According to Choi and Pak,[6] an interdisciplinary approach synthesises and harmonises links between disciplines, thus ensuring a coordinated and coherent whole. In view of the influence of depression on motivation, the interdisciplinary team aims to help older persons manage everyday life more effectively. Wiles and Robinson[7] provided a broad definition of teamwork within primary care, without specifically referring to interdisciplinary aspects: Teamwork involves a group of people from primary care practice with common health goals and objectives. A vital element is that the team members share common values and beliefs in relation to the teamwork as well as actually being supported and aware of this fact.

An ethical dilemma can be experienced by the healthcare team members responsible for older depressed persons due to their understanding of self-management. Ability to manage one's own life has been outlined in self-management literature and research.[8,9] Self-management has also been described as the training, skill acquisition and interventions through which depressed persons take care of themselves and manage their life and illness.[10] However, it requires partnership and shared decision-making.[11] Redman[12] holds that self-management leads to an unreasonable shifting of responsibility to the depressed older person. Each member of the team contributes important knowledge and experience pertaining to the management of depression, which should be documented in the management plan.[12] It is essential to develop an ethical structure as well as goals and expectations for these complementary roles.[12] Wagner et al.[11] described such complementary roles in the chronic care model (CCM), which represents a shift away from the traditional medical model. Macdonald et al.[13] stated that problems arise because the working methods identified in their study were most probably inadequate to support self-management. Koch et al.[14] concluded that healthcare professionals need a new understanding of self-management that includes respect for the expertise that a person brings to the management of her or his condition. Sporrong et al.[15] suggested that one way of supporting professionals to handle ethical dilemmas was education and training and added that organisational factors such as management involvement were crucial. When exploring self-management of chronic disease, Redman[16] identified ethical issues as

> insufficient patient/family access to preparation that will optimize their competence to self-management without harm to themselves, lack of acknowledgement that an ethos of patient empowerment can mask the transfer of responsibility beyond patient/family competency to handle that responsibility, prevailing assumptions that preparation for self-management cannot result in harm and that its main purpose is to deliver physician instructions, and lack of standards for patient selection, which has the potential to exclude individuals who could benefit from learning self-management. (p. 243)

Ethical dilemmas can be experienced by most professionals in an organisation. In healthcare, ethical dilemmas are often addressed by means of the principles of autonomy, non-maleficence, beneficence and justice.[17] According to Sporrong,[15] ethical dilemmas are concerned 'not only with making the right decision in difficult situations but also with justifying these decisions' (p. 223). Ethical dilemmas arise from conflicting values, norms and interests and can be understood as knowing 'the right thing to do, but institutional or other constraints make it difficult to pursue the desired course of action'.[18,19] Thus, healthcare team members can be troubled by their awareness of irresolvable, competing or contradictory moral imperatives.[20] The Code of ethics for nurses[21] comprises ethical standards that guide nurses in various ethically challenging situations in practice. Factors that contribute to ethically difficult decisions include conflicting values or feelings of frustration about actions that are insufficient or inconsistent with one's conscience.[22–24] The psychological consequence of being aware of one's responsibility but lacking the power and resources to act on this awareness (i.e. acting in a regrettable way) confuses the logic of right and wrong.[23] Even when healthcare team members are capable of good judgement and choices, the cultural norms of the workplace may induce conformity and passivity,[25] as their moral conviction puts them at risk of criticism from colleagues, the organisation and the community.[26]

To the best of our knowledge, there is a lack of research on the ethical dilemmas experienced by healthcare team members who care for depressed older persons.

Aim

The aim of this study was to explore healthcare team members' reflections on the ethical dilemmas involved in promoting self-management among depressed older persons. The research question was as follows: how can healthcare team members meet the needs of depressed older persons and at the same time focus on self-management?

Methods

A qualitative study was performed.[27]

Participants and settings

Two professional teams, one from the community (Team A) and the other from a specialist geriatric ward (Team B), were invited to participate in the data collection. The inclusion criteria for Team A were member of the community psychiatric care team with experience of working with depressed older persons. The inclusion criteria for Team B were experience of working with depressed older persons in a specialist geriatric ward. Team A comprised four mental health nurses, all of whom had many years of experience. Team B consisted of two staff members (one geriatric nurse and one physiotherapist) recruited from the specialist geriatric ward at the hospital. The nurse had worked in dementia as well as specialist geriatric care for a long time. The physiotherapist had been employed in the geriatric ward for 2 years. All the participants were women and their age ranged from 35 to 57 years.

