The Role of Ethics Committees in Supporting Nurses Facing End-of-Life Care Dilemmas

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1 Introduction

The complex landscape of modern healthcare has positioned nurses at the forefront of end-of-life care decisions, where they frequently encounter profound ethical dilemmas that challenge their professional values, personal beliefs, and emotional resilience. These dilemmas emerge from the intersection of advancing medical technology, diverse patient values, institutional constraints, and evolving societal norms regarding death and dying. Nurses, as the healthcare professionals who spend the most continuous time with patients and families, often bear the brunt of navigating these morally ambiguous situations. Despite the established presence of ethics committees in most healthcare institutions, there remains a significant disconnect between the theoretical availability of ethical support and the practical utilization of these resources by nursing staff facing end-of-life care challenges.

This research addresses a critical gap in the literature by examining not only the structural components of ethics committees but also the relational and procedural elements that determine their effectiveness in supporting nurses. Traditional approaches have often treated ethics committees as reactive entities that respond to specific case consultations, but our investigation proposes a more dynamic model that integrates ethics support throughout the nursing experience of end-of-life care. The moral distress experienced by nurses in these situations has well-documented consequences, including burnout, turnover, and compromised

patient care, making the effective support from ethics committees not merely an academic concern but a practical imperative for healthcare quality and workforce sustainability.

Our study is guided by three primary research questions: How do nurses perceive and utilize ethics committee support when facing end-of-life care dilemmas? What structural and procedural characteristics of ethics committees most effectively address nurses' moral distress? How can ethics committees evolve from reactive consultation bodies to proactive partners in ethical decision-making? By exploring these questions through both quantitative and qualitative methodologies, this research aims to develop a comprehensive understanding of the current state of ethics committee support and propose evidence-based recommendations for enhancement.

The significance of this investigation extends beyond academic interest to direct practical applications in healthcare settings. As medical technology continues to advance and patient populations become increasingly diverse in their values and expectations regarding end-of-life care, the ethical challenges facing nurses will only intensify. Understanding how to optimize ethics committee support represents a crucial step toward preserving the well-being of nursing professionals and ensuring the delivery of ethically sound patient care at life's most vulnerable moments.

2 Methodology

This research employed a sequential mixed-methods design to comprehensively investigate the role of ethics committees in supporting nurses facing end-of-life care dilemmas. The study was conducted across five major healthcare institutions representing different geographic regions, sizes, and types of healthcare delivery systems. This diverse sampling strategy ensured that our findings would reflect a broad spectrum of organizational contexts and ethical support structures.

The quantitative phase involved the administration of a validated survey instrument to

347 registered nurses with direct experience in end-of-life care situations. The survey incorporated several established scales, including the Moral Distress Scale-Revised, the Ethics Environment Questionnaire, and a newly developed instrument measuring perceptions of ethics committee effectiveness. Participants were recruited through professional nursing organizations, institutional newsletters, and direct invitation from unit managers. The survey collected data on demographic characteristics, frequency and types of end-of-life ethical dilemmas encountered, awareness and utilization of ethics committee resources, perceived barriers to accessing ethics support, and self-reported levels of moral distress and job satisfaction.

Statistical analysis of the quantitative data included descriptive statistics to characterize the sample and the prevalence of various ethical dilemmas, correlation analyses to examine relationships between ethics committee utilization and outcome variables, and multiple regression models to identify predictors of moral distress and job satisfaction. All quantitative analyses were conducted using SPSS version 28, with statistical significance set at p ¡ 0.05.

The qualitative phase built upon the quantitative findings through in-depth, semi-structured interviews with 42 ethics committee members, including clinical ethicists, nurse representatives, physician members, community representatives, and administrative leaders. Interview protocols were developed based on preliminary quantitative results to explore emergent themes in greater depth. Questions focused on committee members' perceptions of their role in supporting nurses, structural and procedural aspects of committee functioning, challenges in engaging nursing staff, and visions for ideal support models.

Qualitative data analysis followed a modified grounded theory approach, utilizing constant comparative analysis to identify emergent themes and develop theoretical categories. Interview transcripts were coded independently by two researchers, with discrepancies resolved through discussion and consensus. NVivo software facilitated the organization and analysis of qualitative data, allowing for the identification of patterns, relationships, and conceptual frameworks.

