The Influence of Teams, Supervisors and Organizations on Healthcare Practitioners' Abilities to Practise Ethically

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Abstract

Healthcare practitioners make many important ethical decisions in their day-to-day practices. Questions arising in daily practice require practitioners to make prudent, balanced and good decisions, which are most effectively made interpersonally and reflectively. It is commonly assumed that the team-based structure of healthcare delivery can provide practitioners with the support needed to address ethical questions in their practice, especially if the team involves multidisciplinary collaboration. A phenomenological study was conducted in which the impact of the team and the larger organization on practitioners' experiences of dealing with moral challenges was uncovered. Various mental healthcare professionals shared their experiences of ethically challenging situations in their practices and described the ways in which their teammates and supervisors affected how they faced these troubling situations. These findings allow us to see that there is considerable room for healthcare managers, many of whom are nurses, to facilitate supportive, ethical environments for healthcare professionals. An understanding of the essential experience of practising ethically allows for an appreciation of the significance of the team's role in supporting it and enables healthcare managers to target support for ethical healthcare work.

Healthcare professionals are faced with daily ethical challenges. Making care decisions without complete or perfect information, allocating scarce resources and interacting with various components of a large and sometimes unresponsive healthcare bureaucracy can be troublesome to practitioners and can create an ongoing sense of distress. It is commonly assumed that the team-based structure of

healthcare delivery can provide practitioners with the support needed to address ethical questions in their practice, especially if the team involves multidisciplinary collaboration. Likewise, it is often assumed that nursing leaders are positioned to be able to facilitate ethical care in their organizations. In today's complex and ever-changing healthcare environment, it is increasingly important to understand how professional colleagues and nursing leaders influence practitioners' ethical experiences at work. This study used a phenomenological approach to examine the ways in which team members, supervisors and organizational characteristics affected practitioners' experiences in their efforts to "do the right thing" in their practices. The ways in which the healthcare team can be a powerful force in practitioners' abilities to cope with the moral demands of professional practice were revealed.

Literature Review

Teams are intact social systems with boundaries, functioning within an organizational context and characterized by interdependence among members in different roles, all working on specific tasks toward a common purpose (Hackman 1990, cited in Parris 2003). Interdisciplinary teams are touted for their potential to improve continuity and quality in healthcare (Hermsen and Ten Have 2005; Kalisch and Begeny 2005; Kvarnstrom and Cedersund 2006; Larkin and Callaghan 2005). As well, the role of the team in contributing to a supportive work environment is gaining popularity as a research topic (Parris 2003). Social support has been found to buffer the negative effects of job stress, protecting an individual against the adverse effects of stress (Sargent and Terry 2000), enhancing performance and making an individual feel comfortable in asking for help from co-workers when faced with uncertainties (AbuAlRub 2004; Heaney et al. 1995). Many studies, however, focus on the outputs of teams, ignoring the experiences of individual people working within them (Parris 2003). "Teamwork," "collaboration" and "interdisciplinary" are buzzwords in the literature and in policy documents, words that can mask what is often a painful, difficult reality (Odegard 2006). Phenomenological research by Parris (2003) among Australian team-based workers demonstrated that team members want and expect to receive emotional, practical and affirming support from their teammates and experience a sense of belonging and of making a unique contribution. However, several of the respondents in her study perceived that support was not always offered to them by their team members, leading to intensified emotions, disappointment, apathy, despondency and isolation.

Professional "tribalism" (Larkin and Callaghan 2005) can also interfere with information sharing and team-based social support. Each profession has a different culture and typically works within its own boundaries. Times of stress, which are ever more frequent in today's healthcare system, can cause team members to retreat further into professional divisions because they are perceived to be safe

(Hall 2005). Practitioners often find it easier to maintain traditional professional boundaries by stereotyping others (Bleakley 2006), thereby perpetuating traditional status clashes within and among professional groups and contributing to an ongoing cycle of distress (Robinson and Cottrell 2005). Well-functioning teams are often characterized by a lack of interprofessional jealousy, where members do not attempt to dominate others, and each sees the other as of equal status (Molyneux 2001). Ultimately, developing a sense of collective responsibility for dealing with moral issues ensures the solidarity of the team and positions it to face future situations from a position of strength (Melia 2001).