Data collection

Data were obtained by means of focus group interviews,[28,29] which implies that reflections shared and developed within a group lead to a deeper understanding of a theme[29] due to the interactive group process. In this study, two focus groups were used and each interview lasted for 1.5–2 h. Both focus groups met on two occasions. The first focus group meeting involved Team A, comprising four mental health nurses from a community psychiatric team within primary healthcare on the west coast of Norway. The focus of the first meeting was (a) the community organisation, (b) cooperation between the community team and specialist healthcare and (c) opportunities for self-management in the community and specialist healthcare. The second focus group session comprised three mental health nurses from the psychiatric team in primary healthcare (Team A) and the geriatric nurse from specialist care (Team B). The purpose was to more deeply explore some of the areas about which more information was required, such as (a) collaboration between members of the healthcare team, self-management problems and cooperation with the older person; (b) safeguarding autonomy, care and dignity; and (c) the meaning of responsibility. The interval between the two focus group meetings was 14 days. The group dynamic was established by the relational interaction within the group. In the focus groups, the researcher (A.L.H.) aimed to explore the participants' experiences, using dialogue to bring the discussion to a higher level in order to detect potential utilitarian value as outlined by Hummelvoll and Severinsson.[30] The role of A.B., who acted as a moderator, was to ensure that the team members were allowed to speak for an equal length of time. She organised the session, observed and later discussed the focus group dialogue with the researcher. Two of the themes, responsibility and the experience of dignity in the self-management process, were explored in greater depth in the second session.

Table 1. Developed themes, sub-themes and example of statements from the healthcare team members' reflections on ethical dilemmas and self-management.

Main theme	Lack of trust in the community healthcare system's commitment to bringing about effectiveness and change	
Themes	Sub-themes	Example of statements
Struggling to ensure the reliable transfer of information about depressed old persons to professionals and family members	Having too much responsibility	'I really wish there was a team with special responsibility that would function in a better way'. 'We have taken our problems to the managers several times, but nothing happens'.
Balancing autonomy, care and dignity	Struggling to allow old, depressed persons to experience dignity	'Older depressed persons may have experienced being intruded upon earlier in life'. 'When the old depressed person recovers I gradually give her/him more responsibility and autonomy'.
Differences in the understanding of responsibility		'You still ask yourself if you could have done more'.

Ethical considerations

The participants were informed about the purpose, method and their right to withdraw from the study, that the data would be treated confidentially and that their names would be removed from the transcripts.[31] They were asked for permission to audio-tape the interviews. The study was approved by the Regional Ethics Committee of Western Norway (No. 2010/2242) and was carried out in accordance with the *Ethical guidelines for nursing research in the Nordic countries*.[32]

Data analysis

The data were analysed using a qualitative thematic analysis as described by Graneheim and Lundman.[33] This analysis deals with the content and describes the visible, obvious components such as quotations, referred to as the manifest content, as well as the latent content. Both manifest and latent content concern interpretation, but the interpretations vary in depth and level of abstraction. Ethical dilemmas can be more or less obvious in the text and the researchers might have interpreted an expression of the latent content. A theme answers the question 'How?' and, as Graneheim and Lundman[33] suggested, it is a thread of an underlying meaning on an interpretative level. A theme can be seen as an expression of the latent content of the text.

The first step involved exploring the interview text in order to find expressions of ethical dilemmas. The text was then structured into a table to identify themes and sub-themes. In this process, the researchers validated the text by discussing how it can be understood and interpreted (Table 1). Both researchers have long experience as psychiatric nurses, which could have influenced the interpretation of the meaning units or quotations. The interpretation of the main theme, themes and sub-themes was important for reaching consensus about the meaning embedded in the quotations, as it enabled the researchers to sort out and label.[27,33]

Findings

One main theme, 'Lack of trust in the community healthcare system's commitment to bringing about effectiveness and change', three themes and two sub-themes emerged: The first theme 'Struggling to ensure the

reliable transfer of information about older depressed old persons to professionals and family members' comprised one sub-theme 'Having too much responsibility'. The second theme 'Balancing autonomy, care and dignity' comprised one sub-theme 'Struggling to allow depressed older persons to experience dignity', while the third theme was 'Differences in the understanding of responsibility'.

