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Ethical issues identified in nurses´ interprofessional collaboration in clinical practice: a meta-synthesis

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ABSTRACT

The aim of this study was to synthesize previous knowledge about ethics in nurses' interprofessional collaboration in clinical practice. Although healthcare professionals have common goals and shared values, ethical conflicts still arise during patient care. We carried out a meta-synthesis of peer-reviewed papers published in any language from 2013–2019, using both electronic searches, with the CINAHL, PubMed, Scopus, and SocINDEX databases, and manual searches. We identified 4,763 papers and selected six qualitative papers, and three theoretical papers, based on predetermined inclusion and exclusion criteria and quality appraisal. The studies came from the USA, Canada, Sweden, Australia, Botswana, and the Netherlands. We found that in ethics studies on nurses' interprofessional collaboration in clinical practice the focus has been on factors that affect how patients receive care. These factors were patients' wishes, whether they were told the truth about their condition, and how different professionals recognized and treated their pain. The focus in the papers we reviewed was on the roles of different professionals during the care process, including ethical conflicts with regard to their aims, commitment, and the balance of power among them and other professions. More research is needed to raise the visibility of how nurses and other professionals recognize, and evaluate, their professional and interprofessional ethics.

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Ethics; interprofessional collaboration; nurses; healthcare professionals; health and social care; meta-synthesis

Introduction

Nurses are increasingly working with other health and social care professionals to deliver effective healthcare. Interprofessional collaboration is a strategy that has been used to comprehensively respond to patients' needs (Reeves et al., 2017; Sidani & Fox, 2014). However, different professions do not always have same values, and this can lead to ethical conflicts. These conflicts highlight the need to identify the values that different professions share, so that patients can receive optimum care, for example, in end-of-life care (Gágyor et al., 2019; Pavlish et al., 2015; Rainer et al., 2018).

Interprofessional collaboration has been defined as different groups of health and social care professionals working together to make a positive impact on care (Reeves et al., 2017). The aim of working together is to give professionals the support they need to achieve their principal objective, which is how to achieve the best care for their patients. Best care includes promoting their health, wellbeing, and safety at individual, group, community, and global levels (Interprofessional Education Collaborative, 2016; Wilhelmsson et al., 2012; World Health Organization, 2010.). In order to achieve interprofessional collaboration in clinical practice, individuals need to develop four core competencies: principles of interprofessional collaboration, awareness of roles and responsibilities of different professions, methods for teamwork, and value-based working practices (Interprofessional Education Collaborative, 2016).

The ethics and values of interprofessional collaboration focus on the right and wrong ways to interact with other professions and being aware of duties and responsibilities (Clark et al., 2007). The role that patients play in this process is crucial, and so is the way that different professionals interact with them (World Health Organization, 2010). For example, this process requires mutual trust, respect, and honesty (Banks et al., 2010; Interprofessional Education Collaborative, 2016), as well as a shared understanding of patients' dignity and privacy (Interprofessional Education Collaborative, 2016). These shared values have also been emphasized by professional associations (International Council of Nurses, 2012; World Confederation for Physical Therapy, 2017; World Medical Association, 2015).

In previous studies, professional values were reasonably consistent among healthcare professions, and the most important values were moral concerns for patients and their need for equality (Moyo et al., 2016; Tsou et al., 2015). Developing a mutual understanding of shared values in interprofessional collaboration in clinical practice is crucial for meeting the multidimensional needs of individual patients and providing them with high-quality care (Engel & Prentice, 2013; Interprofessional Education Collaborative, 2016). Mutual understanding provides benefits for the public, professionals, and organizations and this leads to more effective health and social care (Clark et al., 2007; Engel & Prentice, 2013; Green & Johnson, 2015; Reeves et al., 2017; World Health Organization, 2010).

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Nurses face ethical questions about interprofessional collaboration on a daily basis (Gágyor et al., 2019; Pavlish et al., 2015; Rainer et al., 2018), because they work with other disciplines who are also guided by their professional and interprofessional values. Professionals encounter ethical challenges every day, due to the changing roles of patients and professionals (Engel & Prentice, 2013; Hollman et al., 2014). Patients increasingly expect to be involved in, and have more responsibility for, their own care (Castro et al., 2018; Nordin et al., 2017).

The aim of our study was to synthesize previous knowledge about ethics in nurses' interprofessional collaboration in clinical practice and to deepen understanding of the current ethical issues arising from that collaboration. This new knowledge could help professionals to recognize similarities and differences among professions, in relation to professional and interprofessional ethics and values. It will also help patients receive high-quality care. This knowledge could be used to create new methods for interprofessional training and help professionals work together to handle ethical questions in their daily practice. It could also be used to reform interprofessional collaboration in professions and organizations. Our research questions were:

(1) What methods have been used to explore ethics in nurses' interprofessional collaboration in clinical practice?
(2) What ethical issues have been identified in nurses' interprofessional collaboration in clinical practice?