Several researchers have acknowledged the high level of stress involved in healthcare practice. Healthcare professionals often manage challenges relating to sensitive matters and patient confidentiality (Robinson and Cottrell 2005), deal with intense patient and family interactions (Bruce et al. 2005; Jenkins and Elliott 2004) and confront difficult and challenging patient behaviours (Edward 2005; Jenkins and Elliot 2004; White and Featherstone 2005). If individuals lack positive support from co-workers, these stressors can be so severe that they result in burnout and emotional exhaustion (Bruce et al. 2005; Jenkins and Elliott 2004). Resilience, the ability to recover from and rise above difficult situations, is promoted in large part by the availability of effective social support, according to research by Edward (2005). Saving face, sharing knowledge, having support for decisions and feeling empowered have been shown to be some of the benefits of a trusting team environment (Kvarnstrom and Cedersund 2006).

Although there have been numerous studies on job satisfaction, stress and work environment, few researchers have focused on the moral component of these concepts (Corley et al. 2005). The construction of "ethics" as a situational, biomedical matter has overshadowed the reality that practitioners make many important ethical decisions in their day-to-day practices (Chambliss 1996; Rodney et al. 2002; Varcoe et al. 2004). Ethical discussions have taken on a theoretical character, an abstract approach that is not relevant to the front-line practitioner (Lützén and Schreiber 1998). However, the moral dimension of care is so bound up with practice and its organization that it does not make sense to separate and isolate ethical issues for examination (Melia 2001). Questions arising in daily practice require practitioners to make prudent and balanced decisions, which are most effectively made interpersonally and reflectively. These decisions have a moral dimension because they emphasize values related to life, living and the inclusion of a variety of perspectives (patients, families, other professionals) (Hermsen and Ten Have 2005). With the acknowledgement of the moral aspect of healthcare decision making, a new understanding of work-related stress as "moral distress" has emerged. "Moral distress," a concept first defined by Jameton (1984), arises when one believes one knows "…the right thing to do, but institu-

tional constraints make it nearly impossible to pursue the right course of action" (Jameton 1984: 6), a situation that can lead to pain, anguish and changed relationships, and a perception of having participated in moral wrongdoing (Austin et al. 2005; Lützén and Schreiber 1998). Not only is healthcare practice an inherently moral labour, the promotion of teamwork, communication and knowledge sharing is inherently ethical because it requires "that practitioners suspend self-centeredness for other-centeredness" (Bleakley 2006). However, healthcare professionals appear to have difficulty framing ethical issues in collaborative or team terms (Bleakley 2006). Fear of appearing weak (Parris 2003), fear of being reported, and/or feeling unsupported or misunderstood by others are distractions that keep practitioners focused on team dynamics rather than on sound moral decision making (Lützén and Schreiber 1998).

There is a growing body of literature on ethical challenges in healthcare practice. Some studies touch on the contextual aspects of ethical clinical practice. In a study aimed at exploring the meaning of ethics for nurses providing direct care, researchers found that nurses' abilities to practise ethically are inseparable from contextual factors such as organizational policy, resource availability and hierarchical power structures (Storch et al. 2002). Rodney (1997) found that nurses' work was fraught with everyday ethical problems that created significant moral distress for them. She found that nurses enacted their moral agency by interacting with other team members, a process that was facilitated by trust and authenticity, although it was often observed that poor communication, dominant professional ideologies and a devaluing of certain types of patients were barriers to effective moral decision making. Lützén and Schreiber (1998) found that nurses who attempted to manage or ameliorate their work-related ethical difficulties had to struggle against non-therapeutic practice environments by navigating power relationships, protecting themselves from professional vulnerability and balancing the needs of their patients with the demands of their supervisors. Varcoe and colleagues (2004) found that nurses were required to work in a shifting moral context, constantly balancing their own values with those of the organizations in which they worked and other professionals working within them.