Lack of trust in the community healthcare system's commitment to bringing about effectiveness and change

Team A was concerned about the lack of trust in the community healthcare system's commitment to bringing about effectiveness and change. The community has a department with authority to coordinate the care of all patient groups with physical healthcare needs. There was little communication between Team A and the above-mentioned department. The team members stated that the department does not pay much attention to the psychiatric needs of their patients. Thus, no coordination of the older persons' care needs takes place before admission to in-patient psychiatric care. They reported that the worst aspect is the fact that the professionals in the care coordination department plan the discharge together with the geriatric department without contacting the team, which means that team members no longer have trust in or a sense of loyalty to this department. A member of Team A stated,

> There are too many weak links in the organization of community primary health care that can break and sometimes do. I wish I could trust the community to show commitment to the development of a plan for specific patient groups such as depressed older persons. (A, 4)

The team members stated that the professionals in this department decide what the older persons need, obstruct their opportunities and mainly focus on physical needs. They added that primary care physicians do not pay much attention to the care of depressed older persons, who report receiving little information or assistance and feel quite lost. One of the members of Team A stated,

> It's about neglect of responsibility. (A, 1)

Struggling to ensure the reliable transfer of information about depressed older persons to professionals and family members

All the members of Team A struggled to help the community healthcare system to disseminate information about depression and its consequences:

> In cases of physical illness in an old person, there is a transfer of information from the hospital about how the professionals should help the old person to be in charge of her/his life. (A, 4)

One of the team members revealed that she no longer believed that the professionals in the community really wanted information about the needs of older depressed persons, as they concentrated more on what they could not provide rather than on what was available. The team members were concerned that these older persons did not appear to be their responsibility and regretted the fact that they were unable to provide them with better care.

Having too much responsibility

The members of Team A revealed that the care coordination department often ignores their request for more services for depressed older persons. The team members complained that they have to work alone, which implies too much responsibility and seemed to be an ethical dilemma in cases where they were not sure how

to handle their work situation and their managers and leaders were too distant to support them. One of them stated,

> I sometimes receive support and supervision, but I usually make decisions myself. (A, 3)

Another team member (A, 1) explained that such problems have been raised with their managers several times in order to promote change.

Balancing autonomy, care and dignity

The members of Teams A and B discussed how to balance autonomy, care and dignity when promoting older persons' self-management. One of the team members mentioned ethical judgements such as autonomy versus charity as ethical dilemmas. She also understood this dilemma as trying to balance autonomy, self-management and participation. The members of Teams A and B agreed with her description. Another team member stated,

> The patient cannot stay in bed, as it could lead to her/his death. One needs knowledge about how to handle depression or else we will fail in the care of the patient. (A, 3)

The team members agreed about the difficulties of balancing autonomy, care and self-management. They stated that in order to make the care less intrusive, it is necessary to become more aware of the meaning of self-management and participation when informing the patient about what will happen and why.

Struggling to allow depressed older persons to experience dignity.

All members of both teams discussed dignity and intrusion in an attempt to establish how an older person experiences dignity. One of the participants from the geriatric ward stated that there is not always a need for special knowledge and educated staff when caring for an older person, but that it is important to develop a relationship with her or him. This can be a problem if too many professionals are involved in the care. When the older person encounters many professionals who cannot exactly remember her or his needs, she or he can feel powerless and violated. The old person can reject the professional, making it impossible to establish a dialogue. One of the members of Team A explained,

> Yes, especially vulnerable older persons with depression may have experienced being intruded upon earlier in life. Maybe a transfer or readmission is perceived as a new intrusion. (A, 3)

The members of Team A agreed about the importance of establishing a relationship during the self-management process. However, learning to know a person takes time and involves creating a feeling of safety.

One of the members of Team A stated that she relates the word dignity to communication. All human beings have a need to be met with dignity. She explained it as follows:

> I am very concerned about relationship and dignity. Dignity seems too pompous. I would rather say that I try to meet a person with kindness. The person will indicate that she/he experiences dignity. Dignity can be experienced in many ways, thus being taken seriously can be a form of dignity. (A, 3)

Three of the members of Team A discussed attitudes to self-management and stated that admission to a psychiatric hospital can be an experience of intrusion for older persons.