Methods

Research design

We used the seven-phase meta-synthesis method described by Noblit and Hare (1999) to analyze, compare, interpret, and establish a synthesis of previous knowledge. Carrying out a meta-synthesis enabled us to bring together previous knowledge from qualitative studies and theoretical papers on the ethical issues that arose from nurses' interprofessional collaboration in clinical practice. Our goal was to use the results and discussion sections from each paper to create a synthesis that examined this phenomenon at a higher level.

Study search and selection

The first phase was to identify the research questions (Noblit & Hare, 1999) using preliminary searches and our preconceptions of this phenomenon (Kangasniemi et al., 2012). We refined the questions by focusing on the study methods that had been used to explore ethics in nurses' interprofessional collaboration in clinical practice and the knowledge that had already been identified from those studies. A detailed search was unable to find any recent meta-synthesizes of this phenomenon.

The second phase was selecting published studies (Noblit & Hare, 1999; Figure 1) using electronic and manual searches (Kangasniemi et al., 2012). The electronic searches were carried out using CINAHL, PubMed, Scopus, and SocINDEX databases. We searched for papers focused on ethics and interprofessional collaboration in health and social care by using various search terms, synonyms, and combinations (Figure 1). Our search was limited to papers published from January 2013 to December 2019, and we did not limit the language that they were published in, or the type of study. The electronic searches yielded 4,763 original papers, and we selected 76 based on their titles, then 27 based on their abstracts, and 8 based on their full texts. Our inclusion criteria were peer-reviewed papers that included nurses and at least one other health or social care profession, and focused on the ethical aspects of collaboration. As we wanted to focus on ethics in nurses' interprofessional collaboration in clinical practice, we excluded papers focused on ethics in interprofessional education, and teaching, or interdisciplinary research. We excluded papers focused on the views of nursing students or patients.

We carried out manual searches (Kangasniemi et al., 2012) of a number of journals using the same limitations, inclusion, and exclusion criteria as the electronic searches. These were: *Journal of Interprofessional Care, Journal of Interprofessional Education and Practice, Nursing Ethics, BMC Medical Ethics*, and *Health and Social Care in the Community*. The manual search identified one more paper and this brought the total to nine.

Analyzing and synthesizing papers

In the third phase we read selected papers several times to gain an overview of the content (Kangasniemi et al., 2012; Noblit & Hare, 1999). We then tabulated the data, based on the authors, year of publication, country, aim, and study design (Table 1).

In this phase we sought to deepen our understanding of the selected papers by identifying how the accounts and the interpretative metaphors of each paper addressed our research questions (Kangasniemi et al., 2012; Noblit & Hare, 1999). We gathered and noted all details and descriptions related to ethics, values, or moral issues in nurses' interprofessional collaboration in clinical practice. The data related to different professionals were also recorded if they were reported in the original papers. We placed our notes in a table and conserved the sense of the accounts.

In the fourth phase we explored relationships among studies and identified possible elements that contributed to overall impressions (Kangasniemi et al., 2012; Noblit & Hare, 1999). We juxtaposed and compared key metaphors, accounts, and concepts among papers. This comparison enabled us to identify new themes and explore how they were related to each other. In this phase we identified elements of ethics in nurses' interprofessional collaboration in clinical practice, such as ethical questions that related to patients and other professions. We also formulated our first assumptions about the relationships among the papers during this phase (Kangasniemi et al., 2012; Noblit & Hare, 1999).

According to Noblit and Hare (1999), the fifth phase of this process is translating studies into one another. We did this by creating a shared conceptual framework (Kangasniemi et al., 2012) and comparing the central metaphors and their interactions in, and among, the selected papers. The comparison