It has been only recently that researchers have begun to focus specifically on the ethical nature of the organization (Corley et al. 2005). Healthcare organizations are, however, actually positioned at the heart of issues in health ethics (Silva 1998). The contemporary healthcare system is characterized by a biomedical emphasis on technology and cure, an ideology of scarcity and, increasingly, business-focused structures and values (Varcoe et al. 2004). While there may be nothing inherently unethical about corporate principles in healthcare or the idea of cost containment, organizations must take care to avoid achieving these goals at the expense of the

moral foundation of the healthcare system itself (Mohr and Mahon 1996). James (2000) argues that most ethical dilemmas occur because of aspects of organizations that undermine ethical behaviour by employees, such as over-emphasizing the bottom line, focusing on short-term results, pressuring employees to be "team players" and placing the responsibility for ethical practice on individuals.

Storch and colleagues conclude from the findings of their study about ethics in practice that "nurse leaders must be ready to facilitate identification of ethical and moral issues" (2002: 11) in clinical practice in their organizations. They also note, however, that nursing leaders must balance practitioners' needs with the expectations of other managers, a situation that can cause leaders to be too timid in raising issues or to insist that nurses simply stay silent and cope.

Given the difficulties inherent in teamwork and leadership in today's complex healthcare environments and the lack of research about these contextual aspects of ethical practice, there is much to be gained by further exploring the limits and benefits of collectivity in ethical decision-making. A more profound understanding of moral decision making and its connection to teamwork and organizational functioning is needed. It is only when we really understand the essential and contextual aspects of ethical practice that management support for ethical care can be offered.

Study Method

This was a phenomenological study, the intent of which was, in part, to explore the contextual dimensions of ethically challenging situations in practice. After obtaining research ethics committee approval, participants were recruited by using word of mouth, posters and newsletter advertising. Interviews were conducted with 20 mental health practitioners, including seven nurses, six psychiatrists, five psychologists, one social worker and one psychiatric aide, from a variety of institutional and community-based mental healthcare settings. Phenomenological interviews are a means for exploring and gathering descriptive experiential material that allows for a rich and deep understanding of the meaning of human experience (Van Manen 1990). One interview was conducted with each participant, during which the participant was asked to describe his/her experience with morally distressing situations at work. Interviews were audiotaped and transcribed in order to capture the descriptions accurately. Rigour was ensured by maintaining investigator flexibility and creativity, ensuring congruence between the research question and the research method, using an appropriate research sample consisting of knowledgeable participants, engaging in a collaborative data analysis process to encourage theoretical thinking and ensuring that thematic categories were saturated with and supported by data (Morse et al. 2002).

Phenomenology begins with a thematic analysis of lived experience. Uniquely, however, thematic analysis in phenomenology is intended to conceptualize the meaningful aspects of an experience (Van Manen 1990). Phenomenological themes were identified by reading each interview transcript and looking for coherent sections or passages pertaining to team member, supervisor, or organizational influences in ethically challenging situations. Issues raised by one participant were grouped with similar issues raised by others to form thematic categories. Next, it was determined what phrase best captured the meaning of the grouped passages of text. In this article, we report on the study findings at the level of thematic analysis[1] in order to provide a concise and useful framework for considering the ways in which teams, supervisors and organizations influence practitioners' experiences of practising ethically.

Findings

The thematic analysis reveals several ways in which practitioners' abilities to act ethically in healthcare practice can be affected by others.

Team influences

Although there were a few examples of positive team influences on practitioners' experiences, there were, unfortunately, several ways in which team members' behaviours contributed to heightened moral distress.

Coping with power imbalances. Some practitioners, especially nurses, talked about the constraints on their professional decision-making from inter- and intra-professional power imbalances. One psychologist likened her multidisciplinary healthcare team to a "dysfunctional family" with abusive members exploiting passive and weak members (Ruth).[2] Semira, a nurse, thought that nurses were not being heard by certain physicians. She recalled that in team conferences, patient care decisions were often medical decisions rather than team decisions. She talked about how a physician seemed to "laugh it off" when she voiced her concern about sending a patient home to an abusive situation. Nurses noted a general lack of respect for nursing knowledge that resulted in a devaluing of nurses' assessments of patient need. One nurse, Suzanne, was called "a spy for the pharmacy department" by physicians who were apparently threatened by her extensive pharmacological knowledge; her valuable knowledge was dismissed because she was not viewed as a "typical nurse." Arlene said that "some of my nursing ethical concerns that were brought forward were not addressed" because nurses can be the "lowly one on the totem pole." Heather spoke of a patient situation where the nurses needed physician support to deal with a difficult patient. Although the

[1] The extended phenomenological descriptions are reported elsewhere.