Differences in the understanding of responsibility

One of the members of Team A mentioned a term that had not been in focus, namely, moral responsibility, and stated,

> Having moral responsibility is fine in my view. I also believe that the family has a moral, if not legal, responsibility. I often think about the terms. Have I taken over responsibility and not let the person decide her/himself? It's a matter of sharing, cooperating with and assisting the old person. I have some expectations on the family in this respect. I perceive a professional as well as a legal responsibility. (A, 2)

The members of Team A stated that self-management can be related to autonomy. How much responsibility can she or he take in a given situation and what are her or his chances of becoming involved in the care? One member of Team A revealed that in her experience, the meaning of moral responsibility is the same as professional responsibility. She stated,

> However, the doubt 'have I done the right thing?' is ever present and can perhaps be related to moral responsibility. You doubt whether the things you have done are sufficient. I often have to calm down and tell myself that I have done everything. But even so the doubts emerge, and I ask myself whether they are ethical or moral. I find this meaning the most plausible. (A, 4)

Another member of Team A agreed that the meaning can involve all ethical dimensions and the ethical responsibility that everyone has to help a person in need. One of the members of Team B revealed that, in her opinion, moral responsibility is something you do after you have completed the obligatory tasks and concerns doing something more, a little extra and looking beyond.

Discussion

The researchers are responsible for establishing the trustworthiness of the research process and the truthfulness of the thematic analysis. According to Polit and Beck,[27] criteria for establishing the trustworthiness of qualitative data are credibility, dependability, confirmability and transferability. Credibility refers to confidence in the truth of the data and their interpretation.[27] This implied ensuring that the perspectives of the participants were represented as clearly as possible and demanded an in-depth understanding of the participants' situation. The researchers have included quotations from the text in order to help the reader to judge if they have succeeded in describing the participants' perspectives. Both authors have checked the text several times and enhanced the credibility of the findings by putting critical questions to the text and searching for explanations. Confirmability refers to the objectivity or neutrality of the data[27] where the researchers interpreted the text from their own horizons as researchers and psychiatric nurses. Although they do not have a neutral position, they attempted to interpret the data as neutrally as possible as suggested by Polit and Beck.[27] The themes and sub-themes that emerged represented an attempt to explore the various stages in the process of interpreting the consequences of ethical dilemmas. The summaries of the focus group interviews were read several times before agreeing on the different themes and sub-themes. Lincoln and Guba[34] called this auditability, which is a criterion of the truth value in qualitative research. Dependability refers to the systematic, logical and documented inquiry process in addition to data stability over time and conditions.[27] Such stability was difficult to judge because the situation in the community and in the geriatric ward can change and influence the perceptions of the professionals.

Transferability of the findings depends on the similarity of the context in which the data were collected and that to which the findings are to be transferred.

The thematic analysis of healthcare team members' reflections on ethical dilemmas revealed a main theme, 'Lack of trust in the community healthcare system's commitment to bringing about effectiveness and change', based on three themes. The main theme contained reflections about how ethical dilemmas increased when the team members did not trust in the healthcare organisation's commitment to bringing about effectiveness and change. Lack of engagement on the part of and trust between the different professionals who work in the community is extremely counterproductive with serious implications for patient dignity and safety. Studies have demonstrated how empowerment influences interactional justice, respect and trust as well as the understanding of the patient perspective.[35,36] There is evidence to suggest that changes in the healthcare organisation lead to greater demands on and stress for the professionals.[20] Wagner et al.[11] suggested using the CCM model to change the healthcare system, thereby improving quality of care. However, these authors did not mention trust, but instead outlined the value of collaboration, which implies that the CCM needs to be implemented by a well-functioning collaborative team that includes the patient, where each member contributes information and experience. Ethical dilemmas arise when team members do not understand why they cannot influence the process, which can cause mistrust. The reality seems more complex than the description of the CCM model, where community links to a well-functioning, proactive team are set out in detail. According to previous research, emotionally difficult ethical decisions involve conflicting values and feelings of frustration about inadequate or inconsistent actions relative to one's conscience. Research has demonstrated the ethical consequences of being aware of one's responsibility but lacking the power and resources to act on this awareness, which confuses the logic of right and wrong[22–25] and thereby of doing good.[37] The organisation can be damaged by suppressed feelings and mistrust that weakens the hope of genuine commitment. No trusting organisation can exist without a pervasive sense of justice, and fairness seems to be an essential part of trusting relationships, regardless of one's position in the community.[7]