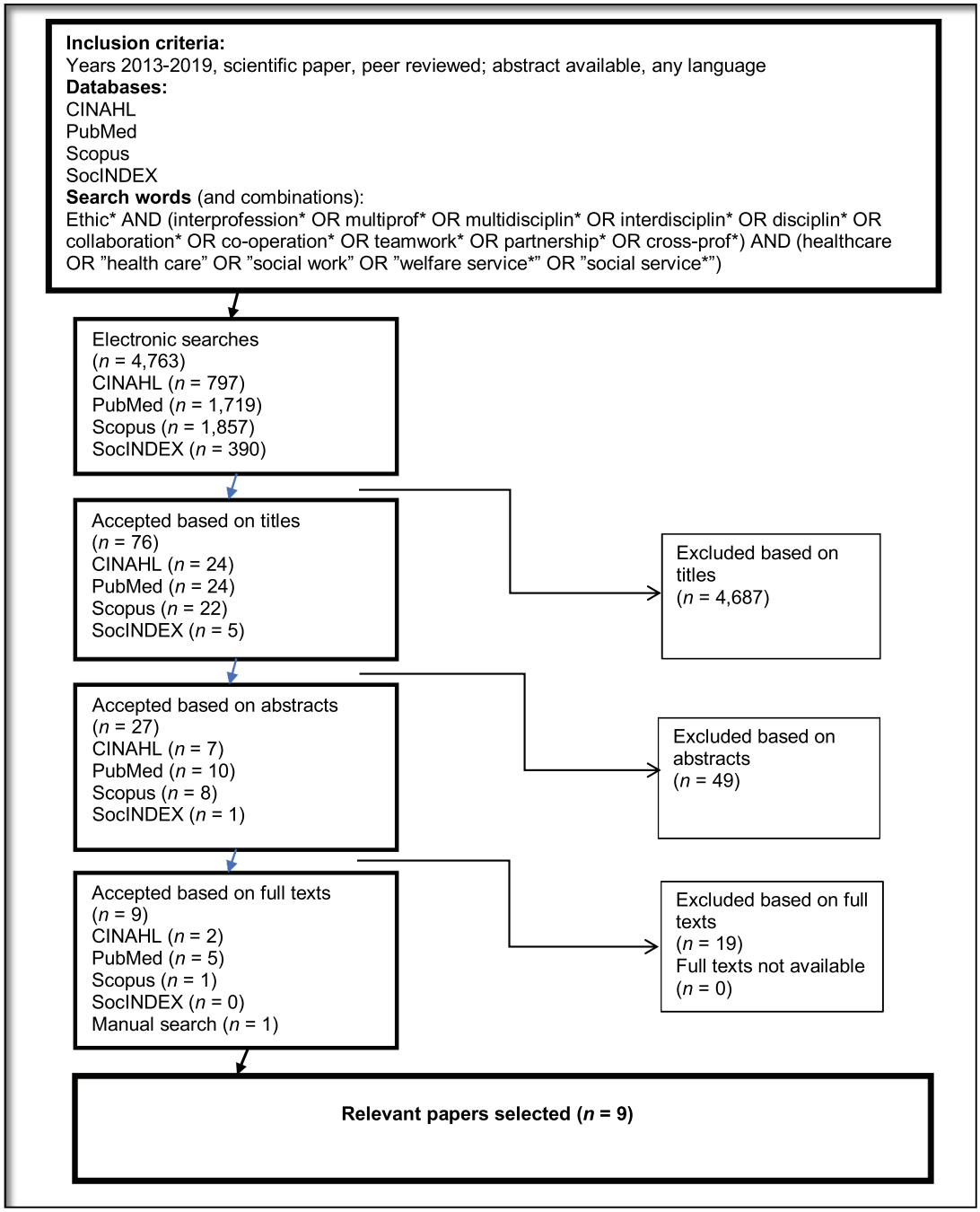

Figure 1. Selection of relevant papers.

enabled us to conserve the uniqueness of the papers. For example, when the papers used different expressions for patients' wills, wants, or wishes, we incorporated these in the expression "patients' wishes."

In the sixth phase, we synthesized the content identified by the translation process (Noblit & Hare, 1999). The synthesis involved bringing together the translations and the single elements to create the whole content and formulate our interpretative synthesis of the content (Kangasniemi et al., 2012). We abstracted the translations to new levels and themes. The seventh phase is reporting our synthesis (Noblit & Hare, 1999) of ethics in nurses' interprofessional collaboration in clinical practice in this paper.

Trustworthiness was assured during each phase of the meta-synthesis (Noblit & Hare, 1999) by intensive collaboration among members of the research group (Kangasniemi et al., 2012). Collaboration included extensive discussions and reflections on the common understandings of the phases that had been processed. We also revisited the original papers. Discussions continued until we achieved mutual agreement

Table 1. Description of the nine relevant studies.

Author (s), year, country, quality appraisal	Aim	Study designs
Qualitative papers		
Bartholdson et al., 2015 Sweden 7/10 points	To describe healthcare professionals' experiences of ethical issues and how to deal with these when caring for children.	Mixed method study. Open-ended and multiple-choice questions. Qualitative content analysis. 87 participants in a pediatric hospital: nurses, physicians and nurse aides.
Oerlemans et al., 2015 Netherlands 8/10 points	To identify and explore ethical dilemmas in healthcare professionals' daily practice.	Qualitative study. Individual and focus group interviews. Qualitative content analysis. 44 participants in 10 hospitals: intensive care unit nurses and physicians, general ward nurses and physicians.
Payne & Farrell, 2015 USA 7/10 points	To report secondary analysis findings from data in a large study related to moral distress in interprofessional ethics consultation and collaboration.	Qualitative study. Qualitative content analysis. 11 participants: physician, nurses, social workers, spiritual guide, genetics counselor.
Rasoal et al., 2016 Sweden 9/10 points	To explore ethically difficult situations that interprofessional healthcare teams highlighted during moral case deliberations.	Qualitative study. Recorded moral case deliberation sessions. Qualitative content analysis. 687 participants in five hospitals and two community care settings: nurses, assistant nurses, physicians, nurse managers, social workers, occupational therapists, physiotherapists and others.
Rider et al., 2014 USA 6/10 points	To identify important values for healthcare interactions and describe the development of the International Charter for Human Values in Healthcare.	Qualitative study. Qualitative content analysis. 114 participants representing: nursing, medicine, other health professions, sociology, education, other sciences and patients.
Sabone et al., 2020 Botswana 9/10 points	To explore the ethical challenges of interdisciplinary collaboration in clinical practice and education in Botswana.	Qualitative study. Individual interviews. Qualitative content analysis. 39 participants in three hospitals: nurses and physicians.
Theoretical papers		
Engel & Prentice, 2013 Canada/USA 5/6 points	To examine the ethics of interprofessional collaboration and ethical issues that arose from the mainstream adoption of interprofessional competencies and the potential for moral distress in nursing.	Theoretical discussion. Previous literature concerning ethics, such as national guidelines, scientific papers and textbooks. Examples from Canada and USA that covered nurses, physicians, social workers and occupational therapists.
Ewashen et al., 2013 Canada 5/6 points	To examine how nurses and other healthcare professionals ensured ethical interprofessional collaboration in everyday practice.	Theoretical discussion. Previous literature concerning ethics, such as scientific papers, national strategies, textbooks and professional codes. Examples from nurses and physicians.
Grace et al., 2017 Australia 5/6 points	To explore relationships among seven health professions of similar status, as reflected in their competency frameworks, to identify common themes and values across the professions.	Theoretical discussion. Previous literature concerning ethics, namely values and competences in seven health professions. Examples from nurses, occupational therapists, osteopaths, physiotherapists, podiatrists, speech therapists and exercise physiologists.