[2] All participant names are pseudonyms.

nurses in this situation charted their concerns and expressed them verbally to the doctor, "you see his notes after [he saw the patient] … it's completely opposite to what you've charted." These nurses felt thwarted in their efforts to provide good care because "your observations aren't really recognized."

The power imbalances described occurred within professions as well. Nurses observed an intra-professional hierarchy, typically based on educational status, leading to marginalizing and exclusionary behaviour or to self-isolation as a way of coping with differing world views. Suzanne was ignored by nurses as well by physicians. Lorraine, another nurse, explained that diploma-educated nurses in her agency were limited in their career choices and felt powerless and less respected and, as a consequence, behaved negatively, especially since a new policy was implemented in her agency to hire only nurses with graduate degrees.

Being unsupported by peers. Several practitioners told of situations in which they were not supported by their peers when attempting to act as patient advocates and shared examples of interference from colleagues. Arlene, an agency nurse, told of a situation involving a family with which she had worked extensively. Although "everything in me said this was wrong," she risked the destruction of a productive therapeutic relationship to comply with her colleagues' wishes that she report an unproven issue in the parent–child relationship. Similarly, Semira had a colleague override her decision not to call security when she was dealing with a difficult patient. She thought that the interference put her "back five steps" from what she had achieved in her therapeutic relationship with that patient. Heather, another nurse, explained how practitioners must make judgment calls that seem right at the time but then wonder if the staff will be supportive after the fact. She experienced this first-hand when she was reported by another nurse for giving a patient a medication in the kitchen. Wally, a psychologist, noted that if nurses disliked his care plans, they actively attempted to illustrate how he was not doing his job properly, despite their lack of knowledge of his profession. Mary, a psychiatrist, was reported to her college by a nurse, who was not deemed credible by her nursing peers, regarding medication decisions. Other colleagues assured her "that I hadn't been acting inappropriately," but she was continually "second guessed" by this nurse and constantly frustrated in her efforts to give good care. Anson, another psychiatrist, experienced initial support from his colleagues for his decision to certify a patient, only to find out that, when it came time to "deal with the fallout," he was on his own.

Some of the professionals in this study decided not to speak up about distressing situations because they "didn't want to alienate [their] position on the team" (Wally). Semira believed that "what's happening is some people are just deciding that if they can't make a change then they're not going to put themselves at any

risk." Heather said, "You don't have the support when you do report something. People don't report things, nor do they believe anybody else should." Ruth, a psychologist, noted that although her colleagues might agree with the issues she raised, they simply would not do anything because they lacked energy due to overwork. Mary, the psychiatrist, thought that dealing with the lack of support from team mates created another set of ethical issues for a practitioner. She found that "knowing whether to push the system further," deciding "should you be writing letters? Should you be doing things?" was "where the ethics come in."

Having nobody with whom to talk. When asked about ways of dealing with ethically challenging issues, Heather, a nurse, responded that "there really isn't anybody at work to talk to." Nicole, a nurse in a casual position, was very aware of what it meant to be professionally isolated: working with a "whole stream of unknown faces day after day, there's not anyone really to turn to." She thought that if she ever experienced an ethically distressing situation, she wouldn't know whom to tell. Semira described a general atmosphere of fear and paranoia regarding confidentiality when practitioners were disclosing issues to each other. Lorraine, a nurse, stopped going to her professional practice committee meetings because they were so negative, losing a potential opportunity to discuss concerns with professional peers. One psychiatrist, Anson, talked about his desire to have more informal collaboration with colleagues to help him deal with his feelings of professional alienation and helplessness. The social worker in this study, Elizabeth, also experienced professional isolation because the uniqueness of her specialty made it difficult for her to find the understanding she needed. Suzanne talked about "putting out feelers" to find like-minded nurses so that there would be "at least some person that you could relate to and trust." Sadly, many of these practitioners were unable to establish these trusting relationships to any significant extent.