Wagner et al.[11] used the term 'decision support' to describe interventions directed at improving professionals' information and skills. There seems to be a struggle to ensure the reliable transfer of information about depresssed old persons to professionals and family members. Transfer of information can mean different things in a community healthcare organisation, and it is impossible to develop loyalty and trust when nobody is responsible for ethical decision-making. The demand for ethical decision-making in healthcare organisations is increasing.[9–11] It must be acknowledged that team members need to employ their own judgement to gain access to knowledge, information and how to make use of them.[38,39] However, community healthcare seems to lack commitment to ethics as well as ethical support groups for various professional categories in order to ensure trusting relationships. Hsu et al.[40] revealed that by stimulating staff commitment, healthcare providers were able to pursue organisational goals and deliver high-quality patient service. To enhance organisational commitment, healthcare managers need to create interpersonal interaction platforms. Lack of reflection on and discussions of ethical dilemmas have also been reported in the literature as leading to moral distress.[41]

The sense of being alone in one's work situation and carrying too much responsibility can be exhausting and lead to a feeling of not handling it properly. It can also give rise to shame and mistrust when one believes there is something wrong with one's own work capacity. Studies have revealed that team members are not fully prepared to handle the numerous ethical challenges they face in research and daily practice.[42,43]

'Balancing autonomy, care and dignity' highlighted the difficulty of focusing equally on these aspects when attempting to promote self-management in the care of older persons. Greater awareness of the meaning of participation and self-management is necessary in community healthcare in order to avoid violating depressed older persons. The current problem in healthcare seems to be partly on the organisational system level that appears to ascribe too much responsibility to both team members and patients.[12] Threats to dignity can result from the perception of being incapable of self-management and of imbalance instead of balance. Community leadership and management do not appear to understand the value of commitment and trust for increased cooperation between specialist and community care when caring for different patient groups with

chronic conditions.[18] The lack of commitment can be related to negative attitudes about ageing and older people, for example their inability to be in charge of their life. Sometimes *depressive ill-health* can imply a lack of self-management, a sense of estrangement and a loss of togetherness[9] as well as a state where the older depressed person has no strength to fight for her or his rights. Ethical dilemmas associated with dignity seem important for team members in view of increasing demands for efficiency and change in the healthcare organisation.[44] The team members described an ethical dilemma as not knowing how best to help depressed older persons to take responsibility for self-management. Team members have a responsibility to respect and enhance patients' autonomy and to maintain a high level of judgement and skill so that patients are safe with self-management. Redman[12] outlined the responsibility of obtaining patient agreement on the planned goals. Such an approach rests on the notion that old persons are moral agents who understand the meaning of skills related to their own values.

Autonomy involves self-determination, independence and self-care, concepts that are difficult to achieve in mental healthcare. However, this study revealed that at times one has to take responsibility for the depressed older person's care. This is a balancing act and ethical dilemmas arise in community and specialist mental health practice because of the vulnerability of the patients. The vulnerability is associated with violation in childhood, adolescent years or in a partnership that was experienced as intrusive and has consequences for the older person's experience of dignity. The general concept of dignity is characterised as a position on a value scale and it is further specified through its relations to the notions of right, respect and self-respect.[44] Ethical dilemmas seem to arise when the team has to apply force. Such experiences can dominate ethical decision-making. Depressed older persons are sometimes restricted by their mental state and unable to take responsibility for their actions.[45] One of the most important objectives of mental healthcare is the development of a person's ability to shape and take control of her or his life.[46] Care without dignity can lead to moral distress for team members when an ethical dilemma arises, due to the experience of threats to dignity in the conflict between the ideal and the reality.[47] Thus, one needs to reflect on whether the older persons experience intrusion rather than dignity. As the team members in this study stated, dignity can be a concept they prefer not to use because it is difficult to know if the patient really feels worthy. Treating someone with dignity means asking whether the person experiences a sense of worthiness or not, and the only one who can answer this question is the older person herself or himself. Dignity is a core concept in nursing care, and care without dignity would negatively influence a person's recovery.[48]