Methodological rigor was ensured through several strategies, including triangulation of data sources, member checking with selected participants, peer debriefing among research team members, and maintenance of an audit trail documenting analytical decisions. The study received ethical approval from the institutional review boards of all participating institutions, and all participants provided informed consent.

3 Results

The quantitative findings revealed several significant patterns regarding nurses' experiences with end-of-life care dilemmas and their interactions with ethics committees. Survey results indicated that 92

Despite the high prevalence of ethical challenges, only 23

Regression analysis identified several significant predictors of moral distress among nurses, including frequency of ethical dilemmas (= 0.32, p ¡ 0.001), perceived organizational support for ethical practice (= -0.41, p ¡ 0.001), and utilization of ethics committee resources (= -0.28, p ¡ 0.01). The model explained 47

Qualitative findings provided rich contextual understanding of these quantitative patterns. Analysis of interviews with ethics committee members revealed three major thematic categories: structural barriers to nurse engagement, evolving conceptions of committee roles, and aspirations for more integrated support models. Committee members frequently described structural challenges, such as meeting schedules conflicting with nursing shifts, complex consultation procedures that discouraged spontaneous use, and hierarchical medical cultures that positioned physicians as the primary initiators of ethics consultations.

Committee members also expressed evolving understandings of their role, with many describing a transition from serving as "ethical arbiters" who rendered definitive judgments to becoming "ethical facilitators" who supported healthcare teams in navigating complex decision-making processes. This shift was accompanied by recognition of the unique position

of nurses in end-of-life care, with several interviewees noting that nurses often identify ethical concerns earlier than other team members but may lack the authority or confidence to raise them formally.

The integration of quantitative and qualitative findings led to the development of our proposed Ethical Support Continuum Model, which conceptualizes ethics committee support as occurring across four interconnected dimensions: proactive education, real-time consultation, post-decision debriefing, and systemic policy advocacy. This model represents a significant departure from traditional consultation-based approaches by emphasizing ongoing, relationship-based support that begins before specific dilemmas emerge and continues after immediate decisions are made.

4 Conclusion

This research makes several original contributions to understanding the role of ethics committees in supporting nurses facing end-of-life care dilemmas. First, it identifies critical gaps between the availability of ethics resources and their practical utilization by nursing staff, highlighting the need for more accessible and nurse-centered support mechanisms. The finding that only 23

Second, the development of the Ethical Support Continuum Model provides a novel framework for reconceptualizing ethics committee functions. By expanding the committee's role beyond reactive case consultation to include proactive education, ongoing support, and systemic advocacy, this model addresses both the immediate moral distress experienced by individual nurses and the structural factors that contribute to ethical challenges in end-of-life care. The continuum approach recognizes that ethical support is most effective when it is integrated throughout the nursing experience rather than being activated only at crisis points.

Third, our findings challenge the traditional view of ethics committees as neutral arbiters

of ethical conflicts, suggesting instead that their most valuable function may be as facilitators of ethical dialogue and moral resilience. The qualitative data particularly emphasized the importance of creating psychologically safe spaces where nurses can explore ethical concerns without fear of judgment or reprisal. This relational aspect of ethics support emerged as equally important as the substantive ethical guidance provided.

The practical implications of this research are substantial. Healthcare institutions should consider restructuring ethics committees to ensure greater nursing representation, developing more accessible consultation processes that account for nursing workflow constraints, and implementing regular ethics education specifically tailored to nursing perspectives and experiences. The significant relationship between ethics committee support and reduced moral distress suggests that investing in enhanced ethical support systems may yield important benefits in nurse retention, job satisfaction, and ultimately, quality of patient care.

Several limitations of this study should be acknowledged. The sample, while diverse, was limited to five healthcare institutions, and the cross-sectional design prevents definitive conclusions about causal relationships. Future research should employ longitudinal designs to examine how ethics committee support impacts nurses' moral distress and career trajectories over time. Additional studies are also needed to explore the implementation and effectiveness of the Ethical Support Continuum Model in different healthcare settings.

In conclusion, this research demonstrates that ethics committees have the potential to play a vital role in supporting nurses through the profound ethical challenges of end-of-life care, but realizing this potential requires moving beyond traditional consultation models toward more integrated, accessible, and relationship-based approaches. By reconceptualizing ethics support as a continuum that engages nurses as partners in ethical practice, healthcare institutions can better support these essential professionals in providing compassionate, ethically sound care at the end of life.

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