Relying on the team. Indeed, there were some positive examples of teamwork and of how team interactions bolstered professionals' capacities to deal with ethically difficult situations. A nurse, Lorraine, explained that she has learned to bring her concerns to her team sooner rather than trying to figure them out on her own. She felt able to count on her teammates and to speak freely about the things that worried her. Another nurse, Connor, told of an incident in which a patient attempted suicide, after which the nurses were able to console each other and make sure that each team member was alright. One psychiatrist talked about how, from her time as a resident, she had learned to rely on and trust nurses (Mary). Other practitioners spoke of a similar respect for team members from other disciplines, explicitly noting the contributions that other professionals make to patient care. Several of the professionals interviewed described experiences of being able to rely on team members for feedback, reassurance, encouragement, clarity and support.

For healthcare professionals working in multidisciplinary teams, hierarchical behaviour, lack of support and isolation can magnify the difficulty of dealing with moral dilemmas at work. When practitioners do experience team support, ethical burdens can be shared and positive solutions can emerge.

Supervisory and organizational influences

Professional practice occurs within a given organizational context and, at times, organizational structures or individual organizational representatives can fail to facilitate ethical professional practice.

Silencing due to fear of reprimand. The problem of not having colleagues with whom to share concerns can be aggravated when supervisors make the sharing of issues a disciplinary matter. Semira felt a lack of supervisory support for moral dilemmas in her work that led to silencing and fear of reprimand. Although her supervisors would say, "Our doors are open – if you ever need to talk about anything, you know, our doors are open," the supportive atmosphere this suggests was not realized in her actual experience. Instead, she was disciplined for expressing emotion (tears) at work after an argument with another nurse. Arlene, also a nurse, was disciplined for raising issues about her physical work environment. When she introduced her concerns at a staff meeting, she was "shut down right away" and then later called into her manager's office and told that it was "inappropriate to complain." Similarly, although Ruth, a psychologist, said "it's not ethical for me to practise with no soundproofing" (which would have prevented clients from overhearing conversations in adjacent rooms), she knew that there was no value in "ruffling feathers." In her long-term care facility, Jean experienced a chronic lack of necessary resources but saw that "if you complain, you're out. Some staff tried to get the union in and they were gotten rid of." Psychologist Heidi observed that "the system is bigger than me and it wants to go back to routine and you keep getting silenced." Without the support of their supervisors in dealing with their ethical concerns, many regarding necessary resources, these professionals experienced profound frustration and distress.

Feeling at odds with organizational goals. Several of the practitioners experienced incongruence between professional and organizational goals. Both Heidi, a psychologist, and Arlene, a nurse, had their "fingers slapped" for writing letters to advocate for their clients, despite the existence, in Arlene's case, of "a mission statement that says we advocate for children." Both of their managers intercepted their letters of advocacy, putting the agency's reputation ahead of the practitioners' professional autonomy and the needs of their clients. The difference between the objectives of administrators and clinicians was also highlighted by George and Ian, two psychiatrists. Ian related a story about struggling through a difficult family situation, working with the hospital administration and a multi-professional team.

He was bothered by "a tiny bit of finger pointing that went on initially by administration" because of their desire to keep the case from becoming negative and high profile. George saw the goal of the hospital and its legal department as minimizing liability, which is different from the need of a clinician to make and live with ethical decisions. Wally, a psychologist, also experienced the tension between organizational and clinical goals. He said:

> The overall goal is to preserve the reputation of the centre. The overall goal is not the health and welfare of the client and sometimes we have to advocate for the client at the risk of alienating the department of which we are a member, because their priorities are slightly different than our priorities as healthcare providers. If I were to do something for the sake of a client that went against a directive of the organization then I would be censured.

All of these practitioners experienced considerable distress as they attempted to balance competing objectives and still serve their clients ethically.