The meaning of self-management can vary as it forms part of each person's personal values throughout life. When ethical dilemmas arise, it can be possible to increase a depressed older person's strength by enhancing her or his self-determination and dignity.[9] Team members need to reflect on the depressed older person's vulnerability and longing to be confirmed, trusted and listened to, which has been proposed as a tool for improving awareness of one's role in the dialogue.[49] Self-determination has been highlighted as the most significant human right.[50] The core of self-management seems to be an existential dimension related to dignity associated with the health process as a 'journeying task of making sense of life itself' (p. 332).[50] Research revealed that in order to achieve self-management, the focus must shift to empowerment and support. This approach is relatively new and underdeveloped in primary care settings.[8,11]

Moral responsibility was interpreted by Lindh et al.[51] as a relational way of being, which involved guidance by one's inner compass comprising ideals, values and knowledge that translate into a striving to do good. Ethical challenges arise when one experiences being unable to act in a good enough way. According to Aristotle,[37] one wants to do good for its own sake and what is good can be recognised through experience. Striving is part of the concept of *eudaimonia*, meaning the achievement of a good life that implies the use of one's ability in a beneficial way.[36] Good teamwork cannot be restricted to correct actions, but requires reflection on ethical dilemmas, knowledge and relational actions.[51] Ethical dilemmas can be associated with a sense of failure to assume moral responsibility.[51] The healthcare team members were burdened by moral responsibility when their actions on the patient's behalf were unclear.[52–54] Redman[12] outlined the

responsibility to obtain patient agreement on planned goals, which is based on the notion that depressed older persons are moral agents with their own values. Thus, team members should be engaged in a discourse about the use of different self-management strategies. The intention behind self-management is for patients to gain an in-depth understanding of their illness. The collaborative approach of a healthcare team is important for empowering older persons by means of self-development and self-management.

Conclusion

Ethical dilemmas cannot be considered an individual issue, as ethical decision-making is complex and research has revealed that healthcare team members are not fully prepared to meet these demands.[14,15,42,43]

The community healthcare system and organisation need to build commitment and trust. One way to achieve this is to increase the level of ethical discussions and reflections in the community when caring for depressed older patients. Ethical discussions can help different groups of healthcare providers to cope with ethical dilemmas. It is essential to build ethical commitment and trust between the team, the depressed older person and the community healthcare system. The depressed older person can experience dignity by being an active member of the team. Dignity concerns being met with respect, protection of privacy as well as emotional support.

Depressed older persons are at risk of losing their dignity in the healthcare system due to lack of a coherent strategy that could contribute to improved care. Furthermore, ethical dilemmas seem to arise when one is unable to maintain one's professional ethical stance and standard of care. The fact that the healthcare organisation is not committed to a plan setting out the standards required for the health and care of depressed older persons can exert a negative influence on patient safety.

Acknowledgements

The authors wish to thank the healthcare team members for participating in the focus group discussions as well as Gullvi Nilsson and Monique Federsel for reviewing the English language.

Funding

The study has been supported by grants from the Research Council of Norway, 'Chronic Disease Management – Implementation and coordination of healthcare systems for depressed elderly persons' (NFR, No. 204238/V50) and 'Knowledge sharing – Utilising the results of the Chronic disease management of depressed elderly persons project' (NFR, No. 227679/H10).

Conflict of interest

The authors declare that there is no conflict of interest.

References

1. Unützer J, Rubenstein L, Katon WJ, et al. Two-year effects of quality improvement programs on medication management for depression. *Arch Gen Psychiatry* 2001; 58(10): 935–942.
2. World Health Organization (WHO). Mental health depression. WHO, 2012, http://search.who.int/search?q=mental+health+depression&;ie=utf8&site=default_collection&client=_en&proxystylesheet=_en&output=xml_no_dtd&oe=utf8 (accessed 27 April 2012).
3. Compton WM, Conway KP, Stinson FS, et al. Changes in the prevalence of major depression and comorbid substance use disorders in the United States between 1991-1992 and 2001-2002. *Am J Psychiatry* 2006; 163(12): 2141–2147.
4. Patten SB, Williams JV, Lavorato DLH, et al. A longitudinal community study of major depression and physical activity. *Gen Hosp Psychiatry* 2009; 31(6): 571–575.