and were able to move on to each new phase. The research process was openly described and quotations that backed up the findings were used to increase trustworthiness.

Quality appraisal

We evaluated the papers using method-specific quality appraisal criteria and checklists from the Joanna Briggs Institute (Lockwood et al., 2015; McArthur et al., 2015). First, two independent researchers (MK, PP) read the selected papers and used method-specific descriptive criteria that focused on the methodological questions: 10 questions for the qualitative studies (Lockwood et al., 2015) and 6 for the theoretical texts (McArthur et al., 2015). The evaluation scale contained four options: yes, no, unclear, and not applicable. Next, after shared discussions, the researchers worked together to evaluate the qualitative studies. These scored 6–9 points out of 10, and the average was 8. The qualitative studies often lacked information about questions of "ethical approval by one appropriate body" and "influence of the researcher on research and vice-versa." All the theoretical papers scored 5 points out of 6. None of the papers we selected were omitted because of their quality appraisal scores (Table 1).

Ethical considerations

The research method meant that ethical committee approval was not required, but research ethics were observed during the entire research process. All authors contributed to the study, treated the studies respectfully, and cited them carefully and honestly (All European Academies, 2017).

Findings

We found that the methods used by the selected papers to explore ethics in nurses' interprofessional collaboration in

clinical practice were qualitative and theoretical. Based on our analysis, ethical issues identified in collaboration related to the patients' role and the roles played by the different professions in the care process.

Methods used by the selected papers

We identified nine papers: six qualitative papers (Bartholdson et al., 2015; Oerlemans et al., 2015; Payne & Farrell, 2015; Rasoal et al., 2016; Rider et al., 2014; Sabone et al., 2020) and three theoretical papers (Engel & Prentice, 2013; Ewashen et al., 2013; Grace et al., 2017). In all the qualitative papers, focus was on ethics in nurses' interprofessional collaboration in relation to healthcare values (Rider et al., 2014), ethical issues (Bartholdson et al., 2015), ethical dilemmas (Oerlemans et al., 2015), ethically difficult situations (Rasoal et al., 2016), ethical decision-making (Payne & Farrell, 2015), and ethical challenges (Sabone et al., 2019). Four of the qualitative papers were based on interviews (Oerlemans et al., 2015; Rider et al., 2014; Rasoal et al., 2016; Sabone et al., 2019), one was based on a questionnaire that included open-ended questions (Bartholdson et al., 2015), and one was a secondary analysis of previously analyzed interview data (Payne & Farrell, 2015). All the qualitative papers selected for the present review had used content analysis as a method.

Four of the qualitative papers were set in hospitals (Bartholdson et al., 2015; Oerlemans et al., 2015; Rasoal et al., 2016; Sabone et al., 2019), and one of those also included community care (Rasoal et al., 2016). Ethics in nurses' interprofessional collaboration was studied in relation to physicians (Bartholdson et al., 2015; Oerlemans et al., 2015; Rasoal et al., 2016; Sabone et al., 2019) and other healthcare professionals, such as nurse aides (Bartholdson et al., 2015; Rasoal et al., 2016), social workers, occupational therapists, and physiotherapists (Rasoal et al., 2016) (Table 2).

One of the qualitative papers included participants from round table groups, interprofessional, national and international conferences, and universities (Rider et al., 2014). The professionals in another study were recruited from a local ethics conference (Payne & Farrell, 2015). In these two studies, the professionals represented various fields, such as palliative care medicine, nursing, pastoral care, social work, and genetics.

The total number of participants in the examined qualitative papers was 982 (Table 2). The participants were experts representing various fields, such as medicine, nursing, other health professions, education, interprofessional training and practice, health sciences, linguistics, health communication, and sociology. In one paper the number of participants belonging to the different professions was not specified (Rider et al., 2014).