Not being understood by a supervisor. Cross-disciplinary reporting structures, common in program management structures, can exacerbate distressing situations. One psychologist felt unable to talk to her supervisor "because she comes from a different theoretical position" (Cleo). Another psychologist, Heidi, reporting to a nurse, found her supervisor to be medically oriented and to have little respect for Heidi's theoretical orientation to practice. The supervisor was not knowledgeable about Heidi's standards of practice, qualifications and capabilities, yet micromanaged Heidi's practice, even reversing her clinical decisions. As well, an understanding of the practice patterns and staffing needs of others is not always present across disciplines. Nurses also find themselves reporting to managers from other disciplines. This can be "really frustrating for the nurses because the unit manager can't really appreciate what the problem is" (Heather). Elizabeth, a social worker, summed up what several of these practitioners had experienced: "Sometimes a discipline supervising another discipline just doesn't quite make it."

Avoiding formal ethical decision-making structures. Interestingly, some of the practitioners expressed wariness about formal ethics structures in their organizations. In Heather's organization, there is a "critical stress team" that can be accessed by staff who wish to debrief stressful incidents. Heather has made use of this team, but "there's only one time I called and felt this person really understood." Mary, a psychiatrist, said that her "ethics committee had a bad reputation and so I never used them." She felt that ethics committee discussions lacked practicality and was concerned about how she might "be able to live with the recommendation," especially if it differed from her professional opinion. Likewise, George (psychiatrist)

also wondered about the competence of his ethics committee and was concerned about whether the committee would really help, "or are they going to be creating more problems." Both George and Anson, another psychiatrist, observed that it is not always clear when a given situation requires an ethics consultation, and both wondered whether committees would be available when needed. While not all practitioners experienced supportive teamwork, many of them expressed greater hope in the potential of local, informal collaboration, rather than formal organizational structures, to yield sound solutions to ethical dilemmas in practice.

For healthcare professionals working in organizations, difficulties in dealing with the ethical demands of practice can be exacerbated by fear of reprimand, incongruence between professional and organizational goals, and cross-disciplinary reporting relationships. Formal organizational ethical supports are not always valued or accessed by practitioners who would prefer, instead, to be able to rely on each other for moral decision-making.

Implications for Leaders

The results of this study reveal many ways in which practitioners' experiences of dealing with moral and ethical issues are impacted, often negatively, by the actions of their teammates and supervisors and by the characteristics of their organizations. The everyday nature of ethical dilemmas in practice (Chambliss 1996; Lützén and Schreiber 1998; Melia 2001; Varcoe et al. 2004) and the need for emotional, practical and informational support and the approval of team members (Parris 2003) are evident among these practitioners. Barriers to effective, collaborative ethical problem solving such as professional hierarchies, lack of resources and other organizational supports, the fear of being reported, feeling unsupported or misunderstood by others, and balancing conflicting clinical and organizational demands are apparent in these findings, which are consistent with other research on this topic (Larkin and Callaghan 2005; Lützén and Schreiber 1998; Parris 2003; Rodney 1997; Storch et al. 2002; Varcoe et al. 2004). These professionals had to struggle against and constantly manage their organizational environments in order to protect themselves and their patients (Lützén and Schreiber 1998; Varcoe et al. 2004) and had to decide whether it was safe to raise issues in order to address distressing circumstances (Austin et al. 2005).

The purpose of this study was to add depth to our understanding of the contextual factors that facilitate (or not) ethically sound professional practice, specifically the influence of the organizational environment on practitioners' abilities to deal with moral dilemmas and their experiences of moral distress when they are thwarted in their attempts to practise ethically. Moral distress is complex, messy and multi-faceted when it is lived in practice (Austin et al. 2005) and does not lend

itself well to "quick fix" solutions. Nevertheless, understanding the moral dimension of professional practice and the moral distress that can arise is the first step toward taking action (Austin et al. 2003). These findings allow us to see that there is room for healthcare managers, many of whom are nurses, to facilitate supportive, ethical environments for healthcare professionals. Turmoil and concern are heightened by lack of support and respect, poor communication, inadequacies in the physical environment and other operational features. The extent to which these issues are addressed can be a reflection of how an organization values its professional employees, especially its nurses (Beaudoin and Edgar 2003).