5. Report no. 47 to the Parliament. *The coordination reform: proper treatment – at the right place and right time*, http://www.regjeringen.no/pages/2206374/PDFS/STM200820090047000DDDPDFS.pdf.
6. Choi BCK and Pak AWP. Multidisciplinarity, interdisciplinarity, and transdisciplinarity in health research, services, education and policy: 2. Promotors, barriers, and strategies of enhancement. *Clin Invest Med* 2006; 30(6): 224–232.
7. Wiles R and Robinson J. Teamwork in primary care: the views and experiences of nurses, midwives and health visitors. *J Adv Nurs* 1994; 20(2): 324–330.
8. Holm AL and Severinsson E. Chronic care model for the management of depression: synthesis of barriers to, and facilitators of, success. *Int J Ment Health Nurs* 2012; 21: 513–523.
9. Holm AL, Lyberg A, Lassenius E, et al. Understanding of older persons' lived experiences of depression and self-management. *Issues Ment Health Nurs*, in press. doi: 10.3109/01612840.2013.809829.
10. Yeung A, Feldman G and Fava M. *Self-management of depression: a manual for mental health and primary care professionals*. Cambridge: Cambridge University Press, 2010.
11. Wagner EH, Glasgow RE, Davis C, et al. Quality improvement in chronic illness care: a collaborative approach. *Jt Common J Qual Improv* 2001; 27: 63–79.
12. Redman BK. The ethics of self-management preparation for chronic illness. *Nurs Ethics* 2005; 12(4): 361–369.
13. Macdonald W, Rogers A, Blakeman T, et al. Practice nurses and the facilitation of self-management in primary care. *J Adv Nurs* 2008; 62(2): 191–199.
14. Koch T, Jenkin P and Kralik D. Chronic illness self-management: locating the 'self'. *J Adv Nurs* 2004; 48(5): 484–492.
15. Sporrong SK, Höglund AT, Hansson MG, et al. We are white coats whirling round – moral distress in Swedish pharmacies. *Pharm World Sci* 2005; 27: 223–229.
16. Redman BK. Responsibility for control; ethics of patient preparation for self-management of chronic disease. *Bioethics* 2007; 21(5): 243–250.
17. Beauchamp T and Childress J. *Principles of biomedical ethics*. 5th ed. New York: Oxford University Press, 2001.
18. Raines ML. Ethical decision making in nurses. Relationships among moral reasoning coping style, and ethics stress. *JONAS Healthc Law Ethics Regul* 2000; 2(1): 29–41.
19. Kälvemark S, Höglund AT, Hansson MG, et al. Living with conflicts – ethical dilemmas and moral distress in the health care system. *Soc Sci Med* 2004; 58: 1075–1084.
20. Lützèn K, Cronqvist A, Magnusson A, et al. Moral stress: synthesis of a concept. *Nurs Ethics* 2003; 10: 312–322.
21. International Council of Nurses (ICN). *Code of ethics for nurses*. Geneva: ICN, http://www.icn.ch/images/stories/documents/about/icncode_english.pdf (2012, accessed 23 August 2013).
22. Sørlie V, Jansson L and Norberg A. The meaning of being in ethically difficult care situations in paediatric care as narrated by female registered nurses. *Scand J Caring Sci* 2003; 17: 285–292.
23. Cronqvist A, Theorell T, Burns T, et al. Caring about – caring for: moral obligations and work responsibilities in intensive care nursing. *Nurs Ethics* 2004; 11: 63–76.
24. Sørlie V, Khilgren A and Khilgren M. Meeting ethical challenges in acute nursing care as narrated by registered nurses. *Nurs Ethics* 2005; 12: 133–142.
25. Meyers DT. *Gender in the mirror: cultural imagery and women's agency*. Oxford: Oxford University Press, 2002.
26. Johnstone MJ. Whistleblowing and accountability. *Aust Nurs J* 2005; 13(5): 8–9.
27. Polit DF and Beck CT. *Essentials of nursing research: appraising evidence for nursing practice*. Philadelphia, PA: Wolters Kluwer/Lippincott Williams & Wilkins, 2010.
28. Morgan DL. *Focus groups as qualitative research*. 2nd ed. Thousand Oaks, CA: Sage, 1997.
29. Liamputtong P. *Focus group methodology principles and practice*. London: Sage, 2011.
30. Hummelvoll JK and Severinsson E. Researchers' experience of co-operative inquiry in acute mental health care. *J Adv Nurs* 2007; 52(2): 180–188.
31. World Medical Association (WMA). *Declaration of Helsinki*, http://www.wma.net/en/30publications/10policies/b3/ (2013, accessed 25 August 2013).