The three theoretical papers were based on previous literature (Table 1). The focus of the studies was on the meaning and fulfillment of ethics during nurses' interprofessional collaboration in daily practice (Engel & Prentice, 2013; Ewashen et al., 2013), and to identifying shared values across health professions (Grace et al., 2017). Ethics in interprofessional collaboration in healthcare practices in Canada and the USA was studied in one paper (Engel & Prentice, 2013), and the ethical competencies in seven health professions was the focus of another (Grace et al., 2017). Future healthcare scenarios were the subject of a third study (Ewashen et al., 2013). The focus of two theoretical papers was on the ethics between nurses and physicians (Engel & Prentice, 2013; Ewashen et al., 2013). In one study, the focus was on interactions among nurses and occupational therapists, osteopaths, physical therapists, physical education instructors, podiatrists, and speech therapists (Grace et al., 2017).

Of the nine papers, two took place in the USA, two in Sweden, and one each in Australia, Botswana, Canada, Canada plus the USA, and the Netherlands (Table 1).

Ethical issues identified in nurses' interprofessional collaboration in clinical practice

Based on our synthesis, ethical issues in nurses' interprofessional collaboration in clinical practice related to the different way that professionals understood the patients' role in the care process and the roles of different professionals during the care process (Table 3).

Different understanding of patients' role in the care process

Professionals did not always agree about the role that patients played in the care process, and this caused ethical conflicts among nurses and colleagues during interprofessional collaboration. Based on our analysis, the studies contained three elements: the meaning of the patients' wishes, telling the truth to patients, and recognizing, and treating, patients' pain.

There were ethical conflicts when professionals had diverse views on what patients wanted. They thought about what to do if patients' wishes were unknown and whether patients should be listened to, or play a role in, shared decisions about their care (Bartholdson et al., 2015; Oerlemans et al., 2015; Rasoal et al., 2016). Nurses and other healthcare professionals had

Table 2. Description of the participants in the six qualitative papers.

Professions	(Bartholdson et al., 2015)	(Oerlemans et al., 2015)	(Payne & Farrell, 2015)	(Rasoal et al., 2016)	(Rider et al., 2014)	(Sabone et al., 2019)
483 nurses	34	24	6	400	x	19
182 nurse aides	38			144		
100 physicians	15	20	1	44	x	20
14 social workers			2	12		
12 occupational therapists				12		
11 physiotherapists				11		
33 nurse managers				33		
33 others			2	31	x	
Total	87	44	11	687	114	39

X = number not specified, just total.

Table 3. Synthesis of ethics in nurses' interprofessional collaboration in clinical practice.

Themes	Content	Six qualitative papers	Three theoretical papers
Different understanding of patients' role in the care process	The meaning of patients' wishes	Bartholdson et al., 2015 Oerlemans et al., 2015 Rasoal et al., 2016 Rider et al., 2014	Engel & Prentice, 2013
	Telling the truth to patients	Bartholdson et al., 2015 Rasoal et al., 2016	
	Recognizing and treating patients' pain	Bartholdson et al., 2015 Rasoal et al., 2016	
Roles of different professionals during the care process	The primary aim of professions	Bartholdson et al., 2015 Oerlemans et al., 2015 Payne & Farrell, 2015 Rasoal et al., 2016 Sabone et al, 2019	Engel & Prentice, 2013 Ewashen et al., 2013 Grace et al., 2017
	The balance of power among professions	Bartholdson et al., 2015 Oerlemans et al., 2015 Rasoal et al., 2016 Rider et al., 2014 Sabone et al., 2019	Engel & Prentice, 2013 Ewashen et al., 2013
	Commitment to collaboration	Bartholdson et al., 2015 Oerlemans et al., 2015 Payne & Farrell, 2015 Rasoal et al., 2016 Sabone et al., 2019	Engel & Prentice, 2013 Grace et al., 2017

different perceptions about what patients wanted. This became clear when treatment was carried out against patients' wishes (Bartholdson et al., 2015; Rasoal et al., 2016). Examples included patients being forced to have urinary catheters or enteral feeding tubes inserted (Rasoal et al., 2016), being restrained while blood samples were taken (Bartholdson et al., 2015; Rasoal et al., 2016), or dementia patients receiving intravenous medication they did not want (Rasoal et al., 2016). Professionals disagreed when patients were over treated. In these cases, conflicts arose because interprofessional teams had not discussed the care process and patients' wishes had not been properly documented (Engel & Prentice, 2013; Oerlemans et al., 2015; Rasoal et al., 2016; Rider et al., 2014). They also arose when physicians (Oerlemans et al., 2015), nurses, and other healthcare professionals (Rasoal et al., 2016) were not aware of the patients' wishes regarding their care. The most critical conflicts arose among professionals if the patients' wishes were ignored with regard to do not resuscitate orders (Oerlemans et al., 2015; Rasoal et al., 2016). Conflicts occurred among nurses, other healthcare professionals, and physicians if patients with status or power were listened to, or provided with, better care than others. In addition, patients who were polite, but vocal about their rights, received more services than patients who kept quiet (Rasoal et al., 2016.)