Rodney and colleagues (2002) have called for nursing leaders to analyze and improve the moral foundations of healthcare policy. Nursing leaders are needed to serve as a "moral compass" and "to mitigate the disjuncture between moral intent and moral action" (Storch et al. 2002: 12). Managers are able to facilitate supportive environments for healthcare professionals by influencing the organizational climate and establishing ethical practice environments, being aware of the significance of teamwork and social support, serving as role models for their staff and influencing structural factors such as team size and stability, work schedules and care assignments, adequate job control and empowerment, and rewards and recognition (AbuAlRub 2004; James 2000; Kalisch and Begeny 2005; Storch et al. 2002; Sutinen et al. 2005). These structural features can have a significant impact on the level of intra- and inter-group conflict (Cox 2003), which was an issue for the professionals in this study. Information, support and strong alliances with co-workers are vital to creating practice environments that minimize distress (Laschinger et al. 2003). Leadership that is emotionally intelligent, relational and democratic has been found to promote quality working environments, especially during times of change (Cummings et al. 2005).

Several investigators have examined the structural features of functional healthcare teams, providing examples of strategies that managers can use in their efforts to build ethical practice environments. Clear lines of communication and opportunities for formal, face-to-face conversations have been found to be important in developing coordinated approaches to care (Larkin and Callaghan 2005; Molyneux 2001; Robinson and Cottrell 2005), and this study has shown that this would likely be well received by practitioners. Managers can support the resolution of ethical dilemmas by granting decision-making authority to those with the most knowledge about the decisions being made, such as the clinicians themselves (James 2000). Further, managers can take the time to listen to nurses' (and other practitioners') moral voices, foster dialogue and give practitioners the time they need to talk to each other about ethical issues in their work, all of which are currently lacking in today's practice environments (Storch et al. 2002; Varcoe et al. 2004), including the workplaces of many of the practitioners in this study. This

would support ethical decision making in a way that ethics committees have not been found to do, both in this research and elsewhere (Storch et al. 2002).
The contemporary healthcare environment emphasizes business principles, scientific practice knowledge and technologically based physician care within a culture of scarcity (Silva 1998; Varcoe et al. 2004; Wall 2008). Daily ethical issues are often sidelined, dismissed as ordinary and not named as ethical issues (Varcoe et al. 2004). Yet, many of the ethical obstacles that nurses and other professionals attempt to overcome are a function of the power dynamics resident in the healthcare system (Storch et al. 2002). While various professionals in this study commented on the positive aspects of multidisciplinary teamwork, many also spoke of power imbalances and professional hierarchies that interfered with practitioners' abilities to act ethically and of organizational priorities that were inconsistent with ethical practice. This is consistent with the findings of other studies that have examined health professionals' ethical experiences (Austin et al. 2003; Austin et al. 2005; Storch et al. 2002; Varcoe et al. 2004). Nursing leaders, while called upon to influence the organizational climate, are in the unenviable position of having to uphold the dominant discourses in healthcare and attend to corporate priorities while serving as advocates for practitioners and patient needs, a task that has proven difficult for them (Storch et al. 2002). As in other research (Storch et al. 2002), practitioners in this study found that their managers silenced their expressions of moral distress and promoted organizational goals over clinical needs. There is considerably more work to be done to understand how the ethical decision-making of marginalized professions can be supported by nursing managers and how nursing managers navigate their conflicted roles. Nevertheless, practitioners can and do find ways to manage their contexts and enact moral agency (Varcoe et al. 2004), and institutional change can occur with widespread support, deliberate action and moral courage on the part of practitioners and managers alike (Austin et al. 2003; Storch et al. 2002).

Ironically, this is an era of both constant change and continuing traditions. Healthcare managers face formidable challenges as they attempt to balance the goals of organizations vis-à-vis those of professional team members. While this makes it difficult for them to enact strategies that will support practitioners in the ways they would prefer (Robinson and Cottrell 2005), there is a significant opportunity, as this study has shown, to address practitioners' needs for the respect, understanding, support and resources that they require to practise ethically and to look in the mirror, approve of the person they see there, and have a sense that they have practised with integrity (Austin et al. 2005).

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