32. Northern Nurses Federation (NNF). *Ethical guidelines for nursing research in the Nordic countries*. NNF, http://www.sykepleien.no/Content/337889/SSNs%20etiske%20retningslinjer.pdf (2003, accessed 25 August 2012).
33. Graneheim UH and Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Educ Today* 2004; 24: 105–112.
34. Lincoln YS and Guba EG. *Naturalistic inquiry*. Newbury Park, CA: Sage, 1985.
35. Laschinger HKS and Finegan J. Using empowerment to build trust and respect in the workplace: a strategy for addressing the nursing shortage. *Nurs Econ* 2005; 23(1): 6–12.
36. Nygårdh A, Malm D, Wikby K, et al. The experience of empowerment in the patient-staff encounter: the patient's perspective. *J Clin Nurs* 2012; 21(5–6): 897–904.
37. Aristoteles. *Den Nikomachiska Etiken*. Göteborg: Daidalos, 1988 (in Swedish).
38. Williams LI. The fair factor in matters of trust. *Nurs Adm Q* 2006; 30(1): 30–36.
39. Cornelissen E, Mitton C and Sheps S. Knowledge translation in the discourse of professional practice. *Int J Evid Based Healthc* 2011; 9: 184–188.
40. Hsu C-P, Chang C-W, Huang H-C, et al. The relationships among social capital, organizational commitment and customer-oriented prosocial behavior of hospital nurses. *J Clin Nurs* 2011; 20: 1383–1392.
41. Hansson MG. Imaginative ethics – bringing ethical praxis into sharper relief. *Med Health Care Philos* 2002; 5(5): 33–42.
42. Redman BK and Fry ST. Nurses' ethical conflicts: what is really known about them? *Nurs Ethics* 2000; 7: 360–365.
43. Georges J-J and Grypdonck M. Moral problems experienced by nurses when caring for terminally ill people: a literature review. *Nurs Ethics* 2002; 9: 155–178.
44. Nordenfelt L. The varieties of dignity. *Health Care Anal* 2004; 12: 69–81.
45. McMillan J. Dangerousness, mental disorder and responsibility. *J Med Ethics* 2003; 29: 232–235.
46. McMillan J and Gillett G. Moral responsibility, consciousness and psychiatry. *Aust N Z J Psychiatry* 2005; 39: 1018–1021.
47. Dwyer L-L, Andershed B, Nordenfelt L, et al. Dignity as experienced by nursing home staff. *Int J Older People Nurs* 2008; 4: 185–193.
48. Watson J. *Nursing: human science and human care: a theory of nursing*. London: Jones & Bartlett, 2007.
49. Stickley T and Freshwater D. The art of listening in the therapeutic relationship. *Ment Health Pract* 2006; 9: 12–17.
50. Barker P. *Mental health ethics: the human context*. Abingdon: Routledge, 2011.
51. Lindh IB, Severinsson E and Berg A. Moral responsibility: a relational way of being. *Nurs Ethics* 2007; 14(2): 129–140.
52. Fry ST and Johnstone M-J. *Ethics in nursing practice: a guide to ethical decision making*. Malden, MA: Blackwell, 2008.
53. Magnusson A, Severinsson E and Lützèn K. Reconstructing mental health nursing in home care. *J Adv Nurs* 2003; 43: 351–359.
54. Magnusson A, Högberg T, Lützèn K, et al. Swedish mental health nurses' responsibility in supervised community care of persons with long-term mental illness. *Nurs Health Sci* 2004; 6: 19–27.