There were also issues about telling the truth to patients. Ethical conflicts occurred when nurses, physicians (Rasoal et al., 2016), or other healthcare professionals (Bartholdson et al., 2015) disagreed about how much, and what kind of, information patients had the right to receive. Nurses believed that sometimes patients were only told some of the facts, that it was often delivered in a begrudging way, or that the truth was completely withheld (Bartholdson et al., 2015; Rasoal et al., 2016). Professionals disagreed about the most ethical way to hold discussions with patients. Nurses and other healthcare professionals preferred these to be on a private one-to-one basis, and physicians believed it was acceptable to discuss issues when other patients were around (Rasoal et al., 2016). Sometimes professionals did not tell patients the truth about their health or treatment. Nurses, physicians (Rasoal et al., 2016), or other healthcare professionals (Bartholdson et al., 2015) disagreed about whether patients had the right to know the real truth about how severe their condition or illness was or if there was a new diagnosis. Physicians believed it was their role, not the nurses', to keep patients updated (Rasoal et al., 2016). Professionals disagreed about whether treatment could be carried out if patients did not know why it was needed (Bartholdson et al., 2015) or had not consented to it (Rasoal et al., 2016). Nurses and other healthcare professionals said they did not always tell patients the truth, for example, when patients were anxious (Bartholdson et al., 2015) or very unwell (Rasoal et al., 2016). Ethical conflicts among professionals meant that some patients did not receive sufficient information about their condition or medication and this reduced their opportunities to get involved in their care (Bartholdson et al., 2015; Rasoal et al., 2016).

Professionals demonstrated differences when it came to recognizing, and treating, patients' pain, and that created ethical conflicts for nurses during interprofessional collaboration. Conflicts occurred when nurses and other healthcare professionals used different standards to recognize patients' pain (Bartholdson et al., 2015; Rasoal et al., 2016) and their need for pain relief (Bartholdson et al., 2015). For example, in one study pain relief was not provided before treatment, or it was given to patients in a hurry and did not help the patient (Bartholdson et al., 2015). Conflicts arose about pain relief methods related to different illnesses. For example, in one study patients received adequate pain relief, delivered using suitable methods, during end-of-life care (Bartholdson et al.,

2015). However, in other studies pain relief had been limited when patients had received life-saving cures, to avoid them developing drug dependency (Bartholdson et al., 2015; Rasoal et al., 2016). Nurses were also reluctant to provide pain relief just because a physician said it was justified (Rasoal et al., 2016). Nurses reported that patients' integrity in interprofessional collaboration was compromised when poor pain care meant that their patients suffered (Bartholdson et al., 2015; Rasoal et al., 2016).

Roles of different professionals during the care process. The roles that different professionals played during the care process raised ethical conflicts for nurses when it came to interprofessional collaboration. These ethical conflicts were connected to the primary aim of professions, the balance of power among professions, and the professionals' commitment to collaboration.

Nurses and other healthcare professionals reported that the primary aims of professions were different and that this caused ethical conflicts when they were trying to make the best decisions about a patient's care (Bartholdson et al., 2015; Engel & Prentice, 2013; Ewashen et al., 2013; Grace et al., 2017; Oerlemans et al., 2015; Payne & Farrell, 2015; Rasoal et al., 2016; Sabone et al., 2019). Ethical conflicts arose when physicians made treatment decisions from a curing point of view, while nurses made decisions from a caring point of view and considered patients holistically (Bartholdson et al., 2015; Oerlemans et al., 2015). Different views were sometimes incompatible, and nurses sometimes believed it was challenging to carry out physicians' orders for patients (Bartholdson et al., 2015; Engel & Prentice, 2013; Oerlemans et al., 2015; Sabone et al., 2019), particularly when nurses believed that the treatment was futile (Bartholdson et al., 2015; Oerlemans et al., 2015; Sabone et al., 2019). Nurses understood that physicians were responsible for the patients' medical care. However, they believed that open discussions by different professions would strengthen ethical patient care and provide what was best for the patient (Bartholdson et al., 2015; Engel & Prentice, 2013). Open discussions decreased the risk of nurses facing ethical dilemmas in patient care by themselves (Oerlemans et al., 2015). They also made it less likely that nurses would have to provide care or treatment that went against patients' wishes or other professions' professional values (Bartholdson et al., 2015; Oerlemans et al., 2015; Rasoal et al., 2016).

The balance of power among professions was addressed in the studies we reviewed. Ethical conflicts arose because professionals had different knowledge and their roles in the care process varied. Conflicts occurred when physicians expected nurses and other healthcare professionals to provide evidence-based knowledge for their decisions during the care process. Meanwhile, physicians did not always justify their own decisions (Engel & Prentice, 2013). Ethical conflicts that arose during interprofessional collaboration were also related to the degree to which all professions were involved in patient care. Nurses stated that it was crucial to know whether their voice would be heard or whether their opinions would be recognized or ignored. They believed that ethical interprofessional collaboration could only be achieved if they were treated as full participants in patient care. Nurses also believed that they could contribute to decision making, because they were working closely with patients and their families on a daily basis and were familiar with their patients' needs (Bartholdson et al., 2015; Oerlemans et al., 2015; Rider et al., 2014; Sabone et al., 2019). Some physicians did not see nurses' knowledge as valuable (Bartholdson et al., 2015; Sabone et al., 2019), and some nurses stated that they were not respected by physicians (Bartholdson et al., 2015; Engel & Prentice, 2013; Ewashen et al., 2013; Sabone et al., 2019). Other professionals, not nurses, also reported that they were not heard or involved during interprofessional collaboration (Engel & Prentice, 2013; Ewashen et al., 2013) and were side-lined by other health care professionals (Ewashen et al., 2013; Rasoal et al., 2016). For example, the contributions that social workers and occupational therapists made about patients' best interests were seen as less valuable than decisions made by other professions (Engel & Prentice, 2013).

Commitment to collaboration was also important. Ethical conflicts arose during nurses' interprofessional collaboration if all the professions who were involved were not committed to collaboration. Examples of ethical conflicts included ignorance of shared values (Grace et al., 2017) or not being aware of their organization's strategies for collaboration (Oerlemans et al., 2015; Sabone et al., 2019). In some studies, individual professionals favored their own methods, instead of seeking mutual agreement (Grace et al., 2017; Oerlemans et al., 2015; Payne & Farrell, 2015; Sabone et al., 2019), and that caused ethical conflicts. Ethical conflicts arose with regard to collaboration when nurses did not provide patients with prescribed medication, and treatment, or monitor them (Sabone et al., 2019). They also occurred when physicians ignored calls from nurses (Rasoal et al., 2016; Sabone et al., 2019).

There were problems with handling ethical conflicts in daily care and participating in ethical reflection. In one study, ethical conflicts arose in interprofessional collaboration when issues had not been discussed or resolved in time (Bartholdson et al., 2015), which threatened good care and violated patients' rights (Bartholdson et al., 2015; Oerlemans et al., 2015; Rasoal et al., 2016; Sabone et al., 2019). Nurses and nurse aides reported that initiatives that encouraged ethical reflection were disregarded, especially by physicians. Physicians said that they were willing to examine ethical issues with their own professional group, but did not have enough experience of mutual reflection with other professional groups (Bartholdson et al., 2015). Nurses and physicians stated that dealing with ethical questions was more difficult if there was lack of interprofessional collaboration and interaction (Bartholdson et al., 2015; Sabone et al., 2019). In one study, interprofessional collaboration in healthcare was identified a moral principle (Engel & Prentice, 2013).

Discussion

Based on our synthesis, the focus in previous studies has been on ethics during nurses' interprofessional collaboration and the roles that patients and different professional groups play in the care process. Ethical conflicts that related to the patients' role in care focused on meaning of their wishes and how treatment and forced procedures were carried out when those wishes were unknown or ignored. Nurses and other

professionals sometimes did not tell patients the truth about their health or why treatment had been carried out. In addition, patients did not always receive the pain relief they needed or benefit from the various pain care methods that were available for their condition.

Different professionals played different roles in caring for patients, and their primary aims could differ. For example, when treatment decisions were being made, physicians primarily focused on curing patients, while nurses considered patients holistically and placed a greater emphasis on care. In addition, the balance of power among professions had a number of effects, including unequal expectations of each other's evidence-based knowledge when it came to shared decision making. Another example of the balance of power was the degree to which all professions got involved and contributed to patient care. Some professionals lacked the commitment needed for collaboration. A lack of commitment resulted in a lack of interprofessional collaboration in clinical practice. This meant that professionals favored their own methods, rather than signing up to shared values or organizational strategies.

Ethics in nurses' interprofessional collaboration in clinical practice

In our synthesis we found that the patients´ role was related to ethical conflicts in nurses' interprofessional collaboration in clinical practice. Professionals had different understandings of patients' rights, autonomy, and integrity during interactions, treatment, and decision making. These findings were similar to other studies of ethics in interprofessional collaboration, where patients had been vulnerable and there were risks that their autonomy and right to provide informed consent had been infringed (Ulrich et al., 2010). However, the aim of health and social care is to provide good, ethical care to patients whose dignity is protected by legislation and professional ethics. Nurses and other professionals are responsible for providing care that responds to this goal (International Council of Nurses, 2012; World Medical Association, 2015). They also need to recognize the important role that patients play in the care process, as this will ensure that they receive good care and are treated with dignity.

It was noteworthy that based on our review patients were not described as active stakeholders when ethical conflicts arose about their care during nurses' interprofessional collaboration. In addition, patients were described in relation to their health status, not their individual characteristics. Therefore, professionals need to have open discussions with patients and develop mutual trust among stakeholders (Gágyor et al., 2019; Interprofessional Education Collaborative, 2016). In addition, it is important to recognize the individual needs of patients when ethical decisions are made during interprofessional collaboration. Collaboration supports shared and independent decision making and recognizes the patients' own responsibilities (Nordin et al., 2017; Sidani & Fox, 2014). In other studies, ethical questions about patient care have been closely linked to such individual characteristics as sex, gender, economic status, and ethnic background (Krok-Schoen et al., 2019; Sahlström et al., 2019). Future researchers need to focus on how to involve patients in decisions about their care when ethical conflicts arise during interprofessional collaboration in clinical practice.

Based on our findings, the different caring roles of various professionals hindered how ethical issues were addressed during interprofessional collaboration. Caring roles were connected to different professionals' different values and unequal levels of power. Values have also varied between health and social care professionals in previous studies, with some professionals expressing limited understanding of the values of other professions (Dennis et al., 2014; Rämgård et al., 2015). Interprofessional collaboration is challenging, because professionals need to acknowledge other professions and their skills (Interprofessional Education Collaborative, 2016) and work together to achieve shared goals (Interprofessional Education Collaborative, 2016; Reeves et al., 2017). Professionals need to realize that open and mutual discussions require respect and trust. They need to highlight the different skills of professional groups and enable each other to use their joint knowledge to optimize patient care (Engel & Prentice, 2013). In addition, professionals need to listen to each other and encourage others to engage in ethical interprofessional collaboration.

Methods chosen by the studies we reviewed

We only identified nine papers, and three of those were theoretical. The concepts that were used were heterogeneous, and it was challenging to create synthesis based on the selected papers. Rainer et al. (2018), who studied how ethical dilemmas were handled in clinical practice, reported similar findings. They reported that previous authors saw moral distress and ethical dilemmas in the same way as ethical questions, challenges, issues, conflicts, and dilemmas. Chiaranai (2011) carried out a concept analysis of ethical dilemmas and reported that ethical and moral concepts had been used interchangeably in the literature. Accordingly, clarifying the concepts that are used would improve our understanding of the phenomenon and make it possible for further empirical research to be carried out into the ethical issues that arise during interprofessional collaboration.

Based on our findings, ethics was mainly studied in regard to the relationships among hospital nurses and physicians. This seems reasonable, as they are two of the largest professional groups in hospitals, and legally physicians have the ultimate responsibility for the care of patients. Therefore, in the future, more attention should be paid to how nurses and physicians are committed to interprofessional ethics and how they engage, and recognize, the values of other professions during the care process. It is worth noting that we only identified a few studies, in which the authors focused on, or separated, other health and social care professionals, such as social workers and physiotherapists. However, these professionals play a crucial role in responding to patients' multidimensional needs. Our findings are connected to developing integrated health and social care services, which requires interprofessional collaboration and shared values to qualify as patient-centered care (Gágyor et al., 2019; Sidani & Fox, 2014). Because of this, it would be useful to carry out a broader multidisciplinary examination of how aware professionals are of professional and interprofessional ethics in advanced service systems in various contexts (Gágyor et al., 2019).

Limitations of the study

Meta-synthesis enabled us to enhance our understanding of the aims of the study by synthesizing qualitative and theoretical papers (Noblit & Hare, 1999). Despite this, some limitations do need to be considered. Our study selection may not have identified all of the relevant papers. We consulted an information specialist to determine our search terms and synonyms, but we would have identified more studies on ethics in interprofessional collaboration if the inclusion criteria had not featured nurses. However, our aim was to study ethics in nurses' interprofessional collaboration. We did not limit the language that the papers were published in, to prevent language bias, but the papers we finally chose were all published in English. In addition, we carried out manual searches to prevent publication bias, but gray literature was not searched. Also, the concepts in relation to the phenomenon of this study were heterogeneous in the selected papers. They often lacked separation and clarification of other professions connected to ethical issues in nurses' interprofessional collaboration. Both of these issues may have affected the interpretation in this synthesis. That is why repeated discussions were carried out among the authors to ensure shared understanding at all stages of the research process. However, any final synthesis is the product of the researchers' approaches and interpretations (Noblit & Hare, 1999).

Conclusions

Our research on ethics during nurses' interprofessional collaboration in clinical practice identified qualitative and theoretical papers that focused on where patients and healthcare professionals were positioned in the care process. The ethical issues related to whether professionals respected patients' wishes, told them the truth, and managed their pain. Ethical issues also related to the primary aims of different professional groups, the balance of power among professions, and their commitment to collaboration. The research mainly focused on hospital nurses and physicians. The findings of this study could be used to inform developments in interprofessional training. It could also guide meetings about ethical issues in clinical practice and support how they are reflected on, and handled, in clinical practice. However, ethics in nurses' interprofessional collaboration is a wider phenomenon, and more research is needed on the ethical issues facing both health professionals and organizations. Future researchers need to take account of the perspectives and experiences of patients. The clinical value and ethical principles of patient participation in nurses' interprofessional collaboration in clinical practice need to be highlighted and strengthened. In future, more attention needs to be paid to the concepts used in interprofessional ethics and both empirical and theoretical research is needed to understand ethics in nurses' interprofessional collaboration in clinical practice.

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The authors have no conflicts of interest to declare.

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